DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Singleton	11-14-07

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000250	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ cc: Wells Cleared 11/30/07, letter attached.	[X] Prepare reply for appropriate signature DATE DUE 11-28-07 [ ] FOIA DATE DUE _____ [ ] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

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November 9, 2007

Mr. Vastine Crouch
South Carolina Department of Health and Human Services
Office of Hearings and Appeals
PO Box
Columbia, South Carolina

RE: Ann Jagar v. South Carolina Dep't Health and Human Services

Dear Mr. Crouch:

Judge Anderson remanded this case to HHS. We appealed that order to the South Carolina Court of Appeals. That Court has determined that Judge Anderson's Order is interlocutory, so that we must obtain a final ruling from HHS before the South Carolina appellate courts will consider her appeal.

We first requested a fair hearing of the denial of adult companion services for Ann on February 1, 2006. 42 C.F.R.§ 431.244 requires HHS to make a final administrative action within 90 days of her request for a fair hearing. In *Doe v. Kidd*, the United States Court of Appeals for the Fourth Circuit upheld the right of Medicaid participants to bring an action in federal court if services are not provided with "reasonable promptness." (Case attached.) Even the dissent in that federal action held that: "Of course, if a state failed to provide a Medicaid recipient with adequate pre-deprivation due process in the form of a fair hearing, then a 42 U.S.C. § 1983 action could be brought against the state, because the Fourteenth Amendment would supply the right in these circumstances. *Cf. Goldberg v. Kelly*, 397 U.S. 254 (1970)." Please advise of the date of the rehearing on Ann's appeal. Thank you for your prompt attention to this request.

Cordially,

Patricia L. Harrison

Log: Singleton
c: Wells
app sig

cc: James Harrison
Emma Forkner
Felicity Meyers
Byron Roberts, Esq.
Steve Hamm, Esq.
Gloria Prevost
Lennie Mullis
Carol King

The South Carolina Court of Appeals

Ann Wells Jagar, Appellant,

v.

South Carolina Department of Health and Human Services, Respondent.

The Honorable Ralph K. Anderson, III
Unknown County
Trial Court Case No. 2006-AL-08-00770

ORDER

We requested memoranda from the parties regarding the appealability of the June 7, 2007 order of the Honorable Ralph King Anderson, III, from which Appellant appeals. After careful consideration of Appellant's memorandum and relevant case law, the above-captioned appeal is hereby dismissed pursuant to Montjoy v. Asten-Hill Dryer Fabrics, 316 S.C. 52, 446 S.E.2d 618 (1994) ("[W]e have consistently held that an order of [the lower court] remanding a case for additional proceedings before an administrative agency is not directly appealable."). Because we dismiss the appeal, we need not address Respondent's motion to dismiss the appeal for failure to timely serve the notice of appeal on the Administrative Law Court.

AND IT IS SO ORDERED.

Joseph M. Cureton A.J.

091907 FED4, 05-1570; Doe v. Kidd;

Doe v. Kidd
091907 FED4, 05-1570

Sue Doe, Plaintiff - Appellant,
v.
Linda Kidd; Stan Butkus; Kathi Lacy; South Carolina Department of Disabilities and Special Needs; Robert Kerr; South Carolina Department of Health and Human Services, Defendants - Appellees.

No. 05-1570

United States Court of Appeals, Fourth Circuit

September 19, 2007

Argued: May 24, 2007.

Appeal from the United States District Court for the District of South Carolina, at Columbia. Margaret B. Seymour, District Judge. CA-03-1918.

COUNSEL

ARGUED:

Patricia L. Harrison, Columbia, South Carolina, for Appellant.

Kenneth Paul Woodington, DAVIDSON, MORRISON & LINDEMANN, P.A., Columbia, South Carolina, for Appellees.

ON BRIEF:

William H. Davidson, II, DAVIDSON, MORRISON & LINDEMANN, P.A., Columbia, South Carolina, for Appellees.

Before KING and GREGORY, Circuit Judges, and Frank D. WHITNEY, United States District Judge for the Western District of North Carolina, sitting by designation.

OPINION

GREGORY, Circuit Judge:

Sue Doe, who has developmental disabilities including epilepsy, mild mental retardation, and cerebral palsy, filed this action concerning her application for Medicaid services from the state of South Carolina. The district court granted summary judgment to Appellees: the South Carolina Department of Disabilities and Special Needs, the South Carolina Department of Health and Human Services, and various officials at the helm of the two departments. Because Doe's two claims on appeal are not, as the district court found, moot, but one of her claims nonetheless fails as a matter of law, we affirm in part and vacate and remand in part.

I.

Medicaid is an optional, federal-state program through which the federal government provides financial assistance to states for the medical care of needy individuals. *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 502 (1990). Once a state elects to participate in the program, it must comply with all federal Medicaid laws and regulations. *Id.* The South Carolina Department of Health and Human Services ("DHHS") is the state agency responsible for administering and supervising Medicaid programs in South Carolina. The South Carolina Department of Disabilities and Special Needs ("DDSN") has specific authority over the state's treatment and training programs for people with mental retardation and related disabilities.

This case involves the Medicaid waiver program created by 42 U.S.C. § 1396n(c) (2000), which permits states to waive the requirement that persons with mental retardation or a related disability live in an institution in order to receive certain Medicaid services. *See generally Bryson v. Shumway*, 308 F.3d 79, 82 (1st Cir. 2002) ("[The program] allow[s] states to experiment with methods of care, or to provide care on a targeted basis, without adhering to the strict mandates of the Medicaid system."). When an individual in South Carolina applies for DDSN services, including the waiver program, DHHS first determines whether the individual is eligible for Medicaid funding. Thereafter, DDSN determines whether the individual is eligible for DDSN services and, if so, what "level of care" the individual requires. To be given the option under the waiver program of receiving services at home or in the community, rather than in an institution, individuals must first qualify for the Intermediate Care Facility for the Mentally Retarded ("ICF/MR") level of care-that is, they must meet the criteria necessary to reside in an institution like a nursing home. If approved, waiver services are provided in a variety of settings including, in order of restrictiveness: (1) a Supervised Living Program II ("SLP II"), an apartment where recipients of DDSN services live together; (2) a Community Training Home I ("CTH I"), a private foster home where a recipient of DDSN services resides with a family, one member of whom is a trained caregiver; and (3) a Community Training Home II ("CTH II"), a group home with live-in caregivers for four or fewer recipients of DDSN services. Appeals from DDSN decisions about the services, if any, it will provide are taken to a DHHS hearing officer and, after that, to the state of South Carolina's Administrative Law Judge Division.

Doe applied for services under DDSN's waiver program in July 2002, after previous requests for DDSN services had been denied in 2000 and 2001. In December 2002, without making a determination as to Doe's eligibility for the waiver program, DDSN placed Doe on the non-critical waiting list for the program. Doe appealed this decision to DHHS, adding a claim that DDSN failed to serve her within a reasonable amount of time as required by federal regulations. While the appeal was pending, DDSN moved Doe to the top of the critical waiting list for the program and developed a plan of care for her, which largely involved her living at home with her mother where she would receive various in-home services. DDSN then moved to dismiss Doe's appeal.

At the March 2003 hearing on DDSN's motion to dismiss, Doe conceded that DDSN had moved her to the top of the critical waiting list and had found her eligible for services under the waiver program earlier that month. Finding that all the appealed issues had already been resolved in Doe's favor, the DHHS hearing officer dismissed Doe's appeal. Doe did not appeal the dismissal to the state's Administrative Law Judge Division. At the end of March, however, Doe learned that she had been terminated from the waiver program. She requested a hearing on this decision and, several months later, learned that her Medicaid eligibility was to terminate as well (although it never did).

During May and June of 2003, Doe requested another hearing on the grounds that she had not yet received the services promised by DDSN in her plan of care. DDSN protested that Doe's family was not cooperating in availing themselves of those services. The DHHS hearing officer held Doe's request for

an appeal in abeyance because he considered Doe's Medicaid eligibility to be in question. Doe had also demanded immediate CTH I or CTH II residential placement (rather than continued in-home services), with a provider of her choice, because her mother, whose mental health was rapidly declining, was no longer able to care for her and was moving out of state without Doe. Doe voiced her opposition to DDSN's chosen provider for residential services, the Babcock Center, based on reports that the center had a history of abusing and neglecting residents. In response to Doe's petitions, DDSN requested proof of her critical family circumstances before taking action.

On June 9, 2003, Doe filed this action, alleging violations of the Medicaid Act, 42 U.S.C. §§ 1396-1396v, the Americans with Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat. 327 (codified as amended in scattered sections of 42 U.S.C.), and various state laws. Only two of Doe's original seven claims are at issue here: (1) a claim under 42 U.S.C. § 1983 that Appellees "have deprived Doe of Medicaid services-namely, residential habilitation services and freedom of choice of providers of those services" and (2) a claim that Appellees have "failed to provide with reasonable promptness the residential habilitation and other Medicaid services Doe has requested since 2000" in violation of § 1396a(a)(8) of the Medicaid Act. Doe sought an order directing DDSN to provide her with residential habilitation services from the provider of her choice, payment of her medical expenses, and fees and costs.

On July 2, 2003, Doe filed a motion for a preliminary injunction seeking relief substantially similar to that requested in her complaint. Doe's mother had by then left South Carolina, and her father was unable to take her into his home. Accordingly, shortly after the hearing on the motion for a preliminary injunction, DDSN placed Doe in a CTH II (group home) facility in Newberry, South Carolina, where she received respite (or temporary) services. DDSN maintains that it did so because of Doe's family circumstances, not because she was qualified for that most-restrictive setting; in fact, DDSN found Doe to need a CTH I (foster home) or SLP II (apartment) setting. Doe continues to reside at the Newberry facility. In light of Doe's placement at Newberry, the district court denied Doe's motion for preliminary injunctive relief.

