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S.C. Supreme Court

STATE OF SOUTH CAROLINA

In the Supreme Court

APPEAL FROM THE SOUTH CAROLINA COURT OF APPEALS

Case No: 2014-002513

Richard Stogsdill, Appellant,

v.

South Carolina Department of Health and Human Services, Respondent

---

RETURN TO PETITION FOR CERTIORARI

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RETURN TO PETITION FOR CERTIORARI

Background

The Petitioner in this matter is a Medicaid-eligible individual, who has been receiving services under the South Carolina Intellectual Disabilities/Related Disabilities (ID/RD) waiver. Under this waiver, beneficiaries can be provided a mix of services through the South Carolina Department of Disabilities and Special Needs (DDSN). Waivers are mechanisms within the Medicaid Program under which, by having certain generic requirements of the Medicaid program "waived," states are able to provide services to individuals in ways not allowed under the regular Medicaid Program. This and other waivers operated by DDSN are for home and community based services under Section 1915(c) of the Social Security Act [42 USC §1396n(c)]. These types of waivers allow services to be provided in the home or community, in lieu of institutional services. On January 1, 2010, the five-year renewal of the ID/RD waiver, as approved by the Centers for Medicare and Medicaid Services (CMS)[1], went into effect. The renewed waiver included a cap or limit on some services and excluded others. The original Hearing Officer took official notice of the Waiver (R. p. 18) and the current waiver documents including the waiver and the approvals by the CMS are at http://www1.scdhhs.gov/openpublic/insideDHHS/Bureaus/BureauofLongTermCareServices/Mental%20RetardationRelated%20Disability%20Waiver.asp.

The Respondent is the single state agency, as described in 42 U.S.C. §1396 et. seq., for

[1] CMS is the federal agency that oversees the states' administration of the Medicaid Program.

administration of the Medicaid Program in South Carolina. See, S.C. Code Ann. §44-6-5 et. seq.

In this case, through the efforts of himself and his family, supported by waiver services, the Petitioner has been able to live in the community. Additional respite services had been added at the time of the hearing. R. p. 158. In addition to regular medical, dental, vison care, psychological services, medications, and personal care–type services; the Petitioner has been provided support equipment and supplies including a motorized wheelchair (R. p. 305, line 4), a Hoyer lift and a Surehands lift (R. p. 325, line 25 & p. 326, line 2), a special door on his apartment and a special van (R. p. 326, lines 4 & 5, p. 326, line 7), and a phone and intercoms (R. p. 308, lines 6-15). With these supports, he is able to volunteer at two places in Camden where he interacts with the public (R. p. 308, lines17-19) and goes out once a week (R. p. 325, line 22). He also at times stays by himself during some hours of the day. R. p. 327, lines15-17. There are other services available under the waiver that support community living (see the list on R. pp. 892-894), We could find no indication in the Record that DDSN staff had designated the Petitioner to a "workshop setting" (group employment). That is only one of the many options available in the waiver for supporting community living.

Even though there are many different types of services available in the waiver as originally conceived, it was never the intention of the Departments to offer 24-hour-a-day care to individuals who participate in the waiver. The first page of the waiver document contains the statement:

> The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.
>
> The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services. Emphasis added

When he was under twenty one years of age, the Petitioner was likely receiving school-based services in addition to waiver services. Care was provided during school hours and, through the waiver, during part of the non-school time. The Petitioner "lost" his school services, probably under the Individuals with Disabilities Education Act (IDEA) because he turned twenty one (21). Waiver services continued. Since he became an adult, according to the waiver guidelines prior to the January, 2010, waiver changes, the Petitioner was receiving a combined 69 hours of Personal Care Aide and Companion Care services per week and about 36 hours of Respite Care per week. Personal Care Aide II (referred to now as PC2 in the waiver document, page 47 of 174) services consist of hands-on personal care that a person needs to accomplish their activities of daily living such as bathing, toileting, dressing and eating. Adult Companion Services are similar to PC2 services but include an aspect of community integration. Waiver document, page 64 of 174. Respite Care can be a range of services, including personal care but is designed

to provide services when the normal caregiver is absent or needs relief. Waiver document, page 50 of 174 and R. p. 335.

