IN 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

Stogsdill, Richard — Appellant

v.

South Carolina Department of Health and Human Services, — Respondent

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BRIEF OF AMICI CURIAE

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASES

STATUTES

REGULATIONS

OTHER AUTHORITIES

INTEREST OF AMICI CURIAE[1]

Protection and Advocacy for People with Disabilities, Inc., the South Carolina Chapter of the National Academy of Elder Law Attorneys, South Carolina Legal Services, and South Carolina Appleseed Legal Justice Center respectfully submit this brief as amici curiae on questions of law, under the Americans with Disabilities Act (ADA),[2] the South Carolina Administrative Procedures Act, and state and federal case law, relevant this appeal.

Protection and Advocacy for People with Disabilities, Inc. (P&A) is a statewide, nonprofit advocacy organization whose purpose is to promote the legal, civil, and human rights of people with disabilities.[3] The State of South Carolina has designated P&A to serve as the federally-mandated Protection and Advocacy System for South Carolina. S.C. Code Ann. § 43-33-310 to 43-33-400 (1976 & Supp. 2013). As such, P&A is authorized by federal and state law to enforce the civil rights of people with disabilities and is specifically charged with protecting and advocating for the rights of people with developmental disabilities. Developmental Disabilities Assistance and Bill of Rights Act of 2000, 42 U.S.C. §§ 15001 to 15009. Under state law, P&A has the power and the duty to advocate for the rights of people with disabilities by "pursuing legal, administrative, and other appropriate remedies." S.C. Code Ann. § 43-33-350(1) (Supp. 2013). P&A assists individuals with disabilities who experience discrimination as a result of a disability, or who are illegally denied needed services by a program or agency. The goals

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[1] Pursuant to Rule 213, SCACR, this brief is conditionally filed and accompanied by a motion for leave to file the brief.

[2] A glossary of acronyms relevant to this case is provided at the conclusion of this brief for the Court's convenience.

[3] Additional information regarding the work of P&A is available at http://pandasc.org/.

of P&A include increasing public knowledge about the rights of people with disabilities and participating in litigation affecting the legal rights and status of people with disabilities. P&A has participated as amicus curiae in cases before South Carolina appellate courts and the United States District Court for the District of South Carolina. *E.g., Singleton v. State*, 313 S.C. 75, 437 S.E.2d 53 (1993); *Clemson Univ. v. Speth*, 344 S.C. 310, 543 S.E.2d 572 (Ct. App. 2001). More specifically, P&A has participated as amicus curiae in two cases addressing the 2010 cuts at issue in this case. *Peter B. v. Sanford*, 6:10-CV-767 (D.S.C. Feb 1, 2011)(order granting preliminary injunction preventing the implementation of the reductions in services; not reported); *Karen W. v. Sanford*, Petition in the Original Jurisdiction of the South Carolina Supreme Court (Petition Denied December 31, 2009).

Many P&A clients receive services through the Intellectual Disabilities/Related Disabilities (ID/RD) waiver. The ID/RD waiver is administered as part of the Medicaid program by the single state Medicaid agency, the South Carolina Department of Health and Human Services (SCDHHS). The South Carolina Department of Disabilities and Special Needs (SCDDSN) oversees the day to day operation of the waiver. *See generally Doe v. Kidd*, 501 F.3d 348 (4th Cir. 2007). Reductions to these waiver services are at issue in this case. P&A represents many individuals who need appropriate services to enable them to live in the community. P&A is committed to ensuring that the principles of the Americans with Disabilities Act (ADA), as interpreted in *Olmstead v. L.C.*, 527 U.S. 538 (1999), are followed in the state's implementation of Medicaid waivers.

South Carolina Chapter of the National Academy of Elder Law Attorneys (SCNAELA) is a state chapter of the National Academy of Elder Law Attorneys

(NAELA).[4] SCNAELA is an education and advocacy organization. Members of SCNAELA are South Carolina attorneys who practice in the area of elder law, which includes advocacy for people who are elderly and people who are disabled. The mission of SCNAELA is to educate and assist attorneys in providing advocacy, guidance and services to enhance the lives of people as they age as well as individuals with special needs. SCNAELA has, as the organization has evolved, an increasing emphasis on institutional, as well as individual, advocacy for people with disabilities, regardless of age, with particular emphasis on access to government benefits and services that are essential to achieving as much dignity and independence as possible.

South Carolina Legal Services (SCLS) is a non-profit statewide law firm providing legal assistance in a wide variety of civil legal matters to eligible low income residents of South Carolina.[5] SCLS is the sole federally funded Legal Services Corporation grantee in South Carolina and receives additional funding from a variety of sources, including the South Carolina Bar Foundation, local United Ways, state court filing fees, and other federal, state and local funding. SCLS' mission is to protect the rights and represent the interests of low income South Carolinians. Among SCLS' priorities are representing low income individuals in Medicaid cases involving home and community based services.

South Carolina Appleseed Legal Justice Center (Appleseed) is a non-profit organization, based in Columbia, South Carolina, and loosely affiliated with 14 other public interest justice centers in the Appleseed network within the United States. The

[4] Additional information regarding the activities of the SCNAELA is available at https://www.naela.org/.

mission of Appleseed is to identify and examine social injustice, make recommendations, and advocate for effective solutions. Appleseed has served a wide range of needs for the low-income community in South Carolina for the past 25 years through legal work, economic development, social legislation, and public and legal education. As an advocate for low-income South Carolinians, Appleseed has an interest in the present case based on the methods employed by SCDDSN to cut Medicaid services, which could be employed to cut services to low-income South Carolinians as well as disabled individuals. Further SC Appleseed is concerned with any state agency circumventing the South Carolina Administrative Procedures Act by establishing binding norms without going through the proper regulatory process. SCDHHS has attempted to implement a hard and fast rule regarding a public benefit without following the rule making procedures required to promulgate regulations. Allowing state agencies to cut services in a manner inconsistent with state and federal law could have a very negative impact on the low income community in South Carolina.

BACKGROUND

SCDDSN provides services to individuals with intellectual disabilities, related disabilities, autism, head injuries, and spinal cord injuries. S.C. Code Ann. § 44-20-10 to 44-20-510 (Supp. 2013). The vast majority of SCDDSN's funding derives from the federal Medicaid[6] program, passed through to SCDDSN from the state Medicaid agency, SCDHHS. Medicaid funds are used to provide health care to those in poverty or with exceptional health care needs, including services to individuals requiring long-term care.

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[5] Additional information regarding the work of SCLS is available at http://www.sclegal.org/.

Medicaid funded long-term care may be provided either in institutions or in the community. *See generally* 42 U.S.C. §§ 1396a, *amended by* Pub. L. No. 113-67, 127 Stat. 1165 (2013); 1396n(c). Because some conditions of federal Medicaid law are waived in order to provide certain groups of people with disabilities services in the community rather than in institutions, these programs have been historically referred to as "waivers." *See generally Doe v. Kidd*, 501 F.3d 348 (4th Cir. 2007). Using Medicaid funds for waiver services, rather than for institutional care, prevents unjustified institutional isolation of persons with disabilities in compliance with the Americans with Disabilities Act (ADA) and the United States Supreme Court's landmark decision in *Olmstead v. L.C.* 527 U.S. 581 (1999). Waivers must be designed so that services in the community are cost neutral compared with institutional care, but such services are typically much less expensive than care in an institution. *See* 42 U.S.C. § 1396n(c); *Fisher v. Oklahoma Health Care Auth.*, 335 F.3d 1175, 1178 (10th Cir. 2003).

SCDDSN provides for the day to day operation the 1915(c)[7] Medicaid waiver relevant to this action, the ID/RD waiver. However, SCDHHS remains the single state Medicaid agency responsible for the Medicaid program. *See* S.C. Code Ann. § 44-6-30(1) (Supp. 2013); 42 C.F.R. § 431.10(a), (e).

The Appellant is a participant in the ID/RD waiver. The ID/RD waiver is for persons who (1) have an intellectual disability (mental retardation) or a related disability, (2) are eligible for Medicaid, (3) meet level of care for an Intermediate Care Facility for

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[6] Medicaid is a joint federal and state program. *See Doe v. Kidd*, 501 F.3d 348, 351 (4th Cir. 2007).

[7] States may operate a variety of Medicaid waivers. The ID/RD waiver is a 1915(c) waiver, named after the section of the Medicaid act that created it. Social Security Act, § 1915(c), as amended, 42 U.S.C. § 1396n(c).

Intellectually Disabled (ICF/ID), and (4) who need home and community based services in order to live in the community. *See generally* DDSN ID/RD Waiver Manual, Chap. 1.[8] All individuals on the waiver must meet a level of care that is similar to that required to receive services in a nursing home. *Doe v. Kidd*, 501 F.3d at 351.[9] In other words, individuals on the waiver have significant deficits and need significant assistance similar to the needs of individuals in institutions.

In late 2009, SCDHHS sought and received the approval of the United States Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS) to amend the ID/RD waiver to limit or cap certain services. R. 940. The amended waiver places a service use cap or flat cap on the number of hours an individual can receive of particular services: Personal Care I and II, Adult Attendant Care, Adult Companion Care, Nursing, and In-Home Respite Services.[10] R. 117 (from the Report and Recommendation of the Magistrate Judge in United States District Court, District of

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[8] The Waiver Manual is available at http://www.ddsn.sc.gov/providers/medicaidwaiverservices/mrrd/Documents/Default/MR_RD%20Waiver%20Manual%20Chapter%201-%20What%20is%20a%20Waiver.pdf (last viewed Feb.12, 2014).

