IN THE STATE OF SOUTH CAROLINA
In the Court of Appeals
APPEAL FROM THE ADMINISTRATIVE LAW COURT

Case No. 2013-000762

Richard Stogsdill,
Appellant,

v.

South Carolina Department of Health
and Human Services,
Respondent.

APPELLANT'S RETURN TO RESPONDENT'S PETITION FOR REHEARING ON THE ISSUE OF WHETHER RICHARD IS AT RISK OF INSTITUTIONALIZATION

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I. Introduction.

This Return is filed by Appellant, Richard Stogsdill in opposition to Respondent's Petition for Rehearing, pursuant to Rules 240 and 242 of the South Carolina Rules of Appellate Procedure. Appellant objects to Respondent's Petition, which challenges the Court's factual finding that Richard is at risk of institutionalization. The Court correctly ruled that *Pashby v. Delia* is controlling in this case and that Richard has demonstrated that he is at risk of institutionalization. 709 F.3d 307 (4th Cir. 2013).

To receive funds from the federal government for Richard's services, DHHS each year certifies to CMS that "but for the provision" of the Medicaid waiver services hard receives, he would require admission to an ICF/ID facility (formerly ICF/MR). R. 209. 42 U.S.C. 1396n(c)(1) provides that DHHS must show CMS that "but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan." *See also* 42 C.F.R. 435.217.

II. Respondent failed to produce *any evidence* from a qualified medical source at either hearing to rebut Dr. Joseph's determination that he is at risk of institutionalization.

42 C.F.R. 431.244(a) requires that fair hearing decisions must be "based exclusively on evidence introduced at the hearing." Despite having two opportunities at fair hearings, and having the home-court advantage of the hearing officer being an employee of the agency, DHHS failed to present even a scintilla of evidence at either hearing to contradict the determination of Richard's physician that he is at risk of institutionalization.[1]

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[1] While this issue does not appear to have been addressed by appellate courts in South Carolina, other states have determined that when the Medicaid Agency terminates of reduces

Dr. Joseph opined that Richard's parents would not be able to provide for his care at home and that he "would be at risk of institutionalization if the needed home-based services are not provided." R. 921. Dr. Joseph provided specific evidence about Richard's condition and he explained why the services he ordered are medically necessary. R. 920-922. Richard's psychological services provider, Lennie Mullis, based her opinion on more than thirty years of experience working with persons who have disabilities, and her familiarity with the services provided through the program as a former director of a County DSN Board. R. 917. She stated in her affidavit that Richard's parents "are getting older and are not physically or mentally able to continue to provide care at the level they provided prior to his reaching age 21." Id. Based her experience in this system for more than three decades, Ms. Mullis opined that Richard's "mental and physical health would decline if he were required to attend a workshop" and that he would be "at risk of harm" due to the aggressive behavior of some workshop attendees and his inability to

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benefits, the burden is on the State to prove that the participant is no longer eligible for the benefits. *Kegel v. State*, 113 N.M. 646, 648, 830 P.2d 563, 565 (Ct. Ap. 1992). See also *Simmons v. Van Alstyne,*65 A.D.2d 869, 410 N.Y.S.2d 400 (1978) (burden of proof when discontinuing benefits is on local agency, not petitioner, in first instance). In *In Re: Johnny M. Adger, Employee, v. City of Manning,* the South Carolina Supreme Court recently reversed the decision of the agency, because it improperly placed the burden of proof on the recipient of benefits. Appellate Case No. 2012-212722, No. 27424 (S.C. July 30, 2014). The Supreme Court held in another case decided in 2014 that when an state agency terminates a license, it is clear that the burden of proof is on the agency to justify the termination. *South Carolina Department of Motor Vehicles v. Brown*, Case No. 27346 (S.C.S.C. January 8, 2014). DHHS has failed to promulgate any regulation addressing who has the burden of proof in Medicaid fair hearings. When the State reduces Medicaid benefits, the burden should be on the State to prove that the change initiated by the agency was justified. The Director admits that the new CMS Final Rule (discussed below) "is a philosophical shift in that the burden is placed on the states to prove settings are integrated into the community." Exhibit 1. (This Court may take judicial notice of minutes of the DHHS CMS Final Rule Work Group located at https://msp.scdhhs.gov/hcbs/sites/default/files/CMS%20Final%20Rule%20Minutes%202-26-2014.pdf.)

defend himself." R. 918.

Respondent now asks that the Court ignore the opinions of these qualified medical professionals, who know Richard well and are familiar with his need for assistance with every single activity of daily living.[2] They are the persons to whom the United States Supreme Court determined the State must give the "greatest of deference." *Olmstead v. L.C.,* 527 U.S. 581, 610 (1999).

A review of the Record on Appeal, prepared by Respondent, reveals that DHHS failed to present any testimony or evidence from a qualified medical source regarding the risk of institutionalization. At the 2009 hearing, only DHHS counsel and Richard's service coordinator appeared on behalf of Respondent and the only exhibits Respondent presented were notices of hearing and the agency's prehearing brief. (According to the decision of Hearing Officer Loomis, the actual Record in those proceedings was omitted by DHHS.) Appellant presented live testimony from Nurse Todd and Richard's mother, along with uncontradicted medical records and an affidavit of Richard's treating physician, Dr. Joseph, into the Record. R. 31 and 32. None

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[2] At the first "fair hearing" in 2009, Richard presented testimony from a nurse, David Todd, who had worked with him for years and was very familiar with his medical needs, but the hearing officer did not mention his testimony in her order or discuss the credibility of this witness. R. 31 and Exhibit 2 that was attached to Memorandum attached to Appellant's Petition for Rehearing. The hearing officer also accepted into evidence a letter from Rena Taylor, a physical therapist (R. 31), an affidavit of Dr. Joseph (R. 32), a two-page letter from Dr. Yajnik, a physical therapy prescription of Dr. Joseph, medical records of Dr. Lawrence Mauldin, an examination report of Dr. Kuzbary and progress notes from Camden Rehab (Id.). The 2009 decision of Hearing Officer Loomis was deemed by DHHS to be "interlocutory" and Richard was not allowed to appeal that decision. Respondent did not object to Richard's request to incorporate the 2009 proceedings into the record and the hearing officer reviewed and claimed to have considered the record in those proceedings. R. 14 and 68. Yet, he refused Appellant's requests to include this transcript in the Record on Appeal. R. 49-50 Richard argued that it was legal error for the hearing officer to omit from the record on appeal the transcript, exhibits and records in this proceeding and Richard's due process rights were violated thereby. R. 84-85, 93 and 97.

of this evidence supports Respondent's argument that Richard is not at risk of being institutionalized.

At the hearing in 2010, Respondent presented two witnesses and four exhibits. The first exhibit admitted at the 2010 hearing was a memo from its first witness, Jacob Chorey. This memo was sent by Chorey to the Director of the Office of Appeals and Hearings on February 18, 2010, without providing a copy to Appellant. R. 88. Mr. Chorey's *ex parte* memo lays out for the hearing officer the framework for the order DHHS sought. It does not provide an individualized assessment of Richard's condition or needs, or even address whether reducing these services would result in his institutionalization. Id.

Respondent's Exhibit 2 is the pre-hearing brief that was submitted by counsel for DHHS. R. 89. Therein, counsel makes legal arguments regarding the agency's interpretation of various federal mandates, but it contains no evidence that would support the agency's argument that this Court erred in making its factual finding regarding the risk of institutionalization.

Respondent's Exhibit 3 is a memo from DHHS' only other witness, Dawn Shealy. R. 97. It includes the assessment that was completed by Richard's DDSN service coordinator, Suzanne Yankovich, before Richard's father died. This assessment documents that Richard "Requires extensive, moderately intense support and supervision (within the same room or nearby, outside of visual supervision for 15 minute periods.") R. 98. The "caregiver stress" assessment prepared by DDSN supports the testimony of Richard's mother that she will be unable to sustain her efforts to provide care for Richard in the home without more supports and services. R. 99. It documents that Richard's mother "has back problems from lifting Richard and as she is getting older she does not have as much strength." Id. at 100. This assessment also documents that

Richard has no friends, neighbors, church members or extended family who can assist in caring for him. Id. It states that Richard's need for Speech Therapy, Occupational Therapy and Physical Therapy are not being met. Id. The DDSN Service Coordinator noted that Richard's family experienced loss of income and that caring for Richard has resulted in the loss of a job or reduction in hours worked outside the home. R 101. DDSN's own assessment clearly supports Dr. Joseph's opinion that Richard is at risk of institutionalization:

> Richard is non ambulatory and relies on the assistance of others to complete all activities of daily living and personal hygiene. Richard's parents are the primary caregivers and provide assistance to help Richard complete activities of daily living and hygiene tasks at the end of the day and throughout the night. Richard will call out to his parents during the night to go to the bathroom or if he does not feel well. Mr. and Mrs. Stogsdill have both had to alter their work schedules in order to ensure there is someone with Richard at all times.
> Mrs. Stogsdill has stated as she is getting older she finds it more difficult to transfers (sic) Richard easily and has back problems as a retult of years of transferring him. Mr. and Mrs. Stogsdill also care for elderly parents and are required to go to their residences, which are not local, to ensure that their needs are being met as well. Mr. and Mrs. Stogsdill have not been able to visit with family and friends or have a vacation for them as they need to make sure Richard is cared for. On the weekends, there is no support for Richard in the house so Mr. and Mrs. Stogsdill must ensure that one of them is home with Richard or take Richard wherever they go. Richard has expressed wanting to spend more time on the weekends with other people and be able to go out and do activities that are being held so that he can meet people his own age.