Appellees then moved for summary judgment. At a hearing on the motion in September 2004, Doe explained that she had consistently requested CTH II residential habilitation services in her home community, near Columbia, South Carolina. Doe explained that she could not avail herself of these providers until DDSN approved the placement, yet DDSN would only approve a CTH I placement. Doe further explained that, although DDSN ultimately found her eligible for the waiver program and is now providing her with CTH II residential services, DDSN considers Doe's current CTH II placement at Newberry temporary and has acknowledged that Doe may be moved out of residential facilities altogether depending on the setting DDSN ultimately finds her to require. Doe therefore argued against summary judgment on the grounds that she has never received the residential services she requested by the provider she chose, nor a fair hearing on the merits, and that she is being threatened with termination of services altogether. Doe admitted at the hearing that she had already prevailed on three causes of action in her complaint.

On December 9, 2004, the district court dismissed as moot three of Doe's causes of action-including the two on appeal here-on the grounds that at the hearing on the motion for summary judgment, Doe admitted that she had already received the relief requested in those counts. The district court granted summary judgment to Appellees on Doe's remaining four counts and denied her request for attorney's fees and for reconsideration. Doe has appealed, asking U.S. to determine (1) whether her claim that Appellees have deprived her of her right to reasonably prompt residential habilitation services is moot because Appellees have provided Doe with temporary services, and (2) whether her claim that she has been denied the freedom of choice of qualified providers of Medicaid services is moot when Appellees have provided her services from a provider they, and not Doe, chose. We review the district court's

summary judgment ruling de novo, viewing the facts in the light most favorable to Doe as the nonmoving party and drawing all reasonable inferences in her favor. *See Varghese v. Honeywell Int'l, Inc.*, 424 F.3d 411, 416 (4th Cir. 2005).(fn1)

II.

Doe first appeals the district court's decision to dismiss as moot her § 1983 claim that Appellees violated the Medicaid Act by providing her with temporary respite services instead of providing her, with reasonable promptness,(fn2) the residential habilitation services approved in her 2003 plan of care. (fn3) Section 1396a(a)(8) of the Act requires that state "medical assistance . . . be furnished with reasonable promptness to all eligible individuals." Federal regulations direct state agencies to determine an applicant's eligibility for Medicaid within ninety **days** of the date of application and to "[f]urnish Medicaid promptly to recipients without any delay caused by the agency's administrative procedures." 42 C.F.R. §§ 435.911, 435.930 (2002).

Appellees argue that Doe's reasonable promptness claim is moot because Appellees began providing Doe with some services before the DHHS hearing on their motion to dismiss, and certainly before the federal court hearing on their motion for summary judgment. Moreover, Appellees argue, Doe conceded the claim's "mootness" by answering in the affirmative when the district court asked her whether she had already prevailed on this claim at the DHHS hearing.

A.

A case is moot "when the issues presented are no longer 'live' or the parties lack a legally cognizable interest in the outcome." *Powell v. McCormack*, 395 U.S. 486, 496 (1969). Where, as here, a defendant's voluntary conduct is the basis for the potential mootness, it is "well settled that [the] defendant's voluntary cessation of a challenged practice does not deprive a federal court of its power to determine the legality of the practice unless it is absolutely clear that the allegedly wrongful behavior could not reasonably be expected to recur." *Friends of the Earth, Inc. v. Laidlaw Envtl. Servs. (TOC), Inc.*, 528 U.S. 167, 189 (2000) (quotation marks and citations omitted). Here, Doe challenges Appellees' failure to provide her with residential habilitation services promptly. Viewing the facts in the light most favorable to Doe, Appellees have not yet voluntarily ceased this conduct: by their own admission, Doe is "only in this Newberry CTH II for respite [services] or until her true status is determined." J.A. 384. Therefore, the issues presented in Doe's reasonable promptness claim continue to be live and the parties continue to have a legally cognizable interest in the outcome.

A separate question is whether, by agreeing with the district court that she "prevailed" on her reasonable promptness claim (without so much as probing the district court's usage of the term "prevail" or explaining to the court the breadth of her claim, as she has done before this Court) and now seeks only attorney's fees, Doe *waived* her claim. "[F]ederal law is well-settled that waiver is the voluntary and intentional relinquishment of a known right, and courts have been disinclined lightly to presume that valuable rights have been conceded in the absence of clear evidence to the contrary." *United States v. Stout*, 415 F.2d 1190, 1192-93 (4th Cir. 1969). Doe's summary judgment and appellate briefs make clear that, whatever misstatements or understatements she made during the summary judgment hearing, she did not intend to relinquish her right to have the district court consider her reasonable promptness claim on its merits. We find that her exchange with the district court at the summary judgment hearing did not constitute a waiver of the claim.

B.

Having determined that Doe's reasonable promptness claim is neither moot nor waived, we consider whether Doe may enforce § 1396a(a)(8) through a § 1983 action. Appellees argue that she may not because Congress provided a comprehensive remedial scheme for individual state Medicaid cases, thereby precluding § 1983 as a means of review. The district court, having dismissed Doe's claim as moot, did not reach this question.(fn4)

Section 1983 imposes liability on any person who, under the color of state law, deprives another person "of any rights, privileges, or immunities secured by the Constitution and laws." Some statutes foreclose private enforcement by § 1983. In absence of an "express provision or other specific evidence from the statute itself that Congress intended to foreclose such private enforcement[,]" the Supreme Court will find "private enforcement foreclosed only when the statute itself creates a remedial scheme that is sufficiently comprehensive . . . to demonstrate congressional intent to preclude the remedy of suits under § 1983." *Wilder*, 496 U.S. at 520-21 (quotation marks and citations omitted).

Using this rule, the Supreme Court has decided that at least one provision of the Medicaid Act does not preclude individual enforcement through a § 1983 action. In *Wilder*, the Court observed that only twice has it found "a remedial scheme established by Congress sufficient to displace the remedy provided in § 1983." *Id.* at 521 (citing *Smith v. Robinson*, 468 U.S. 992 (1984), and *Middlesex County Sewerage Auth. v. Nat'l Sea Clammers Ass'n*, 453 U.S. 1 (1981)). The Court subsequently concluded that "[t]he Medicaid Act contains no comparable provision for private judicial or administrative enforcement." *Id.* It therefore allowed health care providers to sue the Commonwealth of Virginia under § 1983 for violating a provision of the statute, § 1396a(a)(13)(A), regarding reimbursement for providers. Fifteen years later, the Supreme Court cited *Wilder* when it listed the Medicaid Act as an example of a federal statute for which § 1983 is available, given that the statute does not provide a private judicial remedy for rights that have been violated. *See City of Rancho Palos Verdes v. Abrams*, 544 U.S. 113, 121-22 (2005).

Because *Wilder* involved a provision of the Medicaid Act very different from the provision at issue here, we analyze the provision Doe invokes, § 1396a(a)(8), according to the guidelines set forth in *Blessing v. Freestone*, 520 U.S. 329 (1997), to determine whether that provision creates a private right enforceable under § 1983. *See Blessing*, 520 U.S. at 342 (noting the importance of "distinguishing among the numerous rights that might have been created by [the] federally funded" program at issue). *Blessing* listed three factors that this Court must consider in determining whether a statutory provision gives rise to an individual right:

> First, Congress must have intended that the provision in question benefit the plaintiff. Second, the plaintiff must demonstrate that the right assertedly protected by the statute is not so "vague and amorphous" that its enforcement would strain judicial competence. Third, the statute must unambiguously impose a binding obligation on the States. In other words, the provision giving rise to the asserted right must be couched in mandatory, rather than precatory, terms.

Id. at 340-41 (citations omitted). Even when the presence of these three factors creates a presumption that a statutory provision gives rise to an individual right, we must consider whether Congress expressly or impliedly foreclosed a remedy under § 1983. *See Blessing*, 520 U.S. at 341. As a rule, "where the text and structure of a statute provide no indication that Congress intend[ed] to create new individual rights, there is no basis for a private suit." *Gonzaga Univ. v. Doe*, 536 U.S. 273, 286 (2002). This is so because "*rights*, not the broader or vaguer 'benefits' or 'interests,' [are to] be enforced under the authority of [§ 1983]." *Id.* at 283.

Applying the *Blessing* test to the reasonable promptness provision found in § 1396a(a)(8), we

conclude that the provision gives rise to a right enforceable under § 1983.(fn5) First, the provision is expressly intended to benefit "all" individuals eligible for Medicaid assistance, a group that, the parties do not dispute, includes Doe. *See* § 1396a(a)(8). Second, the provision is not so "vague and amorphous" that the judiciary cannot competently enforce it: the provision is clear that the standard for informing applicants of their eligibility for Medicaid services is "reasonable promptness" and the relevant federal and state regulations and manuals define reasonable promptness as forty five **days** or ninety **days**, depending on the applicant. *See, e.g.*, 42 C.F.R. § 435.911; South Carolina Medicaid Manual, cited at J.A. 242; United States Department of Health & Human Services Center for Medicaid and State Operations, Olmstead Update No: 4, at J.A. 290. Third, the provision uses mandatory rather than precatory terms: it states that plans "must" provide for assistance that "shall" be delivered with reasonable promptness. *See* § 1396a(a)(8).

