RECEIVED

JUL 16 2015

S.C. Supreme Court

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.

REPLY BRIEF OF PETITIONER

Patricia Logan Harrison, Esquire
611 Holly St.
Columbia, SC 29205
803-256-2017
Attorney for Petitioner

TABLE OF CONTENTS

TABLE OF AUTHORITIES

FEDERAL CASES

FEDERAL STATUES AND REGULATIONS

STATE CASES

STATE CONSTITUTION, STATUES AND REGULATIONS

OTHER

I. Introduction. Respondent's brief demonstrates the agency's disregard for the authority of the General Assembly and its obligation to comply with state laws, including the South Carolina Administrative Procedures Act (referred to herein as the "APA"). As will be discussed below, Respondent has also ignored not only the decisions of the Court of Appeals for the Fourth Circuit, but this Court's warning to DHHS that it must promulgate its policies as regulations before they will have the force and effect of law.

The record contains uncontradicted evidence that the cost of MR/RD[1] Medicaid waiver services skyrocketed from $242 million in 2008 to more than $278 million in 2010, when Respondent imposed arbitrary and capricious limitations on home-based services and eliminated other therapies that persons at home need to remain in the least restrictive and most integrated setting. R. 75 and 845. It is undisputed that caps were placed on home-based services without conducting a cost analysis or promulgating regulations. Respondent failed to explain, or even to address in its brief its "budget reduction" explanation contained in the the Medicaid waiver application submitted to CMS in 2009. R. 76. To assist the Court in following the actions discussed in this brief, Petitioner begins with a chronology:

II. Chronology. (Items related to Richard's "fair hearing" appeals are in *italics*)

2006

February 2006	An audit of DDSN conducted by DHHS reported "a lack of fiscal oversight of the MR/RD waiver program on the part of both DHHS and DDSN..." and the failure to audit waiver cost reports. R. 473-475.

2008

October 2008	DDSN and DHHS begin meeting to amend the DDSN waiver documents to cap home-based services and eliminate other services. R. 76, 342 and 895.
October 2008	Retroactive effective date of American Recovery and Reinvestment

[1] After this lawsuit was filed, the name of the program was changed from "Mental Retardation/Related Disabilities" to "Intellectual Disabilities/Related Disabilities," or the "ID/RD Medicaid waiver program."

	Act (ARRA) 80% federal match rate. For the last quarter of 2009, DHHS is only required to contribute 20% of cost of Medicaid services, instead of the 30% allocated by the General Assembly in the FY 2008-2009 State Budget.
December 2008	South Carolina Legislative Audit Council releases audit of DDSN Medicaid waiver programs criticizing expenditure of tens of millions of dollars of funds used to buy real estate and for other purposes without authorization from the General Assembly. R. 671-723. LAC also reported lack of oversight in DDSN programs posing health and safety risks to waiver participants. R. 641. This audit reports that DDSN data is "without formal controls," financial reports have not been independently audited, and information "may be unreliable." R. 666-667. The findings of this audit are summarized at Petitioner's Brief at 22 and 23. See also LAC synopsis at R. 659.
	2009
February, 2009	Congress passes ARRA, increasing federal match rate to 80% for South Carolina Medicaid services, retroactive to October, "to preserve and create jobs and to promote economic recovery; assist those most impacted by the recession.. 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) and 5001.
February 13, 2009	*Richard files first request for a fair hearing complaining that he needs additional hours of services. R. 31 and 948. Notice of appeal states that Richard is appealing, among other things, failure to promulgate regulations. R. 948.*
May 13, 2009	General Assembly ratifies H. 3560, the State Budget for FY 2009-2010, which does not include authority to enact still undisclosed plan to place caps on waiver services or for DDSN and/or approval for Budget and Control Board to authorize expenditure of $5,944,738 from DDSN "excess funds" account. H. 3560. Respondent's Brief at 11.
May 19, 2009	DDSN and DHHS staff present plan to cap home-based services and to eliminate therapies to the DHHS "Medical Care Advisory Committee" (MCAC) and plan is approved, based on claims of budget reductions. R. 844-845, 85-856. According to information provided to MCAC, there were 5,700 participants in the MR/RD Medicaid waiver and the program cost in FY 2008 was "approximately" $242 million, with an average cost per participant of $42,456.14. R. 845 and 856.
May 21, 2009	DDSN official Bill Barfield informs Commission members and public that General Assembly appropriated $12.7 million "in recurring state dollars as DDSN had requested" which would allow DDSN to "restore some services since cuts have occurred, but not

	every service at the level they were July 2008."[2] R. 833.
June 5, 2009	DDSN holds "special called meeting" informing governing board waiver amendments are necessary due to "budget cuts" and that DHHS plans to submit the waiver renewal application to CMS on June 25, 2009 (which is before next regularly scheduled DDSN Commission meeting). R. 928. Commission is informed that if CMS does not approve application by September 30, 3009 "all federal funding" will end and it "could result in a complete cancellation of the waiver for all families." Id.
June 9, 2009	Director Eugene A. Laurent sends "Apology" memorandum to directors and chairpersons of local DSN Boards acknowledging that waiver amendments were established "without involving the County Boards in the process, but also without notifying you that the proposal was going to the Commission." R. 914. Respondent's Brief at 12.
June 11, 2009	DHHS director, Emma Forkner, sends letter to CMS requesting a 90 day delay in submitting the waiver renewal request. R. 895. Letter states that DDSN and DHHS have been "working diligently" since October 2008 "on the development of the waiver..." Id. Letter states that service reductions are being requested "in response to a series of reductions in state appropriations for State Fiscal Year 2009 and State Fiscal Year 2010." Id.
June 29, 2009	*Hearing is held on Richard's February 13, 2009 request for a fair hearing, requesting an increase in hours of services and other relief. R. 31. (Hearing is held more than 120 days after his request for a "fair hearing.")*
August 14, 2009	DDSN Director Laurent sends a letter to the Budget and Control Board requesting permission to spend $5,944,738 from a $7.8 million excess funds account held by DDSN to purchase real estate