R. 102. On page 103 of the Record, the Service Coordinator stated that Richard needs "constant hands-on/direct care and supervision due to medically complex condition OR severe disability."

Ms. Shealy based her allocation of respite hours on a false impression that "Mom works part time." Ms. Shealy sent this assessment to Jacob Chorey, but there is no evidence in the Record that any qualified medical provider at DDSN or DHHS reviewed or provided input to the assessment. R. 108.

Respondent's final exhibit is a memo from DDSN employees to DSN Board Executive

Directors, and providers of service coordination and day services informing them that four meetings to be held in November and December. This exhibit has no bearing on whether or not Richard is at risk of institutionalization. Respondent's Exhibit 4. R. 110. The hearing officer included Respondent's Post-Hearing Brief as Respondent's Exhibit 5. R. 113. In this brief, Respondent's counsel argues that, on remand, Richard's case was "reevaluated and reauthorized by the local board, taking into account the orders of Dr. Thomas C. Joseph." R. 114. But there is no evidentiary support for this claim in the Record. It is totally unsupported by evidence *introduced at the hearing*, and only that evidence presented at the hearing may be considered. 42 C.F.R. 431.244(a). Counsel concludes at page 4 of the brief (R. 116) that it is speculative that Richard would be institutionalized, but absolutely no evidence is contained in the Record to support that argument.

Having established that Respondent provided no exhibits or documents at the hearing that Richard is not at risk of institutionalization, Appellant now turns to the testimony of Respondent's witnesses, Jacob Chorey and Dawn Shealy. Ms. Shealy admitted that she had no medical training. R. 33, and 41. Her testimony shows just how much attention she paid to the agency's assessment when she determined how many hours of respite care Richard was entitled to receive. The assessment contains facts supporting Richard's need for assistance with every activity of daily living throughout the day and night. Yet, even after preparing for her hearing testimony, Ms. Shealy still did not know whether Richard could get out of bed without assistance, whether he could toilet himself, feed himself, bathe himself or get out of the house in the event of a fire. R. 36. Contrary to counsel's arguments in the Post Hearing Brief, Ms. Shealy admitted in her testimony that she had not performed any review of the medical necessity for

Richard's services. R 34 and 35. She clearly and unambiguously stated that "I didn't review any medical records" and admitted that she had not communicated with Richard's physician. R. 36. She "just felt like 40 hours a week of respite was sufficient" because "The mother works part time." R. 38. Ms. Shealy was not aware that Mrs. Stogsdill worked six part time jobs or how many hours Mrs. Stogsdill works a week. R. 38. The decision about how many hours of respite care Richard would receive was based on "the assumption that the family would provide those services," in clear violation of 42 C.F.R. 435.602. R. 40.

Respondent's only other witness, Mr. Chorey, holds a Bachelor's in Psychology from BYU and a Masters in Counseling from Webster University. R. 45. He admitted having no involvement in the determination of Richard's need for services. R. 47. He also admitted having no "personal knowledge of Richard Stogsdill." R. 54. Mr. Chorey did not have a "full understanding" of Respondent's implementation of caps on services. R. 56. He began working at DDSN after the amendments to the waivers were implemented. R. 52. According to Mr. Chorey, his job "is to testify at these type of fair hearings to represent our Agency so even if I didn't have a direct role in the determination, I still would have a role in testifying to the processes that have been developed and any related information that I'm aware of." R. 55. Clearly, Mr. Chorey had no qualifications or experience that would allow him to determine the medical necessity of the services Dr. Joseph had ordered or whether Richard was at risk of institutionalization.

When the mandate of 42 C.F.R. 431.244(a), i.e. that hearing officers must base their decisions *exclusively* on the evidence presented at hearings, is considered, it is clear that this Court correctly determined that Richard is at risk of institutionalization. Richard himself provided a sworn affidavit stating that "Without the waiver services I need, I would have to live

in an institution." R. 924. Like Chip. E., in *Peter B. v. Sanford*, Richard is cognitively alert, but he has profound cerebral palsy and is dependent upon others for every activity of daily living. R. 130. As Judge Bruce Howe Hendricks recognized in that case it is "precisely for this reason, the prospect of institutionalization is most terrorizing to him." Report and Recommendation dated November 24, 2010 at R. 134-135. Richard's opportunities to participate as a valued member of the community, like those of Chip E., would be "forfeited upon institutionalization." Id. Judge Hendricks recognized in that case that:

> This is precisely the sort of injury incidental to the prejudice of segregation, which the *Olmstead* mandate contemplates and seeks to redress. *See Olmstead*, 527 U.S. at 60001 ("[C]onfinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.") His experience in an institution would come with all of the adjunct humiliations that violation of personal space and person imposes. "Institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life." *Id.* Where such an experience can be avoided, without significant alteration of the *status quo*, the United States Supreme Court has stated, it should be.

Judge Hendricks also took note in her R&R of the audit of DDSN that had found "unsanitary conditions; abuse; neglect, and exploitation in these institutions" and the "irreparable harm and opportunity cost of a de facto involuntary institutionalization of a person otherwise content and healthy in the community." R. 135. She correctly determined that courts must give the opinions of the plaintiffs' treating physicians deference, citing the mandate of the United States Supreme Court in *Olmstead*, 527 U.S. at 610. Id. at 135. Judge Hendricks found that the "unfavorable resolution" of Peter B.'s administrative appeal was "additional evidence of the likelihood that the plaintiffs' rights in necessary services will not be protected and that they will be forced into institutional facilities but for Court action, now." Id. at 136. The district court

found that maintaining the plaintiffs' services would actually save taxpayer dollars and that granting a preliminary injunction "negligibly impacts" the State. ("In all respects, the undersigned believes that an ongoing violation of the ADA is present." R. 137).

In contrast to the "evidence" Respondent presented at the 2010 hearing in Richard's casee, he presented sworn affidavits from his treating physician and provider of psychological support services supporting his claim that failing to provide the services ordered by Dr. Joseph would lead to his institutionalization. It is important to note that Respondent did not object to these affidavits being received as evidence at the hearing. R. 268. Indeed, Respondent's counsel agreed to admit this evidence into the Record. R. 268, 312-313. The South Carolina Supreme Court recently ruled that a party in an administrative hearing waives his right to challenge the reliability of evidence entered into the Record at an administrative hearing if an objection is not made at the hearing. *S.C.D.M.V. v. Brown, supra.* As in that case, Respondent's after-the-fact objection to the admission of affidavits comes too late.

In any event, Rule 803(4) of the South Carolina Rules of Evidence provides an exception to the hearsay rule for:

> (4) Statements for Purposes of Medical Diagnosis or Treatment. 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; provided, however, that the admissibility of statements made after commencement of the litigation is left to the court's discretion.

Furthermore, DHHS' own website instructs waiver participants to bring medical records and letters from their physicians to the hearing:

Q. What Types of Evidence Can I Present at the Hearing?

Witnesses – someone who can help prove your arguments

Records – These can include any documents that show you meet the eligibility criteria such as income records, property records, medical records, or school records

Documents – These can include items such as income tax documents, bank statements, or a letter from your doctor

https://www.scdhhs.gov/site-page/appeals-and-hearings-frequently-asked-questions.

In its Petition for Rehearing on the issue of whether Richard is at risk of institutionalization, Respondent comes to this Court with unclean hands making arguments that hearing officers are prohibited from considering such evidence based on the hearsay exception. This attempt is made even more egregious by the fact that the live testimony Appellant presented at the 2009 hearing and the extensive medical documentation provided at that hearing was omitted by DHHS in the Record on Appeal, even though Hearing Officer Loomis' order was "interlocutory." R. 31 and 32. Richard's requests to supplement the Record with this wealth of information, obtained at great cost at the first hearing, were ignored by the hearing officer in violation of Richard's due process rights.

