IN THE STATE OF SOUTH CAROLINA

In The Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT
Carolyn C. Matthews, Administrative Law Judge

Case 10-ALJ-08-0774-AP

Richard Stogsdill ..... Appellant,

v

South Carolina Department of Health and Human Services ..... Respondent.

REPLYL BRIEF OF APPELLANT

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1. **The risk of institutionalization is not speculative.** The Hearing Officer made a erroneous finding that Richard is "relatively assured of continuing in a non-institutional setting" because his "parents are in close proximity" and he has "a lot of assistive equipment and services." R. 12. At footnote 1, Respondent informs this Court that respite hours were increased "due to a parent's illness." This Court may take judicial notice that Richard's father died on June 2, 2013 (after a long illness which prevented him from providing any care for his son and leaving his mother as the sole income earner in the home). Parents of non-disabled children have no obligation to support adult children after they reach age 18. Respondent has cited no law which would obligate aging parents of waiver participants to provide care to adult children who have profound disabilities. As is evident from recent events in Richard's life, being dependent upon care provided by an aging parent places him at risk of institutionalization.

Like the court found in *Moore v. Cook*, Richard has shown in this case that services were reduced to "shift more of the burden to her (in this case 'his') caregiver." *Moore v. Cook*, 2012 WL 1380220 (N.D.Ga. April 20, 2012). He has also presented evidence that shows that Respondent and DDSN made these changes to force waiver participants into more profitable congregate programs. The South Carolina District Court and the Fourth Circuit Court of Appeals have both ruled that it is not necessary for a disabled person to wait until he is institutionalized before exercising his rights. *Peter B. v. Sanford*, 6:10-cv-007670JMC-BHH, Entry 71 (S.C.D.C. November 24, 2011) adopted in Entry 95, (S.C.D.C. March 7, 2011) and *Pashby v.Delia*, 709 F.3d 307, 322 (4th Cir. 2013). See Appellant's Initial Brief at page 12 and 13. The lower court erred in concluding that Richard will not be forced into a DDSN sheltered workshop or a DDSN residential program if his services are cut. DDSN congregate programs have been found to place the lives of people like Richard at risk of great harm. See P&A "Unequal Justice" report at R.

289, the South Carolina Legislative Audit Council audit of DDSN at R. 446 and Respondent's own review of DDSN Medicaid waiver programs at R. 231. Respondent has failed to provide evidence from a single source with personal knowledge of his condition to support its claims that Richard's needs could be met safely in a congregate settings, and Richard has provided evidence to the contrary.

Richard's treating physician, Dr. Joseph, and his provider of DDSN psychological supports, Lennie Mullis, provided sworn statements that Richard would be placed at great risk of harm in a DDSN congregate program, where he would be totally unable to defend himself. R. 780 and 783. Ms. Mullis described why "It is foreseeable that Richard's mental and physical health would decline if he were required to attend a workshop." R. at 781. Mullis stated from personal experience that there are individuals at these workshops who exhibit aggressive behaviors and that Richard would not be able to defend himself. R. 781. Dr. Joseph's statements affirmed that he would "expect to see a marked decline in both his physical and mental condition because of the trauma he would experience from being segregated from his community and being forced to live in a congregate setting." R. 785. Dr. Joseph reported that Richard's socialization skills would regress and he would "feel stigmatized" if forced to attend a congregate segregated workshop. R. 785. Richard requires hands-on assistance with ambulation and positioning, which would place him at risk of decubitus ulcers if not provided the attention he needs. R. 783.

Richard's mother served on the Board of Directors of the local DSN Board and had personal knowledge of how the program in Kershaw County was operated. She testified that Richard would be assigned to sit at a table with "people who have no control over what they do and so they have behavior issues." R. 65. According to her personal experience, people get assaulted at the workshop. Id. As the Tenth Circuit held in *Fisher v. Oklahoma Health Care*

Authority: "The Plaintiffs may succeed on their ADA claim if the Defendant's action places them at a "high risk" of premature entry into institutional isolation." 335 F.3d 1175, 1185 (10th Cir. 2003). In *Pashby v. Deliah*, the Fourth Circuit recently joined the Third, Ninth and Tenth Circuits in holding that entry into an institution is not a prerequisite and that forcing persons who live at home into adult care homes could constitute a violation of the ADA. Id. At 314. Respondent's finding that Richard's claim of risk of institutionalization is not supported by any evidence in the record, it is arbitrary and capricious and this Court should rule that it was legal error for Respondent to require him to enter an institution before exercising his rights under the ADA and *Olmstead v. L.C.* 527 U.S. 581 (1999).

2. The hearing officer's finding that Respondent has not violated the ADA was legal error and the administrative appeals process is not his exclusive remedy. This Court should confirm the ruling repeatedly made by the Hearing Officer during the hearing that he does not have jurisdiction to rule upon Richard's claim for violation of the ADA. 24, 25, 26 and 27. In so ruling, the Hearing Officer held "I am not competent to make judgments that are more appropriately before the Supreme Court" and he would not allow Appellant to offer testimony in support of Richard's ADA claim or claims brought under *Olmstead.* R. 27. He actually threatened to terminate Richard's hearing if he attempted to pursue his ADA claims. R. 26 and 51. The parties were allowed to brief the ADA/Olmstead issue after the hearing, but that denied Appellant his right to present witnesses and to cross examine the State's witnesses about violations of the ADA and *Olmstead.* R. 51 to 54. If the Hearing Officer had jurisdiction over ADA claims, then his ruling was a violation of 42 C.F.R. 431.242, which requires the State to allow appellants to "establish all pertinent facts and circumstances," to "present an argument without undue interference" and to "question or refute any testimony or evidence, including

opportunity to confront and cross-examine adverse witnesses." Contrary to his ruling at the hearing that he would shut it down if Appellant attempted to argue violation of the ADA, the order concluded that "It appears to me that the new Waiver is not violative of the Olmstead integration mandate..." R. 13 and 14. The Order did state, however, that "those legal arguments may be preserved for further review, if sought." R. 14. Richard has sought review of those claims in the federal court and he requests a ruling from this Court confirming that the "fair hearing" process is not his exclusive remedy for violations of the ADA and Olmstead. Richard requests a ruling that nothing in the state administrative process or the record in this case limits him in his pursuit of enforcing his ADA claims in the federal court.

