

**THE STATE OF SOUTH CAROLINA
In the Supreme Court**

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APPEAL FROM THE SOUTH CAROLINA COURT OF APPEALS **S.C. Supreme Court**
Case No. 2013-000762

Richard Stogsdill,.....Appellant,

v.

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

PETITION FOR WRIT OF CERTIORARI

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Introduction. Appellant Richard Stogsdill files this Petition for a Writ of Certiorari, respectfully requesting that this Court, in its sound judicial discretion, will consider and grant his Petition due to the special and important reasons in this case, which is of great public importance. Richard asks this Court to consider that (1) there are novel questions of law presented;(2) the decision of the Court of Appeals is in conflict with prior decisions of the Supreme Court; (3) substantial constitutional issues are directly involved; and (4) a federal question is included and the decision of the Court of Appeals conflicts with a decision of the United States Supreme Court. Richard is sincerely grateful for the lower Court's careful analysis of the issues related to his claims brought under the Americans with Disabilities Act (ADA). He believes, however, that the lower Court, unfortunately, may have been misled by defendants' arguments in regards to the due process and notice issue and Richard's claims as they relate to the requirements of the South Carolina Administrative Procedures Act.

Richard Stogsdill. Richard Stogsdill is now twenty-seven years old. He lives in his own apartment next to his mother's home. R. 923. Richard has normal intelligence and has a strong desire to continue to live in the community with his peers, but he is profoundly physically impaired due to his "related disability" of cerebral palsy and he has a history of seizures. R. 304-307.

Richard relies upon others for all daily activities, including, but not limited to toileting, grooming and transferring to and from his wheelchair. Id. Richard attended public schools until he was 21, where he was fully integrated into his school community. R. 305. He socialized mainly with peers who do not have disabilities. According to his mother, in

school, Richard was “hanging with the football team.” He was “brought up with normal people, normal kids...” but his ability to remain in the community is now threatened and the South Carolina Court of Appeals agreed with his physician that he is at risk of institutionalization. R. 921.

At school, Richard received one-on-one supervision, due to the severity of his disabilities. R. 306. When he finished high school, the burden of providing an additional nine hours a day of care and supervision for this adult Medicaid waiver participant was shifted by the State to his parents, who both worked, and his speech, OT and PT services were terminated. R. 314-315. Since these services were terminated, Richard’s muscles have atrophied and he has lost the ability to hold a cup and to use his thumb on the computer. R. 314 and 319. Richard has also lost the ability to hold a book and to turn the pages. His ability to speak has also deteriorated. When Richard’s school career ended, he participated in a program through South Carolina Vocational Rehabilitation, but they were unable to help him find a job. R. 307, 917, and 920.

When he is lying in bed, Richard cannot use his phone or punch the emergency button, so he requires monitoring throughout the night. R. 308. He has “horrible spasms” which hurt Richard to the point that he “sweats and moans...to the point of tears.” R. 306-307, 320. When he is suddenly and unpredictably hit with these spasms, Richard has to be taken out of his wheelchair and stretched out on his bed until the pain subsides. Id. He sometimes crumbles, falling forward without warning, at the onset of these spasms. R. 321. His arms and legs have to be strapped into his wheelchair because of these uncontrolled movements.

Due to his size, weight and spasticity, Richard requires two persons to get him out of bed, and to toilet, shower and dress him. R. 306. His treating physician, Dr. Joseph, affirmed that Richard must have assistance throughout the day to take his medications and requires a regular toileting schedule to prevent life-threatening gastrointestinal obstructions. R. 920-922. According Dr. Joseph, Richard's treating physician of 22 years, the reason his health had been relatively good, at the time of Richard's hearing, was because of the excellent care he has received in his own home, outside of an institutional setting. R. 920-922. Richard's physician has determined that without the services he has ordered, Richard "would be at risk of institutionalization..." R. 921.

During the hearing held in 2009, as well as the second hearing held in 2010, the State failed to provide a scintilla of evidence from a qualified medical professional to contradict the opinion of Richard's treating physician, or the other qualified professionals who agreed that he needs the services ordered by Dr. Joseph. R. 920-921. Both Dr. Joseph and his provider of psychological services have determined that if Richard attended a congregate workshop or moved to an institution, his condition would deteriorate even more. R. 921-922 and 917-919. According to Richard's physician, if he were forced into an institution, he "would expect to see a marked decline in both his physical and mental condition because of the trauma he would experience from being segregated from his community and being forced to live in a congregate setting." Id. Because of the exercise Richard receives from personal care attendants in his current living arrangement, he has been able to avoid many expensive and painful surgeries that would have been required if he had not received the attention he has received in his home. Id.

