THE STATE OF SOUTH CAROLINA
In the Supreme Court

APPEAL FROM THE SOUTH CAROLINA COURT OF APPEALS

Appellate Case No. 2014-002513

Richard Stogsdill,.....Petitioner,

v.

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

BRIEF OF PETITIONER

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TABLE OF AUTHORITIES
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III. Introduction

The South Carolina Department of Disabilities and Special Needs (DDSN) has not promulgated a regulation since 1986. R. 730. The consequences of this lack of legislative involvement are too clearly documented in audits and investigations of DDSN that have reported repeated flagrant violations of state and federal laws, not to mention the unfettered growth of a system that has totally abdicated its duty to spend funds for the purposes appropriated by the General Assembly, while failing to protect the health and safety of South Carolina's most vulnerable citizens.[1] As a matter of public policy, courts have a special duty to zealously protect the rights of parties who are under a disability. Jean Hoefer Toal et al., *Appellate Practice in South Carolina* 69 (1999). *See Joiner v. Rivas*, 335 S.C. 648, 518 S.E.2d 51 (Ct. App. 1999).

IV. Statement of Issue

Have the South Carolina Department of Health and Human Services (DHHS) and its agent, the South Carolina Department of Disabilities and Special Needs (DDSN), violated the South Carolina Administrative Procedures Act (APA) by establishing binding norms for the Medicaid program without promulgating those rules as regulations?

V. Statement of the Case

Petitioner, Richard Stogsdill (hereinafter "Richard"), receives Medicaid services through

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[1] *Unequal Justice for South Carolinians with Disabilities: Abuse and Neglect Investigations* by Protection and Advocacy for People with Disabilities, Inc. Dated October 2005 at R. 486; *Review of the MR/RD Medicaid Waiver as Operated by the Department of Disabilities and Special Needs* by DHHS dated February 28, 2006 at 434; *A Review of the Department of Disabilities and Special Needs* by the South Carolina Legislative Audit Council dated December 2008 at R. 641. Results of audits and investigations that have been issued by reliable government entities since 2009 are not contained in the Record, but this Court may take judicial notice of similar subsequent reports, which will be provided by Petitioner if the Court determines it appropriate to take judicial notice of those reports issued after 2009.

a program designed to prevent institutionalization of persons who have mental retardation or a related disability."[2] To qualify for the program, participants must meet "level of care" requirements entitling them to choose instead to receive Medicaid-funded services in an ICF/MR, which is an institution funded by DDSN and DHHS providing 24-hour care, supervision, counseling, recreation and other activities to persons who have mental retardation or a related disability. R. 491. Richard first initiated an administrative appeal on February 13, 2009 after the burden of providing care during the school day fell to his working parents when he graduated from high school. R. 306 and 947. A DHHS hearing officer issued an interlocutory order, remanding Richard's case back to DDSN on November 16, 2009 to determine the number of hours he required, with orders that DDSN must take into consideration the orders of Richard's physician. R. 31. On January 1, 2010, DDSN implemented an amendment to the MR/RD Medicaid waiver[3] which, for the first time, imposed service limits, or "caps" on some services in

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[2] It is uncontested in this case that Richard is a person who has a "related disability" and qualifies for the ID/RD Medicaid waiver program. S.C.Code § 44-20-30(15) defines a "related disability" as a severe, chronic condition found to be closely related to intellectual disability or to require treatment similar to that required for persons with intellectual disability and must meet the following conditions:

> (a) It is attributable to cerebral palsy, epilepsy, autism, or any other condition other than mental illness found to be closely related to intellectual disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with intellectual disability and requires treatment or services similar to those required for these persons.
> (b) It is manifested before twenty-two years of age.
> (c) It is likely to continue indefinitely.
> (d) It results in substantial functional limitations in three or more of the following areas of major life activity: self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living.

[3] The name of this program has changed since Richard's appeal was initiated to "ID/RD" and the term "mental retardation" has been replaced with "intellectual disabilities," but the definition of the terms have not changed.

the waiver, and eliminated other services. R. 292. Richard and nine other affected Medicaid waiver applicants filed a Petition asking this Court to hear their objections to the planned reductions in its original jurisdiction. R. 337. That Petition was denied and Richard proceeded with his "fair hearing" appeal. In 2012, with his appeal not resolved after three years in the Executive Branch, Richard filed a lawsuit in federal district court, but his federal claims were later dismissed on abstention grounds.[4]

DDSN did not conduct the assessment of Richard's needs, as had been ordered by the DHHS hearing officer, but proceeded instead to apply the new waiver caps to Richard and other waiver participants. R. 335. In order to prevent his services from being reduced pursuant to the waiver amendment, on December 30, 2009, Richard was forced to file a second administrative appeal requesting reconsideration by the Director of DDSN. R. 943. DDSN denied Richard's request for reconsideration on January 12, 2010, finding that "These approved limits cannot be exceeded and must be applied to all MR/RD Waiver participants." R. 940. On February 11, 2010, Richard appealed DDSN's decision to the DHHS Office of Hearings and Appeals. R. 938-939.

A hearing was held on May 11, 2010. R. 263 to 334. The DHHS hearing officer, Jeff Bryson, issued an Order on September 14, 2010, finding that Respondent acted lawfully in

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[4] With his administrative appeal still pending in the Executive Branch, Richard and a HASCI waiver participant filed a lawsuit in the federal district court on January 1, 2012, alleging violation of the Americans with Disabilities Act, Section 504 of the Rehabilitation Act and various provisions of the Medicaid Act. *Stogsdill et. al. v. Sebelius,* Civil Case No. 3:12-cv-00007 (D.C.S.C.). In this federal action, Richard alleged violations of the Americans with Disabilities Act (hereinafter referred to as the "ADA"), Section 504 of the Rehabilitation Act (hereinafter referred to as "Section 504"), the Medicaid Act, the Administrative Procedures Act of the State of South Carolina and both the Supremacy and Due Process Clauses of the United States Constitution. Richard was dismissed from that lawsuit by order dated November 10, 2014. *Stogsdill v. Keck*, 3:12-cv-00007.

implementing the January 1, 2010 caps and in terminating or reducing other services. Richard appealed that decision to the Administrative Law Court on October 20, 2010. R. 933. On March 13, 2013, the Administrative Law Court issued an order finding that DHHS had the statutory authority and to enter into an agreement with CMS to amend the waiver document and that it "properly exercised their authority to amend the waiver..." R. 9. Richard filed a timely appeal of this Order to the South Carolina Court of Appeals on April 9, 2013. R. 2. The Court of Appeals granted the Petition filed by Protection and Advocacy for People with Disabilities, Inc, South Carolina Legal Services, the South Carolina Chapter of the National Academy of Elder Law Attorneys and South Carolina Appleseed Legal Justice Center to file an amicus brief. R. 975 and 1409.

The South Carolina Court of Appeals issued an order on September 10, 2014, ruling that (1) DDSN established a binding norm by reducing the types and amount of services offered under the Waiver, but did not have to promulgate a regulation to enforce that rule, because the changes were approved by the federal Medicaid agency, (2) Richard was not prejudiced by Respondent's inadequate notice, and that (3) Richard is at risk of institutionalization and that the State could accommodate his needs without fundamentally altering its programs. R. 948. *Stogsdill v. DHHS,* Opinion No. 5271 (S.C.Ct.App. September 10, 2014). In its order, the Court of Appeals Court remanded Richard's case back to DDSN "for consideration of the appropriate services to be provided without the reductions of the 2010 Waiver."[5] Id. at 959. Both parties filed motions for rehearing. R. 1061 and 1175. In his Petition for Rehearing, Richard argued that

[5] This Court may take judicial notice that no order on remand has been issued by DDSN or DHHS.

the lower Court's reliance on *Arrowood* was in error and that Respondent violated the Administrative Procedures Act by failing to promulgate the reductions in services as regulations. R. 1077. *Arrowood v. North Carolina Dept. of Health and Human Services*, 353 N.C. 352, 543 S.E.2d 481 (N.C. 2001). The Court of Appeals denied both the Respondent's and the Appellant's Petitions for Rehearing. R. 961 and 963.

Respondent did not appeal the Court of Appeals' ruling finding that applying the 2010 caps to Richard's services violated the Americans with Disabilities Act. This Court may take judicial notice that no order has been issued by DDSN or DHHS on remand from that Court.

Richard Petitioned for Certiorari, which was granted in part by this Court on April 9, 2015.

VI. Standard of Review

In a case raising a novel question of law regarding the interpretation of a statute, the appellate court is free to decide the question *de novo,* with no particular deference to the lower court. *Sloan v. South Carolina Board of Physical Therapy Examiners*, 370 S.C. 452, 636 S.E.2d 598 (2006). This Court is "free to decide the question based on its assessment of which interpretation and reasoning would best comport with the law and public policies of this state and the Court's sense of law, justice, and right." *Croft v. Old Republic Ins. Co.*, 365 S.C. 402, 408, 618 S.E.2d 909, 912 (2005); *Antley v. New York Life Ins. Co.,* 139 S.C. 23, 30, 137 S.E. 199, 201 (1927) ("In [a] state of conflict between the decisions, it is up to the court to `choose ye this day whom ye will serve'; and, in the duty of this decision, the court has the right to determine which doctrine best appeals to its sense of law, justice, and right.")

