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 REPLY TO RESPONDENT'S RETURN TO PETITION FOR REHEARING

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I. **Deference owed to treating physician**. DHHS argues in its Return that *Olmstead v. L.C.* only applies to persons who are already institutionalized. Respondent argues that the "greatest deference" mandate, requiring States to give the greatest of deference to the opinions of treating physicians does not apply to DHHS. 527 U.S. 581 (1999). This totally ignores nearly two decades of court decisions, interpreting the integration mandate of the Americans with Disabilities Act (ADA).[1] Furthermore, the South Carolina District Court in *Peter B. v. Sanford*, a case in which DHHS is a defendant, recognized the deference that must be given to the opinions of treating physicians. *Olmstead* at 610 and *Crabtree v. Goetz* at 2008 WL 533056 at *25. See R&R of Judge Bruce Howe Hendricks at pp. 8 and 22. http://www.clearinghouse.net/chDocs/public/PB-SC-0001-0007.pdf. The term "medical assistance" in 42 U.S.C. § 1396d(a) means:

> ...payment of part or all of the cost" of services like "home health care," and "other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician...within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.

In *Smith v. Benson,* quoting *Rush v. Parham*, 625 F. 2d 1150, 1155-56 (5th Cir. 1980), the federal district court held that:

> ...a state may adopt a definition of medical necessity that places reasonable limits on a

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Helen L. v. DiDario, 46 F.3d 325 (C.A.3 (Pa.), 1995); *Martin v. Taft*, 222 F.Supp.2d 940 (S.D. Ohio, 2002); *Townsend v. Quasim*, 328 F.3d 511, 516-17 (9th Cir.2003); *Fisher v. Oklahoma Health Care Center*, 335 F.3d 1175 (10th 2003); *Radaszewski ex rel. Radaszewski v. Maram,* 383 F.3d 599 (7th Cir., 2004); *Jones v. Department of Public Aid*, 867 N.E.2d 563, 373 Ill.App.3d 184 (Ill. App., 2007); *Grooms v. Maram*, 563 F.Supp.2d 840 (N.D.Ill. 2008); *Smith v. Benson,* 703 F.Supp. 1262 (S.D.Fla. 2010); *Peter B. v. Sanford*, Case No. 6:10-cv-00767-JMC (D.S.C. March 7, 2011); *M.R. v. Dreyfus*, 697 F.3d 706 (9th Cir., 2012), *and Pashby v. Delia,* 709 F.3d 307 (4th Cir., 2013).

> physician's discretion in determining what services are appropriate in a particular medicaid case, although this does not remove from the private physician the primary responsibility of determining what treatment should be made available to his patients.

Supra at 1271. In *Rush*, the 5th Circuit explained that:

> We hold only that the physician is required to operate within such reasonable limitations as the state may impose. This same relationship between the private physician and government exists in the federal Medicare program, which, like Medicaid, is centered around the judgment of the private physician. 625 F.2d 1150.

In addition to ignoring the requirements of *Olmstead*, which requires state agencies to give the greatest deference to the treating physician, Respondent has disregarded the requirement that health insurers (in particular, State Agencies) must base determinations of medical necessity on the opinions of physicians, not lay persons who have no medical training.[2] Respondent's Return gives credence to Richard's fears that, if his case is remanded to DDSN, without this Court specifically requiring that medical necessity for Medicaid services must be determined by qualified health care professionals, DHHS will continue to give nothing but illusory weight to Dr. Joseph's orders, while failing to spend the funds allocated to provide services by the General Assembly. Judicial resources will surely be wasted if Richard's case is remanded again.[3] Respondent's Return demonstrates that the

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[2] S.C. Code Ann. 40-47-20 defines the "Practice of Medicine" as (e) rendering a written or otherwise documented medical opinion concerning the diagnosis or treatment of a patient ... and that (f) rendering a determination of medical necessity or a decision affecting the diagnosis and/or treatment of a patient is the practice of medicine subject to all of the powers provided to the Board of Medical Examiners, except as provided in Section 38-59-25. The record documents that DHHS routinely allows non-physicians to determine medical necessity and make treatment decisions in violation of this statute.