Medicaid Waiver Program. Medicaid is a joint program through which the federal government provides financial assistance to states so that they may furnish medical care to needy individuals. *Doe v. DHHS*, 398 S.C. 62, 64, S.E.2d 605 (2011), citing *Wilder v. Virginia Hosp. Assoc.*, 496 U.S. 498 (1990). Participation in the Medicaid waiver program is voluntary for the states; however, any state that elects to participate “must comply with requirements imposed by the Medicaid Act and related regulations.” *Doe v. DHHS*, *supra* S.C. ___ (2011). The Medicaid Act is found at 42 U.S.C. 1396 et. seq. Congress charged CMS, the federal Medicaid agency, with the authority to promulgate regulations for the administration of the Medicaid program, which are found at 42 C.F.R. 430-456. CMS interpretation of these regulations is contained in the “State Medicaid Manual.” The Second Circuit presented an excellent and helpful explanation of the Medicaid fair hearing system in *Shakhnes v. Berlin*, 689 F.3d 244 (2nd Cir., 2012). As discussed in that case, it is the the State Medicaid Manual to which courts interpreting the requirements of the Medicaid Act owe deference. *Id.* at 259. The State Medicaid Manual provides that “final administrative action” in 42 C.F.R. 431.244(f) refers to only the issuance of fair hearing decisions. (In *Doe v. Kidd I and II*, the Fourth Circuit discussed the requirements of actually providing the services with “reasonable promptness.”) The State Medicaid Manual (SMM) states that a conclusive decision in the name of the State agency must be made by the hearing authority. SMM § 2903.2(A) (emphasis added). Importantly in Richhard’s case, the SMM prohibits States from extending the time allowed for a hearing due to remand back to the agency: “Although the hearing authority may remand the matter to a local hearing officer where the materials submitted are insufficient to serve as [a] basis for a decision,[] the Manual clarifies

that such a remand is not a substitute for definitive and final administrative action.”

Shakhnes v. Berlin, 689 F.3d 244 (2nd Cir., 2012).

For many years, Richard has received services through a “home and community based waiver services” (HCBS) program that is administered by the State Medicaid Agency, the South Carolina Department of Health and Human Services (DHHS). DHHS contracts with the South Carolina Department of Disabilities and Special Needs (DDSN) to administer the ID/RD Medicaid waiver program (formerly MR/RD). The purpose of that program is to provide services that will prevent institutionalization of persons who have intellectual disabilities or related disabilities. Under contract with DHHS, DDSN also operates ICF/ID (formerly ICF/MR) facilities. See SC Protection & Advocacy report: *Unequal Justice for South Carolinians: Abuse and Neglect Investigations* at R. 491. These are institutions housing eight or more persons meeting the same eligibility requirements as Richard. In an ICF/ID, all residents must be provided with around the clock nursing services, as well as physical therapy, occupational therapy, speech and language therapy and other services ordered by their treating physician...services that are now being denied to persons living in the community.¹ 42 C.F.R. 440.150. All persons receiving HCBS services through the ID/RD Medicaid waiver program must prove that they meet all eligibility requirements to be placed in an ICF/ID at government expense. See

¹ Respondent claims that these services are “available,” but the 2010 amendments terminated funding for these services through the Medicaid waiver. 42 U.S.C. 1396a(a)(8) does not require States to “promise” to provide services with reasonable promptness. That federal statute requires the State to actually provide medical assistance with reasonable promptness. This Court may take judicial notice of the cases of *Al Myers v. DHHS* and *Peter B. v. DHHS*, now pending in the South Carolina Court of Appeals where the appellants allege that the services were promised, but never provided years alter.

<http://www.nasddd.org/uploads/documents/NASDDDS-EligibilityReportFinal.pdf>.

The Medicaid Act requires the State to provide every waiver participant the opportunity to choose whether he or she wants to live in an ICF/ID or to receive waiver services in the community. Federal regulations require waiver participants to sign a “freedom of choice” form documenting their decision to choose to receive services in the community, instead of being admitted to a Medicaid-funded ICF/ID facility. R. 198.

In addition to requiring waiver participants to be provided the “freedom of choice” between institutional and home based services, Federal regulations require that participating States provide HCBS through the waiver programs: (1) in the amount, duration and scope necessary to achieve the goals of the program (i.e. keeping the participants out of institutions); (2) determine eligibility for services with reasonable promptness, (3) provide medical assistance (i.e. funding for waiver services) with “reasonable promptness;” (3) establish “reasonable standards” for the operation of the program. R. 101-105. Finally, the Medicaid Act requires participating states to operate the waiver programs in the best interest of the participants and to assure CMS that they are providing services through the waiver program that are necessary to protect the “health, welfare and safety” of the waiver participant in the community. 42 USC Sec. 1396u.

