NHeLP
NATIONAL HEALTH LAW PROGRAM

211 N. Columbia St, 2nd Fl
Chapel Hill, NC 27514
(919) 968-6308
Fax (919) 968-8855

National Health Law Program

Docket of Medicaid Cases to Improve Dental Access

Prepared by
Jane Perkins, J.D., M.P.H.
August 2007

This memorandum provides an annotated listing of Medicaid dental provider participation cases. It does not address the hundreds of cases involving the amount, duration and scope of dental services.

Snapshot of findings:

We located a total of 27 cases, from 21 jurisdictions: Arkansas, California, Connecticut, District of Columbia, Florida, Illinois, Indiana, Kentucky, Maine, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, Tennessee, Texas, and West Virginia.

The complaints in these cases cite a number of Medicaid Act provisions but focus on the following:

- 42 U.S.C. § 1396a(a)(8) (the "reasonable promptness" requirement that Medicaid to be provided with reasonable promptness)

- 42 U.S.C. § 1396a(a)(30)(A) (the "equal access" requirement that payments to be consistent with efficiency, economy, quality of care and assure equal access)

- 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r) (the "EPSDT" requirement for comprehensive Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for children and youth under age 21) and implementing regulations, e.g. 42 C.F.R. § 441.61(b) (requiring states to "make available a variety of individual and group providers")

Historically, most cases have settled without a trial. The settlements typically have addressed payment rates and include provisions to address other barriers, such as claims processing, transportation, and lack of awareness among beneficiaries of the availability of dental services through Medicaid. Recently, however, states have been challenging the plaintiffs' right to enforce the Medicaid Act and/or refused to negotiate, thus requiring the issues to be decided by a trial.

Trends in enforcement

1. Medicaid recipients' and providers' rights to bring Medicaid cases are being strenuously challenged in court. To date, the majority of decisions have maintained Medicaid beneficiaries' access to the courts. Most courts continue to allow private enforcement of four of the most critical Medicaid protections:

- 42 U.S.C. § 1396a(a)(10) (requiring states to provide medical assistance to all individuals who meet the listed qualifications)—all five circuit court rulings since 2002 enforcement;[1]

- 42 U.S.C. § 1396a(a)(8) (requiring states to provide medical assistance with reasonable promptness)—all three circuit courts rulings since 2002 have allowed enforcement,

- 42 U.S.C. § 1983a(a)(3) (requiring states to assure individuals receive the opportunity for a fair hearing when their claim is denial or not acted on with reasonable promptness)—the only circuit court ruling since 2002 allows enforcement; and

- 42 U.S.C. §§ 1396a(a)(43), 1396d(a)(4)(B), and 1396d(r) (providing that Medicaid-eligible children will receive Early and Periodic Screening, Diagnostic and Treatment (EPSDT) and information about EPSDT)—all four circuit court rulings since 2002 have allowed enforcement.

By contrast, private enforcement of other Medicaid provisions and by Medicaid providers is being sharply curtailed. The most affected provision is 42 U.S.C. § 1396a(a)(30)(A), which requires states to establish payments that are sufficient to ensure that Medicaid beneficiaries have access to covered services at least to the extent of the general population. Known as the "equal access provision," this requirement was enforced in federal court by Medicaid beneficiaries and/or providers during the 1990s. Since 2002, however, four circuit courts have refused to allow private enforcement of the provision. Only the Eighth Circuit has ruled otherwise, and that case was vacated by the Supreme Court this past Term.

2. *Courts are reviewing enforcement questions on a provision-by-provision basis.* Early on, three opinions seemed to adopt a sweeping application of *Gonzaga* to find that the Medicaid Act could not be enforced at all. The first of these decisions, *Sabree v. Houston*, formed the basis for the other two. Notably, *Sabree* was reversed by the Third Circuit Court of Appeals in 2004. And, at this point, the courts are fairly uniformly applying a provision-by-provision analysis. Although the provision-by-provision assessment does exact more painstaking briefing and analysis from the parties and the court, it is the consistent with the Supreme Court's teachings.