[3] These are state agencies that have consistently shown disregard for state and federal court orders. Since 2005, DHHS has refused to grant a hearing on the merits in *Peter Brown v. DHHS*, despite this Court unambiguously ordering DHHS to provide a hearing on the merits in 2011. 393 S.C. 11, 709 S.E.2d 701 (S.C.Ct.App. 2011) and *Peter Brown v. DHHS,* 13 ALJ 08-0159-AP, Feb. 4, 2013. This Court may take judicial notice of its own docket at 2014-000443, which documents that Peter still has not received the services at issue in that 2005 appeal. Despite the South Carolina Supreme Court directing DDSN and DHHS, in *Doe v. DHHS*, that the regulation promulgated by the General Assembly requires DDSN to apply an

agency will again base its determination of Richard's need for services on arbitrary and capricious agency policies, because DHHS continues to ignore federal law and federal court decisions with impunity. (The Fourth Circuit instructed SCDHHS and DDSN that "Once a state elects to participate in the program, it must comply with all federal Medicaid laws and regulations." *Doe v. Kidd I*, 501 F.3d 348 (4th Cir. 2007).) In this case, DHHS has even ignored the order of its own hearing officer, who chastised DDSN in the 2009 "fair hearing" decision for failing to obtain input from Dr. Joseph and failing to use "qualified individuals" who were "fitted (as by training and experience) for the care planning process." R. 37-41.

Respondent has refused to give the orders of waiver participants' physicians any real deference at all, while insisting that this Court should not require the agency to establish reasonable standards...or any standards at all. Instead, the record shows that all the agency and the Administrative Law Court have simply recited that DDSN considered the opinions of the

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age 22 age of onset in determining eligibility for DDSN services, DDSN has flagrantly ignored that Court's order and several times revised the eligibility standards since 2011, thereby continuing to require applicants to prove onset by age 18. *Doe v. S. Carolina Dep't of Health & Human Servs.*, 398 S.C. 62, 727 S.E.2d 605 (S.C., 2011).*(This Court may take judicial notice of the SCLAC Audit of DDSN at* **http://lac.sc.gov/LAC_Reports/2014/Documents/DDSN.pdf** at pages 60-62, discussing this violation of the Supreme Court's order.) In 2013, the Director of the DHHS Office of Appeals and Hearings flat out refused to enforce the order of the Fourth Circuit in *Doe v. Kidd II, 2011* WL 1058542 (4th Cir. Mar. 24, *2011*) that required DDSN and DHHS to provide Sue Doe with residential habilitation services. *S.P. v. DHHS*, Appeals Case #05-MISC-025 (MR/RD) dated April 28, 2013(Exhibit 3 attached to Appellant's Petition Requesting Rehearing). Also in 2013, the district court noted that "The Fourth Circuit noted that Defendants still had failed to provide Plaintiff with residential habilitation services..." This was ten years after Doe filed her lawsuit in federal court. *Doe v. Kidd III,* Case No. 3:03-1918-MBS (D.S.C., August 21, 2013). Finally, DDSN and DHHS continue to refuse to provide services to B.W. that were ordered by Hearing Officer Elizabeth Hutto on November 19, 2013. *B.W. v. DHHS*, Case No. 07-MISC-028 attached as Exhibit 4 to Appellant's Petition for Rehearing. Even after B.W. filed a Petition/Complaint for Remedial Writ with DHHS and the South Carolina Attorney General, DHHS has refused to provide critical nursing services, as B.W.'s condition continues to deteriorate. See Exhibit 6 attached to Appellant's Petition for Rehearing. Justice delayed is justice denied, but in these cases, it is forseeable that justice delayed may result in death or other irreversible harm to vulnerable citizens of South Carolina.

treating physician - despite the record showing that this finding is just not true. Any "consideration" DHHS has given to the opinion of Dr. Joseph in this case has been illusory. Indeed, Dawn Shealy admitted that she did not review Richard's medical records or consult with his physician, and that she has no medical training. R. 278 to 288. Ms. Shealy did not even know whether Richard can get out of bed, dress, toilet or feed himself. R. 282.

It is obvious from the transcript of the hearing held in 2010 that, as in *Moore v. Cook*, that DHHS has based its determinations of medical necessity on "bureaucratic gobbledegook having no relation to (the participant's) actual condition or needs." Case No. 1:07-CV-631-TWT, 27 (Ga. D.C. April 19, 2012). As in *Moore v. Cook*: "The reduction in hours was arbitrary and capricious and was not based upon medical necessity." Id. That court found that the State had breached its duty to ensure that the services provided to the plaintiff were "sufficient in amount, duration, and scope to reasonably achieve its purpose." Id. at 27.

