

THE STATE OF SOUTH CAROLINA
In the Supreme Court

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

S.C. Supreme Court

Richard Stogsdill,.....Petitioner,

v.

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

Second Corrected Volume IV
Orders and Briefs

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IN STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT
Carolyn C. Matthews, Administrative Law Judge

Case # 10-ALJ-08-0774-AP

Stogsdill, Richard

Appellant

v.

South Carolina Department of Health and Human Services,

Respondent

BRIEF OF AMICI CURIAE

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INTEREST OF AMICI CURIAE¹

Protection and Advocacy for People with Disabilities, Inc., the South Carolina Chapter of the National Academy of Elder Law Attorneys, South Carolina Legal Services, and South Carolina Appleseed Legal Justice Center respectfully submit this brief as amici curiae on questions of law, under the Americans with Disabilities Act (ADA),² the South Carolina Administrative Procedures Act, and state and federal case law, relevant this appeal.

Protection and Advocacy for People with Disabilities, Inc. (P&A) is a statewide, nonprofit advocacy organization whose purpose is to promote the legal, civil, and human rights of people with disabilities.³ The State of South Carolina has designated P&A to serve as the federally-mandated Protection and Advocacy System for South Carolina. S.C. Code Ann. § 43-33-310 to 43-33-400 (1976 & Supp. 2013). As such, P&A is authorized by federal and state law to enforce the civil rights of people with disabilities and is specifically charged with protecting and advocating for the rights of people with developmental disabilities. Developmental Disabilities Assistance and Bill of Rights Act of 2000, 42 U.S.C. §§ 15001 to 15009. Under state law, P&A has the power and the duty to advocate for the rights of people with disabilities by "pursuing legal, administrative, and other appropriate remedies." S.C. Code Ann. § 43-33-350(1) (Supp. 2013). P&A assists individuals with disabilities who experience discrimination as a result of a disability, or who are illegally denied needed services by a program or agency. The goals

¹ Pursuant to Rule 213, SCACR, this brief is conditionally filed and accompanied by a motion for leave to file the brief.

² A glossary of acronyms relevant to this case is provided at the conclusion of this brief for the Court's convenience.

³ Additional information regarding the work of P&A is available at <http://pandasc.org/>.

of P&A include increasing public knowledge about the rights of people with disabilities and participating in litigation affecting the legal rights and status of people with disabilities. P&A has participated as amicus curiae in cases before South Carolina appellate courts and the United States District Court for the District of South Carolina. E.g., *Singleton v. State*, 313 S.C. 75, 437 S.E.2d 53 (1993); *Clemson Univ. v. Speth*, 344 S.C. 310, 543 S.E.2d 572 (Ct. App. 2001). More specifically, P&A has participated as amicus curiae in two cases addressing the 2010 cuts at issue in this case. *Peter B. v. Sanford*, 6:10-CV-767 (D.S.C. Feb 1, 2011)(order granting preliminary injunction preventing the implementation of the reductions in services; not reported); *Karen W. v. Sanford*, Petition in the Original Jurisdiction of the South Carolina Supreme Court (Petition Denied December 31, 2009).

Many P&A clients receive services through the Intellectual Disabilities/Related Disabilities (ID/RD) waiver. The ID/RD waiver is administered as part of the Medicaid program by the single state Medicaid agency, the South Carolina Department of Health and Human Services (SCDHHS). The South Carolina Department of Disabilities and Special Needs (SCDDSN) oversees the day to day operation of the waiver. See generally *Doe v. Kidd*, 501 F.3d 348 (4th Cir. 2007). Reductions to these waiver services are at issue in this case. P&A represents many individuals who need appropriate services to enable them to live in the community. P&A is committed to ensuring that the principles of the Americans with Disabilities Act (ADA), as interpreted in *Olmstead v. L.C.*, 527 U.S. 538 (1999), are followed in the state's implementation of Medicaid waivers.

South Carolina Chapter of the National Academy of Elder Law Attorneys (SCNAELA) is a state chapter of the National Academy of Elder Law Attorneys

(NAELA).⁴ SCNAELA is an education and advocacy organization. Members of SCNAELA are South Carolina attorneys who practice in the area of elder law, which includes advocacy for people who are elderly and people who are disabled. The mission of SCNAELA is to educate and assist attorneys in providing advocacy, guidance and services to enhance the lives of people as they age as well as individuals with special needs. SCNAELA has, as the organization has evolved, an increasing emphasis on institutional, as well as individual, advocacy for people with disabilities, regardless of age, with particular emphasis on access to government benefits and services that are essential to achieving as much dignity and independence as possible.

South Carolina Legal Services (SCLS) is a non-profit statewide law firm providing legal assistance in a wide variety of civil legal matters to eligible low income residents of South Carolina.⁵ SCLS is the sole federally funded Legal Services Corporation grantee in South Carolina and receives additional funding from a variety of sources, including the South Carolina Bar Foundation, local United Ways, state court filing fees, and other federal, state and local funding. SCLS' mission is to protect the rights and represent the interests of low income South Carolinians. Among SCLS' priorities are representing low income individuals in Medicaid cases involving home and community based services.

South Carolina Appleseed Legal Justice Center (Appleseed) is a non-profit organization, based in Columbia, South Carolina, and loosely affiliated with 14 other public interest justice centers in the Appleseed network within the United States. The

⁴ Additional information regarding the activities of the SCNAELA is available at <https://www.naela.org/>.

mission of Appleseed is to identify and examine social injustice, make recommendations, and advocate for effective solutions. Appleseed has served a wide range of needs for the low-income community in South Carolina for the past 25 years through legal work, economic development, social legislation, and public and legal education. As an advocate for low-income South Carolinians, Appleseed has an interest in the present case based on the methods employed by SCDDSN to cut Medicaid services, which could be employed to cut services to low-income South Carolinians as well as disabled individuals. Further SC Appleseed is concerned with any state agency circumventing the South Carolina Administrative Procedures Act by establishing binding norms without going through the proper regulatory process. SCDHHS has attempted to implement a hard and fast rule regarding a public benefit without following the rule making procedures required to promulgate regulations. Allowing state agencies to cut services in a manner inconsistent with state and federal law could have a very negative impact on the low income community in South Carolina.

BACKGROUND

SCDDSN provides services to individuals with intellectual disabilities, related disabilities, autism, head injuries, and spinal cord injuries. S.C. Code Ann. § 44-20-10 to 44-20-510 (Supp. 2013). The vast majority of SCDDSN's funding derives from the federal Medicaid⁶ program, passed through to SCDDSN from the state Medicaid agency, SCDHHS. Medicaid funds are used to provide health care to those in poverty or with exceptional health care needs, including services to individuals requiring long-term care.

⁵ Additional information regarding the work of SCLS is available at <http://www.sclegal.org/>.

Medicaid funded long-term care may be provided either in institutions or in the community. *See generally* 42 U.S.C. §§ 1396a, *amended by* Pub. L. No. 113-67, 127 Stat. 1165 (2013); 1396n(c). Because some conditions of federal Medicaid law are waived in order to provide certain groups of people with disabilities services in the community rather than in institutions, these programs have been historically referred to as “waivers.” *See generally Doe v. Kidd*, 501 F.3d 348 (4th Cir. 2007). Using Medicaid funds for waiver services, rather than for institutional care, prevents unjustified institutional isolation of persons with disabilities in compliance with the Americans with Disabilities Act (ADA) and the United States Supreme Court’s landmark decision in *Olmstead v. L.C.* 527 U.S. 581 (1999). Waivers must be designed so that services in the community are cost neutral compared with institutional care, but such services are typically much less expensive than care in an institution. *See* 42 U.S.C. § 1396n(c); *Fisher v. Oklahoma Health Care Auth.*, 335 F.3d 1175, 1178 (10th Cir. 2003).

SCDDSN provides for the day to day operation the 1915(c)⁷ Medicaid waiver relevant to this action, the ID/RD waiver. However, SCDHHS remains the single state Medicaid agency responsible for the Medicaid program. *See* S.C. Code Ann. § 44-6-30(1) (Supp. 2013); 42 C.F.R. § 431.10(a), (e).

The Appellant is a participant in the ID/RD waiver. The ID/RD waiver is for persons who (1) have an intellectual disability (mental retardation) or a related disability, (2) are eligible for Medicaid, (3) meet level of care for an Intermediate Care Facility for

⁶ Medicaid is a joint federal and state program. *See Doe v. Kidd*, 501 F.3d 348, 351 (4th Cir. 2007).

⁷ States may operate a variety of Medicaid waivers. The ID/RD waiver is a 1915(c) waiver, named after the section of the Medicaid act that created it. Social Security Act, § 1915(c), as amended, 42 U.S.C. § 1396n(c).

Intellectually Disabled (ICF/ID), and (4) who need home and community based services in order to live in the community. *See generally* DDSN ID/RD Waiver Manual, Chap.

1.⁸ All individuals on the waiver must meet a level of care that is similar to that required to receive services in a nursing home. *Doe v. Kidd*, 501 F.3d at 351.⁹ In other words, individuals on the waiver have significant deficits and need significant assistance similar to the needs of individuals in institutions.

In late 2009, SCDHHS sought and received the approval of the United States Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS) to amend the ID/RD waiver to limit or cap certain services. R. 940. The amended waiver places a service use cap or flat cap on the number of hours an individual can receive of particular services: Personal Care I and II, Adult Attendant Care, Adult Companion Care, Nursing, and In-Home Respite Services.¹⁰ R. 117 (from the Report and Recommendation of the Magistrate Judge in United States District Court, District of

⁸ The Waiver Manual is available at http://www.ddsn.sc.gov/providers/medicaidwaiverservices/mrrd/Documents/Default/MR_RD%20Waiver%20Manual%20Chapter%201-%20What%20is%20a%20Waiver.pdf (last viewed Feb. 12, 2014).

⁹ The Fourth Circuit describes the level of care as being like that of a nursing home, but technically the level of care that must be met is Intermediate Care Facility for Intellectually Disabled or ICF/ID.

¹⁰ Specifically, Personal Care II, Adult Attendant Care, and Adult Companion Care are capped at a maximum of 28 hours per week (the waiver participant may use a combination or a single service, but the single service or combination cannot exceed 28 hours per week); Personal Care I is capped at 6 hours per week; Nursing is capped at 56 hours per week or 42 hours per week depending upon whether an licensed practical nurse (LPN) or registered nurse (RN) provides the service; and in-home respite is capped at 68 hours per month, with some exceptions. The waiver document provides that the respite cap may be exceeded for individuals requiring extraordinary care in order to remain in the community. ID/RD Waiver Manual, Chap. 10, Adult Attendant Care Services, Adult Companion Services, Personal Care Services, Respite Care, Nursing Services available at <http://ddsn.sc.gov/providers/medicaidwaiverservices/mrrd/Pages/default.aspx> (last viewed Feb. 14, 2014).

South Carolina, *Peter B. v. Sanford*, 6:10-CV-767 (D.S.C. Feb. 1, 2011)). These services provide care to address the needs of individuals who live in their own homes or the home of a family member or friend. Only the waivers for which SCDDSN provides the day to day operation were amended to place caps on personal care. The Community Choices waiver, which provides services to people who are elderly or who are disabled, operated by SCDHHS does not cap personal care services. The amount of personal care provided under that waiver is based upon the participant's need for the service. *See generally* Community Choices Waiver Application, Appendix C: Participant Services; C-1/C-3 Service Specification; Service-Personal Care (listing no limits on amount, frequency, or duration of the service).¹¹

Any individual on the ID/RD waiver will have a set of identified and documented health and safety needs, and a plan of care that addresses how those needs are to be met through services or interventions. *See* ID/RD Waiver Manual, Chap. 1, p. 3 ("Upon enrollment, approved providers may be authorized to render the needed services that are indicated on the participant's Support Plan [or plan of care] and included in his/her approved waiver budget").¹² An example of a health-oriented need is continued support with personal care tasks like brushing teeth. The person to support this need would be a caregiver working for a qualified personal care provider; the caregiver would either perform the task or help with it. The cost of this service is \$14.80 per hour. R. 243.

¹¹ Community Choices Waiver Application available at [https://www.scdhhs.gov/internet/pdf/Application%20for%201915\(c\)%20HCBS%20Waiver%20SC_00405_R02_00%20-%20Jul%2001,%202011.htm](https://www.scdhhs.gov/internet/pdf/Application%20for%201915(c)%20HCBS%20Waiver%20SC_00405_R02_00%20-%20Jul%2001,%202011.htm) (last viewed Feb. 12, 2014).

¹² ID/RD Waiver Manual, Chap. 1 available at http://ddsn.sc.gov/providers/medicaidwaiverservices/mrrd/Documents/Default/MR_RD%20Waiver%20Manual%20Chapter%201-%20What%20is%20a%20Waiver.pdf (last viewed Feb. 12, 2014). Appellant's annual budget is \$37,364.45. R. 243.

Also, any service, including personal care, provided through the waiver must be provided in accordance with a written plan of care. 42 C.F.R. § 441.301(b)(1)(i), *amended by* 79 Fed. Reg. 3029 (Jan. 16, 2014, effective Mar. 17, 2014).

In addition to addressing needs and goals, development of an individual's plan of care also involves determining the amount, duration, and scope of services that are necessary. 42 C.F.R. § 440.230. Personal care needs, the subject of this appeal, are generally objective and quantifiable. Even individuals who do not have a disability must spend a certain amount of time on activities of daily living like brushing teeth, bathing, preparing and consuming meals, cleaning clothes, maintaining living space, etc. See generally, ID/RD Waiver Manual, Chap. 10, Personal Care Services.¹³ For individuals, whether assistance with these activities is needed or not, the amount of time and effort expended to accomplish these tasks by the individuals or their caregivers is a fairly consistent and determinate amount. Further, failure to accomplish these activities can place an individual's health and safety at risk. Depending upon the activity and the individual's health, an individual may deteriorate if personal care needs are not met. The failure to provide for an individual's needs in the community may lead to unjustified isolation of the individual in an institution in violation of the Americans with Disabilities Act as interpreted by *Olmstead v. L.C.* 527 U.S. 581 (1999); see 42 U.S.C. § 12132.

¹³ Available at <http://www.ddsn.sc.gov/providers/medicaidwaiverservices/mtrd/Documents/Default/MR-RD%20Waiver%20Manual%20Chapter%2010%20%28Personal%20Care%20Services%29.pdf> (last viewed on Feb. 12, 2014).

STATEMENT OF FACTS

Appellant receives services through the ID/RD waiver because he has cerebral palsy, a related disability. Appellant is a young man who lives in an apartment next to his parents' home. R. 923. Appellant uses a wheelchair and can move his wheelchair with a joy stick, but he cannot get in and out of his wheelchair without assistance. He requires total assistance with all activities of daily living, including bathing, dressing, toileting, preparing food, housekeeping, and he requires two individuals to assist him getting in or out of his wheelchair and to supervise his gait training.¹⁴ R. 920. Appellant also requires assistance to prevent isolation, namely to attend community events and volunteer activities. R. 923. Appellant's disabilities are not intellectual, but physical; he also has been experiencing anxiety and depression as a result of stress over his physical limitations. R. 917-918. As determined by SCDDSN, Appellant's needs are exceptional. R. 282-283, 335, 158 (showing that Appellant met the requirement for the respite exception to the 68 hour cap on respite services). SCDDSN has determined the Appellant has "a serious medical condition resulting in substantial physical impairment or disability requiring comprehensive care management defined as extensive hand-on assistance or total care on a routine basis," and he needs extraordinary supervision and observation or "frequent and/or life saving administration of specialized treatments." R. 164.¹⁵

¹⁴ The Appellant used affidavits for proof in the fair hearing due to witnesses being unavailable. Respondent waived any objection to the use of these affidavits and did not present contrary evidence to what was contained in the affidavits. R. 268.

¹⁵ Also, available at ID/RD Waiver Manual, Chap. 10, Respite Care available at <http://ddsn.sc.gov/providers/medicaidwaiverservices/mrrd/Documents/Default/Chapter10R.pdf> (last viewed Feb. 12, 2014).

This appeal involves three different determinations for the amount, duration, and scope of services for Appellant:

1. **The level of services Appellant's treating physician recommends for him based upon his needs.** Appellant has never received this level of services. Appellant's treating physician recommends the following:

- Per week recommended by treating physician: 56 hours per week of personal care services from two caregivers totaling 112 hours per week of personal care services. In addition to the personal care services, Appellant's treating physician recommended 25 hours per week of companion services.¹⁶ R. 921. Appellant's doctor recognized that one caregiver acting alone could not provide the assistance with transfer and toileting needed by the Appellant to prevent regression and decubitus ulcers. R. 920.
- Per week total: 81 hours of care (137 total hours funded)
- Per day total: 13 hours on weekdays and 8 on weekends.

2. **The level of services SCDDSN assessed Appellant as needing and authorized him to receive.** Appellant has been receiving this level of services at least since 2009. Upon information and belief, Appellant continues to receive this level of services by agreement.

- Per week assessed by SCDDSN in 2009: 54 hours per week of personal care, 15 hours per week of companion services, and 36 hours per week of respite. R. 335. However, the 54 hours results

in only 26 hours of care from two personal care attendants. *See* R.

920.

- Per week total: 105 hours per week.

- Per day total: 15 hours per day.

3. The level of services SCDDSN will impose upon Appellant pursuant to service limits affecting all ID/RD waiver participants and increased respite hours.

- Per week amount pursuant to the caps: 28 hours combined of personal care and companion. 39 hours of respite.¹⁷ R. 335.

However, the 28 hours of personal care results in only 14 hours of care from two personal care attendants. *See* R. 920.

- Per week total: 67 hours of care.

- Per day total: 9.5 hours of care.

In early 2009, Appellant appealed the SCDDSN assessment of his needs because he disagreed with the assessment, which only provided 54 hours of personal care and 15 hours of companion (Number 2 above) and did not take into account his need for two caregivers to work with him. He contended that he needed additional services and that in performing the assessment, SCDDSN had not considered the opinion of his treating physician nor information regarding his well-being provided by family and caregivers

¹⁶ Appellant's physician did not make a recommendation for respite, but presumably some respite would be necessary to give his parents a break from providing care.

¹⁷ Appellant requested 228 hours per month of respite. R. 162. Only 172 hours per month were approved. R. 167. Converting per month hours into weekly hours uses the following formula: $172 \text{ (hours)} \times 12 \text{ (months)} = 2064 \text{ yearly hours}$. $2064 \text{ (hours)} / 52 \text{ (weeks)} = 39 \text{ hours of care per week}$. The increase in respite is 3 hours per week.

(Number 1 above). R. 33-35. Appellant had a hearing on the merits on June 29, 2009.

R. 31. On November 16, 2009, the SCDHHS Hearing Officer ordered the case remanded on the issue of personal care and companion services with regard to those services "for the remainder of 2009." R. 41. In the November decision, the SCDHHS Hearing Officer required SCDDSN to take into consideration an affidavit of Appellant's treating physician about the medical necessity for additional personal care hours and statements from Appellant and his family. R. 41. No such reevaluation is in the record and presumably did not occur. As in January 1, 2010, the Appellant was still receiving the same number of hours he had been receiving in 2009. R. 21.

If the reduction to his services is implemented, Appellant will receive only 67 hours of care per week, rather than the current 105 hours. SCDDSN will reduce his care by more than 5 hours per day. Prior to this current appeal, Appellant's treating physician had determined he needed 105 hours of care per week to live safely in the community, a SCDHHS hearing officer had remanded the issue of the number of hours to SCDDSN to take into account the affidavit of Appellant's treating physician, and SCDDSN had determined that Appellant was medically complex, requiring total care and extraordinary supervision and observation. R. 164 (respite exception criteria approved by SCDDSN on R. 167.). However, because of the arbitrary implementation of an "across the board" flat cap on services, the Respondent plans to reduce Appellant's overall hours of care by 38 hours per week, approximately five hours per day.

ARGUMENT

I. The arbitrary caps on community based services violate the ADA when the cuts place vulnerable citizens at serious risk of institutionalization.

Title II of the Americans with Disabilities Act of 1990 (ADA), prohibits discrimination against individuals with disabilities. 42 U.S.C. § 12132. “[N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.” 42 U.S.C. § 12132; 28 C.F.R. § 35.130(a). In order to implement the ADA, Congress granted the Department of Justice (DOJ) the authority to promulgate regulations. 42 U.S.C. § 12134(a). The ADA does not require a state or other public entity to provide any particular type of program, but for any program the state does provide, individuals with disabilities cannot be denied access to that program due to their disabilities. *See* 42 U.S.C. § 12132; 28 C.F.R. § 35.130(a).

In order to allow access to programs and services, the public entity “shall make reasonable modifications in policies, practices, or procedures . . . unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.” 28 C.F.R. § 35.130(b)(7). The requirement to make reasonable modifications includes programs which provide services, like personal care. Public entities must make reasonable modifications in order to administer services “in the most integrated setting appropriate to the needs of qualified individuals with disabilities.” 28 C.F.R. § 35.130(d) (the “integration mandate”). The most integrated setting appropriate is defined as “a setting that enables individuals with disabilities to interact

with non-disabled persons to the fullest extent possible.” *Olmstead v. L.C.*, 527 U.S. at 592 (citing 28 C.F.R. pt. 35, App. A. p. 450 (1998), redesignated App. B at 75 F.R. 56164-01). “Unjustified isolation . . . is properly regarded as discrimination based on disability.” *Olmstead v. L.C.*, 527 U.S. at 597.

In *Olmstead v. L.C.*, the United States Supreme Court interpreted the ADA and the integration mandate, ruling in favor of individuals seeking to reside in the community, rather than in a segregated facility. 527 U.S. 581 (1999) (citing 42 U.S.C. § 12101(a)(2)). The Court reviewed the Preamble of the ADA and Congressional findings, including the finding that “society has tended to isolate and segregate individuals with disabilities” and that the issue continues to be a “serious and pervasive social problem.” *Id.* at 588 (quoting 42 U.S.C. § 12101(a)(2)). The Court held that the integration mandate of the ADA governed the plaintiffs’ claims. *Id.*

States are required to provide community-based treatment for persons with mental disabilities when the State’s treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities.

Id. at 607.¹⁸

While *Olmstead* involved individuals living in an institution and seeking community based services, much of the recent case law applying the *Olmstead* decision

¹⁸ In addition to the federal right to receive services in the community, South Carolina citizens with developmental disabilities have a right “to receive [the] least restrictive appropriate care and habilitation available.” S.C. Code Ann. § 44-26-140 (Supp. 2013). “No client may remain at a level of care that is more restrictive than is warranted to meet his need, if alternative care is available.” *Id.* at (D). More specifically, clients are to move from more structured to less structured living, from segregated settings to integrated settings, and from dependence to independence. *Id.*

and enforcing the integration mandate has held that a policy or practice of a public entity may violate the integration mandate even if the policy has “not resulted in the actual institutionalization” of a person with a disability. *Pashby v. Delia*, 709 F.3d 307, 321 (4th Cir. 2013). Like this appeal, much of the recent case law involves a reduction in a service an individual is relying upon to remain in the community. The courts have consistently found that such reductions will violate the ADA’s integration mandated if they place the individual at serious risk of being institutionalized. Also, these decisions hold the public entities to closer scrutiny than in cases involving requests for new programs and services needed to assist individuals in getting out of institutional programs. See e.g. *Pashby*, 709 F.3d 307 (reduction in personal care services); *M.R. v. Dreyfus*, 663 F.3d 1100 (9th Cir. 2011), modified by 697 F.3d 706 (9th Cir. 2012) (modified in an order denying petition for rehearing and petition for rehearing *en banc*) (reduction in the amount of in-home personal care services); *Fisher v. Oklahoma Health Care Auth.*, 335 F.3d 1175 (10th Cir. 2003) (imposition of a cap on prescription medication). But see *Arc of Wash. St. Inc. v. Braddock*, 427 F.3d 615 (9th Cir. 2005) (Plaintiffs claimed the ADA required Washington to increase the size of its Home and Community Based Services (HCBS) program to allow additional individuals to qualify for HCBS.)

For example, the Fourth Circuit recently upheld the North Carolina District Court’s grant of a preliminary injunction in a proposed class action case involving the reduction of Medicaid funded personal care services. In *Pashby*, the North Carolina General Assembly had voted to “impose stricter eligibility requirements for in-home personal care services (PCS), an optional Medicaid program that assists disabled adults

with daily tasks such as eating and bathing.” 709 F.3d at 313. The change meant that the Plaintiffs would lose personal care services they had depended upon to live in the community. The Fourth Circuit found that the plaintiffs were likely to succeed on the merits of the case, even though none of them had been forced into an institution due to the reduction in the services. The court was persuaded by the Department of Justice’s determination that “the ADA and the *Olmstead* decision extend to persons at serious risk of institutionalization or segregation and are not limited to individuals currently in institutional or other segregated settings.” *Id.* at 322 (quoting DOJ Statement of Interest). “In sum, individuals who must enter institutions to obtain Medicaid services for which they qualify may be able to raise successful Title II [ADA] . . . [claims] because they face a risk of institutionalization.” *Id.*

The *Pashby* court went on to explain the type of evidence which would support a finding that an individual is at serious risk of institutionalization in violation of the ADA:

Recipients and individuals familiar with the [plaintiffs’] needs made declarations regarding the [Personal Care Services (PCS)] Recipients’ in-home care requirements. These declarants stated that the PCS Recipients could not live on their own without in-home PCS or that it would be unsafe for them to do so. Each of these declarants also attested that the PCS Recipients had no friends or family members who could offer the same amount of care that their aides provided under the in-home PCS program. Finally, the declarations indicate that all but two of the PCS Recipients “may,” “might,” “probably” would, or were “likely” to enter an [Adult Care Home (ACD)] facility due to the termination of their in-home PCS. . . . These declarations demonstrate that the PCS Recipients face a significant risk of institutionalization due to the termination of their in-home PCS

Id. The Fourth Circuit upheld the district court’s order of a preliminary injunction finding the plaintiffs were likely to succeed on the merits of their ADA claim.

In Washington State, Medicaid beneficiaries appealed the denial of a motion for a preliminary injunction to the Ninth Circuit. *M.R. v. Dreyfus*, 663 F.3d 1100 (9th Cir. 2011) *modified by* 697 F.3d 706 (9th Cir. 2012) (slightly modified in an order denying petition for rehearing and petition for rehearing *en banc*). As in North Carolina, the Washington case involved a reduction in personal care services. The district court held that in order for the plaintiffs to state a violation of the ADA's integration mandate, they were required to show the "State's action leaves them no choice but to submit to institutional care" *Id.* at 1116. The Court held that "[a]n ADA plaintiff need not show that institutionalization is 'inevitable' or that she has 'no choice' but to submit to institutional care in order to state a violation of the integration mandate. Rather, a plaintiff need only show that the challenged state action creates a serious risk of institutionalization." *Id.* The court was persuaded by the DOJ's statement of interest which noted that "[t]he elimination of services that have enabled Plaintiffs to remain in the community violates the ADA, regardless of whether it causes them to enter an institution immediately, or whether it causes them to decline in health over time and eventually enter an institution in order to seek necessary care." *Id.* at 1117.

The Seventh Circuit has held that a cap on the amount of hours of private duty nursing could potentially violate the integration mandate, even though CMS had approved the cap. *Radaszewski v. Maram*, 383 F.3d 599, 601, 614 (7th Cir. 2004). The district court entered a judgment on the pleadings for the defendants, and the Seventh Circuit reversed and remanded for further proceedings. *Id.* at 599.

[P]ost-Olmstead, courts have recognized that a State may violate Title II when it refuses to provide an existing benefit to a disabled person that would enable that individual to live in a more community-integrated setting. On the other hand, courts have also held that a State is not

obligated to create new services in order to enable an institutionalized individual to live in a more integrated setting.

