IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF 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

VS. **Case No. 4:01-CV-00830-WRW**

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 and official capacity as DIRECTOR OF THE DIVISION OF MEDICAL SERVICES OF THE ARKANSAS DEPARTMENT OF HUMAN SERVICES; and ARKANSAS FOUNDATION FOR MEDICAL CARE, INC.

DEFENDANTS

ORDER

Pending are Plaintiff Tomorrow's Child Learning Center's ("Plaintiff's) Motion for Temporary Restraining Order (Doc. No. 117) and Motion to Show Cause (Doc. No. 119). Defendants have responded to each motion (Doc. No. 126). Several hearings have been held, and the Motion for Temporary Restraining Order will be treated as a Motion for Preliminary Injunction under Rule 65(a) of the Federal Rules of Civil Procedure.

I. INTRODUCTION

Plaintiff requests an injunction under Rule 65 of the Federal Rules of Civil Procedure, to enjoin Defendants: (1) from denying admission into the CHMS program to eligible children who

have only one diagnosed medical, behavioral, or developmental delay, disability, or handicapping condition; (2) from reducing early intervention day treatment services from 6 hours to 3.5 hours per child, per day, regardless of the child's medical or psychological condition; (3) to publish the names of peer review physicians, upon request, to beneficiaries and providers; and (4) to publish regulations that govern the prior authorization of CHMS services, in order to prevent Defendants from creating new rules without notice to recipients or providers and using the new rules to deny CHMS services to eligible children.

In order to obtain a preliminary injunction, Plaintiff is required to clearly demonstrate a "substantial probability of success at trial by the moving party" and possible "irreparable injury to the moving party" if an injunction is not issued,[1] or to show that "there are sufficiently serious questions going to the merits making them a fair ground for litigation and a balance of hardships tipping decidedly toward plaintiff."[2] For the reasons set forth below, I hold that Plaintiff has not met its burden with respect to the first three issues; however, Defendants should be required to publish the criteria upon which prior authorization is based (recognized standardized tests). Therefore, Plaintiff's Motion for Temporary Restraining Order and Preliminary Injunction is GRANTED in PART and DENIED in PART.

II. THE MEDICAID ACT AND CHMS MODEL

The Medicaid program[3] is a jointly funded federal-state program established by Congress in 1965 to enable each State to furnish medical assistance to certain individuals. A state's participation

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[1] *Frejlach v. Butler*, 573 F.2d 1026, 1027 (8th Cir. 1978).

[2] *Campbell "66" Exp., Inc. v. Rundel*, 597 F.2d 125, 127 (8th Cir. 1979).

[3] 42 U.S.C. §§ 1396-1396v.

in the program is voluntary; however, if a State chooses to participate and receive federal matching funds, it must comply with federal Medicaid law.[4] Arkansas participates in the Medicaid program, and the Arkansas Department of Human Services ("ADHS") is the state agency charged with administering the program.

In 1967, Congress amended the Act to require early and periodic screening, diagnostic and treatment ("EPSDT") services to Medicaid-eligible children. The EPSDT reforms enacted by Congress in 1989 obligate participating states "to provide a comprehensive package of preventive services that meet reasonable standards of medical necessity."[5] Under the EPSDT provisions, states are required to provide, in addition to screening, vision, dental, and hearing services, other health care, diagnostic services, treatment, and other measures which are necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by screening services, regardless of whether those services are covered under the state plan.[6] These amendments, therefore, require states to provide Medicaid coverage for any service "identified as medically necessary through the EPSDT program."[7]

The CHMS program is administered by ADHS and is "the health care model that Arkansas currently uses to provide early intervention diagnostic and therapy services to Medicaid-eligible children between the ages of six months and six years."[8] The CHMS program may be divided into

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[4] 42 U.S.C. § 1396a(a).

[5] *Rosie D. ex rel. John D. v. Swift*, 310 F.3d 230, 232 (1st Cir. 2002).

[6] 42 U.S.C. § 1396d(r)(5).

[7] *Rosie D.*, 310 F.3d at 232.