Respondent does not even attempt to dispute - or address in any reasonable fashion - the fact in its Petition that Richard requires around-the-clock care and supervision. The State failed to explain how, without subjecting him to settings his physician and provider of psychological services have determined to be unsafe, his need for assistance with activities of daily living could be met. The Court should deny Respondent's Petition for a hearing on the issue of whether Richard is at risk of institutionalization, as set forth in *Pashby, supra.*

III. The Court of Appeals properly interpreted controlling law in *Pashby v. Delia* in finding that Richard is at risk of institutionalization.

Having failed to present any testimony or other evidence at either hearing that supports

DHHS' argument in its Petition that Richard is not at risk of institutionalization, Respondent takes a shot at this Court's interpretation of *Pashby v. Delia.* 709 F. 3d 307 (4th 2013). But the Court's reliance on that decision is clearly supported, and nothing in Respondent's Petition changes that fact. *Supra.* In *Pashby*, the United States Court of Appeals for the Fourth Circuit ruled that a state must provide services to persons who have disabilities:

> " in the most integrated setting appropriate to the needs of qualified individuals with disabilities," *id.* § 35.130(d). Pursuant to federal regulations, the " most integrated settings" are those that " enable[ ] individuals with disabilities to interact with nondisabled persons to the fullest extent possible." 28 C.F.R. pt. 35, app. B.

Id. at 321. The Fourth Circuit noted in that case that in *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 119 S.Ct. 2176, 144 L.Ed.2d 540 (1999), the Supreme Court ruled that "unjustified institutional isolation of persons with disabilities is a form of discrimination." *Id.* at 600, 119 S.Ct. 2176. The Fourth Circuit clearly shot down the State of North Carolina's "forceful" arguments" that the plaintiffs in *Pashby* were not likely to succeed because they had not been placed in an institution *yet.* Noting that the United States Department of Justice (DOJ) had already "refuted this argument," the Fourth Circuit dismissed that excuse for reducing services when those reductions might force people like Richard into group homes. Id. at 322.

The Fourth Circuit in *Pashby* recognized that DOJ has determined "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." (Emphasis added.) U.S. Dept. of Justice, *Statement of the Department of Justice on the Integration Mandate of Title II of the ADA and Olmstead v. L.C.,* http:// www. ada. gov/ olmstead/ q& a_ olmstead. htm (last updated June 22, 2011); *see also Olmstead,* 527 U.S. at 597-98, 119 S.Ct. 2176.

Respondent's argument that Richard must not be at risk of institutionalization because he continues to live in his home for now is simply frivolous and it should be dismissed because Respondent has provided no factual support to refute the evidence Richard presented at the hearing.

Federal regulations prohibit the State from considering resources of the parents of an adult Medicaid participant in determining eligibility for Medicaid services. 42 C.F.R. 435.602(1) provides that "Except for a spouse of an individual or a parent for a child who is under age 21 or blind or disabled, the agency must not consider income and resources of any relative as available to an individual." No reasonable person could argue with a straight face that Richard could remain at home without the resources that have been provided by his parents and the Medicaid waiver program. These parental resources, however, cannot be considered in determining his right to services or the number of hours he is entitled to receive, based on his own financial circumstances and his medical condition and needs.

Respondent's reliance upon services provided by Richard's mother, now the family's sole breadwinner working six part time jobs, clearly violates this unambiguous federal regulation. Only Richard's mother knows where her breaking point is. The State cannot determine where that point might lie or base Richard's entitlement to services on her continued gratuitous services, any more than it could require adult children to quit their jobs in order to provide care for elderly parents who meet eligibility requirements for Medicaid funded nursing home care or home and community based services. Forcing such obligation to care for another adult family member violates 42 C.F.R. 435.602 and it confuses the waiver participants *rights* with the agency's strong and unfettered desire to continue spending money allocated for services for

purposes unintended by the General Assembly. It is clearly discriminatory that DHHS would force parents of children with severe disabilities into making the Draconian choice of placing their children in unsafe facilities in order to obtain the services they need to live at home. R. 135. Yet DHHS has never been so bold as to suggest that able bodied adult children of disabled parents must quit their jobs, give up their lives and take care of their parents in their homes. Richard's right to services, without regard for what gratuitous services his mother might provide, is no less significant.

Respondent cites, but then ignores the ruling of the Tenth Circuit cited in *Pashby* that holds "there is nothing in the plain language of the regulations that limits protection to persons who are currently institutionalized." *Fisher v. Okla. Health Care Auth.*, 335 F.3d 1175, 1181 (10th Cir.2003). Like those individuals in *Fisher* and *Pashby*, Richard has demonstrated that he would be required to enter an institution to obtain the Medicaid services he needs, thus he faces a "risk of institutionalization." The Fourth Circuit has now clearly held that group homes are institutions," for purposes of determining whether the State is in compliance with the integration mandate of the ADA. *Pashby* at 322-323. That Court noted that after DOJ conducted an investigation of whether North Carolina's group homes violated *Olmstead* 's integration requirement, the DOJ concluded in a July 28, 2011, letter that " [a]dult care homes are institutional settings that segregate residents from the community and impede residents' interactions with people who do not have disabilities." Id.

Respondent's attempt to distinguish Richard's case from *M.R. v. Dreyfus* also falls short of DHHS' target by a longshot. 697 F.3d 706. Richard's mother testified that he needs constant supervision to perform activities of daily living and instrumental activities that are provided by

personal care attendants and this testimony is supported by Respondent's own assessment of Richard's condition, the stress level of his parents (before his father died and his mother became the sole breadwinner and family caregiver), and his need for services. R. 159 to 169.

Like plaintiff C.B. in *M.R. v. Dreyfus,* it is uncontested that Richard "requires assistance with a range of tasks, including cooking, transporting herself (himself) to and from appointments with physicians, bathing and dressing herself (himself), and cleaning her (his) home. Id. at 729. C.B., however, was able to prepare meals in the microwave, a task Richard will never be able to accomplish. As with C.B., DHHS "did not respond" to the evidence Richard presented, in Richard's case, at two hearings. Also like C.B., Richard presented expert opinions that he is unable to participate in activities that "involve satisfying primary biological functions, this "[unmet] need cannot be tolerated for long." Id. at 730. The court ruled that C.B. "need only show that, by depriving her of access to care that is critical to her health, the regulation exacerbates the risk that she will be institutionalized." Id. at 731. Richard has made such a showing in this case.

The court determined that plaintiff K.S., like Richard, "requires assistance moving, bathing and dressing herself, cooking, managing her medications, using the toilet, and cleaning herself after accidents." Like Richard, if K.S. experiences incontinence while she is left alone, she must sit on the toilet until a provider arrives to help her undress, bathe, and launder her soiled clothes." (Actually, Richard would not be able to sit alone on the toilet, due to his spasticity.) Id. 731. Unlike Richard, K.S. is able to walk. Id. The federal court, however, found that K.S. is at risk of institutionalization because she is:

"worried that I would be unable to remain in my home ... and I very much want to avoid

> going to an adult group home. Staying in my home gives me a feeling of independence and I believe my mental health condition would deteriorate in an adult day home quickly. Even though I would be able to get more continuous hours of care at a nursing home, the lack of privacy and the lack of independence that I would experience there would be very difficult for me."

Id. at 731.

As to the reliance of declarations in *M.R.*, the federal Court of Appeals found that the district court had improperly "relied on an overly strict causation standard," just as Respondent attempts to do in this case by ignoring the affidavits Richard presented. The *M.R.* court ruled that beneficiaries of public assistance programs "may demonstrate a risk of irreparable injury by showing that enforcement of a proposed rule ' may deny them needed medical care.'" In *M.R.*, the appellate court recognized that like Richard, "individuals with disabilities continually encounter various forms of discrimination, including outright intentional exclusion, ... failure to make modifications to existing facilities and practices, ... [and] ... segregation," *id.* § 12101(a)(5). That court held that:

> In an attempt to remedy society's history of discriminating against the disabled—discrimination that included isolating, institutionalizing, and segregating them— the ADA provides that " no 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." *Id.* § 12132; *accord* 29 U.S.C. § 794(a). The Department of Justice has promulgated regulations implementing the ADA. *See* 42 U.S.C. § 12134(a). One of the regulations is the so-called " integration mandate," providing that " [a] public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d). The " most integrated setting" is the one that " enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible." *Id.* Part 35, App. B (2011). The regulation also provides that " [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." *Id.* § 35.130(b)(7).

Id. at 733-734. The Seventh Circuit clearly held in *M.R.* that the lower court erred in requiring the plaintiffs to "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." Significantly, that court held that "[I]mminent risk of institutionalization is not required." Rather, "[t]he elimination of services that have enabled Plaintiffs to remain in the community violates the ADA." Id. at 734.