The Petitioner's physician filed an affidavit stating that the Petitioner's care needs are two (2) care aides for eight (8) hours a day or 112 PC2 hours per week. Additionally, his physician's affidavit stated that the Petitioner needs five (5) hours of Adult Companion Care per day or 25 to 35 hours per week and a continuation of the thirty-six (36) weekly hours of Respite Care being provided prior to the new waiver. R. p. 921. The Petitioner believes that, in this case, the orders of his attending physician should be dispositive of the services provided. For the Respondent, the Georgia cases cited at page 11 of the Respondent's Final Brief, below, demonstrate that the attending physician's orders are not dispositive, but are subject to the State's review.

Further as to the deference due to the attending physician, in the decision of *Olmstead v. L.C.* 527 US 581 (1999), Justices Breyer and Kennedy were concerned about discharging those in need of care into systems with too little supports. That type of "deference" discussed was the deference to the treating physicians' advice about discharge. The other type of deference discussed was deference to the "program funding decisions of the State policymakers." *Olmstead*, page 610. As far as we can see there is nothing in *Olmstead* about deferring to the treating physicians on what must be included in the services available to deinstitutionalized individuals.

Nevertheless, well-reasoned, evidence-based recommendations of attending physicians

should be given the utmost consideration, but it would be naïve of the State to allow such recommendations to be dispositive as to services. In this type of situation, physicians do not generally understand the scope of services available and often just agree with their patients that more is better.

Finally, in this case, there has been no direct testimony by any of the Petitioner's attending physicians. Although an attending physician's affidavit was entered into the Record (R. p. 920-922) for its probative value, it is still fundamentally hearsay evidence. Since the hearing in this case, the Supreme Court has clarified the issue of hearsay evidence in administrative hearings, including probable cause hearings. The Court found that the Rules of Evidence, which are applicable in administrative hearings, expressly exclude the hearsay testimony. *South Carolina Dept. of Motor Vehicles v. McCarson* 391 S.C. 136, 705 S.E.2d 425 (S.C.,2011).

We recognize and accept for this case, that there was insufficient factual information to rebut a certain risk of institutionalization or to show a fundamental alteration of the Program, as is apparently now required under the June 22, 2011, Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead v. L.C.* at *http://www.ada.gov/olmstead/olmstead_ta.htm.*

However, except for the DOJ guidance on the Americans with Disabilities Act, and the developing line of temporary injunctions referenced on pages 11 through 13 of the

Respondent's Reply to the Amici Brief, below, this case, in which the Petitioner is an adult, would be about the "package" of services provided under the waiver. The Petitioner has cited 42 CFR §440.230 as authority for the notion that the services provided to the Petitioner are inadequate. The Petitioner has misunderstood the import of 42 CFR §440.230 as set forth in the Medicaid regulations. As explained in Respondent's Brief, the requirements in §440.230 do not apply to individual Plans of Care, but to the adequacy of the services to meet the general needs of the population served. The language of §440.230 does not require each individual's Plan of Care to be adequate. It does require the amount, duration, and scope of the services to be adequate to generally achieve the purposes of the service. Again, referring to the Supreme Court's earlier case of *Alexander v. Choate*, 469 U.S. 287, 105 S. Ct. 712, 83 L.Ed.2d 661 (1985), wherein the Court addressed this section of the regulations:

> [M]edicaid programs do not guarantee that each recipient will receive the level of health care precisely tailored to his or her particular needs. Instead, the benefit provided through Medicaid is a particular package of health care services... That package of services has the general aim of assuring that individuals will receive necessary medical care, but the benefit provided remains the individual services offered-not "adequate health care."

With respect to individual needs, we agree with the Amici's statement that generally speaking an individual's activities of daily living can be objectively quantified. However, as we see the requirement, the State only needs to set up a program that meets the needs of most of the affected population. For example, PCA services are limited to twenty-eight (28) hours per week. In the usual case, a reasonable authorization would be two (2) hours each morning to prepare for the day and two (2) hours in the evening to

prepare for bed, or twenty-eight (28) hours of personal care per week, the current waiver limits. All that is required, under §440.230 and *Alexander*, is that the level of service generally, not individually, meets the needs of most of the cases.