[8] *Pediatric Spec. Care, Inc., et al. v. Ark. Dept. of Human Servs., et al.*, 293 F.3d 472, 475 (8th Cir. 2002).

three categories: (1) diagnostic and evaluation services; (2) early intervention day treatment; and (3) therapies and other treatments.[9]

CHMS clinics are designed for children who "have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who require health and related services of a type or amount beyond that required by children generally."[10] The program is designed to facilitate the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level. This goal is accomplished by providing full medical multi-discipline diagnosis, evaluation, and treatment in one location to more effectively intervene, treat, and prevent long-term disability for eligible children.

Each CHMS clinic is staffed by a multidisciplinary team of medical professions, including nurses, social workers, therapists, and psychologists, who provide diagnostic and evaluation services. Under this program, the primary care physician refers a child to a CHMS clinic for a "diagnostic evaluation consisting of audiology, medical, behavioral, speech, language, and psychological assessments."[11] Once the evaluation is complete, CHMS staff prepare an individualized treatment

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[9] *Id.* at 475.

[10] *Id.* Plaintiff notes that a child who has been diagnosed with AIDS, cystic fibrosis, child maltreatment syndrome (victim of abuse and neglect), Down Syndrome, lead poisoning, congenital heart disease, cerebral degeneration, or macroephaly, is eligible for the program. CHMS Provider Manual § 217.110. A child who has a developmental diagnosis such as autism, blindness or visual impairment, cerebral palsy, cognitive disorders, deafness or hearing impediment, developmental delay, motor skills disorder, learning disabilities, or mental retardation, may also be eligible for CHMS. CHMS Provider Manual § 217.120. However, CHMS is *required* for children who are diagnosed with three or more medical, developmental, behavioral, or environmental conditions/traumas. CHMS Provider Manual § 217.130. *See also Pediatric Spec. Care, Inc.*, 293 F.3d at 475, n.1.

[11] *Pediatric Spec. Care, Inc.*, 293 F.3d at 475.

plan for the child, and a CHMS physician then prescribes services and treatments for the child.[12] Currently, CHMS is the only program under the state Medicaid plan in which children may receive early intervention day treatment services in conjunction with therapy services.[13]

According to the Eighth Circuit, "[t]he early intervention day treatment program is a type of day care program run by early childhood specialists and overseen by medical staff."[14] This program is designed to "ameliorate conditions discovered by the EPSDT evaluations and to strengthen the skills children learn in therapy."[15] To accomplish this goal, teachers and therapists work closely together, and medical personnel are available for emergencies.[16] The program is meant to serve "children who are not able to function or learn in a normal day care setting such as Head Start."[17] Although Arkansas's State Medicaid Plan need not specifically include CHMS early intervention day treatment services, ADHS cannot refuse to pay for the services for categorically needy children if they are medically necessary.[18]

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[12] *Id.* at 476.

[13] *Id.* at 475. The therapies and treatments provided at the CHMS clinics include: nutrition services, behavior therapies, occupational and physical therapies, speech and language pathology services, psychological therapies, and early intervention day treatment. *Id.* at 476. CHMS clinics provide approximately six hours of early intervention day treatment services in conjunction with therapy services. As I noted in an earlier order, early intervention day treatment is a rehabilitative service with medical and remedial components. *See Pediatric Specialty Care, Inc., et al. v. Ark. Dept. of Human Servs.*, No. 4:01-CV-00830-WRW, slip. op. at 14 (E.D. Ark. Dec. 18, 2001).

[14] *Pediatric Spec. Care, Inc.*, 293 F.3d at 476, n.2.

[15] *Id.*

[16] *Id.*

[17] *Id.* The services are charged in units, and are multiplied by the rates published by AFMC. These services are not paid in bulk.

[18] *Id.* at 479.