Respondent does not provide the Court with *any* authority supporting its interpretation and arguments on pages 1 and 2 of its Return. In *Olmstead,* at page 581, Justice Kennedy unambiguously held that:

> The opinion of a responsible treating physician in determining the appropriate conditions for treatment ought to be given the greatest of deference...
>
> It is of central importance, then, that courts apply today's decision with great deference to the medical decisions of the responsible, treating physicians and, as the Court makes clear, with appropriate deference to the program funding decisions of state policymakers.

But, a review of the legislative history of the Medicaid Act reveals that long before *Olmstead*, the Senate reported that "[T]he *physician* is to be the *key figure in determining utilization of health services*—and ... it is a physician who is to decide upon admission to a

hospital, order tests, drugs and treatments, and determine the length of stay. For this reason the [legislation] would require that payment could be made only if a physician certifies to the medical necessity of the services furnished." (Sen.Rep. No. 404, 89th Cong., 1st Sess.(1965), reprinted in 1965 U.S.Code Cong. & Admin. News, p. 1986.)[3] In a pre-*Olmstead* decision, the Superior Court of Connecticut ruled that:

> ...the attending physician is the one who determines the nature and extent of the medical care provided at public expense based upon the medical needs of the indigent person 25 (pursuant, of course, to such reasonable regulations as are required for the efficient administration of this vast program).

Doe v. Maher, 515 A.2d 134, 144, 40 Conn.Supp. 394 (Conn. Super., 1986). And in *Katie A. v. Bonta*, the federal district court ruled that:

> The Medicaid Act does not define when a service is "medically necessary." Rather, the decision "rests with the individual recipient's physician and not with clerical personnel or government officials." *Pinneke v. Preisser,* 623 F.2d 546, 550 (8th Cir.1980); *Weaver v. Reagen*, 886 F.2d 194, 200 (8th Cir.1989) ("The Medicaid statute and regulatory scheme create a presumption in favor of the medical judgment of the attending physician in determining the medical necessity of treatment.").

433 F.Supp.2d 1065 (C.D. Cal., 2006). In this case, Richard has not asked this Court to give "uncritical discretion to the treating physician's recommendation" nor has he argued that Dr. Joseph's order is dispositive. But, after suffering through two "fair hearings" and months upon months of administrative delays, the State has utterly failed to produce <u>any</u> evidence at a hearing to suggest that Dr. Joseph's order is not reasonable, given the severity of Richard's disabilities.[4] It is burdensome to require Richard to endure yet another "fair hearing," before a

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[4] 42 C.F.R. 431.244(a) requires States to base fair hearing decisions "exclusively" on evidence presented at a hearing. Richard believes that justice would be served if this Court were to consider only the medical evidence presented at the fair hearing.

third hearing officer whose agency obviously gives no regard to the Supreme Court's order in *Olmstead*, to the integration mandate of the ADA or to the Medicaid Act itself. This has been an agency that has historically acted as if it is above the law, without consequence.[5]

Finally, Respondent argues in its Return that "the treating physician's recommendations with respect to setting must be tempered by the State's discretion for program funding." An examination of "program funding" is thus in order. DDSN received at least $14.8 million in new state dollars for FY 2015, which will produce $45 million in new dollars to provide services, when matched with federal funds. Footnote 4 of Appellant's Petition. Not only that, but DDSN was caught by Governor Haley during FY 2014 holding an excess funds account containing more than $9 million. Id. See Governor's Executive Budget on page 237 at

http://www.governor.sc.gov/ExecutiveOffice/ExecutiveBudget/Documents/Executive%20Budget%20for%20Fiscal%20Year%202014-15.pdf.

The same month that the Governor's Executive Budget was released (January, 2014), DDSN informed its Commissioners that the South Carolina Budget and Control Board had advised DDSN to "hold" these excess funds to cover the costs of "a pending lawsuit." See http://www.ddsn.sc.gov/DDSNCommission/Documents/meeting%20minutes/01%20January%2016,%202014%20Commission%20Mtg%20Minutes.pdf. That is great news for Medicaid

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5 Appellant calls this Court's attention to the 2008 findings of the South Carolina Legislative Audit Council, which found that DDSN spent must $7.6 million of the $25.4 million allocated to operate new beds, not counting the loss of the 70% match South Carolina lost in federal funds. Appellant's Petition for Rehearing at 22. That audit found that only $661,463 of state funds, out of $10.5 million, provided by the General Assembly for a new program to serve children with autism was actually spent for the intended purpose, again losing the federal match for every dollar not spent providing Medicaid services. Id. at 23.