[9] The Fourth Circuit describes the level of care as being like that of a nursing home, but technically the level of care that must be met is Intermediate Care Facility for Intellectually Disabled or ICF/ID.

[10] Specifically, Personal Care II, Adult Attendant Care, and Adult Companion Care are capped at a maximum of 28 hours per week (the waiver participant may use a combination or a single service, but the single service or combination cannot exceed 28 hours per week); Personal Care I is capped at 6 hours per week; Nursing is capped at 56 hours per week or 42 hours per week depending upon whether an licensed practical nurse (LPN) or registered nurse (RN) provides the service; and in-home respite is capped at 68 hours per month, with some exceptions. The waiver document provides that the respite cap may be exceeded for individuals requiring extraordinary care in order to remain in the community. ID/RD Waiver Manual, Chap. 10, Adult Attendant Care Services, Adult Companion Services, Personal Care Services, Respite Care, Nursing Services available at http://ddsn.sc.gov/providers/medicaidwaiverservices/mrrd/Pages/default.aspx (last viewed Feb. 14, 2014).

South Carolina, *Peter B. v. Sanford,* 6:10-CV-767 (D.S.C. Feb 1, 2011)). These services provide care to address the needs of individuals who live in their own homes or the home of a family member or friend. Only the waivers for which SCDDSN provides the day to day operation were amended to place caps on personal care. The Community Choices waiver, which provides services to people who are elderly or who are disabled, operated by SCDHHS does not cap personal care services. The amount of personal care provided under that waiver is based upon the participant's need for the service. *See generally* Community Choices Waiver Application, Appendix C: Participant Services; C-1/C-3 Service Specification; Service-Personal Care (listing no limits on amount, frequency, or duration of the service).[11]

Any individual on the ID/RD waiver will have a set of identified and documented health and safety needs, and a plan of care that addresses how those needs are to be met through services or interventions. *See* ID/RD Waiver Manual, Chap. 1, p. 3 ("Upon enrollment, approved providers may be authorized to render the needed services that are indicated on the participant's Support Plan [or plan of care] and included in his/her approved waiver budget").[12] An example of a health-oriented need is continued support with personal care tasks like brushing teeth. The person to support this need would be a caregiver working for a qualified personal care provider; the caregiver would either perform the task or help with it. The cost of this service is $14.80 per hour. R. 243.

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[11] Community Choices Waiver Application available at https://www.scdhhs.gov/internet/pdf/Application%20for%201915(c)%20HCBS%20Waiver%20SC_00405_R02_00%20-%20Jul%2001,%202011.htm (last viewed Feb. 12, 2014).

[12] ID/RD Waiver Manual, Chap. 1 available at http://ddsn.sc.gov/providers/medicaidwaiverservices/mrrd/Documents/Default/MR_RD%20Waiver%20Manual%20Chapter%201-%20What%20is%20a%20Waiver.pdf (last viewed Feb. 12, 2014). Appellant's annual budget is $37,364.45. R. 243.

Also, any service, including personal care, provided through the waiver must be provided in accordance with a written plan of care. 42 C.F.R. § 441.301(b)(1)(i), *amended by* 79 Fed. Reg. 3029 (Jan. 16, 2014, effective Mar. 17, 2014).

In addition to addressing needs and goals, development of an individual's plan of care also involves determining the amount, duration, and scope of services that are necessary. 42 C.F.R. § 440.230. Personal care needs, the subject of this appeal, are generally objective and quantifiable. Even individuals who do not have a disability must spend a certain amount of time on activities of daily living like brushing teeth, bathing, preparing and consuming meals, cleaning clothes, maintaining living space, etc. *See generally*, ID/RD Waiver Manual, Chap. 10, Personal Care Services.[13] For individuals, whether assistance with these activities is needed or not, the amount of time and effort expended to accomplish these tasks by the individuals or their caregivers is a fairly consistent and determinate amount. Further, failure to accomplish these activities can place an individual's health and safety at risk. Depending upon the activity and the individual's health, an individual may deteriorate if personal care needs are not met. The failure to provide for an individual's needs in the community may lead to unjustified isolation of the individual in an institution in violation of the Americans with Disabilities Act as interpreted by *Olmstead v. L.C.* 527 U.S. 581 (1999); *see* 42 U.S.C. § 12132.

[13] Available at http://www.ddsn.sc.gov/providers/medicaidwaiverservices/mrrd/Documents/Default/MR_RD%20Waiver%20Manual%20Chapter%2010%20%28Personal%20Care%20Services%29.pdf (last viewed on Feb. 12, 2014).

STATEMENT OF FACTS

Appellant receives services through the ID/RD waiver because he has cerebral palsy, a related disability. Appellant is a young man who lives in an apartment next to his parents' home. R. 923. Appellant uses a wheelchair and can move his wheelchair with a joy stick, but he cannot get in and out of his wheelchair without assistance. He requires total assistance with all activities of daily living, including bathing, dressing, toileting, preparing food, housekeeping, and he requires two individuals to assist him getting in or out of his wheelchair and to supervise his gait training.[14] R. 920. Appellant also requires assistance to prevent isolation, namely to attend community events and volunteer activities. R. 923. Appellant's disabilities are not intellectual, but physical; he also has been experiencing anxiety and depression as a result of stress over his physical limitations. R. 917-918. As determined by SCDDSN, Appellant's needs are exceptional. R. 282-283, 335, 158 (showing that Appellant met the requirement for the respite exception to the 68 hour cap on respite services). SCDDSN has determined the Appellant has "a serious medical condition resulting in substantial physical impairment or disability requiring comprehensive care management defined as extensive hand-on assistance or total care on a routine basis," and he needs extraordinary supervision and observation or "frequent and/or life saving administration of specialized treatments." R. 164.[15]

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[14] The Appellant used affidavits for proof in the fair hearing due to witnesses being unavailable. Respondent waived any objection to the use of these affidavits and did not present contrary evidence to what was contained in the affidavits. R. 268.

[15] Also, available at ID/RD Waiver Manual, Chap. 10, Respite Care available at http://ddsn.sc.gov/providers/medicaidwaiverservices/mrrd/Documents/Default/Chapter10R.pdf (last viewed Feb. 12, 2014).

This appeal involves three different determinations for the amount, duration, and scope of services for Appellant:

1. **The level of services Appellant's treating physician recommends for him based upon his needs**. Appellant has never received this level of services. Appellant's treating physician recommends the following:
    - Per week recommended by treating physician: 56 hours per week of personal care services from two caregivers totaling 112 hours per week of personal care services. In addition to the personal care services, Appellant's treating physician recommended 25 hours per week of companion services.[16] R. 921. Appellant's doctor recognized that one caregiver acting alone could not provide the assistance with transfer and toileting needed by the Appellant to prevent regression and decubitus ulcers. R. 920.
    - Per week total: 81 hours of care (137 total hours funded)
    - Per day total: 13 hours on weekdays and 8 on weekends.
2. **The level of services SCDDSN assessed Appellant as needing and authorized him to receive.** Appellant has been receiving this level of services at least since 2009. Upon information and belief, Appellant continues to receive this level of services by agreement.
    - Per week assessed by SCDDSN in 2009: 54 hours per week of personal care, 15 hours per week of companion services, and 36 hours per week of respite. R. 335. However, the 54 hours results

in only 26 hours of care from two personal care attendants. *See* R. 920.

- Per week total: 105 hours per week.
- Per day total: 15 hours per day.

3. **The level of services SCDDSN will impose upon Appellant pursuant to service limits affecting all ID/RD waiver participants and increased respite hours.**
    - Per week amount pursuant to the caps: 28 hours combined of personal care and companion. 39 hours of respite.[17] R. 335. However, the 28 hours of personal care results in only 14 hours of care from two personal care attendants. *See* R. 920.
    - Per week total: 67 hours of care.
    - Per day total: 9.5 hours of care.

In early 2009, Appellant appealed the SCDDSN assessment of his needs because he disagreed with the assessment, which only provided 54 hours of personal care and 15 hours of companion (Number 2 above) and did not take into account his need for two caregivers to work with him. He contended that he needed additional services and that in performing the assessment, SCDDSN had not considered the opinion of his treating physician nor information regarding his well-being provided by family and caregivers

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[16] Appellant's physician did not make a recommendation for respite, but presumably some respite would be necessary to give his parents a break from providing care.

[17] Appellant requested 228 hours per month of respite. R. 162. Only 172 hours per month were approved. R. 167. Converting per month hours into weekly hours uses the following formula: 172 (hours) x 12 (months) = 2064 yearly hours. 2064 (hours)/52 (weeks) = 39 hours of care per week. The increase in respite is 3 hours per week.

(Number 1 above). R. 33-35. Appellant had a hearing on the merits on June 29, 2009. R. 31. On November 16, 2009, the SCDHHS Hearing Officer ordered the case remanded on the issue of personal care and companion services with regard to those services "for the remainder of 2009." R. 41. In the November decision, the SCDHHS Hearing Officer required SCDDSN to take into consideration an affidavit of Appellant's treating physician about the medical necessity for additional personal care hours and statements from Appellant and his family. R. 41. No such reevaluation is in the record and presumably did not occur. As in January 1, 2010, the Appellant was still receiving the same number of hours he had been receiving in 2009. R. 21.

