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United States District Court,
E.D. Arkansas,
Western Division.

PEDIATRIC SPECIALTY CARE, INC.; Child & Youth Pediatric Day Clinics, Inc.; Tomorrow'S Child Learning Center, LLC; James And Stacey Swindle, as parents and next friends of Jacob and Noah Swindle, minors; and Susann Crespino, as parent and next friend of Michael Crespino, a minor, Plaintiffs
v.
ARKANSAS DEPARTMENT OF HUMAN SERVICES; Kurt Knickrehm, in his individual and official capacity as Director of the Arkansas Department of Human Services; Ray Hanley, in his individual capacity as Director of the Arkansas Department of Human Services Division of Medical Services; Arkansas Foundation for Medical Care, Inc.; and Roy Jeffus, in his official capacity as Interim Director of Arkansas Department of Human Services Division of Medical Services, Defendants/Third-Party Plaintiffs
v.
The United States Department of Health & Human Services, Centers for Medicare & Medicaid Services; Tommy Thompson, Secretary of the United States Department of Health & Human Services, in his official capacity; and Mark McClellan, Administrator, United States Department of Health & Human Services Center for Medicare & Medicaid Services, in his Official Capacity, Third-Party Defendants.

No. 4:01CV00830 WRW. | Feb. 7, 2005.

Attorneys and Law Firms

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Opinion

ORDER

WM. R. WILSON, JR., United States District Judge.

***1** Pending are Defendants Arkansas Department of Human Services (ADHS), Kurt Knickrehm, Roy Jeffus and Ray Hanley's Motion for Summary Judgment (Doc. No. 162), Supplemental Motion for Summary Judgment (Doc. No. 253), and Motion for Ruling on Qualified Immunity Issue (Doc. No. 221). For the reasons stated below, Defendants' Motion for Summary Judgment and Supplemental Motion are DENIED except with respect to the individual liability of separate Defendant Kirk Knickrehm for civil damages. Defendants' Motion for Ruling on Qualified Immunity is DENIED as MOOT.

I. BACKGROUND

Plaintiffs are composed of medical providers for, and medicaid recipients of special benefits mandated by the Social Security Act ("SSA"). These benefits are identified as Early Periodic Screening Diagnostic and Treatment Services ("EPSDT"). The services are designed to restore developmentally impaired children to their best possible functional level. Arkansas uses a health care model program to effectuate EPSDT benefits: the Child Health Management Services program ("CHMS"). Clinics licensed under the CHMS program provide diagnostic screening and treatment to children to help reduce physical and mental impairments and to ready them for school. Included in the program are day treatment clinics that provide daily monitoring, care, and therapy for eligible children.

Plaintiffs are CHMS providers and recipients. Plaintiffs filed a complaint and five subsequent amended complaints[1] alleging that Defendants, Arkansas Department of Human Services ("ADHS"), Kurt Knickrehm, Ray Hanley, and Roy Jeffus intentionally violated §§ 1396(a)(30)(A), 1396a(a)(8), 1396a(a)(3), and 1396d(a)(13) of the SSA by implementing and manipulating a prior authorization process for the sole purpose of meeting general budget concerns; without

considering economy, efficiency, quality of care, and equal access. In addition, Plaintiffs contend that budget concerns overshadowed the real purpose of the entitlement program-maximum reduction of disability. Plaintiffs also allege that Defendants violated their procedural and substantive due process rights. Plaintiffs' Fifth Amended Complaint adds allegations of misrepresentation and fraud in the peer review process-a process utilized by Defendants to review and authorize eligibility for EPSDT services. Plaintiffs have requested injunctive relief and monetary damages. The monetary damages claim is based solely on the allegedly arbitrary reduction of day treatment from six (6) hours to three and a half (3.5) hours.

[1] Doc.Nos. 1, 76, 95, 144, 173.

The individual defendants are Mr. Knickrehm, current Director of ADHS since January, 1999; Mr. Hanley, Director of Division of Medical Services of ADHS from 1994 through January 6, 2003; and Mr. Jeffus, current Director of Division of Medical Services of ADHS beginning on January 6, 2003. Before becoming Director of the Division of Medical Services, Mr. Jeffus was the division's senior Assistant Director.

Defendants allege in their Motion for Summary Judgement that Plaintiffs' Third Amended Complaint should be dismissed as a matter of law because: (1) Plaintiffs have no standing to bring this action; (2) eligibility for the EPSDT program is properly based on medical necessity; (3) Peer Review Organizations ("PROs") are favored by federal law for the purpose of reviewing recommended treatment to ensure that it is, in fact, medically necessary; (4) all benefits mandated by the Medicaid Act must meet the medical necessity standard before providers and recipients are entitled to benefits as a matter of federal statutory right; (5) the prior authorization process implemented by Mr. Hanley on behalf of ADHS is a legitimate means for avoiding payment of unnecessary Medicaid costs, thereby meeting the standard of medical necessity prescribed by the Medicaid Act; (6) Plaintiffs are provided with sufficient procedural due process to challenge any decisions made as a result of the prior authorization process and have failed to exhaust those processes; (7) the prior authorization process through the use of PROs are rationally related to legitimate government ends of ensuring that only medically necessary services are approved, and consequently, Plaintiffs cannot demonstrate deprivation of substantive due process; and (8) Defendants Kurt Knickrehm, Ray Hanley and Roy Jeffus are entitled to qualified immunity.

***2** In sum, Defendants contend that medical necessity is appropriate justification for making policy changes for medicaid eligibility under the State Plan. Defendants further argue that the individual capacity Defendants-Mr. Knickrehm, Mr. Hanley, and Mr.Jeffus-acted in good faith, and are immune from civil damages.

In their Supplemental Motion, Defendants contend that Plaintiffs can produce no evidence linking Defendants to the alleged misconduct of the AFMC. Finally, Defendants argue that Plaintiffs cannot produce sufficient evidence to show that the individual capacity Defendants intentionally and arbitrarily violated the Social Security/Medicaid Act ("SSMA").

II. SUMMARY JUDGMENT STANDARD

Summary judgment is appropriate only when there is no genuine issue of material fact, so that the dispute may be decided on purely legal grounds.[2] The Supreme Court has established guidelines to assist trial courts in determining whether this standard has been met:

[2] *Holloway v. Lockhart,* 813 F.2d 874 (8th Cir.1987); Fed R. Civ. P. 56.

> The inquiry performed is the threshold inquiry of determining whether there is the need for a trial-whether, in other words, there are any genuine factual issues that properly can be resolved only by a finder of fact because they may reasonably be resolved in favor of either party.[3]

[3] *Anderson v. Liberty Lobby, Inc.,* 477 U.S. 242, 250, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986).

The Court of Appeals for the Eighth Circuit has cautioned that summary judgment is an extreme remedy that should only be granted when the movant has established a right to the judgment beyond controversy.[4] Nevertheless, summary judgment promotes judicial economy by preventing trial when no genuine issue of fact remains.[5] This court must view the facts in the light most favorable to the party opposing the motion.[6] The Motion should be denied if, in reviewing the evidence in this light,

reasonable men can differ as to the conclusions to be drawn from it.[7]

4 *Inland Oil & Transport Co. v. United States,* 600 F.2d 725, 727 (8th Cir.1979).

5 *Id.* at 728.

6 *Id.* at 727-28.

7 *Cargill v. Liberty Mutual Ins. Co.,* 488 F.Supp. 49 (D.C.Minn.1979), affd. 621 F.2d 275 (8th Cir.1980); *Greenwood v. Dittimer,* 596 F.Supp. 235 (D.C.Ark.1984) affd. 776 F.2d 785 (8th Cir.1985).

The above-cited standard has been recently applied and more fully explained by the Supreme Court in *Reeves v. Sanderson Plumbing Products, Inc.:*

> The court must draw all reasonable inferences in favor of the non-moving party and it may not make credibility determinations or weigh the evidence. Thus, although the court should review the record as a whole, it must *disregard all evidence favorable to the moving party that the jury is not required to believe ...* that is, the court should give credence to the evidence favoring the moving party that is *un-impeached, at least to the extent that the evidence comes from disinterested witnesses.*[8]

8 530 U.S. 133, 150, 120 S.Ct. 2097, 147 L.Ed.2d 105 (2000) (emphasis added).

In other words, the Supreme Court has clearly directed that when weighing the record on summary judgment, the evidence presented by the moving party must be evaluated in a much different light than the evidence presented by the non-moving party. When considering the evidence presented by the moving party, only evidence that is presented by witnesses that a jury is obliged to believe should be taken into account-such as evidence presented by disinterested witnesses or evidence that is corroborated by independent sources. On the other hand, all evidence presented by the non-moving party is given deference.