3. *Courts are holding that federal regulations cannot be privately enforced by recipients or providers.* On the other hand, courts continue to cite regulations as evidence of Congressional intent and have enforced regulations that flesh out the terms of a statute that creates federal rights. For example, in *S.D. v. Hood*, a case involving the Medicaid Early and

[1] In 2002, the Supreme Court tightened the enforcement test. *See* Gonzaga Univ. v. Doe, 536 U.S. at 284 (2002).

Periodic Screening, Diagnostic and Treatment provisions, the Fifth Circuit Court of Appeals found that "the rights-creating language relied upon by the plaintiff is contained in the statute itself. Furthermore, the regulations implementing the statute . . . are authoritative interpretations of the statute and are enforceable by § 1983."[2]

4. *Individual beneficiaries are successfully enforcing the EPSDT statutes.* In a number of cases, individuals challenge the state Medicaid agency's refusal to cover a needed service. These cases involve clear facts establishing the need for the service and that the service has been denied by the state or by a managed care organization contracting with the Medicaid program. While the service needed by the child may not be mentioned by name as a covered service in the Medicaid Act, these cases establish that the service can nevertheless be covered if it can be fit into a Medicaid box—that is, the service can properly be described as one of the Medicaid services listed in the Act, 42 U.S.C. § 1396d(a). For example, incontinence supplies may be covered as a home health, rehabilitative, or preventive service.[3]

5. *Individuals with behavioral health needs are looking to EPSDT for help.* Children with mental and behavioral health needs can benefit from the comprehensive package of benefits that EPSDT offers. Case management, care consistency, and a range of home and community based services are essential ingredients to maximize outcomes for these children. The recent cases have reiterated that EPSDT will cover many of the behavioral health services that children need, provided that those services can be fit within a Medicaid box.

6. *Courts are requiring extensive evidentiary proof in cases alleging a systemic breakdown of the EPSDT program*. Advocates have obtained favorable decisions in cases challenging systemic problems with EPSDT programs, particularly where those cases were filed prior to 2002. In contrast to much of the EPSDT advocacy of the 1980s, however, a number of these cases have involved years of hard work, including extensive discovery, evidence gathering, and expert testimony.

7. *A disturbing string of recent cases raises another question: What is Medicaid?* For example, in *Oklahoma Academy of Pediatrics* the Tenth Circuit finds that Medicaid is defined as "medical assistance," which is "payment for all or part of" the care and services listed in the Medicaid Act. *See* 42 U.S.C. § 1396d(a). According to the Court, the only obligation on the state Medicaid program is to provide for prompt payment of claims for care and services when (and if) they are submitted, and there is no obligation to see that the care and services are actually provided promptly. The effect of this reasoning on EPSDT is not clear. The EPDST provisions call for the state to provide for screening and treatment services. *See* 42

[2] S.D. v. Hood, 391 F.3d 581, 607 (5th Cir. 2004). .

[3] For discussion about how to fit a prescribed service within a Medicaid box, *see, e.g.,* Jane Perkins, National Health Law Program, *Medicaid Early and Periodic Screening, Diagnosis and Treatment As A Source of Funding Early Intervention Services* (June 2002); Jane Perkins and Sarah Somers, National Health Law Program, *Toward a Healthy Future: Medicaid Early and Periodic Screening, Diagnosis and Treatment Services for Poor Children and Youth* (April 2003); Jane Perkins, National Health Law Program, *Q&A: EPSDT "Wraparound Services"* (Sept. 2006). All of these resources are available through http://www.healthlaw.org.

U.S.C. § 1396a(a)(43). Notably, the Tenth Circuit expressly did not rule on the EPSDT provisions when it issued its otherwise negative decision.

Annotated case listing:[4]

Arkansas

Arkansas Medical Society v. Reynolds, 819 F. Supp. 816 (E.D. Ark. 1993), *aff'd*, 6 F.3d 519 (8th Cir. 1993)

> Background: This case challenged an across-the-board plan to reduce outpatient reimbursement rates, including those paid to dentists. The Court found the reduction to violate the Medicaid equal access requirement, 42 U.S.C. § 1396a(a)(30)(A).
>
> Outcome: The Medicaid agency was ordered to revise its reimbursement plan within 120 days by removing the reduction. While the rate issue was resolved, this case has become a leading case for the ability of Medicaid providers and beneficiaries to enforce the equal access provision of the Medicaid Act in court.