[2] At that meeting, DDSN official, Kathi Lacy, informed Commissioners that MCAC had recommended changes to the director of DHHS. 844-845 and 855-856. Petitioner needs to correct the last sentence contained in the first paragraph on page 25 of Petitioner's Brief filed in this case. It appears that the Commissioners were provided at the meeting on May 21, 2009 with a copy of Attachment D, which lists the services to be capped or eliminated. R. 844. However, this information was provided to Commissioners only after those changes were approved by MCAC on May 19, 2009 and after the General Assembly adopted the FY 2009-2010 State Budget on May 13, 2009. R. 844. This document does not, however, inform Commissioners that DDSN and DHHS planned to submit an application proposing to increase the number of participants in the MR/RD Medicaid waiver program by 600 participants, from 5,700 to 6,300 or that the cost of the MR/RD Medicaid waiver program would increase by more than $30 million in FY 2010. R. 75 and 856. On the contrary, the handout DDSN provided Commissioners on August 20, 2009 informed them that DDSN was planning to reduce the number of waiver participants by between 85 (if budget was cut 4%) to 95 participants (if budget was cut 10%) to save money. R. 825-827.

for two local DSN Boards and one private corporation ($2.6 million), to expend $100,000 for a contract to "improve its Medicaid billing capacities," and to transfer $3.2 million of these excess funds to the Budget and Control Board to pay for DDSN's "obligations for SCEIS implementation," none of which were included in the State Budget passed on May 13, 2009. R. 879-882.

August 20, 2009

DDSN officials present budget reduction options to governing board of DDSN showing elimination of 85 to 95 MR/RD Medicaid waiver slots to save money (eleven days before DHHS submited the waiver renewal application requesting permission to add 600 new participants to the MR/RD Medicaid waiver program). R. 825-827. Dr. Laurent informed DDSN Commissioners that running a deficit to avoid cuts was "not a likely alternative" and that he was meeting with the Governor's Office "to discuss budget issues and to come up with other alternatives." R. 821. No mention was made at this DDSN Commission meeting regarding Director Laurent's August 14, 2009 letter to Budget and Control Board requesting permission to spend millions of dollars held in an excess funds account. R. 881.

August 31, 2009

DHHS submitted waiver application to CMS showing projected cost of the program for 2010 to be $278,661,600. R. 75-76. The application stated that "minor adjustments" were being made "Due to the State of South Carolina's budget situation..." R. 76. Personal care services and companion services (combined) were capped at 28 hours a week, nursing at 56 hours and in-home respite services at 68 hours a month. Id. Physical therapy, occupational therapy and speech language pathology services were terminated. Id. The waiver application increases the number of waiver participants receiving respite services in ICF/MR facilities from 30 participants (R. 891) to 126 participants (R. 893) and the average number of days from 22 to 33. Id. The per day cost of ICF/MR respite services was increased from $157.30 per day to $270 per day. Id. The cost of these ICF/MR respite services increased more than ten fold, from $103,818 to $1,122,660. Id.

September 3, 2009

Director Laurent appears before the Budget and Control Board requesting authorization to spend $5,944,738 from a $7.8 million excess funds account and obtains that Board's approval for deal which diverts $3.2 million of DDSN funds to the Budget and Control Board to pay for an "obligation" not contained in State Budget nor approved by the General Assembly. Although Director Laurent informs the Board that DDSN Commissioners have approved these expenditures, there is no evidence in the DDSN Minutes of approval to spend "excess funds" and the minutes show the plan was not discussed at the August, 2009 DDSN Commission meeting. R. 879. Board voted unanimously to approve request.

November 6, 2009

DDSN announces "information sessions" (apologizing for "short notice") to be held around the state to inform DDSN supervisory staff of "implementation deadlines" for waiver amendments. R.

	171. Nearly all attendees were employees of DDSN or their local boards, not members of the pubic or waiver participants. Id. Purpose of meeting was to prepare local DSN Boards to inform waiver participants of already approved waiver amendments, not to solicit public input.
November 9, 2009	CMS notifies DHHS that it has approved its renewal of the MR/RD Medicaid waiver application as requested. R. 75. DHHS sought permission to serve 6,700 individuals at a total cost of $278,661,600, with an average cost per participant of $51,869. Id.
November 16, 2009	*DHHS hearing officer remands Richard's "fair hearing" appeal to DDSN with instructions to have qualified persons determine medical necessity of services, giving consideration to the affidavit of his treating physician. R. 31. (Order is issued more than 270 days after Richard's request for a fair hearing.) Because order remands appeal back to DDSN, it is interlocutory and not appealable to the Administrative Law Court.*
December 23, 2009	*Richard and eight other DDSN waiver participants file a Petition requesting South Carolina Supreme Court to grant original jurisdiction to hear request to prohibit Respondent from reducing services and diverting ARRA funds. R. 337.*
December 30, 2009	*Richard files second "fair hearing" requesting services ordered by his physician, compliance with the November 16, 2009 order of the DHHS hearing officer, and complaining of the diversion of ARRA funds. R. 943. This notice of appeal incorporated all allegations contained in the December 23, 2009 Petition filed in this Court. R. 944.*
	2010
January 1, 2010	Medicaid waiver caps and elimination of therapy services go into effect.
January 6, 2010	General Assembly reconvenes in Columbia. Respondent's Brief at 11.
January 11, 2010	*DDSN sends Richard notices informing him that all personal care services, specialized medical equipment and supplies will be terminated on January 21, 2010 because he "moved out of state."*
January 12, 2010	*Director of DDSN denies Richard's request for reconsideration, informing him that "approved limits cannot be exceeded and must be applied to all waiver participants." R. 940.*
February 28, 2010	DDSN Commissioners send letter to Budget and Control Board member Dan Cooper informing him that if services are cut only DDSN clients living in residential programs will receive funding because "We believe that these services must be given the highest priority." R. 915.

April 2010	A survey by the Direct Health Care Alliance reported South Carolina to be fourth from the bottom in spending on home and community based waiver programs v. institutional care. R. 868.
May 11, 2010	*Hearing is held on Richard's second "fair hearing" request filed on December 30, 2009.*
September 14, 2010	*Second DHHS hearing officer issues order upholding decision of DDSN nine months after second appeal is filed and nineteen months after filing February, 2009 appeal. R. 16.*
November 24, 2010	District court granted preliminary injunction prohibiting DDSN and DHHS from reducing services of plaintiffs, finding likely violation of the Americans with Disabilities Act and likelihood of irrevocable harm. R. 113.