In *Doe v. Kidd I*, the Fourth Circuit recognized that the Medicaid Act "does not contain a 'comprehensive enforcement scheme' that is incompatible with individual enforcement under § 1983." 501 F.3d 348, 356 (4th Cir. 2007). The Administrative Procedures Act specifically provides at § 1-23-380 that not only is judicial review available upon exhaustion of administrative remedies available within the agency, but that "This section does not limit utilization of or the scope of judicial review available under other means of review, redress, relief, or trial de novo provided by law." In *Doe v. Kidd I*, the Fourth Circuit held that "There have been state administrative proceedings in Doe's case since she noted her appeal to this Court. *Supra* at fn. 1. 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." In *Peter B. v. Sanford*, reached the same conclusion in addressing the same reductions at issue in this case:

> Lastly, the Court would acknowledge that the plaintiffs have commenced administrative actions concerning these same services, which are at varying stages of resolution. Most notably, it appears that Peter's appeals have been denied. [See Doc. 70.] The Court will address the effect of these proceedings to the extent relevant, but, as will be discussed, finds them to be largely non-dispositive or otherwise non-preclusive of this Court's

> consideration. R&R, 6:10-cv-00767-JMC -BHH, Entry 71 at page 2 (D.C.S.C. November 24, 2010).

Richard requests a ruling from this Court that the DHHS administrative appeals process does not provide a "comprehensive enforcement scheme" and that these proceedings do not in any way restrict his right to pursue private actions in the federal court.

3. The State has not met it burden of proving a fundamental alteration. The Hearing Officer erred as a matter of law by shifting the burden to the Appellant to prove that providing the services he requests would not cause a fundamental alteration in the State's system. *Olmstead v. L.C.*, 527 U.S. 581 (1999). The State has the burden of proving that it would fundamentally alter its programs to provide the services Richard requests. The Hearing Officer committed legal error by shifting the burden of proof of fundamental alteration to Richard. Respondent's argument that a simple claim of general acceptance of budget reductions is sufficient to prove a fundamental alteration is contradicted by the Fourth Circuit ruling in *Pashby* that:

> Although we understand that the North Carolina legislature must make difficult decisions in an imperfect fiscal climate, the public interest in this case lies with safeguarding public health rather than with assuaging North Carolina's budgetary woes.

Id. The Hearing Officer blindly accepted Respondent's claims that the 2010 reductions were necessitated because of state budget reductions, but the State failed to produce credible and probative evidence to support its "budget reduction" theory to overcome its own financial documentation in the 2010 waiver application. The Hearing Officer did not even consider Appellant's evidence showing that this explanation is not true. It is unexplained why the exhibits Appellant introduced were not identified as such in the record. R. 2. The Hearing Officer ruled that budget reductions were the true reason for the reductions and that any review of the State's argument must be decided by "a much higher review panel than this one, and as a matter of comity, I will defer to that body or some higher authority." R. 13. He accepted, without question,

Respondent's claims that the reductions resulted from "recent budget reductions." R. 14. The hearing officer reviewed "the record and the Decision in the previous case." But he refused to include those records in the record transmitted to the ALC. R. 13.

It is significant that the position that Respondent now takes is a reversal of its arguments in the Post-Hearing Brief filed on Juy 13, 2009, where DHHS informed the Hearing Officer that: "The Respondent has not raised any cost concerns." Respondent's Brief at 6. But that Brief was purged from the record. Respondent admitted in that Brief that South Carolina had opted to consider only the aggregate, not the individual cost, in renewing the waiver document. 42 C.F.R. 441.354. (That regulation describes how cost limitations may be calculated, so that some individuals may have significantly greater costs than the cost of institutional care.) Respondent argued in that Brief that any diversion of funds was irrelevant - yet the purported lack of funding was the only justification Respondent provided to CMS for amending the waiver in 2010. Respondent's Brief to this Court at 2 contains website containing waiver document documenting that the reason given for the 2010 amendments was budget reductions.

The Hearing Officer ignored undeniable evidence showing that DHHS projected that it would spend more than $61 million more in 2010 than it spent in 2009, when there were no caps on services. R. 697 to 700. While Respondent's application was pending at CMS, DDSN asked the South Carolina Budget and Control Board to spend more than $7 million of "excess funds" to purchase real estate, to pay a contractor and to split the kitty with that Board, all without approval by the General Assembly. The Hearing Officer's blind acceptance that the reason for reducing Richard's services and finding that Respondent's claim was "a believable statement in these economic times" is not supported by anything more than the agency's explanation, which is contradicted by its own financial records. According to DHHS's own calculations, the average

cost per waiver participant, when there was no cap on services and physical therapy, occupational therapy and speech therapy were provided under the waiver program was $36,209 per year while the projections DHHS submitted to CMS for the waiver that went into effect on January 1, 2010 was $44,232.12 per participant per year. R. 697 and 699.