III. DISCUSSION

A. Standing To Bring Action:

***3** A private action against a State official to vindicate federal statutory rights is authorized by 42 U.S.C. § 1983. Whether a provision of the Medicaid Act creates enforceable procedural and substantive rights turns on whether the provision was intended to benefit a plaintiff. If so, an enforceable right is created unless, it merely reflects a congressional preference for a certain kind of conduct rather than a binding obligation on the governmental unit; or unless the interest the plaintiff asserts is "too vague and amorphous such that it is beyond the competence of the judiciary to enforce."[9]

9 *Wilder v. Virginia Hosp. Ass'n,* 496 U.S. 498, 509, 110 S.Ct. 2510, 110 L.Ed.2d 455 (1990).

Medicaid is a joint federal-state program that provides medical care to low-income individuals. Beneficiaries of the program are the aged, blind, and permanently disabled.[10] Beneficiaries have also been found to include care givers. In *Wilder,* the Supreme Court held that a specific provision of the Medicaid Act created enforceable substantive rights for institutional health care providers, as well as for the aged, blind, and impaired.[11]

10 *See* 42 U.S.C. § 1396 et seq.; *Wilder,* 496 U.S. at 502.

11 *Wilder,* 496 U.S. at 520.

The Medicaid Act sets out a list of sixty-five (65) items that must be contained within a valid state plan.[12] One such item is the so-called "equal access" provision:

12 *See* 42 U.S.C. § 1396a(a) subsections(1) through (65).

> [A State plan for medical assistance must] provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan ... as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and *are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.*[13]

13 42 U.S.C. § 1396a(a)(30) (Emphasis added).

The Eighth Circuit considered whether the *Wilder* rationale also applied to the above-cited equal access provision. The court found that the SSMA created substantive enforceable rights under § 1983 with respect to the equal access provision.[14] Moreover, in *Reynolds,* the court determined that recipients *and* health care providers were intended beneficiaries under the equal access provision, since health care providers, as payees, obviously are affected by substantive changes in state schemes under Medicaid.[15]

14 *Arkansas Med. Soc'y, Inc. v. Reynolds,* 6 F.3d 519, 525 (8th Cir.1993), citing *Wilder,* 496 U.S. at 512. ("[T]he equal access language 'sets forth a congressional command which is wholly uncharacteristic of a mere suggestion or nudge.' ").

15 *Reynolds,* 6 F.3d at 526-28 (emphasis added). *See also Nebraska Health Care Ass'n v. Dunning,* 778 F.2d 1291, 1295 (8th Cir.1985); *Oklahoma Nursing Home Ass'n v. Demps,* 792 F.Supp. 721, 727 (W.D.Okla.1992).

The same conclusion was reached in *Pediatric Specialty Care et al. v. Arkansas Department of Human Services, et al.,*[16] where the Eighth Circuit held that Plaintiffs in the present case properly asserted federal rights enforceable in a § 1983 action. The court found that substantive statutory rights enforceable by § 1983 were created with respect to EPSDT benefits as a whole and specifically, with respect to entitlements in § 1396d(a)(6) and § 1396d(a)(13).[17] The Eighth Circuit held "that a Medicaid-eligible individual has a *federal right* to early intervention day treatment when a physician recommends such treatment."[18]

16 293 F.3d 472, 487 (8th Cir.2002).

17 *Id.* at 480.

18 *Id.* (emphasis added).

***4** In sum, plaintiffs who care for eligible children, along with the children themselves, have enforceable § 1983 rights. Therefore, whether the providers and recipients in this case have standing as beneficiaries to bring this action has been settled by the Eighth Circuit.[19] In fact, the court made it clear that both recipients and providers are intended beneficiaries of the EPSDT services as defined by § 1396d as well as § 1396a.[20] The court also pointed out that "even without individual standing, the provider plaintiffs in this case have standing to assert the rights of their CHMS patients."[21] All Plaintiffs in this case may seek redress for any alleged violation of substantive statutory rights created by the Medicaid Act. Therefore, the threshold basis of standing is met.

19 *Id.*

20 *Id.*

21 *Id. (citing Singleton v. Wulff,* 428 U.S. 106, 115-17, 96 S.Ct. 2868, 49 L.Ed.2d 826 (1976)).

B. Standing to Assert an Interest in the Litigation:

In addition to contending that the medical providers are not beneficiaries of the equal access provision, Defendants argue that Plaintiffs have failed to allege, or present evidence of sufficient injury. In order to meet the constitutional standing requirement, Plaintiffs must suffer an injury-in-fact that is an invasion of a legally protected interest-one that is concrete and particularized.[22] The injury-in-fact requirement serves to distinguish a person

with a direct stake in the outcome of a litigation-even though small-from a person with a mere interest in the problem.[23]

22 *Republican Party of Minn., Third Congressional Dist. v. Klobuchar,* 381 F.3d 785, 791 (8th Cir.2004).

23 *United States v. Students Challenging Regulatory Agency Procedures,* 412 U.S. 669, 689 n. 14, 93 S.Ct. 2405, 37 L.Ed.2d 254(1973).

Plaintiffs allege that Defendants invaded a legally protected interest that is concrete, to which they are its beneficiaries-entitlement to EPSDT benefits. Furthermore, Plaintiffs have more than a "mere interest in the problem." The denial of this federal entitlement results in loss to providers and recipients alike. The evidence indicates that providers have lost significant revenue as a result of an allegedly unlawful prior authorization process; and recipients have been deprived of services crucial to their medical needs.[24]

24 Plaintiffs' original Response Ex. P, affidavit of Dr. Sharon Ramy.

Finally, Defendants contend that Plaintiffs lack standing because Plaintiffs cannot show that they made individual administrative claims challenging the medical necessity determinations at the state level. However, the existence of administrative procedures where health care providers and medicaid recipients can obtain review of individual claims for payment does not foreclose a private remedy in the federal courts through § 1983.[25]

25 *See Patsy v. Board of Regents of Fla.,* 457 U.S. 496, 516, 102 S.Ct. 2557, 73 L.Ed.2d 172 (1982); *Wilder,* 496 U.S. at 523.

In sum, the record offers sufficient evidence that Plaintiffs have standing to bring the current action. The fact that Plaintiffs can challenge denials through a state administrative process is irrelevant to their right to seek redress under § 1983-especially when the denial of benefits is as sweeping as has allegedly occurred in this case.

C. Medical Necessity:

The remainder of Defendants' contentions are based on the standard of "medical necessity." Defendants argue that the state has the discretion to limit the scope of eligibility based on medical necessity of prescribed care. Moreover, Defendants assert that PROs, such as the Arkansas Foundation for Medical Care (AFMC), are an appropriate vehicle through which prescribed treatments may be reviewed for compliance with medical necessity. Defendants assert that any changes implemented through the prior authorization process are consistent with the mandate of the SSMA-to provide only those services that are medically necessary. Finally, Defendants argue that the prior authorization process is within the realm of state authority; and is legitimately based solely on considerations of medical necessity. Defendants vigorously deny improper motive behind the changes.

***5** The state has the right to place limits on treatment based on medical necessity. However, the boundaries of state discretion are limited by the rules and regulations of the Medicaid Act. The state's authority and limitations are addressed in several opinions handed down by the Eighth Circuit, beginning with the role of the treating physician and weight given his opinions: "[t]he Medicaid statute and regulatory scheme create a presumption in favor of the medical judgment of the attending physician in determining the medical necessity of treatment."[26] However, while there is a presumption in favor of the treating physician, the regulations make it clear that treating physicians are not the sole arbiter of medical necessity.

26 *Pinneke v. Preisser,* 623 F.2d 546, 549 (8th Cir.1980); *Smith v. Rasmussen,* 249 F.3d 755, 759 (8th Cir.2001).

There is no question that the Medicaid Act confers broad discretion on the states to adopt standards for determining the extent of needed medical assistance.[27] Indeed, the Department of Health and Welfare regulations read: "The agency may place appropriate limits on services based on such criteria as medical necessity."[28] As the Eighth Circuit has concisely pointed out Medicaid was designed "to provide the largest number of necessary medical services to the greatest number of needy people."[29] However, any medical necessity standards adopted by the state must be "*reasonable* " and "*consistent with the objectives of the Act.*"[30] Further, the Medicaid Act mandates that a

provided service must be "sufficient in amount, duration, and scope to reasonably achieve its purpose."[31] Medical necessity determinations must be consistent with the overall goal of the recommended treatment and the objectives of the program-to provide appropriate care that achieves maximum reduction of impairment. Thus, the Act and its regulations both protect and limit a state's discretion to define the scope of necessary coverage.[32]

27 *Smith,* 249 F.3d at 759.