III. Respondent failed to address issue of claims of "budget reductions" in its brief. It is telling that the question of whether a budget reduction ever existed was not even mentioned in Respondent's brief recently filed in this Court. Petitioner has demonstrated in his briefs, and in the evidence presented to the lower courts shows, that Respondent's reason for dodging this question before this Court is that those claims of budget reductions were fabricated in a scheme to force waiver participants to "choose" services in congregate settings operated by DDSN and its boards. Yet, DHHS continues to argue throughout its brief that CMS' approval of that document (which was based on these false claims of insufficient funding) overrides the General Assembly's policies, which do have the force and effect of law and which require services to be provided in the least restrictive and most integrated setting. Respondent's Brief at 13, 14, 15, 20, 23 and 24.

MCAC was informed by agency staff that these reductions were necessary because of "very tight budget times..." R. 855. See also R. 844. The only reason DHHS provided on the waiver renewal application submitted to CMS was budgetary. R. 76. But, the MCAC was not informed that the cost of the program would increase by more than $36 million, from $242 million to $278,661,600, once waiver caps were placed on home-based services. R. 845 and R. 75. Now it is not reasonably disputed that the General Assembly allocated sufficient funds - and more than was necessary to maintain the level of services (without caps) being provided before

the caps were established. Whereas in 2008, DHHS would have been required to contribute $72.6 million to provide $242 million in MR/RD services, during FY 2010, it could maintain the same level of services with a state fund contribution of only $48,400,000. Thus, the MR/RD waiver program alone could have withstood a reduction of more than $24.2 million without any reduction in services in 2010.

IV. DDSN has a long history of failing to use funds for purposes appropriated by the General Assembly. Respondent's brief ignores the constitutional authority of the General Assembly to make policy decisions and to exercise discretion as to what the law will be. *Hampton v. Haley,* 403 S.C. 395, 743 S.E.2d 258, 262 (2013). The General Assembly had "plenary power over all legislative matters unless limited by some constitutional provision." Id. As this Court held in *Hampton,* allowing Respondent to "reduce appropriations according to its own criteria would be an impermissible delegation of legislative powers in violation of the separation of powers." Id. at 265. That is exactly what Respondent and DDSN have done.

It is undisputed that DDSN has a long history of taking funds allocated by the General Assembly to provide services for disabled persons and using them instead for other purposes not intended by the legislature. R 641 to 743. The LAC audit reported that Advocacy groups not funded by the General Assembly were paid $1.5 million in state funds, resulting in a loss of an additional $3.5 million in federal matching funds (total lost $5 million). More than $9 million out of $10. 5 million in state dollars allocated by the General Assembly to provide services to children with autism were either unused or "used for different purposes. R. 723. LAC reported that "by not providing the funded services, the state did not receive an estimated $13.6 million in federal Medicaid funds in FY 2008 alone. Id. This left $6.8 million to be carried forward in FY 2009, funds that were not accounted for to the General Assembly. Id. DDSN informed the General Assembly that an average of $37,000 would be budgeted for each child with autism, but only actually spent an average of $15,000 per child. Id. DDSN failed to spend 31% of funds allocated by the General Assembly in FY 2008 for head and spinal cord injury survivors,

despite admissions by DDSN that "there are many unserved consumers." R. 724. The LAC found that "DDSN did not request funding from the General Assembly for capital grants..." and "there was no evidence that the General Assembly intended for DDSN to use funds appropriated for operating new residential beds to make capital grants of more than $23 million to DSN Boards." R. 722. As a result of this unauthorized expenditure of state funds, South Carolina lost the 70% matching funds the General Assembly intended to be brought into the state's economy through the waiver program. LAC reported that "The agency carried forward, or used for other purposes, the unspent funds. Id. DDSN lost millions in federal Medicaid dollars it could have received if services were provided." R. 719.

V. Caps on home-based services violate longstanding statutes and "guiding principles" properly enacted by the General Assembly. Petitioner has reviewed, in his initial brief filed with this Court, the statutes which require DDSN and DHHS to provide services that meet fiscal, administrative and program objectives and to assure that those programs are operated cost effectively. S.C. Code of Laws 44-6-40. The General Assembly has directed by statute that DHHS keep it informed of standards and procedures used in delivering services. Id. S. C. Code 44-6-70 requires DHHS to assure that "the most appropriate care is given, tailored to the client's needs, and delivered in the most cost-effective manner." DHHS is charged with the responsibility for promulgating regulations to carry out its duties. S.C. Code 44-60-90. S.C. Reg. 276-295 requires DHHS to administer procedures, treatments, medications and supplies "in accordance with recognized and acceptable medical and/or surgical discipline at the time the patient receives the services and in the least costly setting required by the patient's condition." It is undisputed that the DDSN prepared budget shows that in 2009, before services were capped, Richard's budget for services at home was only $37,364.45 (R. 243) and the cost of DDSN institutional services was $116,800 ($320 per day) in 2008. R. 932. It is also undisputed that the projected average cost per waiver participant under the waiver amendments approved in 2009 (effective January 1, 2010 - after the imposition of caps on home-based services) was $51,869 per

participant. R. 75. Thus, the average cost per ID/RD waiver participant in 2010 (after the caps were established) was more than $14,500 higher than the cost of Richard's services in 2009 (before the caps were established).

One of the many state statutes that Respondent ignored in forcing this sea change in the delivery of services was S.C. Code 44-20-20, which requires services to be delivered to enable clients 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." By placing caps on home-based services and eliminating therapies persons living at home require (which would be provided if Richard was admitted to an ICF/MR), Respondent violated the "guiding principles" the General Assembly established in S.C. Code 44-21-10, which unambiguously direct DDSN to support individuals and their families in their homes, which are "more efficient, cost-effective, and sensitive," as compared to maintaining people with disabilities in out-of-home residential settings. Id. But that is exactly the opposite of what DHHS and DDSN did when, in 2010, when it reduced the home-based services persons like Richard need to remain in their homes, while quadrupling the number of Medicaid waiver participants having to resort to ICF/MR facilities and increasing attendance in congregate day programs. R. 891 to 893. The "guiding principles" properly promulgated by the legislative branch provide that families and individuals served are best able to determine their own needs and "should be able to make decisions concerning necessary, desirable, and appropriate services." S.C. Code 44-21-10(C)(1). The actions DDSN took in enacting the waiver amendments in 2010 ignored the General Assembly's statutory directive to provide supports necessary to provide care in the home, while being sensitive to the "unique needs" of individuals and responsive to the needs of the entire family. S.C. Code 44-21-10(C)(2). Throughout Chapter 21 of Title 44, the General Assembly directed DDSN to provide supports to individuals and their families "as their needs evolve over time" and to encourage "community integration." S.C. Code 44-21-10(C)(4), (5), (6).