VII. Statement of Facts

A. The Medicaid Waiver Program. Medicaid is a joint program through which the federal government provides financial assistance to states to 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; however, any state that elects to participate "must comply with all requirements imposed by the Medicaid Act and related regulations." Id.

B. The State Department of Health and Human Services (DHHS). DHHS was established by the statute contained at S.C. Code § 44-6-10. DHHS has been charged by the General Assembly with the responsibility for administering all Medicaid funds and Medicaid programs in the State. S.C. Code § 44-6-10 and 30. That agency is headed by a Director appointed by the Governor, and it is the "single largest employer in the state..." S.C. Code § 44-6-132(4). DHHS contracts with DDSN to operate programs that provide an alternative to more costly institutional services for persons who have Intellectual Disabilities (formerly called "Mental Retardation") and Related Disabilities, as described in the DHHS audit of DDSN at R. 435.

DDSN is the second largest recipient of DHHS' funds, behind hospital services. R. 668. During FY 08, DDSN's budget was $490,782,746, up from $450,866,073 in FY 07. R. 668 and 669. The cost of the MR/RD Medicaid waiver program has grown from $180,505,914 in 2004 ®. 228) to $278,662,353 in 2010 (as projected in November 2009), with the cost of the program projected to reach $398,815,700 in 2015. R. 75 and 893. Richard is a "medically indigent" person, as defined in 66-6-5(5), who receives Medicaid services that are administered by DHHS

under this contract with DDSN, due to his "related disabilities" of severe cerebral palsy and epilepsy.

DHHS is responsible for (1) preparing and state and federal Medicaid plans prior to submission to the federal Medicaid Agency, CMS, and for state and federal funding. S.C. Code of Laws § 44-6-40(1). In delivering Medicaid services to citizens of South Carolina, the General Assembly has directed DHHS to be guided by the goal of delivering services "in the most effective and efficient ways possible." Id. DHHS is obligated by statute to compile and maintain information concerning all of the Medicaid programs it oversees and to continuously review and evaluate programs to determine the extent to which they meet fiscal, administrative, and program objectives; and to assure that these programs are being operated cost effectively. S.C. Code § 44-6-40(2) and (3). DHHS is obligated by statute to evaluate these Medicaid plans and programs "in terms of their compatibility with state objectives and priorities set forth in S.C. Code § 44-6-70. § 44-6-40(4). S.C.Code § 44-6-70 requires DHHS to give specific attention to prevention measures (a), achievement of optimum cost effectiveness in administration and delivery of services and to provide assurance of the quality of services delivered (e). The General Assembly has charged DHHS with the duty to assure the maximum utilization of private and non-profit providers in administration and service delivery systems. Id. at (f).

By statute, DHHS is charged with formulating "for consideration and promulgation criteria, standards, and procedures that ensure assigned programs are administered effectively, equitably, and economically and in accordance with statewide policies and priorities." S.C. Code § 44-6-40(5). The Director of DHHS is obligated by statute to keep the Governor and the General Assembly informed as to the effectiveness of the criteria, standards, and promulgated procedures.

S.C. Code § 44-6-40(6).

Importantly, the General Assembly has directed DHHS to plan Medicaid services so as to achieve "a balanced health care delivery system assuring that regulations, coverage, and reimbursement policies assure that the most appropriate care is given, tailored to the client's needs, and delivered in the most cost-effective manner." S.C. Code § 44-6-70. (Emphasis added.) The Medicaid Act requires DHHS to assure the federal government that the State will provide "assurances" that its Medicaid waiver plan includes "necessary safeguards ... to protect the health and welfare of individuals" receiving home care. 42 U.S.C. Sec. 1396n(c)(2)(A).[6] The regulation interpreting that section requires the State to provide "Assurance that necessary safeguards have been taken to protect the health and welfare of the beneficiaries of the services." 42 C.F.R. § 441.302. The Director of DHHS must provide these assurances in the Medicaid waiver application. R. 212 and 444. Repeated audits have documented the failure of DHHS and DDSN to assure the health, welfare and safety of waiver participants. R. 434, 487, 671.

The General Assembly has mandated that DHHS must submit to the Governor, the Budget and Control Board and to the General Assembly an annual report detailing improvements in the "cost effectiveness achieved..." through Medicaid programs and recommending changes

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[6] In *Wood v. Tompkins,* the Sixth Circuit held that "Secs. 1396n(c)(2) and 441.302 impose mandatory duties upon participating states. Such states must provide the various enumerated assurances in order to obtain a home care waiver.... there is nothing vague or amorphous about what the statute or corresponding regulations require of participating states. The duties set forth therein do not involve any fuzzy, undefined concepts like 'reasonable efforts.' Rather, these duties involve unambiguous directives that are well within the ability of the judiciary to enforce." 33 F.3d 600 (6th Cir. 1994). At page 610 of that decision, the Sixth Circuit stated: "We find, rather, that Sec. 1396n(c)(2), and its corresponding regulation, Sec. 441.302, places the onus of compliance squarely upon participating states."

for further improvements. S.C. Code § 44-6-80. The agency's budget is determined by the General Assembly based on these required reports and this Court may take judicial notice that these reports are presented to the General Assembly before the final State Budget is adopted at the end of the legislative session. The Court may also take judicial notice that the waiver amendments were enacted after the General Assembly adjourned in 2009 and before the start of the 2010 legislative session, without notice to or approval of the General Assembly.

The statute at S.C. Code § 44-6-90 grants DHHS the authority to promulgate regulations to carry out its duties. The General Assembly has charged the director of DHHS with the responsibility for assuring that "the department's business is conducted according to sound administrative practice. S.C. Code § 44-6-100. As required by the Medicaid Act, DHHS has established a "Medical Care Advisory Committee." 42 C.F.R. § 431.12. This "MCAC" is appointed by the agency to "advise the Medicaid agency about health and medical care services." Id. The MCAC "must have opportunity for participation in policy development and program administration, including furthering the participation of beneficiary members in the agency program," but its recommendations are purely advisory. 42 C.F.R. § 431.12(e). The proposed changes to the MR/RD Medicaid waiver amendment were first presented to the MCAC on May 19, 2009, at the end of the legislative session and they were first mentioned (but not fully explained) to the governing board of DDSN and local DSN Boards at the DDSN Commission meeting held on May 21, 2009. R. 833. See "Apology" at 914.

Regulations promulgated by DHHS are found in Chapter 12 of the South Carolina Code of Regulations, but there are few regulations related to the administration of the DDSN Medicaid waiver programs (although this is the second most expensive program DHHS operates. R. 668).

Subarticle 3 contains the regulations related to "fair hearings," but that section provides little guidance about how these hearings are to be conducted, who has the burden of proof, what standard of proof is required or timeframes for holding a "fair hearing," or issuing a final decision appealable to the judicial branch. As in Richard's case, these "fair hearing" appeals frequently take years to reach the judicial branch. Reg. 126-380 requires DHHS to provide notice "pursuant to Title XIX of the Social Security Act" and to continue services pending a fair hearing decision "in accordance with Title XIX of the Social Security Act and the federal regulations promulgated in accordance therewith." But, the State rarely issues a final decision after providing an evidentiary hearing within 90 days of the request for a hearing. *Shakhnes v. Berlin*, 689 F.3d 244 (2d Cir. 2012).

Reg. 126-425(A)(9) defines "Medically reasonable and necessary" as "procedures, treatments, medications or supplies ordered by a physician, dentist, chiropractor, mental health care provider, or other approved, licensed health care practitioner to identify or treat an illness or injury." But DHHS allows DDSN to deny services ordered by physicians based on "assessments' by persons who have no medical training. R. 276-295. That regulation provides that these procedures, treatments, medications or supplies "must be administered in accordance with recognized and acceptable medical and/or surgical discipline at the time the patient receives the service and in the least costly setting required by the patients' condition." Id. Furthermore, it requires that "All services administered must be in compliance with the patient's diagnosis, standards of care..." Id. Yet, the waiver amendment submitted to CMS in August of 2009 capped home based services while more than quadrupling the demand for ICF/MR waiver services that

are provided in the most costly and restrictive setting in the State's system.[7] R. 891-894.

Reg. 126-304 requires DHHS to provide occupational therapy, physiotherapy, speech therapy services at home, but these home-based services were terminated from the MR/RD Medicaid waiver in 2010. R. 845. That section also requires DHHS to provide "personal care ...in the home provision of the necessary services of support of activities of daily living, home support, medical monitoring, and client transportation services to restore, maintain and promote health status.