III. DISCUSSION

A. PRIOR AUTHORIZATION

Plaintiff first contends that the CHMS program is designed to treat children who carry a prescription for, at a minimum, early intervention day treatment services and at least one form of therapy.[19] Since ADHS contracted with AFMC to provide utilization controls of the CHMS program in 2000, Plaintiff alleges that Defendant AFMC has refused to recognize cognitive, adaptive, or personal/social areas of delay, and will only approve children who are severely delayed in terms of their motor or communication skills.[20] By adopting these standards, Plaintiff contends, Defendants only admit children who have been prescribed early intervention day treatment and two or more forms of therapy.[21] This procedure, according to Plaintiff, violates the Medicaid Act because Defendants may not limit CHMS services to only those children with severe delays, and because admission based on the number of diagnoses ignores the requirement that Medicaid provide services which are medically necessary.[22]

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[19] During the hearings held in this matter, Plaintiff acknowledged that a child who has only a prescription for early intervention day treatment services *or* one form of therapy would not be submitted to AFMC for admission into the CHMS program. Plaintiff admits that, although early intervention day treatment services are available *only* in a CHMS setting, the services are meant to be provided *in conjunction with* another form of therapy. At one time, CHMS services were not subject to any form of utilization review; CHMS services were prescribed by treating physicians, provided and billed by CHMS facilities, and paid for by ADHS. ADHS routinely admitted children for whom early intervention day treatment services and only one form of therapy were prescribed.

[20] Gross motor delays are treated with physical therapy, fine motor delays are treated with occupational therapy, and communication delays are treated with speech therapy.

[21] Affidavit of Melissa Thomas at ¶ 2, Exhibit A.

[22] 42 U.S.C. § 1396d(a)(13) and 1396d(r).

Defendants counter that, under the Medicaid Act, they are permitted to use peer review physicians to determine whether prescribed services are medically necessary, in an effort to ensure that Medicaid funds are only used for medically necessary treatments. It is well-settled that "participating states are not required . . . to fund all medical services falling under one of the mandatory coverage categories . . . because [Congress has conferred] 'broad discretion on the States to adopt standards for determining the extent of medical assistance,'"[23] to ensure that "the largest number of necessary medical services to the greatest number of needy people."[24] The Eighth Circuit, in *Smith v. Rasmussen*,[25] recognized that each state is given "broad discretion . . . to adopt standards for determining the extent of medical assistance," as long as the standards are "reasonable" and "consistent with the objectives of the Act."[26] Thus, a State "may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures."[27]

Congress authorized each State to contract with utilization and quality control peer review organization to perform "medical or utilization review functions . . . with respect to specific services or providers."[28] Under section 1320c-1, a "utilization and quality control peer review organization consists of licensed doctors of medicine . . . engaged in the practice of medicine or surgery in the

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[23] *Hern v. Beye*, 57 F.3d 906, 910 (10th Cir. 1995).

[24] *Smith v. Rasmussen*, 249 F.3d 755, 759 (8th Cir. 2001).

[25] 249 F.3d 755 (8th Cir. 2001).

[26] *Id.* at 759.

[27] *Id.*, *see also Weaver v. Reagen*, 886 F.2d 194, 198 (8th Cir. 1989) (en banc) *and Beal v. Doe*, 432 U.S. 438, 444 (1977) (quoting 42 U.S.C. § 1396a(a)(17).

[28] 42 U.S.C. § 1396a(d).

area [who] . . . perform review functions required under section 1320c-3."[29] Section 1320c-3 lists the various functions of peer review organizations and notes that peer review organizations:

> Review some or all of the professional activities . . . of physicians and other health care practitioners and institutional and noninstitutional providers of health care services in the provision of health care services and items for which payment may be made . . . for the purpose of determining whether -- (A) such services and items are or were reasonable and medically necessary and whether such services and items are not allowable under subsection (a)(1) or (a)(9) of section 1395y of this title . . . .[30]

If the peer review organization concludes that a prescribed treatment is not medically necessary, the beneficiary, practitioner, or provider is entitled to a reconsideration by the peer review organization that made the decision.[31] Before a reconsidered determination may be made, the beneficiary or provider must be given an opportunity to submit new evidence.[32]

Under the peer review system implemented by AFMC, requests for CHMS services are forwarded to AFMC.[33] If the child does not meet the AFMC's internal screening guidelines, the request is forwarded to a peer review physician, who determines whether CHMS treatment is medically necessary for the maximum reduction of disability and functional restoration. If so, the treatment is "prior authorized" and the child will be treated at a CHMS clinic.