VI. 2010 waiver amendments were established as binding norms by Respondent and DDSN without meaningful public review or input without notice to the General Assembly, DDSN Commissioners or the local DSN Board network. Respondent argues on page 11 that the Record does not support Petitioner's claim that the General Assembly was not notified of the plan to reduce home based services.

Respondent filed this appeal requesting a fair hearing in February, 2009, before the plan to place caps on home-based services was made public. R. 31. Unbeknownst to Richard, the public, the governing board of DDSN or even the General Assembly, Respondent and DDSN had been working "for many months" at the time of Richard's first "fair hearing" to formulate a plan to cap and eliminate home-based services in violation the clearly expressed guiding principles and policy directives described in Petitioner's brief that are contained in Title 44 of the South Carolina Code of Laws. R. 76.

After the hearing held on May 27, 2009, on November 16, 2009, the first DHHS hearing officer remanded Richard's appeal back to DHHS, with instructions to have his needs assessed by qualified persons, giving appropriate consideration to the orders of his treating physician.[3] R. 31-42. Nearly six years later, despite the South Carolina Court of Appeals also ordering DHHS to assess Richard's need for services, this assessment of medical necessity still has not been performed.[4]

---

[3] The second DHHS hearing officer stated in his order that he had "reviewed the record and the Decision in the previous case [Petitioner] v. SCDHHS, 09-MISC-017." R. 24. See also Order of Administrative Law Court at R. 14. But, despite Richard's objections, DHHS refused to provide that record in the Record on Appeal. Thus, it has been impossible for reviewing courts to consider the entire record or for Petitioner to refer to testimony or evidence presented in the first hearing in his briefs. (ALC rules require the agency to prepare and file the Record on Appeal. ALC Rule 36.) Thus, because Respondent has failed to promulgate regulations establishing the rules and process to be used in fair hearings, "fair hearing" appellants find themselves with an incomplete record when they return to the ALC after remand.

[4] Even after thirteen years of litigation in *Doe v. Kidd*, where the United States Court of Appeals held that Respondent has been in violation of the reasonable promptness requirement of the Medicaid Act for more than a decade, DHHS refuses to change its illegal ways. The September 10, 2014 order of the South Carolina Court of Appeals reads as follows: "We remand this case to

With Richard's first "fair hearing" having proven to be an expensive and time consuming exercise in futility, on December 23, 2009, Richard joined seven other affected waiver participants asking this Court to prevent DDSN and DHHS from imposing the arbitrary caps on home-based services and from diverting ARRA funds for purposes not intended by Congress in *Karen W. et al. v. Sanford.* R. 337 to 433, see particularly those paragraphs related specifically to Richard at R. 410-413. Three weeks after Richard and others filed this Petition in this Court, instead of complying with the hearing officer's November, 2009 order, on January 11, 2010, Respondent, through its agent, DDSN, sent notices to Richard informing him that his personal care attendant services and equipment and assistive technology would be not just reduced, but terminated because he "moved out of state." R. 925-926.926. (Richard has continuously lived in his current residence in Kershaw County for many, many years.)

Respondent addresses the "binding norm" issue on pages 19 to 21 of its brief. It is undisputed that on January 12, 2010 (the day after sending notices informing Richard that his

---

DDSN for an assessment of required hours and services without reference to the caps in the Waiver." But, more than ten months after that order was issued, DDSN still has not performed the required assessment and Richard is still not receiving the services ordered his physician ordered in 2009. At page 11 of Respondent's Brief, DHHS argues to this Court that "it is not required that all decisions be issued within 90 days." But, as the Court of Appeals for the Fourth Circuit instructed DDSN and DHHS in *Doe v. Kidd I,* determinations of eligibility must be made with reasonable promptness, meaning within 90 days: "Federal regulations direct state agencies to determine an applicant's eligibility for Medicaid within ninety days of the date of application and to '[f]urnish Medicaid promptly to recipients without any delay caused by the agency's administrative procedures.' 42 C.F.R.§§ 435.911, 435.930 (2002)." 501 F.3d 348, 354 (4th Cir., 2007). Four years after the Fourth Circuit issued that opinion, DHHS still had not provided the services that had been in Doe's plan since 2003.*Doe v. Kidd II*, Case No. 10-1191, fn 2 (4th Cir. March 24, 2011). DHHS argued to the Fourth Circuit in 2011 that the applicable regulation was:

> ...§ 435.930, which states only that Medicaid services are to be made available "without any delay caused by the agency's administrative procedures." See, e.g., Doe 1-13 By and Through Doe, Sr. 1-13 v. Chiles, 136 F.3d 709, 721-22 (11th Cir. 1998) (upholding a district court's conclusion that "reasonable promptness" means a period not to exceed ninety days).

Id. Rule 212 of the South Carolina Rules of Appellate Procedure allows this Court to require a report on "any matter related" to the trial or hearing, which shall become a part of the record. Petitioner respectfully requests that this Court inquire at oral argument, or before, as to why the assessment ordered by the Court of Appeals on September 10, 2014 has still not been performed and why the services ordered by Richard's physician in 2009 still have not been provided.

services were being terminated at R. 925-926), the Director of DDSN, Beverly Buscemi denied Richard's request for reconsideration, without providing any other reason for placing caps on services or its failure to comply with the November, 2009 order. R. 940. Her letter also failed to explain why DDSN sent Richard notices informing him that home-based services were being terminated. R. 940. But, Dr. Buscemi's letter informed Richard that since CMS approved the caps placed on MR/RD Medicaid waiver services and, therefore "These approved limits cannot be exceeded and must be applied to all MR/RD Waiver participants." R. 940. This statement puts to rest the arguments on pages 19 and 20 of Respondent's brief which appear to argue that the caps have not been treated as a "binding norm."

The South Carolina Court of Appeals ruled that the caps constitute a binding norm and DHHS did not appeal that decision:

> We agree with Stogsdill that DDSN has established a binding norm by reducing the types and amount of services offered under the Waiver. The record presents no explanation for the reduction in services to Stogsdill other than the cap put in place by the 2010 Waiver renewal.