Finally, the Medicaid Act does not explicitly forbid recourse to § 1983. *Wilder*, 496 U.S. at 521. Nor does the Act impliedly forbid such recourse: although the Act provides that states should adopt a fair hearing process, the Act does not contain a "*comprehensive* enforcement scheme that is *incompatible* with individual enforcement under § 1983." *Blessing*, 520 U.S. at 341 (emphases added). The statute merely requires state plans "to provide for granting an opportunity for a fair hearing before the State agency [responsible for the Medicaid program] to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness," § 1396a(a)(3), and generally states that the United States Secretary of Health and Human Services should withhold future Medicaid payments to states that fail to comply with § 1396a of the Act, *see* § 1396c. Medicaid regulations regarding the fair hearing process are more extensive, but they are not incompatible with § 1983 enforcement. *See* 42 C.F.R. § 431.200-250 (2002); *Blessing*, 520 U.S. at 348 (commenting specifically upon the "limited state grievance procedures for individuals" in the Medicaid Act); *id.* (holding that "a plaintiff's ability to invoke § 1983 cannot be defeated simply by [t]he availability of administrative mechanisms to protect the plaintiff's interests" (alteration in original and quotation marks omitted)); *accord Wilder*, 496 U.S. at 521, 523.

We note that three circuits have engaged in similar analysis of § 1396a(a)(8) and reached the same conclusion. *See Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 183 (3rd Cir. 2004) (holding that an analysis based upon *Gonzaga*, *Blessing*, and other cases "compels the conclusion that the provisions invoked by plaintiffs-42 U.S.C. §§ 1396a(a)(8), 1396a(a)(10), and 1396d(a)(15)-unambiguously confer rights vindicable under § 1983"); *Bryson v. Shumway*, 308 F.3d 79, 88-89 (1st Cir. 2002) (holding that § 1396a(a)(8) is enforceable by Medicaid recipients under § 1983); *Doe ex rel. Doe v. Chiles*, 136 F.3d 709, 714 (11th Cir. 1998) (same).(fn6) In sum, Doe may proceed under § 1983 to address any failure by Appellees to comply with the reasonable promptness provision of the Medicaid Act. Because her claim is neither moot nor waived, we vacate the district court's dismissal of her claim and remand for further proceedings.

III.

Doe next appeals the district court's decision to dismiss as moot her § 1983 claim that Appellees violated the freedom of choice provision in § 1396a(a)(23) of the Medicaid Act. That provision requires state Medicaid plans to provide that any recipient of Medicaid assistance "may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required . . . who undertakes to provide him such services." § 1396a(a)(23). In short, the provision "gives recipients the right to choose among a range of qualified providers, without government interference." *O'Bannon v. Town Court Nursing Ctr.*, 447 U.S. 773, 785 (1980) (emphasis omitted).

Doe contends that Appellees have violated this provision by refusing to approve her for placement at her choice of a CTH II facility in her home community. Doe is not mollified by her current placement at

a CTH II facility in Newberry because Newberry is not her home community and because DDSN has admitted that it placed her there only temporarily because of her family circumstances, not because of her actual need for a CTH II setting.

A.

Aside from a reference in a string citation to § 1902(23) of the Social Security Act, which is the same provision as § 1396a(a)(23) of the Medicaid Act, Doe did not cite § 1396a(a)(23) below. This appeal marks the first time Doe cites § 1396a(a)(23) specifically. Citing our rule that "issues raised for the first time on appeal are generally not considered absent exceptional circumstances," *Wheatley v. Wicomico County*, 390 F.3d 328, 334 (4th Cir. 2004), Appellees argue that this Court should not consider Doe's claim.

Doe, however, has not raised a "new theory at the eleventh hour" or made "a last-minute switch in strategy," the type of tactics this Court's rule is designed to discourage. *Id.* at 335. Below, Doe did not cite the provision of the Medicaid Act upon which she relies, but her complaint did claim that Appellees have denied her the right to choose among providers and she did argue that claim before the district court.

Moreover, the district court did "pass upon" Doe's freedom of choice claim, albeit without reference to § 1396a(a)(23). *Cf. Bakker v. Grutman*, 942 F.2d 236, 242 (4th Cir. 1991) ("Generally, a federal appellate court may not consider an issue which was not passed upon by the trial court."). At the hearing on Appellees' motion for summary judgment, the court repeatedly sought confirmation that Doe's position was that she had been denied the right to move into the CTH II facility of her choice. The court asked both parties whether Doe, Doe's treatment team, or DDSN had the right to choose among the various settings for rehabilitation services, and on what authority the parties relied for their divergent points of view. The court also inquired whether Doe had taken the proper procedural steps in requesting a specific placement by DDSN and whether the court had jurisdiction to review DDSN's determination that Doe required a CTH I setting.

We will not, therefore, refuse to consider Doe's freedom of choice claim on the ground that the question was not considered below. The record is clear that the district court considered the claim and simply determined that it was moot.

B.

We find that Doe's freedom of choice claim is not moot, but lacks merit. Doe's position is that once DDSN finds her to qualify for the ICF/MR level of care, she has a choice among the qualified providers operating the various settings that are alternatives to living in an institution (e.g., a SLP, CTH I, or CTH II setting). Because DDSN has consistently relayed to her that it will approve funding only for a CTH I setting and not a CTH II setting, Doe maintains that she is being denied her right to choose among qualified providers.

The record does not support Doe's position. As noted earlier, DDSN determines whether a recipient qualifies for the ICF/MR level of care. Then, after the recipient exercises his or her right to choose home-based and community-based services rather than ICF/MR services (that is, services in an institution or nursing home), DDSN determines which setting will meet the recipient's needs-here, Doe's need for residential habilitation services-whether it be an apartment (SLP I), a foster home (CTH I), or a group home (CTH II). DDSN must determine the services required because it must insure that it meets the needs of the recipient and that it places the recipient in the least restrictive environment, as required

by state and federal law. *See, e.g., Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999); S.C. Code Ann. § 44-20-20 (2006). The Associate Director of DDSN swore out an affidavit stating that DDSN selects the appropriate setting, a 2003 letter from the General Counsel of DDSN confirms as much, and an official from DDSN testified to the same at the hearing on Doe's motion for a preliminary injunction.

Doe has presented nothing that would contradict this evidence. Her counsel's testimonial argument that, in her ten years' experience, the recipient and his or her family, rather than DDSN, choose the appropriate setting is unavailing. The cases Doe cites for the proposition that the Medicaid Act empowers recipients to choose among CTH I, CTH II, and SLP settings-*Olmstead* and *Antrican v. Odom*, 290 F.3d 178 (4th Cir. 2002)-do not stand for that proposition. Further, Doe has not cited any statutory provision, regulation, or policy directive stating that she has a right to choose among various settings-or, as she terms it, levels of service-and she has not presented a witness to testify as much. Section 1396n of the Act merely requires states to inform participants in the waiver program of "the *feasible* alternatives, *if available* under the waiver, at the choice of individuals, to the provision of . . . services in an intermediate care facility for the mentally retarded." § 1396n(c)(2)(C) (emphases added). The only choice referred to in the Medicaid regulations Doe placed into the record is a choice between institutional or home-based and community-based services as a part of the waiver program, a choice that Doe has already been given. *See* 42 C.F.R. § 441.302(d)(2) (2002). She chose the latter. Finally, the one policy manual in the record, a 2001 United States Department of Health and Human Services update for states, supports Appellees' position that DDSN, and not Doe, determines the appropriate setting for her services. The manual states:

> A State is obligated to provide all people enrolled in the waiver with the opportunity for access to all needed services covered by the waiver and the Medicaid State plan. . . . This *does not* mean that all waiver participants are entitled to receive all services that theoretically could be available under the waiver. The State may control procedures based on the need that individuals have for services covered under the waiver. An individual's right to receive a service is dependent on a finding that the individual needs the service, based on appropriate assessment criteria that the State develops and applies fairly to all waiver enrollees.

J.A. 289-90. Thus, we are left to conclude that DDSN selects the appropriate setting for the provision of waiver services. Once a setting is selected, recipients have a choice of qualified providers among those who offer services in the setting DDSN has approved; this is the freedom of choice that 1396a(a)(23) guarantees.

In this case, at the time of the summary judgment proceedings, DDSN had consistently evaluated Doe as needing a CTH I setting.(fn7)Therefore, Doe had a right to choose among providers of CTH I services, not a right to choose to live in any CTH II setting she wished. *Cf. Kelly Kare, Ltd. v. O'Rourke*, 930 F.2d 170, 178 (2d Cir. 1991) (reading *O'Bannon* as holding that a Medicaid recipient's freedom of choice rights are necessarily dependent on a provider's ability to render services). Doe currently resides in a CTH II facility at Newberry but, as stated above, DDSN made this placement because her case became an emergency one, not because DDSN determined that a CTH II setting was appropriate. *Cf. O'Bannon*, 447 U.S. at 786 ("[W]hile a patient has a right to continued benefits to pay for care in the qualified institution of his choice, he has no enforceable expectation of continued benefits to pay for care in an institution that has been determined to be unqualified.").

Section 1396a(a)(23) "is clearly drawn to give Medicaid recipients the right to receive care from the Medicaid provider of their choice, rather than the government's choice." *Silver v. Baggiano*, 804 F.2d 1211, 1217 (11th Cir. 1986), *abrogated on other grounds by Lapides v. Bd. of Regents of Univ. Sys. of Ga.*, 535 U.S. 613 (2002). Appellees have not violated this provision: Doe has a choice of providers, so

long as the provider operates a CTH I facility, the kind of setting DDSN has determined would constitute the least restrictive environment for Doe. We therefore affirm, but on different grounds, the district court's dismissal of Doe's freedom of choice claim. *See Eisenberg v. Wachovia Bank, N.A.*, 301 F.3d 220, 222 (4th Cir. 2002) (observing that we "can affirm on any basis fairly supported by the record").

C.

Because Doe's freedom of choice claim fails as matter of law, we do not find it necessary to decide whether § 1396a(a)(23) confers a private right on individuals that may be enforced under § 1983. Even assuming Doe may proceed under § 1983 to enforce § 1396a(a)(23), Appellees are entitled to summary judgment on Doe's claim. *Cf. Burks v. Lasker*, 441 U.S. 471, 475-76 (1979) (holding that the "question whether a cause of action exists is not a question of jurisdiction, and therefore may be assumed without being decided").