The 2010 waiver amendments (1) increased program costs drastically and (2) resulted in four times the number of individuals being forced into ICF/MR facilities in 2010 than 2009. Not only were more waiver participants left with no "choice" but this most restrictive and most expensive setting, but the average number of days in confinement in ICF/MR facilities was projected to increase by 50% Not only that, but DHHS increased the rate it paid to DDSN and its local DSN Board for ICF/MR respite from $157.30 per day to $270 per day under the amended waiver. R. 697 and 699. DHHS has fallen far short of meeting its burden of showing that providing the services Richard needs to remain at home where he has always lived would result in a "fundamental alteration" in the State's program. Respondent has failed to prove that providing the services Richard's physician orders (which needs may change, from time to time) would not be a reasonable modification in its programs.

Before the January 1, 2010 amendments there were no caps on services provided to MR/RD Medicaid waiver participants and people like Richard could get the therapies they need to continue to be able to do things like turn a page of a book or hold a cup. R. 68. His mother testified at the 2010 hearing that:

> At this point he cannot use his right hand to do anything. He used to be able to. He used to be able to hold a cup. He used to be able to use his thumb on the computer. He used to be able to use it to kind of push things on a spoon if he was feeding himself. He used to be able to hold a book with one hand and turn the pages with the other and that's all gone.

R. 68. It is important for this Court to consider that Richard is a young man with normal intelligence, who can communicate his thoughts and needs when provided with the supports he needs. Judge Hendricks recognized in *Peter B. v. Sanford* how terrorizing the thought of being institutionalized is for persons who have cognitive ability to understand what that threat means. "His experience in an institution would come with all of the adjunct humiliations that violation of personal space and person imposes." 6:10-cv-007670JMC-BHH, Entry 71 (S.C.D.C. November 24, 2011). The "fundamental alteration" in the program as it relates to Richard is that he health will decline until he requires hospitalization or institutional care, at tremendous costs to taxpayers for medical care as his health deteriorates.[1]

The State has failed to prove how its conscious indifference to Richard's needs will save money and the waiver application documents that the costs - even without considering additional medical costs - are greater than they were before 2010.[2] Dr. Joseph opined that Richard's health has been good because of the care he has received in his current living arrangement. R. 783. He stated that without the hands-on assistance with ambulation and positioning he receives at home, he would develop decubitus ulcers requiring expensive hospitalizations. R. 783. According to Dr. Joseph, Richard has been able to avoid hospitals because of the "hands on assistance with his daily exercise regime which includes gait training." Id.

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[1] Richard's hand and arm have "drawn up" since he left school and his "right leg draws up much more" to the point that his legs have to be strapped to a wheelchair. R. 68. Richard has fortunately experienced only one decubitus ulcer so far, and these costly sores"come(s) up fast then takes forever to go away." R. 68. The State's witness who testified that she evaluated Richard's need for respite services was familiar with decubitus ulcers, but she could not remember whether that risk was "actually considered or discussed" in reaching her decision that he needs fewer respite hours than he received in 2009. R. 41.

[2] The Medicaid waiver does not pay for physicians visits, laboratory services, hospitalization and other basic medical services which are covered by "regular" or "State Plan" Medicaid. See Detailed Claims Report at 552.

When Richard filed his appeal in 2009, the State had operated the MR/RD Medicaid waiver program for decades without arbitrary caps on home based services. Waiver participants were able to use their services on an annual allocation basis. Exhibit 5 attached to brief filed on July 7, 2009. Services were provided based on the medical needs of the individual waiver participant, without individual caps on services. The fact that the services Richard's physician ordered exceed the average cost in an institution is not a fundamental alteration in the MR/RD Medicaid program. In Respondent's 2006 audit and again in the audit conducted by LAC, the State recognized that, historically, the cost of serving some medically complex waiver participants has far exceeded the average and that "outlier" funds had been approved by CMS to pay for their care. R. 263. The "Bands" are averages and some individuals cost significantly less, with others costing significantly more. Id. The average cost of care in a DDSN institutional program was $320 a day in 2008, or $116,800 per year, according to DDSN's annual accountability report. R. 795. The cost of providing the care Richard's physician has ordered would be only $14,243.20 more than the average cost in a DDSN Regional Center. Because the "Bands" DDSN pays providers is an average, some waiver participants are high needs individuals like Richard, paying the additional cost for Richard to remain at home would is reasonable and does not even require a "modification" in the State's program. They already pay more than Richard has requested for some waiver participants CMS found these costs to be allowable. R. 264. An audit by DHHS of DDSN's 2003 expenditures reported the cost a single Medicaid waiver participant who lived in a Community Training Home staffed with around the clock care for one person was $162,975 per year. R. 264. DHHS reported "The costs of care for a limited number of consumers in the MR/RD waiver program are high, but we found no indications that the waiver program does not meet required financial conditions." R. 265. The

costs for these individuals was high because, like Richard "of enhanced staffing needs, and the cost to serve these individuals would be high regardless of where they were placed." R. 266.

The federal government has thrown its full support behind enforcement of *Olmstead* and the ADA. In *Marlo v. Cansler*, the United States Department of Justice filed an amicus brief in a case when the State of North Carolina announced that it was imposing caps on services that placed to plaintiffs at risk of institutionalization. R. 733. Plaintiffs Marlo M. and Durwood W. in that case lived in apartments in the community, where the State of North Carolina provided care and supervision twenty-four hours a day. R. 736, 748 and 749. The federal court granted an injunction prohibiting North Carolina from imposing the proposed caps on services. *Marlo M. v. Cansler,* 679 F.Supp.2d 635 (E.D.N.C. 2010). In considering whether providing the services Richard's physician determines he needs to remain in the community would impose a fundamental alteration in the State's programs, this Court should consider the fact that 69.7% of the costs of Medicaid services are paid by the federal government, which has determined that Congress intended that the rights of people like Richard be enforced to prevent their being segregated and isolated in congregate facilities. R. 232. The cost to the State (in state funds) to provide all of the services Dr. Joseph ordered would only be about $4,000.00 more a year than the State pays for the average resident to live in a DDSN Residential Center.