C. The South Carolina Department of Disabilities and Special Needs. DHHS has contracted with DDSN to administer the day to day operation of the home and community based waiver program at issue in this case, called the "ID/RD Medicaid waiver program" (formerly called the "MR/RD Medicaid waiver program"). DDSN operates its programs pursuant the "South Carolina Intellectual Disability, Related Disabilities, Head Injuries, and Spinal Cord Injuries Act" (ID/RD HASCI Act) at § 44-20-10. In that Act, the General Assembly recognized that persons, like Richard, who have related disabilities are entitled to experience "the benefits of family, education, employment, and community as do all citizens." S.C. Code § 44-20-20. The purpose of the Act is "to assist persons with ... related disabilities... by providing services to enable them to participate as valued members of their communities to the maximum extent practical and to live with their families or in family settings in the community in the least

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[7] DHHS projected in the "old" Medicaid waiver that only 30 participants would require respite services in an ICF/MR, the most restrictive and costly setting operated by DDSN. R. 891. But, DHHS projected that after the reductions were made to home-based services, 126 waiver participants would require ICF/MR placement for respite. R. 893-894. The average number of days waiver participants spent in ICF/MR facilities for respite increased by 50% and the waiver document shows that the rate DHHS paid for respite care in an ICF/MR increased from $157.30 a day in year 5 of the "old waiver" to $270 a day under the 2010 amended waiver. R. 891-894.

restrictive environment available." The General Assembly stressed in that Act "the importance of the role of parents and families in shaping services for persons with ... related disabilities... as well as the importance of providing services to families to enable them to care for a family member with these disabilities." S.C. Code § 44-20-20. In addition, the Act requires "Parental involvement and participation in mutual planning with the department to meet the needs of the client..." Id. This "facilitates decisions and treatment plans that serve the best interest and welfare of the client." Id.

The governing board of DDSN is made up of a Commission consisting of seven members appointed by the Governor, which has authority over all of the state's services and programs for the treatment and training of persons with "related disabilities." S.C. Code §§ 44-20-210 and 240 and R. 667-668. By statute, the DDSN Commission has the responsibility to "determine the policy and promulgate regulations governing the operation of the department..." pursuant to S.C. Code § 44-20-220, but it has not promulgated a single regulation since 1986. R. 730. The statute at S.C. Code § 44-20-220 requires the Commissioners to "consult with the advisory committee of the division for which the regulations shall apply," however, there is no evidence that these required "advisory committees" for each division (ID/RD, Autism and HASCI) have ever been created. S.C. Code § 44-20-220.

SC Code § 44-20-250 requires DDSN to "coordinate services and programs with other state and local agencies for persons with intellectual disability, related disabilities, head injuries, and spinal cord injuries." That section authorizes DDSN to "negotiate and contract with local agencies, county boards of disabilities and special needs, private organizations, and foundations in order to implement the planning and development of a full range of services and programs for

persons with intellectual disability, related disabilities, head injuries, and spinal cord injuries subject to law and the availability of fiscal resources."

The IC/RD HASCI Act establishes a system of local DSN Boards that are appointed by either the county legislative delegation or county council pursuant to S.C. Code § 44-20-375. County DSN Boards may apply to DDSN for funding, but they are prohibited by statute from applying for funds from the federal government or the General Assembly without permission from DDSN. §44-20-380. Local DSN Boards may not even receive unsolicited funds from the General Assembly. ("The county boards may not apply directly to the General Assembly for funding *or receive* funds directly from the General Assembly."[8] S.C. Code § 44-20-375(20)). Each local DSN Boards is the:

> ...administrative, planning, coordinating, and service delivery body for county disabilities and special needs services funded in whole or in part by state appropriations to the department or funded from other sources under the department's control.

S.C. Code § 44-20-385. The Legislative Audit Council Audit of DDSN discussed the relationship between the local DSN Boards and DDSN and how this system creates barriers to competition. R. 699 to 703. See also the summary at R. 650. Local DSN Boards must submit an annual plan and projected budget to DDSN for approval and consideration of funding. By statute, local DSN Boards must "review and evaluate on at least an annual basis the county disabilities and special needs services provided pursuant to this chapter and report its findings and recommendations to the department." DDSN establishes specifications for the personnel

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[8] Local DSN Boards may not borrow money without permission from DDSN if repayment comes "in whole or in part from contract, grant, or other revenues provided by the State." ("However, the department has no responsibility for the debt so approved." S.C. Code § 44-20-385).

employed by Local DSN Boards. S.C. Code § 44-20-385(5). Local Boards are required by statute to "plan, arrange, implement, and monitor working agreements with other human service agencies, public and private, and with other educational and judicial agencies. Id. at (6). They must provide DDSN with "records, reports, and access to its sponsored services and facilities the department may require and submit its sponsored services and facilities to DDSN licensing requirements. Id. at 8.

As required by the United States Supreme Court in *Olmstead v. L.C.*, 521 U.S. 581 (1999) and the integration mandate of the Americans with Disabilities Act, the ID/RD HASCI Act requires DDSN and its providers to deliver services in the "least restrictive environment," which is defined in the Act as "the surrounding circumstances that provide as little intrusion and disruption from the normal pattern of living as possible." S.C. Code § 44-20-30(10). DDSN provides "Residential programs" in congregate facilities "with assistance for activities of daily living ranging from constant to intermittent supervision as required by the individual client's needs." S.C. Code § 44-20-30(16). By statute, DDSN must "implement the planning and development of a full range of services and programs for persons with intellectual disability, related disabilities, head injuries, and spinal cord injuries subject to law and the availability of fiscal resources." S.C. Code § 44-20-250.

The General Assembly charged DDSN with the duty of developing "service standards for programs of the department and for programs for which the department may contract" and S.C. Code § 44-20-250 requires DDSN to review and evaluate these programs on a periodic basis." DDSN is obligated by statute to (1) "establish standards of operation and service for county disabilities and special needs programs funded in part or in whole by state appropriations to the

department or through other fiscal resources under its control; (2) to review service plans submitted by county boards of disabilities and special needs and determine priorities for funding plans or portions of the plans subject to available funds; (3) to review county programs covered in this chapter and (4) to take other action not inconsistent with the law to promote a high quality of services to persons with intellectual disability, related disabilities, head injuries, or spinal cord injuries and their families." Despite this obligation to the local DSN Boards, DDSN did not involve those county DSN Boards in planning to drastically reduce and cap Medicaid waiver services.

S.C Code § 44-20-370 requires DDSN to "seek to develop and utilize the most current and promising methods for the training of persons with intellectual disability, related disabilities, head injuries, and spinal cord injuries." The statute at S.C. Code § 44-20-390 requires DDSN to establish service plans "to assist the individual in developing to the fullest potential in the least restrictive environment available" and to determine what constitutes the "least restrictive environment" for each client. DDSN must review service plans of its clients at least periodically "according to standards prescribing the frequency to ensure that appropriate services are being provided in the least restrictive environment available." Id. This statute requires DDSN to include parents, the legal guardian, the client, and other appropriate parties in this review and DDSN has the responsibility to develop standards prescribing the service plan review according to the goals and objectives set forth in these statutes.

DDSN has promulgated few regulations, the last regulation being promulgated in 1986. R. 730. Most of its regulations are for the operation of recreational camps and day programs. Id. In 2007, Protection and Advocacy for People with Disabilities, Inc. sued DDSN and its Commissioners for failing

to promulgate regulations "...regarding issues of critical concern to applicants and recipients of its services...." This lawsuit is now pending in the South Carolina Court of Appeals. *Protection and Advocacy for People with Disabilities, Inc. v. DDSN*, 2007 cp 40002187, Ct. Appeals Case No. 2014-000244.

D. The South Carolina Administrative Procedures Act (APA). State agencies are creatures of statute and they are vested only with those powers that have been conferred upon them by the legislative branch. *Captains Quarters Motor Inn, Inc. v. SC Coastal Council*, 306 S.C. 488, 413 SE2d 13, 14 (1991). The General Assembly delegates this power to promulgate regulations "to provide detail and substance to the legislative framework." South Carolina Administrative Practice and Procedure (2004 edition), Randolph R. Lowell at 109. Any action taken by an agency outside of its statutory authority is null and void. *Triska v. SCDHEC,* 292 S.C. 190, 355 SE2d 531, 533 (1987), citing 73A C.J.S. Public Administrative Law and Procedures § 117 (1983).

It is undisputed that DHHS and DDSN are "agencies," as defined by the South Carolina Administrative Procedures Act. S.C. Code § 1-23-10(1). As discussed above, both agencies have been authorized by the General Assembly to promulgate regulations that are in keeping with the requirements of the statutes establishing the agencies. South Carolina has adopted a "binding norm" test to determine whether an agency directive must be formally promulgated as a regulation under the APA. *Home Health Services, Inc. v. S.C. Tax Commission*, 312 S.C. 324, 440 SE2d 375 (1994), citing *Ryder Trucking, Inc. v. U.S.,* 716 F.2d 1369 (1983). The South Carolina Court of Appeals ruled in this case that the agency policies at issue in this case constitute binding norms, and Respondent did not appeal that decision.

A regulation may not alter or add to the terms of a statute. *Sanford v. S.C. State Ethics Commission*, 385 S.C. 483, 685 S.E.2d 600, 608 (2009), citing *Society of Professional Journalists v. Sexton*, 283 S.C. 563, 567, 324 S.E.2d 313, 315 (1984) ("Although a regulation has the force of law, it must fall when it alters or adds to a statute.")

The term "Regulation" is defined in the APA as "each agency statement of general public applicability that implements or prescribes law or policy or practice requirements of any agency." Id. at (4). The APA provides that "Policy or guidance issued by an agency other than in a regulation does not have the force or effect of law." Id. The term "Promulgation" means final agency action to enact a regulation after compliance with procedures prescribed in the APA. Id. at (5). If a binding norm is not promulgated as a regulation, it is null and void until submitted to the General Assembly for review, complying with the requirements of the APA for promulgating regulations. The APA requires agencies, in promulgating regulations, to consider the financial impact that the proposed regulation will have on (a) commercial enterprises; (b) retail businesses; (c) service businesses; (d) industry; (e) consumers of a product or service; (f) taxpayers; or (g) small businesses. § 1-23-10(7).