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[29] 42 U.S.C. § 1320c-1.

[30] 42 U.S.C. § 1320c-3.

[31] 42 U.S.C. § 1320c-4. A dissatisfied beneficiary, provider, physician, or other practitioner seeking a reconsideration must submit a written request to the peer review organization that made the initial determination within 60 days after receipt of the notice of an initial determination. *See* 42 C.F.R. §§ 478.18 and 478.20.

[32] 42 C.F.R. § 478.24. This section appears in the regulations governing the Centers for Medicare and Medicaid Services of the Department of Health and Human Services.

[33] See also CHMS Provider Manual, § 242.000, which sets forth the prior authorization procedure to be followed by CHMS providers.

During the hearing, AFMC representatives testified that AFMC's nurses and peer reviewers focus on the number of prescriptions which are medically necessary when deciding whether to prior authorize CHMS services. Because CHMS services are defined as "multidisciplinary care," Defendants interpret this to mean that the CHMS program is not designed to provide a single treatment, such as physical therapy alone. Thus, CHMS services are typically approved for children with multiple medical, behavioral, or developmental delays, disabilities, or handicapping conditions who require multidisciplinary treatment. Children with only a single diagnosis are also approved for CHMS benefits, if the diagnosis is severe enough that multidisciplinary treatment is necessary. If a primary care physician prescribes early intervention day treatment and only one form of therapy, CHMS services are approved if both prescriptions are deemed to be medically necessary. However, if two treatments are prescribed and a peer reviewer determines that only one is medically necessary, CHMS multidisciplinary care is denied.[34]

Plaintiff argues that, because "the decision of whether or not certain treatment . . . is 'medically necessary' rests with the individual recipient's physician and not with clerical personnel or government officials."[35] Applying this principle, Plaintiff contends that Defendants may not second-guess a physician's recommended treatment. I agree that, ordinarily, "[t]he decision of whether or not certain treatment or a particular type of surgery is 'medically necessary' rests with the individual recipient's physician and not with clerical personnel or government officials."[36]

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[34] A child with only one medically necessary treatment, according to Defendants, may seek treatment from a Medicaid-enrolled provider who provides that one service. If a CHMS provider is properly qualified, and enrolled to furnish the necessary single treatment, a child with only one prescription may receive his or her treatment at a CHMS facility.

[35] *Weaver*, 886 F.2d at 199.

[36] *Pinneke v. Preisser*, 623 F.2d 546, 550 (8th Cir. 1980).

Defendants maintain that the determination of whether services are medically necessary is not solely reserved for the physician who prescribes the services, but may ultimately be decided by peer reviewers.[37] I agree.

Congress has authorized states to contract with peer review organizations for the final determination of whether services are medically necessary, despite the fact that each health care practitioner, physician, hospital or other health care facility, organization, or agency is required "to assure, to the extent of his authority that services or items ordered or provided by such practitioner or person to beneficiaries and recipients under this chapter . . . will be provided economically and only when, and to the extent, medically necessary."[38]

Because Congress has authorized Arkansas to contract with a peer review organization to determine whether services are medically necessary, I cannot hold that AFMC is required to approve services for every prescription submitted for prior authorization, so Plaintiff's Motion for Temporary Restraining Order on this specific point is DENIED.[39]

B. Severity of Delay

Plaintiff next contends that AFMC refuses to recognize a need for any form of therapy unless a child is severely delayed. Before January 1, 2003, according to Plaintiff, Defendants recognized a need for therapy if the need was equal to or less than a -1.3 standard deviation.[40] Moreover, CHMS

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[37] 42 C.F.R. § 476.1 defines "peer review" as "review by health care practitioners of services ordered or furnished by other practitioners in the same professional field."

[38] 42 U.S.C. § 1320c-5.

[39] Only after this procedure has been followed may a court review the denial of CHMS services to determine whether AFMC's decision violates the Medicaid Act.