This Court correctly applied *Pashby* and *M.R.* to the facts of this case and determined that Richard is at risk of institutionalization and Respondent's Petition for Rehearing should be denied.

IV. Respondent's Argument that Richard Should Submit to Services in Congregate Setting is Frivololous and it Ignores the Integration Mandate of the ADA.

Respondent's arguments that Richard failed to show risk of institutionalization because he has not simply accepted the agency's scheme and subjected himself to the risks inherent in attending a workshop or receiving respite services in an ICF/MR demonstrates not only insensitivity to his needs, but also a complete disregard for the opinions of his treating physician and psychological services provider who have both determined that these settings would be unsafe for Richard. These arguments support Richard's Petition requesting that this Court determine based on the evidence Richard has already presented that he needs the number of hours his physician has ordered - without remand back to the agency, where Richard will surely cycle through with the same end result for the third time. There is no reason to believe that giving DHHS a third bite at the apple will produce any different or any more equitable results. DHHS has demonstrated in the past that it has no respect for orders of appellate courts, or any attempt to comply with the federal law.

In *Doe v. DHHS,* the South Carolina Supreme Court ruled that DHHS must apply an age 22 onset criteria for a diagnosis of mental retardation and that the age 18 criteria used in determining eligibility for the waiver program violated state law. 398 S.C. 62, 727 S.E.2d 605 (S.C. 2011). This Court may take judicial notice under Rule 201 that three years later, DHHS and DDSN continue to apply the age 18 requirement, in open defiance of the Supreme Court's order, without regard for the consequences to the lives affected by this illegal practice. See LAC audit of DDSN at page 59. http://lac.sc.gov/LAC_Reports/2014/Documents/DDSN.pdf.

In *Peter Brown v. DHHS*, this Court ordered DHHS to provide a fair hearing on the merits of his claim, yet two years later, DHHS dismissed his appeal without providing a hearing and Peter Brown still has not received the services that were wrongfully terminated in 2009. 393 S.C. 11, 709 S.E.2d 701 (S.C.App. 2011). This Court may also take judicial notice of its own docket at 13 ALJ 08-0159 at http://ctrack.sccourts.org/public/caseView.do?csIID=56094, which documents that these services still have not been provided to Peter nearly nine years after he requested a fair hearing, nor has he been provided a hearing on the merits ordered by this Court.

In *Myers v. DHHS*, DHHS led the Administrative Law Court to believe that therapies and a speech device could be obtained through another DHHS funding source other than the Medicaid waiver. Case No. 2014-00048. Yet, years after Myers lost his battle to remain in his home, the physical therapy, speech therapy and needed durable medical equipment promised are still being denied and he remains entangled in litigation with DHHS. (This Court may take notice of its own docket at *Myers v. DHHS*,http://ctrack.sccourts.org/public/caseView.do?csIID=56069)

Any reasonable person reviewing Dr. Joseph's affidavit could not arrive at any conclusion other than that Richard is at a seriour risk of institutionalization if he is not provided with around

the clock care. Respondent argues that his risk of institutionalization could not be "serious" because his mother could not imagine him being admitted to an ICF/ID facility to receive respite services. Must the mother of a soldier imagine her son in a casket in her mind before the serious risk of harm in battle becomes real? Will a mother's imagination make him more safe or more at risk, based on what she thinks in her mind? Whether or not a parent can "imagine" such a nightmare, does not in any way affect the severity of the risk. The right to receive services at home is Richard's right, whether or not his family members can bring themselves to imagine what might happen to him if he should lose his battle and be admitted to a DDSN ICF/MR or other congregate setting.

Respondent's argument that Richard is not at risk of institutionalization because his mother "could not imagine" her son in an ICF/MR is preposterous. There is nothing in the federal statute or laws that allows a State Medicaid Agency to base its allocation of services on what a parent imagines.

Respondent's argument that Richard's qualified professional medical sources do not use the words "serious of significant risk of institutionaliation" plays on words and totally ignores the evidence presented at Richard's two hearings. It is significant that, despite two opportunities, DHHS presented not even a single witness who was qualified to assess Richard's medical needs. DHHS omitted the transcript and exhibits from the first hearing, where Richard presented the live testimony from a nurse and extensive medical records. Exhibit 2, Affidavit of Nancy Stogsdill that was attached to Corrected Memorandum in Support of Appellant's Petition for Rehearing and R. 31-32. The Court should deny Respondent's Petition for a Rehearing on the issue of risk of institutionalization.

V. Respondent's arguments that Richard should be required by this Court to leave his home and "try" receiving services in congregate settings violate the CMS "Final Rule" that became effective on March 17, 2014.

Respondent argues in the Petition to this Court that Richard is not at risk of institutionalization because he has yet not been required to "try" institutional respite or be admitted to a congregate workshop. The audacity of this argument is more fully revealed when one considers the CMS "Final Rule" which must be applied to all home and community based waiver programs and became effective on March 17, 2014. CMS recognized in this regulation that, just as States drag their feet in implementing the integration mandate contained in *Brown v. Board of Education,* States have been slow to put into practice the requirements set forth in *Olmstead* and the integration mandate of the Americans with Disabilities Act. 347 U.S. 483 (1954).

This Court may take judicial notice of the DHHS website informing the public about this Final Rule which is located at https://msp.scdhhs.gov/hcbs/. At this website, HHS informs the public that the Final Rule:

> ...does not just look at location, geography or physical characteristics. It looks at how a person spends their day, where they spend their day and with whom they spend their day. The purpose of the HCBS rule is to enable people to receive services in their home and community, keeping them out of institutions.

Counsel, in DHHS' Petition to this Court, suggests just the opposite for Richard, in gross violation of the Final Rule promulgated by CMS. This Court may also take judicial notice of the DHHS website which, strangely enough, shows that Mr. Hepfer is actually a member of a work group established by DHHS to implement this Final Rule. See https://msp.scdhhs.gov/hcbs/sites/default/files/HCBS%20Rule%20Workgroup%20Member%20

List.pdf. But the proposal Respondent presented to this Court in its Petition for Rehearing for meeting Richard's needs totally ignore this recent mandate to speed up the process of complying with *Olmstead* and the integration mandate.

The Rule was also explained by the Director of DDSN in a powerpoint located at http://ddsn.sc.gov/about/recentnews/Documents/Systems%20In%20Change.pdf and that document is also subject to judicial notice under Rule 201 of the South Carolina Rules of Evidence. A copy of excerpts from that powerpoint presentation to DDSN Commissioners is attached as Exhibit 2, which is also subject to judicial notice under Rule 201. The Final Rule establishes specific guidelines States must meet to assure that they comply with the integration mandate of *Olmstead* and with the Americans with Disabilities Act. This Rule requires DHHS to consider where, how, and with whom Medicaid waiver participants spend their day. Exhibit 2. It requires States to give waiver participants "access to the benefits of community living and the opportunity to receive services in the most integrated setting." It defines a "home and community based setting" as one that "is integrated in and supports access to the greater community.," one which "Provides opportunities to seek employment and work in competitive integrated settings, engage in community live, and control personal resources;" "Ensures the individual receives services in the community to the same degree of access as individuals not receiving Medicaid home and community-based services;" and, importantly "Is selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting." Exhibit 2. In order to be a "home and community based setting," DHHS must ensure " an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint." DHHS must assure that the placement "Optimizes individual

initiative, autonomy, and independence in making life choices" and "Facilitates individual choice regarding services and supports, and who provides them." Id.

The Final Rule requires the State to assure CMS that waiver participants "have freedom and support to control their schedules and activities and have access to food any time." Most importantly, according to Director Buscemi: "The new rule **switches the burden of proof to each state** to demonstrate that whatever models the state has in place are inclusive versus listing examples that are not." Exhibit 1. (Which is subject to judicial notice under Rule 201). Under this Rule, ICF/MR settinngs are presumed NOT to be home and community based, nor are "Settings with the effect of isolating individuals from the broader community of individuals not receiving Medicaid home and community based services are presumed NOT to be community based." Exhibit 2.

In short, the new Final Rule requires DHHS and DDSN to provide services in settings where persons like Richard can be fully integrated into the community, rather than being segregated and isolated with other disabled people in workshops or institutions, like Respondent's counsel suggests in the agency's Petition for Rehearing.