If the reduction to his services is implemented, Appellant will receive only 67 hours of care per week, rather than the current 105 hours. SCDDSN will reduce his care by more than 5 hours per day. Prior to this current appeal, Appellant's treating physician had determined he needed 105 hours of care per week to live safely in the community, a SCDHHS hearing officer had remanded the issue of the number of hours to SCDDSN to take into account the affidavit of Appellant's treating physician, and SCDDSN had determined that Appellant was medically complex, requiring total care and extraordinary supervision and observation. R. 164 (respite exception criteria approved by SCDDSN on R. 167.). However, because of the arbitrary implementation of an "across the board" flat cap on services, the Respondent plans to reduce Appellant's overall hours of care by 38 hours per week, approximately five hours per day.

ARGUMENT

I. The arbitrary caps on community based services violate the ADA when the cuts place vulnerable citizens at serious risk of institutionalization.

Title II of the Americans with Disabilities Act of 1990 (ADA), prohibits discrimination against individuals with disabilities. 42 U.S.C. § 12132. "[N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132; 28 C.F.R. § 35.130(a). In order to implement the ADA, Congress granted the Department of Justice (DOJ) the authority to promulgate regulations. 42 U.S.C. § 12134(a). The ADA does not require a state or other public entity to provide any particular type of program, but for any program the state does provide, individuals with disabilities cannot be denied access to that program due to their disabilities. *See* 42 U.S.C. § 12132; 28 C.F.R. § 35.130(a).

In order to allow access to programs and services, the public entity "shall make reasonable modifications in policies, practices, or procedures . . . unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity." 28 C.F.R. § 35.130(b)(7). The requirement to make reasonable modifications includes programs which provide services, like personal care. Public entities must make reasonable modifications in order to administer services "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d) (the "integration mandate"). The most integrated setting appropriate is defined as "a setting that enables individuals with disabilities to interact

with non-disabled persons to the fullest extent possible." *Olmstead v. L.C.*, 527 U.S. at 592 (citing 28 C.F.R. pt. 35, App. A. p. 450 (1998), redesignated App. B at 75 F.R. 56164-01). "Unjustified isolation . . . is properly regarded as discrimination based on disability." *Olmstead v. L.C.*, 527 U.S. at 597.

In *Olmstead v. L.C.*, the United States Supreme Court interpreted the ADA and the integration mandate, ruling in favor of individuals seeking to reside in the community, rather than in a segregated facility. 527 U.S. 581 (1999) (citing 42 U.S.C. § 12101(a)(2)). The Court reviewed the Preamble of the ADA and Congressional findings, including the finding that "society has tended to isolate and segregate individuals with disabilities" and that the issue continues to be a "serious and pervasive social problem." *Id.* at 588 (quoting 42 U.S.C. § 12101(a)(2)). The Court held that the integration mandate of the ADA governed the plaintiffs' claims. *Id.*

> States are required to provide community-based treatment for persons with mental disabilities when the State's treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities.

Id. at 607.[18]

While *Olmstead* involved individuals living in an institution and seeking community based services, much of the recent case law applying the *Olmstead* decision

[18] In addition to the federal right to receive services in the community, South Carolina citizens with developmental disabilities have a right "to receive [the] least restrictive appropriate care and habilitation available." S.C. Code Ann. § 44-26-140 (Supp. 2013). "No client may remain at a level of care that is more restrictive than is warranted to meet his need, if alternative care is available." *Id.* at (D). More specifically, clients are to move from more structured to less structured living, from segregated settings to integrated settings, and from dependence to independence. *Id.*

and enforcing the integration mandate has held that a policy or practice of a public entity may violate the integration mandate even if the policy has "not resulted in the actual institutionalization" of a person with a disability. *Pashby v. Delia*, 709 F.3d 307, 321 (4th Cir. 2013). Like this appeal, much of the recent case law involves a reduction in a service an individual is relying upon to remain in the community. The courts have consistently found that such reductions will violate the ADA's integration mandated if they place the individual at serious risk of being institutionalized. Also, these decisions hold the public entities to closer scrutiny than in cases involving requests for new programs and services needed to assist individuals in getting out of institutional programs. *See e.g. Pashby*, 709 F.3d 307 (reduction in personal care services); *M.R. v. Dreyfus*, 663 F.3d 1100 (9th Cir. 2011), *modified by* 697 F.3d 706 (9th Cir. 2012) (modified in an order denying petition for rehearing and petition for rehearing *en banc*) (reduction in the amount of in-home personal care services); *Fisher v. Oklahoma Health Care Auth.*, 335 F.3d 1175 (10th Cir. 2003) (imposition of a cap on prescription medication). *But see Arc of Wash. St. Inc. v. Braddock*, 427 F.3d 615 (9th Cir. 2005) (Plaintiffs claimed the ADA required Washington to increase the size of its Home and Community Based Services (HCBS) program to allow additional individuals to qualify for HCBS.)

For example, the Fourth Circuit recently upheld the North Carolina District Court's grant of a preliminary injunction in a proposed class action case involving the reduction of Medicaid funded personal care services. In *Pashby*, the North Carolina General Assembly had voted to "impose stricter eligibility requirements for in-home personal care services (PCS), an optional Medicaid program that assists disabled adults

with daily tasks such as eating and bathing." 709 F.3d at 313. The change meant that the Plaintiffs would lose personal care services they had depended upon to live in the community. The Fourth Circuit found that the plaintiffs were likely to succeed on the merits of the case, even though none of them had been forced into an institution due to the reduction in the services. The court was persuaded by the Department of Justice's determination that "the ADA and the *Olmstead* decision extend to persons at serious risk of institutionalization or segregation and are not limited to individuals currently in institutional or other segregated settings." *Id.* at 322 (quoting DOJ Statement of Interest). "In sum, individuals who must enter institutions to obtain Medicaid services for which they qualify may be able to raise successful Title II [ADA] . . . [claims] because they face a risk of institutionalization." *Id.*

The *Pashby* court went on to explain the type of evidence which would support a finding that an individual is at serious risk of institutionalization in violation of the ADA:

> Recipients and individuals familiar with the [plaintiffs'] needs made declarations regarding the [Personal Care Services (PCS)] Recipients' in-home care requirements. These declarants stated that the PCS Recipients could not live on their own without in-home PCS or that it would be unsafe for them to do so. Each of these declarants also attested that the PCS Recipients had no friends or family members who could offer the same amount of care that their aides provided under the in-home PCS program. Finally, the declarations indicate that all but two of the PCS Recipients "may," "might," "probably" would, or were "likely" to enter an [Adult Care Home (ACD)] facility due to the termination of their in-home PCS. . . . . These declarations demonstrate that the PCS Recipients face a significant risk of institutionalization due to the termination of their in-home PCS . . . .

Id. The Fourth Circuit upheld the district court's order of a preliminary injunction finding the plaintiffs were likely to succeed on the merits of their ADA claim.

In Washington State, Medicaid beneficiaries appealed the denial of a motion for a preliminary injunction to the Ninth Circuit. *M.R. v. Dreyfus*, 663 F.3d 1100 (9th Cir. 2011) *modified by* 697 F.3d 706 (9th Cir. 2012) (slightly modified in an order denying petition for rehearing and petition for rehearing *en banc*). As in North Carolina, the Washington case involved a reduction in personal care services. The district court held that in order for the plaintiffs to state a violation of the ADA's integration mandate, they were required to show the "State's action leaves them no choice but to submit to institutional care . . . ." *Id.* at 1116. The Court held that "[a]n ADA plaintiff need not show that institutionalization is 'inevitable' or that she has 'no choice' but to submit to institutional care in order to state a violation of the integration mandate. Rather, a plaintiff need only show that the challenged state action creates a serious risk of institutionalization." *Id.* The court was persuaded by the DOJ's statement of interest which noted that "[t]he elimination of services that have enabled Plaintiffs to remain in the community violates the ADA, regardless of whether it causes them to enter an institution immediately, or whether it causes them to decline in health over time and eventually enter an institution in order to seek necessary care." *Id.* at 1117.

The Seventh Circuit has held that a cap on the amount of hours of private duty nursing could potentially violate the integration mandate, even though CMS had approved the cap. *Radaszewski v. Maram*, 383 F.3d 599, 601, 614 (7th Cir. 2004). The district court entered a judgment on the pleadings for the defendants, and the Seventh Circuit reversed and remanded for further proceedings. *Id.* at 599.

> [P]ost-Olmstead, courts have recognized that a State may violate Title II when it refuses to provide an existing benefit to a disabled person that would enable that individual to live in a more community-integrated setting. On the other hand, courts have also held that a State is not

> obligated to create new services in order to enable an institutionalized individual to live in a more integrated setting.

Id. at 609 (citations omitted). Therefore, once a service has successfully been provided in the past to prevent institutionalization, Title II may be violated when the state stops providing that successful service, if the cessation or reduction places the individual at serious risk of institutionalization. In addition, several federal district court opinions have found that a reduction in community services violates the ADA's integration mandate by placing the plaintiffs at serious risk of institutionalization. *See e.g. Wilborn v. Martin*, ___ F. Supp. 2d ___, No. 3:13-00574, 2013 WL 4401854 (M.D. Tenn., Aug. 15, 2013)(granting preliminary injunction stopping a reduction in home health services); *Hampe v. Hamos*, 917 F. Supp. 2d 805 (N.D. Ill. 2013)(reduction of in-home skilled nursing services); *Brantley v. Maxwell-Jolly*, 656 F. Supp. 2d 1161 (N.D. Cal. 2009)(loss of two days of adult day health care services). *But see Arc of Cal. v. Douglas*, ___ F. Supp. 2d ___, No. 2:11-CV-02545, 2013 WL 3331145 (E.D. Cal. 2013) (involving a reduction in payments for services compared with a reduction in services). Respondent provides no contrary authority to these interpretations of the *Olmstead* decision and the requirements of the ADA.