When DHHS denies, reduces or does not provide services with reasonable promptness, the Medicaid Act requires the State to provide an opportunity for a “fair hearing” meeting the due process requirements set forth by the United States Supreme Court in *Goldberg v. Kelly*, 397 U.S. 254 (1970), in addition to those established by the Medicaid Act and the regulations contained at 42 C.F.R. 205 et. seq. 42 C.F.R. 431.210 requires the State to

provide written notice of the right to request a “fair hearing,” that contains certain specific information. These requirements include written notice of the reasons for denying, terminating or not acting on a request promptly, and the statute or regulation upon which the State’s decision is based. The hearing must satisfy the due process requirements contained in *Goldberg* and the hearing officer’s decision must be based exclusively on evidence submitted at the hearing. 42 C.F.R. 431.244. A final administrative decision must be issued, ordinarily, within 90 days. *Shakhnes, supra*.

Americans with Disabilities Act and the Rehabilitation Act. In administering programs for disabled persons, the State must also comply with the requirements of the Americans with Disabilities Act (ADA). As interpreted in the landmark disabilities rights case in *Olmstead v. L.C.*, the Supreme Court ruled that services must be provided in the least restrictive settings, it is discriminatory to isolate and segregate persons who have disabilities and that these services must be provided in the least restrictive setting. 527 U.S. 581 (1999). Justice Kennedy held in his concurring opinion that States must give the greatest of deference to the opinions of treating physicians in making treatment decisions. *Id.* at 601. The lower court correctly held that DHHS violated the ADA when it applied the 2010 caps to Richard, because he is at risk of institutionalization and that risk of more than speculative. But it stopped short of requiring DHHS to establish meaningful standards to determine what services must be provided. The record documents that decisions are being made by DDSN employees with no training in medicine in an arbitrary and capricious manner. R. 282-287.

Stogsdill I: 2009 Administrative Appeal. Richard needed additional hours in 2009, to replace the hours provided by the school prior to his aging out of public school. Pursuant

to 42 U.S.C. § 1396a(a)(3) Richard requested a “fair hearing,” raising the following issues in “Stogsdill I” (2009 administrative proceedings):

1. DDSN failed to provide Richard medically necessary services with reasonable promptness.
2. DDSN failed to enlist sufficient providers so as to make MR/RD waiver services available to the extent that they are available to the general public.
3. DDSN based its determination of need for services on its desire to keep workshop seats full, instead of providing services in a less restrictive setting.
4. DDSN failed to promulgate regulations and based the allocation of Richard’s waiver services DDSN on arbitrary and capricious standards which were not been subjected to public rulemaking or compliance with the Administrative Procedures Act.
5. DDSN failed to allocate services based on the opinions of Richard’s treating physician and its funding scheme provided greater funding for persons in more restrictive residential settings, regardless of the individual’s need for services, in violation of *Olmstead*.

R. 947.

A hearing was held more than 90 days after Richard requested the 2009 fair hearing in Stogsdill I. Richard presented live testimony from a nurse who was familiar with his care and his needs. Respondent failed to provide any medical evidence of any kind at the 2009 hearing. Appellant’s Return dated October 2, 2014 at 3, fn 2. The hearing officer issued an order, finding that the number of hours Richard was receiving in 2009 were needed, and she remanded Richard’s case to DDSN for a qualified person determine his need for additional PCA hours and adult companion hours. R. 31. This Stogsdill I order explicitly directed the agencies to consider the opinions of Richard’s treating physician in determining what additional services/hours may be needed. Appeals Case 09MISC-017, November 16, 2009.

R. 36, 37, 39.

Remand of Stogsdill I to DDSN. On remand in 2009, Respondent determined that Richard needed an additional 15 hours a week of Adult Companion Services, but, Richard

was never provided with an appealable order (or any order at all) in Stogsdill I.²

Binding norms established January 1, 2010. Instead of complying with the order of the hearing officer, on January 1, 2010, DHHS imposed caps on the companion services, personal care attendant services and respite services, and totally eliminated speech and language, physical therapy and occupational therapy from the menu of services funded by the MR/RD Medicaid waiver. R. 76, 844, 845. These 2010 amendments to the ID/RD Medicaid waiver program were established without either DDSN or DHHS promulgating regulations.³ Unlike in other states, the General Assembly did not pass a law authorizing the reductions and changes in services.