Id. at 609 (citations omitted). Therefore, once a service has successfully been provided in the past to prevent institutionalization, Title II may be violated when the state stops providing that successful service, if the cessation or reduction places the individual at serious risk of institutionalization. In addition, several federal district court opinions have found that a reduction in community services violates the ADA's integration mandate by placing the plaintiffs at serious risk of institutionalization. *See e.g. Wilborn v. Martin*, ___ F. Supp. 2d ___, No. 3:13-00574, 2013 WL 4401854 (M.D. Tenn., Aug. 15, 2013) (granting preliminary injunction stopping a reduction in home health services); *Hampe v. Hamos*, 917 F. Supp. 2d 805 (N.D. Ill. 2013) (reduction of in-home skilled nursing services); *Brantley v. Maxwell-Jolly*, 656 F. Supp. 2d 1161 (N.D. Cal. 2009) (loss of two days of adult day health care services). *But see Arc of Cal. v. Douglas*, ___ F. Supp. 2d ___, No. 2:11-CV-02545, 2013 WL 3331145 (E.D. Cal. 2013) (involving a reduction in payments for services compared with a reduction in services). Respondent provides no contrary authority to these interpretations of the *Olmstead* decision and the requirements of the ADA.

Like so many of the cases referenced above, this appeal involves a dispute over the reduction of HCBS, namely companion services and personal care services. As of January 1, 2010, Respondent had capped these services to a combined maximum of 28 hours per week for individuals living in the community. R. 22. For individuals living in institutions, the services are not capped but are based upon need as determined in a plan of care developed by a team including the treating physician. 42 U.S.C. § 1396r (b)(2) ("A nursing facility must provide services and activities to attain or maintain the highest

practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care"). The plan is based upon a required and extensive assessment. *Id.* at (b)(3). Appellant argues that because his need for services exceeds the cap, the imposition of the cap, as applied to him, places him at serious risk of needing to seek those services in an institution. In an institution his need would be assessed and his plan of care would be based upon that assessment, not based upon arbitrary caps on services. *Id.* Respondent argues that the ADA does not require it to modify its program, namely to allow Appellant to exceed the arbitrary cap, because the cap on services does not place the Appellant at risk for seeking care in an institution and even if Appellant is at risk, exceeding the cap amounts to a fundamental alteration of the program. Respondent's Brief at p. 7 and p. 15.

A. Serious Risk of Institutionalization or Speculative Risk of

Institutionalization

Respondent argues that the risk that cuts to Appellant's services will cause him to have to go to an institution is "speculative." Respondent's Brief at p. 7. However, the uncontested evidence in the case shows that Appellant faces day to day challenges from a body which simply "cannot cooperate." R. 923, 920, 921. Appellant has had a decubitus ulcer from "sitting in his chair for too long without getting out or at least changing his position." R. 314. Appellant is always at risk of having to seek care in a hospital or other facility. The issue is not whether Appellant is at risk of needing to seek care in a hospital or a skilled facility but whether the 28 hour cap, as applied to Appellant, places him at serious risk of institutionalization in violation of the ADA.

The *Olmstead* decision has been consistently extended to apply to individuals who are placed at serious risk of institutionalization by a public entity's failure to make reasonable modifications to policies, like a cap on services. *Pashby*, 709 F.3d at 322; *M.R.*, 663 F.3d at 115; *Brantley*, 656 F. Supp. 2d at 1171. "Serious" does not mean that "[a]n ADA plaintiff [must] show that institutionalization is 'inevitable' or that she has 'no choice' but to submit to institutional care in order to state a violation of the integration mandate." *M.R.*, 663 F.3d at 1116. The integration mandate "prohibits public entities from pursuing policies that place individuals at risk of unnecessary institutionalization." *Id.* at 1117. Policies which cause a decline in health over time to a Medicaid beneficiary violate the ADA because they may "eventually enter an institution in order to seek necessary care." *Id.* Respondent does not provide support for the argument that *Olmstead* only applies when the risk of institutionalization is "imminent." See Respondent's Brief p. 8. But see *M.R.*, 663 F.3d at 1117 ("[I]mminent risk of institutionalization is not required," quoting the brief of the Department of Justice).

Respondent makes vague assertions regarding alternative services or care which may reduce Appellant's risk of needing to seek services in an institution. Respondent's Brief p. 8. Such vague assertions have not been successful in defense of claims based upon violations of the integration mandate. "[T]o the extent that Defendants are claiming that alternative services satisfy their obligations under the integration mandate, Defendants certainly bear the burden of ensuring more than a 'theoretical' availability of such services." *V.L. v. Wagner*, 669 F. Supp. 2d, 1106, 1120 (N.D. Cal. 2009) (quoting *Brantley*, 656 F. Supp. 2d at 1174).

Respondent refers to the potential availability of isolated and completely segregated day programs also known as "sheltered workshops." See Respondent's Brief, p. 8, referencing R. 891 – 894 (listing various waiver services). Respondent does not provide any evidence that the programs would themselves comply with the integration mandate or that Appellant's complex medical needs could be met in such settings. Under Respondent's theory of what constitutes a sufficient risk of institutionalization, a Medicaid beneficiary would have to systematically go through each and every service available (whether approved for the service or not) and demonstrate that not one service could prevent the beneficiary's deterioration. In other words, the affected beneficiaries would have to demonstrate they would have "no choice" but to go into an institution by providing testimony on services they have never received and for which they have never been approved. In addition, some of those additional services, like day activity services, are provided in segregated and isolating settings. See generally *Disability Advocates v. Paterson*, 653 F. Supp. 2d 184, 223 (E.D.N.Y. 2009) ("[A] plaintiff need not prove that the setting at issue is an 'institution' to establish a violation of the integration mandate. ... Rather, a plaintiff must show that the *setting* does not 'enable interactions with nondisabled person to the fullest extent possible.'" (emphasis added). Such a burden placed on a Medicaid beneficiary would mean that the beneficiary must first go to an institution and then file an ADA claim from that isolated and segregated setting. Respondent, the single state agency responsible for Medicaid, not Medicaid beneficiaries, "bear[s] the ultimate responsibility for ensuring the State's compliance with federal disability law." *V.L.*, 669 F. Supp. 2d at 1120. Respondent has not met its burden to show that alternative services are available, appropriate, and will prevent Appellant's

deterioration and institutionalization. If unsuccessful in his challenges to the actions of Respondent, Appellant will lose five hours of care per day. R. 335. His mother works six different part-time jobs; his father is now deceased. R. 309. She testified that Appellant "would not be safe" if he loses his hours. Appellant will have to be alone and his doctor says his condition will deteriorate if he does not receive the care he needs. R. 920-921. Under these conditions, Appellant can be removed from the home pursuant to the Omnibus Adult Protection Act (OAPA) through a family court action.¹⁹ S.C. Code Ann. § 43-35-5 to 43-35-595 (Supp. 2013). Appellant's potential to be placed in an institution is not necessarily in the control of either Respondent or Appellant.

The Administrative Law Judge (ALJ) stated that "[a]ppellant is living in the community, and it is speculative as to whether the reduction in services will cause him to be institutionalized." R. 14. However, the evidence that without the services requested, Appellant will be neglected as defined in the OAPA, is substantial, under oath, and uncontested with contrary testimony or evidence.²⁰ R. 304-322; R. 917-924. He has already had an incident of getting a decubitus ulcer. R. 314. He has also suffered regression. *Id.* Sadly, in making an argument for these services, Appellant has also made the argument that without these services he will be neglected, either by his parent caregivers or himself or both. The proof in this case, and the provisions of the OAPA

¹⁹ A vulnerable adult is age eighteen or older with "a physical or mental condition which substantially impairs the person from adequately providing for his or her own care or protection." S.C. Code Ann. § 43-35-10 (11) (Supp. 2013). "Neglect includes the inability of a vulnerable adult, in the absence of a caretaker, to provide for his or her own health or safety which produces or could reasonably be expected to produce serious physical or psychological harm or substantial risk of death" S.C. Code Ann. § 43-35-10 (6) (Supp. 2013).

that Appellant is in serious risk of institutionalization if the 34 hour reduction in his services is implemented by Respondent.

B. Fundamental Alteration or Reasonable Modification

The Hearing Officer and the ALJ erred in holding that making an exception to the 28 hour cap is a fundamental alteration rather than a reasonable modification. "A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity." 28 C.F.R. § 35.130 (b)(7). Initially, the Appellant bears the burden of articulating a reasonable accommodation. *Frederick L. v. Dept of Pub. Welfare of Pa. (Frederick L. I)*, 364 F.3d 487, 492 n. 4 (3rd Cir. 2004), *aff'd* by *Frederick L. v. Dep't of Pub. Welfare of Pa. (Frederick L. II)*, 422 F.3d 151 (3rd Cir. 2005); *see Olmstead*, 527 U.S. at 605-606. In this appeal, Appellant's request is for an exception—an exception to unpromulgated policy applying an across the board 28 hour cap on services. "The burden of proof then shifts to the defendant, who must establish that the requested relief would require an unduly burdensome or fundamental alteration of state policy in light of its economic resources and its obligations to other [individuals with disabilities] in the institutional setting." *Frederick L. I*, 364 F.3d at 492 n. 4.; *see K.M. v. Tustin Unified Sch. Dist.*, 725 F.3d 1088, 1096 (9th Cir. 2013). The Respondent bears the burden of proving that the requested modification--making an exception to the cap--is an unduly burdensome request.

²⁰ Respondent's witnesses testified to the policy and the process but could not testify as to Appellant's medical needs. R. 279 ("I don't have any medical training."); R. 291 ("I . . . mainly just deal with policy).

In *Olmstead*, the Court noted that a state could establish a fundamental alteration defense by demonstrating "that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated" 527 U.S. at 605-606. Respondent argues that allowing an exception will "fundamentally alter the program by eviscerating the limit." Respondent's Brief p. 17. However, Respondent does not explain what program is "eviscerated," or how providing a modification would affect any other programs. Appellant's contention is that the Medicaid program violates the ADA if it provides personal care in an ICF/ID based upon need but caps personal care in the community. Caps are not necessary for the program. The waiver program already has a system in place to make an exception to the cap on respite services. With regard to respite services, services intended to benefit caregivers, individuals with extraordinary needs can exceed the cap through a process of review. Appellant's request for an exception to the cap on personal care services is a reasonable modification given that such an exception already exists for respite services.

Courts consistently have held that a fundamental alteration defense requires more than a "singular focus upon a state's short-term fiscal constraints" *Frederick L. I*, 364 F.3d at 495; *Pashby*, 709 F.3d at 323 ("budgetary concerns do not alone sustain a fundamental alteration defense") (quoting *M.R. v. Dreyfus*, 663 F.3d 1100, 1118 (9th Cir. 2011)).

[The fundamental alteration] inquiry requires not simply an assessment of the cost of the accommodation in relation to the recipient's overall budget, but a "case-by-case analysis weighing factors that include: (1)[t]he overall size of the recipient's program with respect to number of employees,

number and type of facilities, and size of budget; (2)[t]he type of the recipient's operation, including the composition and structure of the recipient's workforce; and (3)[t]he nature and cost of the accommodation needed."

Olmstead, 527 U.S. at 606 n. 16 (quoting 28 C.F.R. § 42.511(c)(1988)). While such proof seems extraordinary, the information would be readily available and part of an *Olmstead* plan, a requirement for a fundamental alteration defense. "[A] comprehensive working plan is a necessary component of a successful 'fundamental alteration' defense." *Frederick L. v. Dep't of Pub. Welfare of Pa. (Frederick L. II)*, 422 F.3d 151, 157 (3rd Cir. 2005), *aff'g Frederick L. I*, 364 F.3d 487; *Pa. Prot. & Advocacy v. Pa. Dep't of Pub. Welfare*, 402 F.3d 374, 380-81 (3rd Cir. 2005); *Hampe v. Hamos*, 917 F. Supp. 2d 805, 821 (N.D. Ill. 2013). No such plan was presented by Respondent.

The ADA is designed to require reluctant public entities to make exceptions for individuals with disabilities. For the PGA Tour, the requirement that all golfers walk the course was an important requirement of their program. The Supreme Court, however, found that making an exception to allow the use of a golf-cart for a golfer with a disability, was a reasonable modification and not a fundamental alteration. *PGA Tour Inc. v. Martin*, 532 U.S. 661, 663 (2001). Caps on Medicaid services require exceptions to comply with the ADA. In *Fisher*, imposition of a cap on prescription medications violated the ADA—making an exception to the cap for individuals who needed the additional medications was a reasonable modification. *Fisher*, 335 F.3d at 1182; *see e.g. Wilborn v. Martin*, ___ F. Supp. 2d ___, No. 3:13-00574, 2013 WL 4401854 *18-19 (M.D. Tenn., Aug. 15, 2013) (granting a motion for a preliminary injunction involving a "cost cap" and issuing an injunction requiring exceptions be made). The fundamental

alteration defense does not stand for the proposition that a public entity, like the Respondent, can create a rule and then argue any alteration of the rule is fundamental.

II. The arbitrary caps on services violate the Administrative Procedures Act.

The fundamental alteration defense stems from Respondent's argument that the agency has created a rule which must be followed in all circumstances. Respondent continues to treat the 28 hour cap as an absolute rule, but the cap has not been promulgated as a regulation under the Administrative Procedures Act (APA).

"'Regulation' 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).

In *Home Health Service, Inc. v. South Carolina Tax Commission*, the South Carolina Supreme Court considered whether a rule violated the APA because it established a rule of general applicability without being promulgated as a regulation. 312 S.C. 324, 440 S.E.2d 375 (1994). *Home Health Service* involved whether a bingo operator could allow an employee to temporarily sit in for a player "during the player's absence from the game." *Id.* at 326, 440 S.E.2d at 377. While the Court did not find that the policy issued by the Tax Commission was a rule of general applicability, establishing a binding norm, the Court cautioned the Tax Commission against circumventing the regulation process:

Whether a particular agency proceeding announces a rule or a general policy statement depends upon whether the agency action establishes a binding norm. *Ryder Truck Lines, Inc. v. United States*, 716 F.2d 1369 (1983). In our view, the document issued was similar to a policy

statement as opposed to a binding norm given that the document was not issued by the commissioners and thus, no final agency approval had been given. Therefore, we do not find that the APA was violated in this instance. We caution respondent that when there is a close question whether a pronouncement is a policy statement or regulation, the commission should promulgate the ruling as a regulation in compliance with the APA.

Id. at 328-29, 440 S.E.2d at 378.

In the case of *Sloan v. South Carolina Board of Physical Therapy Examiners*, the Supreme Court again sends a warning to agencies that wish to circumvent the APA. 370 S.C. 452, 636 S.E.2d 598 (2006). *Sloan* involved whether a physical therapist could be employed by a doctor, who will then refer patients to her. The Board had endorsed an opinion by the Attorney General that such employment arrangements violated S.C. Code Ann. § 40-45-110(A)(1) (2011). *Sloan*, 370 S.C. at 476, 636 S.E.2d at 611.

Under the line of federal cases we relied on in *Home Health Service*, courts have held that whether an agency's action or statement amounts to a rule--which must be formally enacted as a regulation--or a general policy statement--which does not have to be enacted as a regulation--depends on whether the action or statement establishes a "binding norm." When the action or statement "so fills out the statutory scheme that upon application one need only determine whether a given case is within the rule's criterion," then it is a binding norm which should be enacted as a regulation. **But if the agency remains free to follow or not follow the policy in an individual case, the agency has not established a binding norm.**

Id. at 475-76, 636 S.E.2d at 610 (emphasis added); *see also*, *S.C. Coastal Conservation League v. S.C. Dep't of Health and Envtl. Control*, 363 S.C. 67, 74-75, 610 S.E.2d 482, 485-86 (2005) (A regulation failed for vagueness because it did not include a test to determine what "small" was; the test had to be promulgated by regulation.); *Courts v. Agency for Health Care Admin.*, 965 So. 2d 154, 159 (Fla. Dist. Ct. App. 2007) (In Florida a similar rule has been applied specifically to the Medicaid agency: "[T]his court

has held that, if an agency changes a non-rule-based policy, it must either explain its reasons for its discretionary action based upon expert testimony, documentary opinions, or other appropriate evidence, or it must implement its changed policy or interpretation by formal rule making." (citations omitted)).

In this case, the agency has attempted to establish a binding norm without promulgating a regulation. The agency policy being interpreted by the hearing officer is a 28 hour cap on a combination of personal care and companion services. R. 335 ("When the waiver was renewed, it included service limits of 28 hours per week"); R. 914 (Memorandum mentioning the caps.); R. 940 ("These approved limits cannot be exceeded and must be applied to all [ID/RD] Waiver participants [W]e are not at liberty to exceed the established limits."). The Respondent notes in its brief, "The limitations were applied across the board in accordance with the terms of the waiver document." Respondent's Brief at p. 14. The Hearing Officer apparently agreed and determined that he was not free to deviate from the policy. R. 271 ("[M]y jurisdiction is limited to interpretation of agency policy.").

The Administrative Law Court (ALC) has already found that this 28 hour cap on services is a binding norm and unenforceable unless it is promulgated as a regulation. *E.g. Hickey v. Dep't of Health and Human Servs.*, Docket No. 10-ALJ-08-0656-AP (July 19, 2011). Att. 1. The decision of the ALC is consistent with case law from other jurisdictions holding that provisions of a waiver document that have not been promulgated as regulations as required by a state's APA are unenforceable and cannot be the basis of reductions in services. *McCrann v. NC Dep't of Health and Human Services*, 704 S.E.2d 899 (N.C. App. 2011)(The provisions of a waiver limiting benefits were rules

that must be promulgated as regulations pursuant to the state APA); *Weaver v. Colo. Dep't of Social Servs.*, 791 P.2d 1230 (Colo. Ct. App. 1990)(Denial of benefits based on an unpromulgated rule violated the state APA); *Mullins v. N.D. Dep't of Human Servs.*, 454 N.W.2d 732 (N.D. 1990)(invalidating unpromulgated manual provisions purporting to define individuals eligible for benefits).

Respondent cites to *Doe v. South Carolina Department of Health & Human Services* in support of the contention that the 28 hour cap does not have to be promulgated as a regulation in order to be applied as a rule. 398 S.C. 62, 727 S.E.2d 605 (2011). Respondent interprets *Doe* to create a distinction between policy that has been approved by CMS and general policy guidelines developed by the agency but not approved by CMS. In *Doe* the Court addressed eligibility for ID/RD waiver services and the definition of "mentally retarded."²¹ 398 S.C. at 66-67, 727 S.E.2d at 607-608. The term mentally retarded is defined partially in terms of the age of onset of the condition. One of the issues before the Court was whether the age of onset requirement was age 18 or age 22. In looking at that issue, the Court simply noted that the waiver document did not address the age of onset issue. 398 S.C. at 66, 727 S.E.2d at 607 ("South Carolina's waiver application with the federal government does not include any age-of-onset requirement and reveals no intent to vary from or otherwise limit the group of individuals encompassed by the SSI definition of mental retardation."); 398 S.C. at 74, 727 S.E.2d at 611 ("South Carolina could have listed additional criteria in the waiver application for the

²¹ The Court noted that "[s]ubsequent to the briefing and arguments in this case, the General Assembly, in 2011 Act No. 47 changed the references to mental retardation . . . to 'intellectual disability.'" The Court used the term "mental retardation" to remain consistent with the record in the case. *Doe*, 398 S.C. at 67 n.5, 727 S.E.2d at 607 n.5.

purpose of defining the population to whom it would provide waiver services.”). The Court found that the age 18 age of onset requirement in SCDDSN's policy guidelines contradicted the age 22 age of onset requirement in S.C. Code Ann. Regs. 88-210 (F).

Id. In contrast, the dissent found that the definitions in Regulation 88-210 only apply to “the licensing of programs.” 398 S.C. at 77-78, 727 S.E.2d at 613. Because the dissent found that Regulation 88-210 was inapplicable, the dissent then turned to DDSN's policy guidelines for the determination of whether the age of onset requirement is 18 or 22 and argued that those guidelines should have been followed by the Court. *Id.* at 8 (“[T]he majority ostensibly agrees the guidelines are in effect unless they conflict with state law.”) The majority's response to the dissent's argument is in footnote 7 of the decision:

[T]he dissent finds the policy guidelines are entitled to deference in interpreting section 44-20-30. 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 “[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. Indeed, the only South Carolina law addressing the age onset requirement is Regulation 88-210.

398 S.C. at 68 n.7, 727 S.E.2d at 608 n.7.

The *Doe* case does not support Respondent's contention that the approval by CMS of the waiver provisions means the rules contained in those provisions do not have to be promulgated under the state APA in order to be enforceable. *Doe* is the only legal support Respondent offers for the argument that the 28 hour cap is not a binding rule in violation of the ADA. CMS's approval of the waiver provisions is irrelevant to whether

the policy's contained in the waiver provisions must be promulgated. The ALC in the *Hickey* decision agreed stating, "I find no legal support for this argument. On the contrary, other states which have considered this precise question have held that the provisions of a waiver document must be promulgated as a regulation under the state's APA in order to be enforceable as a rule or binding norm." *Hickey v. Dep't of Health and Human Servs.*, Docket No. 10-ALJ-08-0656-AP at 7 (July 19, 2011). Att. 1.

CONCLUSION

Identifying and providing services for individuals with disabilities to enable them to live in the community should be an objective and individualized process. "[U]nder Title II of the ADA, States are required to provide community-based treatment for persons with mental disabilities when [1] the State's treatment professionals determine that such placement is appropriate, [2] the affected persons do not oppose such treatment, and [3] the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities."

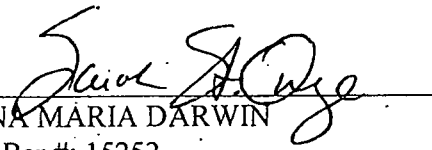
Olmstead v. L.C., 527 U.S. 538, 607 (1999). To help states meet the requirement imposed by Title II, the Medicaid waiver programs were established to provide care in the community for individuals who want to be in the community and whose needs can be met in the community. See generally *Radaszewski v. Maram*, 383 F.3d 599, 601-02 (7th Cir. 2004).

Each amicus in this case represents or advocates for individuals who receive services through SCDHHS and SCDDSN. These amici organizations have seen the negative effect that the Respondent's changes are having on individuals with disabilities and their families. Respondent's changes to the ID/RD waiver, especially the limitation

on personal care hours, place individuals like the Appellant at risk of institutionalization, in violation of the ADA. Implementing a flat hourly cap on personal care services, showing indifference to individuals' needs, is contrary to the ADA. Making that cap a rule without exception is contrary to the APA. For reasons stated herein, Amici respectfully request consideration of this Amici Curiae Brief in rendering a ruling in this appeal.

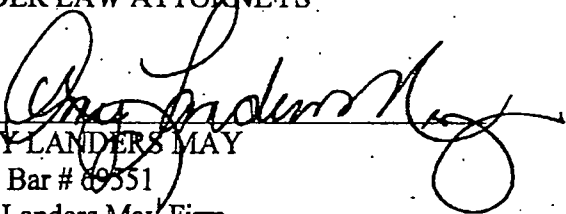
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GLOSSARY OF ACRONYMS

- ADA - Americans with Disabilities Act
- ALC - Administrative Law Court
- APA - Administrative Procedures Act
- CMS - U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services
- HCBS - Home and Community Based Services
- ICF/ID - Intermediate Care Facility for the Intellectually Disabled
- ID/RD - Intellectual Disabilities/Related Disabilities
- OAPA - Omnibus Adult Protection Act
- P&A - Protection and Advocacy for People with Disabilities, Inc.
- SCDDSN - South Carolina Department of Disabilities and Special Needs
- SCDHHS - South Carolina Department of Health and Human Services
- SCLS - South Carolina Legal Services, Inc.
- SCNAELA - South Carolina Chapter of the National Academy of Elder Law Attorneys

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

Barbara Hickey,

Appellant,

vs.

South Carolina Department of Health and
Human Services,

Respondent.

Docket No. 10-ALJ-08-0656-AP

FINAL ORDER AND DECISION

STATEMENT OF THE CASE

This matter is before me pursuant to the appeal of Barbara Hickey (Appellant), from a final decision of the Respondent, South Carolina Department of Health and Human Services (DHHS or Department). This appeal is made in response to Respondent's January 1, 2010 cut in Personal Care Aide (PCA II) services to all those persons who, like the Appellant, rely on these services to live in the community and avoid institutionalization, and to Respondent's denial of Appellant's right to contest this withdrawal of necessary services at a hearing.

On December 1, 2009, Appellant received a letter from Respondent, stating that her in-home PCA II hours had been cut from 50 per week to 28 per week. Petitioner appealed that decision on January 15, 2010. Department of Disability and Special Needs (DDSN) responded to her appeal stating that the "limits cannot be exceeded and must be applied to all [Mental Retardation/Related Disabilities (MR/RD)] Waiver participants." Appellant appealed that decision on January 25, 2010. The hearing officer issued an "interlocutory order" dated January 29, 2010 which stated that she believed that the DHHS had the authority to administer the Medicaid Program in South Carolina, and that the Center for Medicare and Medicaid Services (CMS) had approved the revised Waiver, including the service caps. Petitioner responded on February 12, 2010 stating that she did not understand the decision and requesting a hearing. On

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July 19, 2011

SC ADMIN. LAW COURT

February 17, 2010 the hearing officer dismissed appellant's case stating that she failed to respond to his Interlocutory Order with an allegation of error in fact or in law as ordered. On March 1, 2010, counsel for Appellant filed a Motion to Alter or Amend Judgment and a supporting Affidavit in response to the decision to dismiss Appellant's case and requested a fair hearing be held. On March 10, 2010, DHHS filed a Reply to Appellant's Motion requesting the hearing officer uphold its dismissal of Appellant's case and deny her a hearing. The hearing officer issued a final decision on July 20, 2010 dismissing Appellant's case without a hearing. Appellant received the final decision on July 28, 2010 and appealed to this Court on August 27, 2010. Both parties were represented by counsel at Oral Arguments on April 12, 2011 at the offices of the ALC in Columbia, South Carolina.

Issues on Appeal

1. Has the Department treated its PCA II benefit cap as a binding norm such that promulgation as a regulation is necessary for it to be enforceable?
2. Does inclusion in the waiver document make the PCA II cap enforceable without promulgation?
3. Does S.C. Code § 44-6-90 exempt the Department from promulgating regulations to carry out its duties?
4. Did the Department err in refusing to provide Hickey with a hearing?
5. Did the Department's decision contain erroneous findings of fact?

Standard of Review—

This matter is before the ALC in its appellate jurisdiction pursuant to S.C. Code Ann. § 1-23-600(D) (Supp. 2010). Accordingly, the Administrative Procedures Act's standard of review governs this appeal. See S.C. Code Ann. §§ 1-23-600(E), 1-23-380 (Supp. 2010); see also Byerly Hosp. v. S.C. State Health & Human Servs. Fin. Comm'n, 319 S.C. 225, 229, 460 S.E.2d 383, 385 (1995). The standard used by appellate bodies, including the ALC, to review agency decisions is provided by S.C. Code Ann. § 1-23-380(5) (Supp. 2010). This section provides:

The court may not substitute its judgment for the judgment of the agency as to the weight of the evidence on questions of fact. The court may affirm the decision of

the agency or remand the case for further proceedings. The court may reverse or modify the decision [of the agency] if substantial rights of the appellant have been prejudiced because the administrative findings, inferences, conclusions, or decisions are:

- (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.

S.C. Code Ann. § 1-23-380(5) (Supp. 2010).

A decision is supported by "substantial evidence" when the record as a whole allows reasonable minds to reach the same conclusion reached by the agency. Bilton v. Best Western Royal Motor Lodge, 282 S.C. 634, 321 S.E.2d 63 (Ct. App. 1984). Substantial evidence is not a mere scintilla of evidence, nor the evidence viewed blindly from one side of the case, but is evidence that, considering the record as a whole, would allow reasonable minds to reach the conclusion the agency reached in order to justify its action. Hargrove v. Titan Textile Co., 360 S.C. 276, 289, 599 S.E.2d 604, 611 (Ct. App. 2004). The fact that the record, when considered as a whole, presents the possibility of drawing two inconsistent conclusions from the evidence does not prevent the agency's finding from being supported by substantial evidence. Id.; Waters v. S.C. Land Res. Conservation Comm'n, 321 S.C. 219, 467 S.E.2d 913 (1996); Grant v. S.C. Coastal Council, 319 S.C. 348, 461 S.E.2d 388 (1995). However, § 1-23-380(5) requires the reviewing tribunal to consider not only the amount of evidence, but also the quality of that evidence; it must be both "reliable" and "probative," as well as "substantial." See S.C. Code Ann. § 1-23-380(5) (Supp. 2010).