IV.

For the foregoing reasons, we affirm the district court's grant of summary judgment in Appellees' favor on Doe's freedom of choice claim, vacate the district court's grant of summary judgment on Doe's reasonable promptness claim, and remand for further proceedings consistent with this opinion.

AFFIRMED IN PART, VACATED IN PART, AND REMANDED

WHITNEY, District Judge, concurring in the judgment in part and dissenting in part:

I concur in the result reached in Part III of the majority opinion, because at the very least Doe's "freedom of choice" claim fails as a matter of law, notwithstanding additional doubts I have concerning whether such a claim is even justiciable. I respectfully dissent from the result reached in Part II of the majority opinion, and instead would find Doe's "reasonable promptness" claim to be moot, or would affirm the district court on the alternative basis that Doe has no private right of action under 42 U.S.C. § 1983.

I.

Doe's principal claim on appeal centers around the question of whether the State's decision to provide her with "respite" services in a qualified CTH II group home (instead of "residential habilitation" services in a similar type of setting) comports with the requirement that it furnish "assistance" to "eligible individuals" with "reasonable promptness." 42 U.S.C. § 1396a(a)(8). In order to ensure that there is a live case or controversy for the district court to resolve on remand, I would need to be satisfied of two things: first, that Doe is "eligible" to receive the type of "assistance" she seeks to be provided; and second, that Doe is receiving, or at risk of receiving, a level of "assistance" that does not meet the level of "assistance" to which she is entitled by law. Because neither of these conditions can now be satisfied, I would hold that Doe lacks standing to prosecute her "reasonable promptness" claim and consequently would find that claim to be moot.

A.

To place this issue in proper context, four foundational principles must be laid at the outset of the analysis. First is the principle that Doe's asserted "right" to have certain Medicaid services furnished with reasonable promptness is *wholly contingent* on Doe being deemed eligible for and in need of those

services. *See* 42 U.S.C. § 1396a(a)(8) ("[A]ssistance shall be furnished with reasonable promptness to all *eligible* individuals." (emphasis added)).

Second is the related principle that Medicaid eligibility, once found to exist, does not give rise to a perpetual right to Medicaid-funded support. Doe's level of services may be adjusted (and even terminated) to take into account bona fide changes in her needs or eligibility, provided that she is accorded due process prior to any adverse action. *See* 42 C.F.R. § 435.930(b) ("The agency must . . . furnish Medicaid regularly to all eligible individuals *until they are found to be ineligible*." (emphasis added)); 42 C.F.R. §§ 431.220, -.241 (providing for a fair hearing on the request of an aggrieved Medicaid recipient).

Third is the principle that the state not only has the right to consider how changed circumstances impact Doe's eligibility, but that it also has an affirmative duty to conduct periodic reevaluations to that end. In order to facilitate an efficient allocation of scarce Medicaid resources to those individuals most critically in need, federal regulations require that states "redetermine the eligibility of Medicaid recipients, with respect to circumstances that may change, at least every 12 months." 42 C.F.R. § 435.916(a). Likewise, with respect to services rendered under the Medicaid MD/RD Waiver program (in which Doe participated), South Carolina's Waiver agreement with Health and Human Services obligates it to "provide for an evaluation (and periodic reevaluations, at least annually) of [a recipient's] need for [an intermediate level of care]." (J.A. at 275.)

Last is the principle that sympathy or charity are not sufficient bases for a State to continue providing Medicaid to someone who does not satisfy the very stringent criteria for eligibility. Once a recipient is determined to be ineligible after being afforded a fair hearing, "the agency *must* . . . *discontinue services* after the adverse decision." 42 C.F.R. § 431.232(d) (emphasis added).

B.

With these four principles in mind, Doe's personal story bears recounting. The State has never deemed Doe as meeting the criteria for mental retardation (J.A. at 264), and it has consistently treated with skepticism her claim of "related disability" based on her cerebral palsy and epilepsy (J.A. at 261). However, because she appeared to be experiencing "an acute exacerbation of her seizures which may not continue to be severe or lifelong," DDSN left open the door to Doe's provisional admission into the MR/RD Waiver program. (J.A. at 261.)

Also, around this time, Doe's mother (who was her primary care giver) began experiencing psychiatric episodes that limited her ability to provide adequate care for Doe. (J.A. at 263.) Accordingly, DDSN began providing residential habilitation services to Doe in the form of in-home daytime health care and living assistance,(fn1) which were intended to ease the burden on Doe's mother without uprooting Doe from her family. (J.A. at 265.) This solution was also intended to comply with the State's obligation to serve Doe in the least restrictive environment appropriate for her functional limitations. (J.A. at 210, 250.)

The mental health of Doe's mother deteriorated significantly over subsequent months and DDSN officials determined that Doe was facing an "imminent risk" of losing her primary care giver due to incapacity. (J.A. at 267.) Accordingly, the less restrictive environment of in-home care was no longer a viable option and the State promptly sought to make available out-of-home residential habilitation services in a CTH I (foster home) setting. (J.A. at 267.) This did not satisfy Doe and her family, however, who insisted that she be placed in an even more restrictive CTH II (group home) setting. Ultimately, the State capitulated to Doe's demands and placed her on an interim basis in the Newberry

CTH II facility, until the dispute over a suitable permanent placement could be sorted out.

Although Doe was receiving exactly the level of care she desired once she was moved to the Newberry CTH II facility in July 2003 (this being the reason that the district court dismissed Doe's "reasonable promptness" claim as moot), the State chose to classify these services as "respite" rather than "residential habilitation." Apparently, it is in the subtle distinction between "respite" and "residential habilitation" that the majority finds a live claim. However, unlike the majority, I find no basis to take issue with the State's classification choice since, by the majority's own definition, "respite" services are furnished "due to the regular care giver's absence or need for relief," *supra* note 3, which describes the very facts of this case giving rise to the decision to place Doe in a group home setting.

Moreover, I find no basis to take issue with the inherently "temporary" nature of these "respite" services, since the State should not have to impute upon itself a long-term obligation to keep Doe in a setting that it believes is more restrictive than necessary to meet her needs. Indeed, the majority correctly determines in Part III.B. that DDSN is not legally obligated to keep Doe in a CTH II facility simply because that is her preference, and is free to move Doe to a less restrictive setting more appropriate to her needs. Yet in Part II.B., the majority paradoxically finds that the State has not ceased its allegedly illegal conduct for the sole reason that Doe is "only in the Newberry CTH II for respite [services] or until her true status is determined." (J.A. at 384.) The incongruity of these two conclusions could not be more manifest: How can Doe's temporary placement in a CTH II facility until a more appropriate placement is identified be indicative of the State's continuing failure to provide required Medicaid services with reasonable promptness, when at the same time we hold that permanent placement at a CTH II home is not required by law and that her permanent placement should be determined based upon her particular needs and eligibility status?(fn2)

At the time of the district court's judgment, the legal battle centered around whether Doe ultimately would be placed in a CTH II (group home) facility, in conformity with her wishes and those of her family, or whether she would be placed in a CTH I (foster home) setting, in conformity with the approved Plan of Care in effect at the time. (J.A. at 337, 348-49.) In order for there to have been a live controversy surrounding Doe's "reasonable promptness" claim, at least one of these possible outcomes would have to result in the denial of her right to be furnished Medicaid services with reasonable promptness. The majority tells U.S. today that the placement advocated by the State (CTH I) would not result in any impermissible denial of Medicaid services, since Doe has no legal right to self-determine her level of care and DDSN had determined that she was entitled to only a CTH I level of care. And the alternative placement (CTH II) would, in the words of her attorney, provide Doe with "the placement that we have requested" (J.A. at 338), even if, from DDSN's perspective, such a placement is intended to be temporary or even wholly gratuitous. In other words, no matter what the outcome, Doe would have gotten either what she wanted or what she was entitled. Thus, nothing in the record upsets the district court's finding that Doe's "reasonable promptness" claim was moot.

C.

The district court's dismissal of Doe's "reasonable promptness" claim should not, therefore, be vacated simply on the fact that Doe was at risk of being displaced from a CTH II facility upon determination of her "true status." However, the factual landscape has changed somewhat since the district court's judgment. We now know that the State intends not only to remove Doe from a CTH II facility where she does not belong, but also now intends to discontinue her residential habilitation services altogether, because an investigation into her "true status" has confirmed that she does not meet the stringent eligibility criteria for ICF/MR intermediate level of care. Yet far from providing any additional support for Doe's claim against the State for unreasonably delaying or withholding services, this turn of events squarely forecloses her claim, since standing to assert a "reasonable promptness"

violation necessarily presupposes the recipient's continuing eligibility for the services denied.

Here we pick up again where we last left off from Doe's story. Doe's 2003 Plan of Care (J.A. at 170-88) was in effect for a period of approximately one year, after which it was superseded by a new Plan of Care in May 2004 (J.A. at 113-15). This is consistent with the legal requirement, detailed above, that each recipient's eligibility be reevaluated annually. Following the 2004 evaluation, Doe was approved for a consecutive year of eligibility for "residential habilitation" services (i.e., through Doe's next level of care evaluation scheduled for early 2005).

Shortly thereafter, in or around June 2004, Doe's care givers began to realize that Doe would frequently "initiate[ ] fake or pseudo seizure[s]," which they interpreted to be "manipulative behavior" that created "an unnecessary dependence on others." (J.A. at 116.) This reasonably caused DDSN to question whether Doe might have "the capacity for a greater degree of independence," (J.A. at 116), especially in light of the fact that a sudden "exacerbation" in the severity of her epilepsy was a primary factor in finding that Doe was medically qualified for residential habilitation services under the Medicaid MR/RD Waiver program in the first place (J.A. at 261). This prompted DDSN to begin documenting Doe's true seizure frequency and adaptive functioning abilities, which together suggested that her limitations were not so severe as to justify ICF/MR intermediate level of care. (J.A. at 299-300.)