S.C.Code § 1-23-40(1) requires agencies to file with the Legislative Council and publish in the State Register "All regulations promulgated or proposed to be promulgated by state agencies which have general public applicability and legal effect..." S.C.Code § 1-23-110 requires agencies to give notice of a drafting period by publication of a notice in the State Register before the promulgation, amendment, or repeal of a regulation. This notice must include specific information set forth in that section. Id.

The APA requires agencies to prepare and submit a preliminary assessment report on

regulations which have a substantial economic impact. Id. at (2). Agencies must give notice of a public hearing if requested by twenty-five persons, by a governmental subdivision or agency, or by an association having not less than twenty-five members. S.C. Code § 1-23-110(3). This notice must include a narrative preamble and the text of the proposed regulation. S.C. Code § 1-23-110(3)(3). This preamble must include a section-by-section discussion of the proposed regulation and a justification for any provision not required to maintain compliance with federal law. The statute requires the agency to provide a fiscal impact statement reflecting estimates of costs to be incurred by the State and its political subdivisions in complying with the proposed regulation.

The APA also requires agencies to provide a "statement of the need and reasonableness of the regulation." S.C. Code § 1-23-110(3). For new regulations and significant amendments to existing regulations, the APA requires agencies to prepare and make available to the public upon request a detailed statement of rationale which shall state the basis for the regulation, including the scientific or technical basis, if any, and shall identify any studies, reports, policies, or statements of professional judgment or administrative need relied upon in developing the regulation. S.C. Code § 1-23-110(3)(h). The promulgating agency must mail notices to all persons who have requested notice of proposed promulgation of regulations and the agency must "consider fully all written and oral submissions respecting the proposed regulation." S.C. Code § 1-23-110(B) and (C). After a public hearing is held and the agency has considered all submissions, agencies may not submit a regulation to the General Assembly if the regulation contains a substantive change in the content of proposed regulation and the substantive change was not raised, considered, or discussed by public comment received pursuant to this section. If changes are made, the agency must then refile the regulation for publication in the State Register

as a proposed regulation. S.C. Code § 1-23-110(A)(3).

The APA contains requirements to hold public hearings on proposed regulations and to ensure that all interested persons are treated fairly and impartially. S.C. Code § 1-23-111. The agency must submit into the record the jurisdictional documents, including the statement of need and reasonableness as set forth in the statute. Importantly, the APA requires that the presiding official must allow for questioning of agency representatives or witnesses, or of interested persons making oral statements, in order to explain the purpose or intended operation of the proposed regulation, or a suggested modification, or for other purposes if material to the evaluation or formulation of the proposed regulation. Id. The presiding official then must issue a written report which must include findings as to the need and reasonableness of the proposed regulation.

Upon written request by two members of the General Assembly, the APA requires an agency to prepare an assessment report of any regulation that has a substantial economic impact. S.C. Code § 1-23-115. The legislative committee to which the promulgated regulation has been referred may send a written notification to the promulgating agency informing the agency that the committee cannot approve the promulgated regulation unless an assessment report is prepared and provided to the committee. The agency must also submit to the Office of Research and Statistics of Revenue and Fiscal Affairs Office, a preliminary assessment report on regulations which have a substantial economic impact. Upon receiving this report, the office may require additional information from the promulgating agency, other state agencies, or other sources. That office must prepare and publish a final assessment report within sixty days after the public hearing and must forward the final assessment report and a summary of the final report to the promulgating agency.

The APA requires the preliminary and final assessment reports to disclose the effects of

the proposed regulation on the public health and environmental welfare of the community and State and the effects of the economic activities arising out of the proposed regulation. The assessment report must contain extensive and specific information required by the statute at S.C. Code § 1-23-115, including the legal authority for the regulation, the plan for its implementation, the need and reasonableness of the regulations, a determination of costs and benefits associated with the regulation, an explanation of why the regulation is considered to be the most cost-effective, efficient, and feasible means for allocating public and private resources and for achieving the stated purpose, the effect of the regulation on competition, the effect on the cost of living and doing business in the affected areas, the sources of revenue for implementing and enforcing the regulation, the short and long-term economic impact, the effect on the environment and public health, the detrimental effect on the environment and public health if it is not implemented. S.C. Code § 1-23-115. If any information changes, the corrected information must be provided in a revised assessment report to the Legislative Council for submission to the committees to which the regulation was referred during General Assembly review.

Once these steps have been taken, the proposed regulation must be provided to the General Assembly for review and approval. S.C. Code § 1-23-120.

E. Facts Related to Richard. Richard is now twenty-seven years old. He lives in an apartment next to his mother's home. R. 923. He has normal intelligence and has a strong desire to continue to live in the community with his peers, but Richard is profoundly physically disabled. R. 304-307. He relies upon others for all activities of daily living, 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 and his peers

were mainly students who did not have disabilities. R. 305. Prior to graduating from high school, Richard was provided one-on-one care during the school day. R. 309. After graduation, the burden of providing those hours fell to his parents, who both worked outside of the home. R. 309. Richard filed an appeal in February of 2009 alleging that the home-based services provided through the MR/RD Medicaid waiver were insufficient to meet his needs. R.945. Richard's father became ill in 2012 and died, leaving his working mother as his sole family caregiver. R. 1101-1104.

When Richard is lying in bed, he 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 until the pain subsides. Id. He sometimes crumbles, falling forward without warning, at the onset of these spasms. R. 321.

F. Chronology of Medicaid Waiver Amendment and Richard's Appeals. In October, 2008, DHHS began "working diligently" in secret with DDSN officials "on the development of the waiver renewal." R. 895. The public, the Commissioners of DDSN, and the local DSN Boards were not informed or involved in this process that resulted in drastic reductions in services to disabled persons served by DDSN. R. 914. These changes were aimed primarily at those persons who live at home and they especially affected those individuals, like Richard, who have the most severe disabilities and require more supports to live outside of an institution. ICF/MR services are provided only by DDSN and its county DSN Boards. Home care services are provided by private providers. R. 289 and 302.

In December, 2008, the South Carolina Legislative Audit Council issued its audit of DDSN that was conducted at the request of members of the General Assembly. R. 659. The LAC auditors reported that financial and other information DDSN provided "may be unreliable" because it could not be verified and DDSN cost reports had not been audited.[9] R. 667. LAC found DDSN's information system to be "without formal controls to ensure the accuracy of how the data is input and manipulated." Id. at 666-667. Some of the findings in the LAC audit included:

- gaps in oversight that may pose risks to DDSN's consumers. R. 671.
- a persistent failure to correct deficiencies and lack of criteria to determine when sanctions are warranted. R. 675.
- lack of documentation in follow-up reviews. R. 676.\
- no other states conduct licensing reviews of facilities less often than once annually. R. 678.
- failure to comply with policies re neglect, abuse and exploitation. R. 687.
  waiving financial obligations of chosen DSN Boards' obligations to DDSN. R. 701.
- forgiving debt of more than $2 million owed DDSN by a private corporation. R. 702.
- lack of written guidelines or criteria for awarding "outlier" funding. R. 715 and 716.
- failure to obtain independent audits of cost reports, despite prior audit findings recommending audits of cost reports by DHHS and CMS. R. 717.
- significant gaps in accountability for millions of dollars. R. 718.
- use of funds intended by General Assembly to be used for services for "other purposes" and loss of millions of federal dollars in matching funds. R. 719.
- filling only 380 out of 630 beds funded by the General Assembly. R. 719.
- spending just $7.6 million out of $25.4 million appropriate by General Assembly to operate new beds, thereby losing 70% matching funding. R. 720.
- spending $12.4 million on "infrastructure" grants to chosen DSN Boards and a private corporation not authorized by General Assembly. R. 722.
- requesting new funds to pay for additional new beds in Fy 08-09, when DDSN had not developed beds for which it received appropriations from the General Assembly in FY 06 and FY 07. R. 722.
- carrying forward of using "for other purposes" $3 million allocated by General Assembly in FY 07 intended to be spent providing services to children with

[9] According to this report, even DDSN internal auditors had not audited the agency's information systems. R. 667. See also 738 to 741.

autism. R. 723.

- spending just $661,463 for children's autism program in FY 08 out of $7.5 million allocated by the General Assembly, losing federal matching funding. R. 723.
- spending an average of $15,000 per child with autism, when General Assembly budgeted $37,000 per child. R. 723.
- using $1.7 million in FY 07-FY 08 and $6.7 million in FY 08-09 in funds "carried forward" for purposes not authorized by the General Assembly. R. 724.
- lack of policies to provide services to adult children of aging caregivers. R. 725.
- providing millions of dollars in "grants" to private organizations not authorized by the General Assembly. R. 726-727.
- having a subjective funding process for awarding grants. R. 728.
- loss of $3.5 million in matching federal funds due to award of grants not authorized by General Assembly. R. 729.
- failing to promulgate regulations since 1986. R, 739.
- hindering roles and responsibilities of governing board. R. 735.
- failing to audit cost reports as directed by DHHS. R. 739.
- conflicts of interest of CPA firms used by local DSN Boards. R, 740.