An abuse of discretion occurs when a decision is based upon an error of law, such as application of the wrong legal principle; or, when based upon factual conclusions, the ruling is without evidentiary support; or when the judge is vested with discretion, but the ruling reveals no discretion was exercised; or when the ruling does not fall within the range of permissible decisions applicable in a particular case. Ex Parte Capital U-Drive-It, Inc., 369 S.C. 1, 5, 630 S.E.2d 464, 467 (2006). A decision is arbitrary or capricious when no rational basis for the conclusion exists, when it is based on one's will and not upon any course of reasoning and

exercise of judgment, Converse Power Corp. v. S.C. Dep't of Health & Envtl. Control, 350 S.C. 39, 564 S.E.2d 341 (Ct. App. 2002); Deese v. S.C. State Bd. of Dentistry, 286 S.C. 182, 184-85, 332 S.E.2d 539, 541 (Ct. App. 1985). A decision may be arbitrary or capricious when it is made at one's pleasure without adequate determining principles, or is governed by no fixed rules or principles. Deese, 286 S.C. at 184-85, 332 S.E.2d at 341. Non-uniform, inconsistent, or selective application of authority can indicate arbitrariness. See Mungo v. Smith, 289 S.C. 560, 571, 347 S.E.2d 514, 521 (Ct. App. 1986).

Medicaid MR/RD Waiver Program

Medicaid is an optional state program created under Title XIX of the Social Security Act. It enables states to receive federal financial assistance specifically for the medical care of needy individuals. See 42 U.S.C.A. § 1396; Wilder v. Va. Hosp. Ass'n, 496 U.S. 498, 502 (1990); Doe v. Kidd, 501 F.3d 348, 351 (4th Cir. 2007). States are not required to participate in Medicaid; however, if they choose to do so, they must comply with all federal Medicaid laws and regulations. Wilder, 496 U.S. 498; Doe, 501 F.3d at 351; see also Antrican v. Odom, 290 F.3d 178 (4th Cir. 2002) ("Although North Carolina may retain a special sovereignty interest in choosing whether to participate in the Medicaid program, once it elects to participate, it is not entitled to assert that interest to insulate itself from the requirements of the federal program."), cert. denied, Odom v. Antrican, 537 U.S. 973 (2002). As a prerequisite to receiving federal assistance, a state must submit a detailed plan, referred to as the "State Plan," to the CMS for approval. 42 U.S.C.A. § 1396a.

In South Carolina, DHHS is the state agency responsible for administering and supervising the state's Medicaid programs. S.C. Code Ann. § 44-6-30(1); Doe, 501 F.3d at 351. DDSN is responsible for the state's treatment and training programs for people with mental retardation and related disabilities. Doe, 501 F.3d at 351. Accordingly, in some instances, such as the case at hand, DDSN can act as an agent for DHHS. Id.

Medicaid normally provides funding for individuals with mental disabilities who live in an institution. However, states may make a request to the CMS for a "waiver" to pay for otherwise non-covered Home and Community Based Services (HCBS) for Medicaid-eligible persons who might otherwise be institutionalized as long as the services are cost effective. 42 U.S.C.A. § 1396n(c).

States must seek approval for these waiver programs from the CMS. If a waiver is approved, the CMS waives compliance with state program requirements while permitting states to remain eligible for reimbursement with federal grants. *Id.* The waiver program provides Medicaid reimbursement to participant states for providing HCBS to individuals who would otherwise require institutional care. *See* 42 U.S.C.A. § 1396n(c). Waivers are approved for a period of two to three years and may be renewed thereafter. Under a program operated by DDSN, CMS has waived the requirement that an individual live in an institution to receive services. In this appeal, the waiver program at issue is the MR/RD Waiver Program. The MR/RD Waiver Program permits a recipient to receive services at home or in the community, rather than in an Intermediate Care Facility Mental Retardation (ICF/MR) such as a nursing home. *Doe*, 501 F.3d at 351.

On January 1, 2010 a new MR/RD waiver renewal became effective following approval by CMS. The renewed waiver document includes a cap of 28 hours per week for PCA II services. PCA II services consist of hands-on personal care to help a participant accomplish the activities of daily living such as bathing, toileting, dressing and eating.

I. Has the Department treated its PCA II benefit cap as a binding norm such that promulgation as a regulation is necessary for it to be enforceable?

The central issue raised by the Appellant in this case is whether the Department is entitled to rely on an amendment to the MR/RD waiver document to cut Appellant's PCA II services from 50 to 28 hours per week. It is uncontroverted that the cap on PCA II services was not promulgated as a regulation under the Administrative Procedures Act, S.C. Code Title 1, Chapter 23 (APA). The Department makes three arguments in support of its position that it properly applied the cap on PCA II services in this case without promulgating the cap provision as a regulation.

The Department first asserts that the cap on CPA II services is not a rule that must be promulgated as a regulation in order to be enforceable. "[W]hether an agency's action or statement amounts to a rule--which must be formally enacted as a regulation -- or a general policy statement -- which does not have to be enacted as a regulation -- depends on whether the action or statement establishes a 'binding norm.'" *Sloan v. S.C. Bd. of Physical Therapy Exam'rs*, 370 S.C. 452, 636 S.E.2d 598 (2006). In order for an agency to create a "binding" rule

it must be promulgated as a regulation. Home Health Serv., Inc. v. S.C. Tax Comm'n, 312 S.C. 328, 440 S.E.2d 375 (1994). The key factor in determining whether a policy statement establishes a "binding norm" is the extent to which the challenged policy leaves the agency free to exercise its discretion to follow or not follow the policy at issue in a particular situation. Home Health Serv. Inc. v. S.C. Tax Comm'n, 312 S.C. 324, 328, 440 S.E.2d 375, 378 (1994). If the policy at issue "so fills out the statutory scheme" that the agency will only look to whether the policy's criteria are met in taking action or rendering a decision, the policy will be considered a "rule" or "regulation." Id. As long as the agency remains free to consider the individual facts in taking action or rendering a decision, the policy at issue will not be considered a "binding norm." Id. Thus, to determine whether a policy or guideline establishes a "binding norm," courts look to the actions of the agency, not to the labels given by the agency.

In this case, the Department argues that it has not treated the cap on PCA II services as a binding norm. I find no support for this argument in the record; the Department has consistently treated the PCA II services cap as a binding norm. In its initial letter denying Hickey's request for continued PCA II services benefits at the level she formerly received, the Department stated,

[L]imits or caps were placed on services in the MR/RD Waiver. Approval for these limits or caps was obtained from the [CMS]. These approved limits cannot be exceeded and must be applied to all MR/RD Waiver participants. While we understand and appreciate the hardship these changes may place on you, we are not at liberty to exceed the established limits.

In response to Hickey's appeal of that decision, the hearing officer upheld the Department's decision denying Hickey a hearing in part because, the Department

need not grant a hearing if the sole issue is a Federal or State law requiring an automatic change adversely affecting some or all recipients. The reduction in Petitioner's PC II hours was imposed by caps and limits on these, and other services specified in the MR/RD Waiver as renewed effective January 1, 2010, and imposed upon all Waiver participants. These changes in the Waiver were approved in advance by ...CMS....For the purposes of this decision, it is presumed that this approval, inclusive specifically of the changes approved, by CMS carries the force and effect of law.

Thus, because the Department's decisions in this case look only to whether the services Hickey received were within the cap and not to any other standard or factual issues, the cap on PCA II services was treated as a binding norm and not as a general policy statement. The Department did not treat the cap as a policy statement that it was free to exercise its discretion to

follow or not follow according to the particular facts in Hickey's situation. See Ryder, 717 F.2d at 1377-1378.

II. Does inclusion in the waiver document make the PCA II cap enforceable without promulgation?

The Department next argues that it is not required to promulgate the provisions of the waiver document in order to enforce them because they are a contract between the state and federal government contemplated by the agency statutes and regulations and are entitled to deference as a "federal directive."¹ The Department cites its regulation S.C. Code Ann. Regs. 126-300 and its general grants of authority contained in S.C. Code Ann. § 44-6-30 to 40 in arguing that the PCA II service cap should be enforced.

I find no legal support for this argument. On the contrary, other states which have considered this precise question have held that the provisions of a waiver document must be promulgated as regulations under the state's APA in order to be enforceable as a rule or binding norm. In McCrann v. N.C. Dept. Health and Human Services, 704 S.E.2d 899 (N.C. App. 2011), the North Carolina Court of Appeals held that it was error of law for the agency to rely upon the provisions of a waiver to deny services to a Medicare beneficiary. The court held that the provisions of the waiver limiting benefits were "rules" that must be promulgated as regulations pursuant to the state APA in order to carry the force of law. Likewise, in Hoban v. State of Vermont, Op. No. 200-4-05, Lexis 40 (Vt. Super 2005), the Superior Court of Vermont held that a cap on HCBS contained in a Medicaid waiver program was void due to the agency's failure to promulgate the cap as a regulation under the state APA. See also, Mullins v. N. Dakota Dept. of Human Services, 454 N.W.2d 732 (N.D. 1990) (invalidating unpromulgated manual provisions purporting to define individuals eligible for benefits). Compare, Rennich ex rel. Rennich v. N. Dakota Dept. of Human Services, 2008 ND 171, 756 N.W.2d 182, 188 (N.D. 2008) (distinguishing situation where conditions of eligibility are set by federal statute and regulation).

III. Does S.C. Code § 44-6-90 exempt the Department from promulgating regulations to carry out its duties?

¹ For purposes of this discussion I assume without deciding that the Department's characterization of the waiver document as a "federal directive" is accurate. It appears that the waiver document was authored by the Department and approved by the federal agency, CMS.

Lastly, the Department asserts that South Carolina statutes do not require the Department to promulgate regulations to carry out its duties. In support of this position the Department cites S.C. Code Ann. § 44-6-90, which states, "The department may promulgate regulations to carry out its duties." The Department's argument is that because § 44-6-90 allows, but does not require, the Department to promulgate regulations, that the Department is exempt from the requirements of the APA when carrying out its duties. In South Carolina the cardinal rule of statutory interpretation requires the trier of fact to ascertain the intent of the legislature. State v. Scott, 351 SC 584, 588, 571 S.E.2d 700, 702 (2002). In doing so, the court must give a reasonable and practical construction to the statute that is consistent with the purpose and policy expressed in the statute. Davis v. NationsCredit Fin. Servs. Corp., 326 SC 83, 484 S.E.2d 471 (1997). Where there is one statute addressing an issue in general terms and another statute dealing with the issue in a more specific and definite manner, the more specific statute will be considered an exception to, or a qualifier of, the general statute and given such effect. Capco of Summerville, Inc. v. Gayle Construction Company, Inc., 368 S.C. 137, 628 S.E.2d 38 (2006). Statutes in apparent conflict should, if reasonably possible, be construed so as to allow both to stand and to give effect to each. Higgins v. State, 307 S.C. 446, 449, 415 S.E.2d 799, 801 (1992). I conclude that the general language allowing the Department to promulgate regulations does not override the more specific requirements of the APA. To interpret Section 44-6-90 as urged by the Department would imply that every agency given general authority to promulgate regulations is thereby exempted from the requirements of the APA. Such an interpretation does not yield a reasonable and practical construction consistent with the purpose and policy expressed in either the APA or § 44-6-90. Therefore, the Department erred in treating the cap on PCA II services as a binding and enforceable rule without promulgating the cap as a regulation pursuant to the APA.

IV. Did the Department err in refusing to provide Hickey with a hearing?

The procedures for appealing a decision regarding Medicaid services provided under a HCBS waiver are set forth in the Code of Federal Regulations. See 42 C.F.R. §§ 441.200 *et. seq.* Those regulations provide that a state hearing system for Medicaid recipients under a state waiver "must meet the due process standards set forth in Goldberg v. Kelly, 397 U.S. 254 (1970)." 42 C.F.R. § 431.205(d). The state agency must grant an opportunity for a hearing to any applicant who requests it because his claim for services is denied, 42 C.F.R. § 431.220(a)(1),

or if the state agency takes action to suspend, terminate or reduce services. 42 C.F.R. § 431.200(b). However, the agency need not grant a hearing if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all recipients. 42 C.F.R. § 431.220(b). As a state agency administering the Medicaid program, the Department must comply with all federal Medicaid laws and regulations: Wilder v. Va. Hosp. Ass'n, 496 U.S. 498, 502 (1990); Doe v. Kidd, 501 F.3d 348, 351 (4th Cir. 2007).

The Department advances two arguments in support of its dismissal of Hickey's matter without a hearing. First, the Department argues that the reduction of benefits carried out pursuant to the revised waiver's cap on PCA II services is an issue involving a change in state or federal law and so no hearing is required pursuant to 42 C.F.R. § 431.220(b) (stating that the agency need not grant a hearing if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all recipients). I am unpersuaded by this argument because, as discussed in detail above, the PCA II cap contained in the revised waiver document does not have the force and effect of law. Thus, Hickey's request for a hearing does not fall within the exception to the hearing requirement provided by 42 C.F.R. § 431.220(b).

Second, the Department argues that the process afforded Hickey met the requirements of Due Process and the federal regulations because the Department offered Hickey an opportunity to present written argument in response to the interlocutory order. The Department argues that because Hickey responded to the interlocutory order by requesting a hearing rather than by submitting written statements demonstrating a "valid factual dispute" that she failed to avail herself of the opportunity the Department offered for a hearing. The Department cites Rosen v. Goetz, 410 F.3d 191 (6th Cir. 2005) in support of its argument that only an opportunity for a written argument is minimally required in some cases. Because the Rosen case arose in the context of a challenge of a procedure by hundreds of plaintiffs concerned with the enforcement of a consent order and not in the context of an individual request for a hearing preceeding a reduction in Medicaid benefits, I find the reasoning contained therein insufficient to overcome the hearing requirements applicable to this case pursuant to the controlling federal regulations and the standard enunciated by the Supreme Court in Goldberg. The Goldberg Court held:

The city's procedures presently do not permit recipients to appear personally with or without counsel before the official who finally determines continued eligibility. Thus a recipient is not permitted to present evidence to that official orally, or to

confront or cross-examine adverse witnesses. These omissions are fatal to the constitutional adequacy of the procedures. The opportunity to be heard must be tailored to the capacities and circumstances of those who are to be heard. It is not enough that a welfare recipient may present his position to the decision maker in writing or second-hand through his caseworker. Written submissions are an unrealistic option for most recipients, who lack the educational attainment necessary to write effectively and who cannot obtain professional assistance. Moreover, written submissions do not afford the flexibility of oral presentations; they do not permit the recipient to mold his argument to the issues the decision maker appears to regard as important....Therefore a recipient must be allowed to state his position orally.

Goldberg v. Kelly, 397 U.S. 254, 268- 269, 90 S. Ct. 1011, 1021, 25 L. Ed.2d 287 (1970). The controlling federal regulations specifically require the Department to "meet the due process standards set forth in Goldberg," 42 C.F.R. § 431.205(d). Moreover, federal regulations require the Department to grant an opportunity for a hearing to any applicant who requests it because his claim for services is denied, 42 C.F.R. § 431.220(a)(1), or if the state agency takes action to suspend, terminate or reduce services, 42 C.F.R. § 431.200(b). Because the Department seeks to reduce Hickey's benefits and she requested a hearing, it was error for the Department to deny her a hearing. It was not enough to demand that she present issues of fact in writing and to dismiss her appeal when she requested an in-person hearing. Moreover, where a case involves important questions of novel impression, such as the issues presented here concerning the enforceability of the unpromulgated waiver document and the issues of compliance with the Americans with Disabilities Act currently pending in federal district court,² it is error to dismiss the case for failure to state a claim. Evans v. State Retirement, 344 S.C. 60 543 S.E.2d 547 (2001).

V. Did the Department's decision contain erroneous findings of fact?

Appellant raises several additional issues concerning whether findings of fact and recitations of the history of the proceedings contained in the Department's decision are erroneous. Although I note the lack of support in the record for the challenged findings and statements, the consideration of the remaining issues is unnecessary because the Department's decision is reversed on the grounds discussed above. See Futch v. McAllister Towing of Georgetown, Inc., 335 S.C. 598, 613, 518 S.E.2d 591, 598 (1999) (concluding that an appellate

² Hickey v. Forkner, 4:10-CV-02696-TLW-TER (D.S.C. 2010)

court need not address remaining issues when disposition of a prior issue is dispositive of the case).

ORDER

IT IS HEREBY ORDERED that, the Decision of the South Carolina Department of Health & Human Services reducing Appellant's PCA II services from 50 hours per week to 28 hours per week is **REVERSED**.

IT IS FURTHER ORDERED that before taking further action to reduce Appellant's benefits under the MR/RD waiver, the Department must provide Appellant with a hearing consistent with this Order and Decision; the benefit limitations contained in the January 1, 2010 MR/RD waiver renewal may not serve as the legal basis for a reduction in benefits unless they are promulgated pursuant to the requirements of the South Carolina Administrative Procedures Act.

AND IT IS SO ORDERED.



Deborah Brooks Durden
Administrative Law Judge

July 19, 2011
Columbia, South Carolina

CERTIFICATE OF SERVICE

I, Robin E. Coleman, hereby certify that I have this date served this Order upon all parties to this cause by depositing a copy hereof, in the United States mail, postage paid, in the Interagency Mail Service, or by electronic mail to the address provided by the party(ies) and/or their attorney(s).

Robin E. Coleman

Robin E. Coleman
Judicial Aide to Deborah Brooks Durden

July 19, 2011
Columbia, South Carolina

FILED

July 19, 2011

SC ADMIN. LAW COURT

RECEIVED

FEB 21 2014

SC Court of Appeals

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AUG 12 2013
SC Court of Appeals

IN THE STATE OF SOUTH CAROLINA

In The Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT
Carolyn C. Matthews, Administrative Law Judge

Case 10-ALJ-08-0774-AP

Richard Stogsdill Appellant,

v

South Carolina Department of Health and Human Services Respondent.

FINAL REPLY BRIEF OF APPELLANT

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1. **The risk of institutionalization is not speculative.** The Hearing Officer made a erroneous finding that Richard is "relatively assured of continuing in a non-institutional setting" because his "parents are in close proximity" and he has "a lot of assistive equipment and services." R. 23. At footnote 1, Respondent informs this Court that respite hours were increased "due to a parent's illness." This Court may take judicial notice that Richard's father died on June 2, 2013 (after a long illness which prevented him from providing any care for his son and leaving his mother as the sole income earner in the home). Parents of non-disabled children have no obligation to support adult children after they reach age 18. Respondent has cited no law which would obligate aging parents of waiver participants to provide care to adult children who have profound disabilities. As is evident from recent events in Richard's life, being dependent upon care provided by an aging parent places him at risk of institutionalization.

Like the court found in *Moore v. Cook*, Richard has shown in this case that services were reduced to "shift more of the burden to her (in this case 'his') caregiver." *Moore v. Cook*, 2012 WL 1380220 (N.D.Ga. April 20, 2012). He has also presented evidence that shows that Respondent and DDSN made these changes to force waiver participants into more profitable congregate programs. The South Carolina District Court and the Fourth Circuit Court of Appeals have both ruled that it is not necessary for a disabled person to wait until he is institutionalized before exercising his rights. *Peter B. v. Sanford*, 6:10-cv-007670JMC-BHH, Entry 71 (S.C.D.C. November 24, 2011) adopted in Entry 95, (S.C.D.C. March 7, 2011) and *Pashby v. Delia*, 709 F.3d 307, 322 (4th Cir. 2013). See Appellant's Initial Brief at page 12 and 13. The lower court erred in concluding that Richard will not be forced into a DDSN sheltered workshop or a DDSN residential program if his services are cut. DDSN congregate programs have been found to place

the lives of people like Richard at risk of great harm. See P&A "Unequal Justice" report at R. 484, the South Carolina Legislative Audit Council audit of DDSN at R. 641 and Respondent's own review of DDSN Medicaid waiver programs at R. 434. Respondent has failed to provide evidence from a single source with personal knowledge of his condition to support its claims that Richard's needs could be met safely in a congregate settings, and Richard has provided evidence to the contrary.

Richard's treating physician, Dr. Joseph, and his provider of DDSN psychological supports, Lennie Mullis, provided sworn statements that Richard would be placed at great risk of harm in a DDSN congregate program, where he would be totally unable to defend himself. R. 917 to 924. Ms. Mullis described why "It is foreseeable that Richard's mental and physical health would decline if he were required to attend a workshop." R. at 918. Mullis stated from personal experience that there are individuals at these workshops who exhibit aggressive behaviors and that Richard would not be able to defend himself. Id. Dr. Joseph's statements affirmed that he would "expect to see a marked decline in both his physical and mental condition because of the trauma he would experience from being segregated from his community and being forced to live in a congregate setting." R. 921 to 922. Dr. Joseph reported that Richard's socialization skills would regress and he would "feel stigmatized" if forced to attend a congregate segregated workshop. R. 922. Richard requires hands-on assistance with ambulation and positioning, which would place him at risk of decubitus ulcers if not provided the attention he needs. R. 920.

Richard's mother served on the Board of Directors of the local DSN Board and had personal knowledge of how the program in Kershaw County was operated. She testified that

Richard would be assigned to sit at a table with "people who have no control over what they do and so they have behavior issues." R. 311. According to her personal experience, people get assaulted at the workshop. Id. As the Tenth Circuit held in *Fisher v. Oklahoma Health Care Authority*: "The Plaintiffs may succeed on their ADA claim if the Defendant's action places them at a "high risk" of premature entry into institutional isolation." 335 F.3d 1175, 1185 (10th Cir. 2003). In *Pashby v. Deliah*, the Fourth Circuit recently joined the Third, Ninth and Tenth Circuits in holding that entry into an institution is not a prerequisite and that forcing persons who live at home into adult care homes could constitute a violation of the ADA. Id. At 314. Respondent's finding that Richard's claim of risk of institutionalization is not supported by any evidence in the record, it is arbitrary and capricious and this Court should rule that it was legal error for Respondent to require him to enter an institution before exercising his rights under the ADA and *Olmstead v. L.C.* 527 U.S. 581 (1999).

2. The hearing officer's finding that Respondent has not violated the ADA was legal error and the administrative appeals process is not his exclusive remedy. This Court should confirm the ruling repeatedly made by the Hearing Officer during the hearing that he does not have jurisdiction to rule upon Richard's claim for violation of the ADA. R. 270 to 273. In so ruling, the Hearing Officer held "I am not competent to make judgments that are more appropriately before the Supreme Court" and he would not allow Appellant to offer testimony in support of Richard's ADA claim or claims brought under *Olmstead*. R. 273. He actually threatened to terminate Richard's hearing if he attempted to pursue his ADA claims. R. 272. The parties were allowed to brief the ADA/*Olmstead* issue after the hearing, but that denied Appellant his right to present witnesses and to cross examine the State's witnesses about violations of the ADA and *Olmstead*. R. 297 to 300. If the Hearing Officer had jurisdiction over

ADA claims, then his ruling was a violation of 42 C.F.R. 431.242, which requires the State to allow appellants to “establish all pertinent facts and circumstances,” to “present an argument without undue interference” and to “question or refute any testimony or evidence, including opportunity to confront and cross-examine adverse witnesses.”

Contrary to his ruling at the hearing that he would shut it down if Appellant attempted to argue violation of the ADA, the order concluded that “It appears to me that the new Waiver is not violative of the Olmstead integration mandate...” R. 272. The Order did state, however, that “those legal arguments may be preserved for further review, if sought.” R. 25. Richard has sought review of those claims in the federal court and he requests a ruling from this Court confirming that the “fair hearing” process is not his exclusive remedy for violations of the ADA and Olmstead. Richard requests a ruling that nothing in the state administrative process or the record in this case limits him in his pursuit of enforcing his ADA claims in the federal court.

In *Doe v. Kidd I*, the Fourth Circuit recognized that the Medicaid Act “does not contain a ‘comprehensive enforcement scheme’ that is incompatible with individual enforcement under § 1983.” 501 F.3d 348, 356 (4th Cir. 2007). The Administrative Procedures Act specifically provides at § 1-23-380 that not only is judicial review available upon exhaustion of administrative remedies available within the agency, but that “This section does not limit utilization of or the scope of judicial review available under other means of review, redress, relief, or trial de novo provided by law.” In *Doe v. Kidd I*, the Fourth Circuit held that “There have been state administrative proceedings in Doe's case since she noted her appeal to this Court. *Supra* at fn. 1. We do not consider the outcome of these proceedings because the outcome has no effect, preclusive or otherwise, on the issues Doe raises before this Court.” In *Peter B. v. Sanford*, reached the same conclusion in addressing the same reductions at issue in this case:

Lastly, the Court would acknowledge that the plaintiffs have commenced administrative actions concerning these same services, which are at varying stages of resolution. Most notably, it appears that Peter's appeals have been denied. [See Doc. 70.] The Court will address the effect of these proceedings to the extent relevant, but, as will be discussed, finds them to be largely non-dispositive or otherwise non-preclusive of this Court's consideration. R&R, 6:10-cv-00767-JMC -BHH, Entry 71 at page 2 (D.C.S.C. November 24, 2010).

R. 120. Richard requests a ruling from this Court that the DHHS administrative appeals process does not provide a "comprehensive enforcement scheme" and that these proceedings do not in any way restrict his right to pursue private actions in the federal court.

3. The State has not met its burden of proving a fundamental alteration.

The Hearing Officer erred as a matter of law by shifting the burden to the Appellant to prove that providing the services he requests would not cause a fundamental alteration in the State's system. *Olmstead v. L.C.*, 527 U.S. 581 (1999). The State has the burden of proving that it would fundamentally alter its programs to provide the services Richard requests. The Hearing Officer committed legal error by shifting the burden of proof of fundamental alteration to Richard. Respondent's argument that a simple claim of general acceptance of budget reductions is sufficient to prove a fundamental alteration is contradicted by the Fourth Circuit ruling in

Pashby that:

Although we understand that the North Carolina legislature must make difficult decisions in an imperfect fiscal climate, the public interest in this case lies with safeguarding public health rather than with assuaging North Carolina's budgetary woes.

709 F.3d 307 (4th Cir. 2013). The Hearing Officer blindly accepted Respondent's claims that the 2010 reductions were necessitated because of state budget reductions, but the State failed to produce credible and probative evidence to support its "budget reduction" theory to overcome its own financial documentation in the 2010 waiver application. The Hearing Officer did not even consider Appellant's evidence showing that this explanation is not true. It is unexplained why

the exhibits Appellant introduced were not identified as such in the record. The Hearing Officer ruled that budget reductions were the true reason for the reductions and that any review of the State's argument must be decided by "a much higher review panel than this one, and as a matter of comity, I will defer to that body or some higher authority." R. 24. He accepted, without question, Respondent's claims that the reductions resulted from "recent budget reductions." R. 25. The hearing officer reviewed "the record and the Decision in the previous case." But he refused to include those records in the record transmitted to the ALC. R. 24.

It is significant that the position that Respondent now takes is a reversal of its arguments in the Post-Hearing Brief filed on July 13, 2009, where DHHS informed the Hearing Officer that: "The Respondent has not raised any cost concerns." R. 189. (Respondent's Brief at 6.) But that Brief was purged from the record. Respondent admitted in that Brief that South Carolina had opted to consider only the aggregate, not the individual cost, in renewing the waiver document. 42 C.F.R. 441.354. (That regulation describes how cost limitations may be calculated, so that some individuals may have significantly greater costs than the cost of institutional care.) Respondent argued in that Brief that any diversion of funds was irrelevant - yet the purported lack of funding was the only justification Respondent provided to CMS for amending the waiver in 2010. Respondent's Brief to this Court at 2 contains website containing waiver document documenting that the reason given for the 2010 amendments was budget reductions.