Medicaid Waiver Program

It was with the above general historical understanding of the parameters of the Medicaid waiver option, that the Departments began planning for the 5-year renewal of the waiver to be effective in in 2010 On January 1, 2010, in part to cope with budget cuts, the reconfiguration of the ID/RD waiver services went into effect. It takes a while, sometimes years, to plan, submit, and implement a waiver renewal. Some of the services, which, in the view of the agencies, had been over-utilized, under informal limits, became subject to limits specified in the waiver. Other, less expensive services were also more fully described in an effort to compensate for the loss of services. For example, Respite care (a service somewhat like the PCA service) can now be provided in increasing amounts to compensate for burdens on the primary caregivers.[2] In accordance with the best practice, as they saw it, the DDSN and DHHS staff prepared the new Waiver for submission to CMS. Public hearings were held throughout the State. CMS approved the waiver in accordance with 42 CFR §441.300 et seq. All of the Medicaid application and approval requirements were met. Having done so, there was no doubt for the agencies that the implementation of the Waiver complied with the requirements of the federal

[2] A basic requirement to participate in the Waivers is that there be informal supports such as family, so that the waiver services compliment the informal supports. See page 1 of the Waiver document.

agency that oversees the Medicaid Program. This was the "package" that the State could provide for adult ID/RD individuals in the community. Mr. Jacob Chorey, at R. p. 292 testified about the first renewal that included specific limits of services. The planning led up to a statewide series of meetings by which Participants and Service Coordinators were familiarized with the changes. R. p. 292. The pertinent changes for this case are:

1) Personal Care (PC) Services were limited to twenty-eight (28) hours per week. Personal Care Aides (PCAs) assist Waiver participants with activities of daily living (bathing, dressing, feeding and toileting).

2) Occupational, Speech and Physical Therapies were eliminated from the Waiver, but continue to be available from the regular Medicaid Program.

3) The limits on Respite Services were set at sixty-eight (68) hours per month, but adjustable up to 240 hours per month according to the situation. Respite care services are similar to PCA services.

It is clear that the Petitioner's Service Coordinator attended one of the series of meetings. R. pp. 172, and 292. In any case, the Petitioner determined the potential effects of the cuts on his services and in apparent anticipation of the limits, in late December, 2009, he sought a Reconsideration of the application of the limitations to his services. R. p. 149. The Reconsideration was the first step in the appeals process. On or about January 18, 2010, after the initial cuts, but prior to the appeal of the Reconsideration, the Petitioner's Service Coordinator applied for an increase in Respite care. On March 1, 2010, the local DSN Board increased respite care hours to 104 hours per month for a total of 172 hours of respite care per month (or about 40 hours per week). See, R. pp. 158-168 and the

descriptions of services cited above.[3]

Fair Hearing System

42 CFR §431.244 provides as follows:

> f) The agency must take final administrative action as follows:
> (1) Ordinarily, within 90 days from the earlier of the following:
> (i) The date the enrollee filed an MCO or PIHP appeal, not including the number of days the enrollee took to subsequently file for a State fair hearing; or
> (ii) If permitted by the State, the date the enrollee filed for direct access to a State fair hearing

Thus, the Department is ordinarily supposed to issue final decisions within ninety (90) days of the filing of an appeal. (The language in (i) deals with appeals that initially arise within managed care organization and are then appealed to the State Medicaid agency.) With the many issues raised, this is not the ordinary case. Furthermore, there is no logical relationship between the delay in issuing the Order in this case and a determination that the Petitioners are entitled to additional services. Petitioner's pre-appeal services continued during the pendency of the appeal.

Section 2903.2(A) of the State Medicaid Manual (a federal publication) requires that "A conclusive decision in the name of the State agency shall be made by the hearing authority." and further that: "Remanding the case to the local unit for further consideration is not a substitute for 'definitive and final administrative action.'" There was no remand in this case. The Hearing Officer's decision simply upholds the

[3] In June of 2012, due to a parent's illness, respite services were again increased to 240 hours per month, and in September of 2014, 14 hours/week of nursing services were added, due to the condition of the Petitioner. .

Department's determination with a "conclusive decision in the name of the agency."

Court of Appeals' Decision

The Department has accepted the portion of the court of appeals opinion regarding the risk of institutionalization and fundamental alteration and will continue with the Petitioner's augmented pre-appeal services until the evaluation of the Petitioner's need for services, without regard to service limitations can be accomplished.

2009 Appeal

The Petitioner's position is that his previous case, [R. S.] v. SCDHHS, 09-MISC-017, was the start of this dispute, and this case is just a continuation of that case. We disagree as there is nothing in the previous Decision in 09-MISC-017 to indicate that the Hearing Officer retained jurisdiction for further review. We believe that the Hearing Officer in 09-MISC-017 issued a final decision which was not appealed within the applicable time limits. Shortly after the decision in 09-MISC-017, the new waiver required all services to be reevaluated, taking into consideration the new limits. This case is an appeal of the reduction in services to the Petitioner occasioned by the new January 1, 2010, wavier limits.