In February, 2009, Congress passed the American Recovery and Reinvestment Act of 2009, which resulted in DHHS and DDSN receiving an increased federal match retroactive to October, 2008. This federal economic stimulus legislation was enacted by Congress:

> ...to preserve and create jobs and promote economic recovery; assist those most impacted by the recession; provide investments needed to increase economic efficiency by spurring technological advances in science and health; invest in transportation, environmental protection, and other infrastructure that will provide long-term economic benefits; and stabilize state and local government budgets in order to minimize and avoid reductions in essential services and counterproductive state and local tax increases. ARRA, § 3(a). In the ARRA, as is typical in federal funding legislation, Congress specifies how the federal funds are to be allocated and spent in the respective states.

Edwards v. State, 678 S.E.2d 412, 415 383 S.C. 82 (2009). Section 5001 of the ARRA provided for an increase in the federal Medicaid match rate for FY09, FY10, and first quarter of FY11, retroactive to October, 2008. By May, 2009, DHHS had drawn $234,439,057.91 in federal Medicaid stimulus funds, while informing Budget and Control Board that the agency could not absorb a 2% budget cut ($16 million). R. 848-849. DDSN did not inform the public and DDSN

Commissioners about the plan to cap MR/RD Medicaid waiver services until after the reductions had been approved by the DHHS Medical Care Advisory Committee on May 19, 2009, three months after learning of the stimulus funds (of more than 6% of the costs of the waiver program for the five months preceding the passage of the ARRA) that would be paid retroactively to October, 2008. R. 848-851.

The same month that ARRA was passed, Richard filed an appeal in February, 2009, asking that his services be increased, to replace the 6 hours a day of one-on-one services he lost that had been provided when he was attending school. R. 1101. DHHS failed to present any testimony or evidence from a qualified medical source at the hearing that was held on June 29, 2009 and Richard submitted the affidavits of his treating physician, his provider of psychological services and the testimony of a nurse that the services provided at home were inadequate to meet his needs and that additional services were needed to avoid placement in a more restrictive setting.[10] R. 31, 917 to 919 and 1101.[11]

Only after obtaining approval by the MCAC, in May, 2009, was there any discussion at the DDSN Commission about the agencies' plan to change the services provided through the ID/RD Medicaid waiver. R. 833 and 855-856. At the Commission meeting on May 21, 2009, a deputy director of DDSN announced for the first time that there may be "some changes necessary to the

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[10] More than four years passed between the date Richard filed a "fair hearing" request that his hours of services be increased in 2007 and the date he received an order from the Administrative Law Court that was appealable to the Judicial Branch in 2013.

[11] DHHS did not include the exhibits from the 2009 hearing in the record on appeal sent to the ALC in 2010, so Dr. Joseph's 2009 affidavit is not in the record. But it is evident from his 2010 affidavit that he had treated Richard for many years and that he would have been at risk of institutionalization in 2009 due to the severity of his disabilities. R. 922-923.

waiver." R. 833 and 855-856. But, at that meeting, the finance director of DDSN, Bill Barfield, informed the Commissioners, the local DSN directors and members of the public attending the meeting that the General Assembly had "appropriated $12.7 million in recurring state dollars as DDSN had requested." The news that "DDSN will be able to restore some services since cuts have occurred " provided a false impression that stimulus funds would prevent further cuts and no warning was given that home-based services being provided at that time had been on the DDSN chopping block for months.[12] R. 832. No information was provided at that meeting as to the agency's longstanding plan to cap waiver services and to eliminate physical therapy, occupational therapy and speech services from the waiver, although the details of that plan that had provided to an approved by the MCAC two days earlier. R. 844-845, 855 to 856.

Families and clients of DDSN learned for the first time of "proposed cuts of the MR/RD waiver" at a meeting that was hastily called on June 4, 2009. R. 929. Richard's mother was unable to attend, but she complained in an email sent to DDSN Commissioners that no cost analysis had been conducted, so that there was no evidence that cutting services would reduce the cost of the waiver. (The waiver document submitted to CMS showed that she was right.) She told the Commissioners that "My son, for example would have to be put in an institution!" Her email suggests that the actual waiver document had not been provided to the Commissioners. Id. She asked that the Commissioners in the waiver renewal process to consider whether the agency was

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[12] At the April, 2009 DDSN Commission meeting, Mr. Barfield had announced that "DDSN could collect an additional $28.8M of Medicaid funding this fiscal year." R. 839. There was no discussion at that meeting of the plan to cap Medicaid waiver services. He discussed a 2% reduction plan submitted to Senate Finance that did not include caps on waiver services. R. 839. This appeared to be no cause for alarm, because of the expected increase of at least 6% in federal matching funds through the Medicaid stimulus package.

complying with federal laws regarding fair hearings and that DDSN was allowing bureaucrats to make decisions about medical necessity without involving qualified medical professionals. Id.

A special called meeting of DDSN Commissioners was held the next day, on June 5, 2009, as reported in an email from Commissioner Rick Huntress. R. 928. According to that email, DHHS planned to submit the waiver amendments to CMS in less than three weeks, on June 25, 2009. Surprised by the changes proposed by DDSN and DHHS management at the meeting on June 4, 2009, the Commissioners asked management to submit a request for a 90 day extension for submitting the waiver document. Id. There is no indication in this email that the Commissioners were ever actually provided with a copy of the document DHHS intended to submit. Mr. Huntress indicates that Commissioners intended to scour the "DDSN budget for monies that can be used for waivers to present cuts in services." R. 928.

On June 9, 2009, just two weeks before DHHS and DDSN had planned to submit the waiver application seeking approval for drastic reductions in home-based services, the State Director of DDSN, Eugene A. Laurent, sent a memorandum titled "Apology" to Executive Directors and Chairpersons of local DSN Boards admitting that:

> DDSN initiated proposed reductions and caps in the MR/RD waiver without involving the County Boards in the process, but also without notifying you that the proposal was going to the Commission. An oversight like this should not have happened. At this point, all I can do is apologize and initiate a process that ensures that it does not happen again.

R. 914.

On June 11, 2009, Emma Forkner, the Director of DHHS, sent a letter to CMS informing that federal agency that DHHS and DDSN had been "working diligently...since October, 2008 on the development of the waiver renewal..." and she requested a 90 day extension to file the proposed waiver amendments. R. 895.

On August 14, 2009, the director of DDSN, Eugene A. Laurent, sent a letter to the State Budget and Control Board requesting permission to spend "excess special funds" of $5,944,738 for purposes not approved by the General Assembly. R. 881. On August 20, 2009, the DDSN Commission was presented with two proposals, one to cut waiver services by 4% and another to cut those services by 10%. R. 820. The 4.04% option (Attachment B) shows $300,000 being saved by capping HASCI waiver attendant care. That chart shows a $1.85 million from reducing the MR/RD waiver by 85 slots. (But, the waiver application increased the number of slots requested by 600 slots.) R. 825-826. The 10% reduction option shows reductions of 85 MR/RD waiver slots (savings of $1.85 million) and savings through attrition of residential services, but it does not appear to include cuts in home-based MR/RD Medicaid waiver services.

The waiver amendment was submitted to CMS on August 31, 2009, with a proposed effective date of January 1, 2010. R. 75. The waiver application form required DHHS to describe the "significant changes to the approved waiver that are being made in this renewal application." DHHS responded as follows:

> Due to the State of South Carolina's budget situation, SCDDSN opted to make minor adjustments to the MR/RD waiver program. SCDHHS and SCDDSN worked together for many months to consider possible changes administratively allowed within federal regulations. (Emphasis added.)

R. 76. The waiver application states that DHHS sought public input in making these changes, but it does not mention that this "public input" was sought only after the DHHS Medical Care Advisory Committee approved the changes and the meetings were held to inform the public about the clandestine decisions made by agency officials without complying with the requirements of the APA. R. 844-845, 855-856.

At the September, 2009 Budget and Control Board meeting, Director Laurent asked for the Board's permission to spend $5,944,738 from a $7,847,888 "Capital Reserve Fund" DDSN was holding (while these reductions in services were approved under the pretext of insufficient funding). The minutes of the DDSN Commission do not mention that the Director intended to present this request to the Budget and Control Board. There is no indication in the minutes that Director Laurent was acting with the approval of his governing board to transfer millions of dollars to the Budget and Control Board. Under his proposal, $3,244,738 would be paid to the Budget and Control Board for "obligations" that were not included in the State Budget and had not been discussed at DDSN Commission meetings, $2.6 million would be transferred to two local DSN Boards and the Babcock Center to buy workshops and $100,000 would be spent on a contract "to improve its Medicaid billing capabilities." R. 881. See R. 877 to 887. None of these expenditures had been approved by the General Assembly, nor were they contained in the State Appropriations Act for FY 2010 (or any other year).

On November 9, 2009, CMS sent DHHS a letter approving the waiver amendments, with an average cost of $51,869 per waiver participant and a total cost of $278,661,600. R. 75. Not only did DHHS ask to increase the cost of this program by tens of millions of dollars, but it asked CMS to increase the number of waiver participants served from "approximately 5,700 people"[13] to 6,300, while reducing and capping services for the most disabled participants who were dependent upon waiver services to remain in their homes. Id. and 855.