The issue of home based services costing more, on a case by case basis, has been addressed by other courts. In *Radaszewski v. Garner*, the Second Circuit ruled that a young man with disabilities similar to Richard's was allowed to proceed in his ADA claim in the Illinois federal district court where he required 24 hour private duty nursing costing significantly more than institutional care would have cost. 383 F.3d 599 (2004). In that case, the State attempted to reduce Eric's services when he turned 21, but his physician, like Richard's physician,

determined that Eric's condition would be "seriously medically compromised, which would lead to many hospitalizations" if he were placed in an institution. Id. at 603 to 604. The cost of 24-hour private-duty nursing care at home was estimated in *Radaszewski* to be between $15,000 and $20,000 per month, which was three to four times greater than the exceptional care rate the State had approved for him. Id. at 614. In reversing the lower court, the Second Circuit held that the State had failed to prove a fundamental alteration in its program to serve Radaszewski in his home. Id. 615. A similar result was reached in Texas in *Ryan Knowles v. Adelaide Horn*, where the State attempted to force Ryan into an institution, because the cost of his care at home after he reached age 21 exceeded the cost of institutional care. Case No. 3:08-CV-1492 (N.D.Tx. February 10, 2010). The district court granted Knowles motion for summary judgment for his ADA claim, finding that the State was obligated to pay the costs of his continued care at home, despite those costs exceeding the average cost of institutional care. Id. As in Richard's case, his treating physician opined that his health and safety could not be protected in an institution. Id.

Not only has DHHS reduced home based services through the guise of "budget reductions," the agency fundamentally altered the way in which waiver participants were allowed to use their allocated hours in 2010, which has resulting in forcing waiver participants into congregate programs that profit DDSN and its local DSN Boards. Before the waiver amendments, Richard could utilize his allocated hours as needed (across a one year period). After the waiver amendments, waiver participants have to "use them or lose them" (as allocated by DDSN by the month or week) and could not carry over any unused hours during the year. For example, under the caps imposed by Respondent in 2010, no waiver participant can receive more than 240 hours a month of respite. Prior to the waiver amendments, waiver participants could use the annual allocation of respite hours as necessary to meet the needs of the individual and the

family (who has no legal obligation to take care of an adult child, but does so out of love for the disabled person). In the event that an aging parent had a stroke and spent weeks in the hospital, under the "old" waiver, there was an option that allowed the family to use the number of annually allocated hours to meet this crisis. It is important that this Court recognize that when Respondent placed a cap on respite in 2010, **only those respite services provided in the community were capped. The "new" waiver does not contain limitations for respite services provided in DDSN institutions**. Under the new waiver, individuals who need more than 240 hours of respite during one month (10 days) are provided no other option but to submit to admission into an ICF/MR for respite. Once a community placement is lost, it is very difficult to restore those supports. As the Department of Justice noted in its Amicus Brief in *Marlo:* "...even a temporary placement may lead to dire consequences." R. 748. The Legislative Audit of DDSN and the Unequal Justice report confirms the danger South Carolina waiver participants face in DDSN programs. Arbitrary rules, such as those imposed by Respondent in 2010 make it difficult, if not impossible, to care for an aging parent's own needs while caring for their loved one in the home. This lack of flexibility leads to institutionalization...and profits for DDSN.

Because Richard does not request a fundamental alteration in the rules that were applicable when he filed his appeal (i.e. no caps on services, with hours based on documented medical necessity), this Court should issue an order prohibiting DHHS from fundamentally altering waiver participants' rights to use their services as they need them throughout the year and fundamentally altering the program by placing arbitrary caps on services. Respondent should be ordered to provide the services Richard's physician orders within ten days of receipt of the order and should be held in contempt for any violation of that order. Because of the contemptuous behavior exhibited by Respondent in failing to comply with the 2009 Order, it is

expected that more delays and arbitrary denials would result without court oversight. Respondent should be ordered to provide the services ordered by his physician. The burden should be shifted to Respondent to prove that any service ordered by Richard's physician are not medically necessary, with a hearing and a final determination by the Administrative Law Court (ALC) required within 90 days.

4. Respondent's failure to give "appropriate weight" to the Opinion of Appellant's attending physician" violates the mandate of the United States Supreme Court. The Hearing Officer admitted in his Order that he "reviewed the record and the Decision in the previous case, *[Petitioner] v. SCDHHS,* 09-MISC-017." But his Order ignores the fact that DHHS was bound by Hearing Officer Loomis' order to consider Dr. Joseph's 2009 affidavit in determining his need for PCA services, that the number of hours of respite ordered by Dr. Joseph was appropriate and that the agency have again failed to have persons "fitted (as by training or experience)" for the care planning purpose. November 23, 2009 Order. It is black letter law that "The opinion of a responsible treating physician in determining the appropriate conditions for treatment ought to be given the greatest of deference."[3] Justice Kennedy said that in his concurring opinion in *Olmstead* at 610.