Like so many of the cases referenced above, this appeal involves a dispute over the reduction of HCBS, namely companion services and personal care services. As of January 1, 2010, Respondent had capped these services to a combined maximum of 28 hours per week for individuals living in the community. R. 22. For individuals living in institutions, the services are not capped but are based upon need as determined in a plan of care developed by a team including the treating physician. 42 U.S.C. § 1396r (b)(2) ("A nursing facility must provide services and activities to attain or maintain the highest

practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care . . . ."). The plan is based upon a required and extensive assessment. *Id.* at (b)(3). Appellant argues that because his need for services exceeds the cap, the imposition of the cap, as applied to him, places him at serious risk of needing to seek those services in an institution. In an institution his need would be assessed and his plan of care would be based upon that assessment, not based upon arbitrary caps on services. *Id.* Respondent argues that the ADA does not require it to modify its program, namely to allow Appellant to exceed the arbitrary cap, because the cap on services does not place the Appellant at risk for seeking care in an institution and even if Appellant is at risk, exceeding the cap amounts to a fundamental alteration of the program. Respondent's Brief at p. 7 and p. 15.

A. Serious Risk of Institutionalization or Speculative Risk of Institutionalization

Respondent argues that the risk that cuts to Appellant's services will cause him to have to go to an institution is "speculative." Respondent's Brief at p. 7. However, the uncontested evidence in the case shows that Appellant faces day to day challenges from a body which simply "cannot cooperate." R. 923, 920, 921. Appellant has had a decubitus ulcer from "sitting in his chair for too long without getting out or at least changing his position." R. 314. Appellant is always at risk of having to seek care in a hospital or other facility. The issue is not whether Appellant is at risk of needing to seek care in a hospital or a skilled facility but whether the 28 hour cap, as applied to Appellant, places him at serious risk of institutionalization in violation of the ADA.

The *Olmstead* decision has been consistently extended to apply to individuals who are placed at serious risk of institutionalization by a public entity's failure to make reasonable modifications to policies, like a cap on services. *Pashby*, 709 F.3d at 322; *M.R.*, 663 F.3d at 115; *Brantley*, 656 F. Supp. 2d at 1171. "Serious" does not mean that "[a]n ADA plaintiff [must] show that institutionalization is 'inevitable' or that she has 'no choice' but to submit to institutional care in order to state a violation of the integration mandate." *M.R.*, 663 F.3d at 1116. The integration mandate "prohibits public entities from pursuing policies that place individuals at risk of unnecessary institutionalization." *Id.* at 1117. Policies which cause a decline in health over time to a Medicaid beneficiary violate the ADA because they may "eventually enter an institution in order to seek necessary care." *Id.* Respondent does not provide support for the argument that *Olmstead* only applies when the risk of institutionalization is "imminent." *See* Respondent's Brief p. 8. *But see M.R.*, 663 F.3d at 1117 ("[I]mminent risk of institutionalization is not required," quoting the brief of the Department of Justice).

Respondent makes vague assertions regarding alternative services or care which may reduce Appellant's risk of needing to seek services in an institution. Respondent's Brief p. 8. Such vague assertions have not been successful in defense of claims based upon violations of the integration mandate. "[T]o the extent that Defendants are claiming that alternative services satisfy their obligations under the integration mandate, Defendants certainly bear the burden of ensuring more than a 'theoretical' availability of such services." *V.L. v. Wagner*, 669 F. Supp. 2d, 1106, 1120 (N.D. Cal. 2009) (quoting *Brantley*, 656 F. Supp. 2d at 1174).

Respondent refers to the potential availability of isolated and completely segregated day programs also known as "sheltered workshops." *See* Respondent's Brief, p. 8, referencing R. 891 – 894 (listing various waiver services). Respondent does not provide any evidence that the programs would themselves comply with the integration mandate or that Appellant's complex medical needs could be met in such settings. Under Respondent's theory of what constitutes a sufficient risk of institutionalization, a Medicaid beneficiary would have to systematically go through each and every service available (whether approved for the service or not) and demonstrate that not one service could prevent the beneficiary's deterioration. In other words, the affected beneficiaries would have to demonstrate they would have "no choice" but to go into an institution by providing testimony on services they have never received and for which they have never been approved. In addition, some of those additional services, like day activity services, are provided in segregated and isolating settings. *See generally Disability Advocates v. Paterson*, 653 F. Supp. 2d 184, 223 (E.D.N.Y. 2009) ("[A] plaintiff need not prove that the setting at issue is an 'institution' to establish a violation of the integration mandate. ... Rather, a plaintiff must show that the *setting* does not 'enable interactions with nondisabled person to the fullest extent possible.") (emphasis added). Such a burden placed on a Medicaid beneficiary would mean that the beneficiary must first go to an institution and then file an ADA claim from that isolated and segregated setting. Respondent, the single state agency responsible for Medicaid, not Medicaid beneficiaries, "bear[s] the ultimate responsibility for ensuring the State's compliance with federal disability law." *V.L.*, 669 F. Supp. 2d at 1120. Respondent has not met its burden to show that alternative services are available, appropriate, and will prevent Appellant's

deterioration and institutionalization. If unsuccessful in his challenges to the actions of Respondent, Appellant will lose five hours of care per day. R. 335. His mother works six different part-time jobs; his father is now deceased. R. 309. She testified that Appellant "would not be safe" if he loses his hours. Appellant will have to be alone and his doctor says his condition will deteriorate if he does not receive the care he needs. R. 920-921. Under these conditions, Appellant can be removed from the home pursuant to the Omnibus Adult Protection Act (OAPA) through a family court action.[19] S.C. Code Ann. § 43-35-5 to 43-35-595 (Supp. 2013). Appellant's potential to be placed in an institution is not necessarily in the control of either Respondent or Appellant.

The Administrative Law Judge (ALJ) stated that "[a]ppellant is living in the community, and it is speculative as to whether the reduction in services will cause him to be institutionalized." R. 14. However, the evidence that without the services requested, Appellant will be neglected as defined in the OAPA, is substantial, under oath, and un-contested with contrary testimony or evidence.[20] R. 304-322; R. 917-924. He has already had an incident of getting a decubitus ulcer. R. 314. He has also suffered regression. *Id.* Sadly, in making an argument for these services, Appellant has also made the argument that without these services he will be neglected, either by his parent caregivers or himself or both. The proof in this case, and the provisions of the OAPA

[19] A vulnerable adult is age eighteen or older with "a physical or mental condition which substantially impairs the person from adequately providing for his or her own care or protection." S.C. Code Ann. § 43-35-10 (11) (Supp. 2013). "Neglect includes the inability of a vulnerable adult, in the absence of a caretaker, to provide for his or her own health or safety which produces or could reasonably be expected to produce serious physical or psychological harm or substantial risk of death" S.C. Code Ann. § 43-35-10 (6) (Supp. 2013).

that Appellant is in serious risk of institutionalization if the 34 hour reduction in his services is implemented by Respondent.

B. Fundamental Alteration or Reasonable Modification

The Hearing Officer and the ALJ erred in holding that making an exception to the 28 hour cap is a fundamental alteration rather than a reasonable modification. "A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity." 28 C.F.R. § 35.130 (b)(7). Initially, the Appellant bears the burden of articulating a reasonable accommodation. *Frederick L. v. Dept of Pub. Welfare of Pa. (Frederick L. I)*, 364 F.3d 487, 492 n. 4 (3rd Cir. 2004), *aff'd by Frederick L. v. Dep't of Pub. Wefare of Pa. (Frederick L. II),* 422 F.3d 151 (3rd Cir. 2005); *see Olmstead*, 527 U.S. at 605-606. In this appeal, Appellant's request is for an exception—an exception to unpromulgated policy applying an across the board 28 hour cap on services. "The burden of proof then shifts to the defendant, who must establish that the requested relief would require an unduly burdensome or fundamental alteration of state policy in light of its economic resources and its obligations to other [individuals with disabilities] in the institutional setting." *Frederick L. I,* 364 F.3d at 492 n. 4.; *see K.M. v. Tustin Unified Sch. Dist.*, 725 F.3d 1088, 1096 (9th Cir. 2013). The Respondent bears the burden of proving that the requested modification--making an exception to the cap--is an unduly burdensome request.

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[20] Respondent's witnesses testified to the policy and the process but could not testify as to Appellant's medical needs. R. 279 ("I don't have any medical trainging."); R. 291 ("I . . . mainly just deal with policy).

In *Olmstead*, the Court noted that a state could establish a fundamental alteration defense by demonstrating "that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated . . . . ." 527 U.S. at 605-606. Respondent argues that allowing an exception will "fundamentally alter the program by eviscerating the limit." Respondent's Brief p. 17. However, Respondent does not explain what program is "eviscerated," or how providing a modification would affect any other programs. Appellant's contention is that the Medicaid program violates the ADA if it provides personal care in an ICF/ID based upon need but caps personal care in the community. Caps are not necessary for the program. The waiver program already has a system in place to make an exception to the cap on respite services. With regard to respite services, services intended to benefit caregivers, individuals with extraordinary needs can exceed the cap through a process of review. Appellant's request for an exception to the cap on personal care services is a reasonable modification given that such an exception already exists for respite services.