Notwithstanding this new information, as well as a favorable judgment in the district court, DDSN allowed Doe to finish out the term of her May 2004 Plan of Care in a CTH II group home setting. However, in April 2005, following her annual level of care evaluation earlier that same year, Doe was notified by DDSN that she no longer satisfied the eligibility criteria for ICF/MR intermediate level of care, and that as a consequence her Medicaid MR/RD Waiver services would be terminated effective May 7, 2005, unless she timely requested a fair hearing, which she did. On June 5, 2006, following five **days** of hearings, a DHHS Hearing Officer upheld the determination of ineligibility in a thoughtful and comprehensive 34-page administrative order. (J.A. at 297-330.) That decision is now on appeal to the South Carolina Administrative Law Court, and the State is continuing to provide "respite" services until Doe has exhausted her appeals. (*See* Rule 28(j) filing dated August 6, 2007.)

The sequence of events just described must remove all doubt that, as of today, Doe's "reasonable promptness" claim is moot, because she lacks any basis to assert that she is currently eligible to receive the particular services that she claims are being denied.(fn3) Doe's theory of the case is built on the premise that her entitlement to residential habilitation services is contained within her March 2003 Plan of Care. However, that Plan of Care is no longer of any relevance because it was superseded by the May 2004 Plan of Care. And Doe cannot now point to the May 2004 Plan of Care as the source of her entitlement to residential habilitation services because that Plan of Care would have expired in May 2005, and her eligibility for these services has never been extended by a more current Plan of Care (for the reason, of course, that Doe has been found ineligible). The majority leaves me baffled as to how, upon remand, the district court should go about deciding whether Doe is now entitled to prospective relief(fn4) based on an alleged entitlement to services found in a Plan of Care that expired years ago, while turning a blind eye to the fact that recent state administrative proceedings have resulted in a determination that Doe is not even qualified to be a Medicaid recipient.

The only document in the record showing that Doe has a present entitlement to Medicaid services is a recent Administrative Order of the DHHS Hearing Officer, filed with this Court pursuant to Fed. R. App. P. 28(j), determining that Doe should continue to receive "respite" services, but not "residential habilitation" services, pending the outcome of the administrative appeal of her termination from the Medicaid MR/RD Waiver program. To me, it seems entirely appropriate that the State Medicaid agency, having found Doe to be ineligible for comprehensive "residential habilitation" services, would fund only necessary "respite" services pending the administrative law judge's decision, since by the majority's own

definition "respite" is intended to be a temporary gap-filling measure and not a long-term solution. And since Doe is in fact being provided "respite" services at this time, she has no basis to claim that the State is failing to furnish the services for which she is eligible with the required degree of promptness.

In sum, because Doe cannot, as of today, make a showing that she is entitled to residential habilitations services in the first place, there can be no live controversy surrounding the derivative issue of whether those services have been furnished in a reasonably prompt manner. Moreover, even if we assume that Doe ultimately will prevail in her administrative appeal and that her eligibility for "residential habilitation" services will be reinstated, I have no reason to believe that DDSN would at that point defy the order of a state administrative law judge and refuse to place Doe promptly in an appropriate facility that provides those services. Thus, this is no longer (if it ever was) a case that is capable of repetition yet evading review. Therefore, even if I agreed with the majority that Doe's "reasonable promptness" claim was not moot at the time of the district court's judgment, I would now dismiss her appeal as moot, or at the very least remand to the district court for additional findings with respect to how these post-judgment developments at the administrative level impact her standing.

II.

Because I believe that Doe's "reasonable promptness" claim is moot, I would not reach the thorny issue of first impression in this circuit of whether 42 U.S.C. § 1983 provides Doe with a remedy for alleged violations of 42 U.S.C. § 1396a(a)(8). Nonetheless, because the majority does reach this question in Part II.B. of the lead opinion, I feel compelled to explain why I believe the majority's holding is legally incorrect.

With respect, I do not believe that the three-factor test of *Blessing v. Freestone*, 520 U.S. 329 (1997), should control our analysis in light of the Supreme Court's more current opinion in *Gonzaga Univ. v. Doe*, 536 U.S. 273 (2002), which was explicitly intended to resolve considerable uncertainty stemming from the Court's prior opinions on the subject.(fn5) In the *Gonzaga* opinion, the Supreme Court reemphasized a fundamental principle that had become obscured in cases like *Blessing*: Nothing "short of an unambiguously conferred right" will "support a cause of action brought under § 1983." *Id.* at 283. The Court then went on to hold that the judicial function is exclusively one of determining what "Congress intended" by enactment of the statute - a task which, like other matters of statutory interpretation, is to be resolved in the first instance by looking to the "text and structure" of the relevant statute. *Id.* at 285-86.

In finding an absence of congressional intent to create a privately enforceable right under FERPA, the *Gonzaga* Court considered as relevant three specific features of the statute: It "contain[ed] no rights creating language;" it had an "aggregate, not individual, focus;" and it "serve[ed] primarily to direct the Secretary of Education's distribution of public funds." *Id.* at 290. Additionally, the Court considered whether Congress "chose to provide" an alternative "mechanism" to private litigation "for enforcing those provisions." *Id.* at 289. Importantly, the Court considered the availability of administrative review to be directly relevant to the issue of congressional intent not to create a privately enforceable right, independent of the secondary issue of whether those procedures are so incompatible with private enforcement as to displace a remedy under § 1983. *Id.* at 290 & n.8.

Like FERPA, the Medicaid statute was enacted pursuant to the congressional spending power, and its primary purpose is to direct the appropriate executive branch officer (in this case, the Secretary of Health and Human Services) in the distribution of appropriated funds to accomplish the stated purpose. The Act's preamble speaks directly to these purposes, providing in relevant part as follows:

> For the purpose of enabling each State . . . to furnish (1) medical assistance . . . and (2) rehabilitation and other services . . ., there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance.

42 U.S.C. § 1396. Due to the nature of spending power enactments as such, we begin our analysis with a presumption that Congress has not intended to create a private remedy. *See Pennhurst State School & Hospital v. Halderman*, 451 U.S. 1, 28 (1981) ("In legislation enacted pursuant to the spending power, the typical remedy for state noncompliance with federally imposed conditions is not a private cause of action for noncompliance but rather action by the Federal Government to terminate funds to the State."); *accord* 42 U.S.C. § 1396c (providing that the remedy for State noncompliance with any provision of section 1396a is the withholding of federal funds).

The very next section of the act, codified at 42 U.S.C. § 1396a, sets forth several criteria that a "State plan for medical assistance" must satisfy in order to gain federal approval and enable the Secretary to disburse federal funds. Among these requirements is the provision upon which Doe purports to base her "reasonable promptness" claim:

> A State plan for medical assistance must -
>
> (8) provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals . . . .

42 U.S.C. § 1396a(a)(8). However, this provision lacks the kind of "rights-creating language" that *Gonzaga* requires as a basis for private enforcement, and it has an "aggregate, not individual, focus." Specifically, the statute speaks only to what the state plan must generally "provide" for in order for the state's Medicaid program to qualify for federal funding. Thus, like FERPA, section 1396a(a) is written "in terms of institutional policy and practice," and does not specifically address "individual instances" of noncompliance. *Gonzaga*, 536 U.S. at 288. Indeed, with respect to the daily administration of state Medicaid plans, Congress chose to require only that states "comply substantially" with the requirements of section 1396a in order to remain eligible to receive federal funding. *See* 42 U.S.C. § 1396c. Similarly, the *Gonzaga* Court singled out FERPA's "comply substantially" provision as evidence that Congress did not intend to confer a privately enforceable right. *Gonzaga*, 536 U.S. at 288.

At best it can be said, as the majority holds in its *Blessing* analysis, that Doe falls within the class of persons that section 1396a(a) is intended to benefit. I do not contend otherwise, and certainly do not mean to imply that Congress would require the states to craft their Medicaid plans to protect certain individual interests without regard to whether these provisions are actually followed in practice. However, it is simply not sufficient that Doe "falls within the zone of interest that the statute is intended to protect," because it is "only violations of *rights*, not *laws*, which give rise to § 1983 actions." *Gonzaga*, 536 U.S. at 283 (emphasis in original). And nothing in the text or structure of the statute indicates that Congress intended to create judicially vindicable individual rights under section 1396a(a). Rather, the Medicaid statute in essence defines the parameters of a voluntary, pseudo-contractual relationship between the Federal government on the one hand and the states on the other. *Cf. Pennhurst State School*, 451 U.S. at 17. The statute is directed in the first instance to the Secretary of Health and Human Services, setting forth the conditions upon which federal money under his stewardship is to be released in furtherance of an important public policy. The statute also addresses the states, albeit indirectly, insofar as it imposes on them certain conditions which attach to the receipt of federal money (though it does not categorically mandate state compliance insofar as states remain free to reject federal

funding). But individual Medicaid recipients like Doe are at best third-party beneficiaries to this arrangement, and as such are essentially "stranger[s]" to the underlying bargain. *Blessing*, 520 U.S. at 349 (Scalia, J., concurring). Indeed, nowhere is the statute directly concerned with "whether the needs of any particular person have been satisfied," *id.* at 343, and in fact those types of individual determinations are specifically left to the states as the designated administrators of Medicaid, *see* 42 U.S.C. § 1396a(a)(5). Because the whole focus of the Medicaid statute is on the "regulated [entity] rather than the individuals protected," I must conclude that there is "no implication of an intent to confer rights on a particular class of persons." *Alexander v. Sandoval*, 532 U.S. 275, 289 (2001) (internal quotation marks and citation omitted).