28 42 C.F.R. § 440.230(d).

29 *Ellis v. Patterson,* 859 F.2d 52, 55 (8th Cir.1988).

30 *Beal,* 432 U.S. at 443 (emphasis added).

31 42 C.F.R. § 440.230(b).

32 *Rasmussen,* 249 F.3d at 759.

It should also be noted that Plaintiffs challenge agency prior authorization guidelines that affect the medical care of large categories of impaired children. This is distinct from case-specific determinations of medical necessity. The Supreme Court has indicated that "serious statutory questions might be presented if a state Medicaid plan excluded necessary medical treatment from its coverage"[33] Plaintiffs' allegations suggest that Defendants are using the medical necessity standard as justification for what is, instead, a *de facto* coverage exclusion. The Eighth Circuit recently made it clear that decisions to eliminate components of the CHMS program would result in a substantial change to the level of payment for services mandated by the Medicaid Act.[34]

33 *Beal v. Doe,* 432 U.S. 438, 444, 97 S.Ct. 2366, 53 L.Ed.2d 464 (1977) (emphasis added).

34 *Pediatric Specialty Care, Inc. et al. v. Arkansas Department of Human Services et al.,* 364 F.3d 925 (8th Cir.2004).

Following *Beal,* the Eighth Circuit wrote an exhaustive analysis of the "medical necessity" standard in *Hodgson v. Board of County Commissioners, County of Hennepin.*[35] In *Hodgson,* the court found that, once a state designates services that it will provide, the state may make eligibility decisions only on the basis of individual need. The court held that the only time a state could make sweeping exclusions of a medical procedure were when the procedure is "never, or generally never, of sufficient medical necessity."[36]

35 614 F.2d 601, 608-10 (1980).

36 *Id.* at 608.

***6** The court said that a state may reasonably modify its eligibility requirements and medically necessary services. However, the restrictions must be consistent with the degree of a *recipient's* medical needs.[37] The court further held that within the category of "medical necessity" the scope of review must be in accordance with the Medicaid Act-to provide medical assistance in the *best interest* of the recipient and on an even-handed basis.[38] The court also held that eligibility determinations based on type of condition, illness, or diagnosis are never reasonable. By way of example, the Eighth Circuit explained that a state may *not* choose to provide eyeglass subsidies for only those persons whose poor vision is from an eye disease, even though the state considers them most needy. In other words, simply because a child from a poor family suffers from a serious eye disease, he is not any more eligible for eye glasses than one who is simply near-sighted. The question, and basic criterion, is whether each child needs the corrective therapy.[39] The regulations permit discrimination in benefits based upon the degree of medical necessity, but not upon the extent of medical disorders from which the person suffers.[40] Likewise, Defendants argue that because the CHMS day treatment clinics must provide multidisciplinary care to address the needs of the most seriously impaired children, i.e., those who need a variety of therapies-then children who need day treatment, but are not so seriously impaired, should be excluded from coverage. Again, this ignores the basic

criterion-whether the child needs day treatment corrective therapy to ameliorate his disability. Finally, the Eighth Circuit has also held that state schemes based *solely* on budget concerns are invalid.[41]

37 *Id.* at 610-611 (emphasis added).

38 *Id.* (emphasis added).

39 *Id.* at 608 (*citing White v. Beal,* 555 F.2d 1146, 1150-52 (3d Cir.1977)). *See also* 42 C.F.R. § 230(c).

40 *See Pinneke,* 623 F.2d at 550.

41 *Reynolds,* 6 F.3d at 522, 531 (emphasis added).

As stated above, under the above regulations and precedent, the actions of the state with respect to benefits must be reasonable and consistent with the objectives of the Medicaid Act. Medical necessity determinations must be geared to the medical need of the recipient. The opinion of the treating physician is given reasonable deference. Any coverage denial cannot be based legitimately on the diagnosis of the recipient or on budget concerns. In 1967, Congress amended the Medicaid Act to provide EPSDT services to medicaid eligible children. The stated objective of these services is to facilitate the maximum reduction of physical or mental disability, and restore a child to the best possible functional level. The state plan must provide medically necessary services that reasonably meet this objective. Finally, Plaintiffs' allegations raise a legitimate legal and factual question that is material to this case: to wit, are Defendants denying *coverage* to a large segment of eligible children under the rubric of "medical necessity?" I have already held that any reduction in services that is applied to *all* children without consideration of an individual child's diagnosed medical condition, and prescribed treatment and the accumulated knowledge of the medical community would run afoul of the Medicaid Act.[42]

42 Doc.No. 150, p. 13.

***7** Here, Defendants have provided information from administrators of the ADHS and the AFMC to show that medical necessity is the sole guiding principle by which eligibility for CHMS is determined.[43] These same administrators offer additional testimony that authorization of CHMS services is case specific; is based on the opinions of qualified independent physicians; and is based reasonably on the legitimate need of each medicaid eligible child.[44] In short, Defendants present testimony from its own administrators that the ADHS has limited the scope and duration of services in a manner which complies with the overall objectives of the medicaid act and the EPSDT provisions. However, under the *Reeves* holding, this is not evidence that a fact finder is necessarily obliged to believe.[45]

43 Affidavits of Ray Hanley (Defendants' Exhibit 4); Roy Jeffus (Defendants' Exhibit 5); Marilyn Strickland, Utilization Review Administrator for the Division of Medical Services (Defendants' Exhibit 6); Dr. Michael Moody, Medical Director for AFMC (Defendants' Exhibit 7)

44 Defendants' Motion for Summary Judgment Exs. 2-8.

45 *Reeves,* 530 U.S. at 150.

D. Budget Concerns versus Medical Necessity:

On the other hand, Plaintiffs have provided evidence from which a reasonable fact finder could draw conflicting conclusions-beginning with the original notice announcing the intentions of Mr. Hanley to modify the scope of medicaid coverage.[46] The notice reveals that the proposed changes would provide a significant decrease in medicaid expenditure. Addressing cost benefits, together with a notice of proposed changes in medicaid eligibility, creates a reasonable inference that the proposed modifications were motivated by financial concerns. As pointed out above, this, standing alone, is not a legitimate basis for limiting eligibility or the scope and duration of required services. "A state may not flout the Medicaid Act's requirements in order to suit state budgetary

needs."[47] In affirming the District Court, the Eighth Circuit found that persuasive precedent supports the proposition that budgetary considerations cannot be the conclusive factor in decisions regarding Medicaid.[48] The *conclusive* factor in rate determination *must not be* the amount of money appropriated by a given state's legislature; rather the state Medicaid agency must make an objective, principled decision regarding what is reasonable and adequate to meet the needs of medicaid beneficiaries.[49]

46 PIaintiffs' original Response, Ex. A.

47 *Arkansas Medical Soc., Inc. v. Reynolds,* 819 F.Supp. 816, 824 (E.D.Ark.1993) (*citing Alabama Nursing Home Ass'n v. Harris,* 617 F.2d 388, 396 (5th Cir.1980).

48 *Arkansas Medical Soc., Inc. v. Reynolds,* 6 F.3d 519, 531 (8th Cir.1993).

49 *Illinois Hosp. Ass'n v. Illinois Dept. of Public Aid* 576, F.Supp. 360, 368 (D.C.Ill.1983).

E. Medical Needs of Individual Recipients:

Plaintiffs offer additional evidence that a decrease from six (6) hours to three and a half (3.5) hours per day of treatment services is applied generally, without any specific investigation as to individual recipients; or the effect such a reduction has on equal access to quality care. For instance, not one of the reviewing physicians could provide an example when more than three and a half (3.5) hours of day treatment were approved. Moreover, none of these physicians offered a reasonable medical foundation for the reduction in the scope and duration of intervention therapies offered by CHMS clinics.[50] Plaintiffs presented Dr. Sharon Ramey, an expert in the field of pediatric developmental disabilities, who testified that the most effective manner of achieving maximum improvement for impaired children includes intervention therapies lasting at least six (6) hours each day.[51] Therefore, Plaintiffs have raised an inference that Defendants have violated 42 C.F.R. § 440.230(b), which requires that "each service *must* be sufficient in amount, [and] duration ... to reasonably *achieve its purpose.*"[52] As Defendants are well aware, the stated purpose for EPSDT services, including day treatment, is to provide treatment for the maximum reduction of physical and mental disability.

50 Dr. Whitaker (Plaintiffs' original Response Ex. G, p. 39); Dr. Tracey Steward (Plaintiffs' original Response Ex. H, p. 58); Dr. H. Frazier Kennedy (Plaintiffs' original Response Ex. K, pp. 25-26); Dr. Susan Keathley (Plaintiffs' original Response Ex. L, p. 33).

