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STATE OF SOUTH CAROLINA

In the Supreme Court

**S.C. Supreme Court**

APPEAL FROM THE SOUTH CAROLINA COURT OF APPEALS

Case No. 2014-002513

Richard Stogsdill,

Petitioner,

v.

South Carolina Department of Health and  
Human Services,

Respondent

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BRIEF OF RESPONDENT

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### **Statement of the Issue.**

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?

### **Statement of the Case**

#### **Commencement of the case.**

The Petitioner in this matter is a Medicaid-eligible individual, who has been receiving services under the South Carolina Mental Retardation/Related Disabilities (MR/RD) waiver (now the Intellectual Disabilities/Related Disabilities waiver). Under this waiver, beneficiaries can be provided a mix of services through the Department of Disabilities and Special Needs (SCDDSN). Waivers are mechanisms within the Medicaid Program under which, by having certain generic requirements of the regular state Medicaid program “waived,” states are able to provide services to individuals in ways not allowed under the regular Medicaid Program. This and other waivers operated by DDSN are for home and community based services under Section 1915(c) of the Social Security Act [42 USC §1396n(c)]. These types of waivers allow services to be provided in the home or community, in lieu of institutional services. On January 1, 2010, the five-year renewal of the MR/RD waiver, as approved by the Centers for Medicare and Medicaid Services (CMS), went into effect. The renewed waiver included a cap or limit on some services and excluded others. The current waiver documents including the waiver and the

approvals by the CMS are at

<http://www1.scdhhs.gov/openpublic/insideDHHS/Bureaus/BureauofLongTermCareServices/Mental%20RetardationRelated%20Disability%20Waiver.asp>

The SCDDSN is responsible for the day-to-day operation of this waiver. The Department of Health and Human Services (Department, DHHS, Respondent) is the agency that administers the South Carolina Medicaid Program, and so, is also responsible for the overall administration of the waiver. In this case, certiorari was granted to review an aspect of the Court of Appeals Order in Stogsdill v. SCDHHS, 410 S.C. 273, 763 S.E.2d 638 (S.C. Ct. App., 2014). The issue as indicated above is whether the Department must promulgate regulations in order to create binding norms in the form of criteria set forth in a federal Medicaid waiver document. The Court of Appeals found, in this instance that the waiver criteria, which limited services provided to the Petitioner, could not be enforced because in application to the Petitioner, they were violative of the Americans with Disabilities Act (ADA) as further interpreted by Olmstead v. L.C., 527 U.S. 581 (1999)

When he was under twenty one years of age, the Petitioner was likely receiving school-based services in addition to waiver services. The Petitioner “lost” his school services, probably under the Individuals with Disabilities Education Act (IDEA) because he turned twenty one, not because of anything the Departments did. Since he became an adult, according to the programs and prior to the January, 2010, waiver changes, the Petitioner was receiving a combined 69 hours of Personal Care Aide and Companion Care services per week and about 36 hours of Respite Care per week. Personal Care Aide II (PC2)

services consist of hands-on personal care that a person needs to accomplish their activities of daily living such as bathing, toileting, dressing and eating. Adult Companion Services are similar to PC2 services but include an aspect of community integration. Respite Care can be a range of services, including personal care but is designed to provide services when the normal caregiver is absent or needs relief.

The new waiver capped any combination of PC2 and Adult Companion services at 28 hours per week. The normal cap for Respite Services under the new waiver is 68 hours per month (or almost 16 hours per week), but exceptions can be granted for up to 240 hours per month (or about 56 hours per week). Under these new limits, the Petitioner's services were to be reduced to 28 hours of PC2-type services (including Adult Companion services) per week and 68 monthly hours of Respite Care. Also, in this case, in accordance with the new waiver, the Petitioner's Occupational, Physical and Speech Therapies provided under the waiver were to be discontinued. The limits on services, set forth in the waiver document are the particular "binding norms" at issue.

In apparent anticipation of the reduction in services, on December 30, 2009, the Petitioner sought a Reconsideration of the DDSN's proposed reductions, however, the Reconsideration was denied (R. p. 940). The Reconsideration was conducted by Dr. Beverly A.H. Buscemi, the Director of the DDSN who found that she was "...not at liberty to exceed the established limits." R. p. 940.