ARGUMENTS

1) **Although the waiver limitations at issue here were not promulgated as regulations under the South Carolina Administrative Procedures Act, they are still enforceable under the Department's general grant of authority by the General Assembly and in accordance with the requirements of Medicaid federal statutes and regulations.**

Under a few administrative decisions beginning with the Administrative Law Court's Decision in Hickey v. SCDHHS (10-ALJ-08-0656-AP), the Petitioner believes that the waiver limitations have been found to be unenforceable as un-promulgated binding norms.

First of all, even if the Hickey case is controlling, a careful reading of the case means not that the waiver limitations are unenforceable, as asserted by the Petitioner, but only that they are not binding norms and therefore may not be enforced without an opportunity for an evidentiary hearing. There was an evidentiary hearing in this matter, in which the Hearing Officer found that the services were sufficient to avoid institutionalization of the Petitioner. R. p. 24.

Furthermore, since the Hickey case, in *Jane Doe v. SCDHHS*, 398 S.C. 62, the SC Supreme Court indicated that waiver provisions are enforceable with respect to the administration of the waivers, even though they are distinguishable from promulgated regulations. See page 74 of the S.C. version. Footnote 7 of the opinion does say that a policy cannot contradict a regulation and in that posture should be given no effect, but we know of no contrary regulation or law specifying a different level of services than is set forth in the waiver document.

The Petitioner cites two (2) South Carolina Supreme Court cases for the proposition that, if the rule is a "binding norm" it should be promulgated through the South Carolina

Administrative Procedures Act (APA). However, in neither of those cases was it determined that the rule in question in those cases needed to be promulgated. In *Home Health Services, Inc. v. S.C. Tax Commission*, 312 S.C. 324, 440 S.E. 2d 375 (1994), the rule concerned an interpretation of the Bingo Act under which the bingo operator was fined for having runners, employed by the operator, substitute for players while the players were temporarily excused from the floor. The court held that the APA was not violated since the document issuing the rule was more like a policy statement than a binding norm.

In *Sloan v. S.C. Board of Physical Therapy Examiners*, 370 S.C. 452, 636 S.E. 2d 598 (2006), the rule at issue was a decision of the Board to begin enforcing S.C. Code Ann. §40-45-110(A)(1) of their practice act, which allowed the Board to deny or revoke the license of a PT who was paid by an employing physician. In holding that the APA was not violated the Court found that the policy of the Board was merely their interpretation of a statute. To hold otherwise would require every agency to promulgate its interpretation of the statutes it is entrusted to enforce.

The cases above about the characteristics of a policy as opposed to a regulation, show only that there is no clear overall rule in South Carolina. There should probably be more guidance about what <u>is</u> a "binding norm" or "rule of general applicability" (S.C. Code Ann. §1-23-10(4) that has to be promulgated. Such guidance would have to balance agencies' need to be responsive to changing situations and the public's right to certainty about what is available from their government. In south Carolina, as cited above, the

waiver document is set forth on the Department's public website.

The Waiver document is a contract between the federal government and the State about what services will be billed to the federal Medicaid Program through the State's letter of credit at the Centers for Medicare and Medicaid. The waiver application must conform to the federal regulations at 42 CFR §440.300 et seq. The ability of the Department to negotiate with the Centers for Medicare and Medicaid is consistent with the Department's enabling legislation, specifically at S.C. Code Ann. §§44-6-30 & 40. It is also consistent with the federal regulations regarding the authority and independence of the Single state agency that administers the Medicaid Program at 42 CFR §430.10. The Department is the duly designated single state agency for the administration of the Medicaid Program in South Carolina. 42 U.S.C. §1396 et. seq.; S.C. Code Ann. §44-6-10 et. seq.; and 42 CFR §431.10. The Department's regulations at S.C. Code R. 126-300(D) provide authority to make administrative changes in the Department's Programs. The regulation states:

> D. Services are subject to limits and procedural requirements described in the South Carolina State Plan for Title XIX (Medicaid), provider manuals, Medicaid Bulletins, and federal directives.

In sum, the authority to specify the parameters of the Medicaid waivers is contemplated within the DHHS statutes and regulations.