[40] As I understand it, the standard deviation refers to the severity of a child's delay. For example, if tests reveal that a child's deviation from a standard norm is -1.3, the child is classified

clinics are required to test each child before the prior authorization expires. If the child has improved above a -1.5 standard deviation level, Defendants remove the child from the CHMS program. If the child regresses below the -1.5 standard deviation, the child re-qualifies for CHMS services and is readmitted. According to Plaintiff, under this system, a child receives sporadic treatment and is never able to obtain the maximum reduction of physical and mental disability and restoration to the best possible functional level. Therefore, Plaintiff seeks to enjoin Defendants from limiting services based on this standard.[41]

Defendants admit that AFMC reviews therapy requests to determine if the applicant's impairment is -1.5 deviations below normal. Defendants also assert that this impairment level is generally accepted as the threshold at which therapies become medically necessary, and denies that the threshold was ever -1.3, as Plaintiff alleges but did not prove. For the same reasons set forth in the previous section, I am unable to conclude that the standards established by AFMC as part of its peer review/prior authorization procedures are arbitrary or capricious.

The Medicaid Act requires that treatments administered under the Act comply with professionally recognized standards.[42] Although Plaintiff has presented evidence that AFMC once approved services for children with only a -1.3 standard deviation, Plaintiff has presented no evidence that the -1.5 standard deviation is not the professionally recognized standard at which therapies become medically necessary. Moreover, the Eighth Circuit has recognized that a State may

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as moderately delayed. A child who scores a -1.5 standard deviation is classified as severely delayed.

[41] 42 U.S.C. 1396d(a)(13).

[42] 42 U.S.C. § 1320c-5.

deny benefits upon based on the degree of medical necessity.[43] Thus, I cannot compel Defendants to alter the standards established in the CHMS manual for admission into the program. For the same reasons, I cannot require AFMC to continue to pay for CHMS services once a child improved above the -1.5 standard deviation, although there is evidence that if a child is removed, he or she may regress.

Based on the evidence presented during the various hearings held in this matter, I find that Plaintiff has failed to show that a likelihood of success on the merits on this particular issue. The motion to enjoin Defendants to alter the standards concerning the level at which admission into the CHMS program must be permitted is, therefore, DENIED.

C. Reduction of Early Intervention Day Treatment Services

Plaintiff also seeks an injunction to prohibit AFMC from reducing early intervention day treatment services from six hours to 3 or 3.5 hours per day, per child. Plaintiff notes that, before, March 1, 2000, ADHS required providers to provide a minimum of six hours of early intervention day treatment service, depending on the severity of a child's developmental delays. Now AFMC will only approve between 3 to 3.5 hours of early intervention day treatment services per child per day, a level that will not result, Plaintiff contends, in the maximum reduction of physical and mental impairment, and which will not restore the individual to the best possible functional level.[44]

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[43] *Pinneke*, 623 F.2d at 550.

[44] Affidavit of Dr. Sharon Ramey at ¶ 15, Exhibit B. According to Dr. Ramey, the collective body of research indicates that early intervention day treatment services result in the maximum reduction of physical and mental disability and restoration of an individual to the best-possible functional level when at least six hours of these services are provided per child per day. In contrast, Dr. Ramey points out, there is no evidence that such lesser amounts produce any measurable benefits at all, much less the maximum reduction of disability or the best possible functional level.

Defendants respond that there is no evidence of an "across-the-board" decision to reduce the number of hours available as part of early intervention day treatment services, and admit that such a decision would violate the Medicaid Act. Instead, Defendants contend that the six hour requirement should be altered because: (1) the fixed number is not based on medical necessity, and inevitably results in unnecessary services, which violates the Medicaid Act; (2) it wastes resources by failing to match needs and services; and (3) it overpays providers for children who need less than six hours of treatment.

Defendants argue that each child is different, and the determination of the length of early intervention day treatment services necessary to ensure the maximum reduction of physical and mental impairment and functional restoration should be performed on a case-by-case basis. In other words, the Medicaid Act prohibits the disbursement of funds for services which are not medically necessary. Because not all children have the same needs, the length of early intervention day treatment services should vary depending on the child's needs.