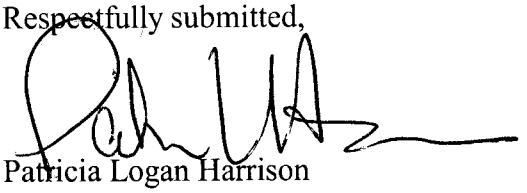
Respondent's Petition for Rehearing suggests that Richard attend a DDSN Day Program. But Dr. Buscemi has admitted that "**The Day Program structure that currently exists in the SC DDSN system is given as an example of something that is not community inclusive." Exhibit 2.** DDSN has acknowledged that its Day Programs are not community inclusive because "individuals go to a building to spend their entire day with other people who have a similar diagnosis as themselves," they "do almost the same thing everyday." and "rarely see people that are not paid support staff."

Richard prays that this Court consider and give the "greatest of deference" to the opinions of his qualified medical professionals who have determined, based on their knowledge of his condition and needs, as well as Ms. Mullis' intimate familiarity of the workshop system, that the Court deny Respondent's Petition for Rehearing the issue of his risk of institutionalization. Richard respectfully requests that this Court will be even more convinced now that DHHS has violated the Americans with Disabilities Act and that it will order DHHS to provide the services Richard's physician has ordered, without remand back to the agencies. By the filing of that Petition, and by its refusal to let go of DDSN's relentless attempt to force Richard into its congregate programs, the agency has demonstrated an obstinate refusal to comply with the integration of the Americans with Disabilities Act.

Richard prays that this Court will determine that he is the prevailing party entitled to legal fees and costs, including the cost of having to defend himself against this most recent attempt to tear apart his plan to remain in his own home.

CMS made it clear in this Rule that DHHS must "Demonstrate that individuals lead individual lives." Exhibit 2. That is exactly what Richard wishes to do, just to be provided with the services necessary to remain in his home, with his family and friends in the community, without further threat of being forced into an unsafe day or residential program, where others will set his schedule, determine what he eats and when he eats, and control his access to the community. Respondent has clearly failed to provide any substantial, probative or reliable evidence in support of its argument that Richard is not at risk - even serious risk - of institutionalization and their Petition should be denied, with fees and costs awarded to Richard and DHHS should be ordered to promptly provide the services ordered by Dr. Joseph.

Respectfully submitted,



Patricia Logan Harrison
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Attorney for Richard Stogsdill

October 2, 2914

Exhibit 1

Meeting Minutes from
SC DHHS "CMS FINAL RULE ON MEDICAID HCBS"
WORGROUP
dated February 26, 2014

Meeting Minutes
CMS Final Rule on Medicaid HCBS

Subject	Initial Meeting	Date/Time	February 26, 2014 /3:30 PM - 5 PM
Location	DHHS Jefferson Square, J11 Conference Room		

Attendees

SC HHS	Y/N	SC HHS	Y/N	Protection & Advocacy	Y/N
Pete Liggett	Y	Brenda Hyleman	N	Gloria Prevost	Y
Kelly Eifert	Y	Alexis Martin	N		
Shealy Reibold	Y				
Rick Hepfer	Y				
George Maky	Y	**DDSN**	**Y/N**		
Kara Wagoner-Lewis	Y	Beverly Buscemi	Y		
Anita Atwood	Y	Susan Beck	Y		
Mike Reynolds	Y	Janet Priest	Y		
Jocelin Dawson	Y	Jacob Chorey	Y		
Cindy Pedersen	Y	Tom Waring	Y		
Lisa Ragland	Y	Dave Goodell	Y		
Belinda Adams	Y	**DMH**	**Y/N**		
Sherry Everett	Y	Ligia Latiff-Bolet	Y		
AnnMarie Dwyer	Y				
Jennifer Gilmore	N				

Agenda

No.	Topic	Owner	References/handouts
1.	Introduction	Pete Liggett	
2.	Identification of Issues		
3.	Timelines and Transition Plan		
4.	Scope of Work		
5.	Other		

Key Points Discussed

No.	Topic	Highlights
1.	Introduction	• Pete welcomed group; Discussed intentionality of group to address changes needed due to CMS Final Rule • Views this as an opportunity to make improvements • We should look at others states to see what they are doing • Beverly noted that this does not lessen the impact of Olmstead but dovetails with it as evidenced by the interagency cooperation between CMS and DOJ
2.	Identification of Issues	• Timeline for submission of Transition Plan • Assessment of Residential settings where HCB services provided

		• Assessment of other day facilities where HCB services provided
		• Populations impacted
		• Medicaid Policy/service authority
		• Person-centered planning
		• Rate structure for services
		• 1915 (i) service authority
		• Financial impact
		• Quality assurance processes/systems
		• Lease agreements for residential placements (provider owned properties)
		• Bigger question –how far beyond our waivers do we want to extend our plan/change?
		  o Mentally ill
		  o CRCFs
		  o Other agencies to partner with to affect this change?
		• SC School for Deaf and Blind
		• Systematic assessment of level of need for individuals
		• Service –Home Supports- can we utilize/expand to help meet requirements?
		• Impacts to systems (like IT for billing, financial reporting, etc)

3.	Other issues/considerations	• Beverly noted that this rule is a philosophical shift in that the burden is placed on the states to prove settings are integrated into the community • Advocacy groups not all in agreement with new requirements of Final Rule • Pete wants to make sure we work with the Provider community to assist with this transition • Pete would like this group to look beyond just waiver populations and requirements; perhaps even beyond the Medicaid population – culture change in SC (ex: Prison population, homeless population, etc)
4.	Others to Invite	• Vocational Rehabilitation • Office on Aging – Lt. Gov. • AARP • Joy Jay/Phil Emery • CRCF Association • Consumer(s) • Provider(s) • Tim Rogers

		• Shelia Chavis & Office of Communications • SC School of Deaf & Blind
5.	Transition Plan	• There is a master transition plan that the state must submit that addresses how it will come into compliance with the Final Rule for all of its Waivers • The timeframe for submitting that Master plan impacted by submission of Waiver renewals or amendments after the effective date (March 17, 2014) • ID/RD Waiver renewal and PDD Waiver Renewal should happen at end of September • CLTC may also be submitting waiver amendments - related to the Duals Demonstration – at the end of September also • Those renewals or amendments must include a transition plan as it relates to those specific waivers • 120 days later after submission of the renewals/amendments (whichever is first), DHHS must submit the Master Transition Plan for the state (all 1915 Waivers) • Need to review services for all waivers to see what should be addressed to come into compliance? • How do we tackle these tasks?
6.	Scope of work	Divide issues into tasks; create subgroups to address

Action Items			
No.	**Action Item**	**Owner**	**Target Completion Date**
1.	Create small group to organize issues/tasks before next meeting	Pete/Kelly	3/7/2014
2.	Invite other stakeholders identified to next meeting	Kelly	3/5/2014

Next Meeting: Monday, March 10th, 9:30 AM – 11 AM, DHHS Jefferson Sq., J10 Conference Rm.

Exhibit 2

SC Department of Disabilities and Special Needs: Systems in Change

March 20, 2014

Presented by Dr. Buscemi at DDSN Commission Work Session

SC Department of Disabilities and Special Needs

Systems in Change

March 20, 2014

Commission Work Session

SC Department of Disabilities and Special Needs

- New approaches and requirements by Medicaid at the federal and state level are necessitating significant changes with the SC DDSN system.
- Many of these new approaches and changes require an examination of multiple systems and business processes.

SC Department of Disabilities and Special Needs

- While reviewing all of the elements of change affecting the statewide system, DDSN is committed to keeping the consumers and families first.
- The agency will make every effort to ensure that changes do not negatively affect families and that all essential needs are met.

Changes Impacting DDSN's Statewide System

Center for
Medicaid/Medicare
Services
Home and Community
Based Settings
New Final Rule

Effective March 17, 2014

HCBS NEW FINAL RULE

- New Home and Community-Based Setting (HCBS) Final Rule applies across multiple populations:
  - Intellectually Disabled/Related Disability
  - Autism
  - Mentally Ill
  - Elderly
- The ID/RD and Autism populations are at the heart of the new rule and will likely be the focus of follow up action from CMS and DOJ.

HCBS NEW FINAL RULE - CONTINUED

- Changes the definition of community inclusion for all Medicaid waiver services
- Previously the rule focused on residential settings, where the person lived. Are they integrated into the community?
- The new rule looks at not only where a person lives, but where, how, and with whom they spend their day.

HCBS NEW FINAL RULE - CONTINUED

- The new rule requirements establish an outcome oriented definition that focuses on the nature and quality of individuals' experiences .

- The requirements maximize opportunities for individuals to have access to the benefits of community living and the opportunity to receive services in the most integrated setting .