The Hearing Officer ignored undeniable evidence showing that DHHS projected that it would spend more than \$61 million more in 2010 than it spent in 2009, when there were no caps on services. R. 891 to 894. While Respondent's application was pending at CMS, DDSN asked the South Carolina Budget and Control Board to spend more than \$7 million of "excess funds" to purchase real estate, to pay a contractor and to split the kitty with that Board, all without

approval by the General Assembly. The Hearing Officer's blind acceptance that the reason for reducing Richard's services and finding that Respondent's claim was "a believable statement in these economic times" is not supported by anything more than the agency's explanation, which is contradicted by its own financial records. According to DHHS's own calculations, the average cost per waiver participant, when there was no cap on services and physical therapy, occupational therapy and speech therapy were provided under the waiver program was \$36,209 per year while the projections DHHS submitted to CMS for the waiver that went into effect on January 1, 2010 was \$44,232.12 per participant per year. R. 891 to 894.

The 2010 waiver amendments (1) increased program costs drastically and (2) resulted in four times the number of individuals being forced into ICF/MR facilities in 2010 than 2009. Not only were more waiver participants left with no "choice" but this most restrictive and most expensive setting, but the average number of days in confinement in ICF/MR facilities was projected to increase by 50%. Not only that, but DHHS increased the rate it paid to DDSN and its local DSN Board for ICF/MR respite from \$157.30 per day to \$270 per day under the amended waiver. Id. DHHS has fallen far short of meeting its burden of showing that providing the services Richard needs to remain at home where he has always lived would result in a "fundamental alteration" in the State's program. Respondent has failed to prove that providing the services Richard's physician orders (which needs may change, from time to time) would not be a reasonable modification in its programs. Before the January 1, 2010 amendments there were no caps on services provided to MR/RD Medicaid waiver participants and people like Richard could get the therapies they need to continue to be able to do things like turn a page of a book or hold a cup. R. 314. His mother testified at the 2010 hearing that:

At this point he cannot use his right hand to do anything. He used to be able to. He used

to be able to hold a cup. He used to be able to use his thumb on the computer. He used to be able to use it to kind of push things on a spoon if he was feeding himself. He used to be able to hold a book with one hand and turn the pages with the other and that's all gone.

R. 314. It is important for this Court to consider that Richard is a young man with normal intelligence, who can communicate his thoughts and needs when provided with the supports he needs. Judge Hendricks recognized in *Peter B. v. Sanford* how terrorizing the thought of being institutionalized is for persons who have cognitive ability to understand what that threat means. "His experience in an institution would come with all of the adjunct humiliations that violation of personal space and person imposes." 6:10-cv-007670JMC-BHH, Entry 71 (S.C.D.C. November 24, 2011). R. 134 and 135. The "fundamental alteration" in the program as it relates to Richard is that he health will decline until he requires hospitalization or institutional care, at tremendous costs to taxpayers for medical care as his health deteriorates.¹

The State has failed to prove how its conscious indifference to Richard's needs will save money and the waiver application documents that the costs - even without considering additional medical costs - are greater than they were before 2010.² Dr. Joseph opined that Richard's health has been good because of the care he has received in his current living arrangement. R. 920. He stated that without the hands-on assistance with ambulation and positioning he receives at home, he would develop decubitus ulcers requiring expensive hospitalizations. R. 920 to 922.

According to Dr. Joseph, Richard has been able to avoid hospitals because of the "hands on

¹ Richard's hand and arm have "drawn up" since he left school and his "right leg draws up much more" to the point that his legs have to be strapped to a wheelchair. R. 314. Richard has fortunately experienced only one decubitus ulcer so far, and these costly sores "come(s) up fast then takes forever to go away." R. 314. The State's witness who testified that she evaluated Richard's need for respite services was familiar with decubitus ulcers, but she could not remember whether that risk was "actually considered or discussed" in reaching her decision that he needs fewer respite hours than he received in 2009. R. 287.

² The Medicaid waiver does not pay for physicians visits, laboratory services, hospitalization and other basic medical services which are covered by "regular" or "State Plan" Medicaid. See Detailed Claims Report at 896.

assistance with his daily exercise regime which includes gait training." Id.

When Richard filed his appeal in 2009, the State had operated the MR/RD Medicaid waiver program for decades without arbitrary caps on home based services. Waiver participants were able to use their services on an annual allocation basis. Exhibit 5 attached to brief filed on July 7, 2009. Services were provided based on the medical needs of the individual waiver participant, without individual caps on services. The fact that the services Richard's physician ordered exceed the average cost in an institution is not a fundamental alteration in the MR/RD Medicaid program. In Respondent's 2006 audit and again in the audit conducted by LAC, the State recognized that, historically, the cost of serving some medically complex waiver participants has far exceeded the average and that "outlier" funds had been approved by CMS to pay for their care. R. 458. The "Bands" are averages and some individuals cost significantly less, with others costing significantly more. Id. The average cost of care in a DDSN institutional program was \$320 a day in 2008, or \$116,800 per year, according to DDSN's annual accountability report. R. 932. The cost of providing the care Richard's physician has ordered would be only \$14,243.20 more than the average cost in a DDSN Regional Center.

Because the "Bands" DDSN pays providers is an average, some waiver participants are high needs individuals like Richard, paying the additional cost for Richard to remain at home would be reasonable and does not even require a "modification" in the State's program. They already pay more than Richard has requested for some waiver participants CMS found these costs to be allowable. R. 459. An audit by DHHS of DDSN's 2003 expenditures reported the cost a single Medicaid waiver participant who lived in a Community Training Home staffed with around the clock care for one person was \$162,975 per year. R. 459. DHHS reported "The costs of care for a limited number of consumers in the MR/RD waiver program are high, but we found

no indications that the waiver program does not meet required financial conditions.” R. 460. The costs for these individuals was high because, like Richard “of enhanced staffing needs, and the cost to serve these individuals would be high regardless of where they were placed.” R. 461.

The federal government has thrown its full support behind enforcement of *Olmstead* and the ADA. In *Marlo v. Cansler*, the United States Department of Justice filed an amicus brief in a case when the State of North Carolina announced that it was imposing caps on services that placed to plaintiffs at risk of institutionalization. 679 F.Supp.2d 635 (E.D.N.C. 2010). Plaintiffs Marlo M. and Durwood W. in that case lived in apartments in the community, where the State of North Carolina provided care and supervision twenty-four hours a day. *Id.* The federal court granted an injunction prohibiting North Carolina from imposing the proposed caps on services. *Id.* In considering whether providing the services Richard’s physician determines he needs to remain in the community would impose a fundamental alteration in the State’s programs, this Court should consider the fact that 69.7% of the costs of Medicaid services are paid by the federal government, which has determined that Congress intended that the rights of people like Richard be enforced to prevent their being segregated and isolated in congregate facilities. R. 435. The cost to the State (in state funds) to provide all of the services Dr. Joseph ordered would only be about \$4,000.00 more a year than the State pays for the average resident to live in a DDSN Residential Center.

The issue of home based services costing more, on a case by case basis, has been addressed by other courts. In *Radaszewski v. Garner*, the Second Circuit ruled that a young man with disabilities similar to Richard’s was allowed to proceed in his ADA claim in the Illinois federal district court where he required 24 hour private duty nursing costing significantly more than institutional care would have cost. 383 F.3d 599 (2004). In that case, the State attempted to

reduce Eric's services when he turned 21, but his physician, like Richard's physician, determined that Eric's condition would be "seriously medically compromised, which would lead to many hospitalizations" if he were placed in an institution. *Id.* at 603 to 604. The cost of 24-hour private-duty nursing care at home was estimated in *Radaszewski* to be between \$15,000 and \$20,000 per month, which was three to four times greater than the exceptional care rate the State had approved for him. *Id.* at 614. In reversing the lower court, the Second Circuit held that the State had failed to prove a fundamental alteration in its program to serve Radaszewski in his home. *Id.* 615. A similar result was reached in Texas in *Ryan Knowles v. Adelaide Horn*, where the State attempted to force Ryan into an institution, because the cost of his care at home after he reached age 21 exceeded the cost of institutional care. Case No. 3:08-CV-1492 (N.D.Tx. February 10, 2010). The district court granted Knowles motion for summary judgment for his ADA claim, finding that the State was obligated to pay the costs of his continued care at home, despite those costs exceeding the average cost of institutional care. *Id.* As in Richard's case, his treating physician opined that his health and safety could not be protected in an institution. *Id.*

Not only has DHHS reduced home based services through the guise of "budget reductions," the agency fundamentally altered the way in which waiver participants were allowed to use their allocated hours in 2010, which has resulting in forcing waiver participants into congregate programs that profit DDSN and its local DSN Boards. Before the waiver amendments, Richard could utilize his allocated hours as needed (across a one year period). After the waiver amendments, waiver participants have to "use them or lose them" (as allocated by DDSN by the month or week) and could not carry over any unused hours during the year. For example, under the caps imposed by Respondent in 2010, no waiver participant can receive more than 240 hours a month of respite. Prior to the waiver amendments, waiver participants could

use the annual allocation of respite hours as necessary to meet the needs of the individual and the family (who has no legal obligation to take care of an adult child, but does so out of love for the disabled person). In the event that an aging parent had a stroke and spent weeks in the hospital, under the "old" waiver, there was an option that allowed the family to use the number of annually allocated hours to meet this crisis. It is important that this Court recognize that when Respondent placed a cap on respite in 2010, **only those respite services provided in the community were capped. The "new" waiver does not contain limitations for respite services provided in DDSN institutions.** Under the new waiver, individuals who need more than 240 hours of respite during one month (10 days) are provided no other option but to submit to admission into an ICF/MR for respite. Once a community placement is lost, it is very difficult to restore those supports. As the Department of Justice noted in its Amicus Brief in *Marlo*: "...even a temporary placement may lead to dire consequences." 5:09-cv-00535-BO (December 23, 2009). The Legislative Audit of DDSN and the Unequal Justice report confirms the danger South Carolina waiver participants face in DDSN programs. Arbitrary rules, such as those imposed by Respondent in 2010 make it difficult, if not impossible, to care for an aging parent's own needs while caring for their loved one in the home. This lack of flexibility leads to institutionalization...and profits for DDSN.

Because Richard does not request a fundamental alteration in the rules that were applicable when he filed his appeal (i.e. no caps on services, with hours based on documented medical necessity), this Court should issue an order prohibiting DHHS from fundamentally altering waiver participants' rights to use their services as they need them throughout the year and fundamentally altering the program by placing arbitrary caps on services. Respondent should be ordered to provide the services Richard's physician orders within ten days of receipt of

the order and should be held in contempt for any violation of that order. Because of the contemptuous behavior exhibited by Respondent in failing to comply with the 2009 Order, it is expected that more delays and arbitrary denials would result without court oversight. Respondent should be ordered to provide the services ordered by his physician. The burden should be shifted to Respondent to prove that any service ordered by Richard's physician are not medically necessary, with a hearing and a final determination by the Administrative Law Court (ALC) required within 90 days.

4. Respondent's failure to give "appropriate weight" to the Opinion of Appellant's attending physician" violates the mandate of the United States Supreme Court.

The Hearing Officer admitted in his Order that he "reviewed the record and the Decision in the previous case, [*Petitioner*] v. SCDHHS, 09-MISC-017." But his Order ignores the fact that DHHS was bound by Hearing Officer Loomis' order to consider Dr. Joseph's 2009 affidavit in determining his need for PCA services, that the number of hours of respite ordered by Dr. Joseph was appropriate and that the agency have again failed to have persons "fitted (as by training or experience)" for the care planning purpose. November 23, 2009 Order. It is black letter law that "The opinion of a responsible treating physician in determining the appropriate conditions for treatment ought to be given the greatest of deference."³ Justice Kennedy said that in his concurring opinion in *Olmstead* at 610.

Instead, Respondent attempts to challenge the sworn affidavits of Dr. Joseph by gobbledegook arguments like "There is no evidence in the Record as to whether Dr. Joseph

³ Juxtaposed against this mandate of the United States Supreme Court, Respondent asks this Court to give more weight to a recent opinion issued by a lower state court in California in *Mendocino Community Health Clinic v. State Department of Health Care Services* than it gives to the opinion of the treating physician who has provided medical care for Richard for more than two decades. 215 Cal. App. 4th 1471, 155 Cal. Rptr. 3d 923, 927 (Cal.App. 3d Dist 2013). In that case a California lower court upheld a state statute limiting the clinic from billing outpatients for more than 2 psychology visits per month based on a state statute allowing those limitations. *Id.*

provided any information before he prepared his Affidavit on May 10, 2010, the day before the hearing.” Respondent’s Brief at 14. This statement blatantly ignores the fact that Richard’s mother testified that Dr. Joseph had been Richard’s treating physician for 22 years and Dr. Joseph also provided a sworn affidavit in 2009, which DHHS purged and did not transmit to the AL C. Brief of Appellant at 6 and Exhibit 5 and R. 318. Respondent cites *Moore v. Cook*, in an attempt to discredit the opinion of Dr. Joseph. But in that case, the waiver participants’ treating physician disagreed with the State’s independent physician as to the medical need for nursing services of Callie, the plaintiff in *Moore*. Case No. 1:07-CV-631-TWT (N.D.Ga April 20, 2012). Here, in Richard’s case, during the four years since he filed his appeal, DHHS has presented no evidence from any qualified medical source - in total disregard for the Order of Hearing Officer Loomis. This Court should rule that there is no issue of fact and grant judgment to Richard, because Respondent has provided no expert medical testimony in support of their claims that Richard does not need the hours ordered by Dr. Joseph. In *Care and Treatment of Thomas S.*, the Supreme Court recently held in a unanimous decision that “a lay witness may only testify as to matters within his personal knowledge and may not offer opinion testimony which requires special knowledge, skill, experience, or training.” Case No. 194610 (S.Ct. April 10, 2013). See Rules 602 and 701, SCRE. In that case, an agency employee, a licensed social worker, was overturned. In Richard’s case, the only individual who evaluated his records and testified did not even hold a master’s degree and she had never met Richard. Respondent admitted that the reductions were imposed without conducting individualized assessments to determine whether the reductions would place waiver participants at risk of institutionalization. Despite claims in 2009 and 2010 that budget reductions necessitated the reductions, no cost analysis was performed by Respondent before capping home-based services and funding for institutional

services was actually increased.

Appellant does not dispute that the Eleventh Circuit ruled in *Moore ex Moore v. Reese*, 637 F.3d 1220 (11th Cir. 2011), that the State has a role to play. But nothing in that case would suggest that this Court should rely on the testimony of a bureaucrat who holds a BA in Sociology, who does not even know if Richard could get out of the house in a fire or get out of bed at all, to override the order of a treating physician. This is exactly the type of "bureaucratic gobbledegook having no relation to her (in this case "his") actual condition or needs" of which the district court spoke in *Moore*. What DHHS has done in this case is to allow Ms. Shealy and bureaucrats at DDSN and DHHS to practice medicine without a license. The evidence in this case documents that, like Georgia attempted to do in *Moore*, reductions in services shifted more of the burden of caring for Richard to his family. *Id.* Even more egregious in this case is the fact that Richard's evidence documents that Respondent was driven by a motive to force persons who have disabilities into more expensive DDSN congregate programs.

Respondent argues that *Moore* is not applicable to this case because the plaintiff in that case complained of violation of the EPSDT provision of the Medicaid Act, which requires the State to provide all medically necessary services that children require. Respondent's Brief at 10. But that argument ignores the fact that, in this case, Richard's mother (his father is now deceased) has absolutely no legal obligation to provide any services or care to her adult son, unlike Callie's mother, who has some duty to provide care for her minor child under state law. *Moore* addressed the issue of how medical necessity must be determined and what weight must be given to the orders of the treating physician.

No one testified at Richard's 2010 hearing that any physician's order or opinion was even reviewed by persons at DDSN and DHHS who reduced his services. On the contrary, both Ms.

Shealy and Mr. Chorey testified that the agency applied the caps “across the board,” without considering medical necessity or Richard’s individual needs. Ms. Shealy repeatedly admitted on the record that she never communicated with Richard’s physician and she never reviewed any of his medical records. R. 280 to 282. It is hard to imagine a decision being more arbitrary and capricious. There is not a scintilla of evidence in the record to contradict the opinion of Richard’s physician that he requires around-the-clock care. Because of his spasticity, Richard requires total assistance with bathing, dressing, toileting, brushing teeth, grooming, purchasing food and preparing meals, housekeeping and doing the laundry. R. 920 to 924. He requires hand-on assistance with ambulation and positioning to avoid decubitus ulcers. Id. It takes two persons to lift Richard when he goes to the toilet or is transferred from his wheelchair. Id. Until age 21, Richard received one-on-one assistance that was provided by the State during the school day. R. 306. Richard is 5'5" tall and weighs between 115 and 120 and he is “dead weight.” R. 307.

It is clear from the record that decision makers at DDSN gave no weight to the opinion of Richard’s physician in reducing and terminating his services. This violates the mandate of *Olmstead v. L.C.* to give the physician the “greatest of deference” and it is a clear violation of Hearing Officer Loomis’ Order. Richard asks this Court to reverse the decision of the agency and to require Respondent to provide all of the services Richard’s physician orders within ten days of such order. The burden to prove that services ordered by Dr. Joseph should be shifted to the Respondent in this case, given the history of blatant disregard for the 2009 Order of Hearing Officer Loomis, the failure to give any weight to the opinions of his treating physicians, the disregard for Richard’s health and welfare and the evidence of retaliation in this case.

5. The affidavit of Richard’s treating physician is not inadmissible hearsay.

Respondent argues in its brief that the affidavits Appellant introduced are hearsay. Respondent's Brief at 14. But Respondent's counsel agreed at his second hearing for these affidavits to be admitted "for whatever probative value they have." R. 268. This issue was not appealed by DHHS and Respondent's argument is not preserved for appeal. In any event, Rule 803(4) and (6) of the South Carolina Rules of Evidence provide exceptions to the hearsay rule for medical records. Rule 804(4) provides an exception for statements made "for purposes of medical diagnosis or treatment and describing medical history, or past or present symptoms, pain, or sensations, or the inception or general character of the cause or external source thereof insofar as reasonably pertinent to diagnosis or treatment..."⁴ The statement of Dr. Joseph was made for the purpose of diagnosing medical conditions, prescribing treatment and describing Richard's medical treatment and he is well qualified, as a licensed physician, to make those determinations. He was not retained for purposes of this litigation, but had treated Richard for the same conditions for more than twenty years and he is the person most knowledgeable about Richard's condition. As the South Carolina Supreme Court held in *Ex parte Department of Health and Environmental Control v. John Doe*, Dr. Joseph's affidavits are also admissible under the business records exception contained in SCRE 803(6) and "The trustworthiness of medical records is presumed, based on the fact that the test is relied on for diagnosis and treatment." *Id.*

⁴ That exception provides that "the admissibility of statements made after commencement of the litigation is left to the court's discretion." The Hearing Officer did not rule at the hearing that he would not allow the affidavit - in any event, a DHHS Hearing Officer is not a Court. The Hearing Officer in the 2010 hearing was not even an attorney and Hearing Officers are not bound by the South Carolina Code of Judicial Conduct. Medical records are routinely admitted in administrative appeals without live testimony from physicians. *Kelley v. South Carolina Budget and Control Board*, 041912 SCALC, 10-ALC-30-0841-AP (SCALC April 19, 2012), *Williamson v. South Carolina Budget and Control Board*, 041712 SCALC, 10-ALJ-30-0828-AP (SCALC April 17, 2012). Historically, the opinions of treating physicians have been received into evidence in Medicaid cases without live testimony from the physician. *Atkinson v. SCDHHS*, 041403 SCADMLCD, 02-ALJ-08-0152-AP (SCALC April 14, 2003).

and 565 S.E.2d 293, 350 S.C. 243 (SC 2002).⁵ Regardless, Respondent's own records provide independent evidence which supports the opinion of Dr. Joseph. The Detailed Claims Reports found at R. 896 document Richard's conditions, as do the Respite Assessment (Respondent's Exhibit 3), which reported that Richard "requires extensive, moderately intense support and supervision," i.e. within the same room or nearby, outside of visual supervision for no more than 15 minute periods." R. 159. This report states that Richard's needs for speech therapy, occupational therapy and physical therapy are not being met. R. 161. It reports that his parents, who have no duty to provide care for Richard, are working providing his care for 90 hours a week and that he is nonambulatory and incontinent and requires catheter care. R. 162.

The unfairness of requiring the Appellant to present live testimony, in addition to sworn affidavits, at Medicaid "fair hearing" should also be considered by the Court. It should be noted that only the Hearing Officer has the power to subpoena a witness in a Medicaid fair hearing. Requiring live testimony of the treating physician would make it impossible for a disabled person who financially qualifies for Medicaid to ever be able to provide any form of expert testimony. Requiring the disabled to meet impossible evidentiary requirements denies them a opportunity for a meaningful hearing and violates their due process rights. Besides, a ruling by this Court that live physician testimony is required in Medicaid fair hearings would cut both ways - it would require the agency to have its physicians to testify at these hearings, at great expense to taxpayers and it would create significant administrative and operational problems for the Agency. Already, the reimbursement rate for physicians who treat Medicaid patients is very

⁵ Dr. Joseph's affidavit was made near the time of the hearing and it is a record of events, conditions and diagnoses made at the time of Richard's fair hearing made by a person with knowledge of his condition and kept in the regular course of business. The South Carolina Supreme Court has ruled that medical records documenting HIV may be admitted by DHEC at trial as a business records. *Ex Parte DHEC* at 297.

low. Requiring treating physicians to drive to Columbia to testify in fair hearings would chill even the most compassionate doctor from accepting Medicaid patients and jeopardize the treating relationships between the most medically needy patients and their physicians. These public policy issues should be taken by consideration by the Court in ruling that medical records of the treating physician do not constitute hearsay in Medicaid appeals.

6. Respondent has failed to provide services with reasonable promptness.

Although Respondent is providing services which were being provided in 2009 (in addition to an increase in respite - still limited to the cap imposed in 2010), it has not provided the number of hours of the services ordered by Dr. Joseph and it will reduce Richard's personal care and attendant services to 28 hours a week in the event that this appeal is unsuccessful. Respondent argues at page 22 of its Brief that this case is distinguished from *Doe v. Kidd II* because Respondent agreed to provide the services at issue in that case. 419 F.Appx. 411 (4th Cir. 2011). This is a strange argument, because for ten years, Respondent has argued to the federal courts in *Doe*, including twice to the Fourth Circuit, that they are not obligated to provide residential habilitation services to Doe. The Fourth Circuit held in 2011 that Respondent has been in violation of 42 U.S.C. 1396a(a)(8) the Medicaid Act for failing to provide those services with reasonable promptness. But this Court may take judicial notice that Respondent still has not provided the services it argues to this Court it agreed to provide to Doe. See Entry 224, containing an admission by Respondent that residential habilitation services have not been provided. 3:03-cv-01918-MBS.

7. Respondent has violated Richard's right to due process. 42 C.F.R. 431.244 requires the State "ordinarily" to take final administrative action within 90 days of the Medicaid participant's request for a fair hearing. In *Konstantinov v. Daines*, the Supreme Court of New

York affirmed that “the federal statute and implementing regulation governing hearings and decisions about Medicaid claims create a right to a final administrative determination within 90 days after a request for a hearing is made.” 956 N.Y.S. 2d 38, 40, 101 A.D.3d 520 (SC 2012). As recognized in that decision, CMS has promulgated the State Medicaid Manual (SMM) “flesh[ing] out” the content of that right to interpret that regulation to mean that “the 90-day time limit must be adhered to ‘except where the agency grants a delay at the appellant’s request, or when required medical evidence necessary for the hearing cannot be obtained within 90 days.’” Id. at 40. (SMM § 2902.10). Even with such extension, Respondent was required to make a final administrative action by the end of June of 2009. As the Supreme Court of New York held, nothing prevents the State from remanding a fair hearing appeal back to the agency, but “the ALJ is still required to render a final determination within the 90 day period. Thus, as the Supreme Court of New York observed, any remand should specify the time in which the agency must act and report back so that the ALJ can render a final determination within that 90 day period.” Id. More than three years has passed in this case since the Hearing Officer remanded Richard’s case back to DHHS for consideration of Dr. Joseph’s opinion. It is uncontraverted that DHHS has stubbornly refused to give any weight to the treating physician’s opinion. Instead, Respondent has recited bureaucratic gobbledegook best interpreted as giving the agency unfettered discretion to give nothing but lip service to the opinion of the treating physician and allowing arbitrary and capricious limits which force waiver participants into profitable congregate programs. Richard’s due process rights were violated when Respondent ignored the Order of Hearing Officer Loomis and determined that it would simply purge the record in this case of all records submitted in this case between February of 2009 and early 2010.

DHHS argues at page 5 to 6 of its brief that the complaints filed in February of 2009

were somehow automatically resolved when the agency imposed state-wide reductions in 2010 on all MR/RD Medicaid waiver participants under the guise of “budget reductions.” The argument is that Respondent, without legislative approval or judicial review, could unilaterally resolve and terminate his 2009 appeal ... without notice of any kind to Richard or a final order being issued in his appeal that had then been pending for almost a year. Richard had complained in February, 2009 that Respondent failed to provide needed services with reasonable promptness, to base his need for services on the opinions of his treating physician, to provide sufficient providers and to promulgate regulations for the operation of the MR/RD Medicaid waiver program. (His notice of appeal sent to DDSN on February 13, 2009 was considered by both DHHS Hearing Officers, but was not included in the Record.) Then, in December of 2009, Richard was one of the plaintiffs who filed a Petition in the Supreme Court, asking that Court hear, in its original jurisdiction, Richard’s objections to the 2010 amendments. R. 337. Richard and his advocates have been targets of retaliation since then. The letter Richard sent to DDSN on February 13, 2009 requesting a fair hearing had asked the director of that agency to “please assure us that there will be no reduction in services or other retaliatory actions taken against Richard or his family during this appeal.” Exhibit 1. (This document dated February 13, 2009 was purged from the record.) But that is exactly what has happened to Richard and his advocates. A month after Richard attempted to prevent Respondent and DDSN from enforcing the 2010 amendments, DDSN sent notices of termination to Richard’s providers of personal care services and specialized medical equipment falsely informing them that he “moved out of state.” R. 925 and 926. Then DDSN simply failed to respond to the November 2009 Order of Hearing Officer Loomis and Richard’s February 2009 appeal was effectively dismissed with no notice to him or opportunity for judicial review. A State may dismiss a fair hearing appeal for

denial of Medicaid benefits only under circumstances which do not exist in this case. 42 C.F.R. 431.223 provides that "The agency may deny or dismiss a request for a hearing if— (a) The applicant or recipient withdraws the request in writing; or (b) The applicant or recipient fails to appear at a scheduled hearing without good cause. *See Fishman v. Daines*, 743 F.Supp.2d 127 (E.D.N.Y. 2010). Richard has never withdrawn his 2009 appeal. He has not failed to appear at a scheduled hearing, but Respondent treated his February 2009 appeal as if it had evaporated into thin air. The ruling of the Hearing Officer was ignored and he was not given the opportunity for judicial review for the next four years.

One of Richard's exhibits presented at the hearing held on May 11, 2010 was the affidavit of Richard's provider of psychological support, Lennie Mullis. R. 917. In that affidavit, Mullis stated that Richard would not be safe in a DDSN sheltered workshop and that he would be at risk of institutionalization if the services ordered by his treating physician were not provided. Id. On May 18, 2010, exactly one week after Mullis' affidavit was submitted to the DHHS Hearing Officer in support of Richard's appeal, DDSN recommended that Mullis be terminated as an approved provider of DDSN psychological supports. *Mullis v. DHHS II*, Dkt. 10-ALJ-08-0775-AP (SCALC April 23, 2012). DHHS upheld the termination one week later. The Order in that case documents a pattern of practice of Respondent and DDSN acting arbitrarily and capriciously in violating due process rights of appellants and participating, as Richard has claimed her, in improper *ex parte communications with the Office of Hearings and Appeals*. Appellant's Brief at 47 and *Mullis v. DHHS II, supra*. As in this case, there was evidence of *ex parte* communications, with a DDSN official instructing the Hearing Officer how to rule. The arbitrary and capricious process used to terminate Mullis parallels the agency's actions in Richard's case. Despite the Hearing Officer admitting in his order that he reviewed

Richard's 2009 appeal, those records were purged from the record the Hearing Officer transmitted to the ALC.