I recognize that Plaintiff has presented evidence that indicated that six hours of early intervention day treatment results in the maximum reduction of physical and mental disability but based on the principles outlined above, I cannot say that the approval of the number of hours a child receives in early intervention day treatment, if based on an individualized determination of medical necessity, violates the Medicaid Act. As noted, however, a rule limiting the amount of services for *all* children, regardless of the severity of their delays and without consideration of a child's diagnosed condition, his prescribed treatment, and the accumulated knowledge of the medical community,[45] may well run afoul of the Medicaid Act's requirements that services be based on

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[45] *Pinneke*, 623 F.2d at 549.

medical necessity. To the extent that Plaintiff seeks an order enjoining Defendants from limiting services based on a case-by-case assessment of each prescription for CHMS services, the Motion is DENIED.

D. PUBLICATION OF REGULATIONS

Finally, Plaintiff contends that AFMC should be enjoined to publish regulations that govern the prior authorization of CHMS services. At this time, Plaintiff asserts that AFMC does not do so, which enables it to create new rules, without notice to CHMS recipients and providers, in order to deny CHMS services to eligible children. As one example, Ms. Bell testified that Defendants often deny prescribed services on the ground that a test used to evaluate a child's needs is not recognized by Defendants. AFMC's Amy Carson stated during one of the hearings in this matter that a list of accepted tests is being put together by different therapy associations, but that the list is incomplete and has not been received by AFMC.

The Eighth Circuit has already warned that providers are required to "inform Medicaid recipients about the EPSDT services that are available to them and . . . must arrange for the corrective treatments prescribed by physicians."[46] Defendants are not permitted to "shirk [their] responsibilities to Medicaid recipients by burying information about available services in a complex bureaucratic scheme."[47]

During the hearing, Ms. Bell testified that the example cited above was only one of many, and that obtaining prior authorization from AFMC has become a trial by which the blind are essentially leading the blind. Although Defendants insist that their guidelines are available to

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[46] *Pediatric Spec. Care, Inc.*, 289 F.3d at 481.

[47] *Id.*

providers upon request, they have clearly been denying services based on unpublished criteria. This is contrary to the Eighth Circuit admonition mentioned above. Nor may Defendants bury requirements or standards for various services so that providers are unable to comply with those requirements by providing the proper information and records. Accordingly, until AFMC's requirements and standards for CHMS services is published, including the tests required to obtain services, Defendants are enjoined from arbitrarily denying services based on unpublished criteria, and from changing its criteria without notice to providers and recipients of Medicaid benefits. Providers are also required to certify that the care or services "will be of a quality which meets professionally recognized standards of health care . . . and will be supported by evidence of medical necessity and quality in such form and fashion and at such time as may reasonably be required by a reviewing peer review organization in the exercise of its duties and responsibilities."[48]

E. Disclosure of Names

Plaintiff seeks an Order enjoining Defendants to reveal the names of peer reviewers responsible for determining when and whether services are medically necessary. Congress has addressed this point and has stated that peer review organizations are not "federal agencies" for purposes of the Freedom of Information Act, and:

> [Any] "data or information acquired by any such organization in the exercise of its duties and functions shall be held in confidence and shall not be disclosed to any person except:
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> (1) to the extent that may be necessary to carry out the purposes of this part,
> (2) in such cases and under such circumstances as the Secretary shall by regulations provide to assure adequate protection of the rights and interests of patients, health care practitioners, or providers of health care, or

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[48] 42 U.S.C. § 1320c-5.