California

**Clark v. Kizer*, 758 F. Supp. 572 (E.D. Cal. 1990), *aff''d in part & vacated in part sub nom. Clark v. Coye*, 967 F.2d 585 (9th Cir. 1992), *on remand,* No. S-87-1700LKK, 1992 WL 370801 (E.D. Cal. 1993), *aff''d in part & remanded in part,* 8 F.3d 26 (9th Cir. 1993), *related references,* 66 F.3d 334 (9th Cir. 1995), *vacating*, 1994 WL 764117 (E.D. Cal., Dec. 13, 1994) (regarding legislation affecting adult eligibility), 60 F.3d 600 (9th Cir. 1995), *rev'g*, 1993 WL 720217 (E.D. Cal., Dec. 17, 1993), *related references,* 1989 WL 265478 (E.D. Cal., Nov. 3, 1989) (settlement regarding availability of obstetrical care providers), 1988 WL 235548 (E.D. Cal., May 9, 1988) (dismissing third party complaint against Secretary of US Department of Health and Human Services)

> Background: This case was brought on behalf of women needing obstetrical care and beneficiaries needing dental services. The obstetrical part of the case settled early on, following a rate increase. The Court held the state Medicaid agency violated 42 U.S.C. § 1396a(a)(30)(A), when it maintained a dental reimbursement fee schedule that did not ensure that Medicaid beneficiaries have access to dental services at least to the extent that the general population has access to these services. The *Clark* court was persuaded by the fact that "the present rates are not even adequate to meet overhead, let alone allowing for some marginal profit." 758 F. Supp. at 577. Other Medicaid violations included § 1396a(a)(1) (statewideness) and § 1396a(a)(10) (comparability).
>
> Outcome: The Medicaid agency was ordered to increase rates to 80% of UCR (Usual Customary and Reasonable) rates for 56 commonly performed procedure codes and to provide annual cost of living adjustments.

[4] The National Health Law Program represents the plaintiffs in cases marked with an asterisk.

At the time *Clark* was filed, about 30% of Medicaid beneficiaries visited a dentist at least once a year. Following entry of the compliance plan in 1994, the Medicaid utilization rate reached 46% by 1998 (Source: DHS Compliance Reporting).

In the late 1990s, the court ordered the state to submit a plan for increasing utilization in 16 under-served counties. Under the approved plan, the state would increase utilization to at least 41.7%.

Note: This is the first dental provider participation case to challenge rates as inadequate (as opposed to challenging a reduction in rates). In finding a violation of the equal access provision, the district court applied a multi-factor approach that has been cited approvingly by subsequent courts. The two major factors considered by the *Clark* court were the level of dental participation in the Medicaid program and the level of reimbursement to participating providers. In addition, the court considered: whether providers are widely opting out of Medicaid or restricting their Medicaid caseloads; whether there is a steady stream of reports that recipients are having difficulty obtaining care; and admissions by state agency personnel that reimbursement rates are inadequate. The *Clark* court also looked to the utilization rate as a factor that may be considered, but noted that this factor was not dispositive.

Connecticut

Carr v. Wilson-Coker, Civ. No. 3:00CV01050 (D. Conn. Jan. 27, 2006)

Background: Medicaid beneficiaries (adults and children) filed this class action lawsuit in 2000, alleging that the Connecticut Department of Social Services had not administered or funded its managed care program to attract an adequate number of dentists as required by federal law. Among other things, the plaintiffs alleged that dental screening had shown decreasing utilization.

Outcome: The Court dismissed a number of the plaintiffs' claims, including an equal access claim. In 2006, the Court focused on the EPSDT claim. It noted federal Medicaid goals for 80% utilization and found the State to have fallen short of the goal. The Court also found it "compelling" that children had to wait for substantial periods of time and travel outside of their local areas to find a dentist. However, the Court found these cases did not show that EPSDT dental services are not provided but rather that they are not provided within a reasonable time at a convenient location. The Court found there were material issues in dispute and ordered the case to proceed toward trial.