Then, on November 16, 2009, the DHHS hearing officer remanded Richard's February,

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[13] According to the LAC Audit, DDSN was serving 5,802 persons in the MR/RD Medicaid waiver in FY 07-08. R. 669.

2009 appeal back to DDSN "for additional care planning that takes Dr. Joseph's June 29, 2009, affidavit recommendations into account" and ordered DDSN to consider his need for adult companion services, taking Richard's need for socialization into account. R. 41. In that Order, the hearing officer stated:

> ...the undersigned would direct the attention of DDSN and DHHS to our Supreme Court's warning that agency policies attempting to establish a "binding norm" should be promulgated as regulations. Home Health Serv., Inc. v. S.C.Tax Commission, 312 S.C. 324, 440 S.E.2d 375 (1994).

R. 41. This was a Kafkaesque move, because when this Order was issued by the DHHS Office of Hearings and Appeals, DHHS had already obtained CMS approval to cap the combination of personal care services and adult companion services at 28 hours a week.

Disregarding the advice in the November 16, 2009 DHHS Order to promulgate policies as regulations, DDSN proceeded full steam ahead with its plan to cap and eliminate services by instructing DDSN service coordinators to notify families about the waiver caps and reductions that would become effective on January 1, 2010. R. 293. In November and December, 2009, DDSN held "six informational meetings throughout the State" to inform the public of the "upcoming waiver changes." R. 292.

When Richard learned of the plan to reduce his services, he filed a request for reconsideration while his 2009 appeal was still on remand. No order was ever issued by DDSN or DHHS on the remand of this February, 2009 appeal, and this appeal was treated by DDSN and DHHS as a totally new case. Richard's February, 2009 appeal just evaporated, along with the record in those proceedings. The State Director of DDSN denied Richard's request for reconsideration, informing him that:

> As you may know, limits or caps have been placed on services in the MR/RD Waiver. Approval for these limits or caps was obtained from the Centers for Medicaid and Medicare Services (CMS). These approved limits cannot be exceeded and must be applied to all MR/RD Medicaid Waiver participants.

R. 940. This response substantiates the Court of Appeals' finding that the waiver amendments established a binding norm.

Richard filed an appeal of that decision with the DHHS Office of Appeals and Hearings and a second hearing was held on May 11, 2010. A transcript of that hearing is contained at R. 263 to 333. During the hearing held in his earlier appeal, 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 agree that he needs the services ordered by his treating physician, Dr. Joseph, to avoid institutionalization. R. 920-921 and 1101. Neither DDSN nor DHHS have promulgated regulations to establish standards to determine medical necessity, or to inform the public who determines what is medically necessary. Services are allocated according to the determination of need by the service coordinator, with no provision in DDSN or DHHS policy to establish exceptions to the caps. The hearing officer issued an order upholding the reduction in Richard's personal care and adult companion services to 28 hours a week. R. 16.

Richard appealed that decision to the Administrative Law Court, which ruled on March 13, 2013 that "Respondent has the statutory authority to enter the Waiver agreement with the Centers for Medicare and Medicaid Services (CMS)...and the Departments have properly exercised their authority to amend the Waiver, and CMS, the responsible federal agency has approved the change." R. 9. The ALC ruled that "Therefore, I find that the substantial evidence in

the Record on Appeal supports the finding that the changes in the waiver were lawfully made." R. 11.

When Richard appealed that decision to the Court of Appeals, that Court agreed with Richard's physician that reducing his services would place him at risk of institutionalization and that the 2010 cap on waiver services violated the Americans with Disabilities Act (ADA). R. 959. But it stopped short of requiring Respondent to establish standards or a time line for reassessing his needs without application of the caps. R. 954. The Court of Appeals ruled that it was not necessary for DHHS or DDSN to promulgate regulations to impose the service reductions and waiver caps. R. 954.

The cost of Richard's Medicaid waiver services during 2009, prior to the implementation of the caps, was $37,364,45. R. 243. According to the November 9, 2009 letter CMS sent to the director of DHHS, Emma Forkner, DHHS requested, and the federal government approved, its request to increase the average annual cost per MR/RD Medicaid waiver participant to $51,869 under the amended waiver during 2010.[14] R. 75. In its application, DHHS requested and obtained CMS approval to increase the average cost per MR/RD Medicaid waiver participant to $59,078 by 2015. Id. According to the "old" waiver document that covered the years 2004 to 2009, the average cost per participant had been projected to be $36,209 in 2009. R. 232. The DHHS

[14] But the waiver application states that the average cost per participant in 2010 would be $44,232.12. R. 893. The inconsistency in these figures supports the LAC finding that DDSN's data "may be unreliable." R. 667. DDSN continues to administer the program applying regulations that were promulgated prior to 1986 and, thereby, avoid those pesky APA requirements to demonstrate the costs and benefits associated with the regulation required by 1-23-115, or to hold a public hearing where questions could be asked of agency officials. R. 730. These figures contradict the sole reason - i.e. budgetary - that DHHS provided to CMS for reducing and terminating services. R. 76.

Medical Care Advisory Committee was informed that DHHS spent $242 million on the MR/RD Medicaid waiver program FY 2008 and that it served 5,700 participants. Based on these figures, the average annual cost per participant was $42,456 in 2009, prior to the waiver amendments. The average cost per participant after the waiver amendments were put into place was still at least $6,247 more than Richard's services cost before the reductions were applied to him. R. 844 and 845. Thus, CMS approved an increase in annual cost for the program of between $31,661,600 and $61,408,995 based on the pretext of "South Carolina's budget situation." R. 76-76, 232, 844-845.

Federal Medicaid regulations and the Medicaid Act give Richard the option of choosing to receive Medicaid funded services in an institutional setting. Social Security Act § 1915(c). Should Richard choose that institutional option, the cost of care in a DDSN ICF/MR institutional setting would be in excess of $320 per day in 2008, or $116,000.00 per year. R. 931-932 (based on FY 08 costs).

On May 11, 2010, DHHS presented two witnesses at Richard's "fair hearing." The first witness, Dawn Shealy provided no testimony to support Respondent 's contention that reductions were made to Richard's services due to budget cuts. She testified that "I think that the caps was a good idea, putting caps on some services I thought was a good idea." R. 278. Ms. Shealy had never met Richard and had not reviewed his medical records. R. 281, 282, 283. She has no medical training. R. 279. According to her testimony, the caps were enacted because "respite in the past has been widely abused," a reason not mentioned in the waiver amendment or discussed at Commission meetings. R. 287-288.

DHHS' second witness, Jacob Chorey likewise had never met Richard. R. 300. He also had no knowledge of the precipitating factors for reducing services in 2010, because he was not

working at DDSN when the waiver was amended. R. 298. When asked why the caps were implemented, Mr. Chorey admitted having no understanding of that decision. R. 302. Mr. Chorey testified that the reason the caps were implemented was "because there was a cap instituted." R. 302.

The only exhibits DHHS presented at the hearing were (1) an *ex parte* memo from Jacob Chorey to the Director of the DHHS Division of Appeals outlining the decision DDSN was seeking, and (2) DHHS counsel's cover letter transmitting a pretrial brief to the hearing officer. R. 335 and 336. The prehearing brief states that "The reduction was the result of the limitations set forth in the renewed Waiver." R. 151. It does not contain an explanation, or even an argument that the cuts resulted from a lack of funding. There is no evidence in the Record that DHHS or DDSN performed any cost study or individualized assessment of the risk these cuts imposed on the most severely disabled waiver participants.

VIII. Argument

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?

A. The Court of Appeals erred in its finding that approval of the waiver amendments by CMS exempted DDSN and DHHS from promulgating those agency policies as regulations under the South Carolina Administrative Procedures Act.

DHHS submitted its request to cap waiver services and to eliminate physical therapy, occupational therapy and speech and language services from the ID/RD Medicaid waiver package to the CMS Regional Office. These changes were not required by any change in federal law. The APA contains an exception at S.C. Code § 1-23-120(G) for review of agency rules or policies

established (1) "to maintain compliance with federal law..." But the changes at issue in this case were not required by any federal law. DHHS and DDSN exceeded its authority by capping, reducing and eliminating services from the DDSN waiver programs based on secret meetings between a few DDSN and DHHS officials, without prior public notice, involvement of DSN Boards or consideration of the effect of these changes on public health, individuals affected by the amendments or review of the financial consequences of their actions. The Court of Appeals ruled that the waiver amendments "established a binding norm by reducing the types and amount of service offered under the Waiver." R. 951. This ruling was not appealed by DHHS. However, that Court held that DDSN was not required to promulgate regulation to enact the waiver caps, based on the "federal/state nature of Medicaid and the Waiver" and the "relevant statutory scheme." R. 951.

