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IN THE SUPREME COURT OF THE STATE OF DELAWARE

EDWARD and PAMELA PRUNCKUN, as parents and legal guardians of ROBERT PRUNCKUN, Appellants Below, Appellants, v. DELAWARE DEPARTMENT OF HEALTH AND SOCIAL SERVICES, Appellee Below, Appellee.	No. 93, 2018 On appeal from the Superior Court of the State of Delaware, C.A. No. N16A-05-010 FWW

APPELLANTS' OPENING BRIEF

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NATURE OF PROCEEDINGS

Robert Prunckun ("Plaintiff" or "Robert") is a severely disabled adult and Medicaid beneficiary who receives around-the-clock supervision, care and treatment at the Judge Rotenberg Educational Center, Inc. ("JRC") in Canton, Massachusetts. Though he is a Delaware citizen, he has resided in community group homes operated by JRC in Massachusetts for more than a decade because no other provider could safely and effectively treat and control his uniquely severe behavioral and other disabilities.

In November 2013, Robert's parents/guardians initiated the administrative proceedings below by formally requesting a "fair hearing" regarding Robert's Medicaid benefits, a process required by applicable federal and state Medicaid laws.[1] Specifically, Plaintiff sought a meaningful and fair opportunity to challenge the arbitrary and capricious actions by the Department of Health and Social Services ("DHSS")[2] to terminate medically necessary, court-ordered aversive treatment safely provided to Robert for many years at JRC, to impose a new behavioral treatment plan for him with behavioral procedures that had already proved

[1] *E.g.*, 42 U.S.C. §1396a(a)(3); 42 C.F.R. §§431.200 *et seq.*; 16 Del. Admin. Code §§5000 *et seq.*

[2] DHSS oversees Delaware's Medicaid program. *See* 42 U.S.C. §1396a(a)(5). The mandate was issued to JRC in October 2013 by the Division of Developmental Disabilities Services ("DDDS"), a political subdivision of DHSS. DHSS is used in lieu of, and synonymously with, DDDS herein.

ineffective in the past, and to stop making medical assistance payments to JRC for services provided to Robert.

Plaintiff was never afforded an opportunity to challenge DHSS' action through such an evidentiary fair hearing. Rather, by final decision issued on April 21, 2016 ("Final Decision"), the administrative proceedings were dismissed without any evidence or testimony being taken. Instead, the administrative hearing officer ("HO") erroneously concluded, as a matter of law, that aversive treatment was no longer a "covered" service under Delaware's Medicaid waiver program and, as a result, that Plaintiff was not entitled to a fair hearing.

On appeal to the Superior Court below, the reviewing judge erroneously affirmed the Final Decision, failing to recognize the fundamental violation of Plaintiff's due process right to present evidence at a fair hearing and ignoring the HO's legal errors.[3]

In this appeal, Plaintiff seeks reversal of the Final Decision and vindication of his due process rights to a meaningful and fair evidentiary hearing regarding his medical assistance benefits.

[3] A companion case that was consolidated in the Superior Court, but not yet consolidated on appeal, is also pending before this Court for the benefit of Ashlee Oldham, whose legal issues are virtually identical to those in this appeal for Robert. *See* Del. Supr. No. 94, 2018.

SUMMARY OF ARGUMENT

1. The administrative process preceding the Final Decision violated Robert's due process rights as a Medicaid beneficiary to meaningfully challenge the State action to terminate or reduce his Medicaid entitlement benefits. "The State of Delaware recognizes that Medicaid benefits are property rights and as such, the recipient may not be deprived of these benefits without due process of law." *Lawson ex rel Lawson v. DHSS*, 2004 WL 440405, at *3 (Del. Super. 2004) (citing *Collins v. Eichler*, 1991 WL 53447, at *3, 4 (Del. Super. 1991)). Applicable federal and state precedent, laws and regulations require that the procedural due process requirements established by the United States Supreme Court in *Goldberg v. Kelly* be satisfied before a proposed termination or reduction in the amount, nature or scope of an individual's Medicaid benefits can occur. *See, e.g.*, *Goldberg v. Kelly*, 397 U.S. 254, 267-68 (1970); 42 U.S.C. §1396a(a)(3); 42 C.F.R. §431.205(d); Delaware Social Services Manual ("DSSM") §§5300; 5302; 5308, ¶1; 5404; 5406. Because such due process was denied to Plaintiff, the Final Decision must be reversed and Plaintiff's full support services and medical assistance payments must be restored, and JRC must be fully reimbursed for services provided to Robert, for which DHSS has failed to pay since 2014.

2. Aversives are a form of "covered" behavioral treatment services under Delaware's Medicaid waiver program such that Plaintiff's right to a fair hearing to

challenge DHSS' efforts to terminate those services cannot be extinguished through *post hoc* rulemaking and interpretation. From 2004 onward, all of the comprehensive and necessary behavioral support services received by Plaintiff at JRC's community-based program, including aversive treatment, were "covered" services under Delaware's Home and Community-Based Services Waiver ("HCBS Waiver"). *See, e.g.*, A931. The purpose of Delaware's HCBS Waiver is to provide "an array of services and supports that promote community integration and independence" for qualified individuals "as an alternative to institutional placement …." *See* A398; *see also* A271 and A401. The individual treatment needs of each beneficiary is critical to the HCBS Waiver program. *See* A476; A398. Because an individual's specific medical needs are integral to the issue of whether or not a particular service may be "covered" under the HCBS Waiver, it was an error of law for the HO to preclude evidence and testimony regarding Plaintiff's medical needs, and to consequently determine that services and supports critical to meeting those needs are no longer "covered" under the Waiver.

3. The Final Decision constitutes prohibited discrimination by DHSS against Plaintiff in violation of Title II of the Americans with Disabilities Act ("ADA"). From the outset of this dispute in 2013, Plaintiff argued that DHSS' misguided and uninformed action to discontinue all aversive treatment for Robert placed him at risk of unjustified isolation and/or institutionalization in violation of

Title II of the ADA and related laws. *See* A25-26, 28. The Final Decision sanctions DHSS' prohibited discrimination against Robert based on the unique severity of his behavioral disabilities which are refractory to other forms of treatment. DHSS' actions constitute a clear violation of the ADA, *see* 42 U.S.C. §§12132, including its integration mandate. *See* 28 C.F.R. §35.130(d); *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 600 (1999).

STATEMENT OF FACTS

I. Robert's Severe Disabilities And Treatment Needs.

Robert is an adult Medicaid beneficiary and Delaware citizen with uniquely severe behavioral, developmental and emotional disorders and disabilities. A19. Robert requires intensive behavioral health services in order to treat his violent, self-injurious and life-threatening conditions. A19-21. Prior to the commencement of these administrative proceedings, Robert received medical assistance benefits pursuant to the Delaware Medicaid HCBS Waiver for the Developmentally Disabled, a joint federal-state entitlement program administered by DHSS, primarily through DDDS. A19.