Courts consistently have held that a fundamental alteration defense requires more than a "singular focus upon a state's short-term fiscal constraints . . . ." *Frederick L. I*, 364 F.3d at 495; *Pashby*, 709 F.3d at 323 ("budgetary concerns do not alone sustain a fundamental alteration defense") (quoting *M.R. v. Dreyfus*, 663 F.3d 1100, 1118 (9th Cir. 2011)).

> [The fundamental alteration] inquiry requires not simply an assessment of the cost of the accommodation in relation to the recipient's overall budget, but a "case-by-case analysis weighing factors that include: (1)[t]he overall size of the recipient's program with respect to number of employees,

> number and type of facilities, and size of budget; (2)[t]he type of the recipient's operation, including the composition and structure of the recipient's workforce; and (3)[t]he nature and cost of the accommodation needed."

Olmstead, 527 U.S. at 606 n. 16 (quoting 28 C.F.R. § 42.511(c)(1988)). While such proof seems extraordinary, the information would be readily available and part of an *Olmstead* plan, a requirement for a fundamental alteration defense. "[A] comprehensive working plan is a necessary component of a successful 'fundamental alteration' defense." *Frederick L. v. Dep't of Pub. Welfare of Pa. (Frederick L. II)*, 422 F.3d 151, 157 (3rd Cir. 2005), *aff'g Frederick L. I*, 364 F.3d 487; *Pa. Prot. & Advocacy v. Pa. Dep't of Pub. Welfare,* 402 F.3d 374, 380-81 (3rd Cir. 2005); *Hampe v. Hamos*, 917 F. Supp. 2d 805, 821 (N.D. Ill. 2013). No such plan was presented by Respondent.

The ADA is designed to require reluctant public entities to make exceptions for individuals with disabilities. For the PGA Tour, the requirement that all golfers walk the course was an important requirement of their program. The Supreme Court, however, found that making an exception to allow the use of a golf-cart for a golfer with a disability, was a reasonable modification and not a fundamental alteration. *PGA Tour Inc. v. Martin*, 532 U.S. 661, 663 (2001). Caps on Medicaid services require exceptions to comply with the ADA. In *Fisher*, imposition of a cap on prescription medications violated the ADA—making an exception to the cap for individuals who needed the additional medications was a reasonable modification. *Fisher*, 335 F.3d at 1182; *see e.g. Wilborn v. Martin*, ___ F. Supp. 2d ___, No. 3:13-00574, 2013 WL 4401854 *18-19 (M.D. Tenn., Aug. 15, 2013) (granting a motion for a preliminary injunction involving a "cost cap" and issuing an injunction requiring exceptions be made). The fundamental

alteration defense does not stand for the proposition that a public entity, like the Respondent, can create a rule and then argue any alteration of the rule is fundamental.

II. The arbitrary caps on services violate the Administrative Procedures Act.

The fundamental alteration defense stems from Respondent's argument that the agency has created a rule which must be followed in all circumstances. Respondent continues to treat the 28 hour cap as an absolute rule, but the cap has not been promulgated as a regulation under the Administrative Procedures Act (APA). "'Regulation' means each agency statement of general public applicability that implements or prescribes law or policy or practice requirements of any agency. Policy or guidance issued by an agency other than in a regulation does not have the force or effect of law." S.C. Code Ann. § 1-23-10(4) (2005).

In *Home Health Service, Inc. v. South Carolina Tax Commission*, the South Carolina Supreme Court considered whether a rule violated the APA because it established a rule of general applicability without being promulgated as a regulation. 312 S.C. 324, 440 S.E.2d 375 (1994). *Home Health Service* involved whether a bingo operator could allow an employee to temporarily sit in for a player "during the player's absence from the game." *Id.* at 326, 440 S.E.2d at 377. While the Court did not find that the policy issued by the Tax Commission was a rule of general applicability, establishing a binding norm, the Court cautioned the Tax Commission against circumventing the regulation process:

> Whether a particular agency proceeding announces a rule or a general policy statement depends upon whether the agency action establishes a binding norm. *Ryder Truck Lines, Inc. v. United States,* 716 F.2d 1369 (1983). In our view, the document issued was similar to a policy

> statement as opposed to a binding norm given that the document was not issued by the commissioners and thus, no final agency approval had been given. Therefore, we do not find that the APA was violated in this instance. We caution respondent that when there is a close question whether a pronouncement is a policy statement or regulation, the commission should promulgate the ruling as a regulation in compliance with the APA.

Id. at 328-29, 440 S.E.2d at 378.

In the case of *Sloan v. South Carolina Board of Physical Therapy Examiners*, the Supreme Court again sends a warning to agencies that wish to circumvent the APA. 370 S.C. 452, 636 S.E.2d 598 (2006). *Sloan* involved whether a physical therapist could be employed by a doctor, who will then refer patients to her. The Board had endorsed an opinion by the Attorney General that such employment arrangements violated S.C. Code Ann. § 40-45-110(A)(1) (2011). *Sloan,* 370 S.C. at 476, 636 S.E.2d at 611.

> Under the line of federal cases we relied on in *Home Health Service,* courts have held that whether an agency's action or statement amounts to a rule--which must be formally enacted as a regulation--or a general policy statement--which does not have to be enacted as a regulation--depends on whether the action or statement establishes a "binding norm." When the action or statement "so fills out the statutory scheme that upon application one need only determine whether a given case is within the rule's criterion," then it is a binding norm which should be enacted as a regulation. **But if the agency remains free to follow or not follow the policy in an individual case, the agency has not established a binding norm.**

Id. at 475-76, 636 S.E.2d at 610 (emphasis added); *see also, S.C. Coastal Conservation League v. S.C. Dep't of Health and Envtl. Control*, 363 S.C. 67, 74-75, 610 S.E.2d 482, 485-86 (2005) (A regulation failed for vagueness because it did not include a test to determine what "small" was; the test had to be promulgated by regulation.); *Courts v. Agency for Health Care Admin.*, 965 So. 2d 154, 159 (Fla. Dist. Ct. App. 2007) (In Florida a similar rule has been applied specifically to the Medicaid agency: "[T]his court

has held that, if an agency changes a non-rule-based policy, it must either explain its reasons for its discretionary action based upon expert testimony, documentary opinions, or other appropriate evidence, or it must implement its changed policy or interpretation by formal rule making." (citations omitted)).

In this case, the agency has attempted to establish a binding norm without promulgating a regulation. The agency policy being interpreted by the hearing officer is a 28 hour cap on a combination of personal care and companion services. R. 335 ("When the waiver was renewed, it included service limits of 28 hours per week . . . ."); R. 914 (Memorandum mentioning the caps.); R. 940 ("These approved limits cannot be exceeded and must be applied to all [ID/RD] Waiver participants .... [W]e are not at liberty to exceed the established limits."). The Respondent notes in its brief, "The limitations were applied across the board in accordance with the terms of the waiver document." Respondent's Brief at p. 14. The Hearing Officer apparently agreed and determined that he was not free to deviate from the policy. R. 271 ("[M]y jurisdiction is limited to interpretation of agency policy.").

The Administrative Law Court (ALC) has already found that this 28 hour cap on services is a binding norm and unenforceable unless it is promulgated as a regulation. *E.g. Hickey v. Dep't of Health and Human Servs.*, Docket No. 10-ALJ-08-0656-AP (July 19, 2011). Att. 1. The decision of the ALC is consistent with case law from other jurisdictions holding that provisions of a waiver document that have not been promulgated as regulations as required by a state's APA are unenforceable and cannot be the basis of reductions in services. *McCrann v. NC Dep't of Health and Human Services*, 704 S.E.2d 899 (N.C. App. 2011)(The provisions of a waiver limiting benefits were rules

that must be promulgated as regulations pursuant to the state APA); *Weaver v. Colo. Dep't of Social Servs.*, 791 P.2d 1230 (Colo. Ct. App. 1990)(Denial of benefits based on an unpromulgated rule violated the state APA); *Mullins v. N.D. Dep't of Human Servs.*, 454 N.W.2d 732 (N.D. 1990)(invalidating unpromulgated manual provisions purporting to define individuals eligible for benefits).