Stogsdill v. DHHS, Case No. 2013-000762, Opinion No. 5271 at 4-5 (S.C. Court of Appeals Sept. 10, 2014). The link to the current waiver document contained on page 2 of Respondent's Brief are not functional, but DHHS provided Petitioner with this link:

https://www.scdhhs.gov/historic/insideDHHS/Bureaus/BureauofLongTermCareServices/Mental%20RetardationRelated%20Disability%20Waiver.html

It is notable that none of the waiver amendments inform waiver participants or their advocates that the federal district court granted an injunction in *Peter B. v. Sanford,* Case No. finding that the waiver amendments placed the plaintiffs at risk of institutionalization, nor have waiver participants been informed of the ruling of the South Carolina Court of Appeals in *Stogsdill v. DHHS*, finding that the waiver caps may not be enforced against participants who are at risk of institutionalization.

VII. The waiver amendments were established without performing cost studies and reducing home-based services resulted in a significant increase in costs and forced entry into more restrictive settings. Respondent has not provided in its brief filed in this Court even a scintilla of evidence that contradicts the fact that the agencies knew when they imposed the limitations on home-based services on January 1, 2010 that it would cost tens of millions of dollars more to operate the MR/RD Medicaid waiver program than it had cost to operate the program with no caps on home-based services in 2008. R. 75, 845, 856. Not only was the aggregate cost of the program more than $30 million higher than in 2008, but the applications DHHS filed with CMS show that the average per participant annual cost increased from $42,456 in 2009[5] to $51,869 when home based services were reduced in 2010. Id. DHHS has failed to rebut the evidence Petitioner presented (waiver documents DHHS submitted to CMS at R. 891 to 893) that DHHS knew that these changes would increase by four fold the number of individuals forced into institutions to receive respite services, and that the average number of days per "respite" admission in DDSN operated ICF/MR's would increase by 50%. Id. This resulted in the cost of institutional respite services provided in the most restrictive and least integrated setting increasing more than ten fold.

VIII. Approval of CMS does not relieve DHHS and DDSN of their obligation to comply with the South Carolina Administrative Procedures Act and other statutory requirements enacted by the General Assembly. Throughout its brief, DHHS argues that it has been relieved of any obligation to comply with the Administrative Procedures Act, because the Regional Office

---

[5] This figure is based on the numbers DHHS provided to the MCAC on May 19, 2009, reporting that the total cost of the program was $242 million, with 5,700 participants. R. 850-851. However, the 2004-2009 waiver application showed the average costs per participant to be only $36,209. R. 232. Even using the higher cost per participant provided to MCAC ($42,456), it is undisputed that the annual average cost per participant increased by more than $9,400 per participant, to $51,869 in 2010, when this figure is compared to the cost contained in the waiver application DHHS filed with CMS on August 31, 2009. R. 75. This was an increase of more than 18% in the per-participant cost of waiver services during the year home-based services were reduced.

of CMS approved the application it submitted in August, 2009, and because the waiver document is many pages long and, presumably, too complicated for the General Assembly to understand. Respondent's Brief 13-24 and see waiver amendments at https://www.scdhhs.gov/historic/insideDHHS/Bureaus/BureauofLongTermCareServices/Mental%20RetardationRelated%20Disability%20Waiver.html (this is the corrected web address provided to Petitioner's counsel by counsel for DHHS). This argument ignores the fact that the ID/RD Medicaid waiver is "merely an optional tool, which states can use to provide services in the community and to save money on providing institutional care." *Peter B. v. Sanford*, Case No 6:10-cv-00767-JMC-BHH, Entry 71 at fn 6, (S.C.D.C. November 24, 2010). As Judge Bruce Howe Hendricks noted in that case:

> In other words, use of waivers is simply one way a state may meet the integration mandate of the ADA. "Medicaid can be an important resource to assist states in fulfilling their obligations under ADA. The [Home and Community-Based Services (HCBS)] waiver program in particular is a viable option for states to use to provide integrated community-based long-term care services and supports to qualified Medicaid eligible recipients." HCBS Waivers – 1915(c), at http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers-Section1915%28c%2 9.asp (last viewed Nov. 22, 2010).

Id. Judge Hendricks recognized in in *Peter B.* that "whether a service is funded by Medicaid "does not seem to absolve the defendants of their obligation to provide services to the plaintiff, which would keep in him the community as mandated by *Olmstead.*" Likewise, the fact that the State of South Carolina has the option to have the federal government pay for 70% of the cost of the services Richard's physician ordered (80% when the caps were put into place) does not in any way absolve the agencies from their duty to comply with the South Carolina Administrative Procedures Act.

Respondent's argument on page 13 that "there was no doubt for the agencies that the implementation of the waiver complied with the requirements of State law..." totally ignores the obligation the agencies have to promulgate regulations under the South Carolina Administrative Proceedings Act. Had DHHS followed the prescribed procedure and provided the General

Assembly with the required economic impact statement, Richard's legislators would have been informed that the waiver amendment reducing home-based services, as submitted in August, 2009 to CMS increased the cost of the program by more than $36 million and increased the per participant cost by more than $9,400, an increase of more than 18%. Under the waiver amendment, the pre-2010 cost of Richard's services was $14,000 less than the average waiver participant's services, when his disabilities and needs are extreme.

IX. Any "scramble" to obtain CMS approval of the waiver amendments was due to Respondent's failure to inform the General Assembly, DDSN Commissioners, local DSN Boards and the public about its plan to cap home-based services until the end of the 2009 legislative session. The public was not aware of the plan to cap home-based waiver services until after the DHHS Medical Care Advisory Committee (MCAC) voted to approve the amendments staff at DDSN and DHHS recommended on May 19, 2009. R. 831-835. On May 21, 2015, DDSN Associate Director, Kathi Lacy, informed the DDSN Commissioners that these changes were necessary "Due to budget cuts..." Id. at 833. Even the directors and county Disabilities and Special Needs Boards were kept in the dark about the scheme until just weeks before DHHS intended to file the application with CMS.[6] R. 914. Emma Forkner was the director of DHHS when the caps on home-based services were put into place. Respondent argues in its brief that Dr. Forkner's letter of June 11, 2009 shows that there was "something of a scramble" to get the waiver application to CMS, but the MCAC report at R. 855 documents that DDSN and DHHS had been secretly working on the scheme for "a number of months." Respondent's Brief at 12. Ms. Forkner's letter states that DHHS had been working with DDSN (without knowledge of

[6] Respondent claims that the public was informed at hearings, but there is no evidence in the record that any of these "hearings" were held before the MCAC voted to enact the caps. Kathi Lacy informed the MCAC that the decision about what services to cut were based on a survey sent to waiver participants. R. 856. But the "survey" is not in the record and only several hundred waiver participants supposedly responded. The results were not collected and tabulated by an independent source, but by Kathi Lacy herself who based her report on her own review of the responses, which were also not put into the record. Id.