Any lingering doubt that Congress might have intended to create a new battery of individual rights enforceable by section 1983 is in my mind dispelled by the fact that Congress has made other provision for redressing individual deprivations under section 1396a(a). Aside from the threat of loss of federal funding if the state's practices do not meet the substantial compliance threshold, Congress has sought to ensure the protection of individual recipients' interests by requiring that each state plan for medical assistance provide for an "opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness." 42 U.S.C. § 1396a(a)(3). Thus, Congress specifically contemplated circumstances where a Medicaid recipient has been denied the benefit of reasonably prompt agency action, and specifically provided that recourse should be available in the form of a fair hearing before the agency. Where Congress has seen fit to establish an administrative mechanism to deal with individual grievances arising in the daily administration of a program as massive and complex as Medicaid, it seems to me a reasonable presumption that Congress would have deemed the administrative remedy both appropriate and adequate to address the problem.(fn6) Thus, any inference that Congress might have intended to create individual rights which are judicially actionable under 42 U.S.C. § 1983 seems weak indeed. *Gonzaga*, 536 U.S. at 289-90.

If Congress had intended to subject the countless Medicaid decisions made by state agencies each day to the scrutiny of the federal judiciary, I would expect to find clear and unmistakable language in the statute stating as much. In the absence of such language, I cannot be so cavalier as the majority in imputing to Congress an intent to allow dissatisfied Medicaid recipients to have their routine grievances aired in federal court under the auspices of 42 U.S.C. § 1983, and instead would exercise the cautious skepticism toward the recognition of new "rights" by implication which the Supreme Court adopted in the now-controlling *Gonzaga* opinion. Because I cannot meaningfully distinguish between the provisions of the Medicaid Act relevant to Doe's claims and the analogous features of FERPA with respect to which the *Gonzaga* Court found no privately actionable rights, I would hold, on the authority of *Gonzaga* alone, that 42 U.S.C. § 1983 does not provide Doe with a remedy for the State's alleged violations of section 1396a(a)(8)'s "reasonable promptness" standard.

For these reasons, I respectfully dissent from Part II of the majority opinion and concur only in the judgment as to Part III.

Footnotes:

1. There have been state administrative proceedings in Doe's case since she noted her appeal to this Court. We do not consider the outcome of these proceedings because the outcome has no effect, preclusive or otherwise, on the issues Doe raises before this Court.

2. Given the paucity of references to "reasonable promptness" in Doe's appellate brief, Appellees argue that Doe has abandoned this issue on appeal. We are able to discern Doe's claim from her brief

and therefore disagree.

3. Respite services and residential habilitation services are distinct. Respite care, which Doe is currently receiving, "is furnished on a short term basis due to the regular care giver's absence or need for relief." *Benjamin H. v. Ohl*, No. 3:99-0338, 1999 WL 34783552, at *2 (S.D. W. Va. July 15, 1999). Residential habilitation, which Doe has requested, "helps recipients with the skills needed for daily living, such as eating and performing personal hygiene, household chores, and food preparation. It also focuses on the social and adaptive skills which enable an individual to avoid institutionalization." *Id.* at *3.

4. The district court did decide that § 1396a(a)(30), a freedom of choice provision that Doe does not raise in this appeal, does not create an individual right enforceable under § 1983.

5. Section 1396a(a)(8) provides:

> A State plan for medical assistance must-
>
> (8) provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals . . . .

6. We have once before declined to dismiss a § 1983 action seeking to enforce § 1396a(a)(8), among other provisions of the Medicaid Act, but we did so on the unrelated ground of sovereign immunity. *Antrican v. Odom*, 290 F.3d 178, 191 (4th Cir. 2002).

7. The March 2003 plan of care that Doe, Doe's family, and DDSN officials developed noted her desire to be in "a residential setting location within the Columbia area chosen by the family" and to have United Cerebral Palsy, a CTH II provider, as her provider. J.A. 179. But the plan did not indicate whether Doe would be sent to a CTH I or CTH II facility and, if so, who would select between the two types of settings. The recommendation in the plan of care merely stated that Doe "will receive residential habilitation from a DDSN approved provider." J.A. 179.

1. If, as the majority holds in Part III.B. of the lead opinion, DDSN is vested by law with the right to "select[ ] the appropriate setting for the provision of waiver services," then it was not a violation of either 42 U.S.C. §§ 1396a(a)(8) or (23) for the State to provide in-home residential habilitation as opposed to out-of-home residential habilitation, and Doe's lawsuit was meritless even at its inception.

2. Ironically, Doe has not been removed from a CTH II facility to-date, and so the "respite" services that the majority worries are so ephemeral in nature have been continuously provided by the State for more than three years, with all indications being that the State will continue to provide them until all legal proceedings (both here and at the State level) have been concluded. Today's holding proves the adage that "no good deed goes unpunished" by using the State's indulgence in allowing Doe to stay in the setting of her choice pending resolution of her legal challenges to provide support for the conclusion that the State's alleged failure to provide Medicaid services with reasonable promptness is ongoing. This dangerous precedent now encourages states to do the worst possible thing: deny the provision of Medicaid services to those whose eligibility is in question pending exhaustion of administrative appeals and final resolution of judicial review.

3. The parties' briefs focus on whether these state administrative decisions should be given preclusive effect pursuant to *Univ. of Tennessee v. Elliott*, 478 U.S. 788 (1986). This line of argument

misses the point. The state administrative actions are not collateral estoppel in the present case not only because there has not yet been a final judgment (on account of Doe's appeal to the State Administrative Law Court), but more importantly because there is no identity of issues: the issue before the State administrative decisionmakers is whether Doe is eligible for Medicaid ICF/MR services at all, while the issue before U.S. is whether Doe has been furnished with reasonable promptness the services for which she has been deemed eligible. Nonetheless, the State administrative decisions must be factored into our standing analysis, because maintaining a legally cognizable interest in the outcome of this lawsuit presupposes that Doe's eligibility has not changed in a way that would render the relief sought nugatory.

4. Any prayer for retroactive, compensatory relief would be barred by the Eleventh Amendment. *See Lynn v. West*, 134 F.3d 582, 587 (4th Cir. 1998).

5. *Id.* at 278 ("[O]ur [prior] opinions in this area [have not been] models of clarity. We therefore granted certiorari . . . to . . . resolve any ambiguity in our own opinions."); *see also id.* at 282-83 (limiting the import of the *Blessing* test).

6. Of course, if a state failed to provide a Medicaid recipient with adequate pre-deprivation due process in the form of a fair hearing, then a 42 U.S.C. § 1983 action could be brought against the state, because the Fourteenth Amendment would supply the right in these circumstances. *Cf. Goldberg v. Kelly*, 397 U.S. 254 (1970).

Log # 000250

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

November 30, 2007

Emma Forkner
Director

CERTIFIED MAIL

Honorable Ralph K. Anderson, III
Administrative Law Judge
Administrative Law Court
1205 Pendleton Street
Edgar A. Brown Building, Suite 224
Columbia, SC 29201-3755

Re: Appeal Matter of Ann W. Jagar v. SCDHHS
Appeals' Case # 06-MISC-007
ALC Docket No. 06-ALJ-08-0770-AP

Dear Judge Anderson:

In accordance with your Order of June 7, 2007, please find enclosed the Amended Decision in the above referenced matter.

If there are any questions, or if I may be of further assistance, you may contact me at 803-898-2600.

Sincerely,

Vastine G. Crouch, Director
Division of Appeals and Hearings

Cc: Byron R. Roberts, Esquire, Attorney for Respondent
Patricia L. Harrison, Esquire, Attorney for Appellant

FINAL ADMINISTRATIVE DECISION (AMENDED)

Denying the Appeal of Ann Jagar

brought by her Attorney, Patricia Harrison

In the Matter of Ann Jagar vs. DHHS

Appeal Case #: 06-MISC-007

Hearing Date: May 9, 2006 Hearing Officer: James S. Guignard

I. BACKGROUND

This **Amended Final Administrative Decision** is issued as a result of an Order by the Honorable Ralph King Anderson, III, Administrative Law Judge, dated June 7, 2007, stemming from an appeal of the original Final Administrative Decision (originally dated August 29, 2006) to the Administrative Law Court under Docket Number 06-ALJ-08-0770-A.

In his Order, Judge Anderson upheld the Hearing Officer's Final Administrative Decision in most respects, but he remanded the case to Respondent for issuance of an Amended Order on two issues:

1. to reflect whether Petitioner was entitled to a *de novo* review at the Hearing Officer level; and

2. for more specific findings of fact regarding any special circumstances leading to a determination of eligibility for Adult Companion Services.

This **Amended Final Administrative Decision** is now issued as required by the aforementioned Order of the Administrative Law Judge.

See **Section IV HEARING** for consideration of a *de novo* hearing and **Section VIII SPECIFIC FINDINGS OF FACT** for additional findings of fact.

II. JURISDICTION

This case is adjudicated under the authority granted by the South Carolina General Assembly to the South Carolina Department of Health and Human Services (DHHS) to administer various programs and grants (See, *e.g.*, S.C. Code Ann. 44-6-10, *et seq.*). This appeal has been conducted pursuant to the provisions of the Appeals and Hearings regulations of the South Carolina Department of Health and Human Services (Reg. 126-150, *et seq.*) and the South Carolina Administrative Procedures Act (S.C. Code Ann. 1-23-310, *et seq.*).

It appears to me, the undersigned Hearing Officer, that there is a serious question of my jurisdiction in Petitioner's case. I find that Petitioner has not fully exhausted her appellate remedies through the Department of Disabilities and Special Needs (DDSN) as specified in the attachment to the letter from Dr. Butkus, dated February 15, 2006, which was the basis for the instant appeal.

At the same time, I further find that Petitioner's appeal is more an attack on the laws and regulations of the provision of services under the state's Department of Disabilities and Special Needs and under the federal Medicaid program than it is an appeal of a decision by DHHS. As a Hearing Officer for DHHS, I do not have authority to rule on matters of DDSN policy and administration which do not fall under the purview of DHHS. In this regard, I conclude that Petitioner would be better served by mounting a direct court challenge to the underlying statutes and their method of administration.