Respondent cites to *Doe v. South Carolina Department of Health & Human Services* in support of the contention that the 28 hour cap does not have to be promulgated as a regulation in order to be applied as a rule. 398 S.C. 62, 727 S.E.2d 605 (2011). Respondent interprets *Doe* to create a distinction between policy that has been approved by CMS and general policy guidelines developed by the agency but not approved by CMS. In *Doe* the Court addressed eligibility for ID/RD waiver services and the definition of "mentally retarded."[21] 398 S.C. at 66-67, 727 S.E.2d at 607-608. The term mentally retarded is defined partially in terms of the age of onset of the condition. One of the issues before the Court was whether the age of onset requirement was age 18 or age 22. In looking at that issue, the Court simply noted that the waiver document did not address the age of onset issue. 398 S.C. at 66, 727 S.E.2d at 607 ("South Carolina's waiver application with the federal government does not include any age-of-onset requirement and reveals no intent to vary from or otherwise limit the group of individuals encompassed by the SSI definition of mental retardation."); 398 S.C. at 74, 727 S.E.2d at 611 ("South Carolina *could have* listed additional criteria in the waiver application for the

[21] The Court noted that "[s]ubsequent to the briefing and arguments in this case, the General Assembly, in 2011 Act No. 47 changed the references to mental retardation . . . to 'intellectual disability.'" The Court used the term "mental retardation" to remain consistent with the record in the case. *Doe*, 398 S.C. at 67 n.5, 727 S.E.2d at 607 n.5.

purpose of defining the population to whom it would provide waiver services."). The Court found that the age 18 age of onset requirement in SCDDSN's policy guidelines contradicted the age 22 age of onset requirement in S.C. Code Ann. Regs. 88-210 (F). *Id.* In contrast, the dissent found that the definitions in Regulation 88-210 only apply to "the licensing of programs." 398 S.C. at 77-78, 727 S.E.2d at 613. Because the dissent found that Regulation 88-210 was inapplicable, the dissent then turned to DDSN's policy guidelines for the determination of whether the age of onset requirement is 18 or 22 and argued that those guidelines should have been followed by the Court. *Id.* at 8 ("[T]he majority ostensibly agrees the guidelines are in effect unless they conflict with state law.") The majority's response to the dissent's argument is in footnote 7 of the decision:

> [T]he dissent finds the policy guidelines are entitled to deference in interpreting section 44–20–30. In accordance with our statutory law, we hold an agency guideline does not have the force of law, and in any event, can never trump a regulation. Our law provides that "'[r]egulation' means each agency statement of general public applicability that implements or prescribes law or policy or practice requirements of any agency. *Policy or guidance issued by an agency other than in a regulation does not have the force or effect of law.*" S.C.Code Ann. § 1–23–10(4) (2005) (emphasis added). Thus, because the age-eighteen-onset requirement found in DDSN's policy guidelines has not been formally adopted as a regulation, it does not have the force and effect of law and is entitled to no deference. Indeed, the only South Carolina law addressing the age onset requirement is Regulation 88–210.

398 S.C. at 68 n.7, 727 S.E.2d at 608 n.7.

The *Doe* case does not support Respondent's contention that the approval by CMS of the waiver provisions means the rules contained in those provisions do not have to be promulgated under the state APA in order to be enforceable. *Doe* is the only legal support Respondent offers for the argument that the 28 hour cap is not a binding rule in violation of the ADA. CMS's approval of the waiver provisions is irrelevant to whether

the policy's contained in the waiver provisions must be promulgated. The ALC in the *Hickey* decision agreed stating, "I find no legal support for this argument. On the contrary, other states which have considered this precise question have held that the provisions of a waiver document must be promulgated as a regulation under the state's APA in order to be enforceable as a rule or binding norm." *Hickey v. Dep't of Health and Human Servs.*, Docket No. 10-ALJ-08-0656-AP at 7 (July 19, 2011). Att. 1.

CONCLUSION

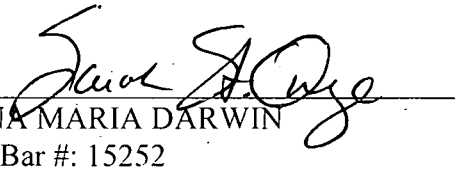
Identifying and providing services for individuals with disabilities to enable them to live in the community should be an objective and individualized process. "[U]nder Title II of the ADA, States are required to provide community-based treatment for persons with mental disabilities when [1] the State's treatment professionals determine that such placement is appropriate, [2] the affected persons do not oppose such treatment, and [3] the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities." *Olmstead v. L.C.*, 527 U.S. 538, 607 (1999). To help states meet the requirement imposed by Title II, the Medicaid waiver programs were established to provide care in the community for individuals who want to be in the community and whose needs can be met in the community. *See generally Radaszewski v. Maram*, 383 F.3d 599, 601-02 (7th Cir. 2004).

Each amicus in this case represents or advocates for individuals who receive services through SCDHHS and SCDDSN. These amici organizations have seen the negative effect that the Respondent's changes are having on individuals with disabilities and their families. Respondent's changes to the ID/RD waiver, especially the limitation

on personal care hours, place individuals like the Appellant at risk of institutionalization, in violation of the ADA. Implementing a flat hourly cap on personal care services, showing indifference to individuals' needs, is contrary to the ADA. Making that cap a rule without exception is contrary to the APA. For reasons stated herein, Amici respectfully request consideration of this Amici Curiae Brief in rendering a ruling in this appeal.

Respectfully submitted,

PROTECTION AND ADVOCACY FOR
PEOPLE WITH DISABILITIES, INC.

BY: 
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GLOSSARY OF ACRONYMS

- ADA - Americans with Disabilities Act
- ALC - Administrative Law Court
- APA – Administrative Procedures Act
- CMS - U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services
- HCBS - Home and Community Based Services
- ICF/ID - Intermediate Care Facility for the Intellectually Disabled
- ID/RD – Intellectual Disabilities/Related Disabilities
- OAPA - Omnibus Adult Protection Act
- P&A – Protection and Advocacy for People with Disabilities, Inc.
- SCDDSN - South Carolina Department of Disabilities and Special Needs
- SCDHHS - South Carolina Department of Health and Human Services
- SCLS – South Carolina Legal Services, Inc.
- SCNAELA – South Carolina Chapter of the National Academy of Elder Law Attorneys

IN 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

Stogsdill, Richard — Appellant

v.

South Carolina Department of Health and Human Services, — Respondent

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CERTIFICATE OF SERVICE

I certify that I have served the Motion for Leave to File an Amici Curiae Brief along with the attached copy of the conditionally filed Amici Curiae Brief as follows:

1. Emailing a copy to the following:
    a. Richard Hepfer at hepfer@scdhhs.gov
    b. Patricia Harrison at plh.cola@worldnet.att.net
2. Depositing a copy of these documents in the United States Mail, postage prepaid, on the 21th day of February, 2014, addressed as follows:

    Ms. Patricia L. Harrison
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    Mr. Richard Hepfer
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Dated this 21 day of February, 2014.

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Attachment 1

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

Barbara Hickey, Appellant, vs. South Carolina Department of Health and Human Services, Respondent.	Docket No. 10-ALJ-08-0656-AP **FINAL ORDER AND DECISION**

STATEMENT OF THE CASE

This matter is before me pursuant to the appeal of Barbara Hickey (Appellant), from a final decision of the Respondent, South Carolina Department of Health and Human Services (DHHS or Department). This appeal is made in response to Respondent's January 1, 2010 cut in Personal Care Aide (PCA II) services to all those persons who, like the Appellant, rely on these services to live in the community and avoid institutionalization, and to Respondent's denial of Appellant's right to contest this withdrawal of necessary services at a hearing.

On December 1, 2009, Appellant received a letter from Respondent, stating that her in-home PCA II hours had been cut from 50 per week to 28 per week. Petitioner appealed that decision on January 15, 2010. Department of Disability and Special Needs (DDSN) responded to her appeal stating that the "limits cannot be exceeded and must be applied to all [Mental Retardation/Related Disabilities (MR/RD)] Waiver participants." Appellant appealed that decision on January 25, 2010. The hearing officer issued an "interlocutory order" dated January 29, 2010 which stated that she believed that the DHHS had the authority to administer the Medicaid Program in South Carolina, and that the Center for Medicare and Medicaid Services (CMS) had approved the revised Waiver, including the service caps. Petitioner responded on February 12, 2010 stating that she did not understand the decision and requesting a hearing. On

February 17, 2010 the hearing officer dismissed appellant's case stating that she failed to respond to his Interlocutory Order with an allegation of error in fact or in law as ordered. On March 1, 2010, counsel for Appellant filed a Motion to Alter or Amend Judgment and a supporting Affidavit in response to the decision to dismiss Appellant's case and requested a fair hearing be held. On March 10, 2010, DHHS filed a Reply to Appellant's Motion requesting the hearing officer uphold its dismissal of Appellant's case and deny her a hearing. The hearing officer issued a final decision on July 20, 2010 dismissing Appellant's case without a hearing. Appellant received the final decision on July 28, 2010 and appealed to this Court on August 27, 2010. Both parties were represented by counsel at Oral Arguments on April 12, 2011 at the offices of the ALC in Columbia, South Carolina.

Issues on Appeal

1. Has the Department treated its PCA II benefit cap as a binding norm such that promulgation as a regulation is necessary for it to be enforceable?
2. Does inclusion in the waiver document make the PCA II cap enforceable without promulgation?
3. Does S.C. Code § 44-6-90 exempt the Department from promulgating regulations to carry out its duties?
4. Did the Department err in refusing to provide Hickey with a hearing?
5. Did the Department's decision contain erroneous findings of fact?

Standard of Review—

This matter is before the ALC in its appellate jurisdiction pursuant to S.C. Code Ann. § 1-23-600(D) (Supp. 2010). Accordingly, the Administrative Procedures Act's standard of review governs this appeal. See S.C. Code Ann. §§ 1-23-600(E), 1-23-380 (Supp. 2010); see also Byerly Hosp. v. S.C. State Health & Human Servs. Fin. Comm'n, 319 S.C. 225, 229, 460 S.E.2d 383, 385 (1995). The standard used by appellate bodies, including the ALC, to review agency decisions is provided by S.C. Code Ann. § 1-23-380(5) (Supp. 2010). This section provides:

> The court may not substitute its judgment for the judgment of the agency as to the weight of the evidence on questions of fact. The court may affirm the decision of

the agency or remand the case for further proceedings. The court may reverse or modify the decision [of the agency] if substantial rights of the appellant have been prejudiced because the administrative findings, inferences, conclusions, or decisions are:

(a) in violation of constitutional or statutory provisions;
(b) in excess of the statutory authority of the agency;
(c) made upon unlawful procedure;
(d) affected by other error of law;
(e) clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; or
(f) arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

S.C. Code Ann. § 1-23-380(5) (Supp. 2010).