Medicaid waivers are granted by CMS for a period of five years. The State must submit an application to renew the program, which identifies and explains the reasons for any changes. In its application, DHHS claimed that these changes were made out of necessity, due to state budget reductions. R. 76 and 855. The “new” waiver capped home-based personal care and companion services (combined) at 28 hours a week. Respondent capped respite services at 68 hours a month, but would allow Richard to receive unlimited respite services in an ICF/MR, the most restrictive and expensive setting in the DDSN system. In

² During the appeal, Respondent continued to provide Richard the services he was receiving in 2009, in addition to 15 hours a week of adult companion services. After his father died and his working mother became the sole family caregiver, Respondent increased the number of respite hours to the amount allowed under the special exception cap in 2010.

³ In 2007, Protection and Advocacy for Persons with Disabilities, Inc. filed a lawsuit in the Richland County Court of Common Pleas, asking that court to order DDSN to promulgate regulations. But DDSN has staunchly refused to promulgate regulations and this lawsuit is now pending in the South Carolina Court of Appeals after the circuit court judge granted summary judgment to the agency. Case No. 2007-cp-40-2187.

2008, Respondent paid \$320 per day for institutional ICF/MR (now ICF/ID) services. R. 931. Prior to the 2010 reductions, Richard's services cost \$37,364.45, or \$102 a day. R. 243.

Respondent failed to conduct cost studies before reducing and terminating services in 2010. But, an analysis of the cost data Respondent submitted to CMS shows that the cost of the program actually increased by more than \$50 million a year when home based services were reduced and/or terminated. R. 227 to 236. The total cost for the new program was \$278,661,600, or \$51,869 per waiver participant. The 2009 cost of Richard's Medicaid waiver program was approximately \$217,252,605 million, or \$36,209 per participant. While capping the number of hours of respite services for persons living at home, under the amended waiver, a participant would have to be admitted to an ICF/ID facility - the most expensive setting in the DDSN system - to receive more than 240 hours a month, in the event of illness or absence of a family caregiver. R. 891 compared to 893. Also, the reimbursement rate for ICF/ID services increased by 70%, from \$157.30 a day (R. 891) to \$270 a day. (R. Id 893).

Respondent failed to provide Richard or his guardian written notice of the 2010 reductions and terminations of waiver services or to notify him of his right to appeal.

Stogsdill II: 2010 administrative appeal. Having heard through the grapevine about the waiver service reductions being implemented, Richard filed Stogsdill II on December 30, 2009, requesting reconsideration of the threatened reduction of his services and he objected to the failure to provide the number of hours his physician had ordered, other violations of due process, the Medicaid Act and the Americans with Disabilities Act (ADA). R. 943.

Respondent sends notices to providers terminating Richard's services. Ignoring

his request to provide the services his physician had ordered and the other systemic issues he appealed, on January 11, 2010, DDSN sent notices to Richard's providers, informing them that funding for his personal care services and specialized medical equipment, supplies and assistive technology would be **terminated** (not just reduced) on January 21, 2014. R. 925-926. The reason provided on the notices of termination was that Richard "moved out of state." Id. Since he was a young child, Richard has always lived in Camden, South Carolina.

The following day, on January 12, 2010, the director of DDSN denied Richard's request to exceed the limits under the amended waiver:

These approved limits cannot be exceeded and must be applied to all MR/RD Waiver participants. While we understand and appreciate the hardship these changes may cause, we are not at liberty to exceed the established limits. Therefore, I must uphold the decision to reduce Personal Care II, Companion, and Respite Services.

R. 940.

2010 "fair hearing." Another hearing was held on May 11, 2010. Despite the first hearing officer ordering Respondent to have a qualified person evaluate Richard's need for services, giving consideration to the opinion of his physician, instead, a DDSN employee with no training in medicine, who did not even know whether Richard could get up out of the bed by himself, determined that he does not need all of the hours he requested. R. 282. This employee testified that she made this decision because Richard's mother works only part time, ignoring the fact that Nancy Stogsdill works six part time jobs, which is more than the equivalent of a full time job. Richard's mother testified about his need for the services ordered by Dr. Joseph and submitted affidavits from Richard's treating physician and provider of psychological services. Respondent again failed to present any evidence from any qualified medical source at the 2010 hearing. The DHHS hearing officer issued a final order

on September 14, 2010 and an appeal was filed in the South Carolina Administrative Law Court on October 20, 2010. R. 16. Although a final, appealable order had never been issued from the 2009 hearing, the agency and the Administrative Law Court treated the appeal as a separate proceeding and the Record (provided by the agency) filed with the Administrative Law Court did not contain the transcript from the hearing in 2009, where Richard's nurse presented live testimony.

