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 INITIAL BRIEF OF APPELLANT

Patricia L. Harrison
611 Holly Street
Columbia, South Carolina 29205
(803) 256-2017

Attorney for Appellant

TABLE OF CONTENTS

TABLE OF AUTHORITIES

FEDERAL CASES

STATE STATUTES AND REGULATIONS

OTHER

I. Table of Contents and Cases.

II. Statement of Issues on Appeal.

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?**

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 (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 April19, 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 April19, 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\msjtwt2.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 *Omstead 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 to893. 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 oid, 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 intend." 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 spent $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).

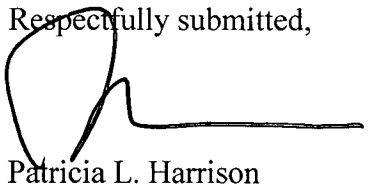
The "comparability statute" of the Medicaid Act requires that services provided to one member of a covered group must be made available to all participants in that program. 42 U.S.C. § 1396a(a)(10)(B)(I), (ii). Services provided to any individual in a group of covered persons must be "equal in amount, 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,



Patricia L. Harrison
611 Holly Street
Columbia, South Carolina 29205
803 256-2017
plh.cola@att.net

Attorney for Appellant

August 10, 2013

IN THE 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,

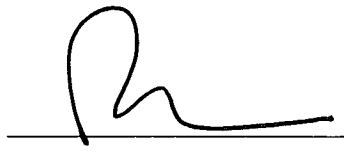
v.

SC Department of Health and Human Services, ... Respondent.

CERTIFICATE OF COUNSEL

The undersigned certifies that this Final Initial Brief complies with Rule 211(b) of the South Carolina Rules of Appellate Procedure.

August 14, 2013



Patricia L. Harrison
611 Holly Street
Columbia, South Carolina 29205
(803) 256-2017
Attorney for Appellant