Instead, Respondent attempts to challenge the sworn affidavit of Dr. Joseph by gobbledegook arguments like "There is no evidence in the Record as to whether Dr. Joseph provided any information before he prepared his Affidavit on May 10, 2010, the day before the

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[3] Juxtaposed against this mandate of the United States Supreme Court, Respondent asks this Court to give more weight to a recent opinion issued by a lower state court in California in *Mendocino Community Health Clinic v. State Department of Health Care Services* than it gives to the opinion of the treating physician who has provided medical care for Richard for more than two decades. 215 Cal. App. 4th 1471, 155 Cal. Rptr. 3d 923, 927 (Cal.App. 3d Dist 2013). In that case a California lower court upheld a state statute limiting the clinic from billing outpatients for more than 2 psychology visits per month based on a state statute allowing those limitations. Id.

hearing." Respondent's Brief at 14. This statement blatantly ignores the fact that Richard's mother testified that Dr. Joseph had been Richard's treating physician for 22 years and Dr. Joseph also provided a sworn affidavit in 2009, which DHHS purged and did not transmit to the AL C. Brief of Appellant at 6 and Exhibit 5 and R. 72. Respondent cites *Moore v. Cook*, in an attempt to discredit the opinion of Dr. Joseph. But in that case, the waiver participants' treating physician disagreed with the State's independent physician as to the medical need for nursing services of Callie, the plaintiff in *Moore*. Case No. 1:07-CV-631-TWT (N.D.Ga April 20, 2012). Here, in Richard's case, during the four years since he filed his appeal, DHHS has presented no evidence from any qualified medical source - in total disregard for the Order of Hearing Officer Loomis. This Court should rule that there is no issue of fact and grant judgment to Richard, because Respondent has provided no expert medical testimony in support of their claims that Richard does not need the hours ordered by Dr. Joseph. In *Care and Treatment of Thomas S.*, the Supreme Court recently held in a unanimous decision that "a lay witness may only testify as to matters within his personal knowledge and may not offer opinion testimony which requires special knowledge, skill, experience, or training." Case No. 194610 (S.Ct. April 10, 2013). *See* Rules 602 and 701, SCRE. In that case, an agency employee, a licensed social worker, was overturned. In Richard's case, the only individual who evaluated his records and testified did not even hold a master's degree and she had never met Richard. Respondent admitted that the reductions were imposed without conducting individualized assessments to determine whether the reductions would place waiver participants at risk of institutionalization. Despite claims in 2009 and 2010 that budget reductions necessitated the reductions, no cost analysis was performed by Respondent before capping home-based services and funding for institutional services was actually increased.

Appellant does not dispute that the Eleventh Circuit ruled in *Moore ex Moore v. Reese*, 637 F.3d 1220 (11th Cir. 2011) that the State has a role to play. But nothing in that case would suggest that this Court should rely on the testimony of a bureaucrat who holds a BA in Sociology, who does not even know if Richard could get out of the house in a fire or get out of bed at all, to override the order of a treating physician. This is exactly the type of "bureaucratic gobbledegook having no relation to her (in this case "his") actual condition or needs" of which the district court spoke in *Moore*. What DHHS has done in this case is to allow Ms. Shealy and bureaucrats at DDSN and DHHS to practice medicine without a license. The evidence in this case documents that, like Georgia attempted to do in *Moore*, reductions in services shifted more of the burden of caring for Richard to his family. Id. Even more egregious in this case is the fact that Richard's evidence documents that Respondent was driven by a motive to force persons who have disabilities into more expensive DDSN congregate programs.

Respondent argues that *Moore* is not applicable to this case because the plaintiff in that case complained of violation of the EPSDT provision of the Medicaid Act, which requires the State to provide all medically necessary services that children require. Respondent's Brief at 10. But that argument ignores the fact that, in this case, Richard's mother (his father is now deceased) has absolutely no legal obligation to provide any services or care to her adult son, unlike Callie's mother, who has some duty to provide care for her minor child under state law. *Moore* addressed the issue of how medical necessity must be determined and what weight must be given to the orders of the treating physician.

No one testified at Richard's 2010 hearing that any physician's order or opinion was even reviewed by persons at DDSN and DHHS who reduced his services. On the contrary, both Ms. Shealy and Mr. Chorey testified that the agency applied the caps "across the board," without

considering medical necessity or Richard's individual needs. Ms. Shealy repeatedly admitted on the record that she never communicated with Richard's physician and she never reviewed any of his medical records. R. 34, 35 and 36. It is hard to imagine a decision being more arbitrary and capricious. There is not a scintilla of evidence in the record to contradict the opinion of Richard's physician that he requires around-the-clock care. Because of his spasticity, Richard requires total assistance with bathing, dressing, toileting, brushing teeth, grooming, purchasing food and preparing meals, housekeeping and doing the laundry. R. 783, 786, . He requires hand-on assistance with ambulation and positioning to avoid decubitus ulcers. Id. It takes two persons to lift Richard when he goes to the toilet or is transferred from his wheelchair. Id. Until age 21, Richard received one-on-one assistance that was provided by the State during the school day. R. 59, 60, 783, and 784. Richard is 5'5" tall and weighs between 115 and 120 and he is "dead weight." R. 61.

It is clear from the record that decision makers at DDSN gave no weight to the opinion of Richard's physician in reducing and terminating his services. This violates the mandate of *Olmstead v. L.C.* to give the physician the "greatest of deference" and it is a clear violation of Hearing Officer Loomis' Order. Richard asks this Court to reverse the decision of the agency and to require Respondent to provide all of the services Richard's physician orders within ten days of such order. The burden to prove that services ordered by Dr. Joseph should be shifted to the Respondent in this case, given the history of blatant disregard for the 2009 Order of Hearing Officer Loomis, the failure to give any weight to the opinions of his treating physicians, the disregard for Richard's health and welfare and the evidence of retaliation in this case.