Taken from www.cms.gov

HCBS NEW FINAL RULE - CONTINUED

- The new final rule establishes:
  - Mandatory requirements for the qualities of home and community-based settings
  - Settings that are not home and community-based
  - Settings presumed not to be home and community-based
  - State compliance and transition requirements

Taken from www.cms.gov

HCBS NEW FINAL RULE - CONTINUED

- The home and community-based setting:
  - Is integrated in and supports access to the greater community
  - Provides opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources
  - Ensures the individual receives services in the community to the same degree of access as individuals not receiving Medicaid home and community-based services

Taken from www.cms.gov

HCBS NEW FINAL RULE - CONTINUED

- The home and community-based setting (continued):
  - Is selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting
  - Person-centered service plans document the options based on the individual's needs, preferences, and for residential settings, the individual's resources

Taken from www.cms.gov

HCBS NEW FINAL RULE - CONTINUED

- The home and community-based setting (continued):
  - Ensures an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint
  - Optimizes individual initiative, autonomy, and independence in making life choices
  - Facilitates individual choice regarding services and supports, and who provides them

Taken from www.cms.gov

HCBS NEW FINAL RULE - CONTINUED

- Additional requirements:
  - Specific unit/dwelling is owned, rented, or occupied under legally enforceable agreement
  - Same responsibilities/protections from eviction as all tenants under landlord tenant law of state, county, city or other designated entity

Taken from www.cms.gov

HCBS NEW FINAL RULE - CONTINUED

- Additional requirements (continued):
  - If tenant laws do not apply, state ensures lease, residency agreement or other written agreement is in place providing protections to address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law
  - Each individual has privacy in their sleeping or living unit

Taken from www.cms.gov

HCBS NEW FINAL RULE - CONTINUED

- Additional requirements (continued):
  - Units have lockable entrance doors with the individual and appropriate staff having keys to doors as needed
  - Individuals sharing units have a choice of roommates

Taken from www.cms.gov

HCBS NEW FINAL RULE - CONTINUED

- Additional requirements (continued):
  - Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement
  - Individuals have freedom and support to control their schedules and activities and have access to food any time
  - Individuals may have visitors at any time
  - Setting is physically accessible to the individual

Taken from www.cms.gov

HCBS NEW FINAL RULE - CONTINUED

- The new rule switches the burden of proof to each state to demonstrate that whatever models the state has in place are inclusive versus listing examples that are not.
  - This provides a lot of flexibility to states to develop various models that take into account specific local community dynamics.
  - But that flexibility makes it difficult to know for certain in advance exactly what will be approved and what will not.

HCBS NEW FINAL RULE - CONTINUED

- Settings presumed NOT TO BE home and community based:
  - Institution for mental diseases (IMD)
  - Intermediate care facility for individuals with intellectual disabilities (ICF/IID)
  - Nursing facility
  - Hospital

Taken from www.cms.gov

HCBS NEW FINAL RULE - CONTINUED

- Settings presumed NOT TO BE home and community based (continued):
  - Settings in a publicly or privately-owned facility providing inpatient treatment
  - Settings on grounds of, or adjacent to, a public institution
  - Settings with the effect of isolating individuals from the broader community of individuals not receiving Medicaid HCBS

Taken from www.cms.gov

HCBS NEW FINAL RULE - CONTINUED

- South Carolina Residential Settings
  - Some settings that may not meet the new rule:
    - Clusters of homes in close proximity
    - Homes located on the same campus or directly beside a day program or other large facility
    - Supported apartment settings where the apartments are clustered together and not interspersed within a larger complex of apartments.

HCBS NEW FINAL RULE - CONTINUED

- The Day Program structure that currently exists in the SC DDSN system is given as an example of something that is not community inclusive.

HCBS NEW FINAL RULE - CONTINUED

- What makes the current day program structure not community inclusive?
  - The fact that individuals go to a building to spend their entire day with other people who have a similar diagnosis as themselves.
  - People do almost the same thing everyday.
  - Individuals rarely see people that are not paid support staff

HCBS NEW FINAL RULE - CONTINUED

- What does CMS want the states to do?
  - Demonstrate that individuals lead individual lives
  - Individualize programming options
  - Increase employment opportunities

HCBS NEW FINAL RULE - CONTINUED

- What is the timeframe for implementation of the new final rule?
  - States have to submit a plan of compliance in no more than one year from March 17, 2014.
  - If a state submits a waiver renewal or amendment, the submission must include a plan for that waiver population, and a plan for the entire state must be submitted within 120 days.

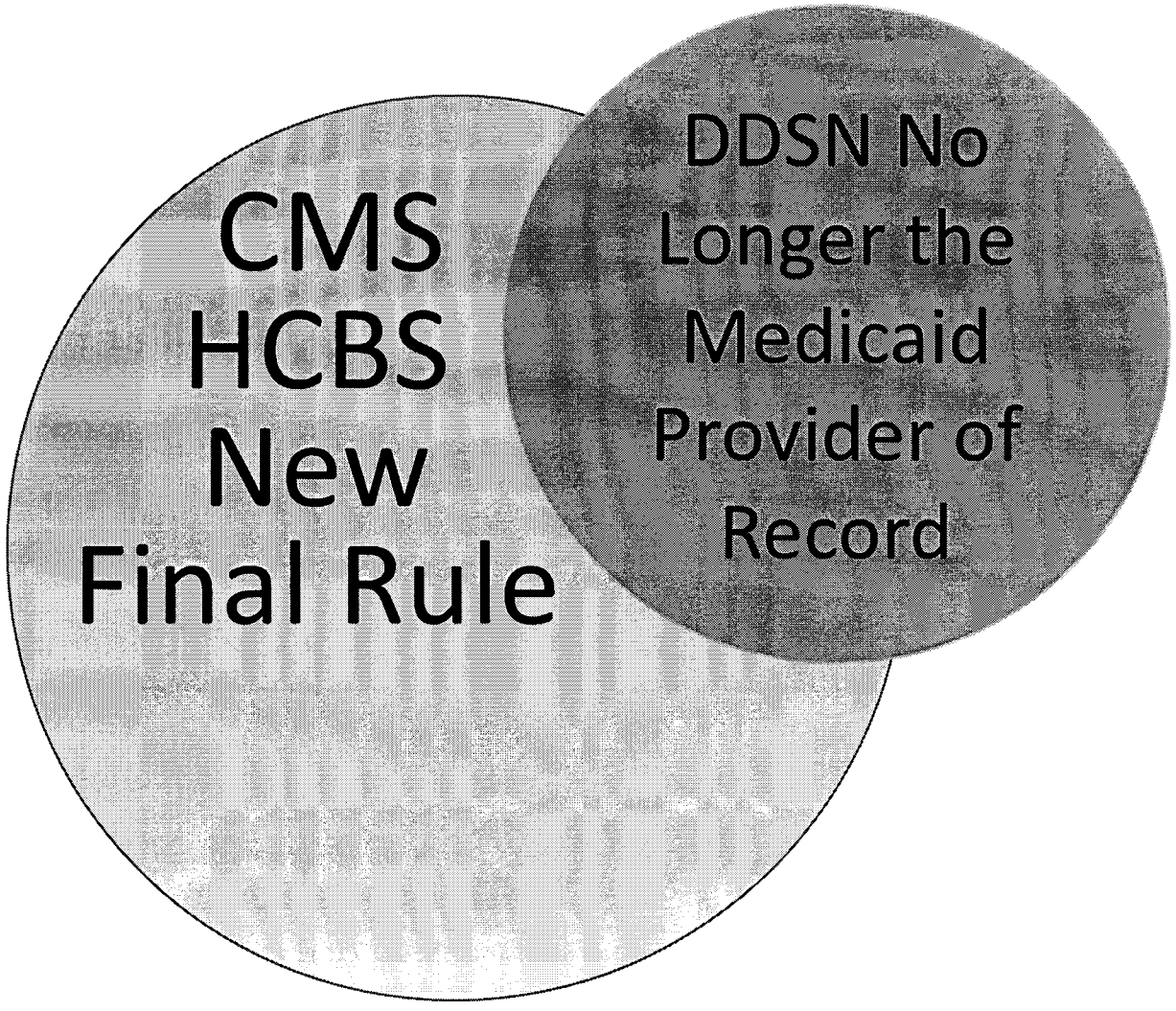
HCBS NEW FINAL RULE - CONTINUED

- What is the timeframe for implementating the new final rule?
  - SC must submit a waiver renewal for the ID/RD and PDD waivers by end of September 2014.
  - Therefore, the plan for the entire state must be submitted before the end of December 2014.

HCBS NEW FINAL RULE - CONTINUED

- What is the timeframe for the new final rule?
  - CMS will allow states five years from submission of the plan to come into compliance for all populations.

Changes Impacting DDSN's Statewide System



SC DDSN No Longer the Provider of Record for all Medicaid Services

- For almost 30 years, SC DDSN has been the provider of record for all Medicaid services for the populations served by the agency.
- This system of an Organized Health Care Delivery System has been accepted in the past by CMS with the support of SC DHHS (Medicaid agency).