Semerzakis v. Wilson-Coker, 873 A.2d 911 (Conn. 2005), *rev'g,* No. CV030520876S, 36 Conn. L. Rptr. 237, 2003 WL 23177501 (Conn. Super. Dec 24, 2003).

Background*:* The plaintiff sought payment for orthodontic treatment for her daughter, an EPSDT recipient with an overbite. The State Department of Social Services uses a tool known as the Salzmann Assessment as one component of its process for determining whether the orthodontia sought in any given case is medically needed and thus subject to EPSDT coverage. If a recipient reaches the statutory minimum on

the tool, her orthodontia is considered per se medically necessary. If, however, she falls short of the bar, the Department will consider "additional information of a substantial nature" in its deliberations. The EPSDT recipient in *Semerzakis* did not meet the bar; nor did she, according to the State, present sufficient additional information proving medical necessity.

The plaintiff persuaded the trial court that the State's decision was incorrect because the State should have adhered to the EPSDT requirement that states provide "[s]uch other necessary health care, diagnostic services, treatment, and other measures…to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan." 42 U.S.C. § 1396d(r)(5). The plaintiff argued that the State's eligibility requirements were stricter than those authorized by Congress.

Outcome*:* The State Supreme Court reversed. It held that, because EPSDT coverage of dental services is explicitly addressed in section 1396d(r)(3), the catch-all provision, 1396d (r)(5), setting forth the "correct or ameliorate" standard, did not apply. In addition, the Court found that Connecticut's procedure for determining medical necessity (using the Salzmann Assessment and the "substantial nature" savings clauses) was "valid as a reasonable utilization control that does not cause recipients to receive less care than was envisioned" by Congress when it addressed dental care with subsection (r)(3). Thus, the Supreme Court reversed the earlier judgment for the plaintiff.

District of Columbia

**Salazar v. District of Columbia*, No. CA-93-452 (GK), (Jan. 25, 1999) (Consent judgment; Order modifying amended remedial order); 1997 WL 306876 (D.D.C., Jan. 17, 1997) (Remedial order), *earlier case history*, 938 F. Supp. 926 (D.D.C.), *amended and superceded by,* 954 F. Supp. 278 (D.D.C. 1996), *same case, Wellington v. District of Columbia,* 851 F. Supp. 1 (D.D.C. 1994) (allowing private enforcement of Medicaid Act)

Background: Plaintiffs are a class of poor children, including those with special health care needs and those with limited English proficiency.

Outcome: In 1996, the Court found that the District of Columbia violated EPSDT laws when it failed to assure that children were receiving screening and treatment services, including dental services, in either fee-for-service or managed care organizations (MCOs). *See* 954 F. Supp. at 328 (ordering the District to "design and employ policies and methods to assure that children receive screening and treatment when due.") In 1997, the parties entered into a consent judgment. The District agreed to engage in extensive outreach and informing of Medicaid families regarding the scope of EPSDT services and to monitor MCOs to assure that contracted services actually are being delivered. The parties also agreed that MCOs would develop and implement corrective action plans for problematic plans and that financial penalties could be imposed for noncompliance. All of the MCOs have developed corrective action plans to improve the delivery of oral health services.

In 2004, the plaintiffs filed a motion for enforcement, using data reported by the District and the MCOs showing that utilization of dental services was quite low. The Court entered further injunctive relief on October 18, 2004, ordering the District to make progress with rate increases, to increase utilization and to assure that services were available system-wide, including to children with limited-English proficiency. The Court ordered the District, by September 30, 2007, to show that:

(a) at least 80% of EPSDT-eligible children three-years old and older receive a dental service in the previous 12 months;
(b) 85% of school-age children receive an oral health screening by a dentist upon entering school for the first time; and
(c) 70% of all 8-14 year-old children receive protective sealants on their permanent teeth.

On May 26, 2006, the District filed a motion asking for the dental injunction to be lifted, and that motion is currently being briefed by the parties. Meanwhile, the Court monitor is meeting with the parties and area dentists to better understand the barriers to access, and MCOs continue to submit corrective action plans.