Petitioner has presented novel questions of law regarding:

1. **Whether Respondent and its agent establishing binding norms for the Medicaid program that cannot be exceeded, without promulgating regulations, violates the South Carolina Administrative Procedures Act (APA);**
 2. **If these agencies are not required to promulgate regulations under the APA, weight must the Respondent give to the opinions of treating physicians in determining medical necessity for Medicaid services until regulations are promulgated?**
 3. **Did the lower court err in determining that DHHS complied with the requirements of *Goldberg v. Kelly* and the Medicaid Act's fair hearing requirements?**
-
1. **Did DHHS and its agent, DDSN violate the South Carolina Administrative Procedures Act by establishing binding norms for the administration of the ID/RD Medicaid waiver program because they did not promulgate regulations?**

The lower Court misinterpreted this Court's ruling as it pertains to the promulgation of regulations in *Doe v. DHHS, supra*. It is the understanding of counsel that the Court intended to set forth a rule that in order to establish a binding norm, an agency must promulgate regulations.

The lower Court also based its affirmation of the lower Court's decision that DHHS did not violate the SC APA in capping and terminating waiver services on *Arrowood II*, a case that was not mentioned in briefing by the Appellant, the Respondent or the Amici. That

2-1 decision did not involve the Medicaid Act, and its facts are clearly distinguishable from those in Richard's appeal. In *Arrowood I*, the North Carolina Court of Appeals ruled that the North Carolina Department of Health and Human Services violated the North Carolina Administrative Procedures Act by limiting AFDC benefits to 24 months, as allowed by the federal government. *Arrowood v. North Carolina Department of Health and Human Services*, 140 N.C.App. 31, 535 S.E.2d 585 (N.C.Ct.App. 2000) (Hereinafter referred to as "*Arrowood I*.") In *Arrowood I*, the plaintiff had signed a statement agreeing that his AFDC benefits would be limited and he agreed to a termination date for those benefits. *Id.* Subsequently, unlike the present case, the North Carolina General Assembly enacted a statute limiting those benefits to 24 months. *Id.* Despite the plaintiff having agreed in writing to the 24 month limitation, the North Carolina Court of Appeals ruled in *Arrowood I* that the limitation was unenforceable, because it had not been promulgated as a regulation under the NC APA at the time the plaintiff's benefit period began.

It is interesting to note that on the same day that the North Carolina Court of Appeals issued *Arrowood I*, it also issued a unanimous opinion in a case that did involve Medicaid benefits, *Dillingham v. North Carolina Department of Human Resources*, 132 N.C. App. 704, 513 S.E.2d 823 (N.C.App. 1999). Judge Martin authored both the *Arrowood I* and the *Dillingham* decisions. Judge Lewis concurred with Judge Martin in *Arrowood I*, and Judge Walker dissented.

In *Dillingham*, the North Carolina Court of Appeals ruled that the changes set forth in the agency's Medicaid Manual were unenforceable, because they had not been promulgated "in accordance with the requirements of the Administrative Procedures Act." *Id.* at 825. The

Court held that the Manual “must be construed as nothing more than incidental support for the decision...” Id. It ruled that the DHHS policy “creates a binding standard which interprets the eligibility provision of the medical law...” and that it was not “valid unless adopted in accordance with the provisions of Article 2A of the Administrative Procedure Act. N.C. Gen. Stat. § 150B-18.”

Three months later, the North Carolina Court of Appeals issued another unanimous decision involving the Medicaid Act. In *Duke Medical Center v. Bruton*, that Court ruled that the DHHS Medicaid policy in question “was not a properly promulgated rule within the meaning of the North Carolina Administrative Procedure Act (NCAPA), G.S. § 150B-18, and was therefore not binding on the public.” 134 N.C.App. 39, 41, 516 S.E.2d 633, 634 (N.C.App. 1999). The court ruled in *Duke* that the policy was not only “contrary to federal law,” but that the action “constitutes an unpromulgated legislative rule such that enforcement amounts to an ‘unlawful procedure’ under the NCAPA.” Id. at 637. The court concluded that the policy was “an administrative ‘rule’” that “creates a binding standard which interprets the eligibility and coverage provisions of the Medicaid law and, in addition, denies a substantial right.” Id. 641. As such, the *Duke* court ruled the policy was an “unpromulgated legislative rule and amounts to an unlawful procedure...” Id. at 641. Judges Greene and Wynn (now on the Fourth Circuit Court of Appeals) agreed that the policy violated the NC APA.