Nonetheless, in fairness to Petitioner's Attorney, who had spent many hours and much effort preparing for this hearing, I elected to proceed on the narrow issue of Petitioner's eligibility for Adult Companion Services while she is receiving other services under Medicaid. Any other issues must be appealed

directly to DDSN or challenged in the appropriate venue.

III. ISSUES

Petitioner's Attorney raised five issues in total:

1) Denial of Adult Companion Services
2) Bundling of Services
3) Free choice of providers
4) Failure to protect health and welfare
5) Failure to follow and monitor the Plan of Care

Petitioner claims, among other things, that DHHS must make available to her any and all services under the provisions of the Section 1915(c) waiver.

Respondent stipulated that it would make available those services to which Petitioner is entitled, but contended that it is not required to provide duplicative services.

Having made the determination that I do not have authority to direct services of DDSN that are not within the Medicaid frame-work, I ruled during the course of the hearing, and so affirm in this **Amended Final Administrative Decision,** that only one issue is properly before me, to wit:

> Did the South Carolina Department of Health and Human Services (DHHS) (Respondent) commit any errors of fact or law in adhering to a determination by the South Carolina Department of Disability and Special Needs (DDSN) to deny Adult Companion Services to Petitioner?

IV. HEARING

At a hearing on May 9, 2006, I studied the documents presented along with the testimony of the witnesses and passed upon their credibility; I considered the weight of the evidence; and I considered the burden of proof required of the parties (that being a preponderance of the evidence). Having fully reviewed the matter herein, I make the Findings of Fact and Conclusions of Law set forth below.

Question Concerning *de novo* Hearing

South Carolina provides for hearings at the agency level, not local evidentiary hearings, thus 42 CFR 431.205(b)(1) applies:

> 42 CFR 431.205 Provision of hearing system.
>
> (a) The Medicaid agency must be responsible for maintaining a hearing system that meets the requirements of this subpart.
> (b) The State's hearing system must provide for--
> **(1) A hearing before the agency** (emphasis added); or
> (2) An evidentiary hearing at the local level, with a right of appeal to a State agency hearing.

I find that this hearing at the agency appellate level is not a *de novo* hearing of the underlying facts, as there is no provision in South Carolina Medicaid law for such. In South Carolina, the agency level hearing is on the facts which prompted the decision.

Inasmuch as the hearing in this matter is one by the agency and is a review of the appropriateness of agency decisions based on facts then available, not new facts, I conclude that there is no absolute right to a *de novo* hearing; thus there was no requirement to notify Petitioner concerning a *de novo* hearing.

V. EXHIBITS OFFERED

Petitioner's Attorney handed up 33 exhibits. Respondent objected in general to their admission on the basis that few, if any, had any relevance to the matter on appeal.

Having narrowed the issue to one of Petitioner's eligibility for Adult Companion Services while she is receiving other services under Medicaid, I limited Petitioner's Attorney's evidentiary offerings to only those exhibits on that point.

I note for the record Petitioner's Attorney's continuing objection to my evidentiary ruling.

Petitioner's Attorney indicated a willingness to proffer some of the excluded exhibits and I directed her to do so in writing with reasons for desiring their admissibility. No such proffers have been received. I also requested that Petitioner limit her introduction of exhibits to those directly relating to the matter before me and I indicated that if she disagreed with my exclusions, she had the right to take a further appeal to the Administrative Law Court.

VI. MOTION TO ACT AS WITNESS

At the outset of the hearing, Petitioner's Attorney moved to be allowed to testify as a witness familiar with Petitioner's situation. Respondent objected, citing South Carolina Appellate Court Rule 407, Rules of Professional Conduct (RPC), specifically Rule 3.7.

I take judicial notice of Rule 3.7, a copy of which is attached hereto and

made a part hereof as Hearing Officer's Exhibit 1.

I denied Petitioner's Attorney's motion to be allowed to testify as a witness on the basis of RPC Rule 3.7, and further on the grounds that there were other witnesses who could testify on Petitioner's behalf and that ample time had been allowed for preparation and presentation of those witnesses.

VII. EVIDENCE AND TESTIMONY

1. On February 21, 2006, the Appeals Division received a request from Petitioner's Attorney for a fair hearing in the matter of a denial by DDSN of Adult Companion Services. (See copies in the case file, incorporated herein by reference.)

2. By letter dated February 27, Petitioner and other parties were notified by me, the undersigned Hearing Officer, that the hearing was scheduled for April 18, 2006. Notice to Petitioner's Attorney was by letters sent via Registered Mail with return receipt requested and via First Class Mail. (A copy of this notice and proof of mailing is included in the case file and is incorporated herein by reference.)

3. Subsequent to this notice, it was determined that the original date of the hearing conflicted with a summons for jury duty for a necessary party, and through letters, telephone conversations, and e-mail, all parties agreed on a new hearing date of May 9, 2006.

4. All parties were notified of the date and place of hearing. Appearing for Petitioner was Patricia L. Harrison, Esquire, Authorized Representative and attorney for Petitioner. Appearing for Respondent were the following:

Byron R. Roberts, Esquire, Counsel for DHHS
James R. Hill, Jr., Esquire, Counsel for DDSN
Lynn Lugo, Special Needs Contractor for DDSN
Jennifer Duell, DDSN
Cynthia Prevette, Babcock Center
Kara Lewis, DHHS (observer)
George Maky, DHHS (observer)
Vicki Coleman, DDSN (observer)

5. All parties were duly sworn. Petitioner's Attorney and Respondent's agents reviewed Petitioner's file in an effort to frame the issues. (*See* **ISSUES** above.)

Exhibits

6. Respondent's agents testified and offered into evidence the following exhibits:

Respondent's Exhibit 1 – Single Plan of Care dated 02/10/05.
Respondent's Exhibit 2 – SC DDSN MR/RD Waiver Manual
Respondent's Exhibit 3 – Blue Book Tab 5: Dr. Butkus's letter dated 02/15/06
Respondent's Exhibit 4 – Petitioner's handwriting exemplar dated 05/08/06

7. Petitioner's Attorney offered extensive exhibits, 33 in number, which filled two large ring binder notebooks. Only those exhibits deemed pertinent by me were admitted and are attached hereto.

Petitioner's Exhibit 1 – Red Book Tab 4: SC MR/RD contract with CMS

Petitioner's Exhibit 2 – Red Book Tab 2: 42 CFR 441.301 Waiver Request

Petitioner's Exhibit 3 – Red Book Tab 7: Olmstead Update #4 01/01/01

(Note: Counsel for DHHS objected to the admission of Petitioner's Exhibit 3 and it was admitted only for clarification and reference.)

Petitioner's Exhibit 4 – Red Book Tab 3: Medicaid Manual 4-442.3, paragraph 4

Petitioner's Exhibit 5 – Blue Book Tab 8: Incident Report

(Eventually ruled not relevant and therefore not admitted.)

8. I admitted four other documents:

Hearing Officer's Exhibit 1 – Copy of RPC Rule 3.7

Hearing Officer's Exhibit 2 – Section 1915(c) Waiver Format

(Not attached hereto due to its size; copy in the appeals file or available from DDSN.)

Hearing Officer's Exhibit 3 – Blue Book Tab 4: Ms. Harrison's letter to Dr. Butkus dated 02/01/06

Hearing Officer's Exhibit 4 – Blue Book Tab 6: Ms. Harrison's letter to Mr. Pursley dated 02/21/06

Testimony

9. Ms. Lugo, Petitioner's Case Supervisor at Richland-Lexington Disabilities and Special Needs Board (contractor for DDSN), testified that Petitioner is at Supervised Living Program (SLP) Level II and that the formulation of the Plan of Care (Respondent's Exhibit 1) considered all elements of treatment necessary for the physical, mental, and emotional well-being of Petitioner.

She further testified that Petitioner was receiving the following services at Commanche Trail, a residential unit of Babcock Center

1. Residential Habilitation
2. Behavioral Support
3. Pre-vocational training services
4. Psychological services
5. Psychiatric services
6. Health care
7. Prescribed drugs
8. Adult Dental Services
9. Adult Vision Services
10. Occupational Therapy

10. Ms. Lugo testified that Residential Habilitation encompassed a number of socialization elements, including church attendance, beauty parlor appointments, visiting family members, shopping expeditions, individual instruction, and classes at Lake View School and the West Columbia Work Activities Center.

11. According to Ms. Lugo, Petitioner's attendance at the Work Activities Center ceased when Petitioner refused to return to the center after an altercation with another person. Additionally, arrangements were made for Petitioner to attend activities at another location, but she refused and requested Adult Companion Services (ACS) instead.

12. Ms. Lugo testified that Petitioner's family employs Family Preservation Services, Inc., a private agency, to provide a companion for Petitioner and that Petitioner's Plan of Care was amended to add Adult Companion

Services at the request of Petitioner and Petitioner's family, even though Ms. Lugo believed the request would be denied inasmuch as Petitioner was already receiving such services as part of her SLP II habilitation. Eventually, the addition of ACS was in fact denied.

13. Jennifer Duell, DDSN, testified that she oversees all waivers for care under treatment programs for Mental Retardation and Related Disabilities (MR/RD) in South Carolina. She further noted that she oversees implementation of the waiver program throughout the state.

14. She testified that not all services are required to be offered to all recipients, but that all recipients must meet eligibility requirements based on established need. She testified that the level of care provided in each case is determined by the level of need.

15. Ms. Duell testified that Petitioner is classified as a person at Level II of the Supervised Living Program (SLP), requiring care 24 hours a day, 365 days a year. She also contrasted SLP I as covering a person who does not need constant supervision, and who could live independently with the provision of minimal assistance.