5. The affidavit of Richard's treating physician is not inadmissable hearsay.

Respondent argues in its brief that the affidavits Appellant introduced are hearsay. Respondent's

Brief at 14. But Respondent's counsel agreed at his second hearing for these affidavits to be admitted "for whatever probative value they have." R. 22. This issue was not appealed by DHHS and Respondent's argument is not preserved for appeal. In any event, Rule 803(4) and (6) of the South Carolina Rules of Evidence provide exceptions to the hearsay rule for medical records. Rule 804(4) provides an exception for statements made "for purposes of medical diagnosis or treatment and describing medical history, or past or present symptoms, pain, or sensations, or the inception or general character of the cause or external source thereof insofar as reasonably pertinent to diagnosis or treatment..."[4] The statement of Dr. Joseph was made for the purpose of diagnosing medical conditions, prescribing treatment and describing Richard's medical treatment and he is well qualified, as a licensed physician, to make those determinations. He was not retained for purposes of this litigation, but had treated Richard for the same conditions for more than twenty years and he is the person most knowledgeable about Richard's condition. As the South Carolina Supreme Court held in *Ex parte Department of Health and Environmental Control v. John Doe*, Dr. Joseph's affidavits are also admissible under the business records exception contained in SCRE 803(6) and "The trustworthiness of medical records is presumed, based on the fact that the test is relied on for diagnosis and treatment." Id. and 565 S.E.2d 293,

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[4] That exception provides that "the admissibility of statements made after commencement of the litigation is left to the court's discretion." The Hearing Officer did not rule at the hearing that he would not allow the affidavit - in any event, a DHHS Hearing Officer is not a Court. The Hearing Officer in the 2010 hearing was not even an attorney and Hearing Officers are not bound by the South Carolina Code of Judicial Conduct. Medical records are routinely admitted in administrative appeals without live testimony from physicians. *Kelley v. South Carolina Budget and Control Board*, 041912 SCALC, 10-ALC-30-0841-AP (SCALC April 19, 2012), *Williamson v. South Carolina Budget and Control Board*, 041712 SCALC, 10-ALJ-30-0828-AP (SCALC April 17, 2012). Historically, the opinions of treating physicians have been received into evidence in Medicaid cases without live testimony from the physician. *Atkinson v. SCDHHS*, 041403 SCADMLCD, 02-ALJ-08-0152-AP (SCALC April 14, 2003).

350 S.C. 243 (SC 2002).[5] Regardless, Respondent's own records provide independent evidence which supports the opinion of Dr. Joseph. The Detailed Claims Reports found at R. 551 document Richard's conditions, as do the Respite Assessment (Respondent's Exhibit 3), which reported that Richard "requires extensive, moderately intense support and supervision," i.e. within the same room or nearby, outside of visual supervision for no more than 15 minute periods." R. 98. This report states that Richard's needs for speech therapy, occupational therapy and physical therapy are not being met. R. 100. It reports that his parents, who have no duty to provide care for Richard, are working providing his care for 90 hours a week and that he is nonambulatory and incontinent and requires catheter care. R. 101.

The unfairness of requiring the Appellant to present live testimony, in addition to sworn affidavits, at Medicaid "fair hearing" should also be considered by the Court. It should be noted that only the Hearing Officer has the power to subpoena a witness in a Medicaid fair hearing. Requiring live testimony of the treating physician would make it impossible for a disabled person who financially qualifies for Medicaid to ever be able to provide any form of expert testimony. Requiring the disabled to meet impossible evidentiary requirements denies them a opportunity for a meaningful hearing and violates their due process rights. Besides, a ruling by this Court that live physician testimony is required in Medicaid fair hearings would cut both ways - it would require the agency to have its physicians to testify at these hearings, at great expense to taxpayers and it would create significant administrative and operational problems for the Agency. Already, the reimbursement rate for physicians who treat Medicaid patients is very

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[5] Dr. Joseph's affidavit was made near the time of the hearing and it is a record of events, conditions and diagnoses made at the time of Richard's fair hearing made by a person with knowledge of his condition and kept in the regular course of business. The South Carolina Supreme Court has ruled that medical records documenting HIV may be admitted by DHEC at trial as a business records. *Ex Parte DHEC* at 297.

low. Requiring treating physicians to drive to Columbia to testify in fair hearings would chill even the most compassionate doctor from accepting Medicaid patients and jeopardize the treating relationships between the most medically needy patients and their physicians. These public policy issues should be taken by consideration by the Court in ruling that medical records of the treating physician do not constitute hearsay in Medicaid appeals.

6. Respondent has failed to provide services with reasonable promptness. Although Respondent is providing services which were being provided in 2009 (in addition to an increase in respite - still limited to the cap imposed in 2010), it has not provided the number of hours of the services ordered by Dr. Joseph and it will reduce Richard's personal care and attendant services to 28 hours a week in the event that this appeal is unsuccessful. Respondent argues at page 22 of its Brief that this case is distinguished from *Doe v. Kidd II* because Respondent agreed to provide the services at issue in that case. 419 F.Appx. 411 (4th Cir. 2011). This is a strange argument, because for ten years, Respondent has argued to the federal courts in *Doe*, including twice to the Fourth Circuit, that they are not obligated to provide residential habilitation services to Doe. The Fourth Circuit held in 2011 that Respondent has been in violation of 42 U.S.C. 1396a(a)(8) the Medicaid Act for failing to provide those services with reasonable promptness. But this Court may take judicial notice that Respondent still has not provided the services it argues to this Court it agreed to provide to Doe. See Entry 224, containing an admission by Respondent that residential habilitation services have not been provided. 3:03-cv-01918-MBS.