A decision is supported by "substantial evidence" when the record as a whole allows reasonable minds to reach the same conclusion reached by the agency. Bilton v. Best Western Royal Motor Lodge, 282 S.C. 634, 321 S.E.2d 63 (Ct. App. 1984). Substantial evidence is not a mere scintilla of evidence, nor the evidence viewed blindly from one side of the case, but is evidence that, considering the record as a whole, would allow reasonable minds to reach the conclusion the agency reached in order to justify its action. Hargrove v. Titan Textile Co., 360 S.C. 276, 289, 599 S.E.2d 604, 611 (Ct. App. 2004). The fact that the record, when considered as a whole, presents the possibility of drawing two inconsistent conclusions from the evidence does not prevent the agency's finding from being supported by substantial evidence. Id.; Waters v. S.C. Land Res. Conservation Comm'n, 321 S.C. 219, 467 S.E.2d 913 (1996); Grant v. S.C. Coastal Council, 319 S.C. 348, 461 S.E.2d 388 (1995). However, § 1-23-380(5) requires the reviewing tribunal to consider not only the amount of evidence, but also the quality of that evidence; it must be both "reliable" and "probative," as well as "substantial." See S.C. Code Ann. § 1-23-380(5) (Supp. 2010).

An abuse of discretion occurs when a decision is based upon an error of law, such as application of the wrong legal principle; or, when based upon factual conclusions, the ruling is without evidentiary support; or when the judge is vested with discretion, but the ruling reveals no discretion was exercised; or when the ruling does not fall within the range of permissible decisions applicable in a particular case. Ex Parte Capital U-Drive-It, Inc., 369 S.C. 1, 5, 630 S.E.2d 464, 467 (2006). A decision is arbitrary or capricious when no rational basis for the conclusion exists, when it is based on one's will and not upon any course of reasoning and

exercise of judgment. Converse Power Corp. v. S.C. Dep't of Health & Envtl. Control, 350 S.C. 39, 564 S.E.2d 341 (Ct. App. 2002); Deese v. S.C. State Bd. of Dentistry, 286 S.C. 182, 184-85, 332 S.E.2d 539, 541 (Ct. App. 1985). A decision may be arbitrary or capricious when it is made at one's pleasure without adequate determining principles, or is governed by no fixed rules or principles. Deese, 286 S.C. at 184-85, 332 S.E.2d at 341. Non-uniform, inconsistent, or selective application of authority can indicate arbitrariness. See Mungo v. Smith, 289 S.C. 560, 571, 347 S.E.2d 514, 521 (Ct. App. 1986).

Medicaid MR/RD Waiver Program

Medicaid is an optional state program created under Title XIX of the Social Security Act. It enables states to receive federal financial assistance specifically for the medical care of needy individuals. See 42 U.S.C.A. § 1396; Wilder v. Va. Hosp. Ass'n, 496 U.S. 498, 502 (1990); Doe v. Kidd, 501 F.3d 348, 351 (4th Cir. 2007). States are not required to participate in Medicaid; however, if they choose to do so, they must comply with all federal Medicaid laws and regulations. Wilder, 496 U.S. 498; Doe, 501 F.3d at 351; see also Antrican v. Odom, 290 F.3d 178 (4th Cir. 2002) ("Although North Carolina may retain a special sovereignty interest in choosing whether to participate in the Medicaid program, once it elects to participate, it is not entitled to assert that interest to insulate itself from the requirements of the federal program."), cert. denied, Odom v. Antrican, 537 U.S. 973 (2002). As a prerequisite to receiving federal assistance, a state must submit a detailed plan, referred to as the "State Plan," to the CMS for approval. 42 U.S.C.A. § 1396a.

In South Carolina, DHHS is the state agency responsible for administering and supervising the state's Medicaid programs. S.C. Code Ann. § 44-6-30(1); Doe, 501 F.3d at 351. DDSN is responsible for the state's treatment and training programs for people with mental retardation and related disabilities. Doe, 501 F.3d at 351. Accordingly, in some instances, such as the case at hand, DDSN can act as an agent for DHHS. Id.

Medicaid normally provides funding for individuals with mental disabilities who live in an institution. However, states may make a request to the CMS for a "waiver" to pay for otherwise non-covered Home and Community Based Services (HCBS) for Medicaid-eligible persons who might otherwise be institutionalized as long as the services are cost effective. 42 U.S.C.A. § 1396n(c).

States must seek approval for these waiver programs from the CMS. If a waiver is approved, the CMS waives compliance with state program requirements while permitting states to remain eligible for reimbursement with federal grants. Id. The waiver program provides Medicaid reimbursement to participant states for providing HCBS to individuals who would otherwise require institutional care. See 42 U.S.C.A. § 1396n(c). Waivers are approved for a period of two to three years and may be renewed thereafter. Under a program operated by DDSN, CMS has waived the requirement that an individual live in an institution to receive services. In this appeal, the waiver program at issue is the MR/RD Waiver Program. The MR/RD Waiver Program permits a recipient to receive services at home or in the community, rather than in an Intermediate Care Facility Mental Retardation (ICF/MR) such as a nursing home. Doe, 501 F.3d at 351.

On January 1, 2010 a new MR/RD waiver renewal became effective following approval by CMS. The renewed waiver document includes a cap of 28 hours per week for PCA II services. PCA II services consist of hands-on personal care to help a participant accomplish the activities of daily living such as bathing, toileting, dressing and eating.

I. Has the Department treated its PCA II benefit cap as a binding norm such that promulgation as a regulation is necessary for it to be enforceable?

The central issue raised by the Appellant in this case is whether the Department is entitled to rely on an amendment to the MR/RD waiver document to cut Appellant's PCA II services from 50 to 28 hours per week. It is uncontroverted that the cap on PCA II services was not promulgated as a regulation under the Administrative Procedures Act, S.C. Code Title 1, Chapter 23 (APA). The Department makes three arguments in support of its position that it properly applied the cap on PCA II services in this case without promulgating the cap provision as a regulation.

The Department first asserts that the cap on CPA II services is not a rule that must be promulgated as a regulation in order to be enforceable. "[W]hether an agency's action or statement amounts to a rule--which must be formally enacted as a regulation -- or a general policy statement -- which does not have to be enacted as a regulation -- depends on whether the action or statement establishes a 'binding norm.'" Sloan v. S.C. Bd. of Physical Therapy Exam'rs, 370 S.C. 452, 636 S.E.2d 598 (2006). In order for an agency to create a "binding" rule

it must be promulgated as a regulation. Home Health Serv., Inc. v. S.C. Tax Comm'n, 312 S.C. 328, 440 S.E.2d 375 (1994). The key factor in determining whether a policy statement establishes a "binding norm" is the extent to which the challenged policy leaves the agency free to exercise its discretion to follow or not follow the policy at issue in a particular situation. Home Health Serv. Inc. v. S.C. Tax Comm'n, 312 S.C. 324, 328, 440 S.E.2d 375, 378 (1994). If the policy at issue "so fills out the statutory scheme" that the agency will only look to whether the policy's criteria are met in taking action or rendering a decision, the policy will be considered a "rule" or "regulation." Id. As long as the agency remains free to consider the individual facts in taking action or rendering a decision, the policy at issue will not be considered a "binding norm." Id. Thus, to determine whether a policy or guideline establishes a "binding norm," courts look to the actions of the agency, not to the labels given by the agency.

In this case, the Department argues that it has not treated the cap on PCA II services as a binding norm. I find no support for this argument in the record; the Department has consistently treated the PCA II services cap as a binding norm. In its initial letter denying Hickey's request for continued PCA II services benefits at the level she formerly received, the Department stated,

> [L]imits or caps were placed on services in the MR/RD Waiver. Approval for these limits or caps was obtained from the [CMS]. These approved limits cannot be exceeded and must be applied to all MR/RD Waiver participants. While we understand and appreciate the hardship these changes may place on you, we are not at liberty to exceed the established limits.

In response to Hickey's appeal of that decision, the hearing officer upheld the Department's decision denying Hickey a hearing in part because, the Department

> need not grant a hearing if the sole issue is a Federal or State law requiring an automatic change adversely affecting some or all recipients. The reduction in Petitioner's PC II hours was imposed by caps and limits on these, and other services specified in the MR/RD Waiver as renewed effective January 1, 2010, and imposed upon all Waiver participants. These changes in the Waiver were approved in advance by ...CMS....For the purposes of this decision, it is presumed that this approval, inclusive specifically of the changes approved, by CMS carries the force and effect of law.

Thus, because the Department's decisions in this case look only to whether the services Hickey received were within the cap and not to any other standard or factual issues, the cap on PCA II services was treated as a binding norm and not as a general policy statement. The Department did not treat the cap as a policy statement that it was free to exercise its discretion to

follow or not follow according to the particular facts in Hickey's situation. See Ryder, 717 F.2d at 1377-1378.

II. Does inclusion in the waiver document make the PCA II cap enforceable without promulgation?

The Department next argues that it is not required to promulgate the provisions of the waiver document in order to enforce them because they are a contract between the state and federal government contemplated by the agency statutes and regulations and are entitled to deference as a "federal directive."[1] The Department cites its regulation S.C. Code Ann. Regs. 126-300 and its general grants of authority contained in S.C. Code Ann. § 44-6-30 to 40 in arguing that the PCA II service cap should be enforced.