SC DDSN No Longer the Provider of Record for all Medicaid Services - continued

- The current Administration of SC's Medicaid agency does not support this organizational structure.
- Therefore, DDSN must now change how the agency's statewide delivery system is organized.

SC DDSN No Longer the Provider of Record for all Medicaid Services - continued

- DDSN's role will change.
- DDSN will continue to be the subject matter expert for DDSN's populations.
- DDSN will continue to operate the four waivers on behalf of DHHS.

SC DDSN No Longer the Provider of Record for all Medicaid Services– continued

- DDSN will continue to develop policy.
- DDSN will continue to monitor services.
- DDSN will continue to assure health and safety.
- DDSN will continue quality assurance role.

SC DDSN No Longer the Provider of Record for all Medicaid Services– continued

- The fact that DDSN will no longer be the provider of record requires the agency to re-examine all business processes.

SC DDSN No Longer the Provider of Record for all Medicaid Services– continued

- Each function must be examined to determine which of three areas it falls into:
  1. Service
  2. Administrative
  3. Not Billable to Medicaid

SC DDSN No Longer the Provider of Record for all Medicaid Services– continued

1. Service
   - Billable to Medicaid at the service rate
   - 30 % state dollars and 70% federal dollars
   - DDSN has previously been able to bill all Medicaid services at the service rate because we were the provider of record.
   - DDSN will likely be able to only bill for some service functions in the future, such as ICF/IID.

SC DDSN No Longer the Provider of Record for all Medicaid Services– continued

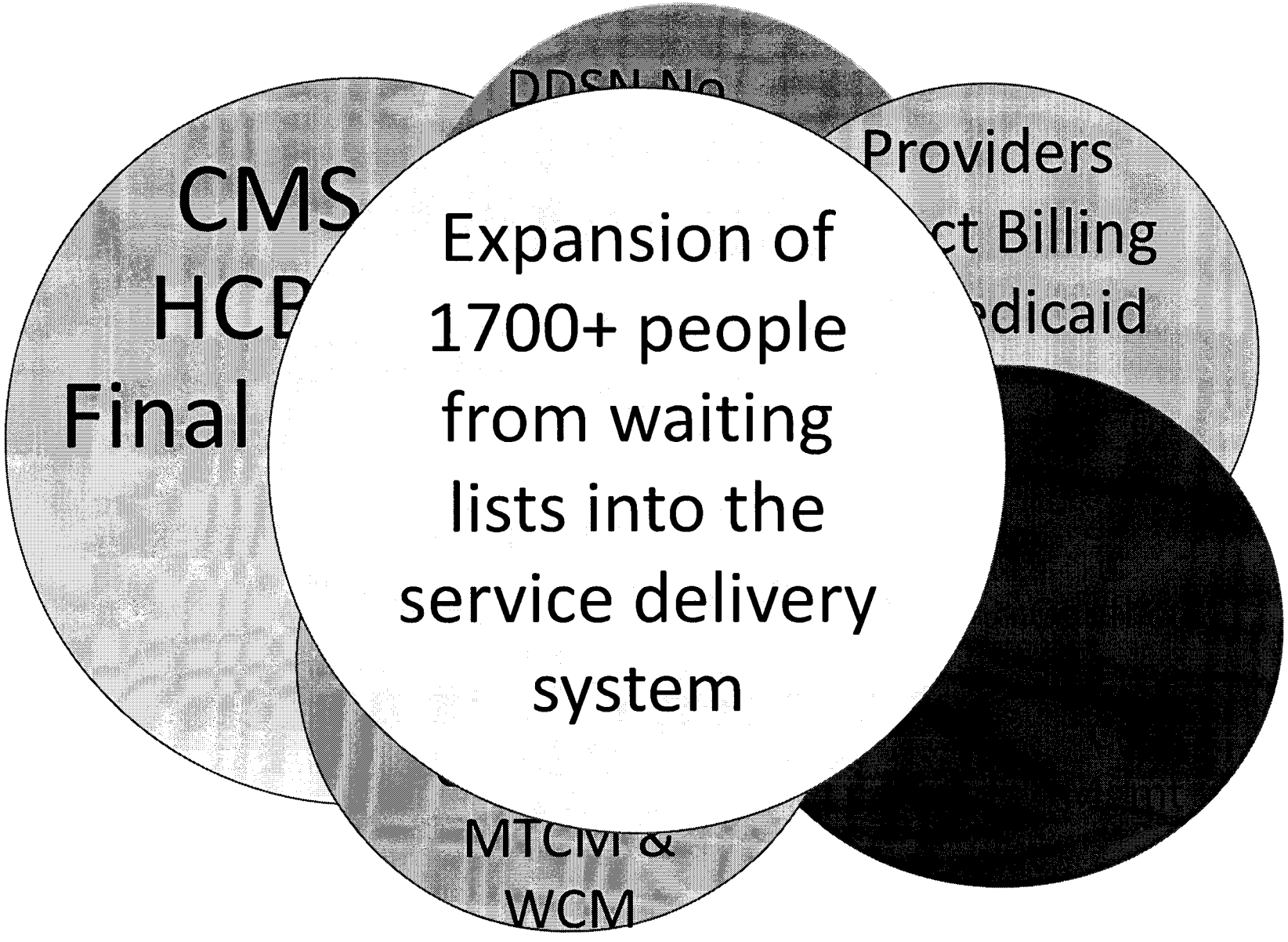
2. Administrative
   - DDSN will enter into new administrative contracts with DHHS.
   - Administrative contracts are for the purpose of assisting with the administration of the Medicaid program.
   - Only those functions that assist with the administration of the Medicaid program can be included in an administrative contract.

SC DDSN No Longer the Provider of Record for all Medicaid Services– continued

2. Administrative - continued
   - Billable to Medicaid at an administrative rate
   - 50 % state dollars and 50 % federal dollars
   - This is a reduction in federal dollars
   - It will cost 20 % more state dollars to perform the same functions previously billed at the service rate

In the midst of all these system changes, DDSN will be implementing a major waiting list reduction effort.

Changes Impacting DDSN's Statewide System



Expansion of Services to Waiting List

- Head and Spinal Cord Injury (HASCI) Program
  - Currently expanding HASCI services to approximately 300 additional people currently on the waiting list.
  - This represents almost a 50 % increase in the total number of people served through this program.
  - Will include primarily in home supports, but may include limited residential expansion.

Expansion of Services to Waiting List – continued

- Intellectual Disability/Related Disability (ID/RD) and Community Supports (CS) Waivers
  - Starting July 2014 expanding ID/RD and CS services to approximately 1400 additional people.
  - This represents over a significant increase in the total number of people served through these programs.
  - Will include primarily in-home supports, and limited residential expansion as well.

Expansion of Services to Waiting List – continued

- THIS IS GREAT!
  - The appropriation of additional funds to move the waiting list represents a dedicated commitment on behalf of the Governor and General Assembly to people with disabilities.
  - This will offer significant relief to families who are in need of and waiting for services.

Expansion of Services to Waiting List – continued

- THIS IS GREAT, but carries some challenges.
  - It will require a significant staff effort to roll out such a high number of waiting list slots to new people in such a short period of time.
  - In order for all the necessary Medicaid enrollment activities to be completed, slots are allocated in manageable "batches."