In 2000, the North Carolina Supreme Court issued a one sentence *per curium* opinion in *Arrowood II* that adopted the dissenting opinion of Judge Walker in *Arrowood I*. *Arrowood II*, 353 N.C. 351, 543 S.E.2d 481 (N.C. 2001). In his dissent, Judge Walker noted that the plaintiff failed to petition DHHS to adopt the ADFC rule pursuant to the

Administrative Procedures Act. He based the dissent, in part, on a North Carolina statute which prohibits the state from adopting a rule that “repeats the content of a law, a rule or a federal regulation.” *Arrowood I* at 593. Most importantly, Judge Walker recognized that “... an APA rule was necessary in *Dillingham*.” *Id.* at 593. Thus, he clearly distinguished the ADFC case from the decision involving the Medicaid Act in *Dillingham*.

More than a decade later, in *McCrann ex rel. McCrann v. Department of Health and Human Services*, any question about the need to promulgate changes in the State’s Medicaid program pursuant to the Administrative Procedures Act was put to rest. 704 S.E.2d 899 (N.C. 2011). In *McCrann*, as in Richard’s case, the State received approval from CMS for the amendments to the Medicaid waiver program in question.⁴ *Id.* 902. In a unanimous opinion, three different judges, who had not been involved in the *Arrowood* or the *Dillingham* decisions, distinguished the *Arrowood* case from the court’s holding in *Dillingham*:

Additionally, the *Arrowood I* dissent agreed with the holding in *Dillingham* that promulgation of a rule under the APA was required in that case in order for the rule to be valid.

Id. at 906. The court ruled that: “We conclude that the present case is similar to the facts presented in *Dillingham* and we agree with petitioners that *Arrowood II* is not controlling.”

Id. Like Richard, the Medicaid participant in *McCrann* had not signed a written agreement, as did the plaintiff in *Arrowood I*. The court emphasized in *McCrann* that the Medicaid participant’s knowledge of the changes simply “cannot equate” with the “contractual agreement” that existed in *Arrowood I*.” (“Mere knowledge of the potential for denial of

⁴ CMS also approved the caps that were subsequently determined likely to violate the ADA in *Peter B. v. Sanford, Supra*, as well as the caps at issue in *Moore v. Cook*, 1:07-cv-631 (Ga.D.C. April 19, 2012).

services is quite distinct from an agreement to be bound by terms explicitly set forth in a written contract.”) The Court of Appeals ruled that to extend the holding of *Arrowood II* to the facts of this Medicaid case would “enact fundamental changes in administrative law.” *Id.* at 906.

The unintended consequences of this ruling could be seismic and have far reaching unintended results across the State, thereby giving the Executive Branch unfettered power, in excess of that intended by the General Assembly of the State of South Carolina or the framers of the Constitution of the State of South Carolina. In *McCarrn*, the court held that “Such a holding would be in stark contrast to the uniformity in this area of the law in jurisdictions across the United States.” *Id.*

As recognized in *McCarrn*, in *In re Deil*, the Vermont Supreme Court ruled that the provision by Vermont’s Human Services Board that resulted in the denial of welfare benefits was invalid, because it had not been adopted as a regulation. 158 Vt. 549, 614 A.2d 1223 (1992). In that case, the Court held that:

The Legislature has authorized the Commissioner of the Department of Social Welfare to issue regulations necessary to administer the laws for which she is responsible. 33 V.S.A. § 105(c)(1), (2). It has not provided the Department an exemption from complying with the APA. Hence, the Commissioner must adopt rules in the manner prescribed by the APA. 3 V.S.A. § 831(a); see 3 V.S.A. §§ 836-843 (rulemaking procedures providing for publication, hearings, and legislative review). The APA does not exempt rules concerning benefits from its coverage. See 3 V.S.A. § 832 (exemptions from rulemaking).

Id. 1226. Further, the court found, in that case, that “As the Human Services Board noted, there would have been no conflict over the Department’s calculation of income if it had followed the APA throughout the process.”⁵ *Id.* 1228.

⁵ In *Smith v. Department of Human Services Director* the Michigan Court of Appeals ruled that:

The North Carolina Court of Appeals recognized in *McCrann* that:

...Arrowood II is an exception to the general principal that “[a]n administrative rule is not valid unless adopted in accordance with the provisions of Article 2A of the Administrative Procedure Act” and its holding is limited to the *unique facts of that case*. (Emphasis added.) Citing *Dillingham*, 132 N.C.App. At 710, 513 S.E.2d at 827; N.C. Gen. Stat. § 150B-18.