DDSN Commissioners) since October, 2008. R. 895. The record in this case supports Petitioner's arguments that any "scramble" was due to DHHS' desire to avoid legislative review by waiting until the end of the legislative session to make its plans public.

Respondent takes issue in its brief with Petitioner's claims that the waiver amendments were enacted "without notice to or approval of the General Assembly." Respondent's Brief at 11. But, the memorandum from the director of DDSN, Eugene A. Laurent, dated June 9, 2009 documents that even the directors of the county DSN Boards and the chairmen of those Board were not informed of the plan to place caps on home-based services until after the DDSN Commissioners were informed in June, 2009 of the MCAC approval of the plan. R. 914.

It is inconceivable that no one in the General Assembly would have contacted their local DSN Board to inquire about this seismic change in the way that services are delivered, in total contradiction of the statutory requirement to provide services in the least restrictive setting, giving preference to supporting DDSN consumers in their own homes. Respondent failed to present any evidence to show that anyone in the General Assembly was notified or consulted and the timing of the announcement, at the end of the legislative session, and implementation prior to the General Assembly's return to Columbia in January, 2010 supports Petitioner's arguments. Instead of developing a mechanism for local planning, DHHS did not even inform local DSN Boards of this scheme until after it was presented to and approved by the DHHS Medical Care Advisory Committee (MCAC). R. 914. S.C. Code 44-6-40(8).

Respondent's citation on page 15 of its brief of a federal regulation issued in 2014 adds no support to its argument that its obligation to notify and involve the public was satisfied when it reduced waiver participants' home-based services in January, 2010. In any event, even if DHHS complies with this federal regulation in the future, this does not satisfy its statutory obligation to comply with the APA and to operate the program as directed by the General Assembly.

X. DDSN has violated the Separation of Powers provision of the South Carolina

Constitution by failing to use allocated funds for the purposes intended by the General Assembly. This Court has repeatedly ruled that the General Assembly "has the duty and authority to appropriate money as necessary for the operation of the agencies of government and has the right to specify the conditions under which the appropriated monies shall be spent." *Edwards v. State of South Carolina,* 678 S.E.2d 412, 416 383 S.C. 82 (2009), citing *State ex rel. McLeod v. McInnis*, 278 S.C. 307, 312, 295 S.E.2d 633, 636 (1982). In *McLeod*, this Court discussed the importance of providing a system of checks and balances that will prevent "the concentration of power in the hands of too few..." 278 S.C. at 312. The record in this case documents that power to reduce services funded by the General Assembly was illegally concentrated in the hands of a few DDSN and DHHS employees.

In *McLeod,* this Court dealt with the problem, as here, of agencies receiving and spending "not only appropriations which the legislature meant for them to have but, in addition, substantial federal contributions." Id. at 637. This Court found that: "As a result, the General Assembly was not effectively controlling departmental programs and appropriations." As in that case, DDSN has spent money inconsistently with "the right and duty of the legislature to determine the appropriations of agencies and the programs undertaken." Id. In this case, Respondent has thwarted the oversight of the General Assembly by obtaining necessary funds, then changing the rules for how those funds would be spent, in contradiction with the guiding policies and statutory directives of the General Assembly to provide services in the least restrictive setting. Importantly, in *McLeod,* this Court held that:

> Any allocation, distribution, or consolidation of federal funds between or among any approved recipients or state agencies shall only be authorized by appropriations acts passed by the General Assembly. (Emphasis added.)

Id. at 638. Federal funds must be deposited in the State Treasury and "if not in conflict with Federal regulations, and withdrawn therefrom as needed, in the same manner as that provided for the disbursement of state funds." Id at 317.

In this case, DHHS and DDSN have accepted funds allocated by the General Assembly that are intended to be leveraged with federal dollars, bringing in to the State's economy (during the stimulus years from 2008 to 2011) four dollars for each dollar invested by the State. It was a violation of the Separation of Powers doctrine for DDSN to use those funds for other purposes, losing the ability to receive the federal matching funds. Likewise, it was unconstitutional for Respondent to use funds allocated by the General Assembly that were intended to provide uncapped services to waiver participants living in their own homes for a contrary purpose, i.e. paying for services in more restrictive settings.

In *Edwards,* this Court reiterated that the General Assembly "must appropriate all federal funds" and "include any conditions on the expenditure of those funds, consistent with federal laws and regulations." Supra at 417. That is exactly what the General Assembly has done in Title 44, Chapter 6 and S.C. Regs. 126-304 and 126-425 by requiring DDSN and DHHS to provide cost-effective services in participant's homes based on their assessed individual needs, as assessed by qualified professionals to restore, maintain and promote health status. See also S.C. Code 44-6-40 and 44-6-70. To determine cost effectiveness, cost analysis is required. But, Respondent capped waiver services without performing any cost analysis and then ignored the fact that costs increased by more than $30 million.

In its brief, Respondent twists the case law, statutes and regulations with its argument that a federal bureaucrat in Atlanta has the authority to override the intent of the General Assembly by approving changes to the waiver program which violate the clear statutory directives to provide disabled persons the supports they need to remain in their own homes and to provide greater funding for services provided in congregate facilities operated by DDSN and its local boards. *Olmstead v. L.C.*, 521 U.S. 581 (1999) and S.C. Code 4-20-20. Just as the ARRA did not grant the Governor the "exclusive and unfettered discretion to accept or refuse" federal stimulus funds in *Edwards,* the executive branch here does not have that authority to use those funds in contravention of the statutory requirements established by the General Assembly. Id. 418.

Instead of providing services in the "least restrictive setting," where "surrounding circumstances provide as little intrusion and disruption from the normal pattern of living as possible," as required by S.C. Code 44-20-30(10), DDSN has, instead, forced waiver participants into ICF/MR facilities, the most restrictive setting in the DDSN system, to receive respite services when the family requires more than the caps allow.

The interpretation urged by Petitioner is "consistent with federal laws and regulations." Id. at 417. Respondents' position is not, because it violates the Americans with Disabilities Act, the directive of the United States Supreme Court in *Olmstead v. L.C.* to give the greatest of deference to the treating physician, 521 U.S. 581 (1999).