**Petitioner's and Respondent's positions and the previous actions of the**

**administrative tribunals and court.**

The Petitioner appealed the denial of Reconsideration by SCDDSN to the DHHS Appeals Division on the grounds that:

- 1) the waiver amendment was not a change in law, nor was it promulgated through the Administrative Procedures Act;
- 2) the Petitioner did not receive the proper notice of the agency action reducing his services;
- 3) the reductions in services were violative of the Americans with Disabilities Act as interpreted by Olmstead v. L.C., 527 U.S. 581 (1999) because they placed the Petitioner in a serious risk of institutionalization.

(See Brief at R. p.174-182)

The Respondent argued that:

- 1) Medicaid law, generally provides authority for states to amend waivers and place reasonable limits on services;
- 2) the Petitioner had actual practical notice of the agency actions affecting his services;
- 3) under Olmstead, the Petitioner's risk of institutionalization was speculative, and even if the reductions placed him at a greater risk of institutionalization, the State's responsibility under Olmstead is not boundless.

(See, Respondent's Brief, R. pp. 139-44 & pp. 151-57)

The SCDHHS Hearing Officer found that:

- 1) the Department did have the authority to renew the waiver with reasonable limitations on services;
- 2) although the individual notice provided to the Petitioner was defective, the Petitioner did have actual notice;
- 3) the reduction in services did not place the petitioner at great risk of institutionalization because of the supports in his then-current situation and the other services available through the waiver.

(See R. pp. 16-26)

On or about October 20, 2010, the Petitioner appealed to the Administrative Law Court, alleging:

- 1) Due process, reasonable standards, and reasonable promptness flaws in the Departments' processes;
- 2) Violations of the Medicaid requirements to make sufficient payments to providers, to provide comparable services among similar beneficiaries, and to provide services irrespective to diagnosis and condition;
- 3) Violations of the American Recovery and Reinvestment Act (stimulus funds);
- 4) Failure to prove feasible alternatives;
- 5) Violations of the Americans with Disabilities Act, as further explained by the Olmstead decision; and
- 6) Failure to defer to the Petitioner's treating physicians.

Notice of Appeal (R. pp. 933-937).

The Respondent argued that:

- 1) both State and federal law gave the Department the authority to administer the Medicaid Program including the authority to amend waivers;
- 2) that the Medicaid requirement that the states provide services “sufficient in amount duration and scope” does not require that each participant get services tailored to his need;
- 3) The Petitioner received actual notice of the reductions;
- 4) Although the attending physician’s recommendations should be given great deference, they are not dispositive of the services authorized.
- 5) That the Petitioner was not put in serious risk of institutionalization as a result of the reductions in his services.

(See R. pp. 57-74)

The ALC upheld the DHHS Appeals Division on March 13, 2013, finding that:

- 1) the risk of institutionalization raised by the Petitioner was speculative and the actions of the Respondent were not violative of the Americans with Disabilities Act (ADA);
- 2) in authorizing the Petitioner’s services, appropriate weight was given to the information submitted by the Petitioner’s attending physician;
- 3) providing the Petitioner services in the amount that he wants would be a fundamental alteration of the nature of the Respondent’s program;

- 4) the 2010 reductions were lawful and not violative of the South Carolina Administrative Procedures Act;
  - 5) the Petitioner was afforded adequate due process;
  - 6) the DHHS provided services with reasonable promptness, it is the adequacy of those services that is in dispute; and
  - 7) the Respondent did not violate the comparability requirements of the Medicaid Act?
- ALC Decision dated March 13, 2013, R. pp. 5-15.

Appeal to the Court of Appeals followed. Notice of Appeal, April 9, 2013, R. pp. 933-937.

The Petitioner alleged that:

- 1) the risk of institutionalization was not speculative;
- 2) the hearing officer erred in determining that the ADA was not violated;
- 3) the state has not proved a “fundamental alteration” in its program;
- 4) appropriate weight was not given to the orders of the Petitioner’s attending physician;
- 5) the affidavit of the attending was not hearsay;
- 6) Respondent failed to provided services with reasonable promptness;
- 7) Respondent violated the Petitioner’s due process;
- 8) Respondent violated the S.C. Administrative Procedures Act and the Medicaid

comparability requirements.

In addition, several public interest groups filed a joint Amicus Brief arguing succinctly that:

- 1) The limits on services set forth in the waiver violated the ADA by placing participants in serious risk of institutionalization and the state failed to show that not to do so would fundamentally alter the State's program;
- 2) The limits were issued in violation of the S.C. Administrative Procedures Act; (See R. pp.1409-1450).