After a long history of unsuccessful treatment and institutionalization for his severe behavior disorders and other disabilities, Robert was referred to JRC, where for more than ten years he has resided in a home-like community setting where he has received a variety of services, formerly via the Medicaid HCBS Waiver, to treat his severe behavioral disabilities and control his extreme, self-injurious behavior. A19-21. As a result of his ongoing comprehensive treatment at JRC, Robert no longer requires any restraint, and has avoided the highly restrictive institutional or isolated settings and debilitating high dosages of psychotropic drugs that once were the norm for him. A20-21. Due to his success as a result of the JRC program, Robert has also been able to realize, maintain and enjoy a quality of life once thought

unattainable and has been able to integrate into the community and avoid institutionalization. *Id.*

Robert Prunckun, a 42 year-old male diagnosed with moderate mental retardation and autism, has a long-documented history of self-injurious and destructive behavior, including: throwing chairs; destroying property; kicking and biting others, including his parents; smearing his feces; urinating on the floor and in electrical outlets; banging his head on tables and objects; refusing necessary medical and dental care; and causing serious injuries to himself through repeated elopement, such as jumping out of a second-story window twice, both times causing severe orthopedic injuries including a broken pelvis. A19. Robert has also been diagnosed with intermittent explosive disorder, impulse control disorder, pervasive developmental disorder, and personality change secondary to brain injury. *Id*.

Robert has an extensive history of unsuccessful treatment at residential treatment facilities, group homes and hospital settings in Virginia, Georgia, Wisconsin and New Jersey, beginning at the age of four. *Id*. At these facilities and institutions, the medical staff unsuccessfully attempted all forms of treatment, including among other things psychiatric hospitalizations, positive-only programming, mechanical and chemical restraints, large and increasing dosages and combinations of psychotropic medications, and isolation. A19-21. None of these treatments could effectively treat Robert's behavior disorder or keep him or staff

members safe. A20. Robert suffered, and continues to suffer, side effects from his prior medication regimen, including severe diarrhea, facial tics, tremors in his hands and a seizure from Clozaril. *Id*. His providers nonetheless kept increasing his dosages due to lack of available or effective treatment alternatives, with the result being that Robert's dangerous behaviors actually intensified. *Id*. Robert also has a history of neuroleptic malignant syndrome which is one of the most severe side effects of antipsychotics. A164. Despite these aggressive treatments provided, and because no effective treatment for his behavior disorders was found, Robert continued to cause severe physical harm to himself and others. A20. Ultimately, DHSS conceded that the State of Delaware was simply incapable of treating Robert and recommended JRC in Massachusetts to Robert's parents as a facility and placement of last resort. *Id*.

Robert was admitted to JRC in September 2005 and was initially treated with intensive positive-only Applied Behavior Analysis ("ABA") programming, which once again proved unsuccessful in treating his dangerous and self-destructive behaviors. *Id*. In January 2006, with the assent of DHSS and Robert's parents/co-guardians and Robert's court-appointed counsel, the approval of a peer review committee and a human rights committee, and based on the professional recommendations of Robert's treating clinicians and physicians, a Massachusetts Probate and Family Court judge issued an order following an evidentiary process

and hearing approving a new, proposed behavioral treatment plan for Robert, which featured the ongoing reward ABA procedures supplemented with aversive treatment procedures including the Graduated Electronic Decelerator (GED) device, which applies a harmless two-second, low-level surface application of electrical stimulus to Robert's skin in response to targeted harmful behaviors. *Id.*; *see also* A38-39. The implementation of this court-approved treatment program by JRC has dramatically reduced Robert's aggressive, self-abusive and other harmful behaviors, resulting in a significantly improved quality of life.[4] A20-21. This individually-approved treatment program is reviewed annually by the judge. A38-39. With this treatment plan at JRC, Robert became and remains currently healthy; free from psychotropic medication and mechanical restraint; lives in a community group home; is integrated into the community; works in a supportive work environment; and cooperates with medical, dental and other personnel. A20-21. Significantly, Robert can now meaningfully participate in community outings, and can interact socially with other classmates and during visits with his family, whereas previously Robert was rarely able to even go into the public and had to be kept out of integrated settings for his safety and the safety of those around him. *Id.*

[4] Prior to the implementation of aversive treatment at JRC, Robert engaged in, on average, 668 aggressive behaviors, 194 self-abusive behaviors, and 54 destructive behaviors per month. A20. With aversive treatment, these behaviors are now at zero or near-zero levels. *Id.*

It is the opinion of Robert's physicians, parents and co-guardians, as well as a human rights committee, a peer review committee, and the Massachusetts Probate and Family Court, that the behavioral treatment with supplemental aversive interventions currently provided by JRC is "the most effective, least restrictive means currently available for treating [Robert] without the risk of any significant adverse side effects." *See* 38-39; *see also* A161-202. It also is the unequivocal opinion of Robert's clinicians and Guardians that the cessation of his current court-approved, effective treatment plans including GED would result in the sudden and significant deterioration in his physical and mental condition and quality of life, with a corresponding regression to his prior dangerous and self-injurious behaviors, no safe access to the community and his family, and the need for mechanical, physical and/or chemical restraint, most likely in an institutional and/or isolated setting as was the case before his admission to JRC. A21; A199. DHSS also has concluded that, "in the absence of home and community based services" that are provided by JRC, Robert "would require the level of care required in an [institution]." *See* A1529.

II. Robert's Treatment, Including GED, As Covered Services Under The Medicaid Program.

Since Robert was first placed at JRC in 2005 and continuing until October 2013, DHSS knew of, approved and supported JRC's treatment of Robert, including its court-approved use of the GED, as covered services under the Delaware HCBS

Waiver program. *See, e.g.*, A719-720. Indeed, DHSS placed Robert at JRC so he could receive such a unique behavioral treatment program with positive programming supplemented with aversives to promote his health and well-being, independence and safety – fundamentally important support goals that DHSS had not been able to provide before Robert's admission to JRC. *See* A19-21. At all times, the services rendered by JRC to Robert, including GED, were specifically included and covered by both the Delaware HCBS Waiver and the provider contracts between DHSS and JRC and at no point prior to October 2013 did DHSS ever suggest that JRC's use of the GED was in any way against or contrary to any state or federal law, regulation or policy. *See* A719-720.

Despite Robert's documented and unprecedented improvement due specifically to the aversive treatment he was receiving at JRC, in October 2013 DHSS, through DDDS, demanded that JRC discontinue the aversive services being provided to Robert pursuant to the Medicaid program and develop an entirely new behavioral treatment plan for him. *See* A14-17. DHSS provided no professional or clinical basis for its directive to JRC, nor did DHSS claim that Robert's health, safety or welfare was in any way in danger or at risk. *See id.* On October 1, 2014, in an effort to coerce JRC and Robert into mooting his administrative challenge, DHSS stopped making medical assistance payments to JRC for Robert's services. A945-946.

III. Plaintiff's Fair Hearing Request.

On November 27, 2013, Plaintiff, through counsel, timely submitted a fair hearing request to DHSS, thereby invoking his federally-conferred rights to participate in pre-termination administrative proceedings related to DHSS' proposed discontinuance of aversive services pursuant to the HCBS Waiver. A28-45. Specifically, Plaintiff requested a "Fair Hearing evidentiary review … with respect to any and all issues associated with … DDDS's proposed termination of 'the use of aversive procedures' … in any treatment rendered to Beneficiaries via the Medicaid HCBS/DD waiver program." *Id.*, at 12. In addition, Plaintiff specifically requested "an opportunity to present (and receive from DHSS) evidence and witnesses without undue interference" as to a detailed enumeration of facts and issues material to the relevant legal issues and Robert's medical needs. *See id.* On January 8, 2016, Plaintiff filed a motion *in limine* seeking to present medical and clinical evidence and testimony related to the reasonableness and necessity of aversive services, specifically relating to the question of whether such services were "covered" under the HCBS Waiver. A853-900. The HO denied the motion. A909.