Id. at 907. The Court unambiguously held in *McCrann* that “*Arrowood* draws a clear line by which courts can recognize this exception - where the recipient of the benefits has contractually agreed to the terms of the waiver, obviating the need for further notice from promulgation of the rule in accordance with the APA.”⁶ In conclusion, the court held that

An agency's failure to substantially comply with the procedural requirements for promulgating rules under the APA renders a rule invalid and precludes it from having the force of law. MCL 24.243; *Goins v. Greenfield Jeep Eagle, Inc.*, 449 Mich. 1, 9-10, 534 N.W.2d 467 (1995). Because the DHS's policy constitutes a rule, no exception to the rulemaking requirements of the APA applies, and the DHS failed to follow the procedures for promulgating rules, the circuit court correctly concluded that the rule is invalid to the extent that state funding is involved.

822 N.W.2d 616, 628, 297 Mich.App. 148 (Ct. App. 2012). After the State agency complied with the state's APA the parties settled this case. 828 N.W.2d 18 (Mich. 2013). DHHS could avoid continued litigation, which has resulted from its ongoing violations of the APA, by simply promulgating regulations that establish reasonable standards which are not arbitrary and capricious to be used in the review of Medicaid State Plan and waiver amendments.

⁶ Also, unlike the S.C. A.P.A., N.C.'s APA specifically exempts its State Medicaid Agency from the rule making requirements contained in the APA. N.C. Statutes §150B-1(d)(9). But, it requires the North Carolina Department of Health and Human Services to comply with another statute setting out the requirements the agency must follow prior to changing its policies. Chapter § 108A-54.2 establishes the requirements DHHS must follow before changing its “medical coverage policy,” which is defined as “those policies, definitions, or guidelines utilized to evaluate, treat, or support the health or developmental conditions of a recipient so as to determine eligibility, authorization or continued authorization, medical necessity, course of treatment and supports, clinical outcomes, and clinical supports treatment practices for a covered procedure, product or service.” At least 45 days prior to adopting a new policy or amending existing coverage, the North Carolina General Assembly requires the agency to provide specific notice to providers and participants. In some cases a shorter period may be allowed.

“because the provision of the waiver at issue here was a rule that was not promulgated in accordance with the APA, and the circumstances presented do not fit within the *Arrowood II* exception, the provision is not legally binding and could not properly serve as the legal basis for DHHS’ denial of Jonathan’s benefits.” *Id.*

As did South Carolina, during 2010, the State of North Carolina reduced the service package provided by the Medicaid waiver program that serves persons with intellectual disabilities and related disabilities. But, those changes in North Carolina were enacted by the North Carolina General Assembly, unlike the changes at issue in *Stogsdill v. DHHS*, which were announced after adjournment of the Genral Assembly, and went into effect just prior to the beginning of the 2010 Session. *Pashby v. Cansler*, 709 F.3d 307 (4th Cir. 2023).

But, even though approved by the North Carolina General Assembly, the Fourth Circuit held the reductions made by North Carolina DHHS violated of the Americans with Disabilities Act. *Id.* As this Court noted, the Fourth Circuit held in that case that:

...[s]tate budgetary concerns cannot ... be ‘the conclusive factor in decisions regarding Medicaid,’ ” *id.* (quoting *Ark. Med. Soc’y v. Reynolds*, 6 F.3d 519, 531 (8th

Importantly, unless directed by the North Carolina General Assembly to change medical policy that affects the amount, sufficiency, duration and scope of health care services and who may provide services, the Division of Medical Assistance must prepare a five-year fiscal analysis before making changes. The agency must submit any changes in medical policy costing in excess of \$500,000 to (or \$50,000 for NC Health Choice in any given fiscal year) to the Office of State Budget and Management and Fiscal Research Division. That Office must identify and approve the source of funding for any such change. By November 1 of each fiscal year, DHHS must report “all medical policy changes with total requirements” less than \$500,000 to the Office of State Budget and Management and the Fiscal Research Division of the Legislative Services Commission. In Richard’s case, DHHS and DDSN made changes to a program that, by their own records cost South Carolina taxpayers tens of millions of dollars a year. The average cost per participant increased by more than \$8,000 a year when the caps were put into place and other services were eliminated from the waiver program

Cir.1993)). *Pashby* at 330. And, as the Fourth Circuit held in *Pashby*: "...the public interest always lies with upholding the law and having the mandates of the Medicaid Act, the ADA, the Rehabilitation Act, and due process enforced." *Id.* at 356.

2. **If these agencies are not required to promulgate regulations under the APA, weight must the Respondent give to the opinions of treating physicians in determining medical necessity for Medicaid services until regulations are promulgated?**

If the agency is not required to promulgate regulations, what standards must be used to comply with the mandate of *Olmstead* to give the greatest deference to the opinions of the Medicaid waiver participant's treating physician? *Olmstead* at 601. (Justice Kennedy's concurrence) and the Medicaid Act's mandate that the State establish "reasonable standards" for the administration of the Medicaid program. Will the agency continue to be allowed to have medical decisions made by persons with no medical training that affect the health and well being of South Carolina's most vulnerable citizens?