Respondent has violated the Separation of Powers provision of the South Carolina Constitution by establishing binding norms for the operation of the ID/RD Medicaid waiver program that are not consistent with the intentions of the General Assembly, without promulgating regulations, as required by the South Carolina Administrative Procedures Act. Where non-legislative bodies make such policy determinations absent delegation by the General Assembly, such policymaking "is an intrusion upon the legislative power." *Hampton v. Haley*, 403 S.C. 395, 743 S.E.2d 258, 262 (2013). In that case, the Budget and Control Board attempted to take funds allocated by the General Assembly to pay for employee health benefits to use for other purposes. Id. This Court held that an agency may "fill up the details" or laws promulgated by the General Assembly, but unless a statute gives an agency "unbridled, uncontrolled or arbitrary power," the legislature may not delegate the power to allocate funds in violation of a statute. Id. at 264. DHHS and DDSN in this case acted "beyond its statutory authority and infring[ed] upon the General Assembly's power to make policy determinations" when they declined to use the appropriate funds" for the intended purpose of providing services necessary to allow persons like Richard to remain in their homes and diverted a significant portion of those funds to increase services provided in congregate settings. Id. at 265.

XI. Respondent and the lower court misinterpreted *Arrowood.* Respondent seems to

acknowledge in its brief that *Arrowood v. North Carolina Department of Health & Human Services*, 543 S.E.2d 481 (N.C. 2001) (rev'g 535 S.E.2d 585 (N.C. Ct. App. 2000) was distinguished by *McCrann ex rel. McCrann v. Department of Health and Human Services,* 704 S.E. 899 (N.C. App. 2011). For all of the reasons discussed in Petitioner's Brief, *Arrowood* is not controlling, or even persuasive in this case. Because Richard never agreed to limit his right to receive the services his physician has determined to be medically necessary for him to remain in his own home, Arrowood is not dispositive of Richard's claims.

XII. Respondent misinterprets *Doe v. DHHS.* Respondent's argument that its decision to cap services is entitled to "due respect and consideration" because it "was not contrary to any State statute or regulations" ignores the statutes at Chapters 20 and 21 of Title 44 that Respondent is obligated to follow. Respondent's Brief at 20. See also Respondent's Brief at 13. Respondent argues that federal law, this Court's decision in *Doe v. SCDHHS*, 398 S.C. 62, 727 S.E.2d 605 (2011) and DHHS regulation at S.C. Code R. 126-300(D) "provide authority" that allows DDSN and DHHS to shift funds and to impose binding norms capping services without promulgating regulations, as required by the South Carolina Administrative Procedures Act (APA). Respondent's Brief at 14-16. But, on page 15 of its brief, Respondent ignores this Court's warning in *Doe v. DHHS* that reads as follows:

> In accordance with our statutory law, we hold an agency guideline *does not have the force of law,* and in any event, can never trump a regulation. Our law provides that a "[r]egulation" means each agency statement of general public applicability that implements or prescribes law or policy or practice requirements of any agency. *Policy or guidance issued by an agency other than in a regulation does not have the force or effect of law.* S.C.Code Ann. § 1-23-10(4) (2005) (emphasis added). Thus, because the age-eighteen-onset requirement found in DDSN's policy guidelines has not been formally adopted as a regulation, it does not have the force and effect of law *and is entitled to no deference. (Emphasis added.)*

Doe v. S. Carolina Dep't of Health & Human Servs., 398 S.C. 62, fn 7, 727 S.E.2d 605 (S.C. 2011). Respondent is absolutely correct on page 14 of its brief that the statutes, regulations and caselaw cited in the brief "contemplate that Department will further specify the limits and procedural requirements of the Program." But, Respondent's argument that it may specify

binding limits without promulgating regulations is totally unsupported by this Court's directive in Doe, as well as the clear and unambiguous requirements of the South Carolina Administrative Procedures Act at S.C. Code 1-23-10(4). The APA contains a clearly established path DHHS and DDSN must take to "specify limits and procedural requirements" of the ID/RD Medicaid waiver program which Respondent has failed to follow.

As a "creature of statute," Respondent and DDSN are "possessed of only those powers expressly conferred or necessarily implied for it to effectively fulfill the duties with which it is charged." *Captain's Quarters Motor Inn, Inc. v. South Carolina Coastal Council*, 413 S.E.2d 13, 306 S.C. 488 (S.C., 1991). As in *Captain's Quarters,* the state agency "overstepped its statutory authority" by imposing binding norms without "formalizing" them by promulgating regulations. Id. Had the General Assembly intended to exempt DHHS from the obligation to promulgate regulations as set forth in the Administrative Procedures Act, it would have listed DHHS and DDSN in the specific list of exempt entities, which include policy statements of local school boards and rules related to penal institutions, which do not have to be promulgated as regulations to have the force and effect of law. Id. But, this list of exemptions does not include the actions by DHHS that are at issue in this case. If the General Assembly had intended to allow a state agency to change the law by simply securing permission of a federal official to limit medically necessary services, it could easily have included rules established by DHHS in the administration of the Medicaid program in these exemptions. But the APA contains no such exemption and, without an exemption in the statute, DHHS is obligated to promulgate the waiver amendments as regulations in order for them to be binding, because the caps and other changes are contrary to the statutes and regulations established by the General Assembly related to the delivery of DDSN services to disabled persons. Respondent's apparent misunderstanding of that ruling demonstrates why it is important for this Court to issue an order DHHS can understand that clearly prohibits the agency from enforcing rules that deny medically necessary treatment ordered by licensed physicians without promulgating those rules as regulations. Respondent's Brief at 15.

The APA contains specific steps all state agencies must follow to promulgate binding rules as regulations.[7] S.C. Code 1-23-10 et. seq. For nearly three decades, DDSN has stubbornly ignored the APA, resulting in not only unimaginable human suffering, but audits show that its arbitrary and capricious administration of the Medicaid waiver programs has also resulted in a tremendous waste of taxpayer dollars. Respondent has not disputed Petitioner's claims that when it established caps and other limitations on home-based services, the cost per waiver participant increased from approximately $42,000 per year (according to MCAC report) to more than $51,000 per year. R. 75. As discussed above, the cost of the program actually increased by tens of millions of dollars. This is exactly the type of unfettered abuse of authority and recklessness with taxpayer funds that the General Assembly intended to prevent by enacting the APA.

Respondent's argument that DHHS and DDSN are not obligated to comply with the South Carolina Administrative Procedures Act because CMS approved the changes misses the point of the APA and it is clearly without merit. Respondent's Brief at 14. No one has suggested that DHHS cannot prepare and submit contracts to CMS. Certainly they can. But, no federal law would be violated by complying with the APA. Thus, the argument that the State can simply ignore those clear and unambiguous statutory requirements in the APA, as well as this Court's directive in *Doe v. DHHS* should be soundly rejected by this Court.