16. Ms. Duell explained that any assessment of needs must reflect the person's actual therapeutic needs, not necessarily that person's wants, citing the Waiver Format (Hearing Officer's Exhibit 1), Page 3, Item 13: "An individual written plan of care will be developed by qualified individuals for each individual under this waiver. This plan of care will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care."

17. Ms. Duell testified that the waiver itself provides for ". . . home and community based services to individuals who, but for the provision of such services would require the following levels of care, the cost of which could be reimbursed under the approved Medicaid State Plan: Intermediate Care Facility for mentally retarded or persons with related disabilities (ICF/MR) . . ." Hearing Officer's Exhibit 1, Page 1, Item 2.

18. Ms. Duell made reference to MR/RD Waiver Manual (Respondent's Exhibit 2 – MR/RD Waiver Manual for Service Coordinators and Early Interventionists), which she explained is a summary of the requirements of the waiver document. In response to questions from Petitioner's Attorney, she explained that DDSN does not have regulations *per se*, but that the Manual specifies what is allowable under the waiver.

19. She further testified that services that duplicate other services, or that over-lap the elements of another service, are not allowed, as the waiver does not provide for the provision of duplicative services. She cited as an example Chapter 10 from the Manual in which the discussion of Adult Companion Services clearly prohibits a person from receiving ACS while receiving Residential Habilitation unless that person resides in a SLP I facility, and then only when **not** receiving Residential Habilitation, and only on the basis of where one hour of non-habilitation service equals one hour of ACS.

20. For ACS to be considered, ". . . The need for the services must be documented in the recipient's plan . . ." Furthermore, the Manual clearly shows ". . . there must be clear documentation that the therapeutic goals addressed by the companion cannot be addressed through habilitation."

21. Ms. Duell testified that Petitioner's request for ACS was denied as being duplicative of services provided under Residential Habilitation and the request was not fully documented in her plan of care.

22. Ms. Privette, Residential Coordinator at Babcock Center, testified that she is Petitioner's service supervisor. She indicated that Petitioner responds well to her environment at Babcock Center; keeps her room clean, neat and well-decorated; enjoys activities at the Center and off-campus; and that she is capable of conducting some banking transactions for herself, albeit with help from the Babcock Center staff.

23. She also testified that Petitioner's daily activities include habilitation assistance by staff of a varying nature, including grocery store shopping (where Petitioner has learned how to select proper foods), paying bills, reinforcement with homework assignments from attending classes off-campus, and hands-on assistance with making lists and writing notes.

24. As an example of habilitation assistance already being provided to Petitioner, Ms. Privette produced a sample of letters and numbers written by Petitioner and admitted as Respondent's Exhibit 4.

VIII. SPECIFIC FINDINGS OF FACT

1. I find that not all services are required to be offered to all recipients, and for specific services to be provided, the recipient must meet eligibility requirements based on established need and specific facts.

2. I find that the level of care provided in each case is determined by the level of need, which is independently established under the program's

guidelines, not by the mere desires of the recipient.

3. I find that Petitioner is classified as a person at Level II of the Supervised Living Program (SLP), requiring care 24 hours a day, 365 days a year.

4. I find that Petitioner is and has been provided extensive services under the category in which she has been assessed, to wit: Level II in the Supervised Living Program. I find that these services include:

1. Residential Habilitation
2. Behavioral Support
3. Pre-vocational training services
4. Psychological services
5. Psychiatric services
6. Health care
7. Prescribed drugs
8. Adult Dental Services
9. Adult Vision Services
10. Occupational Therapy

5. I further find that these services include extensive socialization services, including church attendance, beauty parlor appointments, visits with family members, shopping expeditions, individual instruction, and classes at Lake View School and the West Columbia Work Activities Center.

6. I find that Petitioner ceased to attend the West Columbia Work Activities Center on her own decision based on an alleged incident at that site, and I find further that Petitioner refused to avail herself of alternate activities at a different location, but that she continued to receive all of the

aforementioned other socialization services at her place of residence.

7. I find that Petitioner requested Adult Companion Services be added to her Plan of Care, but that after appropriate review, this request was denied as being duplicative of services being offered in her residential setting.

8. I find that a reasonable interpretation of Medicare law is reflected in the MR/RD Waiver Manual.

9. I find that in order for Adult Companion Services to be considered, the recipient's Plan of Care must clearly document the therapeutic goals desired and must show that these goals are not being met in the residential habilitation setting.

10. I find that the burden rests on Petitioner to show special circumstances which would justify the addition of Adult Companion Services to her present regimen of services provided under her residential treatment program.

11. I find that the only issue raised by Petitioner that might be considered special circumstances was the question of alleged assaults. From the testimony, I find one alleged incident of assault is relatively remote in time (2002) and that the other resulted in Petitioner being offered activities at an alternative site.

IX. CONCLUSIONS OF LAW

1. A Hearing Officer has the authority, among other things, to: direct all procedures; issue interlocutory orders; schedule hearings and conferences;

preside at formal proceedings; rule on procedural and evidentiary issues; require the submission of briefs and conclusions of law; call witnesses; recess, continue, and conclude any proceedings; dismiss any appeal for failure to comply with the requirements of this sub-article. South Carolina Department of Health and Human Services, Chapter 126, "Administration" R.126-154, §44-6-90, S.C. Code, 1976, as amended.

2. I conclude that the Section 1915(c) waiver (the MR/RD waiver) is intended "to provide home and community based services to individuals who, but for the provision of such services, would require the following level of care – Intermediate Care facility for mentally retarded persons and persons with related disabilities, the cost of which could be reimbursed under the approved medical state plan." The only services covered by the waiver and over which I have jurisdiction are services designed to keep the recipient out of an ICF/MR facility and I conclude that this threshold has been met by the habilitation services provided by DDSN to Petitioner at the Babcock Center.

3. I conclude that Petitioner is ineligible to receive Adult Companion Services while she is receiving residential habilitation absent extremely special and limited circumstances.

I base this conclusion on the evidence presented and a thorough reading of the waiver and the MR/RD Waiver Manual and their inherent prohibition of duplication of services.

See specifically Petitioner's Exhibit 3, page 5, Section 3, paragraph 3, "This does not mean *(sic)* that all waiver participants are entitled to receive all services that theoretically could be available under the waiver."

I further conclude that Petitioner had not met the burden of proof as to "special and limited circumstances." (See below.)

4. I conclude that under the enumerated and defined services included in the waiver, the term "habilitation" includes socialization and the improvement of adaptive skills "necessary to enable the individual to reside in a non-institutional setting" (*i.e.*, but for the provision of such services the individual would need to be in an ICF/MR facility).

In this vein, I further conclude Adult Companion Services also include socialization services to individuals too impaired to be assisted under habilitation and that those services must be therapeutic in nature. I also conclude that these therapeutic goals must be included in the Plan of Care, and those services must not be solely diversional in nature.

5. I conclude that Petitioner is receiving these services in her category of Level II of the Supervised Living Program (SLP) and that these services are being lawfully and adequately provided in meeting her defined level of care.

6. I conclude that an appropriate person could withdraw from residential habilitation and request Adult Companion Services instead of such residential care. In order for this result to obtain, those companion services (provided in lieu of residential services) must be appropriate and must be necessary to keep that person out of an ICF/MR Facility. These services could not be covered under the waiver unless they are embodied in the Plan of Care with appropriate therapeutic goals. DDSN offered to do this in Dr. Butkus's letter of February 15, 2006, but Petitioner has not

exhausted this remedy, thus I conclude that she does not meet the aforementioned standard of appropriateness.

7. I conclude that Petitioner, through her Attorney, has failed to meet the burden of proof necessary to demonstrate that Adult Companion Services are required in her case, either as a matter of her identified needs or as a matter of her health and welfare. I further conclude that Petitioner has not met the burden of proof to show that the services she is receiving do not meet the level of established need or that they are not appropriate in her case.

8. I conclude that the possible issue of personal protection raised by Petitioner's attorney, while troubling, is not dispositive of this matter in that one incident of alleged assault is remote in time (2002) and the other was resolved by the offer of activities at an alternative location. I further conclude that the provision of Adult Companion Services may not, in and of itself, have prevented the incidences of alleged assaults, or would be sufficient to prevent such incidents in the future.

9. I further conclude that Petitioner and her Attorney have failed to exhaust administrative remedies in all other elements of the purported appeal. While I make no conclusions on the merit of the other matters raised by Petitioner's Attorney in her letters to Dr. Butkus (Hearing Officer's Exhibit 3) and to Mr. Pursley (Hearing Officer's Exhibit 4), I conclude that they are inappropriate for the instant hearing.

10. I conclude that DDSN has special expertise in the area of Mental Retardation and Related Disabilities (MR/RD); therefore DDSN should be

granted great deference as to the determination of appropriate needs of a patient and the services to address these needs.[1]

11. Based on my review of the facts produced in this matter, I conclude that Respondent has presented sufficient and credible evidence in support of its position and I further conclude that Petitioner has not produced evidence of any mistake of law or fact, thus the decision by **DHHS is AFFIRMED**.

X. ORDER

Based on the Findings of Fact and Conclusions of Law, **this appeal is hereby DENIED**;

AND IT IS SO ORDERED in this Amended Final Administrative Decision,

this 19th **day of** November, **2007**
at Columbia, South Carolina

for James S. Guignard
Hearing Officer

[1] The decisions of an Agency with respect to interpreting its own Regulations are entitled to great deference. Callie J. White v. SCDHEC & Rudolph Meggett; 04-ALJ-07-0357-CC, December 30, 2005, citing Dunton v. South Carolina Bd. of Examiners in Optometry, 291 SC 221, 223, 353 S.E.2d 132, 133 (1987). Brown v. SCDHEC, 348 SC 507, 560 S.E.2d 410 (2002)