Whether the refusal to produce the entire record is an attempt not to disclose other *ex parte* communications will not be known until all of those records are produced. The pattern of DDSN providing the Office of Hearings and Appeals with *ex parte* instructions is well documented. *Mullis v. DHHS II*, *supra*. See also *S.E. v. DHHS*, *supra*, *M.M. v. DHHS*, *supra* and *J.C.E. v. DHHS*, *supra*. In Mullis' case, a DDSN official instructed the Hearing Officer to keep evidence of Mullis' 2005 order out of the Record that would be transmitted to the ALC, just as the Hearing Officer kept Richard's 2009 Order out of the record. *Mullis v. DHHS I*, 04-ALJ-03-0194-AP (SCALC 2005). In Mullis' 2012 case, Dr. Kathi Lacy, the Associate State Director of DDSN, had emailed the Hearing Officer an *ex parte* message stating that "I believe [the Appellant] wants to bring up a previous appeal, likely 6 years ago where her appeal for disenrollment was overturned by the [hearing officer]. It has nothing to do with the current issue." This email was in response to the Hearing Officer's email to DDSN which stated "I need your input about this." *Id.* This Court should inquire about the extent of such *ex parte* communications in Richard's case which Respondent may have been purged. As the ALC held in Mullis "... the hearing officer's decision to exclude the 2005 ALC order was not only unsupported by the Record and based on an error of law, but was also based on Dr. Lacy's improper opinion about the relevancy of the Order." *Id.* ("The hearing officer denied Appellant's request and based this denial on an error of law because it relied upon Dr. Lacy's improper opinion regarding the relevancy of documents." *Id.* at 15.)

Richard has been prejudiced by these retaliatory acts and the failure of the Office of Hearings and Appeals to transmit the entire record. It is important for this Court to consider that

the second DHHS Hearing Officer, Jefferson Bryson, even admitted in his order that he had reviewed and considered those records which the Director of the Office of Appeals and Hearings subsequently refused to transmit to the ALC. R. 13. ("I have reviewed the record and the Decision in the previous case, [Petitioner v. SCDHHS, 09-MISC-017]" at R. 24.) In the briefs filed with the ALC, Appellant objected to DHHS purging the records the agency's failure to include all records of the first fair hearing that were reviewed and considered by the Hearing Officer. R.86, 97, 100. The ALC also acknowledged that the Hearing Officer had considered evidence received outside of the 2010 hearing that was not transmitted in the record to that court. R. 14. It is impossible for a reviewing court to determine whether the decision of the lower tribunal is supported by the record when the record is limited to only those documents the government chooses to include. It is notable that the ALC ruled that DHHS did not object to the incorporation of the previous case in the appeal before that court (without ordering those records to be produced) and the ALJ specifically stated in that court's opinion that the second Hearing Officer reviewed those records in reaching his decision.⁶ Order of ALC at 10 at R. 14. It is the obligation of the "agency with possession of the Record" to file the Record with the ALC and to serve a copy on each party within forty-five days of the notice of assignment. South Carolina ALC Rules, Rule 36. DHHS failed to include the records from the 2009 proceedings in the Record and should be ordered to produce all records, including correspondence, emails, memos and all other writings related to Richard since February 13, 2009. Instead of providing those records, in its Brief, Respondent now argues that Judge Matthews was wrong and that DHHS will not include those records which that court reported were reviewed and considered by the Hearing Officer in reaching his decision. This constituted a serious legal error, and a gross

⁶ It was legal error for the lower court to issue an order without providing a hearing, addressing Appellant's objection to these documents being omitted and without reviewing the factual evidence the hearing officer relied upon to reach his decision. Appellant objected in her brief to the ALC that these records were not included in the Record on Appeal. Appellant's Brief filed in the ALC dated February 13, 2011. Appellant again objected to these records being purged in Appellant's Reply Brief dated April 13, 2011. Since the ALC's order was issued without providing oral arguments, these objections were not addressed by the lower court.

violation of Richard's due process rights, which should not be tolerated by this Court, but should be corrected by an order finding that Respondent has violated Richard's due process rights and ordering Respondent and its agent, DDSN, and their employees to produce all records, pleadings, correspondence, reports, memos or other documents in their possession related to Richard Stogsdill within ten days. Appellant prays for an opportunity to file a supplemental brief once those records are produced.

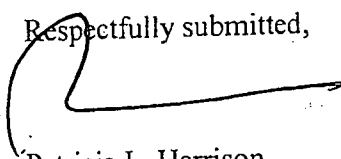
8. Appellant has addressed Respondent's arguments related to the violation of the South Carolina Administrative Procedures Act and the comparability requirements of the Medicaid Act in his Initial Brief.

The ALC has ruled that the 2010 MR/RD Medicaid waiver amendments are unenforceable because they establish a binding norm that the agency is not free to ignore. Exhibits 4 and 5. Respondent did not appeal these decisions and it should be collaterally estopped from enforcing the caps which are being applied to Richard and other severely disabled Medicaid participants who wish to live in their homes. Respondent has not imposed caps on services provided to waiver participants who filed lawsuits in the federal court and has informed that Court that it will not impose these reductions on those individuals. *Elledge v. DHHS*, 2011-185006 (S.C. 2012); *Hickey v. Forkner*, 4:10-2696-TWL-TER (D.S.C. May 5, 2011); *Peter B. v. Sanford, supra*; *J.C.E. v. DHHS*, 10-ALJ-08-0502-AP (SCALC October 29, 2010), and *M.M. v. DHHS* 10-ALJ-08-0502-AP (SCALC October 29, 2010).

Conclusion

Appellant prays that this Court reverse the decision of the lower Court, an order requiring Respondent to provide all services ordered by his treating physician, an order preventing Respondent from enforcing binding norms not promulgated as regulations, an order directing Respondent to promulgate regulations for the operation of the MR/RD Medicaid waiver program and the fair hearing process and an award of legal fees and costs.

Respectfully submitted,



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August 10, 2013
Columbia, South Carolina

STATE OF SOUTH CAROLINA

In the Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT

Carolyn C. Matthews, Administrative Law Judge

Case No. 10-ALJ-08-0774-AP

Richard Stogsdill,

Appellant,

v.

South Carolina Department of Health and
Human Services,

Respondent

BRIEF OF RESPONDENT

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SC Court of Appeals

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STATEMENT OF THE ISSUES ON APPEAL

Is there Substantial Evidence in the Record to uphold and does the law support the Hearing Officer's and the Administrative Law Judge's (ALJ's) decisions that:

- 1) the risk of institutionalization raised by the Appellant was speculative and the actions of the Respondent were not violative of the Americans with Disabilities Act (ADA);
- 2) in authorizing the Appellant's services, appropriate weight was given to the information submitted by the Appellant's attending physician;
- 3) providing the Appellant 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 Appellant 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?

STATEMENT OF THE CASE

General Background:

The Appellant in this matter is a Medicaid-eligible individual, who has been receiving services under the South Carolina Mental Retardation/Related Disabilities (MR/RD) 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 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. This appeal is directly from an Administrative Law Court Order sustaining the Decision of the SCDHHS Appeals Division upholding SCDDSN's action reducing services to the Appellant. The reduction was the result of the

limitations set forth in the renewed waiver.

When he was under twenty one years of age, the Appellant was likely receiving school-based services in addition to waiver services. The Appellant "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 Appellant was receiving a combined 69 hours of Personal Care Aide and Companion Care services per week and about 36 hours of Respite Care per week. Personal Care Aide II (referred to now as PC2 in the waiver document, page 47 of 174) services consist of hands-on personal care that a person needs to accomplish their activities of daily living such as bathing, toileting, dressing and eating. Adult Companion Services are similar to PC2 services but include an aspect of community integration. Waiver document, page 64 of 174. Respite Care can be a range of services, including personal care but is designed to provide services when the normal caregiver is absent or needs relief. Waiver document, page 50 of 174 and R. p. 335.

The 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 Appellant'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 Appellant's Occupational, Physical and Speech Therapies were to be discontinued.

In apparent anticipation of the reduction in services, on December 30, 2009, the Appellant 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.

The Appellant appealed all of the waiver reductions and elimination of services to the DHHS Appeals Division on the grounds of due process, reasonable standards, prompt provision of service, the Americans with Disabilities Act as interpreted by Olmstead v. L.C., 527 U.S. 581 (1999); and improper use of federal stimulus funds. Notice of Appeal (R. pp. 933-939). In his Decision of September 14, 2010 the Department's Hearing Officer sustained the Departments' actions. The Hearing Officer concluded:

1. that the waiver was lawful;
2. that the Appellant had actual notice of the DDSN's proposed actions;
3. That the Olmstead integration mandate was not violated;
4. That the discussions leading up to the waiver changes, the various audits and funding of the DDSN and the stimulus funds were not relevant to the issue;
5. That the previous case had ended; and
6. That States had experienced budget reductions, so the stated purpose of the reductions seemed reasonable.

The Department's Final Administrative Decision (R. pp. 16-26).

On or about October 20, 2010, the Appellant 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 explicated by the Olmstead decision; and
6. Failure to defer to the Appellant's treating physicians.

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

The ALC upheld the DHHS Appeals Division on March 13, 2013, essentially agreeing with the Hearing Officer. ALC Decision dated March 13, 2013, R. pp. 5-15. This appeal followed. Notice of Appeal, April 9, 2013, R. pp. 933-937.

The Appellant's position is that his previous case, [R. S.] v. SCDHHS, 09-MISC-017, was the start of this dispute, and this case is just a continuation of that case. We disagree as we believe there is nothing in the previous Decision in 09-MISC-017 to indicate that

the Hearing Officer retained jurisdiction for further review. We believe that upon remand to the DDSN, the Appellant's case was reevaluated and reauthorized by the local board. Then, the new waiver required all services to be reevaluated, taking into consideration the new limits. This case is about the reduction in services to the Petitioner occasioned by the new January 1, 2010, waiver limits.

On or about January 18, 2010, after the initial cuts, but prior to the appeal, the Appellant's Service Coordinator applied for an increase in respite care. On March 1, 2010, the local DSN Board increased respite care hours to 104 hours per month for a total of 172 hours of respite care per month (or about 40 hours per week). See, R. pp. 158-168 and the descriptions of services cited above.¹

Nature of the Action

Thus, this is a matter before the Court of Appeals 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;

¹ In June of 2012, due to a parent's illness, respite services were increased to 240 hours per month.

- (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) and ESA Services, LLC v. South Carolina Dept. of Revenue, 392 S.C. 11, 19, 707 S.E.2d 431, 436 (Ct.App.2011)

ARGUMENT

- 1) **The risk of institutionalization raised by the Appellant was speculative and the actions of the Respondent were not violative of the Americans with Disabilities Act;**

The Appellant would have the Court equate any risk of institutionalization to a serious and imminent risk. In fact, most courts that have addressed the issue have found that:

under Olmstead and the applicable ADA regulations, when treatment professionals have determined that community placement is appropriate for disabled individuals, those individuals do not oppose the placement, and the provision of services would not constitute a 'fundamental alteration,' states are required to place those individuals in community settings rather than institutions.... The Plaintiff may succeed on his ADA claim if the Defendant's action places him at a "high risk" of premature entry into institutional isolation.

Royal ex rel. Royal v. Cook 2012 WL 2326115, 8 (N.D.Ga.) (N.D.Ga.,2012). See also Fisher v. Oklahoma Health Care Authority, 335 F.3d 1175, 1181 (10th Cir.2003)

For the disabled then, States must meet the heightened standard that a limitation in services must not violate the integration mandate as articulated in Olmstead. In this case we believe that means that the limitation in services cannot put the Appellant in high or

serious jeopardy of institutionalization, unless to avoid doing so, the State has to fundamentally alter its program.

Assuming that the decision in Olmstead, extends to persons at serious risk of institutionalization, there is not enough in this case to indicate that serious and imminent possibility for the Appellant.

In this case, although it has certainly been a hardship on his family as it would be on any family, the Appellant has been maintained in the community. Additional respite services have been added. The Appellant has support equipment including a motorized wheelchair (R. p. 305, line 4), a Hoyer lift and a Surehands lift (R. p. 325, line 25 & p. 326, line 2), a special door on his apartment and a special van (R. p. 326, lines 4 & 5, p. 326, line 7), and a phone and intercoms (R. p. 308, lines 6-15). He volunteers at two places in Camden where he interacts with the public (R. p. 308, lines 17-19) and goes out once a week (R. p. 325, line 22). He also at times stays by himself during some hours of the day. R. p. 327, lines 15-17. There are other services available under the waiver that support community living (see the list on R. pp. 892-894), but the Appellant and his family are unwilling to try them. R. pp. 310 & 311. It is speculative at best to assume that the services in place or available are not enough to maintain the Petitioner in the community.

Furthermore, it was never the intention of the Departments to offer 24-hour-a-day care to individuals who participate in the waiver. The first page of the waiver document contains the statement:

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services. Emphasis added

2) In authorizing the Appellant's services, appropriate weight was given to the information submitted by the Appellant's attending physician.

The Appellant would have the attending physician's orders be dispositive of the services provided. It is reasonable, and required, to give deference to a rendered opinion of a waiver participant's attending physician. However, the Departments must exercise oversight as to the medical necessity of the services ordered and their reasonableness within the limits of service allowed under the program. Surely the Appellant is not suggesting that a service ordered by the attending must be provided even, for example, if the service is not covered at all by the program.

In the case of an able bodied adult, the Medicaid program may limit the services, no matter what the beneficiary's attending physician believes is medically necessary.²

In the case of an adult, under the Medicaid program's regulations, at 42 CFR §440.230, all that is required is that the service be sufficient in amount duration and scope as follows:

- (a) The plan must specify the amount, duration, and scope of each service that it provides for--
 - (1) The categorically needy; and
 - (2) Each covered group of medically needy.
- (b) Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.
- (c) The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under Sec. 440.210 and 440.220 to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition.
- (d) The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures. (Emphasis added)

Most recently, this provision was interpreted in Mendocino Community Health Clinic v. State Department of Health Care Services 155 Cal.Rptr.3d 923, 927 (Cal.App. 3 Dist.2013). In that case, the court said:

For many years, the federal government has allowed, even required, states to adopt utilization controls to insure efficient use of Medicaid funds. "The federal Medicaid Act ... gives the States substantial discretion to choose the proper mix of amount, scope, and duration limitations on coverage, as long as care and services are provided in 'the best interests of the recipients.' 42 U.S.C. § 1396a(a)(19)." (*Alexander v. Choate* (1985) 469 U.S. 287, 303, 105 S.Ct. 712, 83 L.Ed.2d 661, 673.) The Medicaid Act requires each state to impose "reasonable standards" for medical assistance. (42 U.S.C. § 1396a(a)(17); see also 42 C.F.R. § 440.230 [requiring state Medicaid plan to specify the amount, duration, and scope

² That is not true in the case of a child, as explained below. See §1905(r) of the Social Security Act [42 USC §1396d(r)].

of each provided service].) In *Alexander v. Choate*, *supra*, the United States Supreme Court held that a state is free under the Medicaid Act to limit the duration of a benefit. (469 U.S. at p. 303, 105 S.Ct. 712.)

In deciding that the Plaintiffs could not show that the reduction violated the standard, the Mendicino court referenced the earlier case of Alexander v. Choate, 469 U.S. 287, 105 S. Ct. 712, 83 L.Ed.2d 661 (1985). In that case, the Supreme Court said:

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

The Appellant also asserts that the orders of his attending physician should be dispositive as to the initial authorization for personal care services under an 11th federal circuit line of cases. But see Moore ex rel. Moore v. Reese, 637 F.3d 1220 (11th Cir. 2011) in which the court found that the treating physician's determination could be reviewed by the State, which had an interest in ensuring that only medically necessary services were provided.

We do realize that upon the remand ordered in the circuit court case, the district court roundly chastised the State's experts for their stance, See Moore by Moore v. Cook, 2012 WL 1380220 (N. D. Ga., April 20, 2012). Nevertheless, the holding of the circuit court cannot be denied: that the orders of the attending physicians are not dispositive, and the State has a right to review the attending physician's orders to ensure that only necessary services are covered by the Program. The Georgia line of cases involved a child, not an adult.

If the Appellant were a child, under the EPSDT provisions, and if the services he wants were medically necessary, they would have to be provided under the Medicaid program, even if the services were not covered under South Carolina's Medicaid program. EPSDT is the acronym for early and periodic screening, diagnosis and treatment, described at §1905(r) of the Social Security Act [42 U.S.C. §1396d(r)]. Under that service, children are to be screened for medical problems according to professional screening schedules and be provided vision, dental, and hearing services. In addition, under §1905(r)(5), children are to be provided "...other necessary health care, diagnostic services, treatment or other measures described in section 1905(a) to correct or ameliorate defects and physical and mental illnesses discovered by screenings,...".

Every State has to cover certain of the listed services in §1905(a), but a State can cover some or all of the listed optional services. Nevertheless, even if the State should choose to cover none of the optional services, under the EPSDT provisions, they would have to cover any optional service determined to be medically necessary for a child.

Thus, under the Georgia line of cases, the court was applying the medical necessity standards. If the services were determined to be "medically necessary" for the child, the services had to be provided, if they could be provided under any Medicaid Program. The medical necessity standards do not apply to limiting services to adults. The general analysis in adult cases only goes to whether the limitation in services still provides sufficient services. Under the general rules of the Program, the Respondent has the responsibility to control the utilization of services and limit them to those that are

medically necessary. See 42 CFR §440.230 and Part 456, especially Subpart A. Simply authorizing services without performing a review is antithetical to those regulations.

As to disabled adults, then, what is the role of the attending physician's orders? At least in the case of the mentally impaired, the Olmstead case gives us a glimpse of the Court's preference in a concurring opinion – Kennedy and Breyer.

These two Justices were concerned that in deinstitutionalizing mentally ill patients, the States would place them in situations "...devoid of the services and attention necessary for their condition.....It is of central importance, then, that courts apply today's decision with great deference to the medical decisions of the responsible, treating physicians and, as the Court makes clear, with appropriate deference to the program funding decisions of state policymakers." Olmstead, at 610. (Emphasis added)

To their credit, treating physicians are natural advocates for their patients, and that is as it should be and central to the doctor/patient relationship. However, in their advocacy for their patients, treating physicians are often unmindful of the true availability of services under the various programs, much less the cost of the services they order. Furthermore, although their training is extensive, not every physician is aware of the evidence-based approaches that have been shown to be effective in the area of home-based or community services. Every order received from a treating physician should be given the utmost consideration and attention by State agency staff charged with authorizing services, but services not covered or varying widely from the normal scope which experience has shown to be adequate and varying from program limits should not be authorized.

Again, waiver services, particularly, are designed to "...complement and/or supplement the services that are available to participants through the Medicaid State Plan and other federal, state and local public programs as well as the supports that families and communities provide." See Page 1 of the waiver document.

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

The Respondent's witness, Ms. Dawn Shealy neither determined what medical services were necessary nor made a medical determination of the risk of institutionalization. The limitations were applied across the board in accordance with the terms of the waiver documents. Her primary testimony was regarding the Service Coordinator's request for an increase in respite services. As to that, she merely applied the waiver limits as she was instructed to do according to the application at R. pp. 158-166. There is no evidence in the Record as to whether Dr. Joseph provided any information before he prepared his Affidavit on May, 10, 2010, the day before the hearing. Ms. Shealy was only making a

program decision by applying the waiver limits. She did testify that she looked at the Appellant's care and support plans.. R. pp. 286-287.

3) Providing the Appellant services in the amount that he wishes would fundamentally alter the nature of the Respondent's program;

Under Olmstead, States are required to provide community-based treatment for person with mental and related disabilities when the State's treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities. Olmstead, at 587.

In the Olmstead case, the Court was considering the Justice Department's regulations and general approach in enforcing the ADA. It found that courts must consider the totality of the expenses and programs undertaken by the State when evaluating the fundamental alteration defense. More generally, the States retain the right, as explained in the implementing regulations not to "take any action that [they] can demonstrate would result in a fundamental alteration in the nature of a service, program, or activity or in undue financial and administrative burdens." 28 C.F.R. § 35.150(a)(3). The concept of "fundamental alteration" is further explained, in part, below:

Sec. 35.130 General prohibitions against discrimination.

(a) No qualified individual with a disability shall, on the basis of disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any public entity.

(b)

.....
(7) A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.

“Sensibly construed, the fundamental-alteration component of the reasonable-modifications regulation would allow the State to show that, in the allocation of available resources, immediate relief for the plaintiffs would be inequitable, given the responsibility the State has undertaken for the care and treatment of a large and diverse population of persons with mental disabilities.” Olmstead, at 604.

In evaluating a fundamental-alteration defense, the [court] must consider, in view of the resources available to the State, not only the cost of providing community-based care to the litigants, but also the range of services the State provides others with mental disabilities, and the State's obligation to mete out those services equitably. Olmstead, at 597.

Thus, the courts have acknowledged the fundamental alteration defense in applying the rules in Olmstead. In essence, consideration must be given to the cost of the services, and the impact on the State's ability to continue to provide care for others in its charge. The Departments submitted a proper waiver renewal describing the types and limits of services available under this waiver. The renewal (including the limits) was duly

evaluated and approved by CMS. The DDSN has responsibility, under the waiver and under State statutes, not only for providing services to the Appellant, but to all of the other participants in the waiver and all intellectually disabled and those with related disabilities. In order to equitably apportion services, the Department must be allowed to reasonably limit otherwise "boundless" services. In short, it is obvious that if the Department spends too much on any one participant, others accessing DDSN care will suffer.

To permit waiver participants to circumvent the established limits when they can show that the limits have a mere tendency to nudge them toward institutionalization is to fundamentally alter the program by eviscerating the limits.

Throughout his Brief, the Appellant has used dated audit information, isolated schedules, and previous management reviews to allege that appropriations and other funding were diverted from providing direct community waiver services. The audit and management findings are alleged to substantiate that DDSN stands to benefit by restricting access to community based services and thereby encouraging clients to enter institutional care, which the Appellant defines as any environment other than home. Rather than attempting to refute facts that are not in evidence, we simply assert that the Appellant makes too great a cognitive leap from previous reports to nefarious motive. We believe that the Appellant has not established the necessary connection.

**4) The 2010 reductions were lawful and not violative of the South Carolina
Administrative Procedures Act;**

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

First of all, even if the Hickey case is controlling, a careful reading of the case means not that the waiver limitations are unenforceable, as asserted by the Appellant, but only that they are not binding norms and therefore may not be enforced without an opportunity for an evidentiary hearing.

Furthermore, since the Hickey case, in Doe v. SCDHHS, cited above, the SC Supreme Court seemed to indicate 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 the level of services provided to participants of this waiver.

Finally, the Department's promulgated regulations, at S.C. Code Ann. R. 126-300(D), include, by reference, the waiver approvals issued by CMS as federal directives. 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.

5) The Appellant was afforded adequate due process.

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

§431.210 Content of notice.

A notice required under Sec. 431.206 (c)(2), (c)(3), or (c)(4) of this subpart must contain--

- (a) A statement of what action the State, skilled nursing facility, or nursing facility intends to take;
- (b) The reasons for the intended action;
- (c) The specific regulations that support, or the change in Federal or State law that requires, the action;
- (d) An explanation of--
 - (1) The individual's right to request an evidentiary hearing if one is available, or a State agency hearing; or
 - (2) In cases of an action based on a change in law, the circumstances under which a hearing will be granted; and
- (e) An explanation of the circumstances under which Medicaid is continued if a hearing is requested.

Specifically, the Plaintiff complains that the notice does not set forth the specific "regulations that support...the action."

Ultimately, the "regulations that support... the action" are set forth in the general description of the home and community based waivers in 42 CFR §440.180 of the Medicaid Regulations:

440.180 Home or community-based services.

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

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

..... (emphasis added)

Obviously, that is a very general, over-arching and abstract concept, and, thus it is much more meaningful for a participant to be apprised of the particular service and service limits in the waiver that apply to the particular action being taken by the agency. It is also much more concretely contestable than the general statement in the actual federal regulations. Under the wording of the federal regulation at 42 CFR §431.210, it would have been permissible to simply have set forth the general statement in §440.180.

We believe that the public hearings on the changes that took place in and the communications by the Service Coordinators (R. pp. 292 & 293), gave the Appellant actual notice of limits. Furthermore, the fact that he, through counsel, sought a reconsideration of the limits two (2) days before they became effective indicates that Appellant did have actual knowledge of the effects that the limits would have on his services. Finally, we believe that the Reconsideration decision and notice of appeal rights issued by Dr. Buscemi (R. pp. 940 & 941) provided adequate notice of the issues and the opportunity to be heard by the DHHS Appeals Division.

The Appellant complains that impermissible Ex parte communication took place between SCDDSN and the Director of the Appeals Division, in violation of S.C. Code Ann. §1-23-360, entitled "Communication by members or employees of agency assigned to decide contested case." (Emphasis added.) The communication complained of was a memo from an employee of DDSN to the Director of the Division of Appeals and Hearings. R. p. 335. The memo stated what services the Appellant had been getting and how the waiver limitation would change those services. The Director of the Appeals Division was not the person assigned to make the findings of fact and conclusions of law in this case. Even if he had been the person, it goes against reason that the adjudicator cannot find out what the posture of the case is before issuing a Notice of the Hearing. Furthermore, we fail to see how that communication can be shown to have prejudicial the Appellant.

6) The DHHS provided services with reasonable promptness, it is the adequacy of those services that is in dispute.

42 USC §1396a(a)(8) provides as follows:

A State plan for medical assistance must—

(8) provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals; (Emphasis added)

Since March 23, 2010, under the Patient Protection and Affordable Care Act (ACA, Pub.L 111-145) the definition of "medical assistance" in 42 USC §1396d(a), has read as follows:

(a) The term “medical assistance” means payment of part or all of the cost of the following care and services or the care and services themselves, or both. (Amendment by ACA emphasized.)

In Doe v. Kidd II, an unpublished opinion at 419 Fed. Appx. 411 (4th Cir., 2011), the court did indeed find that the Respondent (and DDSN) did not provide Doe with agreed upon services with reasonable promptness. However, to add an important point about the services in Doe: they were services that the Respondent had already agreed should be provided to Doe. Here the level of services is the basis of the dispute. The Doe case in no way stands for the proposition that the Appellant should get whatever he thinks he needs with reasonable promptness. The Doe case only requires reasonably prompt provision of services that the State agrees should be provided. The Appellant misapplies the reasonable promptness provision to the waiver services he wanted to maintain.

The rule applies to the reasonably prompt provision of what the Program authorizes. Obviously, the applicant can dispute, through an administrative appeal, the scope of the authorization, but the applicant does not automatically get anything he additionally requests while the appeal is pending.

7) The Respondent did not violate the comparability requirements of the Medicaid Act.

Section 1902(a)(10)(B) of the Social Security Act [42 USC §1396a(a)(10)(B)] provides essentially that the amount duration and scope of services available to one person in an

eligibility group must be available, under the program, to all individuals in the same eligibility group. For example, all individuals eligible by virtue of their Supplemental Security Income (SSI) award must have access to the same array of services. Not at issue in South Carolina, since we do not have a medically needy program³, the law also prohibits a state from offering services to the medically needy that are not available to the categorically needy.