While neither the Court of Appeals nor this Court are bound by decisions of the ALC, it is notable that the ALC has repeatedly held in other cases that approval by CMS "does not make it a binding document"...and that in order for the DHHS rule to become "binding," it must be promulgated as a regulation. *Corbett v. DHHS,* 07-ALJ-08-0278-AP (2007) (vacated after appeal and settlement). On July 19, 2011, the South Carolina Administrative Law Court ruled in another case that the waiver amendments that were approved by CMS established a "binding norm" and were not enforceable without being promulgated as a regulation in *Hickey v. DHHS.* R. 1456-1457. In that case, the ALC relied upon cases from other states where courts held that Medicaid waiver amendments must be promulgated as regulations to be enforceable. *McCrann v. N.C. Dept. Health and Human Services*, 704 S.E.2d 899 (N.C. App. 2011), *Hoban v. State of Vermont,* Op. 200-4-05, Lexis 40 (Vt. Super. 2005), and *Mullins v. N. Dakota Dept. of Human Services*, 454

N.W.2d 732 (N.D. 1990). In *Hickey*, the Administrative Law Court correctly concluded that:

> ...the general language allowing the Department to promulgate regulations does not override the more specific requirements of the APA. To interpret Section 44-6-90 as urged by the Department would imply that every agency given general authority to promulgate regulations is thereby exempted from the requirements of the APA. Such an interpretation does not yield a reasonable and practical construction consistent with the purpose and policy expressed in either the APA or § 44-6-90. Therefore, the Department erred in treating the cap on PCA II services as a binding and enforceable rule without promulgating the cap as a regulation pursuant to the APA.

R. 1458. In that case, the ALC reversed DHHS' decision to reduce Hickey's personal care attendant services from 50 hours a week to 28 hours a week. R. 1461. DHHS did not appeal that decision.

Then, on November 9, 2011, the ALC reached the same decision, in appeals brought by four other MR/RD Medicaid waiver participants subsequent to CMS approving the waiver amendments. *Susan Edge v. DHHS*, Docket No. 10-ALJ-08-0501-P, *Jimmy W. Eubanks, Jr. v. DHHS*, Docket No. 10-ALJ-08-0502, *Michelle Morgan v. DHHS*, Docket 10-ALJ-08-0503-AP and *Albert Cooper Myers v. DHHS*, Docket No. 10-ALJ-08-0504-AP at page 14.

Petitioner respectfully asks this Court to consider that the "relevant statutory scheme" that the Court of Appeals found to override the APA gives the State the option of participating - or not - in the Medicaid waiver program, but it does not give the agencies the unfettered authority to ignore the laws of the State of South Carolina that do not conflict with any provision of the Medicaid Act or other federal law. As this Court recognized in *Doe v. DHHS*, the federal government has given states "wide discretion in designing a waiver program that is tailored to the needs of the particular state." 398 S.C. 62, 71-72, 727 S.E.2d 605 (2011). The application for a § 1915© Home and Community Based Services Waiver program promulgated by CMS provides:

> 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.

Id. But, once the General Assembly established clear duties in the ID/RD HASCI Act and authorized funding for that program, it was an abuse of discretion for DHHS and DDSN to join together to establish binding norms that deny citizens of this State the right to receive services they need to remain in their homes and communities without promulgating the changes as regulations under the APA. The shift of funds in this case, from the least restrictive setting (waiver participants own homes) to ICF/MR facilities operated by the State, and other restrictive congregate settings, was contrary to the clearly stated policies of the General Assembly contained in Title 44, Chapters 6 and 20, which require DHHS and DDSN:

- to assist persons with ... related disabilities... by providing services to enable them to participate as valued members of their communities to the maximum extent practical and to live with their families or in family settings in the community in the least restrictive environment available." S.C. Code § 44-20-20.
- to respect the importance of the role of parents and families in shaping services for persons with ... related disabilities... as well as the importance of providing services to families to enable them to care for a family member with these disabilities. S.C. Code § 44-20-20.
- to provide for parental involvement and participation in mutual planning with the department to meet the needs of the client..." S.C. Code § 44-20-20.
- to facilitate decisions and treatment plans that serve the best interest and welfare of the client." S.C. Code § 44-20-20.

- to deliver services in the "least restrictive environment," which is defined in the Act as "the surrounding circumstances that provide as little intrusion and disruption from the normal pattern of living as possible." S.C. Code § 44-20-30(10).
- to provide assistance for activities of daily living ranging from constant to intermittent supervision as required by the individual client's needs. S.C. Code § S.C. Code § 44-20-30(16).
- to implement the planning and development of a full range of services and programs for persons with intellectual disability, related disabilities, head injuries, and spinal cord injuries. S.C. Code § 44-20-250.
- to promote a high quality of services to persons with intellectual disability, related disabilities, head injuries, or spinal cord injuries and their families. S.C. Code § 44-20-250.

The agencies in this case ignored the unambiguous directive of the General Assembly to be guided by the goal of delivering services "in the most effective and efficient ways possible." S.C. Code §44-6-40. It is undisputed that all of the figures DDSN and DHHS have provided to CMS show that the cost of the waiver program increased dramatically in 2010. Every projection of even the average cost of ID/RD waiver services exceeds the amount DDSN was spending on Richard's services before the 28 hour cap was enacted. The impact on private companies of shifting millions of dollars from home-care services to congregate facilities, mostly operated by DDSN and its local DSN Boards was not considered, because there was no study of economic impact or even whether any money might be saved by reducing home-based services.

The audits of this program demonstrate that DHHS has continually failed to review and evaluate DDSN waiver programs to determine the extent to which they meet fiscal, administrative, and program objectives and to assure that these programs are being operated cost

effectively. S.C. Code § 44-6-40(2) and (3). Instead of holding DDSN accountable for delivering services in the least restrictive and most cost effective manner, DHHS submitted a waiver amendment to CMS that more than quadrupled the number of waiver participants receiving respite services in ICF/MR facilities and increased by 50% the number of days the affected individuals spent in those institutions. R. 914. There is no indication in the record that the actual waiver document was ever provided to the governing board of DDSN or digested by its Commissioners. There was no opportunity for public comment after the waiver amendments were finalized.

The agencies' scheme failed to consider the policy directives imposed by the General Assembly in Chapter 6 of Title 44 and, by waiting until the General Assembly was ready to adjourn, after DDSN and DHHS budgets were established, then implementing the waiver amendments before the General Assembly returned to Columbia in January, 2010. DHHS thereby failed to keep the General Assembly informed the criteria, standards, and (unpromulgated) procedures of the agency. S.C. Code § 44-6-40(6). Through the implementation of the waiver amendments, DHHS failed to achieve "a balanced health care delivery system assuring that regulations, coverage, and reimbursement policies assure that the most appropriate care is given, tailored to the client's needs, and delivered in the most cost-effective manner." S.C. Code § 44-6-70. (Emphasis added.) The cost of the program increased by millions of dollars after the reductions were put into place and the audits from 2005 forward show that DHHS already was failing to provide "necessary safeguards ... to protect the health and welfare of individuals" receiving home care. 42 U.S.C. Sec. 1396n(c)(2)(A). R. 434, 487, 671.

The scheme caused DHHS to deny services without regard for the medical necessity for

the requested care, without establishing a procedure to provide exceptions to the waiver caps. Reg. 126-425(A)(9). DHHS violated Reg. 276-295 that requires procedures, treatments, medications or supplies to be administered in accordance with recognized and acceptable medical and/or surgical discipline at the time the patient receives the service and in the least costly setting required by the patients' condition. By capping home based services, DHHS' own projections showed the use of ICF/MR waiver services provided in the most costly and restrictive setting in the State's system quadrupling, with the average length of stay increasing by 50%. R. 891-894.

DHHS eliminated occupational therapy, physiotherapy, speech therapy services that had been provided to prevent regression under the Medicaid waiver program to simply maintain the status quo and prevent regression, where rehabilitation is not possible. R. 845. Reg. 126-304. Instead of seeking to develop and utilize the most current and promising methods for the training of persons with intellectual disability, related disabilities, head injuries, and spinal cord injuries, the effect of the waiver amendments was to segregate and isolate the most severely affected waiver participants and to force them into the most restrictive setting - an ICF/MR when their parents could no longer handle the demands of their care under the reduced limits.

Instead of obtaining input from parents, legal guardians, clients, and other appropriate parties in this review, the agencies launched a costly scheme that reduced access to waiver services and "public participation" consisted only of DDSN officials holding six meetings around the state to announce the done deal. The failure to involve the governing board of DDSN, local county DSN Boards, the public and businesses affected by the waiver amendments violated the clear intention of the General Assembly under the ID/RD HASCI Act and the APA.

The record shows that a handful of bureaucrats at DDSN and DHHS ignored the authority

of the governing board of DDSN to "determine the policy and promulgate regulations governing the operation of the department..." pursuant to S.C. Code § 44-20-220. Instead, that governing body was expected to act as a rubber stamp late in the planning process, when the waiver amendment was due. The officials who planned this scheme violated SC Code S.C. Code § 44-20-250 by failing to "coordinate services and programs with other state and local agencies for persons with intellectual disability, related disabilities, head injuries, and spinal cord injuries." They intentionally hindered the local DSN Boards from fulfilling their responsibility as the "administrative, planning, coordinating, and service delivery body for county disabilities and special needs services..." S.C. Code § 44-20-385.