51 Plaintiffs' original Response Ex. P, pp. 8-14.

52 42 C.F.R. § 440.230(b) (emphasis added).

F. Eligibility based on Single Impairment Diagnosis:

***8** Defendants have created guidelines where a child with a malady that creates a single impairment-requiring only one type of therapy such as speech therapy, physical therapy, etc.-is not prior authorized for CHMS services, despite the severity of the impairment. Plaintiffs have produced evidence indicating that this "prior authorization" guideline has excluded large numbers of children from EPSDT services, discouraging providers from making additional attempts to obtain EPSDT services for such children.[53] Such a policy may well violate the requirement set forth in 42 C.F.R. § 440 .230(c) which reads: "The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of required services ... to an otherwise eligible recipient solely because of the diagnosis."[54] Defendants justify this guideline by asserting that the CHMS provider manual, prepared by ADHS, describes CHMS services as multi-disciplinary. I am not persuaded that the term "multi-disciplinary" is sufficient justification for denying required medicaid services to eligible children. Such a rationale-that only those children who are afflicted with the most serious conditions are entitled to medicaid benefits-was rejected by the Third Circuit.[55] More importantly, there is nothing in the Medicaid Act which limits EPSDT services to only children with a need for two or more intervention therapies. Therefore, the across-the-board denial of CHMS day treatment services to children with a single impairment raises a reasonable inference that children are being denied their right to

EPSDT services because of their disorder without consideration of individual medical need. As the court in *Pinneke* made clear, this is an improper basis for the denial of a statutory right.[56] Moreover, a recent opinion issued by the Fifth Circuit strongly advised that EPSDT services cannot, under any circumstances, be limited by state plans. Citing to several other circuit decisions, including the Eighth Circuit opinion issued in the present case, the Fifth Circuit held:

> Congress did not allow states the discretion to define what types of health care and services would be provided to EPSDT children, and that participating states must provide all services within the scope of § 1396d(a) which are necessary to correct defects, illnesses, and conditions in children discovered by the screening services.[57]

In the *Dickson,* the Fifth Circuit unequivocally stated that the states have very little discretion with regard to the EPSDT provisions: "We reject the notion that Congress made the provision of [EPSDT] treatment mandatory on the states only to cede to the states complete discretion to decide upon the contents of the medical assistance programs available to EPSDT eligible children."[58] The Fifth Circuit held that the twenty seven categories of medical assistance outlined in the EPSDT provisions are not "empty vessels" to be filled according to the state's discretion.[59] The court emphasized that the state must provide all assistance that is necessary to treat or ameliorate conditions in children discovered by the screening process.[60]

***9** The evidence strongly indicates that Defendants, by denying EPSDT services to children in need of only one type of therapy, have exceeded their boundaries in the exercise of their responsibilities under the Medicaid Act.

G. Alleged Misconduct within the Prior-Authorization Process:

Plaintiffs filed a supplemental response to Defendants' Motion for Summary Judgment. Plaintiffs' supplemental response presents the testimony of Ms. Brenda Gassaway, a nurse and former employee of AFMC; and Dr. Whitaker, a board certified pediatrician and contract physician for AFMC. The sworn statements of both these witnesses, if accepted by the trier of fact, implicate the ADHC and the AFMC in widespread abuses that demonstrate a disregard for the medical needs of eligible children as well as a disregard for the objectives of the Medicaid Act, the Orders of this Court, and the Circuit Court.

Ms. Gassaway was employed at AFMC for four years, reviewing charts for personal care, targeted health management, and child health management programs.[61] In January 2002, Ms. Gassaway discovered that another nurse reviewer, Ms. Tilerra Coates, had altered files by overriding opinions of reviewing physicians and reducing the scope and duration of approved treatment.[62] Ms. Gassaway immediately reported the discrepancies to the department manager, Ms. Amy Carson, who is also a nurse. Thereafter, Ms. Gassaway began to monitor Ms. Coates's charts, and made frequent reports to Ms. Carson concerning discovered alterations that contravened physician opinions and recommendations.[63]

53 Plaintiffs' original Response Ex. C, Ex. H, p. 42; Ex. G, p. 25.

54 *See also Pinneke,* 623 F.2d at 550.

55 *White v. Beal,* 555 F.2d at 115.

56 *Pinneke,* 623 F.2d at 550.

57 *S.D. Dickson v. Hood,* 391 F.3d 581 (5th Cir.2004).

58 *Id.* at 592.

59 *Id.*

60 *Id.*

61 Plaintiffs' Supplemental Response Ex. B, p. 8.

62 Plaintiffs' Supplemental Response Ex. B, pp. 12-16.

63 Plaintiffs' Supplemental Response Ex. B, pp. 16-18.

Ms. Gassaway identified several codes that were singled out by general policy and by Ms. Carson that could not be approved under any circumstances.[64] According to Ms. Gassaway, the AFMC also developed a system of canned denials[65] referred to as "one minute charts."[66] The nurse reviewers are allowed to enter the canned denials that then turned over to Dr. Whitaker for signature. Ms. Gassaway began to monitor Ms. Coates's charts and discovered that eighty percent (80%) of the "one minute" charts were altered. Although Ms. Gassaway frequently brought these improprieties to Ms. Carson's attention, nothing was done.[67]

64 Plaintiffs' Supplemental Response Ex. B, pp. 19-20.

65 Canned denials are rote rationales used when authorization for certain designated services are routinely denied.

66 Plaintiffs' Supplemental Response Ex. B, pp. 17-19.

67 Plaintiffs' Supplemental Response Ex. B, p. 18.

The existence of the canned denials were disclosed to separate Defendant AFMC counsel, Mr. Mike Rainwater. Ms. Gassaway testified that Mr. Rainwater advised the nurses "not to bring up" the use of canned denials during the course of their depositions.[68] Ms. Gassaway testified that there were no in house guidelines *per se,* but that each nurse reviewer received frequent memos from Ms. Carson identifying what services could and could not be approved.[69] Ms. Gassaway was told by her supervisors, Ms. Kenya Harkin and Ms. Carson, that cost savings was the only basis for renewal of the contract between AFMC and ADHS. Ms. Gassaway indicated that cost savings was the primary incentive for decisions made by AFMC, and further testified that the ADHS required monthly cost savings reports.[70] Ms. Gassaway described her general observations of the internal workings of AFMC in the following manner: "I worked there for four years and I saw the patterns of how the programs are worked and it seems like the goal is always to cut services and to make the centers jump through hoops to get the kids approved, so that they will just quit."[71] Ms. Gassaway went on to describe various practices that she observed including capping the scope and duration of recommended services; and making constant changes in authorization criteria.[72]

68 Plaintiffs' Supplemental Response Ex. B, pp. 18-19.

69 Plaintiffs' Supplemental Response Ex. B, p. 21.

70 Plaintiffs' Supplemental Response Ex. B, pp. 33-35.

71 Plaintiffs' Supplemental Response Ex. B, p. 36.

72 Plaintiffs' Supplemental Response Ex. B, pp. 36-37.

***10** Ms. Gassaway described the response of AFMC administrators to complaints lodged since January 2002 concerning Ms. Coates' alteration of physician recommendations: "Hide it, get rid of the people that know, lock it up, deny access, cover it up."[73]

73 Plaintiffs' Supplemental Response Ex. B, p. 43.

When asked about the truthfulness of Dr. Moody's testimony with respect to the assistance given by AFMC to CHMS providers, Ms. Gassaway offered the most stark statement in her deposition: "No, that was not the truth. *The truth is no matter what they ask for you don't give it to them ever until they beg for it ...* That's the truth."[74]

74 Plaintiffs' Supplemental Response Ex. B, p. 22 (emphasis added).

With respect to the involvement of the ADHC in the decision making processes of AFMC, Ms. Gassaway indicated that Ms. Wilson and Ms. Strickland, both Directors of Utilization for the ADHC, frequently directed Ms. Carson to deny generally the duration and scope of certain recommended services. Ms. Gassaway indicated that when she first began working for AFMC, several memos were issued containing directives from Ms. Wilson, via Ms. Carson.[75] Finally, Ms. Gassaway stated that Mr. Rainwater and Mr. Hopkins, counsel for ADHC and AFMC, were aware of the "one minute" charts and the use of canned denials.[76]