Notwithstanding his requests for a truly "fair" hearing at which he might challenge DHSS' actions through medical and other evidence, Plaintiff was never afforded such an opportunity. Rather, in the April 21, 2016 Final Decision, the administrative proceedings were dismissed without any evidence or testimony being

taken, on the erroneous conclusion, as a matter of law, that aversive treatment was no longer a "covered" service under Delaware's HCBS Waiver and, accordingly, that Plaintiff was not entitled to a fair hearing. A952.

ARGUMENT

I. The Administrative Process Violated Plaintiff's Due Process Rights.

A. Question Presented

Whether the administrative process preceding the Final Decision violated Robert's due process rights as a Medicaid beneficiary to meaningfully challenge the State action to terminate or reduce his Medicaid entitlement benefits. This question was preserved, as it was presented to the court below. (Ex. 1 at 17.)

B. Standard of Review

The Final Decision is subject to judicial review pursuant to 31 *Del. C.* §520.

> "Any … recipient of public assistance benefits … against whom an administrative hearing decision has been decided may appeal such decision to the Superior Court …. The appeal shall be on the record without a trial de novo. The Court shall decide all relevant questions and all other matters involved, and shall sustain any factual findings of the administrative hearing decision that are supported by substantial evidence on the record as a whole. …"

31 *Del. C.* §520.

The Supreme Court's standard of review "mirrors that of the Superior Court." *Stoltz Mgmt. Co. v. Consumer Affairs Bd.,* 616 A.2d 1205, 1208 (Del. 1992). "Where there is a review of an administrative decision by both an intermediate and a higher appellate court and the intermediate court received no evidence other than that presented to the administrative agency, the higher court does not review the decision of the intermediate court but, instead, directly examines the decision of the agency."

Id.; *see also Urban v. Meconi*, 930 A.2d 860, 864 (Del. 2007) (citing 31 *Del. C.* § 520; *Stoltz Management*, 616 A.2d 1205 (Del.1992)).

Questions of law are reviewed by the Supreme Court *de novo*. *United Parcel Serv. v. Ryan Tibbits*, 93 A.3d 655 (Del. 2014); *see also Pub. Water Supply Co. v. DiPasquale*, 735 A.2d 378, 380 (Del. 1999) (holding that a *de novo* standard of review applies to judicial review of an administrative agency's interpretation of a statute administered by the agency). Therefore, this Court independently analyzes the legal issues decided below.

C. Merits of Argument

The Final Decision rests upon a procedure that violated Plaintiff's procedural due process rights to a meaningful, pre-deprivation process and hearing. "The State of Delaware recognizes that Medicaid benefits are property rights and as such, the recipient may not be deprived of these benefits without due process of law." *Lawson*, 2004 WL 440405, at *3 (citing *Collins*, 1991 WL 53447, at *3, 4 (holding that Medicaid benefits "cannot be terminated absent a demonstration of a change in circumstances or other good cause")). Applicable federal and state precedent, laws and regulations require that the procedural due process requirements established by the United States Supreme Court in *Goldberg v. Kelly* be satisfied before a proposed termination or reduction in the amount, nature or scope of an individual's Medicaid

benefits can occur. *See, e.g.*, *Goldberg*, 397 U.S. at 267-68; 42 U.S.C. §1396a(a)(3); 42 C.F.R. §431.205(d); DSSM §§5300; 5302; 5308, ¶1; 5404; 5406.

1. DHSS' Failure to Provide Plaintiff Adequate Notice of the Legal and Factual Basis For Its Actions.

DHSS failed to provide Plaintiff with the requisite "timely and adequate notice detailing the reasons for [the] proposed termination …." *Goldberg*, 397 U.S. at 267-68. Significantly, "adequate notice" is required even when "changes in either state or federal laws … require automatic adjustments for [benefits rendered to certain] classes of individuals." *See* DSSM §5302(K) (requiring such "mass change notices [to] be adequate and timely" and include statements regarding the state's intended action, the reasons for the intended action, the specific change in law, and "[c]ircumstances under which a hearing may be obtained and assistance continued[.]"). Thus, even if – as DHSS argues, and the HO ruled – alleged "changes in … state or federal laws" did occur which had the effect of legally prohibiting aversives, DHSS still clearly violated Plaintiff's procedural due process rights to "adequate notice" as set forth in its own regulations.[5] *See id*.

Throughout the administrative proceedings, DHSS utterly failed to provide any factual basis for its October 2013 instruction to JRC to terminate Robert's

[5] Even the HO recognized the "procedural anomaly" in this case due to DHSS' failure to provide "the standard DDDS letter decision" regarding the proposed termination and/or reduction in services. *See* A290.

aversive treatment services. DHSS overtly wishes to defend its actions as a matter of law only, and thereby avoid a fair evidentiary hearing regarding the lack of any factual or clinical basis for DHSS' actions.[6]

DHSS has suggested that it demanded the immediate cessation of aversives in 2013 because DHSS felt that it could not provide the necessary assurances to CMS regarding Robert's ongoing "health and welfare" as a participant in the Medicaid program.[7] As a whole, DHSS appears to believe that its actions were and are necessary "to protect the well-being" of Plaintiff via "necessary safeguards … to protect [his] health and welfare".[8]

DHSS, however, has never presented any factual basis for an alleged potential risk of harm to Robert, and has no legitimate basis to assume Robert's health and welfare was somehow at risk due to his court-approved, clinician-supervised treatment at JRC. Indeed, the factual record is devoid of any instance of abuse, neglect, mistreatment or any other harm to Robert while at JRC, whether as a result of aversives or otherwise. Plaintiff instituted these administrative proceedings in large part to present compelling evidence and testimony regarding the safety, effectiveness and appropriateness of aversive treatment for Robert, the lack of any

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[6] *See* A911.
[7] *See* 42 U.S.C. §1396n(c)(2)(A); 42 C.F.R. §§441.302(a), 441.303(a). *See also* A47 (citing and attaching copies of 42 C.F.R. §§441.302; 441.303); A502-503
[8] *See* A794 (quoting *Wood v. Tompkins*, 33 F.3d 600, 602 (6th Cir. 1994)). *See also* A778.

effective alternative treatment, and the dire consequences to Robert if treatment is terminated and, by so doing, challenge DHSS' incorrect and unfounded assumption that aversives somehow placed Robert's "health and welfare" in jeopardy. Due process entitles Plaintiff to a coherent explanation why DHSS demanded the immediate cessation of aversives in 2013 without any preceding inquiry or investigation.

Remarkably, DHSS has admitted that it lacks any medical or other expert support for its various efforts to prohibit aversive treatment.[9] Instead of determining whether its relentless efforts to prohibit aversives can be sanctioned by actual health care practitioners, DHSS has repeatedly argued that Robert's medical needs are irrelevant and that there has been a purported federal determination regarding "the standard of care" that DHSS and Plaintiff are simply bound to accept.[10] This is insufficient. *See Goldberg*, 397 U.S. at 268 ("[Due process] rights are important in cases such as those before us, where recipients have challenged proposed terminations as resting on incorrect or misleading factual premises or on misapplication of rules or policies to the facts of particular cases."); *see also Urban*,

[9] A588-589. *See also* A306-307.