The Respondent separately answered both briefs, essentially saying that:

- 1) the risk of institutionalization raised by the Petitioner was speculative and the actions of the Respondent were not violative of the Americans with Disabilities Act (ADA);
- 2) in authorizing the Petitioner's services, appropriate weight was given to the information submitted by the Petitioner's attending physician;
- 3) providing the Petitioner services in the amount that he wants would be a fundamental alteration of the nature of the Respondent's program;
- 4) the 2010 reductions were lawful and not violative of the South Carolina Administrative Procedures Act;
- 5) the Petitioner was afforded adequate due process;
- 6) the DHHS provided services with reasonable promptness, it is the adequacy of

those services that is in dispute; and

- 7) the Respondent did not violate the comparability requirements of the Medicaid Act?

The Court of Appeals held that:

- 1) although specific notice to the Petitioner was not properly issued, that the Petitioner had actual notice of the reductions in his services and therefore there was no prejudice;
- 2) the Department had created a binding norm, but was entitled to do so through DHHS' state and federal authority to administer the Medicaid Program in South Carolina; but
- 3) that in imposing the services limitations on the Petitioner, the Respondent had placed him in serious risk of institutionalization and had not shown that not to do so would fundamentally alter the Department's program.

The Petitioner and the Respondent sought rehearings:

1. The Petitioner's grounds for a rehearing request were:
  - a) "Greatest deference" was not given to the Petitioner's physician's orders;
  - b) Failure to comply with the S. C. Administrative Procedures Act;
  - c) Failure to provide proper due process
  - d) Violations of the reasonable promptness requirement;
  - e) Violation of the comparability requirement.
2. The Respondent's grounds for a rehearing were:

- a) That the Court of Appeals applied the wrong standard in not finding that the Petitioner had to show a “serious” risk of institutionalization; and
- b) That the Affidavits relied upon were hearsay evidence.

Both requests for a rehearing were denied.

The Petitioner petitioned for certiorari on three (3) issues:

- 1) Whether the Respondent impermissibly established binding norms with going through the APA;
- 2) Whether the Respondent was required to give greater deference to the orders of the petitioner’s attending physician;
- 3) Whether the Respondent complied with the Medicaid Act’s requirements for a “fair hearing.”

The Court granted certiorari on the first issue. Thus, the matter is before the Court on certiorari from the Court of Appeals on issue 1, above, the matter having been originally decided by an administrative hearing officer and the ALC was in accord. As an Appeal from an Order of the Administrative Law Court, issued on March 13, 2013. As recently articulated by the Appellate Courts:

This court's scope of review is set forth in section 1–23–610(B) of the South Carolina Code (Supp.2009). That section provides:

The review of the administrative law judge's order must be confined to the record. The court may not substitute its judgment for the judgment of the administrative law judge as to the weight of the evidence on questions of fact. The court of appeals may affirm the decision or remand the case for further proceedings; or it may reverse or modify the decision if the substantive rights of the petitioner have been prejudiced because the finding, conclusion, or decision is:  
(a) in violation of constitutional or statutory provisions;

- (b) in excess of the statutory authority of the agency;
  - (c) made upon unlawful procedure;
  - (d) affected by other error of law;
  - (e) clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; or
  - (f) arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.
- Doe v. South Carolina Dept. of Health and Human Services 398 S.C. 62, 727 S.E.2d 605, (S.C.,2011).

**Current status of the Parties.**

There has been no change in the Parties, although additional services have been authorized for the Petitioner since the initiation of this matter.

**The Respondent takes issue with a few facts in the Petitioner's Statement:**

- 1) Page 6 of Petitioner's Brief: The Department is not the "single largest employer in the state." S.C. Code Ann. §44-6-132(c)(4) appears to be referring to the health care market.
- 2) Page 9 of Petitioner's Brief: We cannot find any showing in the Record that the amendments were enacted "without notice to or approval of the General Assembly."
- 3) Page 10 of Petitioner's Brief: We cannot find any showing in the Record that decisions from SCDHHS evidentiary hearings are rarely issued within 90 days. Furthermore, it is not required that all decisions be issued within 90 days. See 42 CFR §431.244.
- 4) Page 11 of the Petitioner's Brief: The Department's cited regulation,

at 126-304 deals with the Community Long Term Care Waivers operated by the Department, itself, not those contracted to DDSN, such as the ID?RD waiver at issue here .