75 Plaintiffs' Supplemental Response Ex. B, pp. 38-39.

76 Plaintiffs' Supplemental Response Ex. B, p. 45.

Dr. Whitaker is the only board certified pediatrician working with AFMC. Dr. Whitaker corroborated the testimony of Ms. Gassaway. He stated that he also audited the files and discovered alterations made by Ms. Coates on a large percentage of the "one minute charts." Like Ms. Gassaway, Dr. Whitaker brought this to the attention of Ms. Carson, yet no action was taken.[77] Most of the changes made by Ms. Coates involved the reduction of services for particular codes.[78] Dr. Whitaker also reported the discrepancies to the medical director of AFMC, Dr. Moody, and to other physicians, including Dr. Keathley.[79]

77 Plaintiffs' Supplemental Response Ex. E, pp. 8-18.

78 Plaintiffs' Supplemental Response Ex. E, p. 22.

79 Plaintiffs' Supplemental Response Ex. E, pp. 30-31.

Dr. Whitaker admitted that he was the author of the "canned denials" and that they were composed at the request of Ms. Carson. After the canned denials were created, nurse reviewers were allowed to apply them at their discretion. The canned denials were used to save time and money. The nurse reviewers never received formal training in the proper application of the canned denials.[80] Dr. Whitaker testified, as did Ms. Gassaway, about AFMC practices that intentionally made the application and authorization process as difficult as possible.[81] Dr. Whitaker summarized his complaints:

80 Plaintiffs' Supplemental Response Ex. E, pp. 52-55.

81 Plaintiffs' Supplemental Response Ex. E, pp. 68-69.

> I made the decision ... it's been altered ... the child services have been reduced, which hurts the child ... that's what bothers me ... my driving force is ... to serve these kids like they need to be served ... I don't like it when what I've done has been changed and child services reduced ... I certainly don't like it when rationales that I have done turn up missing from the chart.[82]

82 Plaintiffs' Supplemental Response Ex. E, p. 89.

Dr. Whitaker testified that he was always told to deny services for a child with only one diagnosis, that he was to look for two qualifiers, and that units of recommended services were capped despite guidelines to the contrary.[83]

83 Plaintiffs' Supplemental Response Ex. E, pp. 75-77, 89-92.

***11** Like Ms. Gassaway, Dr. Whitaker testified that directives were given to Ms. Carson from the ADHS through Ms. Marilyn Strickland-Ms. Wilson's successor.[84] When asked why he has not resigned, Dr. Whitaker responded that if he leaves "things would only get worse."[85]

84 Plaintiffs' Supplemental Response Ex. E, pp. 77, 100-01.

85 Plaintiffs' Supplemental Response Ex. E, p. 104.

In view of the above referenced testimony, together with the voluminous documentation offered in support, there remains a question of fact as to whether Defendants,

through its authorized PRO and the application of the prior authorization process-are providing services mandated by federal law and the Constitution. The testimony creates genuine issues from which a reasonable inference could be drawn that AFMC engaged in arbitrary, capricious, and unreasonable conduct designed to deny EPSDT services to qualified recipients, violating the objectives of the Medicaid Act in general, and the equal access clause in particular. Plaintiffs provide sufficient evidence from which an inference may be drawn that Defendants' certified PRO-AFMC-failed to give proper deference to the recommendations of treating physicians; failed to ensure that medical reviews are performed by qualified independent physicians; failed to ensure that reviews are based on reasonable medical standards; denied authorization for services based upon diagnosis alone; and limited the duration and scope of recommended services without reasonable cause, solely for budget concerns. In short, the evidence raises the inference that AFMC limited the amount of certain services for all children, regardless of the severity of their delays; and without consideration of a child's diagnosed condition and prescribed treatment, and the accumulated knowledge of the medical community. The testimony further creates the inference that Defendants Ray Hanley and Roy Jeffus were not only aware of the practices, but also given incentives and rewarded for their practices by maintaining its contract with AFMC.

There is testimony that administrative officers with the ADHC issued verbal directives to the AFMC to cap services across the board with respect to certain recommended treatment codes. These officers were in charge of utilization for the Department of Medical Service-Ms. Marilyn Strickland and Ms. Sharon Wilson. There is further testimony that Defendants' attorneys, Mr. Hopkins and Mr. Rainwater, were aware of the existence of the utilization of "canned denials" and the "one minute reviews." There is evidence that monthly cost reports and the ability of AFMC continuously to reduce cost by reducing services was the sole basis for AFMC's contract with the State.

Defendants assert that Plaintiffs are merely complaining that their rights are being violated because they are subject to federally mandated medical necessity criteria. But Plaintiffs have produced sufficient evidence creating an inference that the criteria utilized by Defendants is not based on reasonable medical necessity determinations. Rather, Plaintiffs complain that Defendants violated federal laws by unreasonably depriving eligible children of benefits to which they were entitled.

***12** In their Supplemental Motion for Summary Judgement, Defendants assert that the testimony of Ms. Gassaway and Dr. Whitaker does not render the state defendants liable. Defendants assert that the testimony of these two witnesses shows that a rogue nurse-Ms. Coates-engaged in unsanctioned misconduct. However, for all the reasons set forth above, the testimony of Ms. Gassaway and Dr. Whitaker raise questions that go far beyond Ms. Coates's activities.

H. Procedural Due Process:

Defendants contend that Plaintiffs have not identified a protected property interest entitled to due process protection. This issue was settled by the Eighth Circuit, which held "We find it entirely appropriate for Plaintiffs to base their procedural due process claim on their clearly established right to have equal access to quality medical care as defined by § 1396(a)(30)(A)."[86] The Eighth Circuit instructed Defendants to complete a proper study to insure that factors such as quality of care and equal access are not jeopardized by changes in the methods and procedures for payment of these mandatory services.[87] Moreover, in their earlier opinion, the Eighth Circuit found that § 1396d(a)13 creates a federal right to day treatment prescribed by a treating physician.[88]

86 *Pediatric,* 364 F.3d at 930.

87 *Id.*

88 *Pediatric,* 293 F.3d at 480-81.

There is no question that Plaintiffs have provided sufficient evidence from which an inference can be drawn that Defendants have failed to follow the directives of this Court and the Court of Appeals. Defendants engaged in undisclosed practices that jeopardized the ability of eligible children to obtain equal access to quality care and to medically necessary day treatment services. Plaintiffs have offered additional evidence that may lead to the conclusion that the prior authorization process is arbitrarily used with the intent of eliminating all CHMS services. The practices of AFMC as described by Ms.

Gassaway raise questions about the willingness of Defendants to comply with my last directive: "Nor may Defendants bury requirements or standards for various services so that providers are unable to comply with those requirements."[89]

89 Doc.No. 150, p. 13.

Defendants contend that the administrative procedures available to Plaintiffs are more than sufficient to protect the rights of the providers and beneficiaries. They also contend that the remedies provided by the state should have been exhausted before Plaintiffs filed the current action. This is not the law. "The availability of state administrative procedures ... does not foreclose resort to § 1983."[90] Moreover, § 1983 relief is not precluded by the failure to exhaust state administrative and judicial remedies.[91]

90 *Wilder,* 496 U.S. at 523.

91 *See Monroe v. Pape,* 365 U.S. 167,183 (1961) ("The federal remedy is supplementary to the state remedy, and the latter need not be first sought and refused before the federal one is invoked."); *See also Greenstein by Horowitz v. Bane,* 833 F.Supp. 1054, 1068 (S.D.N.Y., 1993).

Plaintiffs, therefore, have a property interest in the provision of quality care equal to that of the general population. Plaintiffs are not required to seek redress for the denial of this interest by exhausting state remedies. Instead, Plaintiffs may appropriately file a § 1983 action alleging the denial of their Constitutional right to procedural due process. However, a consideration of the state administrative process provided to medicaid recipients is clearly part of the analysis of any due process issue.

***13** It is well established that a possessory interest in property invokes procedural due process, consisting of two crucial elements: (1) adequate notice; and (2) a meaningful hearing. Both elements must be met before depriving an individual of his property right.[92] The Supreme Court's definition of adequate notice is "notice [that is] reasonably calculated, under all circumstances, to apprise interested parties of the pendency of the action and afford them an opportunity to present their objections."[93] The Supreme Court further clarified the standard for adequate notice in *Goldberg v. Kelley,*[94] when it required that notice be reasonably calculated to inform the recipient of the action to be taken; and to also provide an effective opportunity to be heard.

92 *Thomas v. Cohen,* 304 F.3d 563, 576 (6th Cir.2002) (citing *Fuentes v. Shevin,* 407 U.S. 67, 87, 92 S.Ct. 1983, 32 L.Ed.2d 556 (1972)); *See also Mathews v. Eldridge,* 424 U.S. 319, 96 S.Ct. 893, 47 L.Ed.2d 18 (1976) (Holding that a claim of entitlement to social security benefits triggers due process protection).