[10] *See* A97, A605. *Accord* A808 (DHSS argument that "[b]oth the federal and state entities charged with effectuating Medicaid laws, have deemed the use of such electrical shock methods quite simply unacceptable in the HCBS context, … and generally an unacceptable practice in modern day society."). This is a pure standard of care argument which necessitates fact-finding.

930 A.2d at 865 (DHSS must give substantial weight to opinions of treating physicians regarding the standard of care and medical need for certain treatment). DHSS' failure and inability to disclose any expert support for its actions not only violates due process, it necessitates the entry of judgment for Plaintiff as a matter of law when the Final Decision is reversed because DHSS simply lacks any competent evidence supporting its proposed prohibition and treatment mandates.

2. DHSS' Failure to Provide a Meaningful, Pre-Deprivation Evidentiary Hearing.

Plaintiff's procedural due process rights also were violated by the failure of the HO to conduct a full evidentiary hearing as requested by Plaintiff, including the presentation of all evidence and witnesses relevant to the factual issues in dispute, including but not limited to: the applicable standard of care; Robert's unique medical needs; the effectiveness and benefits of aversive treatment for Robert; DHSS' misconception that aversive treatment is harmful to Robert or places his health and welfare in jeopardy; the unavailability and ineffectiveness of other forms of treatment or placements; Robert's risk of irreparable harm, pain and potentially death without aversives, and isolation and/or institutionalization with the new treatment plan ordered by DHSS that cannot include them. It was a clear error of law for the HO to improperly preclude Plaintiff from presenting all evidence and witnesses relevant to these and other material factual issues related to Robert's Medicaid benefits and the challenged action by DHSS.

Plaintiff's procedural due process rights to a pre-deprivation evidentiary hearing are constitutional, statutory, and regulatory in nature.[11] Federal regulations applicable to this proceeding could not be clearer that an evidentiary fair hearing must be permitted to "[a]ny applicant who requests it because his claim for services is denied or is not acted upon with reasonable promptness[;]" to "[a]ny beneficiary who requests it because he or she believes the agency has taken an action erroneously[;]" and/or where a state agency "takes action … to suspend, terminate, or reduce services" provided pursuant to the Medicaid program. 42 C.F.R. §§431.200(a), (b); 431.220(a)(1)-(2).[12] Applicable federal regulations governing procedural rights of beneficiaries also clearly provide that a Medicaid beneficiary "must be given an opportunity to--

> (a) Examine at a reasonable time before the date of the hearing and during the hearing:
>
> (1) The content of the applicant's or beneficiary's case file; and
>
> (2) All documents and records to be used by the State . . . at the hearing;
>
> (b) Bring witnesses;
>
> (c) Establish all pertinent facts and circumstances;
>
> (d) Present an argument without undue interference; and
>
> (e) Question or refute any testimony or evidence, including opportunity to confront and cross-examine adverse witnesses."

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[11] *See, e.g., Goldberg*, 397 U.S. at 262 (constitutional restraints apply to the withdrawal of public assistance benefits); 42 U.S.C. §1396a(a)(3) (each state "must … provide … an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the [state Medicaid] plan is denied or is not acted upon with reasonable promptness[.]"); 42 C.F.R. §§431.200 *et seq.*; DSSM §§ 5000 *et seq.*

[12] Amended in 2016, after the Final Decision.

42 C.F.R. §431.242.

As interpreted by the United States Court of Appeals for the Third Circuit, the language used in 42 C.F.R. §431.242 is "devoid of ambiguity." *Ortiz v. Eichler*, 794 F.2d 889, 895 (3d Cir. 1986), *quoting*, *e.g.*, 42 C.F.R. §431.242(e). Thus, the HO erred in refusing Plaintiff an opportunity to, *inter alia*, "[e]stablish all pertinent facts and circumstances" relative to the specific Medicaid services DHSS is attempting to terminate and "present [his] arguments", whether legal or factual in nature, "without undue interference[.]" *See* 42 C.F.R. §431.242(c)-(d).[13] Moreover, evidentiary fair hearings are required to cover "[a]gency decisions regarding changes in the type or amount of services" that are provided pursuant to the Medicaid program. *See* 42 C.F.R. §431.241(a)-(b). Federal regulations also prohibit any attempt to "limit or interfere with . . . [a Medicaid] beneficiary's freedom to make a request for a hearing" (as DHSS has done throughout). 42 C.F.R. §431.221(b).

Taken as a whole, the federal regulatory framework unequivocally requires that Medicaid beneficiaries be provided with a meaningful opportunity to present all relevant factual and legal arguments germane to a dispute regarding the availability or termination of Medicaid benefits to an impartial decision-maker in the context of

[13] *See also Brooks v. Meconi*, 2004 WL 2744616, at *3 (Del. Super. 2004) ("Due process affords [Medicaid recipients] the right, in an administrative proceeding, to controvert every material fact which bears on the questions in the matter involved."); *accord Lawson*, 2004 WL 440405, at *8-9.

an evidentiary hearing. *See Goldberg*, 397 U.S. at 267-68 ("The fundamental requisite of due process of law is the opportunity to be heard. … at a meaningful time and in a meaningful manner. In the present context these principles require that a recipient have timely and adequate notice detailing the reasons for a proposed termination, and an effective opportunity to defend by confronting any adverse witnesses and by presenting his own arguments and evidence orally." (internal quotations and citations omitted)). Delaware regulations either mimic or expand the procedural due process rights of Medicaid beneficiaries beyond the already broad federal requirements. *See generally* 16 Del. Admin. Code §§5000 *et seq.*

Between 2013 and 2016, Plaintiff made numerous specific, detailed requests to the HO, and even filed a prior appeal to the Superior Court, solely to vindicate his procedural due process rights to have a meaningful opportunity to challenge DHSS' proposed actions through a full evidentiary proceeding.[14] Nonetheless, on the first and only day of the purported "fair hearing" in January 2016, Plaintiff was *still* precluded from calling or examining any witnesses or presenting any medical or clinical evidence regarding the services at issue. Indeed, the HO denied Plaintiff's motion *in limine* specifically seeking an opportunity to present testimony and evidence regarding how Robert's medical needs uniquely relate to what services are

[14] *See, e.g.*, A25-27; A357-381; A386-394; A677-691; A854-900. Plaintiff respectfully incorporates by reference each of these prior filings herein.

"covered" under Delaware's HCBS Waiver. *See* A854-900; A909. Instead, the scope of the "Fair Hearing" was explicitly limited to the purported legal issue of whether aversives were "covered services" under the Delaware HCBS Waiver program, without allowing any evidence regarding the intertwined factual issue of Robert's unique medical needs.[15]

This was clear legal error, particularly in light of the undisputed fact that, prior to DHSS' October 2013 mandates, aversive treatments were unequivocally provided to Robert pursuant to the Medicaid HCBS program (i.e., they were "covered" services) with DHSS' explicit agreement and consent. At its core, DHSS' determination in 2013 that aversives were unsuitable for Robert amounts to an inappropriate and uninformed administrative decision regarding Robert's medical needs and the medical standard of care, which Robert should be permitted to meaningfully rebut through the evidentiary process to which he is clearly entitled.[16]

Plaintiff also was denied a meaningful opportunity to challenge DHSS' actions in the limited hearing that the HO actually permitted. Specifically, while the HO would not permit Plaintiff to present any witnesses or evidence regarding

[15] A826; A907-909.