XIII. Requiring DHHS to promulgate regulations does not conflict with its responsibility to prepare a State Medicaid Plan. No one is challenging here that the General Assembly has "unequivocably authorized the Department to prepare a State Plan for the Medicaid Program." Respondent's Brief at 19. That is the primary purpose of DHHS. But, the General Assembly did not grant DHHS or DDSN the unfettered authority to administer the program without regard to

[7] DHHS claims that it held public hearings, but these hearings were held around the state only to inform the public after the decision was made to place arbitrary caps on services. Respondent's reliance on a federal regulation that was issued in 2014 cannot be used to justify its failure to comply with state notice requirements, through compliance with the ADA, in 2010. Respondent's Brief at 15.

the plain language of the APA and Chapters 6 and 20 of Title 44 of the South Carolina Code of Laws. S.C. Code of Laws 44-6-730 provides that DHHS (formerly the State Health and Human Services Finance Commission):

> ...shall promulgate regulations as are necessary for the implementation of this article and as are necessary to comply with federal law. (Emphasis added.)

That section requires DHHS to amend the State Medicaid Plan "in a manner that is consistent with this article."The enabling legislation that established DHHS requires services to be provided cost effectively (S.C. Code 44-6-40(3)(a) and (b)) and it requires DHHS to promulgate "criteria, standards, and procedures that ensure assigned programs are administered effectively, equitably, and economically, in accordance with statewide policies and priorities" (Id. at item (5)). Likewise, the General Assembly unambiguously directed DDSN, in S.C. Code 44-20-220, to promulgate regulations:

> The commission *shall* determine the policy and promulgate regulations governing the operation of the department... (emphasis added).

This statute is mandatory, not precatory. In promulgating regulations, the General Assembly required DDSN to consult with the Advisory Committees that section authorized it to appoint. Id.

XIV. CMS authorization cannot override the mandate of the United States Supreme Court in *Olmstead v. L.C.* requiring the State to give the greatest deference to the opinions of the treating physician. Undoubtedly, the General Assembly contemplated that Respondent and DDSN would further specify limits and procedural requirements for the waiver program. Respondent's Brief at 14. But, by imposing arbitrary caps on home-based services, DHHS has established a "one size fits all" limit that not only violates the ADA, but it fails to take into consideration the severity of waiver participant's disability and the medical necessity for services, as determined by the treating physician. In *Olmstead v. L.C.,* Justice Kennedy wrote in his concurring opinion that "The opinion of a responsible treating physician in determining the

appropriate conditions for treatment ought to be given the greatest of deference."527 U.S. 581, 610 (1999)(Kennedy concurrence.) The Kennedy concurrence in *Olmstead* follows the Supreme Court's holding in *Youngberg v. Romeo,* where the Court recognized the need to give deference to the judgment of treating professionals in determining the appropriateness of care. 457 U.S. 307 (1982).

The General Assembly directed in S.C. Code 44-20-410 that "The appropriate services and programs must be determined by the evaluation and assessment of the needs, interests, and goals of the client. And S.C. Reg. 126-300(A) provides that "Clients eligible for Medicaid may obtain medically necessary services from providers enrolled in the program." By establishing binding and arbitrary caps on waiver services, DHHS has violated this statute and regulation.

As Justice Hearn noted in her dissent in *Doe v. DHHS*, weight must be given to the opinion of the treating physician's opinion and "if a treating physician's diagnosis has not been called into question or there are no competing diagnoses, not giving it controlling weight may be arbitrary and an abuse of discretion." *Doe v. DHHS*, 727 SE 2d 615, fn 16 (2011). But that has been exactly how DHHS has determined whether services will be authorized in fair hearings. *See B.W. v. DHHS*, Final Administrative Order, Appeals Case ALJ 07-MISC-28 (DHHS Hearing Officer Hutto, November 19, 2013). Order may be viewed at Record on Appeal, page 14 at http://ctrack.sccourts.org/public/caseView.do?csIID=55254.

CMS approval of waiver service caps simply cannot override the mandate of the United States Supreme Court requiring the agency to give deference to the opinion of the Medicaid participant's treating physician. Until DHHS and DDSN actually promulgate enforceable regulations establishing criteria that is rationally related to the waiver program's objectives and uses objective evidence, clinical observation and reliable and valid assessments of medical necessity, the door will be left open for Respondent and DDSN to simply replace one arbitrary standard with another. As in *Myers v. DHHS*, the agency would be able to have a person with no training in medicine or license to lose to conduct an illusory "assessment" finding that the

number of hours allowed by the caps is sufficient. See appeal pending in the South Carolina Court of Appeals in Case No. 2014-000418 at http://ctrack.sccourts.org/public/caseView.do?csIID=56069.

The Court should order DHHS and DDSN to promulgate regulations that specify the weight that must be given to the opinions of the treating physician in keeping with the mandate in *Olmstead* and require, as Justice Hearn has suggested that the opinion of a treating physician may only be overridden by evidence presented by another qualified physician.

XV. Conclusion. Petitioner prays that this Court will reverse the decision of the lower court by ruling that Respondent violated the Administrative Procedures Act when it established and enforced binding norms without promulgating regulations. Pursuant to 42 C.F.R. 431.250, federal matching funds (FMAP) may be claimed for expenditures incurred by a state to carry out hearing decisions and for services provided within the scope of the Federal Medicaid program and made under a court order, as well as to extend the benefit of a hearing decision or court order to individuals in the same situation as those directly affected by the decision or order.

It is respectfully requested that this Court order Respondent to provide the services ordered by Richard's treating physician until Respondent comes into full compliance with the APA. Richard requests an order finding that Respondent has not been substantially justified in denying services ordered by Richard's physician and failing to obtain an assessment by a qualified physician for more than six years. He requests an award of legal fees and costs, with instructions for determining how these fees and costs will be determined.

Respectfully submitted,

Patricia Logan Harrison
611 Holly Street
Columbia, South Carolina 29205
plh.cola@att.net
803 360 5555
Attorney for Petitioner

June 13, 2015

RECEIVED
JUL 16 2015
S.C. Supreme Court

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 *Reply 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 July13, 2015.

John N. Harrison
Law Office of Patricia Logan Harrison
611 Holly St.
Columbia, SC 29205
803-256-2017