93 *Mullane v. Cent. Hanover Trust Co.,* 339 U.S. 306, 314, 70 S.Ct. 652, 94 L.Ed. 865 (1950).

94 397 U.S. 254, 90 S.Ct. 1011, 25 L.Ed.2d 287 (1970).

Plaintiffs in this case have presented sufficient evidence from which it may be inferred that Defendants are responsible for establishing guidelines in violation of these constitutional standards. There is additional evidence from which an inference may be drawn that internal procedures that were designed to further hinder Plaintiffs rights to quality care were formulated with the cooperation and tacit approval of Defendants.[95] Finally, Plaintiffs have provided evidence that Defendants failed to notify medicaid beneficiaries that canned denials formulated by AFMC replaced individualized medical necessity reviews. It is reasonable to assume that Plaintiffs would have wanted an opportunity to be heard on these matters.[96] The failure to disclose this conduct represents a basis for Plaintiffs' procedural due process claim. The Sixth Circuit recently found that medicaid recipients had been denied due process because beneficiaries were not given clear indication of the reason for denial. Moreover, the Sixth Circuit noted that procedures were utilized that were designed to delay and complicate the review process in a manner that is very similar to the evidence presented here.[97]

95 *See* Plaintiffs' Supplemental Response Ex. B, pp. 22, 36-38.

96 *See* Plaintffs' Original Response, Ex. C-Affidavit of Melissa Thomas.

97 *Hamby v. Neel,* 368 F.3d 549, 560-61 (6th Cir.2004).

Plaintiffs also assert a violation of due process based on Defendants' refusal to identify and compel the testimony of physicians and any other individuals responsible for making eligibility decisions. The power of the subpoena as well as the ability to gather evidence is an intricate part of the right to a "meaningful hearing." Citizens must be able to compel the testimony of material witnesses and to have access to all relevant evidence.[98] However, my recent decision enjoining Defendants from non-disclosure of the names of physicians and other individuals responsible for making eligibility decisions has rendered this part of Plaintiffs' due process claim moot. Based on this interpretation of the pertinent provision of the Medicaid Act, recipients may compel the testimony of each member of the PRO responsible for adverse decisions. Accordingly, recipients may compel such testimony and request relevant evidence in connection with state administrative hearings.[99]

98 *See United States v. Valenzuela-Bernal,* 458 U.S. 858, 867, 102 S.Ct. 3440, 73 L.Ed.2d 1193 (1982); *Wright v. Lockhart,* 854 F.2d 309, 312 (8th Cir.1988).

99 Doc. No. 249.

I. Substantive Due Process:

***14** The Eighth Circuit addressed the issue of substantive due process in its second opinion addressing this case and found that "issues may come to light as to whether cutting CHMS services would result in a substantive due process violation."[100] It was further held by the court that this is not a case involving "fundamental rights." Thus, Plaintiffs must demonstrate either that Defendants' actions are not rationally related to legitimate government ends or that Defendants' conduct deprived Plaintiffs of their right to EPSDT services and to equal access to medicaid benefits in a manner that would "shock the conscience."

100 *Pediatric,* 364 F.3d at 925.

The core of the substantive due process is protection against arbitrary action and against the exercise of power without any reasonable justification in the service of a legitimate governmental objective. It is conduct that is intended to injure in some way, and that is unjustifiable by any government interest. The threshold question in a due process challenge to abusive conduct by a state actor is "whether the behavior of the governmental officer is so egregious, so outrageous, that it may fairly be said to shock the contemporary conscience."[101]

101 *County of Sacramento v. Lewis,* 523 U.S. 832, 846, n. 8 (1998); *See also Rogers v. City of Little Rock, Ark.,* 152 F.3d 790, 796-97 (8th Cir.1998).

Plaintiffs have presented sufficient evidence from which it can reasonably be inferred that Defendants engaged in conduct that violated Plaintiffs' right to substantive due process. The Eighth Circuit reminded the ADHS that it was bound to provide CHMS services under the Medicaid Act, and cannot legitimately avoid its responsibility without ensuring that its conduct does not adversely affect Plaintiffs' equal access to quality care.[102] The testimony of Ms. Gassaway and Dr. Whitaker, combined with the other evidence presented, raises an inference that Defendants were aware of and encouraged the alleged denial of benefits in a manner that violated federal medicaid regulation. In sum, Plaintiffs have raised an inference that Defendants' conduct was not rationally related to a legitimate end and that the conduct also represented an unreasonable and arbitrary exercise of executive power.

102 *Pediatric,* 364 F.3d at 932.

J. Qualified Immunity:

Defendants Ray Hanley, Kirk Knickrehm and Roy Jeffus have plead qualified immunity. Defendants assert that they are not personally responsible for any violation of Plaintiffs clearly established rights. Qualified immunity is also known as "good faith immunity" because the underlying principle for the application of immunity to state actors is "good faith." An official will not be held liable for conduct that he could not have reasonably

known was illegal, nor may such an official be held liable for actions of his subordinates without some showing of personal involvement. Therefore, in order to answer the question of qualified immunity, I must consider first whether the *rights* Defendants are alleged to have violated were clearly established at the time of the violation; and second, whether there is evidence of Defendants' personal involvement in the violations.

***15** Government officials performing discretionary functions are shielded from liability for civil damages and are entitled to qualified immunity unless their conduct violates clearly established statutory or constitutional rights of which a reasonable person would have known.[103] Plaintiffs must assert the violation of a federal right that a reasonable official in Defendants' position would have recognized as such a violation.[104] The right to immunity set forth in the *Harlow* opinion is a right to immunity *from certain claims,* not from litigation in general.[105] In *Harlow,* the Supreme Court held: "[W]e emphasize that our decision applies only to suits for civil *damages*."[106] The claims to which Defendants have a right to immunity are only those claims for civil damages. In this case Plaintiffs have claimed civil damages for violation of a federal statute, not for violation of a constitutional right to due process.

103 *Harlow v. Fitzgerald,* 457 U.S. 800, 818, 102 S.Ct. 2727, 73 L.Ed.2d 396 (1982); *Samuels v. Meriwether,* 94 F.3d 1163, 1166 (8th Cir.1996).

104 *Walden v. Carmack,* 156 F.3d 861, 868-69 (8th Cir.1998); *Audio Odyssey, Ltd. v. Brenton First Nat. Bank,* 245 F.3d 721, 737 (8th 2001).

105 *Behrens v. Pelletier,* 516 U.S. 299, 312, 116 S.Ct. 834, 133 L.Ed.2d 773 (1996).

106 *Id.* at 819.

I am aware that Plaintiffs have requested punitive damages in each count of their complaint-particularly with regard to alleged due process violations. However, Plaintiffs failed to request actual or compensatory damages for any due process violations. Generally speaking, compensatory damages are a prerequisite to punitive damages.[107] The U.S. Supreme Court has found that due process violations are not a basis for presumed damages, but can support claims for nominal damages.[108] Plaintiffs have failed to assert any actual injury or request even nominal damages in connection with the due process violations alleged. The Supreme Court has explained that § 1983 damages should be based on general principles of tort law including the doctrine that punitive damages must be prefaced on compensatory or actual damages.[109] In view of this, I find that the issue of qualified immunity is only applicable to the Plaintiffs' claims for actual damages.[110]

107 *Hale v. Ladd,* 308 Ark. 567, 826 S.W.2d 244 (Ark.1992).

108 *Carey v. Piphus,* 435 U.S. 247, 263, 98 S.Ct. 1042, 55 L.Ed.2d 252 (1978).

109 *Memphis Community School Dist. v. Stachura,* 477 U.S. 299, 308, 106 S.Ct. 2537, 91 L.Ed.2d 249 (1986).

110 Any other claims for punitive damages, that are made without allegations of actual injury, and a request for compensation for the injury, are without substantial merit, and need not be addressed in connection with the issue of qualified immunity.

To receive qualified immunity, a government official first must prove that he was acting within his discretionary authority. A law that fails to specify the precise action that the official must take in each instance creates only discretionary authority; that authority remains discretionary however egregiously it is abused.[111] Once Defendants establish that they were acting within their discretionary authority, the burden shifts to Plaintiffs to show that Defendants are not entitled to qualified immunity.

111 *Davis v. Scherer,* 468 U.S. 183, 196, 104 S.Ct. 3012, 82 L.Ed.2d 139 (1984).