5) Pages 11-16 of Petitioner's Brief: Under the federal regulations, at 42 CFR §430.25(e), the Governor, the head of the Medicaid agency or an authorized designee may submit a waiver request. Once approved, as stated in the Petitioner's Brief at p. 11, day-to-day operation of this waiver is contracted to DDSN. Thus. DDSN is bound by the provisions of the waiver and the contract. The lack of advisory committees (of which there the record is silent), the relationship between the DDSN and the Local Boards, and any lack of Local Board input into the waiver renewal (of which the Record is silent) have nothing to do with the enforceability of the waiver provisions issued by DHHS.

6) In the Petitioner's Chronology:

a) Page 21 of the Petitioner's Brief: Ms. Faulkner's letter of June 11, 2009, at R. 895 shows collaboration with the DDSN Commission in developing the waiver renewal, it also perhaps shows something of a scramble to get the renewal submitted 90 days before the expiration date of the previous waiver, but it does not show that it was developed "in secret" as the Petitioner alleges.

b) Page 31 of the Petitioner's Brief: the figure \$37,364.45 at R.

243 is a January, 2009, estimate of the Petitioner's cost of care. The record does not contain the actual cost, except for a claims report for a different period of time, at R. 747 and following.

- c) The remainder of this section in the Petitioner's Brief deals with various reasons why the reductions should not have been imposed on the Petitioner. The Court of Appeals has ruled on that issue and the Respondent did not appeal the ruling. As the law of this case now stands, the Respondent cannot impose the limits on this Petitioner, not because they are impermissibly established "binding norms" but because to do so for the Petitioner would violate the Olmstead integration mandate by subjecting the Petitioner to a serious risk of institutionalization

Thus, as the Respondent sees the facts, and as reflected in the Medical Care Advisory Committee meeting Minutes of May 19, 2009, R. pp.848-852, in accordance with the best practice, as they saw it, with the advice of DDSN and under the authority of State and federal law, DHHS staff prepared the waiver renewal for submission to The Centers for Medicare and Medicaid Services (CMS). Public sessions were held throughout the State. R. p.292. CMS approved the Waiver in accordance with 42 CFR §441.300 et seq. All of the Medicaid application and approval requirements were met. Having done so, there was no doubt for the agencies that the implementation of the waiver complied with the requirements of State law and the federal agency that oversees the Medicaid Program

**Arguments:**

**The Department has the authority to administer the Medicaid Program in South Carolina; the waiver provisions were renewed correctly under the federal regulations and therefore should be enforceable:**

**Legislative authorization:** The Waiver document is a contract between the federal government and the State about what services the federal Medicaid Program will help pay for through the State's letter of credit at the Centers for Medicare and Medicaid. The waiver application must conform to the federal regulations at 42 CFR §440.300 et seq. The ability of the Department to negotiate with the Centers for Medicare and Medicaid is consistent with the Department's enabling legislation, specifically at S.C. Code Ann. §§44-6-30, 40 & 70. It is also consistent with the federal regulations regarding the authority and independence of the single state agency that administers the Medicaid Program at 42 CFR §430.10. The Department is the duly designated single state agency for the administration of the Medicaid Program in South Carolina. 42 U.S.C. §1396 et. seq.; S.C. Code Ann. §44-6-10 et. seq.; and 42 CFR §431.10.

**Regulations:** The Department's regulations at S.C. Code R. 126-300(D) provide authority to make changes in the State's Medicaid Program. The regulation states:

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

The statutes, regulations, and caselaw above contemplate that Department will further specify the limits and procedural requirements of the Program. That further specificity is

not contrary to the cited statutes and regulations. Since the Department is charged, by statute with the administration of the Medicaid Program, some respect and consideration should be given to its interpretation of the rules governing the Program.

**Caselaw:** Furthermore, in Jane Doe v. SCDHHS, 398 S.C. 62, 727 S.E.2d 605 (2011) the SC Supreme Court indicated that waiver provisions are enforceable with respect to the administration of the waivers, even though they are distinguishable from promulgated regulations. See page 74 of the S. C. version. Footnote 7 of the opinion does say that a policy cannot contradict a regulation and in that posture should be given no effect, but we know of no contrary regulation or law specifying a different level of services than is set forth in the waiver document.