[16] *See* A942-943 (arguments by DHSS that its actions stemmed from an alleged "evol[ution]" in "therapeutic practice" whereby "[t]hings that were formerly considered okay acceptable become at times no longer acceptable" akin to professional views regarding "the involuntary sterilization of the mentally retarded"). *See also* A97, A605.

Robert's clinical history or the medical need for aversive services, the HO improperly considered and relied upon hearsay evidence – particularly, a December 2012 letter from an associate regional administrator within the Boston office of the Centers for Medicare & Medicaid Services ("CMS") of the United States Department of Health and Human Services ("HHS"), the federal agency charged with oversight of the Medicaid program, to the Commonwealth of Massachusetts, which requested that the use of aversive interventions including GED be eliminated for individuals enrolled in Massachusetts' HCBS waiver (the "2012 McGreal Letter"),[17] and a March 10, 2015 letter from CMS to DHSS affirming DHSS' litigation position that Delaware's amended HCBS Waiver prohibits aversives (the "2015 CMS Letter")[18] – over Plaintiff's objections and in violation of applicable Delaware procedure.[19] This is not harmless error because, among other issues, Plaintiff was at the time not advised of and never afforded an opportunity to respond to DHSS' December 23, 2014 communication to CMS soliciting an advisory opinion related to this specific dispute,[20] nor was Plaintiff ever afforded an opportunity to

[17] A799.
[18] A563.
[19] *See* A697 (objecting and citing, *e.g.*, DSSM §5600, ¶2 ("If a party to the hearing objects to the use of hearsay evidence, the evidence will not be admitted.")).
[20] *See* A632; *see also* A671-672 (discussing DHSS' solicitation of the 2015 CMS letter).

discover or challenge the legal or factual basis for either CMS letter (which is not apparent on their face).[21]

Ultimately, the Final Decision erroneously concluded that aversive treatment is not a "covered" service – and that dismissal of the administrative proceedings was required – based upon the mere *ipse dixit* of the informal, conclusory CMS letters (one of which DHSS covertly solicited in 2014 and the other which does not relate to Delaware) and Delaware's amended HCBS Waiver language (which DHSS itself drafted solely as a result of this dispute).[22] This ruling was both erroneous and grossly unfair, particularly given DHSS' belief that Plaintiff cannot challenge CMS directly regarding its letters or positions which relate directly to him.[23] The HO's ultimate reasoning that informal agency determinations by CMS and/or DHSS bureaucrats regarding the standard of care moot Plaintiff's constitutional due process rights is simply untenable.[24]

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[21] *See* A699 (at 50 & n. 30), A702.

[22] The Final Decision's ruling directly contradicts the HO's ruling denying DHSS' motion to dismiss based on its *post hoc* rulemaking and maneuvering just a few months earlier. *Compare* A951-961 (Final Decision) *with* A849-852 (Nov. 30, 2015 disposition).

[23] A565 (p. 17) ("I believe JRC would have no right to challenge that federal interpretation with CMS.").

[24] *See* A943-944. The HO also erred by failing to consider or afford any weight to the Massachusetts court orders specifically finding, after an evidentiary process, that treatment plans with aversives were "the most effective, least restrictive, means currently available for treating [Robert] without the risk of any significant adverse side effects." *See* A43.

In addition, the HO failed to properly allocate the burden of proof upon DHSS, as the party moving to dismiss the administrative proceedings as well as the party attempting to change the *status quo*.[25] Delaware decisional law is clear that Medicaid benefits "cannot be terminated absent a demonstration of a change in circumstances or other good cause" and that, in the administrative context, DHSS carries the burden of proving Medicaid benefits "should have been terminated."[26] *See Collins*, 1991 WL 53447, at *3, 4.

Similarly, because the January 13, 2016 hearing amounted to a *de facto* rehearing on DHSS' motion to dismiss (and because the HO did not permit any factual or clinical evidence to be introduced into the record), it was prejudicial error for the HO not to take all of the numerous, material facts asserted by Plaintiff in the fair hearing demand as true, including that Robert's court-approved treatment plans including aversive interventions are "necessary to avoid Beneficiaries' institutionalization;" "sufficient in amount, duration and scope to reasonably achieve their purpose;" *see* 42 C.F.R. §440.230, and "generally in 'the best interests of'

[25] *See* A953.

[26] Prior DHSS regulations clearly assigned the burden of proof upon the moving party and/or the party attempting to change the *status quo*. *See* DSSM §5405, ¶3(b) (eff. Apr. 14, 2008) ("The moving party will present its case first. The burden of proof is on the moving party. The moving party is the party to the hearing seeking a change in the *status quo ante*. The Department is the moving party for actions to discontinue, terminate, suspend, or reduce assistance."). DHSS has since deleted that regulation.

Beneficiaries, as required by the federal Medicaid Act, 42 U.S.C. § 1396a(a)(19)."[27] Taking these and other facts alleged by Plaintiff in the fair hearing demand as true, and taking all reasonable inferences related to such facts in Plaintiff's favor, the HO could not have reached the erroneous result that she did.

3. DHSS' Other Coercive, Discriminatory and Prejudicial Conduct.

DHSS has actively taken numerous other steps to thwart the fair, evidentiary process sought by Plaintiff to challenge DHSS' actions. Most obviously, DHSS attempted to retroactively justify its mandates to JRC and moot the fair hearing process by concocting a legal basis for its actions after the fact, primarily through its HCBS Waiver amended effective July 1, 2014 and its solicitation of an advisory letter regarding this specific dispute from CMS in December 2014 based upon DHSS' own amended waiver language.[28] DHSS also stopped making medical assistance payments to JRC for Robert's services on October 1, 2014.[29] These deliberate actions by DHSS violated Plaintiff's due process rights because they are targeted, adverse actions directly relating to Robert specifically and attempting to adjudicate his individual rights notwithstanding the ongoing administrative proceedings. It would grossly elevate form over substance, and render Plaintiff's

[27] Plaintiff's initial fair hearing demand fully listed these and many other significant, material facts which the HO simply ignored and erroneously failed to take as true. *See* A19-21; A25-26.
[28] *See* A669-672.
[29] *See* A945-946.

due process rights meaningless, to lend credence to DHSS' characterization of its purported prohibition on aversive treatment as an across-the-board change in law or policy affecting all waiver participants[30] where, as DHSS admits, Robert is one of only two Delaware waiver participants who reside at JRC, receive aversive treatment with the GED, and that JRC is the only provider in the country which even uses the GED.[31]

In this precise context, "due process requires an adequate hearing **before** termination of welfare benefits, and the fact that there is a later constitutionally fair proceeding does not alter the result." *Goldberg*, 397 U.S. at 261 (emphasis added) (internal quotations and citation omitted). As the Supreme Court has observed:

> …[W]hen welfare is discontinued, only a pre-termination evidentiary hearing provides the recipient with procedural due process. For qualified recipients, welfare provides the means to obtain essential food, clothing, housing, and medical care. Thus the crucial factor in this context … is that termination of aid pending resolution of a controversy over eligibility may deprive an eligible recipient of the very means by which to live while he waits. Since he lacks independent resources, his situation becomes immediately desperate. His need to concentrate upon finding the means for daily subsistence, in turn, adversely affects his ability to seek redress from the welfare bureaucracy. *Id.*, at 264 (internal citation and footnote omitted).