7. Respondent has violated Richard's right to due process. 42 C.F.R. 431.244 requires the State "ordinarily" to take final administrative action within 90 days of the Medicaid participant's request for a fair hearing. In *Konstantinov v. Daines*, the Supreme Court of New

York affirmed that "the federal statute and implementing regulation governing hearings and decisions about Medicaid claims create a right to a final administrative determination within 90 days after a request for a hearing is made." 956 N.Y.S. 2d 38, 40, 101 A.D.3d 520 (SC 2012). As recognized in that decision, CMS has promulgated the State Medicaid Manual (SMM) "flesh[ing] out" the content of that right to interpret that regulation to mean that "the 90-day time limit must be adhered to 'except where the agency grants a delay at the appellant's request, or when required medical evidence necessary for the hearing cannot be obtained within 90 days." Id. at 40. (SMM § 2902.10). Even with such extension, Respondent was required to make a final administrative action by the end of June of 2009. As the Supreme Court of New York held, nothing prevents the State from remanding a fair hearing appeal back to the agency, but "the ALJ is still required to render a final determination within the 90 day period. Thus, as the Supreme Court of New York observed, any remand should specify the time in which the agency must act and report back so that the ALJ can render a final determination within that 90 day period." Id. More than three years has passed in this case since the Hearing Officer remanded Richard's case back to DHHS for consideration of Dr. Joseph's opinion. It is uncontraverted that DHHS has stubbornly refused to give any weight to the treating physician's opinion. Instead, Respondent has recited bureaucratic gobbledegook best interpreted as giving the agency unfettered discretion to give nothing but lip service to the opinion of the treating physician and allowing arbitrary and capricious limits which force waiver participants into profitable congregate programs. Richard's due process rights were violated when Respondent ignored the Order of Hearing Officer Loomis and determined that it would simply purge the record in this case of all records submitted in this case between February of 2009 and early 2010.

DHHS argues at page 5 to 6 of its brief that the complaints filed in February of 2009 were somehow automatically resolved when the agency imposed state-wide reductions in 2010 on all MR/RD Medicaid waiver participants under the guise of "budget reductions." The argument is that Respondent, without legislative approval or judicial review, could unilaterally resolve and terminate his 2009 appeal ... without notice of any kind to Richard or a final order being issued in his appeal that had then been pending for almost a year. Richard had complained in February, 2009 that Respondent failed to provide needed services with reasonable promptness, to base his need for services on the opinions of his treating physician, to provide sufficient providers and to promulgate regulations for the operation of the MR/RD Medicaid waiver program.(His notice of appeal sent to DDSN on February 13, 2009 was considered by both DHHS Hearing Officers, but was not included in the Record.) Then, in December of 2009, Richard was one of the plaintiffs who filed a Petition in the Supreme Court, asking that Court hear, in its original jurisdiction, Richard's objections to the 2010 amendments. Richard and his advocates have been targets of retaliation since then. The letter Richard sent to DDSN on February 13, 2009 requesting a fair hearing had asked the director of that agency to "please assure us that there will be no reduction in services or other retaliatory actions taken against Richard or his family during this appeal." Exhibit 1. (This document dated February 13, 2009 was purged from the record.) But that is exactly what has happened to Richard and his advocates. A month after Richard attempted to prevent Respondent and DDSN from enforcing the 2010 amendments, DDSN sent notices of termination to Richard's providers of personal care services and specialized medical equipment falsely informing them that he "moved out of state." R. 788 and 789. Then DDSN simply failed to respond to the November 2009 Order of Hearing Officer Loomis and Richard's February 2009 appeal was effectively dismissed with no

notice to him or opportunity for judicial review. A State may dismiss a fair hearing appeal for denial of Medicaid benefits only under circumstances which do not exist in this case. 42 C.F.R. 431.223 provides that "The agency may deny or dismiss a request for a hearing if— (a) The applicant or recipient withdraws the request in writing; or (b) The applicant or recipient fails to appear at a scheduled hearing without good cause. *See Fishman v. Daines*, 743 F.Supp.2d 127 (E.D.N.Y. 2010). Richard has never withdrawn his 2009 appeal. He has not failed to appear at a scheduled hearing, but Respondent treated his February 2009 appeal as if it had evaporated into thin air. The ruling of the Hearing Officer was ignored and he was not given the opportunity for judicial review for the next four years.

One of Richard's exhibits presented at the hearing held on May 11, 2010 was the affidavit of Richard's provider of psychological support, Lennie Mullis. R. 780. In that affidavit, Mullis stated that Richard would not be safe in a DDSN sheltered workshop and that he would be at risk of institutionalization if the services ordered by his treating physician were not provided. R. 780. On May18, 2010, exactly one week after Mullis' affidavit was submitted to the DHHS Hearing Officer in support of Richard's appeal, DDSN recommended that Mullis be terminated as an approved provider of DDSN psychological supports. *Mullis v. DHHS II,* Dkt. 10-ALJ-08-0775-AP (SCALC April 23, 2012). Exhibit 2. DHHS upheld the termination one week later. The Order in that case documents a pattern of practice of Respondent and DDSN acting arbitrarily and capriciously in violating due process rights of appellants and participating, as Richard has claimed her, in improper ex parte *communications with the Office of Hearings and Appeals. Appellant's Brief at 47 and Mullis* v. DHHS II, supra. As in this case, there was evidence of *ex parte* communications, with a DDSN official instructing the Hearing Officer how to rule. The arbitrary and capricious process used to terminate Mullis parallels the agency's

actions in Richard's case. Despite the Hearing Officer admitting in his order that he reviewed Richard's 2009 appeal, those records were purged from the record the Hearing Officer transmitted to the ALC.

Whether the refusal to produce the entire record is an attempt not to disclose other *ex parte* communications will not be known until all of those records are produced. The pattern of DDSN providing the Office of Hearings and Appeals with *ex parte* instructions is well documented. *Mullis v. DHHS II*, supra. *See also S.E. v. DHHS, supra, M.M. v. DHHS, supra and J.C.E. v. DHHS, supra.* In Mullis' case, a DDSN official instructed the Hearing Officer to keep evidence of Mullis' 2005 order out of the Record that would be transmitted to the ALC, just as the Hearing Officer kept Richard's 2009 Order out of the record. *Mullis v. DHHS I*, 04-ALJ-03-0194-AP (SCALC 2005). In Mullis' 2012 case, Dr. Kathi Lacy, the Associate State Director of DDSN, had emailed the Hearing Officer an *ex parte* message stating that "I believe [the Appellant] wants to bring up a previous appeal, likely 6 years ago where her appeal for disenrollment was overturned by the [hearing officer]. It has nothing to do with the current issue." This email was in response to the Hearing Officer's email to DDSN which stated "I need your input about this." Id. This Court should inquire about the extent of such *ex parte* communications in Richard's case which Respondent may have been purged.