**Public Notice:** Federal rules issued on January 16, 2014, require a process of public comment for substantive changes to waivers and new waivers. The federal regulations are at 42 CFR §441.304

(e) The agency must provide public notice of any significant proposed change in its methods and standards for setting payment rates for services in accordance with § 447.205 of this chapter.

(f) The agency must establish and use a public input process, for any changes in the services or operations of the waiver.

(1) This process must be described fully in the State's waiver application and be sufficient in light of the scope of the changes proposed, to ensure meaningful opportunities for input for individuals served, or eligible to be served, in the waiver.

(2) This process must be completed at a minimum of 30 days prior to implementation of the proposed change or submission of the proposed change to CMS, whichever comes first.

(3) This process must be used for both existing waivers that have substantive changes proposed, either through the renewal or the amendment process, and new waivers.

(4) This process must include consultation with Federally-

recognized Tribes, and in accordance with section 5006(e) of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111-5), Indian health programs and Urban Indian Organizations.

**If the legislative, regulatory, case authority and due process safeguards are inadequate or of insufficient specificity, then the analysis in South Carolina should be based upon a consideration of whether all “binding norms” are such that they must be promulgated by regulations in order to be enforceable.**

The Respondent’s position has been that the requirements set by the waiver are well within the contemplation of the statutes set forth in the Department’s enabling legislation above, which tell the Department to: prepare, approve and submit the Medicaid State Plan to CMS for approval.

The Court of Appeals found instructive the North Carolina case of Arrowood v. North Carolina Department of Health & Human Services, 543 S.E. 2d 481 (N.C. App, 2001)(rev’g 535 S.E.2d 585 (N.C 2000)). In that case, the North Carolina Supreme Court reversed the holding of the superior court that a waiver involving the North Carolina welfare program had to be promulgated to be valid. In reversing, the Supreme Court adopted the dissent in the lower case that relied on the clarity of the waiver language and a contractual relationship between the parties. McCraun ex rel. McCraun v. Department of Health and Human Services, 704 S.E. 899 (N.C. App, 2011) has since distinguished the Arrowood cases due to the contractual relationship, but the other distinguishing factor was interpretation of the waiver language. As in the present case, the Arrowood involved a straightforward application of the waiver language. In the South Carolina waiver document, the limitations in services are set forth in actual number of hours, not subject

to interpretation.

Furthermore, in relying on Arrowood, the S. C. Court of Appeals focused on the effect of waivers on the overall statutory and regulatory operation of the State's Medicaid Program. As between the states and federal government, the parameters of Medicaid Programs are governed by the federal regulations. See primarily 42 CFR §430.0 through §456.725. Although there are other federal regulations throughout Title 42 and Title 45 of the federal regulations that may affect specific aspects of Medicaid Programs, the federal regulations following 42 CFR §430.0 are the core governing rules. Those regulations and the underlying federal statutes (§1902 et seq. of the Social Security Act [42 USC §1396a et seq.]) deal with the general administration of the program, fiscal management, eligibility, services covered, payment for those services, program integrity (fraud and abuse) and utilization control (eliminating unnecessary services).

Under 1902(a)(10)(A)(i) of the Social Security Act [42 USC §1396a(a)(10)], Medicaid Programs are required to cover certain categories of individuals, such as: pregnant women with incomes less than 133% of the Federal Poverty Level (FPL); children between one and six years of age with family incomes up to 133% of the FPL; recipients of adoption assistance and foster care; individuals who are eligible for Supplemental Security Income (SSI); etc. In addition, under §1902(a)(10)(A)(ii) of the SSA [42 USC §1396a(a)(10)(A)(ii)] there are numerous optional eligibility categories, such as: non-institutionalized disabled children; institutionalized individuals under a special income limit; etc.

With respect to services under the Medicaid Program, states must provide certain mandatory services such as inpatient hospital services and physician services.

§1902(a)(10)(A) of the SSA [42 USC §1396a(a)(10)(A)] & §1905(a) [42 USC §1396d(a)]. Other services listed in §1905(a) not specifically made mandatory by §1902(a)(10)(A) are optional.

There are certain general requirements that apply to all services. For example, under 1902(a) (1) of the SSA [42 USC §1396a(a)(1)] and 42 CFR §431.50, services must be made available on a statewide basis. As another example, the federal statutes at §1902(a)(10)(B)[§1396a(a)(10)(B)] and regulations at 42 CFR §440.240(b) require that services available to any categorically eligible individual must be available to all categorically eligible individuals. This is called the “comparability” requirement.