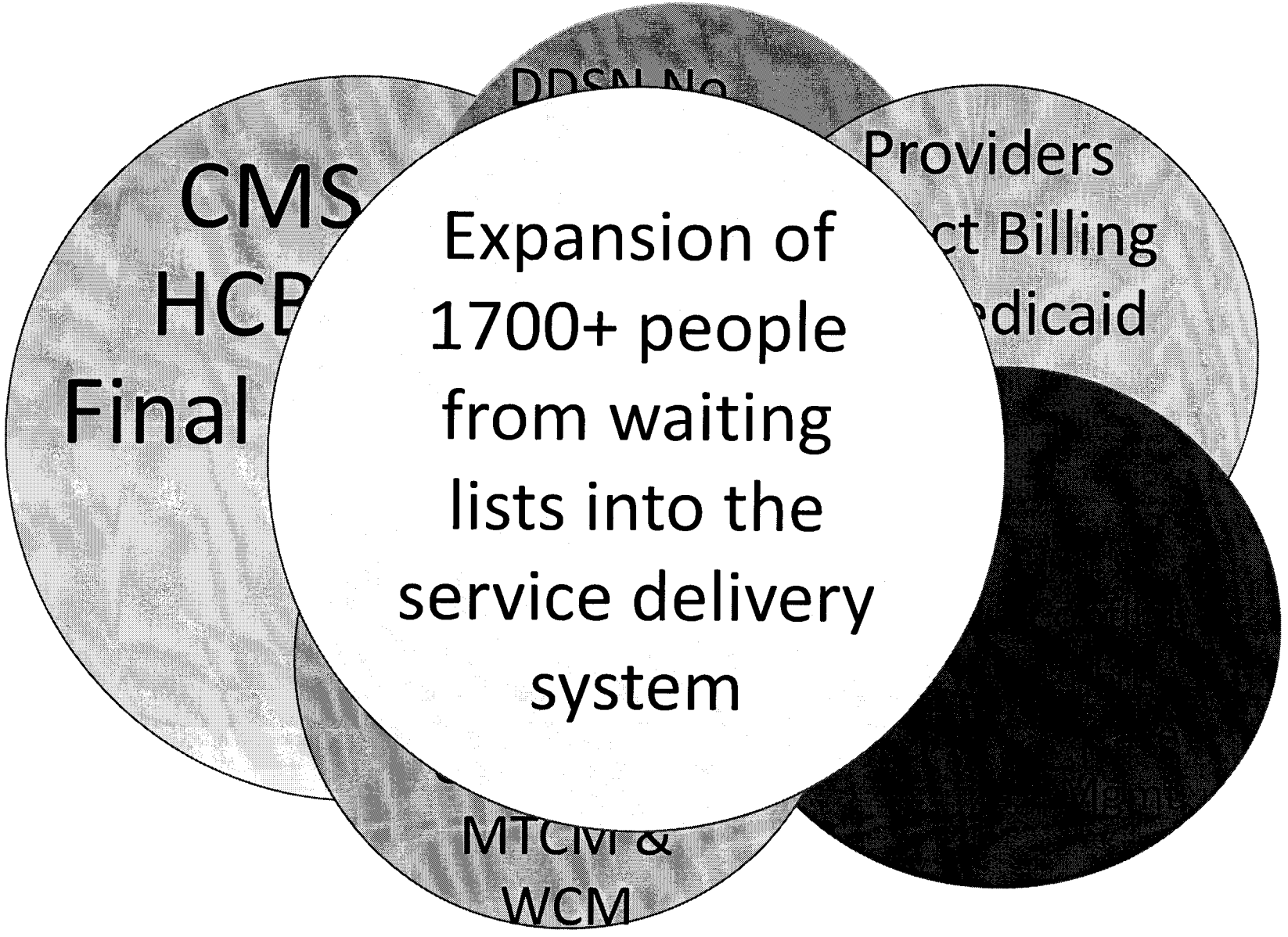
Expansion of Services to Waiting List – continued

- Some areas of the state still have capacity that can accommodate expansion to serve additional people.
- In other areas of the state where providers are at or near capacity, expansion needs to occur in such a way that it is consistent with the new Home and Community Based Settings Final Rule from CMS.

Expansion of Services to Waiting List – continued

- Should not develop more traditional work shop settings
- Need to look at targeted expansion that is consistent with community inclusion
- Expand employment opportunities

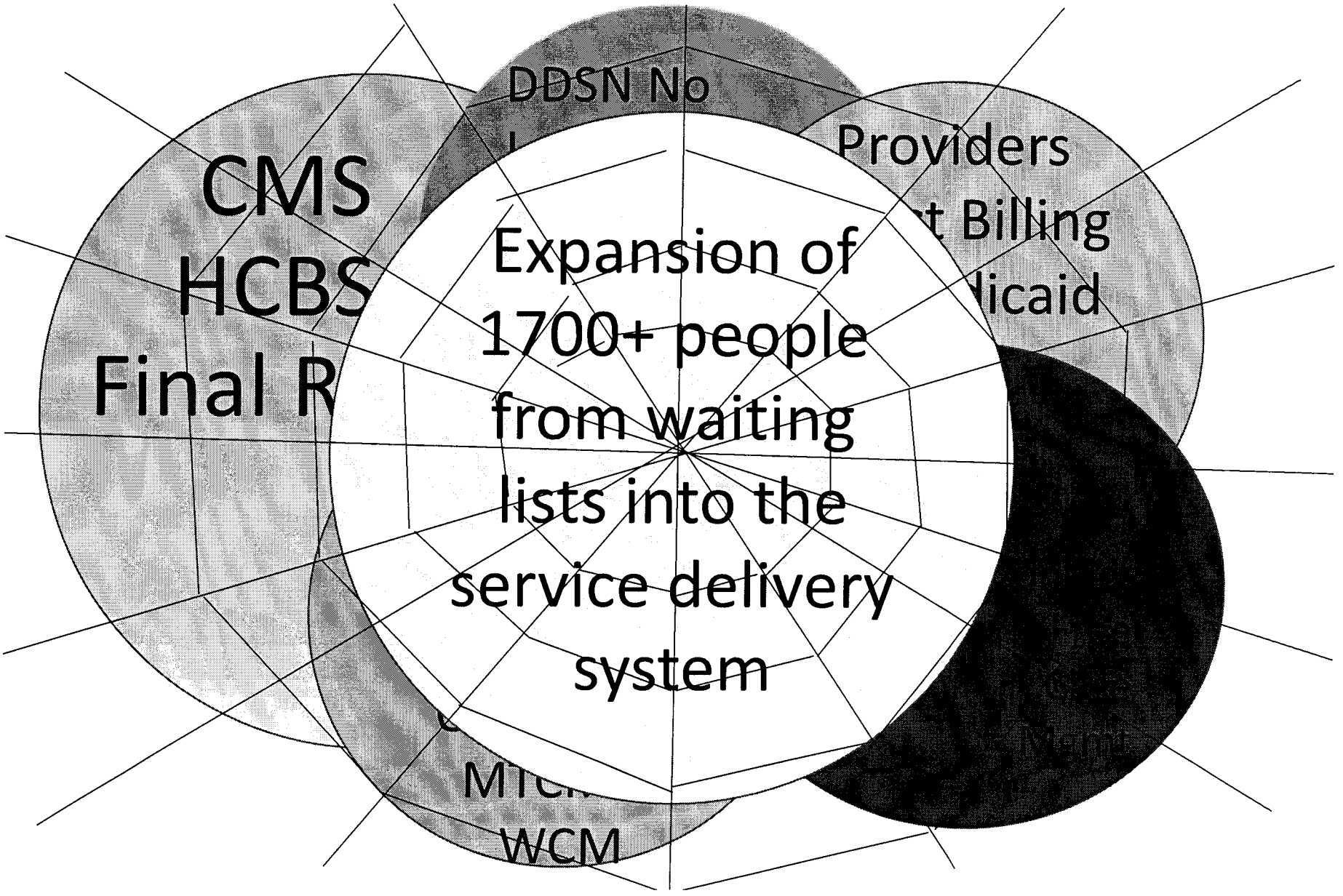
Changes Impacting DDSN's Statewide System



- Each of these circles of change requires examinations and possible modifications of DDSN's business processes.

- Think of a spider web overlapping all of these circles of change.

Changes Impacting DDSN's Statewide System



- Each line of the spider web represents an individual DDSN business process.
- If you pull one of the lines of the web, it affects all of the other lines.
- Changing one business process often necessitates changing multiple processes that are affected by that one change.

Focusing on our Mission

- DDSN will continue to focus on what is most important: meeting the needs of the people we support.
- DDSN will continue to focus on individualized supports and services and increased community participation.
- DDSN is committed to working with self-advocates, families, providers, and other stakeholders to improve services though these system changes.

IN THE STATE OF SOUTH CAROLINA

In The Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT

Case No. 2013-000762

Richard Stogsdill, Appellant,

v

South Carolina Department of Health and Human Services, Respondent.

CERTIFICATE OF SERVICE

Patricia L. Harrison certifies that she has served *Appellant's Return in Opposition to Respondent's Petition for Rehearing* in the above captioned case on the Respondent by US Mail to Richard G. Hepfer, Esq., Office of General Counsel, SC Dept of Health and Human Services, PO Box 8206, Columbia, SC 29202-8206 on October 2, 2014.

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October 2, 2014

The Honorable Jenny Abbott Kitchings
Clerk, South Carolina Court of Appeals
PO Box 11629
Columbia, SC 29211

Re: **Richard Stogsdill v. SCDHHS**
Lower Court Case No. 2010ALJ080774AP
Appellant Case No. 2013-000762

Dear Ms. Kitchings:

Enclosed are original *Appellant's Return in Opposition to Respondent's Petition for Rehearing* and a Certificate of Service, along with six copies of all and a copy to be clocked.

Please advise if anything else is needed at this time. We appreciate your assistance.

Sincerely,

Patricia L. Harrison

Enclosure

c: Richard G. Hepfer, Esq.

PLH:jnh