The implementing federal regulations in 42 CFR provide:

§ 440.240 Comparability of services for groups. Except as limited in §440.250— (a) The plan must provide that the services available to any categorically needy beneficiary under the plan are not less in amount, duration, and scope than those services available to a medically needy beneficiary; and (b) The plan must provide that the services available to any individual in the following groups are equal in amount, duration, and scope for all beneficiaries within the group: (1) The categorically needy. (2) A covered medically needy group.

One of the exceptions referenced in §440.240 provides:

§ 440.250 Limits on comparability of services.

.....
(j) If CMS has approved a waiver of Medicaid requirements under §431.55, services may be limited as provided by the waiver.

The services at issue here are manifestly offered under a waiver as referenced in the regulations. Therefore the comparability provisions do not apply. Even if the waivers were not excluded, the regulation (§440.240) clearly requires comparability within the State Plan, the contract with the federal government that describes the State's Medicaid Program. It does not deal with occasional settlements the Department from time to time

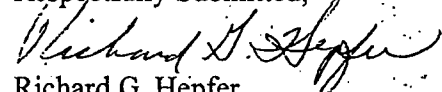
³ A state may choose to cover those whose medical expenses, if subtracted from their income and resources, would put them below the State's financial eligibility criteria.

may choose to enter.

CONCLUSION

The Decisions of the Hearing Officer and ALC should be affirmed to allow the limitations in the waiver to take effect, understanding that should a problem arise, the Appellant does, at all times, have recourse to the Service Coordinator and all of the other services available within the waiver, including respite services.

Respectfully Submitted,



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Columbia, SC
August 1, 2013

IN THE STATE OF SOUTH CAROLINA

In The Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT
Carolyn C. Matthews, Administrative Law Judge

RECEIVED
AUG 12 2013
SC Court of Appeals

Case 10-ALJ-08-0774-AP

Richard Stogsdill Appellant,

v

South Carolina Department of Health and Human Services Respondent.

FINAL INITIAL BRIEF OF APPELLANT

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- Issue 2.** What weight must Respondent and the Courts give to the opinion of the treating physician in determining medical necessity in consideration of *Olmstead’s* “greatest of deference” standard?
- Issue 3.** Has Respondent failed to meet its burden under the Americans with Disabilities Act, as set forth in *Olmstead v. L.C.*, of proving that it would place an unreasonable burden on the State to provide the medically necessary services ordered by Richard’s physician, or that providing these services would force the State to fundamentally alter the nature of its programs?
- Issue 4.** Did the lower court and the hearing officer erred as a matter of law in concluding that the 2010 reductions were “lawful” based solely on the federal Medicaid Agency, CMS, approving them, despite the clear and unambiguous requirements of the South Carolina Administrative Procedures Act prohibiting DHHS from establishing binding norms without promulgation of regulations?
- Issue 5.** Has DHHS violated Richard’s rights of due process and the Constitutional requirements of separation of powers?
- Issue 6.** Has Respondent violated the reasonable promptness requirements contained in 42 U.S.C. 1396a(a)(8) of the Medicaid Act?
- Issue 7.** Has Respondent violated the “comparability” requirements of the Medicaid Act by denying services in excess of the arbitrary caps imposed in 2010 while not enforcing the caps against waiver participants who have filed lawsuits against Respondent and/or DDSN in federal court?

III. Statement of the Case.

This is an appeal of a 2009 decision of the South Carolina Department of Disabilities and Special Needs (DDSN) denying Richard’s request for additional Medicaid home and community based waiver services and the agency’s failure to act with reasonable promptness. This appeal was

authorized by 42 U.S.C. 1396a(a)(3), 42 C.F.R. 431.200 et. seq. and S.C. Code Regs. 126.380.¹

This case was first initiated on February 13, 2009, when Richard requested that DDSN reconsider its decision to deny his request for services. A decision was issued by DDSN on March 3, 2009 denying Richard's request for reconsideration. DDSN determined that there had been "no suspension, reduction, or termination" of Richard's services. Richard appealed this decision to DHHS on April 1, 2009.

On November 16, 2009, the DHHS hearing officer issued an interlocutory order, remanding Richard's case to DDSN. In December of 2009, DDSN decided to reduce Richard's waiver services pursuant to a state wide reduction in services. Richard's DDSN service coordinator informed Richard's guardian that his PCA and Respite hours would be reduced effective January 1, 2010, below the number of hours he was receiving when he filed the 2009 appeal requesting additional services, but no written notice was provided to Richard.

On December 23, 2009, Richard and other affected waiver participants Petitioned the South Carolina Supreme Court to hear their objections to the planned reductions in that Court's

¹ S.C. Code. Regs. § 126-380. **Denial, Termination, or Reduction of Benefits** provides that:

A. When an individual's Medicaid benefits are denied, discontinued or changed, the individual shall receive notice pursuant to Title XIX of the Social Security Act. The notice shall include an explanation of the individual's right to a fair hearing, the method to obtain a hearing, and the right to representation.

B. Fair hearings shall be conducted pursuant to R. 126-150.

C. An individual's Medicaid benefits may be continued pending a fair hearing decision in accordance with Title XIX of the Social Security Act and the federal regulations promulgated in accordance therewith.

original jurisdiction. Richard requested an injunction to prohibit DDSN and DHHS from implementing these caps which were scheduled to take place on January 1, 2010. R. 337. The Supreme Court denied Richard's Petition for original jurisdiction, without ruling on the merits of his case.

On December 30, 2009, Richard's counsel filed a request with DDSN for reconsideration of its decision to reduce his services and he again requested a fair hearing, compliance with the November 16, 2009 Order of the DHHS Office of Hearings and Appeals and reconsideration of the decision to reduce and cap PCA, Companion and Respite Services. Richard also requested reconsideration of the decision to terminate his right to receive Physical Therapy, Occupational Therapy and Speech and Language Services. In this appeal, Richard restated the complaints contained in his 2009 appeal, he objected to the agency's violation of the 2009 DHHS Order and he incorporated by reference in this appeal the contents of the Petition he had filed (along with other waiver participants) in the South Carolina Supreme Court on December 23, 2009.

On January 11, 2010, Richard's DDSN service coordinator sent Notices of Termination of all of Richard's PCA Services and Specialized Medical Equipment, Supplies and Assistive Technology to the providers of those services. R. 925 and 926. These notices were not provided to Richard or his attorney, only to the providers. The reason for the termination of these services was "Participant moved out of state." Id. Richard has not moved from his home.

The next day, on January 12, 2010, DDSN responded to Richard's December 30, 2009 appeal denying all of his requests for relief. DDSN included a notice informing Richard of his right to appeal this decision to SCDHHS, but this response did not contain the reasons for the

adverse action, nor did it state the statute or regulations DDSN relied upon to deny his appeal. R. 149 to 150.

On February 11, 2010, Richard appealed DDSN's decision to the DHHS Office of Hearings and Appeals. Richard's appeal consisted of the following issues:

1. Improper reduction of waiver services, including, but not limited to PCA, Adult Companion Services and Respite Services.
2. Termination of daily respite as a waiver option.
3. Termination of speech and language, physical therapy and occupational services.
4. The State's failure to apply reasonable medical standards to determine medical necessity.
5. Violation of Richard's right of due process, including, but not limited to, the failure to provide proper notice and to determine eligibility for services with reasonable promptness.
6. Failure to determine eligibility for and to provide medically necessary services prescribed by Richard's treating physician.
7. Failure to provide services in the least restrictive setting pursuant to the mandates contained in *Olmstead*.
8. Failure to spend federal stimulus funds to maintain waiver participants' services.

R. 147 to 148.

A hearing was held on May 11, 2010 at DHHS and the hearing officer issued an Order on September 14, 2010, acknowledging that DDSN failed to provide proper notice. The hearing officer provided no relief or protection from future violations of this due process violation. R. 16. The Hearing Officer determined that the November 19, 2009 Order was superceded by the "intervening factor of the new Waiver with new limits." R. 13. The Order determined that Respondent acted lawfully in implementing the January 1, 2010 caps and in terminating Physical Therapy, Occupational Therapy and Speech and Language Services. The Hearing Officer summarily dismissed Richard's claims that DHHS violated *Olmstead*, but he ruled that "those

legal arguments may be preserved for further review.” He ruled that the November 16, 2009 order of DHHS Hearing Officer Loomis was not binding on him or the agency and his order dismissed Richard’s claims of violation of the Medicaid Act and the American Recovery and Reinvestment Act.

Richard received this second order of the DHHS Office of Hearings and Appeals on September 22, 2010 and filed an appeal in the South Carolina Administrative Law Court on October 20, 2010.

In January of 2012, Richard filed a lawsuit in the federal district court against the Director of the U.S. Department of Health and Human Services, DHHS and its State Director, Anthony Keck. *Richard S. v. Sebelius*, Case No. Civil Case No. 3:12-cv-00007-TMC (D.C.S.C.). In this federal action, Richard alleged violations of the Americans with Disabilities Act (hereinafter referred to as the “ADA”), Section 504 of the Rehabilitation Act (hereinafter referred to as “Section 504”), the Medicaid Act, the Administrative Procedures Act of the State of South Carolina and both the Supremacy and Due Process Clauses of the United States Constitution.

The South Carolina Administrative Law Court issued an order on Richard’s administrative appeal on March 13, 2013, without oral argument, upholding Hearing Officer Bryson’s decision.

R. 5. The Administrative Law Judge ruled that the waiver amendments were lawfully made, services were provided with reasonable promptness, the ex parte communications Richard complained of were proper and that due process was afforded to Richard. The Administrative Law Court ruled that the November 16, 2009 Order was a final order that was “carried out while confirming with the changes in the Waiver.” R. 14. The Administrative Law Judge denied

Richard's claims brought under the ADA, ruling that his claims were "speculative" and that the State's responsibilities under *Olmstead* are not "boundless."

This Order of the Administrative Law Court was received by counsel on March 14, 2013. This appeal was filed in the South Carolina Court of Appeals on April 9, 2013.

IV. STANDARD OF REVIEW

The standard of review for Medicaid appeals is governed by the Administrative Procedures Act. S.C.Code Ann. § 1-23-380(5) (Supp.2010). *Jane Doe v. DHHS*, 398 S.C. 62, 71, 727 S.E.2d 605, 609 (S.C. 2011). The Court may affirm the agency's decision, remand the matter, or reverse or modify the lower court's order if substantial rights of the appellant have been prejudiced because the administrative findings, inferences, conclusions, or decisions are: (a) in violation of constitutional or statutory provisions; (b) in excess of the statutory authority granted 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. *Id.*

In this case, Richard seeks injunctive relief to prevent Respondent from imposing binding norms that have not been promulgated as regulations. "Actions for injunctive relief are equitable in nature." *Shaw v. Coleman*, 373 S.C. 485, 492, 645 S.E.2d 252, 256 (Ct.App.2007). *See also* Jean Hoefer Toal, et al., *Appellate Practice in South Carolina* at 193 (1999). In equitable actions, the appellate court may review the record and make findings of fact in accordance with its own view of a preponderance of the evidence. *See Ingram v. Kasey's Assocs.*, 340 S.C. 98, 105, 531

S.E.2d 287, 290-91 (2000); *Townes Assocs. v. City of Greenville*, 266 S.C. 81, 85, 221 S.E.2d 773, 776 (1976). In actions in equity this Court may find facts in accordance with its own view of the preponderance of the evidence. *Shaw* at 492.

"Substantial evidence is not a mere scintilla; rather, it is evidence which, considering the record as a whole, would allow reasonable minds to reach the same conclusion as the agency." *Friends of Earth v. Pub. Serv. Comm'n of S.C.*, 387 S.C. 360, 366, 692 S.E.2d 910, 913 (2010). An appellate court may reverse the decision of the ALC if it is affected by an error of law or is "arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion." *S.C. Dep't of Motor Vehicles v. Blackwell*, 389 S.C. 293, 295, 698 S.E.2d 770, 771 (2010) (quoting S.C. Code Ann. § 1-23-610(B) (Supp. 2008)).

"Statutory interpretation is a question of law." *Hopper v. Terry Hunt Constr.*, 373 S.C. 475, 479, 646 S.E.2d 162, 165 (Ct.App.2007). This court may decide matters of law with no particular deference to the lower court. *Pressley v. REA Constr. Co.*, 374 S.C. 283, 287-88, 648 S.E.2d 301, 303 (Ct.App.2007). Particularly, in a case raising a novel question of law regarding the interpretation of a statute, the appellate court is free to decide the question with no particular deference to the lower court. *I'On, L.L.C. v. Town of Mt. Pleasant*, 338 S.C. 406, 411, 526 S.E.2d 716, 719 (2000) (citing S.C. Const. art. V, §§ 5 and 9 ; S.C.Code Ann. §§ 14-3-320 and -330 (1976 & Supp.2005), and S.C. Code Ann. § 14-8-200 (Supp.2005)); *Osprey, Inc. v. Cabana Ltd. Partnership*, 340 S.C. 367, 372, 532 S.E.2d 269, 272 (2000) (same); *Clark v. Cantrell*, 339 S.C. 369, 378, 529 S.E.2d 528, 533 (2000) (same). "The appellate court is free to decide the question based on its assessment of which interpretation and reasoning would best comport with the law and public policies of this state and the Court's sense of law, justice, and right." *Sloan v. South*

Carolina Bd. of Physical Therapy Examiners, 370 S.C. 452, 636 S.E.2d 598 (S.C. 2006). Citing *Croft v. Old Republic Ins. Co.*, 365 S.C. 402, 408, 618 S.E.2d 909, 912 (2005) ; *Antley v. New York Life Ins. Co.*, 139 S.C. 23, 30, 137 S.E. 199, 201 (1927) (“In [a] state of conflict between the decisions, it is up to the court to ‘choose ye this day whom ye will serve’; and, in the duty of this decision, the court has the right to determine which doctrine best appeals to its sense of law, justice, and right.”)

V. FACTUAL BACKGROUND

Appellant, Richard Stogsdill (hereinafter “Richard”) is a person who has severe disabilities meeting the criteria as “related disabilities” for purposes of qualification for the MR/RD Medicaid waiver program. Richard is 23 years old and has severe cerebral palsy resulting from prematurity and respiratory distress at birth. R. 920. He was born three months early and had patent ductus arteriosis, sepsis, seizures and apnea. Id and R. 304. Richard has normal intelligence, but he is profoundly physically impaired. R. 320.

Richard attended school until he was 21, which allowed both of his parents to work. His mother testified that while in school, Richard was fully integrated into his school community and he socialized mainly with peers who do not have disabilities. R. 321. In school, Richard was “hanging with the football team.” R. 321. He was “brought up with normal people, normal kids...” and “He’s very frustrated by the fact that he can’t be a part of their life because he’s stuck...” Id. Before he reached age 21, Richard received services from an aide provided by the school district during the entire time he was at school. R. 322.

Soon after Richard lost the services that were being provided by his school during the work day, DDSN reduced the number of hours of home-based care he was receiving. For a while,

he attended a program at South Carolina Vocational Rehabilitation, but that state agency was unsuccessful in finding employment for Richard due to his severe disabilities and they terminated his services. R. 307 to 309, 348. Since he left school, Richard's speech, OT and PT services have been terminated. R. 314 to 315. As a result of the loss of these services, Richard's muscles have atrophied and he developed a decubitus ulcer which took a long time to heal. R. 314, 319 and 324. He has lost the ability to hold a cup and to use his thumb on the computer since these therapies were terminated. Id. He has also lost the ability to hold a book and turn the pages since these services were terminated. Id. Richard's ability to speak has also deteriorated since he left school. R. 315.

When Richard was attending school, his mother worked full-time as a bookkeeper. R. 307. His father traveled in his work. But when Richard left school, his mother was forced to quit her full-time job. R. 307 and 308. She is unable to lift Richard because of injury to her back. R. 309. Now his mother has taken on a number of part time jobs to accommodate his schedule and make ends meet. His mother leaves the house around seven a.m. to go to work and returns to help Richard mid-day. R. 326. Then she returns to work and usually does not get home until 5:30 or 6:00. R. 327. Then her "second shift" job begins: providing care to Richard at home. Id.

Richard cannot sit up straight and he "wears out easily." R. 306 to 308. When he is in his bed, Richard cannot use his phone or punch the emergency button. R. 308. His condition of cerebral palsy sometimes causes "horrible spasms" which hurt Richard to the point that he "sweats and moans...to the point of tears." R. 320. When he is suddenly hit with these spasms, Richard has to be taken out of his wheelchair and stretched on his bed. Id. He sometimes crumbles without warning at the onset of these spasms, falling forward. R. 306 and 321. His arms and legs

have to be strapped into his wheelchair because of these uncontrolled movements. R. 306.

Richard lives independently in an apartment next to his parent's home. He requires two persons to get him out of bed, toilet, shower and dress him. R. 306 and 920. He requires assistance taking his medications and requires a regular toileting schedule to prevent life-threatening gastrointestinal obstructions. R. 920. Once Richard is transferred from his bed by two caregivers, he can drive his motorized wheelchair and can use one or two fingers on his left hand to manipulate his computer. R. 305. After his food is prepared and cut into small pieces by someone else, Richard can feed himself. Id. Richard volunteers at the fine arts center, using his two fingers that work to hand out programs, welcoming people and taking tickets. R. 308. He also volunteers to read to patients at the long term care wing of the local hospital. Id.

Effective January 1, 2010, DDSN imposed caps on companion services, personal care attendant services and respite services and totally eliminated speech and language, physical therapy and occupational therapy from the menu of services funded by the MR/RD Medicaid waiver. These changes were made by the Respondent without promulgating regulations and they were made while the General Assembly was adjourned *sine die*. There is no evidence that the legislature was informed of the agency's intent to impose caps on services. DHHS obtained approval from CMS for these reductions based on their claims that there had been a severe budget reduction prohibiting the state from continuing to pay for home based services. However, under the new rules, waiver participants can receive unlimited respite services in an ICF/MR, the most restrictive setting in the DDSN system. (An ICF/MR is a nursing home for persons who have mental retardation or a related disability.) The rate of reimbursement for these institutional services was increased by 70% under the new rules, while the reimbursement rate for some home-

based services was reduced. These institutional respite services, which cost \$270 per day, replaced daily respite which had cost about \$70.00 per day before the amendments.

VI.

ARGUMENTS

Issue 1. Did the lower court err as a matter of law in determining that Richard is not at risk of institutionalization and that any risk is “speculative” in determining whether Respondent’s acts have violated the Americans with Disabilities Act?

At the “fair hearing,” the hearing officer prohibited Richard making any arguments alleging violations of the Americans with Disabilities Act. R. 271 to 275. This prohibition violated 42 C.F.R. 431.242(c) and (d), which require the agency to allow the participant to establish all pertinent facts and circumstances and to present an argument without undue interference. When counsel attempted to present testimony or evidence supporting his claims of violation of the ADA, the hearing officer threatened to terminate the hearing. R. 272. Despite these prejudicial rulings, Appellant believes that the violations of the ADA are so egregious that the record supports this Court’s finding of impermissible violations.

The lower court erred in its finding that “Appellant is living in the community, and it is speculative as to whether the reduction in services will cause him to be institutionalized.” R. 14 (ALJ Order at 10). The United States Court of Appeals for the Fourth Circuit has recently ruled on this issue. In *Pashby v. Delia*, 709 F.3d 307, 322 (4th Cir. 2013), the Fourth Circuit recognized that it is not necessary for the qualified individual to have actually entered an institution to prove a violation of the ADA. Simply the *risk* of institutionalization is sufficient. It is also notable that the court in *Pashby* held that the ADA applies not only to persons threatened with admission into traditional institutions, but those at risk of placement in other isolated or segregated settings are protected as well. In *Pashby*, the Fourth Circuit found that the State violated the ADA by reducing

the personal care services the plaintiffs needed to live at home where they were at risk of being placed in a congregate residential setting that was not a traditional "institution." In reaching this decision, the court analyzed the United States Department of Justice's (DOJ) integration mandate that is at issue in this case:

Because Congress instructed the DOJ to issue regulations regarding Title II, we are especially swayed by the DOJ's determination that " the ADA and the *Olmstead* decision extend to persons at serious risk of institutionalization or segregation and are not limited to individuals currently in institutional or other segregated settings." U.S. Dept. of Justice, *Statement of the Department of Justice on the Integration Mandate of Title II of the ADA and Olmstead v. L.C.*, [http:// www. ada. gov/ olmstead/ q& a_ olmstead. htm](http://www.ada.gov/olmstead/q&a_olmstead.htm) (last updated June 22, 2011); *see also Olmstead*, 527 U.S. at 597-98, 119 S.Ct. 2176 (" Because the Department is the agency directed by Congress to issue regulations implementing Title II, its views warrant respect." (citation omitted)). Moreover, the Tenth Circuit has held that "there is nothing in the plain language of the regulations that limits protection to persons who are currently institutionalized." *Fisher v. Okla. Health Care Auth.*, 335 F.3d 1175, 1181 (10th Cir.2003). In sum, individuals who must enter institutions to obtain Medicaid services for which they qualify may be able to raise successful Title II and Rehabilitation Act claims because they face a risk of institutionalization.

Pashby v. Delia, 709 F.3d 307, 322 (4th Cir. 2013). In that case, the Fourth Circuit unambiguously determined that group homes (Adult Care Homes) qualify as "institutions" under the ADA and that even the risk of going into one of these homes if personal care services are terminated meets the criteria for a violation of the ADA. *Id.* at 323.

In *Peter B. v. Sanford*, the South Carolina Federal District Court reached the same conclusion, granting a preliminary injunction that prohibited DHHS from enforcing the very same 2010 MR/RD Medicaid waiver amendments that are at issue in this case. Case No. 6:10-cv-00767-JMC -BHH R&R dated November 24, 2010 (R. 114) and Order dated March 7, 2011 adopting the R&R. Chip E. and Michelle M. in that case, like Richard, live at home with aging parents who have provided care, without a legal obligation to do so, for years. In *Peter B.*, the court held:

To echo the briefs of the plaintiffs and the *amici*, cases involving ADA integration claims have consistently recognized that even *the risk* of institutionalization is sufficient to establish a violation of Title II and certainly to justify preliminary relief. *See Fisher v. Oklahoma Health Care Authority*, 335 F.3d 1175, 1184 (10th 2003) (holding that Medicaid participants not currently institutionalized but at “high risk for premature entry into a nursing home” could bring claim for violation of the integration mandate); *Brantley v. Maxwell-Jolly*, 656 F. Supp. 2d 1161, (N.D. Cal. 2009); *Mental Disability Law Clinic v. Hogan*, 2008 WL 4104460, at *15 (E.D.N.Y. Aug. 28, 2008) (stating “even the risk of unjustified segregation may be sufficient under *Olmstead*”). The case law is clear that plaintiffs need not wait to be institutionalized before relief is sought. (Underline added.)

R&R at page 13. In discussing the waiver amendment that is central to Richard’s case, the district court unequivocally held in *Peter B.* that: “More to the point, it is this reduction in hours that the plaintiffs contend will drive them to an institution against their will and hope and in violation of the Americans with Disabilities Act.” The risk of institutionalization to Richard is equally menacing, due to these same caps that were at issue in *Peter B.*

In *Royal v. Cook*, the district court in Georgia determined that a waiver participant may succeed on his ADA claim where the state imposed state wide cuts in services “if the Defendant’s action places him at a ‘high risk’ of premature entry into institutional isolation.” Case No.1:08-cv-2930 (N.D.Ga. June 19, 2012), citing *Fisher* at 1185.

Respondent’s only defense has been that Richard lives at home now, so he must not be at risk of institutionalization. But Richard’s treating physician, his provider of DDSN psychological services, his mother and Richard himself have all testified or provided sworn statements that he is at risk of being forced into a congregate setting if the services ordered by his physician are not provided. R. 322, 917 to 924. His mother testified that if Richard was forced into an ICF/MR for Respite Services or to attend a sheltered workshop:

...that would kill Richard. That would kill Richard. I mean he’d be...there’d be no individualism there...I mean even at the workshop they group them together and throw

them all in a van and take them all to the same place. I mean there's no - that's not a life for somebody that's a normal human being.

R. 322. Richard's circumstances are most similar to Chip's, because he has the mental capacity to understand the consequences of losing the battle to stay at home. As the court said of Chip in

Peter B.:

He is the highest functioning of the three plaintiffs and, maybe, precisely for this reason, the prospect of institutionalization is most terrorizing to him. (Pl. Ex. 9 ¶ 12.) The threat of irreparable injury to Chip exists exactly in the lost opportunity that community living offers. This is precisely the sort of injury incidental to the prejudice of segregation, which the *Olmstead* mandate contemplates and seeks to redress. See *Olmstead*, 527 U.S. at 600-01 (“[C]onfinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.”) His experience in an institution would come with all of the adjunct humiliations that violation of personal space and person imposes. “Institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life.” *Id.* Where such an experience can be avoided, without significant alteration of the *status quo*, the United States Supreme Court has stated, it should be.

R&R at 19-20.

Richard's physician is best qualified to determine the amount, duration and scope of services Richard needs to remain at home. *Moore v. Cook*, 1:07-CV-631-TWT (GANDC April 19, 2012). Respondent has not disputed that Richard requires care and supervision around-the-clock. There is no evidence in the record which would support any argument that he can safely be left alone for more than a brief period of time. R. 307. His mother, of all persons, knows best how many of those service hours she and her husband will be able to contribute to his care at home. R. 307 and 308. While parents may voluntarily provide care for adult children in the home, Respondent has illegally based assessments on the presumption that parents are obligated to provide the hours of services that are not covered by paid caregivers. The South Carolina Code of

Laws imposes no such obligation upon parents of adult disabled children, just as there is no legal obligation imposed by the State to provide care and supervision for a non-disabled child over age eighteen. The right to receive MR/RD Waiver services belongs to the participant, not to the parent and it was legal error for Respondent to presume, in determining the risk of institutionalization if needed services are not provided, that the parents would be responsible for hours in excess of those they willingly provide. Presuming parental support in excess of hours volunteered by the parents violates 42 C.F.R. 435.602, which prohibits States from considering "income and resources of any relative as available to an individual." Any assessment of need for services that is based on parents of adult disabled children being expected, against their will, to provide services exceeds the authority of the Respondent and is reversible.

The assessment of Richard's need for Respite Services was performed by Dawn Shealey, the DDSN employee authorized to determine whether a waiver participant will receive more than 68 hours a month of Respite (with a maximum of 240 hours allowed, with her permission, under the amended waiver). Ms. Shealy has no training in medicine and she holds a bachelor's in sociology. Ms. Shealy based her determination on an erroneous belief that "The mother works part time and we just felt that 40 hours a week of respite was sufficient." R. 284. This determination was arbitrary and capricious and it was made at pleasure, without rational basis or fixed rules or principles. S.C. Code Ann. 1-23-380(A)(6). Ms. Stogsdill testified that she actually works six part-time jobs, since she was forced to quit her full time job to have a more flexible schedule to take care of Richard when he left school at age 21. R. at 309. Ms. Shealy never met Richard and did not have a clue as to as to his needs for support of activities of daily living, as is evidenced by this exchange:

Q. What happens when Richard wakes up? Can he get out of bed?
 Shealy I don't know. I don't know.
 Q. Okay. Can he toilet himself?
 Shealy I don't know. I don't think so. I know that in the justification the service coordinator had said that the mother does have to get up with him periodically for toileting. But I...
 Q. Can Richard feed himself?
 Shealy I don't know.
 Q. Can Richard take a shower by himself?
 Shealy I don't know.
 Q. Can he get out of - could he get out of the house if the house was on fire?
 Shealy I don't know.
 Q. Okay. What medical reports did you review to determine that 172 hours was sufficient?
 Shealy We didn't - I didn't review any medical records.
 Q. Okay. Have you, have you communicated with his physician?
 Shealy No.

R. 282. When asked "What medical training do you have?" Ms. Shealy responded "I don't have any medical training." R. 279. She was "not sure" whether the risk of Richard developing decubitus ulcers was considered in determining how many respite hours he needs. R. 287.