The Court of Appeals found instructive the North Carolina case of *Arrowood v. North Carolina Department of Health & Human Services*, 543 S.E. 2d 481 (N.C. App, 2001)(rev'g 535 S.E.2d 585 (N.C 2000). In that case, the North Carolina Supreme Court reversed the holding of the superior court that a waiver involving the North Carolina

welfare program had to be promulgated to be valid. In reversing, the Supreme Court adopted the dissent in the lower case that relied on the clarity of the waiver language and a contractual relationship between the parties. *McCrann ex rel. McCrann v. Department of Health and Human Services*, 704 S.E. 899 (N.C. App, 2011) distinguished the *Arrowood* cases due to the contractual relationship, but the other distinguishing factor between the cases was the clarity of the waiver language. The *McCrann* case involved an interpretation of the waiver language. As in the present case, the *Arrowood* involved a straightforward application of the waiver language. In the South Carolina waiver document, the limitations in services are set forth in actual number of hours, not subject to interpretation.

Thus, the court of appeals decision regarding promulgation is in accord with the Supreme Court's decision in *Doe*, not in conflict with federal law, and presents no Constitutional issues.

2) Although the proposed reduction in the Petitioner's specific services was not accompanied by the proper notice under 42 CFR §431.210, the Petitioner was not prejudiced by the omission.

The Petitioner has asserted that the initial notice to the Petitioner was defective because it did not comply with the following regulation in Title 42 CFR:

> §431.210 Content of notice.
>
> A notice required under Sec. 431.206 (c)(2), (c)(3), or (c)(4) of this subpart must contain--
> (a) A statement of what action the State, skilled nursing facility, or nursing facility intends to take;
> (b) The reasons for the intended action;

(c) The specific regulations that support, or the change in Federal or State law that requires, the action;

(d) An explanation of--

(1) The individual's right to request an evidentiary hearing if one is available, or a State agency hearing; or

(2) In cases of an action based on a change in law, the circumstances under which a hearing will be granted; and

(e) An explanation of the circumstances under which Medicaid is continued if a hearing is requested.

Specifically, the Plaintiff complains that he did not directly receive the notice and that the notice did not set forth the specific "regulations that support...the action."

The Departments have admitted that he is correct on both counts and have taken remedial measures. Ultimately, the "regulations that support... the action" are set forth in the general description of the home and community based waivers in 42 CFR §440.180 of the Medicaid Regulations:

440.180 Home or community-based services.

(a) Description and requirements for services. ``Home or community-based services'' means services, not otherwise furnished under the State's Medicaid plan, that are furnished under a waiver granted under the provisions of part 441, subpart G of this chapter.

(1) These services may consist of any or all of the services listed in paragraph (b) of this section, as those services are defined by the agency and approved by CMS.

..... (emphasis added)

Obviously, that is a very general, over-arching and abstract concept, and, thus it is much more meaningful for a participant to be apprised of the particular service and service limits in the waiver that apply to the particular action being taken by the agency. It is also much more concretely contestable than the general statement in the actual federal

regulations. Under the wording of the federal regulation at 42 CFR §431.210, it would have been permissible to simply have set forth the general statement in §440.180.

The public hearings on the changes that took place in the communications with the Service Coordinators (R. pp. 292 & 293), gave the Petitioner actual notice of the limits. Furthermore, the fact that he, through counsel, sought a reconsideration of the limits before they became effective indicates that Petitioner did have actual knowledge of the effects that the limits would have on his services. Finally, the Reconsideration decision and notice of appeal rights issued by Dr. Buscemi (R. pp. 940 & 941) provided adequate notice of the issues and the opportunity to be heard by the DHHS Appeals Division. Therefore, as further supported by the citations set forth by the court of appeals (R. p. 955), the Petitioner experienced no prejudice.

Thus, as to notice, the decision of court of appeals is in accord with the Supreme Court cases. Although the Constitutional and federal issue of due process is involved in this matter, it is resolved by lack of prejudice.

For the reasons set forth above, the Petition should be denied.

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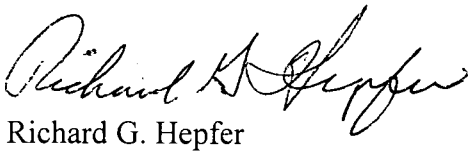
Respectfully submitted,



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CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Respondent in the above-captioned matter and that on the 22nd day of December, 2014, in Columbia, South Carolina, I served a copy of the forgoing Petition for Rehearing on the following persons by depositing the same in the United States Mail, postage paid, and addressed as follows:

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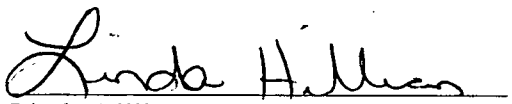

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