A civil action for damages may be brought under § 1983 against anyone who-under color of state statute,

regulation, or custom-deprives another of any rights, privileges, or immunities secured by the Constitution and *federal laws.* This encompasses claims based on purely statutory violations.[112] In *Harlow,* the Court acknowledged that officials may lose their immunity by violating clearly established statutory rights.[113]

112 *Maine v. Thiboutot,* 448 U.S. 1, 100 S.Ct. 2502, 65 L.Ed.2d 555 (1980) (Holding that § 1983 creates a cause of action against state officials for violating federal statutes).

113 457U.S. at 818, n. 34.

For purposes of § 1983, violating "statutory rights" is separate from violation of the law itself.[114] There is no point in explaining the analytical framework concisely described in the *Reynolds* opinion. Section1396a(a)30 (also known as the equal access provision), and § 1396d(a)13 have already been determined to create "rights" for purposes of § 1983 actions.[115] Shortly before the Eighth Circuit filed its first *Pediatric* opinion, the Sixth Circuit concluded that medicaid providers and recipients had an enforceable right to EPSDT services.[116]

114 *Golden State Transit Corp., Inc. v. City of Los Angeles,* 493 U.S. 103, 106, 110 S.Ct. 444, 107 L.Ed.2d 420 (1989). *See Reynolds,* 6 F.3d 519 at 523.

115 *See Reynolds,* 6 F.3d at 528 ("the equal access provision involves a federal right"); *Pediatric,* 293 F.3d at 480; ("a Medicaid-eligible individual has a right to early intervention day treatment when a physician recommends it"); *Pediatric,* 364 F.3d at 930 ("over ten years ago our court held that § 1396a(a) 30 created enforceable rights for Medicaid recipients and providers").

116 *Westside Mothers v. Haveman,* 289 F.3d 852, 863 (6th Cir.2002).

***16** The damages claims in the present action are based upon the equal access provision and, also upon § 1396d(a)13. The equal access provision has been a "clearly established" statutory right for ten years-which was so recognized in the *Reynolds* opinion handed down in a case involving the ADHS. Thus, a reasonable official in the position of Defendants should have anticipated that broad reductions in the scope and duration of medicaid services would result in legal actions.[117] The statutory right to day treatment and other EPSDT services was recognized by the Sixth Circuit and the Eighth Circuit in 2002. The mandatory language of § 1396d(a)13, the medicaid regulations, and opinions from the Supreme Court and from the Eighth Circuit filed before 2002-should have given rise to a reasonable expectation that at the time Defendants allegedly implemented broad reductions in the duration of recommended treatment, they were taking actions that would raise questions of a violation of the Medicaid Act, its regulations, and the rights that it created for physically and mentally impaired children.[118] In sum, the violations alleged by Plaintiffs were, at the time they occurred, clearly established statutory rights enforceable by § 1983. Defendants should have known that any actions adversely affecting equal access to quality care in general-and to EPSDT benefits in particular-would have legal consequences. Even if I were to determine that the right to EPSDT day treatment was not a clearly established right at the time of the alleged violation-any violation of the clearly established equal access provision is sufficient to deny qualified immunity to Defendants on this first ground.

117 *Harlow,* 457 U.S. 818.

118 *See Maine v. Thiboulot, supra; Beal v. Doe, supra; Pinneke v. Preisser, supra; Arkansas Medical Soc'y v. Reynolds, supra;* 42 C.F.R. § 440.230(b).

Officials sued for violations of rights conferred by a statute or regulation become liable for damages only to the extent that there is a clear violation of the statutory rights that give rise to the cause of action for damages. If a statute or regulation does give rise to a cause of action for damages, clear violation of the statute or regulation forfeits immunity only with respect to damages caused by that violation.[119]

119 *Davis,* 468 U.S. at 94.

Plaintiffs alleged and have offered sufficient evidence that a second layer of the prior authorization process was

implemented by the individual capacity defendants resulting in an across-the-board reduction in the scope and duration of day treatment recommended by the CHMS providers. Consequently, all medicaid eligible children were allegedly denied their full array of recommended treatment. Plaintiffs contend that this reduction has violated the equal access provision of the Medicaid Act as well as entitlement to day treatment in accordance with § 1396d(a)13. There is sufficient evidence in the record which raise a reasonable inference that the conduct of Defendants reduced the quality of care available to low income children as compared to other children in the general population. Moreover, there is sufficient evidence that costs for the additional hours of care may be borne by the CHMS providers to such an extent that it jeopardizes the future availability of their services. Finally, according to Ms. Gassaway, elimination of such services is goal of the prior authorization practices engaged in by AFMC with the encouragement and tacit approval of Defendants.

***17** Plaintiffs have requested damages based on the reduction in day treatment from the recommended six (6) hours of treatment per day to no more than three and a half (3.5) hours per day. Therefore, the civil damages requested by Plaintiffs arise from the alleged deprivation of statutory rights. Plaintiffs also allege that Defendants reduced the duration of early intervention treatment in an arbitrary manner. As I have emphasized throughout this order-the stated purpose of early intervention day service is maximum reduction of medical and physical disabilities. As stated above, the Eighth Circuit found that a "Medicaid-eligible individual has a right to early intervention day treatment when a physician recommends such treatment."[120] The court unequivocally stated:

120 *Pediatric,* 293 F.3d 472 at 480.

> If a CHMC physician prescribes early intervention day treatment as a service that would lead to maximum reduction of medical and physical disabilities and restoration of the child to his or her best possible functional level, the *Arkansas plan must reimburse the treatment.*[121]

121 *Id* at 481.

In view of the above, Plaintiffs have alleged a violation of an established right and have requested civil damages related to the violation. There is enough evidence provided by Plaintiffs that the individual capacity Defendants should have been aware that their discretionary actions were in violation of the equal access provision of the Medicaid Act as well as provisions pertaining to rights created by § 1936d(a)(13). No reasonable official would claim to be unaware of the statutory right of medicaid recipients to equal access to quality medical care.[122] Therefore, the individual Defendants have failed to show that they are entitled to qualified immunity. This brings me to the second issue in the analysis of Defendants' entitlement to good faith immunity-the question of their personal involvement in alleged violations.

122 *Groh v. Ramirez,* 540 U.S. 551, 564, 124 S.Ct. 1284, 157 L.Ed.2d 1068 (2004); *Crawford-El v. Britton,* 523 U.S. 574, 587, 118 S.Ct. 1584, 140 L.Ed.2d 759 (1998).

K. Vicarious Liability:

To establish personal liability in a § 1983 action, a plaintiff must show that the official, acting under color of state law, caused the deprivation of a federal right.[123] Causation cannot be based on the concept of imputed liability-there is no supervisory strict liability in § 1983 actions.[124] Supervisory officials are not liable under § 1983 for the unconstitutional acts of their subordinates on the basis of *respondeat superior* or vicarious liability.[125] Instead, for a supervisor to be held liable for the acts of a subordinate, something more must be shown than merely the existence of the supervisor-subordinate relationship must be shown.[126] Supervisory liability under § 1983 occurs either when the supervisor personally participates in the alleged unconstitutional conduct; or when there is a causal connection between the actions of a supervising official and the alleged constitutional deprivation.[127] It must be noted that personal participation is not required for liability to attach.[128]

123 *Kentucky v. Graham,* 473 U.S. 159, 160, 105 S.Ct. 3099, 87 L.Ed.2d 114 (1985).

124 *Harris v. Greer,* 750 F.2d 617, 618 (7th Cir.1984).

125 *Hartley v. Parnell,* 193 F.3d 1263, 1269 (11th

Cir.1999).

126 *Hahn v. McLey,* 737 F.2d 771, 773 (8th Cir.1984) (per curiam).

127 *Brown v. Crawford,* 906 F.2d 667, 671 (11th Cir.1990).

128 *Wilson v. Attaway,* 757 F.2d 1227, 1241 (11th Cir.l985); *Henzel v. Gerstein,* 608 F.2d 654, 658 (5th Cir.1979).

A necessary causal connection can be established when a history of widespread abuse puts the responsible supervisor on notice of the need to correct the alleged deprivation and he fails to do so.[129] Once an official is so notified, either actually or constructively, it is reasonable to infer that the *failure* to take such steps-as well as the actual *taking* of them-is a choice.[130] When supervisory liability is imposed, it is imposed against the supervisory official in his individual capacity for his own culpable choice between action or inaction in the training, supervision, or control of his subordinates.[131] In other words, the causal connection may be established where a history of widespread prior abuse puts the official on notice for the need to improve training or supervision.[132]

129 *Braddy v. Fla. Dept. of Labor & Employment,* 133 F.3d 797, 802 (11th Cir.1998).

130 *Pembaur v. City of Cincinnati,* 475 U.S. 469, 483-84, 106 S.Ct. 1292, 89 L.Ed.2d 452 (1986).