Ms. Shealy testified that the number of respite hours authorized was based on "the family's work schedule." R. 285. In determining the risk of institutionalization, the State exceeded its authority and erred in presuming that Richard's parents would pick up responsibility for hours not awarded by DDSN. 42 CFR 441.302 requires DHHS to assure CMS that the health and welfare of waiver participants is protected. 42 CFR 435.602, titled "Financial responsibility of relatives and other individuals," prohibits DHHS from considering the income and resources of any relative of a waiver participant over age 21 as being available to an individual.

The only other witness to testify for the Respondent at the 2010 hearing was Mr. Chorey.

He does not have any medical training to determine Richard's risk of institutionalization if the requested services are not provided. R. 291 and 303. Mr. Chorey had no personal knowledge of Richard and was present just to testify that "the process was implemented appropriately per the regulations that we operate under." R. 300 and 301. There is no evidence in the record that anyone at DDSN or DHHS ever contacted Richard's physician or considered the opinions of his treating physician in determining what services he would receive or the level of risk of institutionalization if the services ordered by Richard's physician were not provided. The Administrative Law Court's finding that Respondent took the opinions of Richard's treating physician into consideration, as required by the 2009 order issued by Hearing Officer Loomis, is not supported by any fact in the record. R. 11. (ALC Order at 7.)

Richard was prejudiced by the lower court relying upon the assessments of Respondents' unqualified witnesses as to his risk of institutionalization. The South Carolina Supreme Court recently held that it was improper for the lower court to rely upon the assessment of state employees who were not qualified by training or experience to make assessments as to the need for treatment. *In re Care and Treatment of Thomas S.*, Case No.27241 (S.C.S.Ct. April 10, 2014). In that case, the Court held that the need for treatment must be made by experts, not by lay witnesses who are state employees with no first hand knowledge of the individual's condition. *Id.*

There is not a scintilla of evidence that supports the finding of the lower court that Richard's risk of institutionalization is "speculative." Respondent has failed to rebut the opinions of Richard's treating physician and his provider of psychological services, who provided sworn statements that he is at risk of institutionalization if the services ordered by his physician are not provided. His mother testified that she and Richard's father are incapable of providing the care and supervision required to maintain Richard at home if these services are not provided. R. 307 and 308. Richard requests a declaration by this Court that the threat of his institutionalization is a sufficient basis for an ADA claim and that he has proven that this claim is not "speculative." He

requests an order finding that Respondent erred in basing its assessments for services on the presumption that Richard's parents would provide more hours of care than they have agreed that they are capable of providing. He requests a finding that Respondent improperly shifted the burden of caring for Richard during the day from the school system to his parents, who have no legal duty to provide for his care, in violation of the requirements of the Medicaid Act to provide services in the amount, duration and scope to meet the purposes of the waiver program, i.e. to keep Richard out of an institution. *Moore v. Cook*, 1:07-CV-631-TWT (GANDC April 19, 2012). Richard requests a finding that the lower court erred in its finding that Respondent gave consideration to the opinions of Richard's treating physician and that Respondent has thus violated the 2009 order that required Respondent to consider these opinions on remand.

Issue 2. What weight must Respondent and the Courts give to the opinion of the treating physician in determining medical necessity in consideration of *Olmstead's* "greatest of deference" standard?

In *Olmstead*, the United States Supreme Court established the standard that states must apply in making treatment determinations for qualified persons with disabilities. Justice Kennedy wrote in that opinion that States are obligated to give the opinions of the treating physician the "greatest of deference." *Supra* at 610. Justice Kennedy cautioned States against placing persons like Richard in settings where they would receive "too little assistance and supervision," warning that the States may not satisfy their obligations under *Olmstead* by leaving qualified individuals in "integrated settings devoid of the services and attention necessary for their condition." *Id.* That is exactly what Respondent has done in this case.

In *Peter B. v. Sanford*, the Federal District Court for the District of South Carolina relied upon the "greatest of deference" standard to determine that the 2010 waiver amendments violate the ADA and that the opinions of the plaintiffs' treating physicians must be given deference:

The care the plaintiffs require is complicated, burdensome, and inexact. In some respects, there is no easy answer to their situations. But certainly, if anyone knows what might be the best, among many less than perfect alternatives, it is the plaintiffs, their families, and

their physicians. To credit those accounts, earnestly, seems in keeping with the manner in which these cases are to be considered. *See Olmstead*, 527 U.S. at 610 (Kennedy, J., concurring) (“The opinion of a responsible treating physician in determining the appropriate conditions for treatment ought to be given the greatest of deference.”)

R&R, *supra* at 7.

This standard of deference to the treating physician that was set forth in *Olmstead* is in keeping with the legislative history of the Medicaid Act, which states that “(t)he physician is to be the key figure in determining utilization of health services.” S.Rep. No. 404, 89th Cong., 1st Sess., 46, Reprinted in [1965] U.S.Code Cong. & Admin.News pp. 1943, 1986. As the United States Supreme Court noted in *Beal v. Doe* “Thus the very heart of the congressional scheme is that the physician and the patient should have the complete freedom to choose those medical procedures for a given condition which are best suited to the need of the patient.” 432 U.S. 438, 450 (1977). This medical judgment must be exercised in light of all relevant factors - physical, emotional, psychological, familial - and it allows the attending physician “the room he needs to make his best medical judgment.” *Id.* See also *In re Ryan*, 2008 Vt. 93, 958 A.2d 678 (Vt. 2008) (Vermont Supreme Court decision where physician’s opinion was given weight in reversing decision of agency where physician determined medical necessity for more hours of personal care services than awarded by state.)

42.U.S.C. 1396a(a)(17) of the Medicaid Act requires the state to apply “reasonable standards” in determining the need for Medicaid services. In order to be reasonable, the standards for determining medical necessity must comply with the directives set forth in *Olmstead*, as well as state law. Deference to the reasonable opinions of treating physicians is also required by the South Carolina Medical Practice Act. In South Carolina, the act of determining medical necessity

or appropriateness of proposed medical care, so as to affect the diagnosis or treatment of a patient located in South Carolina, is the practice of medicine, as defined by Section 40-47-40 of the 1976 Code of Laws of South Carolina, and that act can only be performed by a physician licensed to practice medicine in this State. Making determinations of medical necessity and determining appropriateness of medical care “requires independent medical judgment that is reserved to physicians, **especially determinations to deny, reduce, or terminate health care services or to deny payment for a health care service because that service is not medically necessary.**” Feb. 5-7, 2001 order of the SC Board of Medical Examiners at T:\ORDERS\07\Moore\07cv631\msjtw2.wpd .

Instead of applying reasonable standards, that comply with the deferential standard set by the Supreme Court in *Olmstead* and the Medical Practice Act, the record demonstrates that Respondent has denied and reduced Richard’s waiver services without review by any physician or other medical professional qualified to make these determinations. As the state agency attempted to do in *In the care and treatment of Thomas S.*, Respondent has illegally relied upon medical determinations made by lay persons who have no license to practice medicine. As the Supreme Court did in *Thomas S.*, this Court should reverse that decision and order the agency to provide the services ordered by Richard’s physician.

As the Georgia Medicaid agency attempted to do in *Moore v. Cook*, Respondent in this case has based its decision to reduce Richard’s hours of services “on bureaucratic gobbledegook having no relation to her [in this case “his”] actual condition or needs.” Case No. 1:07-CV-631-TWT, 2012 WL 1380220, at *10 (N.D. Ga. Apr. 20, 2012). In *Moore*, a physician retained by the State reviewed only medical summaries and denied services ordered by the plaintiff’s physician.

In holding that the opinions of Moore's treating physician must be given greater weight, the court considered the fact that her treating physician had treated her since she was an infant and his determination of what services were medically necessary were based on "his actual knowledge of what was going on in the child's home and what care was available." In this case, Dr. Joseph treated Richard since he was young and the record demonstrates that the persons making decisions at DHHS did not even review or consider his medical records. In Richard's case, the gatekeepers had no medical training at all, they had never met Richard and they were totally unfamiliar with his day to day need for assistance with activities of daily living.

Applying these factors to Moore's case, the district court held: "I am convinced that the real reason for reducing Callie's nursing care hours was an unreasonable application of the GAPP policy to wean nursing care and shift more of the burden to her caregiver." *Id.* The court concluded that the state breached its duty to ensure that plaintiff's services were "sufficient in amount, duration and scope to reasonably achieve its purpose." *Id.* 42 C.F.R. 440.230(b). Before Richard reached age 21 in 2008, the State provided one-on-one supervision for him during the school day. R. 306. But this burden was shifted to his parents upon graduation.

Certainly, where a physician's opinion departs substantially from accepted standards the Courts will not blindly enforce that physician's orders, but that is not the case here. But, since this appeal was filed in 2009, Respondent has failed to provide an opinion from a single qualified medical professional to support its contention that Richard requires fewer hours of supervision than Dr. Joseph has ordered. This is not a case where any responsible licensed physician is claiming that Dr. Joseph's ordered treatment departs from accepted standards.

It is well established in the record that Richard needs two caregivers to lift him. R. 306 and 920. The record shows that due to his spasticity, Richard requires total assistance with bathing, dressing, toileting, brushing his teeth, grooming, purchasing food, preparing meals and doing laundry. R. 920. Without hands on care with ambulation and positioning, he will develop decubitus ulcers which would likely jeopardize his general health status. R. 920. Richard's treating physician, Dr. Joseph determined, based on his experience treating Richard for many years, that Richard is not an appropriate candidate for a congregate program. R. 921. Dr. Joseph determined that Richard needs 16 hours a day of PCA services to remain in his home (two persons, eight hours a day) and there is no evidence in the record that this is order "departed from accepted standards" of medical care. R. 921. His physician determined Richard also needs five hours a day of Adult Companion Services to prevent regression in his social skills and to maintain good mental health. Id. Dr. Joseph determined in 2010 that these services are needed in addition to the 172 hours a month of Respite Services, which were authorized in May of 2010. According to Dr. Joseph, if Richard were to be placed in an institution, he would experience a marked decline in both his mental and physical health. R. 921 and 922.

Dr. Joseph provided a well reasoned explanation for the services he ordered. Id. Richard would experience "trauma" from being segregated from non-disabled persons and being forced to live in a congregate setting. R. 92. Richard's psychological services provider, agreed with his physician that placement in a congregate setting would increase Richard's anxiety and depression and that his parents are unable to continue providing the services they have provided in the past to prevent his institutionalization. R. 917. Ms. Mullis opined that Richard requires the combination of services ordered by his physician if his parents are going to be able to provide the supports he

needs to remain in his home. R. 918. She signed a sworn statement stating that his physician is “most capable of determining the hours of personal care which are needed to protect his health and welfare and to allow him to remain in the community.” R. 919.

Richard has provided evidence from audits and reports issued by Respondent, the South Carolina Legislative Audit Council and Protection and Advocacy for Persons with Disabilities, Inc. which provide a foundation for the concerns Dr. Joseph and Ms. Mullis expressed as to the risk of harm if the home-based services ordered are not provided. In 2005, Protection and Advocacy for Persons with Disabilities, Inc. issued a report on DDSN programs titled: *Unequal Justice for South Carolinians with Disabilities: Abuse and Neglect Investigations*, which detailed reports of a massive failure to protect individuals in DDSN programs. R. 484 to 560. In the Executive Summary, this report begins:

Physical Abuse. Sexual Abuse. Neglect. Misuse of medications. Few incidents are reported. Fewer are properly investigated. Rarely are offenders held accountable. Those who should protect people with disabilities often fail to do so.

R. 487. The report goes on to describe the failure of DDSN to protect individuals in its programs. A report describing the failure of state agencies to protect persons living in Community Residential Care Facilities was issued by P&A in 2009, documenting no improvement in conditions. R. 561. Respondent’s own audit of the DDSN Medicaid MR/RD waiver program documented deficiencies including “homes that were unsanitary and in need of repair and maintenance; a lack of background checks on caregivers; and multiple medication errors.” R. 433,436. Then, in 2008, the South Carolina Legislative Counsel reported no significant improvement in conditions in DDSN programs:

...DDSN may not have ensured enforcement of its personnel policies related to abuse, neglect, or exploitation incidents. Also, DDSN does not have an adequate system to ensure that caregivers dismissed for consumer safety infractions are not rehired elsewhere in the system.

R. 685. The lower court erred in failing to give the greatest of deference to the opinions of Dr. Joseph and Ms. Mullis as to Richard's need for services to remain in the community and the risks to his health and welfare, perhaps even his life, if these services are not provided at home and he were to be forced into a DDSN residential program. This was the case in *Knowles v. Horn*, where the plaintiff had disabilities quite similar to Richard's and required 24 hour around-the-clock care. Case No. 3:08-cv-1492-k (N.D.Tx. February 10, 2010). The State of Texas provided Knowles the choice of reduction in his home-based services or admission into a State institution. *Id.* Like Richard, Knowles wanted to live in the community and opposed entry into the institution. As did Richard's physician and Ms. Mullis, Knowles' treating physicians determine that his health and safety could not be protected in an institution. Despite the fact that the cost of his care at home exceeded the average cost of institutional care, the Court held that "the State's plan would cause an unjustified institutional isolation of Knowles, which would result in an ADA violation. *Id.*

The Administrative Law Court erred in its finding that the 2009 Order requiring consideration of the opinion of Richard's physician was followed on remand, because there is not a scintilla of evidence in the record that the physician's opinion was considered by, or even known to Richard's service coordinator, Ms. Shealy or Mr. Chorey. R. 14. (Order of ALC at 10.) Richard has proven that the failure to provide the services he has requested place him at risk of institutionalization and Respondent failed to present any evidence to contradict the credible evidence presented by Appellant. For this reason and the reasons set forth below, Richard requests

an order requiring Respondent to provide the PCA, Adult Companion and Respite services ordered by his physician.

Issue 3. Has Respondent failed to meet its burden under the Americans with Disabilities Act, as set forth in *Olmstead v. L.C.*, of proving that it would place an unreasonable burden on the State to provide the medically necessary services ordered by Richard's physician, or that providing these services would force the State to fundamentally alter the nature of its programs?

The Administrative Law Court ruled that "If the accommodation would fundamentally alter the State's program, the State does not have to make the accommodation." R. 15. (Order at 11.) But, the Court failed to explain how Respondent's system would be fundamentally altered by providing the services Richard's physician determined that he needs to remain in the home or to describe why providing those services would cause an "unreasonable burden" to the agency..

DDSN is required by the ADA and *Olmstead*, as well as state law, to provide services in the least restrictive environment. *Doe v. Kidd*, 501 F.3d 348 (4th Cir. 2007), citing *Olmstead v. L.C.* 527 U.S. 581 (1999); S.C.Code Ann. § 44-20-20 (2006). The United States Supreme Court has determined that the burden of proving whether an action would cause a fundamental alteration under the ADA lies with the State. *Olmstead* at 603. Once a qualified individual proves his *prima facie* case in an action brought under the ADA, i.e. demonstrates that (1) he is a qualified person with disabilities, as defined in the ADA, (2) the State has determined that community based treatment is appropriate and (3) he does not oppose living in the community, then the burden shifts to the State to prove that providing the requested services would require a "fundamental alteration" in the nature of its programs. *Olmstead*, 527 U.S. at 604. Richard has clearly met his burden and he has requested reasonable modifications to the MR/RD Medicaid waiver program, but Respondent has failed to prove, during the four years it has had since he filed his 2009 appeal,

that it would cause “fundamental alteration” for the State to provide the services he needs to live in the community.

In discussing the meaning of “fundamental alteration,” the plurality in *Olmstead* instructed the States that:

Sensibly construed, the fundamental-alteration component of the reasonable-modifications regulation would allow the State to show that, in the allocation of available resources, immediate relief for the plaintiffs would be inequitable, given the responsibility the State has undertaken for the care and treatment of a large and diverse population of persons with mental disabilities.

Id. at 604. One way that the State may meet its burden by demonstrating that it has made reasonable modifications to its programs is to demonstrate that it has a comprehensive or effectively working plan to provide services in less restrictive settings:

If, for example, the State were to demonstrate that it had *a comprehensive, effectively working plan* for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated, the reasonable-modifications standard would be met.

Id. at 605-606 (emphasis added). But, unlike most states, South Carolina does not have a comprehensive or effectively working *Olmstead* plan. In fact, Richard has provided evidence showing that the real purpose of the 2010 amendments was to keep DDSN's institutional beds in ICF/MR's full with waiver participants who need Respite care and to fill slots in segregated workshops operated by DSN Boards, where waiver participants are segregated from non-disabled persons and isolated during many of their waking hours. The number of waiver participants forced to resort to submission to ICF/MR admission for Respite, by Respondent's own admission, increased more than four fold under the amended waiver. R. 891 to 893. After the amendments, the number of bed days waiver participants were predicted to spend in ICF/MR Respite increased

by more than 50% and the cost of Respite Services provided in institutional settings was predicted to be more than ten times the amount spent in 2009.² Id.

AARP has reported that between 2004 and 2006, in South Carolina, “the number of Medicaid participants receiving home and community-based services (HCBS) decreased,” while the number receiving institutional services remained constant. R. 860. The Direct Care Alliance organization reported that South Carolina was one of the worst performing states, spending above average amounts for institutional services when compared to community-based services. R. 868.

According to Respondent’s July 19, 2009 brief, it would be improper for the Court to even consider the costs of Richard’s services in this appeal. R. 189 to 190. When Richard’s request for additional hours was denied in 2009, Respondent filed a brief on July 13, 2009, just after DDSN informed the DDSN Commission that it was necessary to amend the waiver due to budget reductions. In this brief, Respondent disavowed that the costs of the services Richard’s doctor ordered was a factor in the agency’s decision to deny his request: “The Respondent has not raised any cost concerns.” R. 189. In that brief, Respondent argued that “indications about the diversion of funds to the workshops and purchases of real property” were “not relevant to this case.” Id.

Prior to the amendment approved by Respondent, there were no caps placed on the number of days or hours of Respite Services a waiver participant could receive in his own home or in a community setting, outside of an institution. Before 2009, under the terms of the waiver,

² Respondent reported to CMS that the total cost for ICF/MR Respite Services would increase by more than \$1 million in 2010, from \$103,818 to \$1,122,660. R. 891 to 893. Richard provided evidence that under the amended waiver, Respondent actually increased the rate paid to DDSN and its local DSN Boards for these institutional ICF/MR Respite Services by 70%. R. at 697 to 700. Under the “new” waiver, the daily rate for ICF/MR respite increased from \$157 per day in 2009 (R. at 697) to \$270 per day.

limitations on home-based Respite Services, PCA and Companion Services were based solely on medical necessity. R. 152. After the 2010 amendments, pursuant to the terms of the Waiver Document (which established binding norms without promulgation of regulations or approval of the legislature), any waiver participant who requires more hours than allowed under the caps had no choice but to enter a congregate residential program or be admitted to an ICF/MR for Respite care. Prior to these amendments, allocated hours were available to the waiver participant to be used on an annual, not monthly or weekly bases. R. 243. Under the waiver amendments, if a waiver participant does not use the hours allocated for the week (PCA and Companion Services) or the month (Respite), they are forever lost. Any waiver participant needing more than 10 days a month, under any circumstances, would have no option but to submit to entering a DDSN institution. For example, in the event that an aging parent breaks a hip and requires 6 weeks of rehabilitation before she can resume providing supports in the home for her adult child, the only option would be to place the child in an institution for this care. It is uncontradicted that the risk of waiver participants entering an institution increased significantly by the Respite Service caps imposed in 2009, as demonstrated by the cost neutrality charts contained in Respondent's Waiver Documents. R. 891 to 894.

Federal regulations at 42 C.F.R. 441.303 require the State to report to CMS the average cost per waiver participant as "Factor D" on the waiver application. These costs must be compared with "Factor G," which is the average cost of services if these participants were provided services in an ICF/MR. *Id.* In 2009, the average cost per MR/RD Medicaid waiver participant was \$36,209, according to the Waiver Document. R. 891. According to the waiver application for 2010 (Year 1 of the amended waiver), the average annual cost per participant

(Factor D) increased to \$44,232.12. R. 893. According to the Waiver Documents, which were not contested by the Respondent at the hearing, this was an increase in costs of \$8,023.32 per waiver participant per year. Id. But the letter CMS sent to the director of DHHS on November 9, 2009 states that Factor D, i.e. the average cost per participant was projected to be \$51,869. This letter, which was attached to Respondent's brief, appears to have been omitted from the Record. If this "Factor D" is correct, the total cost of waiver services under the "new" waiver amendments would be \$326,774,700, an increase of \$109,522,095 per year over the total MR/RD Waiver program costs in 2009.

Although the State can legally limit the number of waiver participants, while claiming lack of necessary funding to provide waiver services to the individuals it was obligated to serve, as documented in the amended waiver and the CMS letter dated November 9, 2009, DHHS chose to increase the number of waiver participants from 6,000 to 6,300 during FY 2010 (according to Waiver Documents). If the real reason for reducing services was budget reductions, it is unexplainable why Respondent would increase the costs of the overall program by adding participants. The evidence Richard provided, including adding new participants and increase in the total cost of the waiver reported by DDSN to CMS support his allegations that the real intent of the amendments was to force disabled persons into the lucrative sheltered workshops, where DDSN profits from their labors and into ICF/MR facilities operated by the State and its local DSN Boards to keep their beds full.

It is no wonder that by the time of Richard's hearing, the DHHS cries that home-based service reductions were due to "budget reductions" had been abandoned, although that was the justification for the service reductions provided to CMS on page 1 of the waiver amendment

application.³ (Page 1 of 194 of the Waiver Document attached to Respondent's Pre-hearing Brief.)

The description of changes Respondent submitted to CMS in the 2010 waiver amendment application states:

Due to the State of South Carolina's budget situation, SCDDSN opted to make some adjustments to the MR/RD Medicaid waiver program. SCDHHS and SCDDSN worked together for many months to consider possible changes administratively allowed within federal regulations...The information gained guided SCDDSN toward making necessary budgetary adjustments...

Attachment to Respondent's Pretrial Brief dated May 6, 2010 at page 90 to 96 of the Record (this attachment and the letter from CMS to the Director of DHHS appear to have been erroneously omitted from Record provided by Office of Appeals and Hearings. These documents should appear at pages 97 and 98 of the Record). The order of the hearing officer contains a cursory finding on page 10 stating that it was "common knowledge" that state agencies experienced budget reductions and it was "fairly obvious" that reducing services would reduce costs. Order at page 10. But these findings are not supported by the evidence in the record, which documents that more money was spent on MR/RD Medicaid waiver services in 2010 than 2009. At the hearing, the Hearing Officer stopped Richard from presenting additional evidence to demonstrate that the reasons given by the agency, i.e. budget reductions, in 2010 were a farce. In his order, the hearing officer held that it was not necessary to prove or demonstrate that the reductions were necessitated due to budget reductions, because CMS had approved the amendments. R. 25. (Order at page 10.)

³ See also the May 19, 2009 Minutes of the Medical Care Advisory Committee Meeting which state "Because of the very tight budget times we face, this became a unique opportunity for the DDSN to look very critically at the services being offered in the waiver package." R. 853.

The hearing officer deferred to a “much higher review panel” the allegations Richard made that federal stimulus funds were diverted. *Id.* The order issued by the Administrative Law Court is totally silent as to the reasons for the reductions in home based services or any lack of funding or resources to provide these services.

Richard provided extensive evidence in the form of audits by DHHS and the South Carolina Legislative Audit Council showing that there has been a long history of the General Assembly allocating millions of dollars to DDSN, with the agency not spending the funds as intended, then spending the money to purchase real estate. R. 701 . LAC Audit. In considering whether the relief Richard requests would impose an unreasonable financial burden on the State, he requests that this Court consider in its “fundamental alteration” analysis that in 2008, the South Carolina Legislative Audit Counsel reported that DDSN failed to spend “more than \$9 million in state appropriations” provided by the General Assembly for services to children with autism, resulting in those funds “remaining unused or being used for different purposes.” R. 647. As a result, according to this audit: “DDSN has not recouped millions in federal dollars it could have received if the services were provided.” *Id.* This audit reported that DDSN “spent just \$7.6 out of the \$25.4 million appropriated” by the General Assembly for new beds for the intended purpose. R. 720. As a result of not spending those funds to provide residential services, as authorized by the General Assembly, DDSN “did not receive the federal funds associate with these beds.” *Id.* (Matching rate was 30% state and 70% federal. *Id.*) The LAC audit reported that it appeared that DDSN actually developed only 60% of the beds for which it had received appropriations from the General Assembly. *Id.* (Although DDSN reported it had developed 76% of these beds, those results were not confirmed by LAC auditors. *Id.*) Between FY 2005 and FY 2008, DDSN

distributed \$17,853,501 in "Capital Grants," but there is no evidence that these capital expenditures were authorized by the General Assembly. R. 701.

This diversion of funds allocated by the General Assembly should have been no surprise to Respondent, because DHHS reported in its own audit of the DDSN MR/RD Medicaid Waiver program in 2006 that "there is a lack of fiscal oversight of the MR/RD waiver program by both DHHS and DDSN." R. 437. The LAC auditors reported in 2008 that "we found that DHHS staff in the Division of Ancillary Reimbursements are not reviewing the DSN Board's audited financial statements..." R. 474.

In considering Richard's arguments that providing services to him would not have caused an unreasonable financial burden on the State, the Court should consider that the federal government increased the matching funding for all Medicaid services so that, according to the agency's finance director, DDSN "could collect an additional \$28.8M of the Medicaid funding" in FY 2009. R. 839. Unlike the federal stimulus funds provided for local governments and education, Governor Sanford did not object to DHHS receiving these federal funds. Richard has alleged in these proceedings that the State diverted federal stimulus funds that were intended to provide services to persons who have disabilities. (As mentioned above, the hearing officer would not allow Richard to introduce this evidence. Order age page 9.)

It is admitted that the cost of Richard's services would increase from \$37,364.45 a year to \$149,774 a year, if the services ordered by his physician were provided. R. 243. Exhibit 5 of Appellant's brief filed on July 6/7, 2009. (This figure is determined by multiplying the number of hours ordered by Richard's physician by the rates contained in the cost chart on pages 891 to 894. But the Court should consider that prior to Richard turning 21 in 2008, the services he received

from DDSN were supplemented by state-funded six to eight hours a day of one-on-one services at school.⁴ The costs of the services his physician ordered would be as follows:

PCA services	16 hours/day, 365 days/year	@ \$16/hr	\$93,440
Adult Companion Services	5 hours/day, 365 days/year	@ \$10.80	\$19,710
Respite (daily)	24 hours/day, 52 days/year	@ \$10.50	\$13,104
Respite (hourly)	2,240 hours/year	@ \$10.50	\$23,520
Total			\$149,774

The *Olmstead* Court rejected a construction of the fundamental alteration defense that simply allows the State to compare the cost of the community services for the plaintiffs with the state's budget, and it declined to hold that relief that results in increased costs would constitute a fundamental alteration *per se*. *Id.* Instead, the Supreme Court directed, that the State must show that the request cannot "be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities." *Id.* at 587, 607. The State of South Carolina "reasonably accommodated" Richard needs, providing the services he needed while in school. It is unreasonable to shift that burden to his aging parents, who have no legal obligation to support him. It is a reasonable accommodation and would not cause a fundamental alteration for DDSN to provide the personal care services formerly provided by the school.

⁴ Richard was promised services from South Carolina Vocational Rehabilitation when he graduated from school, but he went from May to February "with nothing, literally nothing to do." R. at 61. Richard's mother was forced to quit her full time job, because it was not safe to leave Richard at home alone. Richard's father traveled in his work and for a while, his mother was able to find friends who would help, but she finally "... just couldn't do it anymore" R. 61 and 62. Richard's mother had to find six part time jobs "to make ends meet...it's not cheap to have a child with disabilities." R. 63. Richard's mother cannot lift him due to back problems, so she has to have two people in the house to lift him out of bed in the mornings. R. 63.