Therefore, under the regular Medicaid Program, if a state wanted to offer personal care services (an optional service), those services would have to be available for all categorically eligible individuals. With a waiver, the state can ask the federal government to “waive” the comparability requirement (for example) so that personal care services need only be provided (targeted) to individuals who are disabled and would need care in an institution (as described in the waiver at issue here).

In its ruling on the Stogsdill case, the Court of Appeals was exactly correct in holding that “[t]his Waiver authority had the legal effect of superseding existing federal statutes that would not allow for [such] community-based services.” Stogsdill, at 280 & 642.

The McCraan case applies the North Carolina Administrative Procedures Act in a vacuum, ignoring the statutory and regulatory operation of the jointly administered federal-state Medicaid Program. The waivers are essentially modifications of the approved Title XIX (Medicaid) State Plans. The South Carolina General Assembly has unequivocally authorized the Department to prepare a State Plan for the Medicaid Program. From the Department's enabling statute:

**SECTION 44-6-30. Duties and limitations**

The department shall:

(1) administer Title XIX of the Social Security Act (Medicaid), including the Early Periodic Screening, Diagnostic and Treatment Program, and the Community Long-Term Care System;

**SECTION 44-6-40. Duties.**

For all health and human services interagency programs provided for in this chapter, the department shall have the following duties:

(1) Prepare and approve state and federal plans prior to submission to the appropriate authority as required by law for final approval or for state or federal funding, or both.

**SECTION 44-6-70. Preparation of state plan and resource allocation recommendations.**

A state plan must be prepared by the department for each program assigned to it and the department must also prepare resource allocation recommendations based on such plans. The resource allocation recommendations must be approved pursuant to state and federal law. The state plans must address state policy and priority areas of service with specific attention to the following objectives:

**Based on experience with several similar administrative cases, the waiver provisions were not treated as binding norms by the hearing officer in the initial hearing in this case, but the limitations on services were subjected to an evidentiary hearing as if the agency had the discretion to apply or not apply the limits expressed in the waiver document.**

In Corbett v. DHHS, 07-ALJ-08-0278-AP, 2008 WL 3863531, A waiver participant challenged the force and effect of waiver eligibility provisions as not having been promulgated as regulations in the State. The Department asserted that since the waiver provisions were approved by the Centers for Medicare and Medicaid (CMS), the federal agency that administers the Medicaid Program, it did not have to be promulgated as a regulations in the State.

Relying on the description of “binding norm” in Home Health Services, Inc. v. S.C. Tax Commission, 312 S.C. 324, 440 S.E. 2d 375 (1994) and Sloan v. S.C. Board of Physical Therapy Examiners, 370 S.C. 452, 636 S.E. 2d 598 (2006), the ALJ ultimately rejected that assertion and found that CMS’ approval of the waiver did not make it a binding document. Although it did not have the force and effect of law, because it had not been promulgated, the agency treated the document as binding. In other words, the agency looked only to whether the policy’s criteria were met in order to make the eligibility decision.

Even though the document did not have the force and effect of law, and the Department treated the unpromulgated document as a binding norm, the ALJ upheld the agency decision because the Court gave due respect and consideration to the Department’s interpretation of federal law and that interpretation was not contrary to any State statute or regulations.

In Hickey v. SCDHHS, 10-ALJ-08-0656 (July 19, 2011) the ALC again found that provisions set forth in the Waiver could not be enforced as binding norms without a hearing because they had not been promulgated as regulations. In Hickey, one of the same provisions in issue in this (Stogsdill) case was at issue, the provision that limits personal care-type services to 28 hours per week. Since the Petitioner had been receiving 50 hours of personal care-type services prior to the January 1, 2010 waiver renewal, the DDSN sought to reduce the Petitioner's hours back to 28 per week without considering additional facts, but relying solely on a straight application of the waiver provision. The agency did not exercise any discretion or offer an evidentiary hearing.

Following Hickey, the ALC issued a similar decision in Edge v. SCDHHS, 10-ALC-08-0501 (November 9, 2011).

The briefs and the arguments in these cases may have made an impact on the DHHS hearing officers. Thus, by the time this case came up for processing, the Department's Appeals Division, which under S.C. Code R. 126-150, et seq., has the authority to issue the Department's final decision on agency matters, was not applying the waiver provisions without discretion, but was scheduling evidentiary hearings on the 2010 waiver reductions. The hearings were on appeals of DDSN staff decisions which were, admittedly applied without discretion as required by the waiver document and by contract. The hearing in this case was held on May 11, 2010. (R. 19).