I find no legal support for this argument. On the contrary, other states which have considered this precise question have held that the provisions of a waiver document must be promulgated as regulations under the state's APA in order to be enforceable as a rule or binding norm. In McCrann v. N.C. Dept. Health and Human Services, 704 S.E.2d 899 (N.C. App. 2011), the North Carolina Court of Appeals held that it was error of law for the agency to rely upon the provisions of a waiver to deny services to a Medicare beneficiary. The court held that the provisions of the waiver limiting benefits were "rules" that must be promulgated as regulations pursuant to the state APA in order to carry the force of law. Likewise, in Hoban v. State of Vermont, Op. No. 200-4-05, Lexis 40 (Vt. Super 2005). the Superior Court of Vermont held that a cap on HCBS contained in a Medicaid waiver program was void due to the agency's failure to promulgate the cap as a regulation under the state APA. See also, Mullins v. N. Dakota Dept. of Human Services, 454 N.W.2d 732 (N.D. 1990) (invalidating unpromulgated manual provisions purporting to define individuals eligible for benefits). Compare, Rennich ex rel. Rennich v. N. Dakota Dept. of Human Services, 2008 ND 171, 756 N.W.2d 182, 188 (N.D. 2008) (distinguishing situation where conditions of eligibility are set by federal statute and regulation).

III. Does S.C. Code § 44-6-90 exempt the Department from promulgating regulations to carry out its duties?

[1] For purposes of this discussion I assume without deciding that the Department's characterization of the waiver document as a "federal directive" is accurate. It appears that the waiver document was authored by the Department and approved by the federal agency, CMS.

Lastly, the Department asserts that South Carolina statutes do not require the Department to promulgate regulations to carry out its duties. In support of this position the Department cites S.C. Code Ann. § 44-6-90, which states, "The department may promulgate regulations to carry out its duties." The Department's argument is that because § 44-6-90 allows, but does not require, the Department to promulgate regulations, that the Department is exempt from the requirements of the APA when carrying out its duties. In South Carolina the cardinal rule of statutory interpretation requires the trier of fact to ascertain the intent of the legislature. State v. Scott, 351 SC 584, 588, 571 S.E.2d 700, 702 (2002). In doing so, the court must give a reasonable and practical construction to the statute that is consistent with the purpose and policy expressed in the statute. Davis v. NationsCredit Fin. Servs. Corp., 326 SC 83, 484 S.E.2d 471 (1997). Where there is one statute addressing an issue in general terms and another statute dealing with the issue in a more specific and definite manner, the more specific statute will be considered an exception to, or a qualifier of, the general statute and given such effect. Capco of Summerville, Inc. v. Gayle Construction Company, Inc., 368 S.C. 137, 628 S.E.2d 38 (2006). Statutes in apparent conflict should, if reasonably possible, be construed so as to allow both to stand and to give effect to each. Higgins v. State, 307 S.C. 446, 449, 415 S.E.2d 799, 801 (1992). I conclude that the general language allowing the Department to promulgate regulations does not override the more specific requirements of the APA. To interpret Section 44-6-90 as urged by the Department would imply that every agency given general authority to promulgate regulations is thereby exempted from the requirements of the APA. Such an interpretation does not yield a reasonable and practical construction consistent with the purpose and policy expressed in either the APA or § 44-6-90. Therefore, the Department erred in treating the cap on PCA II services as a binding and enforceable rule without promulgating the cap as a regulation pursuant to the APA.

IV. Did the Department err in refusing to provide Hickey with a hearing?

The procedures for appealing a decision regarding Medicaid services provided under a HCBS waiver are set forth in the Code of Federal Regulations. See 42 C.F.R. §§ 441.200 *et. seq.* Those regulations provide that a state hearing system for Medicaid recipients under a state waiver "must meet the due process standards set forth in Goldberg v. Kelly, 397 U.S. 254 (1970)." 42 C.F.R. § 431.205(d). The state agency must grant an opportunity for a hearing to any applicant who requests it because his claim for services is denied, 42 C.F.R. § 431.220(a)(1),

or if the state agency takes action to suspend, terminate or reduce services. 42 C.F.R. § 431.200(b). However, the agency need not grant a hearing if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all recipients. 42 C.F.R. § 431.220(b). As a state agency administering the Medicaid program, the Department must comply with all federal Medicaid laws and regulations. Wilder v. Va. Hosp. Ass'n, 496 U.S. 498, 502 (1990); Doe v. Kidd, 501 F.3d 348, 351 (4th Cir. 2007).

The Department advances two arguments in support of its dismissal of Hickey's matter without a hearing. First, the Department argues that the reduction of benefits carried out pursuant to the revised waiver's cap on PCA II services is an issue involving a change in state or federal law and so no hearing is required pursuant to 42 C.F.R. § 431.220(b) (stating that the agency need not grant a hearing if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all recipients). I am unpersuaded by this argument because, as discussed in detail above, the PCA II cap contained in the revised waiver document does not have the force and effect of law. Thus, Hickey's request for a hearing does not fall within the exception to the hearing requirement provided by 42 C.F.R. § 431.220(b).

Second, the Department argues that the process afforded Hickey met the requirements of Due Process and the federal regulations because the Department offered Hickey an opportunity to present written argument in response to the interlocutory order. The Department argues that because Hickey responded to the interlocutory order by requesting a hearing rather than by submitting written statements demonstrating a "valid factual dispute" that she failed to avail herself of the opportunity the Department offered for a hearing. The Department cites Rosen v. Goetz, 410 F.3d 191 (6th Cir. 2005) in support of its argument that only an opportunity for a written argument is minimally required in some cases. Because the Rosen case arose in the context of a challenge of a procedure by hundreds of plaintiffs concerned with the enforcement of a consent order and not in the context of an individual request for a hearing preceeding a reduction in Medicaid benefits, I find the reasoning contained therein insufficient to overcome the hearing requirements applicable to this case pursuant to the controlling federal regulations and the standard enunciated by the Supreme Court in Goldberg. The Goldberg Court held:

> The city's procedures presently do not permit recipients to appear personally with or without counsel before the official who finally determines continued eligibility. Thus a recipient is not permitted to present evidence to that official orally, or to

> confront or cross-examine adverse witnesses. These omissions are fatal to the constitutional adequacy of the procedures. The opportunity to be heard must be tailored to the capacities and circumstances of those who are to be heard. It is not enough that a welfare recipient may present his position to the decision maker in writing or second-hand through his caseworker. Written submissions are an unrealistic option for most recipients, who lack the educational attainment necessary to write effectively and who cannot obtain professional assistance. Moreover, written submissions do not afford the flexibility of oral presentations; they do not permit the recipient to mold his argument to the issues the decision maker appears to regard as important....Therefore a recipient must be allowed to state his position orally.

Goldberg v. Kelly, 397 U.S. 254, 268- 269, 90 S. Ct. 1011, 1021, 25 L. Ed.2d 287 (1970). The controlling federal regulations specifically require the Department to "meet the due process standards set forth in Goldberg." 42 C.F.R. § 431.205(d). Moreover, federal regulations require the Department to grant an opportunity for a hearing to any applicant who requests it because his claim for services is denied, 42 C.F.R. § 431.220(a)(1), or if the state agency takes action to suspend, terminate or reduce services. 42 C.F.R. § 431.200(b). Because the Department seeks to reduce Hickey's benefits and she requested a hearing, it was error for the Department to deny her a hearing. It was not enough to demand that she present issues of fact in writing and to dismiss her appeal when she requested an in-person hearing. Moreover, where a case involves important questions of novel impression, such as the issues presented here concerning the enforceability of the unpromulgated waiver document and the issues of compliance with the Americans with Disabilities Act currently pending in federal district court,[2] it is error to dismiss the case for failure to state a claim. Evans v. State Retirement, 344 S.C. 60 543 S.E.2ed 547 (2001).

V. Did the Department's decision contain erroneous findings of fact?

Appellant raises several additional issues concerning whether findings of fact and recitations of the history of the proceedings contained in the Department's decision are erroneous. Although I note the lack of support in the record for the challenged findings and statements, the consideration of the remaining issues is unnecessary because the Department's decision is reversed on the grounds discussed above. See Futch v. McAllister Towing of Georgetown, Inc., 335 S.C. 598, 613, 518 S.E.2d 591, 598 (1999) (concluding that an appellate

[2] Hickey v. Forkner, 4:10-CV-02696-TLW-TER (D.S.C. 2010)

court need not address remaining issues when disposition of a prior issue is dispositive of the case).

ORDER

IT IS HEREBY ORDERED that, the Decision of the South Carolina Department of Health & Human Services reducing Appellant's PCA II services from 50 hours per week to 28 hours per week is **REVERSED**.

IT IS FURTHER ORDERED that before taking further action to reduce Appellant's benefits under the MR/RD waiver, the Department must provide Appellant with a hearing consistent with this Order and Decision; the benefit limitations contained in the January 1, 2010 MR/RD waiver renewal may not serve as the legal basis for a reduction in benefits unless they are promulgated pursuant to the requirements of the South Carolina Administrative Procedures Act.

AND IT IS SO ORDERED.

Deborah Brooks Durden
Administrative Law Judge

July 19, 2011
Columbia, South Carolina

CERTIFICATE OF SERVICE

I, Robin E. Coleman, hereby certify that I have this date served this Order upon all parties to this cause by depositing a copy hereof, in the United States mail, postage paid, in the Interagency Mail Service, or by electronic mail to the address provided by the party(ies) and/or their attorney(s).

Robin E. Coleman

Robin E. Coleman
Judicial Aide to Deborah Brooks Durden

July 19, 2011
Columbia, South Carolina