DDSN and Respondent have “accommodated” other waiver participants who have extremely high needs without a fundamental alteration to its program through “outlier” funding. In Respondent’s 2006 audit of DDSN, the agency reported that: “The cost to care for a limited number of consumers in the MR/RD waiver program are high, but we found no indications that the waiver program does not meet required financial conditions.” R. 460. In that audit, Respondent reported that the cost of one waiver participant was \$158,921 per year and that these costs were appropriately paid by DHHS through the MR/RD Medicaid waiver. R. 459 to 461.

In North Carolina, a federal district court judge granted emergency injunctive relief in 2010, prohibiting the state from reducing home-based services to persons who have a dual diagnosis of mental retardation and mental illness, just three days after the plaintiffs in that case filed their complaint alleging violation of the ADA. *Marlo M. Ex rel. Parris v. Cansler*, 679 F. Supp.2d 635 (E.D.N.C. 2010). The court determined that the plaintiffs, like Richard, were well integrated into the community and that it would be a violation of the ADA to reduce state funding that would force them into group homes or institutional settings. *Id.* See also *Ball v. Rogers*, No. 00-67 (D. Ariz. April 24, 2009) (holding that failure to provide plaintiffs with needed services “threatened Plaintiffs with institutionalization, prevented them from leaving institutions, and in some instances forced them into institutions in order to receive their necessary care” in violation of the ADA and Rehabilitation Act); *Mental Disability Law Clinic v. Hogan*, No. 06-6320 (E.D.N.Y. Aug. 28, 2008) (“even the risk of unjustified segregation may be sufficient under *Olmstead*”); *M.A.C. v. Betit*, 284 F.Supp. 2d 1298, 1309 (D. Utah 2003) (adopting *Fisher*’s position that a plaintiff need not currently be institutionalized to bring integration regulation claim).

The lower court erred as a matter of law by not considering financial evidence in resolving the question of whether immediate relief for Richard would have been inequitable, given “the responsibility the State has undertaken for the care and treatment of a large and diverse population of persons with mental disabilities.” *Olmstead* at 604. The lower court erred as a matter of law in not considering Richard’s argument that DDSN has established a pattern and practice of spending millions of dollars allocated for services “to keep its institutions [i.e. sheltered workshops] fully populated” in violation of the ADA and the State’s obligation to provide services in the least restrictive setting. Richard requests an order finding that the State has failed to meet its burden of proving an unreasonable burden or fundamental alteration and that the Court order Respondent to provide the services Richard’s physician has ordered.

Issue 4. Did the lower court and the hearing officer erred as a matter of law in concluding that the 2010 reductions were “lawful” based solely on the federal Medicaid Agency, CMS, approving them, despite the clear and unambiguous requirements of the South Carolina Administrative Procedures Act prohibiting DHHS from establishing binding norms without promulgation of regulations?

The agency and the lower court erred as a matter of law in finding that the caps on waiver services were legally imposed based on CMS approval of the amendments. That federal agency has absolutely no authority to excuse a state agency from complying with the South Carolina Administrative Procedures Act. The court’s reliance upon CMS approval to determine the legitimacy of the caps was clearly and plainly in error. Congress directed the Attorney General of the United States, not CMS, to issue regulations to implement the ADA. See 42 U.S.C. § 12134; 28 C.F.R. § 35.190(a); Executive Order 12250, 45 Fed. Reg. 72995 (1980), reprinted in 42 U.S.C. § 2000d-1. These regulations require public entities to “administer services, programs, and

activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.” 28 C.F.R. § 35.130(d). The preamble of this “integration mandate” explains that “the most integrated setting” is the one that “enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible.” 28 C.F.R. § 35.130(d), App. A, at 571 (2009). The United States Supreme Court recognized that the federal agency to whom States must give respect in interpreting the ADA is the Department of Justice. *Olmstead* at 583. CMS has no authority to waive compliance with *Olmstead* or the ADA.

Although the Administrative Law Judge in this case did not mention any of these decisions in her order, the Administrative Law Court has repeatedly held that the caps are unenforceable, because they exceeded the authority of DHHS and established binding norms without approval of the General Assembly or promulgation of regulations. *Hickey v. DHHS*, Docket No. 10-ALJ-08-0650AP (SCALC July 19, 2011); *Edge v. DHHS*, Docket No. 10-ALJ-08-0501-AP (SCALC October 29, 2010); *Eubanks v. DHHS*, Docket No. 10-ALJ-08-0502-AP (SCALC October 29, 2010); *Morgan v. DHHS*, Docket No. 10-ALJ-08-0503-AP (SCALC October 29, 2010).

In South Carolina, as in most states, a binding agency policy that has not formally been promulgated as a regulation in accordance with the Administrative Procedures Act (APA) cannot carry the force and effect of law. S.C. Code Ann. 1-23-10(4) specifically states that “policy or guidance issued by an agency other than a regulation does not have the force or effect of law. Respondent and its hearing officers have treated the across the board caps as a binding regulation, but the failure to properly promulgate these changes as regulations, in accordance with the APA renders them invalid and unenforceable. *Hickey v. DHHS*, *supra*. Although an agency is free to develop applicable policies and procedures without the promulgation of regulations, once these

policies and procedures reach the level of being applied as “binding norms” by the agency, they must go through the APA process to be enforceable. *Home Health Serv., Inc. v. S.C. Tax Com’n*, 312 S.C. 328, 440; 440 S.E.2d 375, 378 (1994). To determine whether a challenged policy leaves the agency free to exercise discretion to follow or not follow the policy at issue in a particular situation depends upon whether the agency treats it as a binding norm. *Sloan v. S.C. Bd. Of Physical Therapy Exam’rs*, 370 S.C. 452, 476; 636 S.E.2d 598, 610 (2006). When the policy at issue “so fills out the statutory scheme” that the agency will only look to whether the policy’s criteria are met in taking action or rendering a decision, the policy is considered by the court to be a “binding norm.” *Id.* If, however, the agency remains “free to follow or not follow the policy in an individual case, the agency has not established a binding norm and no promulgation of the policy is necessary. *Id.* See also *Ryder Truck Lines, Inc. v. U.S.*, 716 F.2d 1369; 1377 (115h Cir. 1983). Further, the Supreme Court has cautioned that in cases where it is a “close question whether a pronouncement is a policy statement or a regulation, the [agency] should promulgate the ruling as a regulation in compliance with the ADA.” *Sloan* at 475.

In this case, Respondent has, throughout these proceedings, treated the 2010 caps as a binding norm by which all recipients are bound, without exception to their individualized needs. The Director of DDSN, Beverly Buscemi, affirmed in her response to Richard’s request for reconsideration of the agency’s decision that: “These approved limits cannot be exceeded and must be applied to all MR/RD Medicaid Waiver participants.” R. 940. Because the benefit cuts have been treated and applied as a binding norm, they were required to be promulgated as a regulation under the plain terms of the APA. This Court should note that the Respondents’ failure to do so is not a new phenomenon and it should not be countenanced by this Court. For example,

in *Corbett v. DHHS*, the Respondent argued (unsuccessfully) that DHHS was not required to promulgate regulations concerning the waiver program, despite the fact that the agency treats the Manual as a binding document. No. 07-ALJ-08-0278-AP (July 16, 2008). In a firm rejection of this argument, the Administrative Law Court held that “CMS’ approval of the State’s Medicaid Plan or Manual does not make it a binding document...[and] it must be promulgated as a regulation” in order to be considered “binding.” Id.

The APA requires a state agency to comply with specific, statutorily mandated steps before a policy can become a regulation. S.C.Code of Laws 1-23-110 to 160, *Sloan*, 370 S.C. 452, 474 (2006). It is undisputable that Respondent has failed to comply with these requirements and the agency and the lower court relied entirely erroneously upon the fact that an employee of the Atlanta Regional Office of CMS approved the amendments, ignoring the internally inconsistent fact that the cost of operating the program would increase by millions of dollars and add 300 new waiver participants - while the reason given for the need to reduce services was severe budget reductions. Such binding norms that are not “established pursuant to rulemaking formalities” under the APA are “unenforceable, null and void, and without legal effect.” *W. Carolina Reg’l Sewer Auth. v. SCDHED*, Nos. 98-ALJ-07-0267-CC; 98 ALJ-07-0585-CC (Sept. 22, 1999), 1999 ENV. LEXIS 102. Because Respondent has made no attempt to comply with the APA and to promulgate its binding service caps as regulation, the lower court erred in its finding that the amendment was lawfully made.

The caps are “unenforceable, null and void” and cannot be used to deny medically necessary services ordered by Richard’s treating physician. Richard respectfully requests an order from this Court holding that Respondent must comply with the APA and promulgate the policy as

regulation before applying these caps to any Medicaid beneficiaries, including Richard. The wrongs Richard and others have suffered due to this illegal action by Respondent are subject to repetition, yet they have evaded review. In *Myers v. DHHS*, the Administrative Law Court adopted the holding in *Hickey*, finding the caps to be unenforceable. Docket No. 10-ALJ-08-0504-AP. Yet, on remand to DHHS, the agency once again applied the same illegal caps, ignoring the holding of the Administrative Law Court that the caps were unenforceable, because they had not been promulgated as regulation. *Myers v. DHHS*, 11-MISC-302 (MR/RD Waiver) (SCDHHS March 13, 2012). (Myers case is now pending in Administrative Law Court.) On remand, the DHHS Hearing Officer ignored *Hickey* and other cases in which the Administrative Law Court held the caps to be unenforceable and held that: "...in the case of *Hickey v. SCDHHS*, the enforcing of Waiver limitations is not prevented as long as an evidentiary hearing is offered. Order age page 3. Despite the Administrative Law Court holdings that the caps are unenforceable, on remand, the agency applied the caps to Myers, who, subsequent to the remand order was institutionalized. Order at 3. See also *Myers v. DHHS*, 11-MISC-302(MR/RD) (SCDHHS February 9, 2012).

In other states, even where the reductions in home and community based services were approved by the state legislature, courts have prohibited the reductions, even though CMS approved the waiver amendments. *Crabtree v. Goetz*. No. 08-cv-0939, 2008 WL 5330506 (M.D. Tenn. Dec. 19. 2008) at *30. In *Crabtree*, the State of Tennessee sent written notices to Medicaid participants informing them that the legislature had passed a law limiting home health and nursing benefits to no more than 40 hours a week. Case No. 3:08-cv-00939, Document 23 at page 2 to 5, "Defendant's Memorandum in Opposition to Plaintiff's Motion for Preliminary Injunction." Prior

to this amendment, which was approved by CMS, waiver participants could receive unlimited number of hours of home health aide and nursing services, up to 24 hours a day when ordered by a physician. *Id.* at 3. The cost of these at-home services was up to \$192,720 a year for some participants, compared to \$55,250 a year it would cost in a nursing facility. *Id.* As in Richard's case, the State in *Crabtree* first attempted to enact these reductions without an individual assessment of medical necessity. The federal district court granted plaintiffs' motion for a preliminary injunction in that case, prohibiting the State from reducing these waiver services based on plaintiffs' claims that the amendment would violate the Americans with Disabilities Act. No. 08-cv-0939, 2008 WL 5330506 (M.D. Tenn. Dec. 19, 2008) at *30. The district court determined that irreparable harm was likely and enjoined the State from implementing reductions to home based waiver services, *even though CMS had approved the reductions*. In *Crabtree*, the federal district court recognized that forcing the plaintiffs into institutions would cause mental depression, a shorter life expectancy, and for some, even death. *Id.*

In *M.R. v. Dreyfus*, the district court determined that the plaintiffs were not entitled to a hearing when Medicaid-funded personal care services were reduced pursuant to an executive order issued by the governor of the State of Washington due to the "national economic downturn." 663 F.3d 1100, 1105 (9th Cir. 2011). The services that were reduced included assistance with eating, bathing, dressing, moving from place to place, and using the toilet, similar to the services at issue in Katie's case. The district court determined that the waiver participants had no right to appeal the reductions because it was a "a mass change that affects ... all recipients." *Id.* at 1107. But the Ninth Circuit disagreed, holding that the Americans with Disabilities Act was likely

violated because the plaintiffs were at risk of institutionalization due to the reductions in services, which averaged ten percent per beneficiary. *Id.* at 1115.

States around the country have responded to this trend of enforcement of the ADA by the courts by increasing, not decreasing as South Carolina has done, services in the least restrictive settings. In *Hutchinson v. Patrick*, the First Circuit held that the plaintiffs were the prevailing party in a settlement requiring the Commonwealth to expand community services for Medicaid-eligible individuals with acquired brain injuries. 636 F.3d 1 (1st Cir. 2011). In *Ball v. Rodgers*, the Arizona district court found irreparable harm where the state created mental and physical distress by failing to provide home based services instead of forcing plaintiffs to enter more expensive nursing homes. 4:00-cv-00067-EHC.(D. Ariz. April 24, 2009). In that case the court held that the state violated the Americans with Disabilities Act by failing to provide services in the most integrated setting appropriate to the needs of plaintiffs.

Issue 5. Has DHHS violated Richard's rights of due process and the Constitutional requirements of separation of powers?

Respondent's theory, which was erroneously adopted by the lower court, that it may legally alter the use of funds allocated by the General Assembly based on DHHS staff convincing CMS Regional Office staff in Atlanta to approve their applications for amendments to the MR/RD Medicaid Waiver program, simply does not hold water. According to DHHS, CMS Regional Office approval is all that it needs to impose caps on PCA, Adult Companion Services, Respite and Nursing Services and to totally terminate other medically necessary services, like Physical Therapy, Occupational Therapy and Speech and Language Therapy. This reliance on the power of CMS is grossly misplaced. If the Court should accept Respondent's theory, an executive arm of

the government, without promulgation of regulations or oversight by any court, could divert funds that were intended by the General Assembly to provide home-based services to Richard (and other waiver participants like him) to institutions run by DDSN and its local DSN Boards.

As the South Carolina Supreme Court recently discussed in *Hampton v. Haley*: The South Carolina Constitution establishes three branches of government and requires they be "forever separate and distinct from each other, and no person or persons exercising the functions of one of said departments shall assume or discharge the duties of any other." S.C. Const. art. I, § 8. This mandate of a separation of powers stems from "the desirability of spreading out the authority for the operation of the government. It prevents the concentration of power in the hands of too few, and provides a system of checks and balances." *State ex rel. McLeod v. McInnis*, 278 S.C. 307, 312, 295 S.E.2d 633, 636 (1982).

Case No. 27244 (S.C. S.Ct. April 24, 2013). That is exactly what has happened in the administration of the MR/RD Medicaid waiver program. Audits have demonstrated that the millions of dollars of funds appropriated by the General Assembly are not being spent for the intended purposes. R. 718 to 729. The 2008 audit by the Legislative Audit Council reviewed "whether DDSN used state appropriations for new and expanded services in accordance with legislative intent." R.718. LAC found that "DDSN has not yet provided many of the new services for which it received funding. In addition, DDSN has not recouped millions in federal Medicaid dollars it could have received if services were provided." R. 719. The General Assembly appropriated \$11.5 million for 630 beds in FY 06 and FY 07. But LAC reported its auditors "could not determine how many beds DDSN developed," however, the agency was serving only 380 more individuals by the end of FY 08 than it had served in FY 05. R. 719. DDSN only developed 60% of the beds it had received appropriations to provide. R. 720. LAC estimated that DDSN spent just \$7.6 million of the \$25.4 million appropriated for new beds and it lost the 70% matching federal funds associated with these beds. R. 720. During this period, DDSN granted a

private corporation “approximately \$2.4 million in infrastructure grants for a new administration building and other non-residential purposes...” R. 722. LAC reported that “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. During FY 07, the General Assembly appropriated \$3 million for a new program to serve children with autism, but only \$10,454 was spent for this purpose. R. 723. During FY 08, the General Assembly appropriated an additional \$7.5 million for this program, but DDSN only spent \$661,463 for the intended purpose. Id. Because the funds were not spent as intended, the State lost approximately \$13.6 million in matching federal funds. Id. The General Assembly appropriated enough to spend \$37,000 per participant, but only an average of \$15,000 per child was spent on the few children who actually received services. Id. Only 69% of funds allocated by the General Assembly for post-acute rehabilitation for persons with head and spinal cord injuries was spent for the intended purpose. R. 724. DDSN reportedly spent millions providing funding to private advocacy groups that had not been appropriated for that purpose by the General Assembly. R. 726. One private organization received \$170,330 to purchase an administrative office building without legislative approval. R. 727. LAC reported that “If the General Assembly intended for DDSN to fund the operations of other private non-profit groups, it could fund them directly through DDSN’s budget.” R. 717. The \$1.5 million paid without legislative approval to private organizations could have generated a federal match of \$3.5, had those funds been spent providing services for waiver participants. R. 726 and 729.

Richard has alleged in this case that funds appropriated by the General Assembly to provide services to him and other waiver participants were illegally diverted. Instead of spending

appropriated funds providing home and community based services, Respondent and DDSN waited until the General Assembly adjourned for the year to obtain "permission" from CMS to divert funds to DDSN workshops, ICF/MR facilities operated by DDSN and its local Boards and to purchase real estate by means of a waiver amendment. While claiming to have no choice but to drastically cut funding for PCA, Companion and Respite Services provided in the home and community to Richard and others, within weeks of approving the service reductions, the Director of DDSN obtained authorization from the South Carolina Budget and Control Board to spend approximately \$2.6 million out of \$7.8 million of "excess funds" to purchase real estate for two local DSN Boards and a private corporation. R. 881 to 887. The quid pro quo appears to have been DDSN transferring \$3,244,738 of these "excess funds" to the South Carolina Budget and Control Board. R. 885. Those funds transferred to the Budget and Control Board were purportedly "to meet the department's obligation to the SCEIS" (the computer system purchased by Budget and Control Board). R. 881. But those expenditures, (including the purported obligation for the transfer of funds for SCEIS) do not appear to have been reviewed or allocated by the General Assembly. None of these expenditures were of an emergency nature and there appears to be no justification for not obtaining legislative authorization for them.

In *Hampton v. Haley*, the Supreme Court recognized that:

At its simplest, the constitutional division of powers can be described as "[t]he legislative department makes the laws; the executive department carries the laws into effect, and the judicial department interprets and declares the laws." *State ex rel. McLeod v. Yonce*, 274 S.C. 81, 84, 261 S.E.2d 303, 305 (1979). In our division of powers, the General Assembly has plenary power over all legislative matters unless limited by some constitutional provision. *Clarke v. S.C. Pub. Serv. Auth.*, 177 S.C. 427, 438–39, 181 S.E. 481, 486 (1935). Included within the legislative power is the sole prerogative to make policy decisions; to exercise discretion as to what the law will be. *State v. Moorer*, 152 S.C. 455,

479, 150 S.E. 269, 277 (1929); *Sutton v. Catawba Power Co.*, 101 S.C. 154, 157, 85 S.E. 409, 410 (1915).

Id. But, because DDSN and Respondent have refused to promulgate regulations for the operation of the Medicaid waiver programs, they have usurped the power of the legislature by denying services based on binding norms written by agency staff without review or approval of the General Assembly. As the Supreme Court held in *Hampton*:

Of course, the executive branch, including the Board, may exercise discretion in executing the laws, but only that discretion given by the legislature. *See Moorer*, 152 S.C. at 478, 150 S.E. at 277. Thus, while non-legislative bodies may make policy determinations when properly delegated such power by the legislature, absent such a delegation, policymaking is an intrusion upon the legislative power.

Supra.

Through the agency's operation of the "fair hearing" system, Respondent and the executive branch have intruded on the power of the judicial department to interpret the laws. Although federal regulations require a final determination within 90 days, in this case, Richard has spent four years before his case came before a tribunal outside of the executive branch. 42 C.F.R. 431.244(f)(1). Other waiver participants have experienced the same delays. In 2005, Jane Doe filed an appeal with DHHS. *Jane Doe v. DHHS*, *supra*. Her appeal finally made its way to the Supreme Court, which reversed the agency's decision and remanded for review by the agency. Id. Seventeen months later, no final order has been issued by DHHS. In 2005, Peter Brown filed an appeal with DHHS, but his case was dismissed by the hearing officer without providing a fair hearing on the merits. *Brown v. DHHS*, 393 S.C. 11, 709 S.E.2d 701 (S.C.App. 2011). The South Carolina Court of Appeals reversed and remanded Brown's case for a hearing on the merits. Id. But, in April of 2013, DHHS again dismissed Brown's case, over his objections, without providing a fair hearing. Order of DHHS Hearing Officer in *Brown v. DHHS* dated March 12,

2013. In *Hickey, Edge, Eubanks, Morgan and Myers*, DHHS dismissed each request for a fair hearing, which forced these disabled persons to spend time and resources filing an appeal with the Administrative Law Court instead of what Congress intended to be a simple and speedy administrative review. *Supra*.

The Fourteenth Amendment of the United States Constitution, the Due Process Clause, prohibits state and local governments from depriving persons of life, liberty, or property without certain steps being taken to ensure fairness. 42 CFR 431.201 defines notice as “a written statement that meets the requirements of § 431.210.” Article I, Section 22 of the South Carolina Constitution states “ [t]he fundamental requirements of due process under the United States Constitution and the South Carolina Constitution include notice, an opportunity to be heard in a meaningful way, and judicial review.” Due process requires, at a minimum, providing an opportunity for presenting to designated personnel empowered to rectify an error made by the State in wrongfully denying Medicaid services, and here such a procedure was not made available to Appellant. Richard’s interest in “not having services terminated is self-evident, the risk of erroneous deprivation of services is not insubstantial, and the utility’s interests are not incompatible with affording the notice and procedure described above.” *Matthews v. Eldridge*, 424 U.S. 319, 16-19 (1976). Notice in a case of this kind “does not comport with constitutional requirements when it does not advise the customer (“consumer”) of the availability of an administrative procedure for protesting a threatened termination of ... services as unjustified...” *Id*. Even if Respondent had made "good faith efforts" (which it has not), notice would not be effective absent strict compliance with 42 CFR 431.210. Medicaid's implementing regulations set forth very detailed requirements for written notice related to the right to appeal which require DHHS to

provide not only the reasons for the reduction, suspension or termination of benefits, but the specific regulations or change in Federal or State law which requires the action. 42 U.S.C. 1396a(a)(3), 42 C.F.R. 431.206(b)-(c), 431.210. The written notice must be sent to the waiver participant at least ten days prior to the proposed action. 42 CFR 431.211. Where these regulations are violated, the agency must begin from the beginning and notify the participant in writing not only of the reasons for the action, but the regulation or change in law which authorizes the action.

Due process was violated in this case by Mr. Chorey providing ex parte memos to the Office of Hearings and Appeals. This practice violates 42 C.F.R. 431.244, which requires decisions to be based “exclusively on evidence introduced at the hearing,” as well as basic due process standards. 42 C.F.R. 431.205. *Goldberg v. Kelly*, 397 U.S. 254 (1970). In *Mullis v. DHHS*, the South Carolina Administrative Law Court affirmed that improper *ex parte* communications occurred in another fair hearing. 10-ALJ-08-0775 (S.C.A.L.C. April 23, 2012). In that case, the hearing officer emailed Kathi Lacy, the Associate Director of DDSN, asking “I need your input on this.” Dr. Lacy responded: “I believe [the appellant] wants to bring up a previous appeal, likely 6 years ago. ...It has nothing to do with the current issue.” *Id.* But both the Administrative Law Court in former appeal and the appeal decided in 2012 held that Respondent had arbitrarily violated Mullis’ due process rights by terminating her contract to provide services to DDSN consumers. *Id.*

Issue 6. Has Respondent violated the reasonable promptness requirements contained in 42 U.S.C. 1396a(a)(8) of the Medicaid Act?

In 2009, Appellant filed an appeal requesting additional home-based waiver services which had been determined by his physician to be medically necessary to prevent institutionalization or placement in another congregate setting. 42 U.S.C. 1396a(a)(8) of the Medicaid Act requires that state "medical assistance ... be furnished with reasonable promptness to all eligible individuals." *Doe v. Kidd*, 501 F.3d 348, 354 (2007). 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. *Id.* As the Fourth Circuit noted in *Doe*: "...the relevant federal and state regulations and manuals define reasonable promptness as forty-five days or ninety days, depending on the applicant." *See, e.g.*, 42 C.F.R. 435.911; South Carolina Medicaid Manual, cited at J.A. 242; United States Department of Health & Human Services Center for Medicaid and State Operations, Olmstead Update No: 4. *Id.* at 356.

Despite having an order in 2010 requiring DDSN to have Richard's need for PCA services evaluated by a qualified person and giving consideration to the opinions of his treating physician, Respondent arbitrarily, capriciously, willingly and knowingly ignored that order and the well supported treatment decisions of Richard's physician. 42 U.S.C. 1396a(a)(8) requires Respondent to provide medically necessary services with reasonable promptness. Courts have interpreted "reasonable promptness" to mean no more than 90 days. *Doe v. Kidd*, *supra* at f.n. 3. Respondent has violated Richard's right to receive services with reasonable promptness and he respectfully asks this Court to order that those services ordered by his physician be provided immediately.

Issue 7. Is Respondent required by the "comparability" requirements of the Medicaid Act to provide services in excess of the arbitrary caps, because it continues to

provide services above the caps for those waiver participants who filed lawsuits in federal court?

This Court may take judicial notice that Respondent has made exceptions to the caps in attempts to moot federal lawsuits brought by other waiver participants. In *Hickey v. Forkner*, the plaintiff's case was dismissed by Respondent agreeing to provide 50 hours a week of PCA services. Case No. 4:10-2696-TWL-TER (D.S.C. May 5, 2011). In *Peter B. v. Buschemi, C/A* No. 6:10-767-TMC (D.S.C. March 7, 2013), the federal district court dismissed the lawsuits brought by Chip E. and Michelle M., because they prevailed in their administrative appeals and Respondent decided not to enforce the caps against them. (These plaintiffs have appealed on other issues to the Fourth Circuit). In *K.E. v. DHHS*, the plaintiff's lawsuit was voluntarily dismissed in the South Carolina Supreme Court when Respondent agreed not to enforce the caps and her federal lawsuit was withdrawn. Case No. 10-ALJ-03-0353-AP (S.C.2010).

The "comparability statute" of the Medicaid Act requires that services provided to one member of a covered group must be made available to all participants in that program. 42 U.S.C. § 1396a(a)(10)(B)(I), (ii). Services provided to any individual in a group of covered persons must be "equal in amount, duration, and scope for all recipients within the group." 42 C.F.R. §§ 440.240. Courts have consistently recognized that states have violated the comparability requirement when some recipients are treated differently from other recipients where each has the same level of need. *Schott v. Olszewski*, 401 F.3d 682, 688-89 (6th Cir.2005) (finding treatment was not comparable when Medicaid did not reimburse recipient for medical expenses she paid out of pocket after she was wrongfully denied coverage); *White v. Beal*, 555 F.2d 1146, 1151-52 (3d

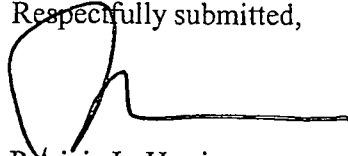
Cir.1977) (finding statute was illegal when it covered eyeglasses for those suffering from eye diseases but did not cover glasses for patients when refractive error caused poor eyesight).

VII.

CONCLUSIONS

Appellant prays that this Court order Respondent to provide the services determined by his treating physician to be medically necessary and that the Court grant the relief set forth above.

Respectfully submitted,



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Attorney for Appellant

August 10, 2013

THE STATE OF SOUTH CAROLINA
In the Supreme Court

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

Richard Stogsdill,.....Appellant,

v.

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

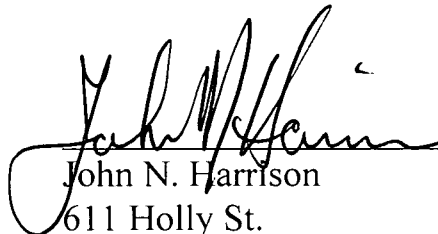
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S.C. Supreme Court

I, John N. Harrison, certify that I have hand-delivered the *Second Corrected Volumes III & IV* in the above case to the Office of General Counsel, South Department of Health and Human Services, 1801 Main Street, Columbia, SC 2920, on December 4, 2014.



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