**McCraun also did not consider the practical considerations in promulgating the waiver provisions, which in South Carolina is a long process which takes considerable advanced planning and does not work well with a process which involves frequent negotiated changes and various CMS interpretation of federal law.**

First of all, each of the waiver documents is over 150 pages long as is the basic State Plan. There are currently nine (9) waiver documents. The General Assembly gave the SCDHHS general authority to administer the Medicaid Program in South Carolina by developing the Medicaid State Plan in negotiation with CMS. S.C. Code Ann. §§44-6-30, 40 & 70. The State Plan and each document (nine waivers) by which the DHHS obtained approval to waive the State Plan requirements are 170 -180 pages long, involving every aspect of the waiver. That is too much detailed information to be in the State Regulations.

The federal government may require amendments to the waiver document at any time, as has happened to the waiver at issue at least once since originally approved. The waiver is at

<http://www1.scdhhs.gov/openpublic/insideDHHS/Bureaus/BureauofLongTermCareServices/Mental%20RetardationRelated%20Disability%20Waiver.asp>

If more specificity is required, the better practice would be to incorporate the document by reference, like other federal documents. Other State agencies administer programs in partnership with the federal government. The State enabling statutes do not require explicit regulations to be promulgated to detail the criteria for each program, but allow the agency to administer the program under the authority of the enabling statute.

The Department of Social Services, for example, administers the State Plan for Maternal and Child Welfare Funds, under an application (State Plan) submitted to the federal government.

**SECTION 43-1-110.** State Department may cooperate with Federal Government in administration of Federal Child Welfare Services.

The State Department may cooperate with the Federal Government, its agencies or instrumentalities, in the administration of Child Welfare Services as provided in Title V, Part 3, of the Federal Social Security Act relative to establishing, extending and strengthening services for the protection and care of homeless, dependent and neglected children and children in danger of becoming delinquent in predominantly rural areas and other areas of special need and may receive and expend all funds made available to the Department by the Federal Government, the State or its political subdivisions for such purposes.

McCran also is silent as to whether North Carolina has available a state depository library system. Under S. C. Code Ann. §60-2-10, et seq. (State Documents Depository) documents, such as the State Plan are publically available within the eleven (11) State Depository Libraries located throughout the State. Copies of agency documents can be obtained at these locations. This availability is in addition to the access to all of these documents available on the Department's website, at [www.scdhhs.gov](http://www.scdhhs.gov).

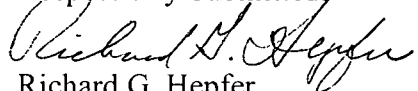
### **Conclusion**

State and federal statutes and regulations give the Department the authority to prepare and administer the South Carolina State Medicaid Plan (Title XIX). Waivers modify the

State Plan by allowing certain populations to receive Medicaid services in ways not allowed under the regular Medicaid Program. That specific criteria will be included in the State Plan and therefore also in the waivers is within the contemplation of the enabling statutes and regulations. Furthermore, in this case, the limits were not treated as binding norms by the Department's hearing officer, nor ultimately were they binding, in the sense of being enforceable because, as applied in this case they violated the Olmstead integration mandate. Finally, the volume of detailed information contained in the State Plan and the waivers and the frequent changes necessary make it impractical to promulgate them as regulations.

For those reasons and any reason appearing in the record, the Court should affirm the decision of the Court of Appeals on this issue.

Respectfully Submitted,



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June 11, 2015

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JUN 11 2015

STATE OF SOUTH CAROLINA

In the Supreme Court

**S.C. Supreme Court**

APPEAL FROM THE SOUTH CAROLINA COURT OF APPEALS

Case No. 2014-002513

Richard Stogsdill,

Petitioner,

v.

South Carolina Department of Health and  
Human Services,

Respondent

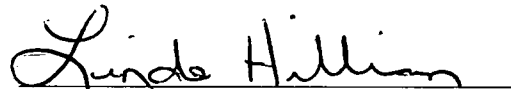
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CERTIFICATE OF SERVICE

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I hereby certify that I am employed by the Respondent in the above-captioned matter and that on the 11th day of June, 2015, in Columbia, South Carolina, I served a copy of the forgoing Brief of Respondent on the following person by depositing the same in the United States Mail, postage paid, and addressed as follows:

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