131 *Clay v. Conlee,* 815 F.2d 1164, 1169 -70 (8th Cir.1987); *Hahn,* 737 F.2d at 773.

132 *Bowen v. Watkins,* 669 F.2d 979, 988 (5th Cir.1982). *See also Clement v. Gomez,* 298 F.3d 898, 905 (9th Cir.2002).

***18** Alternatively, the causal connection may be established when a supervisor's custom or policy results in deliberate indifference to constitutional or statutory rights; or when the supervisor directed the subordinates to act unlawfully or knew that the subordinates would act unlawfully and failed to stop them from doing so.[133] In sum, a state official, sued in his individual capacity, can be held liable for the behavior of his subordinates if (1) the behavior of such subordinates results in a statutory violation; and (2) the officials action or inaction was affirmatively linked to the violation.[134] An affirmative link may be inferred from supervisory condonation or acquiescence which tacitly encourages conduct depriving citizens of their rights.

133 *Rivas v. Freeman,* 940 F.2d 1491, 1495 (11th Cir.1991); *Hartley,* 193 F.3d at 1263; *see also Post v. City of Ft. Lauderdale,* 7 F.3d 1552, 1560-61 (11th Cir.1993).

134 *See Oklahoma City v. Tuttle,* 471 U.S. 808, 823, 105 S.Ct. 2427, 85 L.Ed.2d 791 (1985).

Plaintiffs have provided sufficient evidence from which a reasonable inference can be drawn that the individual capacity defendants, Mr. Hanley and Mr. Jeffus, implemented a policy that reduced the scope and duration of day treatment for beneficiaries of the Medicaid Act. In fact, guidelines issued by Mr. Hanley on behalf of ADHS clearly demonstrate that the policy in 1998 provided for six (6) hours per day for recommended day treatment for the following codes: 99211, 99212, Z1570, Z1571, Z1572, and Z1575.[135] However, subsequent guidelines issued to CHMS providers, reduced the time period for 99211 services to five (5) minutes; 99212 services to ten (10) minutes; and Z1575 services to one (1) hour.[136]

135 Plaintiffs' original Response to Motion for Summary Judgment, Ex. I.

136 Plaintiffs' original Response to Motion for Summary Judgment, Ex. J.

Drs. Whitaker, Stewart and Kennedy all testified that there was a threshold prior authorization of three and a half (3.5) hours of day treatment. None of these physicians could explain the "medical necessity"

foundation for the reduction in hours.[137] A reasonable conclusion can be drawn from such evidence that Mr. Hanley and Mr. Jeffus were motivated to reduce benefits in order to save money. This inference is buttressed by the testimony of Ms. Gassaway that cost savings was the primary reason for awarding AFMC the peer review contract. It was also the underlying reason that AFMC was thereafter able to maintain the contract relationship.[138] Furthermore, Dr. Whitaker's testimony confirmed that Marilyn Strickland, with ADHS, gave direct orders to AFMC administrators on how to limit nursing services in the day treatment centers. Dr. Whitaker stated that nursing services were primarily used for catheterized children and children in need of respiratory therapies. According to Dr. Whitaker, when it was discovered that such services could not be capped, Ms. Strickland instructed the nurses to send all requests for more than one unit per day for physician review before further approval. Dr. Whitaker identified the code numbers for nursing services as 99211 and 99212-numbers which, under the new medicare guidelines, were limited to five (5) and ten (10) minutes per unit.[139] According to Dr. Whitaker, his approval of more than one (1) unit of nursing services per day for a catheterized child was overridden at the directive of "Medicaid."[140] Finally, Dr. Whitaker's "canned denials" present substantive evidence of an intent to deny the scope and duration of EPSDT services without a thorough evaluation of individual medical needs.[141]

137 Plaintiffs' original Response to Motion for Summary Judgment, Ex. G p. 39, Ex. H, Plaintiffs' original Response, Ex. K p. 26.

138 Plaintiffs' Supplemental Response to Motion, Ex. B pp. 33-35.

139 Plaintiffs' Supplemental Response to Motion, Ex. E pp. 58-59.

140 Plaintiffs' Supplemental Response to Motion, Ex. E. pp 75-77.

141 Plaintiffs' Supplemental Response to Motion Exhibit D.

***19** Mr. Knickrehm, is director of the ADHS and has held that position since January, 1999. Mr. Ray Hanley was director of the Division of Medical Services of ADHS from 1994 through January 6, 2003. Roy Jeffus is the current director of Division of Medical Services of the Department of Human Services beginning on January 6, 2003. Before becoming director of the Division of Medical Services, Mr. Jeffus was its senior assistant director.

Consequently, the evidence demonstrates that Mr. Hanley and Mr. Jeffus have been deeply involved in the administration of the state medical services program for many years. Mr. Hanley states that he was responsible for implementing the prior authorization process to curtail payment of unnecessary medical services.[142] It is the prior authorization process that is the focus of the controversial testimony of Ms. Gassaway and Dr. Whitaker. Mr. Jeffus states that the AFMC was awarded the state contract as a result of a bidding process and a review AFMC's proposals.[143] The contract entered into between the ADHS and the AFMC gave the Director of Medical Services oversight power as well as disciplinary power.[144] The testimony of Ms. Gassaway raises a reasonable inference that the bidding process and proposals included an evaluation of AFMC's willingness to make cost reduction its primary goal. Moreover, according to Ms. Gassaway, the only periodic information gathered by ADHC from AFMC related to cost savings, and not meeting the medical needs of eligible children.

142 Defendants' Motion for Summary Judgement Ex. 4.

143 Defendants' Motion for Summary Judgement Ex. 3.

144 Plaintiff's Response to Summary Judgement Ex. 24 pp. 24-26.

Plaintiffs' presented evidence that Mr. Hanley and Mr. Jeffus-as key administrators of the division of medical services-either actually or constructively knew that the prior authorization process was being manipulated in a fashion that did not comport with the dictates of the Medicaid Act; and that abuses within the AFMC were condoned and overlooked.[145] In other words, the inference can be drawn that these two defendants acted

affirmatively to reduce EPSDT services based on cost savings alone, without regard to medical need. There is evidence that the attorney for the individual capacity defendants was aware of the canned denials created and implemented by AFMC. It is a fair assumption that attorneys would, in turn, make their clients aware of material facts. There is evidence that administrators with Utilization-namely Ms. Wilson and Ms. Strickland-were instrumental in formulating AFMS undisclosed prior authorization guidelines. It is also a reasonable assumption that these two women were acting with the knowledge and support of their direct supervisors-Mr. Hanley and Mr. Jeffus.

[145] *Pembaur,* 475 U.S. 483-84.

In sum, Plaintiffs have presented evidence reasonably indicating that the individual Defendants knew that reducing the scope and duration of EPSDT services would adversely affect equal access to quality medical services for eligible children. There is sufficient evidence that equal access to these services was a clearly established right at the time Defendants implemented the policies in question here. Finally, Plaintiffs have come forward with enough evidence to create an inference that Mr. Hanley and Mr. Jeffus made affirmative choices that resulted in injury to Plaintiffs. However, Plaintiffs have failed to make a sufficient showing that Mr. Knickrehm, was in a position to know or take part in the conduct of Ms. Strickland and Ms. Wilson-or was aware of the alleged misconduct of individuals associated with AFMC. Consequently, Mr. Knickrehm is not liable for the actions of his subordinates in reducing medical care at the day treatment clinics.

CONCLUSION

***20** In view of the above, Defendants' Motion for Summary Judgement and Supplemental Motion for Summary Judgment is DENIED. I find, as a matter of law, Plaintiffs have standing to bring this action. Genuine disputes of material fact exist with respect to the motive for Defendants' implementation of the prior authorization process; with respect to the legitimacy of Defendants' medical necessity determinations; and with respect to the legitimacy of the manner in which the prior authorization process is applied. There are facts in dispute raising inferences pertinent to the violation of Plaintiffs' procedural and substantive due process rights; and that Ray Hanley and Roy Jeffus are not entitled to qualified immunity. There is not sufficient evidence to support liability against Kurt Knickrehm for civil damages.

It is therefore CONSIDERED, ORDERED AND ADJUDGED that Defendants' Motion for Summary Judgement and Supplemental Motion for Summary Judgment are DENIED (Doc. Nos. 162 and 253). The individually named Defendants-Ray Hanley and Roy Jeffus-are not entitled to qualified immunity. Kurt Knickrehm is entitled to immunity from civil damages. Finally, the Motion to Rule on the Issue of Qualified Immunity is DENIED as MOOT.

IT IS SO ORDERED.