waiver participants and their families who have struggled to keep their loved ones at home! Matched with federal dollars (70%), this excess funds account alone should produce $30 million in previously unaccounted for funds. Put together, this should provide DDSN with more than $70 million of new money to provide services to persons with disabilities. The relatively small amount of money DDSN would spend providing Richard the services he needs to remain at home, will be a drop in the bucket. Keeping Richard home should actually save state taxpayers money. Dr. Joseph opined that he has avoided expensive hospitalizations because of the care he has received at home and that his health would deteriorate in an institution. R. 920-922.

Respondent's claims that it must to "temper" physician's recommendations based on "program funding" concerns. That claim must be considered in light of the Comptroller's FY 2014 press release. That report documented that DHHS failed to spend a whopping $280,258,725 during FY 2014 alone. See page 4 at **http://www.cg.sc.gov/publications**and reports/Documents/Press/2014YearEndPressRelease.pdf. The Comptroller reported that the State of South Carolina's final net budgetary surplus of $266 million exceeded prior estimates by $32 million during FY 2014. These funds were placed in a "Contingency Reserve Fund," according to the State Comptroller. By the end of FY 2014, the State had accumulated an additional "Rainy Day Fund" of $293 million, apparently not counting the $117 million South Carolina held at the end of FY 2014 in Capital Reserve Funds. Providing Richard the services he needs could not possibly require DDSN or DHHS to fundamentally alter its programs to keep Richard at home. Anyway, we now know that the cost of the MR/RD Medicaid waiver (now ID/RD waiver) went UP when home-based services were cut in 2010. That year, the cost

of the program increased by more than $50 million over the amount CMS approved for the prior year. So, if these funds were to be appropriately spent, the citizens of South Carolina, disabled and non-disabled alike, should expect the cost of operating the ID/RD program to go down when the caps are removed and PT, OT and speech services are restored.

It will truly be a Great Day in South Carolina, when people like Richard will be given options to be fully integrated into the community, instead of being forced to attend isolated and warehoused in DDSN workshops during the day, where the "revenue" from their labors are paid to DDSN, to build up its "excess funds account."[6]

2. **Violation of Administrative Procedures Act.** Courts across the country have held that CMS approval of waiver amendments does not prevent courts from determining that waiver caps are illegal. *Crabtree v. Goetz, supra*; *Peter B. v. Sanford, supra; B.N. v. Murphy,* Case No. 3:09-cv-199 at 4.[7] In *B.N. v. Murphy*, CMS approved caps on waiver services and the

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[6] Proviso 36.1 in the 2014-2015 State Budget for South Carolina provides that "All revenues derived from production contracts earned by mentally retarded trainees in Work Activity Programs be retained by the South Carolina Department of Disabilities and Special Needs and carried forward as necessary into the following fiscal year to be used for other operating expenses and/or permanent improvements of these Work Activity Programs." This is the slush fund that contained $7.8 million in September, 2009, when services to people like Richard were slashed due to contrived agency claims of budget reductions. Appellant's Petition at footnote 4. According to the Governor's Executive Budget for FY 2015, this DDSN "excess funds account grew by more than $6 million during the prior year. The Court may take judicial notice that DDSN's website contains a recent presentation by the Director of DDSN in which she admits 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 attached to Appellant's Return in Opposition to Respondent's Petition for Rehearing.

[7] In *B.N.*, CMS approved the cap, but the Court held that the cap violated the ADA and found that "no agency deference is appropriate with respect to statutes not administered by CMS." The court found that "no evidence before the Court suggests that CMS administers the Indiana ARPA, the ADA, the RA or Indiana Medicaid." Id. at 22. As in Richard's case, the

State Medicaid Agency failed to promulgate the changes as regulations under Indiana's Administrative Procedures Act. The federal district court held that "Such a cap meets the definition of a rule under Indiana law, is more than a merely internal policy, and, absent promulgation, is invalid." Id. at 8. ("The ...cap ... which was approved by the Department of Health and Human Services in 2008 has never been properly promulgated under Indiana law, and is therefore void." Id. at 9-10.) The court granted the plaintiffs' summary judgment due to the State's failure to comply with the provisions of the Indiana ARPA." Id. at 10.