DHSS' violation of Plaintiff's due process rights to a pre-termination evidentiary hearing is thus clear.

[30] *See, e.g.*, A805-806, A940.
[31] *See, e.g.*, A99, A565 (p.18), A922.

II. Aversives Are "Covered" Services under Delaware's Medicaid Waiver Program.

A. Question Presented

Whether aversives are "covered" services under Delaware's Medicaid waiver program. This question was preserved, as it was presented to the court below. (Ex. 1 at 15.)

B. Standard of Review

The Final Decision is subject to judicial review, on the record without a trial *de novo*, pursuant to 31 *Del. C.* §520. "The Court shall decide all relevant questions and all other matters involved, and shall sustain any factual findings of the administrative hearing decision that are supported by substantial evidence on the record as a whole." *Id*.

The Supreme Court's standard of review "mirrors that of the Superior Court" and this Court "does not review the decision of the intermediate court but, instead, directly examines the decision of the agency." *Stoltz Mgmt. Co.*, 616 A.2d at 1208; *see also Urban*, 930 A.2d at 864 (citing 31 Del. C. § 520; *Stoltz Mgmt. Co.*, 616 A.2d 1205 (Del.1992)).

Questions of law are reviewed by the Supreme Court *de novo*. *United Parcel Serv.*, 93 A.3d 655; *see also Pub. Water Supply Co.*, 735 A.2d at 380. Therefore, this Court independently analyzes the legal issues decided by the trial court.

C. Merits of Argument

1. Necessary Behavioral Support Services Have Always Been, and Remain, "Covered" Services Under Delaware's HCBS Waiver.

The HO erroneously dismissed Plaintiff's fair hearing request by concluding, as a matter of law, "that GED treatment services were no longer covered services by Medicaid under the Delaware HCBS Waiver."[32] The HO committed legal error by restricting the hearing to this one issue, *see* 42 C.F.R. §431.242, and by precluding factual evidence and testimony necessary to resolve even the limited issue presented, which is a mixed question of law and fact, *see* A687-681, A858-871, A865-901. The parties do not dispute that Robert received comprehensive and necessary behavioral support services at JRC – including positive programming supplemented with clinician-supervised, court-approved aversive treatment as deemed appropriate in Robert's individualized treatment plan – from 2004 onward and that all such services provided to Robert at JRC were "covered" services under Delaware's HCBS Waiver.[33] Since Robert was first placed at JRC and continuing for approximately ten years until October 2013, DHSS had full knowledge of, approved and supported JRC's treatment of Robert, including its use of the GED, pursuant to the HCBS Waiver program. Moreover, contrary to DHSS' misrepresentation to the HO,[34] from

[32] A965.
[33] *See, e.g.,* A941 (admission by counsel for DHSS that aversives were "covered" services under Delaware's HCBS Waiver until, at earliest, the 2012 McGreal Letter).
[34] *See* A305.

2005 through 2014, DHSS' provider contracts with JRC specifically authorized the use of aversive treatments if deemed clinically appropriate for an individual and ordered by a reviewing court.[35]

Robert's treatment at JRC was wholly "covered" by DHSS for essentially a decade because DHSS knew that Robert was receiving safe and effective treatment (for the first time in his life) from JRC's intensive behavioral treatment program and because the very purpose of Delaware's HCBS waiver is to provide "an array of services and supports that promote community integration and independence" for qualified individuals "as an alternative to institutional placement …."[36] DHSS acknowledges that individuals served by Delaware's HCBS Waiver would be institutionalized absent their receipt of waiver services. *See* A401 (§G); *accord* 42 C.F.R. §441.302(c) (requiring states to provide this assurance). As designed by DHSS, the HCBS Waiver program is implemented on an individualized basis through a "participant-centered planning process" that results in the development of individualized treatment plans that identify "individual support needs" and which

[35] *See* A720-733 (addendum to JRC's 2005 contract with DHSS, providing, at ¶2(a), that JRC may use "restraints and the application of noxious stimuli … pursuant to a court-ordered treatment plan."); A134 (addendum to JRC's FY2014 contract with DHSS).

[36] A398; *see also* A271 (§1.0) ("The [HCBS] waiver includes support services necessary to maintain individuals in the community as an alternative to institutionalization.").

are "developed in the best interests of each participant."[37] The individual treatment needs of each beneficiary are critical to the HCBS Wavier program; indeed, case managers are assigned to ensure that services are provided to each waiver participant in accordance with each individual's personalized treatment plan and that such "services meet the participant's needs …."[38] Because an individual's specific medical needs are integral to the issue of whether or not a particular service may be "covered" under the HCBS Waiver, it was an error of law for the HO to preclude evidence and testimony regarding Robert's medical needs.

Participants in Delaware's HCBS Waiver are entitled to receive "all services normally covered by Medicaid."[39] In addition, waiver participants are eligible for multiple additional categories of "appropriate services, [which] allow[] them to remain safely in the community"[40] and which include, among other covered services, case management services (which ensure that "[n]eeded medical … services (regardless of funding source)" are provided to each beneficiary)[41]; clinical support services (which "are defined as []behavioral … services and supports provided to

[37] *See* A471.
[38] *See* A476; *see also* A398 (Services provided under the waiver "are intended to … respect[] [each individual's] needs and preferences.").
[39] A901 (§6.10.1); *accord* A951 (waiver services "are provided in addition to Medicaid State Plan services (doctor visits, prescriptions, hospitalizations) and help you to live independently in the community.").
[40] A887 (§1.32.3.1).
[41] A897 (§6.1.1.3); *accord* A475-477.

consumers to maintain, remediate or enhance functioning" as deemed necessary in an individual's personalized care plan)[42]; and day and residential habilitation (which are defined as "assistance with acquisition, retention, or improvement in skills related to activities of daily living" and "self-help, socialization and adaptive skills").[43] In particular, the waiver specifically includes "Behavioral Consultation" services which "results in individually designed behavior plans and strategies for waiver participants who" – like Robert – "have significant behavioral difficulties that jeopardize their ability to remain in the community due to their inappropriate responses to events in their environments."[44] "Appendix C" of Delaware's HCBS Waiver describes each of these and additional "covered" services available to each participant in detail.[45] Significantly, Delaware's HCBS Waiver also claims that "[t]he State does not limit or restrict participant access to waiver services except as provided in **Appendix C**."[46]

The HCBS Waiver itself thus confirms that the necessary behavioral support services provided by JRC to Robert pursuant to his individualized, court-ordered treatment plans have always been, and remain, "covered" services under Delaware's

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[42] A898 (§6.2.1). DHSS admits that GED "is a type of behavioral intervention …." *See* A941.
[43] A898 (§6.3.1); 899 (§6.4.1).
[44] A449.
[45] *See* A435-469 (Appendix C).
[46] A401-402 (emphasis in original). The purported ban on aversives is in Appendix G. *See* A503

HCBS Waiver. DHSS' attempt to restrict one particular treatment modality within the broad range of services that are expressly "covered" under the HCBS Waiver, and which have been provided to Robert for approximately ten years, constitutes a *per se* reduction in those services.[47]