(3) in accordance with subsection (b) of this section.[49]

Subsection (b) lists specific instances where the peer review organization "shall" provide date an information, none of which includes the scenario set forth by Plaintiff, when Plaintiff wants the name to challenge the peer review physician. Moreover, under subsection (c), the statute provides that it is illegal to disclose the information for any other reason, and may result in a fine of not more than $1,000 and imprisonment of 6 months, together with the costs of prosecution. Section (d) goes so far as to specifically provide that "no patient record in the possession of an organization . . . shall be subject to subpoena or discovery proceedings in a civil action."[50]

There is a federal regulation that explains this more effectively, providing that, "at the request of a provider, practitioner or beneficiary, the [peer review organization] must provide an opportunity for examination of the material upon which the initial denial determination was based."[51] However, under the regulations, the peer review organization is absolutely prohibited from furnishing any of the following:

> (1) A record of the PRO deliberation; or
> (2) The identity of the PRO review coordinators, physician advisors, or consultants who assisted in the initial denial determination without their consent.[52]

I do not cotton to the notion that "secret doctors" are able to perform peer reviews; it seems to me that this procedure places Medicaid beneficiaries and providers at an unfair advantage when they attempt to challenge the denial of benefits based on a peer reviewers assessment. Although I do not

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[49] 42 U.S.C. § 1320c-9.

[50] 42 U.S.C. § 1320c-9.

[51] 42 C.F.R. § 478.24.

[52] *Id.*

like it at all, it appears to be the law, and I therefore DENY Plaintiff's Motion to compel the publication of peer reviewer's names.

IV. CONCLUSION

In previous orders, I have held that the Arkansas Department of Human Services may not refuse to provide CHMS services in all cases under the Medicaid Act.[53] Now, Plaintiff asks that AFMC be required to approve all prescriptions for CHMS services; to compel Defendants to lower the standards they have set for admission into the program; and to disclose the names of peer reviewers who make the decision to deny services. After reviewing the applicable law, Plaintiff's Motion is DENIED with respect to these points. However, it is clear that Defendants deny services based on standards which are not always published (the DAYC test example). In this regard, I hold that Plaintiff *has* shown a likelihood of success on the merits and irreparable harm; therefore, Plaintiff's Motion is GRANTED, and Defendants are enjoined from denying services based on an unpublished list of accepted testing criteria. Further, Defendants must forthwith compile a list of recognized tests which establish a need for the various therapies and services provided by CHMS providers.

For the reasons set forth above, Plaintiff's Motion for Temporary Restraining Order (Doc. No. 117) is GRANTED in part and DENIED in PART; however, Plaintiff's Motion to Show Cause (Doc. No. 119) should also be, and hereby is, DENIED. Notwithstanding this holding, I leave

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[53] This holding reflects the well-established principle that, although a State has considerable discretion in fashioning its Medicaid program, the discretion of the state is not unbridled. A state may not "arbitrarily deny or reduce the amount, duration, or scope of a required service . . . to an otherwise eligible recipient solely because of the diagnosis, type of illness or condition." *Weaver*, 886 F.2d at 197-98.

Defendants with a quote from Salazar v. *District of Columbia*,[54] in which the Honorable Gladys Kessler observed that:

> [A Medicaid] case is about people--children and adults who are sick, poor, and vulnerable--for whom life, in the memorable words of poet Langston Hughes, "ain't been no crystal stair." It is written in the dry and bloodless language of "the law"--statistics, acronyms of agencies, and bureaucratic entities, Supreme Court case names and quotes, official governmental reports, periodicity tables, etc. But let there be no forgetting the real people to whom this dry and bloodless language gives voice: anxious, working parents who are too poor to obtain medications or heart catheter procedures or lead poisoning screens for their children, AIDS patients unable to get treatment, elderly persons suffering from chronic conditions like diabetes and heart disease who require constant monitoring and medical attention. Behind every "fact" found herein is a human face and the reality of being poor in the richest nation on earth.[55]

IT IS SO ORDERED this 18th day of May, 2004.

UNITED STATES DISTRICT JUDGE
WM. R. WILSON, JR.

THIS DOCUMENT ENTERED ON DOCKET SHEET IN COMPLIANCE WITH RULE 58 AND/OR 79(a) FRCP ON 5/28/04 BY

[54] 954 F. Supp. 278 (D.C. 1996).

[55] *Salazar*, 954 F. Supp. at 281.

dc

UNITED STATES DISTRICT COURT
Eastern District of Arkansas
U.S. Court House
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May 28, 2004

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