Likewise, the majority ruled in *Jane Doe v. DHHS* that "Policy or guidance issued by an agency other than in a regulation does not have the force or effect of law." *Supra* and S.C. Code Ann. § 1-23-10(4). For the reasons set forth above, as well as those discussed in *McCrann ex rel McCrann v. DHHS,* Richard respectfully prays that this Court will reconsider its decision so as to require DHHS to promulgate regulations, declaring the reductions in services to be unenforceable and requiring that DHHS give the greatest of deference to the treating physician. 704 S.E.2d 899 (N.C. Ct. App. 2011).

3, 4 and 5. Violation of due process, reasonable promptness and comparability. Respondent argues that the comparability mandate is not applicable in this case, because DHHS obtained a waiver from CMS. Respondent is wrong. That waiver only allows DHHS to use more liberal income criteria and to waive that participants receive services in an institution. Richard clearly meets the definition of "categorically needy." As the South

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plaintiff argued that the State Medicaid Agency had failed to provide CMS with "full information about the effect the cap would have on waiver enrollees." Id. at 23. Because the court granted declaratory and injunctive relief on other grounds, it did not make a ruling on whether the State violated the Medicaid Act by implementing the caps on services.

Carolina Supreme Court held in *Doe v. DHHS,* persons who receive home and community based services (HCBS) are a "defined subset of categorically needy persons."[8] Thus, 42 C.F.R. 440.240 clearly is applicable in Richard's case. DHHS must assure that the services available to any individual in the categorically needy group are equal in amount, duration, and scope for all beneficiaries in the group (in Richard's case, the ID/RD Medicaid waiver).

DHHS has assured the federal court that it has exempted the plaintiffs in *Peter B. v. Sanford* from the caps imposed on services in 2010. Thus, denying these services to Richard violates the comparability mandate. This issue is quite complicated and was not addressed in Richard's "fair hearing," because the decision in *Peter B. v. Sanford* came after that hearing.

Violations of Richard's rights to due process and to receive services with reasonable promptness have been ongoing and much of the evidence of those violations is not in the record before this Court. In addition, DHHS has refused to put into the record the transcripts and evidence presented at the 2009 hearing, thereby denying Richard's due process rights. In the federal court, depositions have been taken and the case is ready for trial in November. Richard suggests that it would "foster wise judicial administration and conserve judicial resources" for those issues related to due process and the Medicaid Act to be determined by the federal district court. Richard prays that the Court will deny Respondent's Petition and that the Petition of the Appellant be granted, as clarified herein. Richard requests a rehearing, if the Court deems appropriate, in the issue of violation of the Administrative Procedures Act.

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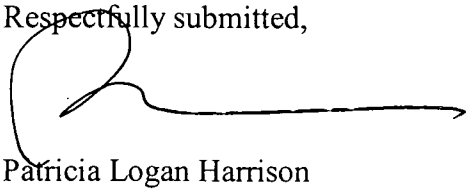
The DHHS website states that "All persons applying for Medicaid must be categorically eligible. To be categorically eligible for Medicaid, an individual must be: receiving cash assistance such as SSI ... aged; blind; disabled;..." http://medsweb.scdhhs.gov/mppm/mppmtoc.htm. Richard is disabled and receives SSA cash assistance, thus he is "categorically eligible."

Respectfully submitted,



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October 9, 2014

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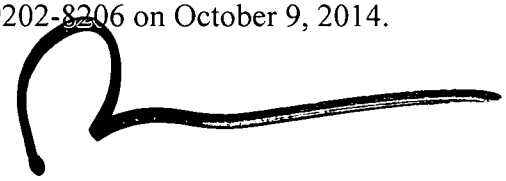
CERTIFICATE OF SERVICE

Patricia L. Harrison certifies that she has served *Appellant's Reply to Respondent's Return to Appellant'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 9, 2014.



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October 9, 2014

The Honorable Jenny Abbott Kitchings
Clerk, South Carolina Court of Appeals
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Re: **Richard Stogsdill v. SCDHHS**
Lower Court Case No. 2010ALJ080774AP
Appellant Case No. 2013-000762

Dear Ms. Kitchings:

Enclosed is the original *Appellant's Reply to Respondent's Return to Appellant's Petition for Rehearing* along with a Certificate of Service and six copies.

Please clock and return the additional copy in the enclosed envelope. We appreciate your assistance.

Sincerely,

Patricia L. Harrison

Enclosure

c: Richard G. Hepfer, Esq.

PLH:jnh