The waiver amendments were not approved by the Secretary of the United States Department of Health and Human Services, or even the Director of CMS. They were approved by the "Acting Associate Regional Administrator" of the "Division of Medicaid and Children's Health Operations," who was a mid-level bureaucrat at the Atlanta Regional Office of CMS. Nothing in the Medicaid Act or the South Carolina Administrative Procedures Act authorizes a state agency employee, acting in conjunction with another bureaucrat in a federal office building in Atlanta, to override the unambiguous statute enacted by the General Assembly requiring promulgation of binding norms as required by the APA. By accepting federal funds to provide Medicaid services to poor and disabled citizens in South Carolina, the State obligated itself to comply with the Medicaid Act and properly promulgated rules and regulations of CMS, but nothing obligates any state agency or this Court to allow an act of a federal employee down the chain of command from excusing a state agency from complying with the laws of this State.

Petitioner prays that this Court will find that the lower court erred in its determination that

CMS' approval of the waiver amendments was sufficient to override the requirements of the APA and will rule that State agencies must promulgate Medicaid waiver amendments as regulations for them to be enforceable.

B. Did the Court of Appeals err in its reliance on *Arrowood* in determining that the agencies were not required to promulgate the reductions as regulations pursuant to the South Carolina Administrative Procedures Act?

Petitioner respectfully suggests that the Court of Appeals' reliance on *Arrowood* was incorrect. That case that was not mentioned in briefing by the Appellant, the Respondent or the Amici. That 2-1 decision of the North Carolina Supreme Court 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 its Department of Health and Human Services violated the North Carolina APA by limiting not Medicaid, but 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.*") Unlike Richard's case, in *Arrowood I,* the plaintiff had signed a statement agreeing to limit his benefits to 24 months 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 limitation enacted by statute, 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.

But, in *Dillingham v North Carolina Department of Human Resources*,[15] the North Carolina Court of Appeals ruled in a unanimous decision 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." 132 N.C.App. 704, 513 S.E.2d 823 (N.C.App. 1999). In *Dillingham*, the court 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."[16] 134 N.C.App. 39, 41, 516 S.E.2d 633, 634 (N.C.App. 1999). In *Duke,* that court held 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, finding the policy to be "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. 637 and 641. As such, the *Duke* court ruled the policy

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[15] It is interesting to note that *Dillingham* was decided on the same day as *Arrowood I* and that Judge Martin authored both the *Arrowood I* and the *Dillingham* decisions. Judge Lewis concurred with Judge Martin in *Arrowood I,* but Judge Walker dissented.

[16] Judges Greene and Wynn (now on the Fourth Circuit Court of Appeals) agreed with Judge Martin in *Duke* that the policy violated the NC APA.

was an "unpromulgated legislative rule and amounts to an unlawful procedure..." Id. at 641.

Then, in 2000, the North Carolina Supreme Court issued a one sentence *per curium* opinion in *Arrowood II* adopting Judge Walker's dissenting opinion in *Arrowood I*. *Arrowood II,* 353 N.C. 351, 543 S.E.2d 481 (N.C. 2001). Most importantly, Judge Walker distinguished *Dillingham* from *Arrowood I* in this dissent in *Arrowood*. So, even as dissenting judge in *Arrowood,* he recognized that "... an APA rule was necessary in *Dillingham*.." Id. at 593.

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 that State's APA should have been put to rest. 704 S.E.2d 899 (N.C. 2011). In *McCrann*, as in Richard's case, the State had received approval from CMS for the amendments to the Medicaid waiver program in question.[17] Id. 902. In a unanimous opinion, three different judges, who had not been involved in either 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 held in *McCrann* 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 had the plaintiff in *Arrowood I.* The court emphasized in *McCrann* that the Medicaid participant's

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[17] 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) and *Pashby v. Delia*, cited by the Court of Appeals in this case. 709 F.3d 307 (4th Cir. 2013).

knowledge of the changes simply "cannot equate" with the "contractual agreement" that existed in *Arrowood I.*" ("Mere knowledge of the potential for denial of services is quite distinct from an agreement to be bound by terms explicitly set forth in a written contract." *McCrann* at 907.) 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 North Carolina Court of Appeals discussed 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 II* 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." Id. at 907. In its conclusion, the court held that "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 recognized in *McCrann*, 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, as here[18], the Department provided no opportunity for public input and 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." Id. 1228.

In *Smith v. Department of Human Services Director,* the Court of Appeals of Michigan found that reductions in TANF cash assistance benefits must be promulgated as a regulation to be enforceable. 822 N.W.2d 616, 628, 297 Mich.App. 148 (Ct. App. 2012). In that case, after the State agency complied with the state's APA the parties settled. 828 N.W.2d 18 (Mich. 2013).

In *Ex parte Traylor Nursing Home, Inc. V. Alabama Statewide Health Coordinating Council*, the Supreme Court of Alabama granted cert. and reversed the lower court's decision upholding the Medicaid Agency's amendment to Alabama's State Health Plan. 543 S.2d 1179 (Ala. 1989). The Supreme Court held that the agency's argument that it complied with federal law did not relieve the State Medicaid Agency of its obligations to comply with the State's APA:

> ...the fact that the Governor or the state agency has final approval of the amendment is irrelevant, given the purpose of the AAPA. The AAPA provides a mechanism for both business people and the general public to participate in the development and adoption of

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[18] In the present case, DHHS and DDSN attempted to create the allusion that the public had an opportunity for input, but that input was not sought until after the MCAC had approved the waiver amendments sought by the agencies while the legislature was adjourned, and the reductions were already a "done deal," giving advocates insufficient time to present their case to their duly elected representatives in the General Assembly.

> rules, regulations, standards, or procedures that affect the public or a specific industry. If the state health care agencies in this state can circumvent the procedural requirements by dividing their powers, then the public lacks the protection the legislature intended it to have.
>
> ...because this is a rule affecting the public's rights, we conclude that there should have been compliance with the AAPA. ..
>
> ...Assuming that the health council followed the federal requirements, the fact that it did so would not be an excuse for its admitted failure to abide by the state requirements. The health council does not have the option of choosing the rules applicable to it.

Id. at 1186-1187. See also *Stratford Nursing & Convalescent Center v. Division of Medical Assistance and Health Services*, 215 N.J. Super. 479, 522 A.2d 442, 483 (1986) ("Because it was not duly adopted, as it should have been, pursuant to the Administrative Procedure Act...that so-called policy is a nullity and unenforceable against appellant."); *White Bear Lake Care Center, Inc. v. Minnesota Department of Public Welfare,* 319 N.W.2d 7 (1982) (Change in calculation of per diem rate not enforceable without complying with APA).

Approval by CMS does not relieve a Medicaid agency of its obligations to comply with other statutes. 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 General Assembly, and went into effect just prior to the beginning of the 2010 Session. *Pashby v. Cansler*, 709 F.3d 307 (4th Cir. 2023). Petitioner prays that this Court will consider, however, that even though the Medicaid waiver reductions were approved by the North Carolina General Assembly, as well as CMS, the Fourth Circuit held the reductions made by North Carolina DHHS violated of the Americans with Disabilities Act. Id. As the Court of Appeals recognized in this case, 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 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.

Providing due process includes providing the public with a meaningful opportunity to have input and to have time and opportunity to enlist the assistance of their elected representatives in challenging agency policies that violate the law.

IX. Conclusion.

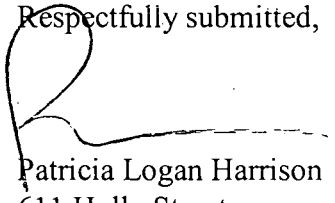
Richard prays that this Court will reverse the holding of the lower Court and rule that the agencies violated the APA by failing to promulgate waiver amendments as regulations. The unintended consequences of the lower Court's ruling could be seismic and have far reaching unintended results across the 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.

The past patterns of disregard for the rule of law and the patterns of spending tens of millions of dollars for purposes other than those authorized by the General Assembly should set off an alarm in this case. Twenty-nine years of disregard for the APA and the role of the Legislative Branch in promulgating regulations by DHHS' agent, DDSN, is enough. The human consequences at issue in this case have been immeasurable and the damages irreversible. It is unlikely that the financial consequences of the agencies illegal actions will ever be fully brought to light. Petitioner asks that this Court will consider the results of this decades long lack of legislative oversight, as demonstrated in the findings contained in the audits of Protection &

Advocacy, DHHS and LAC. R. 434, 484 and 641.

Richard respectfully requests an order requiring DDSN and DHHS to provide the services ordered by his treating physicians until DDSN and DHHS come into compliance with the APA by promulgating regulations for the operation of the DDSN Medicaid waiver programs. An order finding that Respondent has not been substantially justified in actions Petitioner has complained of that have violated the APA and the Americans with Disabilities Act is requested. It is also requested that this Court order the payment of legal fees and costs pursuant to S.C. Code of Laws 15-77-300 (the "state action statute"), either as determined by this Court to be reasonable or that the Court refer this case to a circuit court judge specifically designated to hear and rule upon a Petition for legal fees and costs.

Respectfully submitted,



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May 12, 2015

THE STATE OF SOUTH CAROLINA
In the Supreme Court

APPEAL FROM THE SOUTH CAROLINA COURT OF APPEALS

Appellate Case No. 2014-002513

Richard Stogsdill,.....Petitioner,

v.

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

CERTIFICATE OF SERVICE

I, John N. Harrison, certify that I sent by US Mail the *Brief of Petitioner* in the above case to Richard G. Hepfer, Esq., Office of General Counsel, South Department of Health and Human Services, PO Box 8206, Columbia, SC 29202-8206 on May12, 2015.

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