As the ALC held in Mullis "... the hearing officer's decision to exclude the 2005 ALC order was not only unsupported by the Record and based on an error of law, but was also based on Dr. Lacy's improper opinion about the relevancy of the Order." Id. ("The hearing officer denied Appellant's request and based this denial on an error of law because it relied upon Dr. Lacy's improper opinion regarding the relevancy of documents." Id. at 15.)

Richard has been prejudiced by these retaliatory acts and the failure of the Office of Hearings and Appeals to transmit the entire record. It is important for this Court to consider that the second DHHS Hearing Officer, Jefferson Bryson, even admitted in his order that he had reviewed and considered those records which the Director of the Office of Appeals and Hearings subsequently refused to transmit to the ALC. R. 13. ("I have reviewed the record and the Decision in the previous case, [Petitioner v. SCDHHS, 09-MISC-017" at R. 13.) In the briefs filed with the ALC, Appellant objected to DHHS purging the records the agency's failure to include all records of the first fair hearing that were reviewed and considered by the Hearing Officer. The ALC also acknowledged that the Hearing Officer had considered evidence received outside of the 2010 hearing that was not transmitted in the record to that court. It is impossible for a reviewing court to determine whether the decision of the lower tribunal is supported by the record when the record is limited to only those documents the government chooses to include. It is notable that the ALC ruled that DHHS did not object to the incorporation of the previous case in the appeal before that court (without ordering those records to be produced) and the ALJ specifically stated in that court's opinion that the second Hearing Officer reviewed those records in reaching his decision.[6] Order of ALC at 10. It is the obligation of the "agency with possession of the Record" to file the Record with the ALC and to serve a copy on each party within forty-five days of the notice of assignment. South Carolina ALC Rules, Rule 36. DHHS failed to include the records from the 2009 proceedings in the Record and should be ordered to produce all records, including correspondence, emails, memos and all other writings related to Richard since February 13, 2009. Instead of providing those records, in its Brief, Respondent now argues that Judge Matthews was wrong and that DHHS will not include those records which

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[6] It was legal error for the lower court to issue an order without providing a hearing, addressing Appellant's objection to these documents being omitted and without reviewing the factual evidence the hearing officer relied upon to reach his decision. Appellant objected in her brief to the ALC that these records were not included in the Record on Appeal. Appellant's Brief filed in the ALC dated February 13, 201. Appellant again objected to these records being purged in Appellant's Reply Brief dated April 13, 2011. Since the ALC's order was issued without providing oral arguments, these objections were not addressed by the lower court.

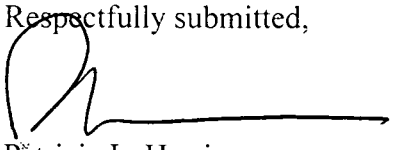
that court reported were reviewed and considered by the Hearing Officer in reaching his decision. This constituted a serious legal error, and a gross violation of Richard's due process rights, which should not be tolerated by this Court, but should be corrected by an order finding that Respondent has violated Richard's due process rights and ordering Respondent and its agent, DDSN, and their employees to produce all records, pleadings, correspondence, reports, memos or other documents in their possession related to Richard Stogsdill within ten days. Appellant prays for an opportunity to file a supplemental brief once those records are produced.

8. Appellant has addressed Respondent's arguments related to the violation of the South Carolina Administrative Procedures Act and the comparability requirements of the Medicaid Act in his Initial Brief. The ALC has ruled that the 2010 MR/RD Medicaid waiver amendments are unenforceable because they establish a binding norm that the agency is not free to ignore. Exhibits 4 and 5. Respondent did not appeal these decisions and it should be collaterally estopped from enforcing the caps which are being applied to Richard and other severely disabled Medicaid participants who wish to live in their homes. Respondent has not imposed caps on services provided to waiver participants who filed lawsuits in the federal court and has informed that Court that it will not impose these reductions on those individuals.*Elledge v. DHHS*, 2011-185006 (S.C. 2012); *Hickey v. Forkner*, 4:10-2696-TWL-TER (D.S.C.May 5, 2011); *Peter B. v. Sanford, supra*; *J.C.E. v. DHHS*, 10-ALJ-08-0502-AP (SCALC October 29, 2010), and *M.M. v. DHHS* 10-ALJ-08-0502-AP (SCALC October 29, 2010).

Conclusion

Appellant prays that this Court reverse the decision of the lower Court, an order requiring Respondent to provide all services ordered by his treating physician, an order preventing Respondent from enforcing binding norms not promulgated as regulations, an order directing Respondent to promulgate regulations for the operation of the MR/RD Medicaid waiver program and the fair hearing process and an award of legal fees and costs.

Respectfully submitted,



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June 25, 2013
Columbia, South Carolina

IN THE STATE OF SOUTH CAROLINA

In The Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT

Carolyn C. Matthews, Administrative Law Judge

Case No. 10-ALJ-08-0774 AP

Richard Stogsdill, Appellant,

v

South Carolina Department of Health and Human Services, Respondent.

CERTIFICATE OF SERVICE

Patricia L. Harrison, attorney for Appellant, certifies that she has served the *Reply Brief* in the above captioned case on The South Carolina Department of Health and Human Services by US Mail, with sufficient postage attached, to the Office of General Counsel, SC Dept of Health and Human Services, PO Box 8206, Columbia, SC 29202 on June 25, 2013.

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