Federal law requires that each service provided through Delaware's Medicaid program "be sufficient in amount, duration, and scope to reasonably achieve its purpose" and prohibits DHSS from "arbitrarily den[ying] or reduc[ing] the amount, duration, or scope of a required service … to an otherwise eligible beneficiary solely because of the diagnosis, type of illness, or condition" for which the service is required (here, severe behavioral disabilities that are refractory to other forms of treatment). 42 C.F.R. §440.230(b), (c); *see also* 42 U.S.C. §1396a(a)(17) (requiring a state to implement "reasonable standards" for the provision of medical assistance under a Medicaid plan). "[A] state's failure to provide Medicaid coverage for non-experimental, medically-necessary services within a covered Medicaid category is both per se unreasonable and inconsistent with the stated goals of Medicaid." *Lankford v. Sherman*, 451 F.3d 496, 511 (8th Cir. 2006). The applicable HCBS Waiver language further confirms (as Plaintiff repeatedly argued below) that

[47] Likewise, DHSS did not prove that aversive treatment with GED is a "non-covered service" as a matter of law, an inquiry which under applicable DHSS policies largely relates to whether a particular service is or is not "medically justified" or "medically necessary." *See* A882-883.

whether or not a service may be "covered" under the waiver program requires, at a minimum, a factual determination regarding an individual's specific medical needs and whether or not the proposed services would permit the individual to avoid institutionalization, remain in a community-based setting, and thus meet the fundamental goals of both the HCBS Waiver program specifically and the Medicaid program as a whole. *See* 42 U.S.C. §1396n(c)(1) (authorizing states to provide home and community-based alternatives to institutional care via a Medicaid waiver).[48]

2. The Decision Below Lacks an Adequate Legal Basis.

The decision below also rests upon an inadequate legal basis. Specifically, the HO ruled "that GED treatment services were no longer covered services by Medicaid under the Delaware HCBS Waiver" based upon "[1] the CMS letters directed to Massachusetts and Delaware" in 2012 and 2015, respectively, which the HO found to be "authoritative" and entitled to "substantial deference," "in conjunction with [2] the duly promulgated Delaware HCBS Waiver" as amended effective July 1, 2014, which the HO found to "carr[y] the force and effect of law

[48] *See also* A395 (the HCBS "program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization."). The fundamental purpose of the entire Medicaid program is to "furnish … necessary medical services" to disabled and other eligible individuals, *see* 42 U.S.C. §1396-1, that are in the "best interests of the recipients" and consistent with "quality of care". *See* 42 U.S.C. §§1396a(a)(19), (30).

…."[49] As extensively briefed by Plaintiff below, these purported authorities do not, and cannot, require the dismissal of Plaintiff's fair hearing request as a matter of law because aversives are simply not prohibited by law and because Plaintiff is entitled to challenge in an evidentiary proceeding DHSS' targeted, attempted adjudication of Robert's individual medical assistance benefits.[50]

As noted above, the 2012 McGreal Letter should not have been considered by the HO because, under applicable DHSS rules, it constitutes inadmissible hearsay to which Plaintiff timely objected[51] and because Plaintiff was afforded no opportunity to discover the factual and/or legal grounds for the purported statements and conclusions it sets forth (which are not apparent on its face), or even learn "how DHSS interpreted and relied upon such communication in developing its proposed actions which Beneficiaries challenge."[52] Moreover, the McGreal Letter was sent by an associate CMS employee in a different region than Delaware, to a different state than Delaware, concerning a waiver program designed by a state other than Delaware. As such, the McGreal Letter is irrelevant to these proceedings – and

[49] *See* A965-966.
[50] *See* A691-709.
[51] *See, e.g.*, DSSM §5600, ¶2 ("If a party to the hearing objects to the use of hearsay evidence, the evidence will not be admitted."); *see also* Fed. R. Evid. 803; D.R.E. 803.
[52] A697 n.29.

cannot justify the dismissal of Plaintiff's fair hearing request concerning services rendered under Delaware's HCBS Waiver as a matter of law.

Decisional law cited by Plaintiff also confirms that such an "informal written interpretive guidance letter" is simply not entitled to any deference, let alone is dispositive, absent a showing that it "represents an official statement of the CMS or has been adopted by the Secretary of HHS or incorporated into federal Medicaid statutes or regulations, giving it authoritative weight or enforceability." *See Aplin v. McCrossen*, 2014 WL 4245985, at *13, 14 (W.D.N.Y. 2014) (only affording a letter authored by Mr. McGreal "a modicum of respectful consideration" – but not deference – because the letter did not contain "any reference to the specific language of the regulations" at issue and "offere[d] little clarity on the question before [the court]."). [53] No such showing was made here.

The McGreal Letter cites no legal authority and, rather, rests entirely upon Mr. McGreal's subjective, unqualified and irrelevant opinion that "reasonable people will agree that electric shock … ha[s] no place in their homes or

[53] *See also* A696-701 (and cases cited). To the extent it is entitled to any deference, the informal McGreal Letter is, at most, only entitled to *Skidmore* deference, meaning that any weight afforded to it "in a particular case will depend upon the thoroughness evident in its consideration, the validity of its reasoning, its consistency with earlier and later pronouncements, and all those factors which give it power to persuade, if lacking power to control." *Kai v. Ross*, 336 F.3d 650, 655 (8th Cir. 2003) (quoting *Skidmore v. Swift & Co.*, 323 U.S. 134, 140 (1944)).

communities[.]"[54] It was legal error for the HO to give the McGreal Letter legal weight because it amounts to uninformed, lay speculation and not the considered, official interpretation by HHS of any identified or applicable statute, regulation or other law. It was also legal error for the HO to rely upon an associate federal administrator's informal lay opinion regarding the standard of care as related to Massachusetts' HCBS Waiver program while at the same time ignoring the specific findings of fact by the Massachusetts judges who actually reviewed evidence related to Robert's clinical needs and found that Robert's current treatment plan with aversives was the "most effective, least restrictive" and most appropriate treatment available for Robert specifically.[55] As a whole, the McGreal Letter "is worth no more than its inherent persuasive value" and thus "deserve[s] no legal weight" or deference because it, and the opinion it expresses, are simply not "persuasive" even if (improperly) considered in these proceedings. *See Kai*, 336 F.3d at 655 (affording "no legal weight" to a letter from an associate regional administrator of CMS' predecessor agency).

Likewise, Delaware's HCBS Waiver language as amended effective July 1, 2014 is not dispositive of this matter. Though DHSS attempts to characterize its

[54] *See* A812-813.