3. **Did the lower court err in determining that DHHS complied with the requirements of *Goldberg v. Kelly* and the Medicaid Act's fair hearing requirements?**

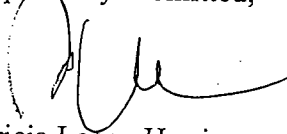
The Medicaid Act clearly and unambiguously requires States to provide a fair hearing system that provides notice to participants of their right to be heard and it contains very specific and easy to understand contents for notices. It also very clearly mandates that fair hearing decisions must be made based exclusively on evidence presented at the fair hearing. But DHHS has established a pattern and practice of dismissing appeals after requiring poor, and often uneducated Medicaid participants to prepare and file an "Interlocutory" order, without providing a hearing. This not only violates the mandate of 42 U.S.C. 1396a(a)(3) to provide an opportunity for a hearing, but also 42 C.F.R. 431.244, that requires decisions to be

made exclusively on evidence presented at a hearing. The failure to provide a final decision with "reasonable promptness" is also a novel issue for this Court to decide that will prevent persons like Richard from spending years in appeals. The lower court remanded Richard's decision back to DDSN. If this question is not answered by this Court, his victory may be hollow indeed.

Conclusion

Richard prays that this Court will consider his Petition and give him and the amici attorneys an opportunity to brief these important issues.

Respectfully submitted,



Patricia Logan Harrison

611 Holly Street

Columbia, South Carolina 29205

Attorney for Richard Stogsdill

November 24, 2014

THE STATE OF SOUTH CAROLINA
In the Supreme Court

APPEAL FROM THE SOUTH CAROLINA COURT OF APPEALS
Case No. 2013-000762

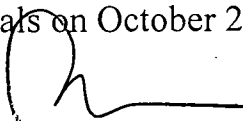
Richard Stogsdill,.....Petitioner,

v.

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

Certificate of Counsel

Counsel for petitioner certifies that the Petition for Rehearing was made and finally ruled upon by the Court of Appeals on October 23, 2014.



Patricia Logan Harrison
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NOV 26 2014
SC Court of Appeals

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November 26, 2014

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

RECEIVED
NOV 26 2014
SC Court of Appeals

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

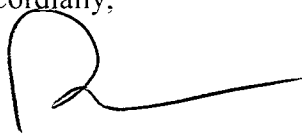
Dear Ms. Kitchings:

Enclosed is the *Petition for Writ of Certiorari* that was filed in the South Carolina Supreme Court on November 24, 2014. Also enclosed are other documents which have been filed and served.

Please clock the copy of this letter.

I hope that you will have a blessed Thanksgiving. Thank you for your assistance.

Cordially,



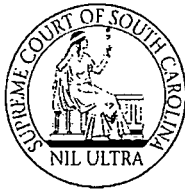
Patricia L. Harrison

Enclosures

c: Richard G. Hepfer, Esq.

PLH;jnh

Rcvd 11.26.14



The Supreme Court of South Carolina

DANIEL E. SHEAROUSE
CLERK OF COURT

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November 25, 2014

Patricia Logan Harrison, Esquire
611 Holly Street
Columbia SC 29205

RECEIVED

NOV 26 2014

SC Court of Appeals

Re: Richard Stogsdill v. SCDHHS
Appellate Case No. 2014-002513

Dear Counsel:

This Court has received your Petition for Writ of Certiorari and Appendix, and the case has been assigned the appellate case number that appears above. **Please use this number on all future correspondence relating to this matter.**

All parties to this matter are advised that all filings must comply with the requirements of Rule 242 of the South Carolina Appellate Court Rules (SCACR). The SCACR are available online at www.sccourts.org/courtreg. Additionally, any filings submitted by counsel admitted in South Carolina must include counsel's bar number.

The attention of the parties is directed to the order relating to the inclusion of personal data identifiers and other sensitive information in documents filed with the Supreme Court of South Carolina and the South Carolina Court of Appeals. The order can be found at www.sccourts.org/whatsnew/displaywhatsnew.cfm?indexID=932. Please note that the responsibility for insuring that information is redacted or sealed as required by

this order rests with counsel and the parties. **This office will *not* review filings for redaction or to determine if materials should be sealed.**

Very truly yours,

David E. Shearson
DS

CLERK

cc: Richard G. Hepfer, Esquire
The Honorable Jenny Kitchings