[55] *See* A34-35, A38-39. Because the McGreal Letter ultimately concerns the applicable standard of care, Plaintiff must also be afforded an opportunity to challenge its conclusion through relevant expert testimony in an evidentiary process.

waiver language as an across-the-board prohibition on aversive treatment for all waiver participants, it is undisputed that Robert – who invoked these proceedings in 2013 – is one of the only two individuals who are actually impacted by DHSS' insertion of this language into its statewide waiver in 2014. This is nothing more than a manufactured litigation position taken by DHSS after Plaintiff filed the Fair Hearing Demand and is entitled to no deference. *See Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 213 (1988) ("Deference to what appears to be nothing more than an agency's convenient litigating position would be entirely inappropriate."). Moreover, in substance, the amended waiver language constitutes an adjudication by DHSS of Robert's individual rights and not the general rulemaking that DHSS has attempted to make it in form. This does not defeat and, indeed, entitles Plaintiff to the evidentiary hearing he seeks. *See Hannah v. Larche*, 363 U.S. 420, 442 (1960) ("[W]hen governmental agencies adjudicate or make binding determinations which directly affect the legal rights of individuals, it is imperative that those agencies use the procedures which have traditionally been associated with the judicial process."); *Am. Airlines, Inc. v. Civil Aeronautics Bd.*, 359 F.2d 624, 631 (D.C.Cir. 1966), *cert. denied*, 385 U.S. 843 (1966) ("…[A] proceeding that in form is couched as rule making, general in scope and prospective in operation, but in substance and effect is

individual in impact and condemnatory in purpose" warrants evidentiary hearing because it constitutes an adjudication of individual rights).[56]

Finally, the one-page letter DHSS solicited from CMS in 2015 could not justify the dismissal of the administrative proceedings. First, the 2015 CMS letter suffers from the same, fatal infirmities as the McGreal Letter: it cites no legal authority or factual support, and is entirely unpersuasive and conclusory. Thus, it should be entitled to no deference.[57] Second, the 2015 CMS letter also merely restates what DHSS informed CMS in its December 23, 2014 letter based on the waiver language DHSS adopted to defeat Plaintiff's Fair Hearing Demand: *to wit*, that "[u]nder Delaware's approved DDDS HCBS waiver, … aversive interventions are prohibited in community settings."[58] This statement – like DHSS' amended waiver language – merely restates the agency's convenient litigating position and is pure *ipse dixit*. Indeed, DHSS all but wrote the very response that DHSS wanted from CMS to use in these proceedings against Plaintiff. Because the 2015 CMS letter constitutes a "nonprecedential letter ruling" restating DHSS' stated *ad hoc*

[56] *See also* A682-695, A702-705.

[57] *Compare* A816 *with Mass. v. Sebelius*, 638 F.3d 24, 30 (1st Cir. 2011) (recognizing that "[d]eference is not given … to a '*post hoc* rationalizatio[n] advanced by an agency seeking to defend past agency action against attack" or when there is reason to "suspect that the interpretation does not reflect the agency's fair and considered judgment on the matter in question."), quoting *Chase Bank USA, N.A. v. McCoy*, 562 U.S. 195, 196 (2011).

[58] *Compare* A632 (Dec. 23, 2014 DHSS letter to CMS) *with* A816 (CMS response).

litigation position, rather than a generally applicable agency interpretation, it is entitled to neither deference nor weight. *See Estate of Landers v. Leavitt*, 545 F.3d 98, 110 (2d Cir. 2008), as revised (Jan. 15, 2009), *cert. denied*, 557 U.S. 937 (2009).

At its core, DHSS has transparently attempted to cloak under the color of law its inaccurate and uninformed opinion that aversive treatment does not conform with the standard of care and is inappropriate for Plaintiff specifically. DHSS' discretionary actions were taken subsequent to Plaintiff's Fair Hearing Demand merely to bolster DHSS' litigation position that aversives are prohibited by law so that DHSS can avoid any factual, evidentiary process at which it will have to justify its unsupported and erroneous conclusions regarding the safety and efficacy of aversive treatment. This Court should afford such actions no deference and recognize that it was prejudicial legal error for the HO to do so, warranting reversal of the Final Decision.

III. The Final Decision Constitutes Prohibited Discrimination by DHSS Against Plaintiff in Violation of Title II of the Americans with Disabilities Act.

A. Question Presented

Whether the Final Decision constitutes prohibited discrimination by DHSS against Plaintiff in violation of Title II of the ADA. This question was preserved, as it was asserted in Plaintiff's initial Fair Hearing Demand (A25-26, A28) and was presented to the court below. (Ex. 1 at 19.)

B. Standard of Review

Questions of law are reviewed by the Supreme Court *de novo*. *United Parcel Serv.*, 93 A.3d 655; *see also Pub. Water Supply Co.*, 735 A.2d at 380. Therefore, this Court independently analyzes the legal issues decided by the trial court.

C. Merits of Argument

The Court below erroneously concluded that Plaintiff failed, at the administrative proceeding, to preserve his claim that DHSS' actions violated Title II of the ADA, its integration mandate, and other applicable law and precedent. The administrative record, however, clearly supports viable and substantive discrimination claims against DHSS. Further, this Court is broadly empowered on appeal to "decide all relevant questions and all other matters involved" with this dispute, including issues related to DHSS' ongoing discriminatory conduct which necessitates judicial intervention. 31 *Del. C.* § 520.

As DHSS knows, and as the treatment records contained in the record on appeal make clear, prior to Robert's admission to JRC in September 2004, he was perpetually isolated and institutionalized away from the community via locked, segregated rooms, paralyzing dosages of medication, massive amounts of restraint and other attempted treatments or interventions that still left his "health and safety … at risk." *See* A1088-1090; A1371; A1386-1388. Given this undisputed reality, Plaintiff rightfully asserted that the complete overhaul of his long-term, medically necessary treatment plan at JRC and cessation of aversive treatment as arbitrarily mandated by DHSS without any clinical input or basis will again lead to his unjustified isolation, segregation and institutionalization. Significantly, even Delaware officials have concluded that, "in the absence of home and community based services" that are provided by JRC, Robert "would require the level of care required in an [institution]." *See* A1529.

From the outset of this dispute in 2013, Plaintiff has demanded a fair evidentiary hearing to prove that DHSS' misguided and uninformed mandate to discontinue all aversive treatment placed Robert at risk of unjustified isolation and/or institutionalization in violation of Title II of the ADA and related laws. *See* A25-26, A28. Nonetheless, DHSS and the HO disregarded Plaintiff's ADA claim and dismissed his medical conditions and treatment needs as "just simply irrelevant." *See* A786-787, 789; *accord* A101 n.9; A623; and A904.

It is well-settled that individuals with disabilities like Robert need not wait until they are unjustifiably isolated or institutionalized to assert a viable claim under Title II of the ADA, 42 U.S.C. §12132, and its integration mandate, 28 C.F.R. §35.130(d). *See M.R. v. Dreyfus*, 697 F.3d 706, 734 (9th Cir. 2012) ("… [A] plaintiff need only show that the challenged state action creates a serious risk of institutionalization" to state an ADA claim). Unjustified segregation, isolation or institutionalization constitutes *per se* prohibited discrimination. *See Olmstead* v. *L.C.*, 527 U.S. 581, 597, 600-601 (1999) (holding that "[u]njustified isolation * * * is properly regarded as discrimination based on disability" prohibited by Title II and the integration mandate because it "perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life" and because "confinement 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."). DHSS' obligations under the Medicaid Act are separate and apart from its obligations under the ADA to, *inter alia*, "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities," and to "make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability …." 28 C.F.R. §35.130(b)(7), (d); *see also*

42 C.F.R. §431.205(f). DHSS' "deliberate indifference" to Robert's medical needs and the potential ramifications of its misguided *post hoc* prohibition on aversive treatment in the provision of public assistance benefits – and Robert's subsequent exclusion from the Medicaid program despite his eligibility – thus constitutes prohibited intentional discrimination under the ADA.

CONCLUSION

Therefore, for the foregoing reasons, the Court should reverse the Superior Court's ruling and order the administrative Final Decision to be reversed and vacated, and enter judgment for Plaintiff, and further order necessary injunctive relief for Plaintiff providing that he shall continue to receive medically necessary treatment and services and that DHSS shall continue to timely make full medical assistance payments for such medical treatment and services rendered by JRC, including full reimbursement for services provided since October 1, 2014.

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