Florida

Florida Pediatric Society/The Florida Chapter of the American Academy of Pediatrics v. Levine, No. 05-23037-CIV-HUCK (S. D. Fla., filed Nov. 21, 2005).

The district court has denied the State's motion to dismiss, arguing that the provider groups cannot privately enforce the federal Medicaid law, including the equal access, EPSDT, and reasonable promptness requirements.

Illinois

Memisovski v. Maram, No. 92 C 1982, 2004 U.S. Dist. LEXIS 16772 (N.D. Ill., Aug. 23, 2004)

Background: This case was filed by children in Cook County, Illinois who complained about the lack of access to Medicaid services, including dental services.

Outcome: The Court found violations of the equal access and EPSDT requirements. Regarding dental care, the Court found that dentists limit the number of Medicaid patients they will see because their practices would fail financially if they accepted all Medicaid patients who presented themselves for treatment. The Court found that 75% of children did not obtain a dental screen. Following the ruling, the State:

(a) increased rates for dental codes for the basic office services for preventive dentistry (checkup, cleaning, prophylaxis), roughly doubling the old rate and bringing these codes into parity with the state employees health plan; and
(b) initiated a study of access to specialty care (including dental) that should evidence any further problems.

Indiana

Bond v. Stanton, 630 F.2d 1231 (1980), *appeal after remand,* 655 F.2d 766 (7th Cir.) (EPSDT screening, identification of providers, and follow up), *same case,* 372 F. Supp. 872 (N.D. Ind. 1974), *aff"d,* 504 F.2d 1246 (7th Cir.)

Background: The case was fled by Medicaid-eligible children.

Outcome: The Seventh Circuit decided: "Indiana's somewhat casual approach to EPSDT hardly conforms to the aggressive search for early detection of child health problems envisaged by congress.... EPSDT programs must be brought to the recipients; the recipients will not ordinarily go to the programs until it is too late to accomplish the congressional purpose." 504 F.2d at 1251.

The state was required to provide guidance to providers as to what services are covered under EPSDT, including dental screens and to engage in aggressive outreach to inform beneficiaries of these services.

Kentucky

Greer. v. Childress, No. 95-CV-11 (E.D. Ky.) (Voluntary dismissal, March 1995)

This case was filed by the Kentucky Dental Association (KDA) in 1994, after the state Medicaid agency reduced dental reimbursement rates. The suit was dismissed after the state Medicaid agency raised rates, erasing the reduction.

Maine

**Spencer v. Concannon*, Civ. No. 97-197-B-C (D. Me.) (Agreed order of dismissal, Apr. 27, 1998)

Background: The Medicaid beneficiaries' complaint in this case claimed violations of § 1396a(a)(30) (equal access), § 1396a(a)(1) (statewideness), § a(a)(8) (reasonable promptness), § a(a)(10)(B) (comparability in the provision of services), and §§ a(a)(43), d(a)(4)(B), and d(r) (EPSDT).

Outcome: The case settled when the state Medicaid agency agreed to:

(a) increase payment rates;
(b) engage in an educational campaign to increase provider participation;
(c) revise the dental claim form;
(d) provide toll-free telephone assistance to refer beneficiaries to dentists;
(e) monitor provider participation and beneficiary utilization of dental services; and
(f) arrange dental services for the named plaintiffs, including entering into private pay arrangements if necessary.

Massachusetts

Health Care for All v. Romney, Civ. No. 1:00-CV-10833-RWZ, 2005 U.S. Dist. LEXIS 14187 (D. Mass., July 14, 2005)

Background: The class action case, filed by Medicaid beneficiaries in July 2000, alleged that the state Medicaid agency failed to provide adequate oral heath services to members of the MassHealth Medicaid program. A number of Medicaid Act violations were alleged: 42 U.S.C. § 1396a(a)(1) (statewideness), § a(a)(8) (reasonable promptness), § a(a)(10)(B) (comparability), § a(a)(30) (quality and equal access), and § a(a)(43) (EPSDT).

Outcome: The Court held that Massachusetts' low Medicaid payment rates for dentists significantly contributed to a lack of available providers for children, but not for adults. The Court found a violation of the reasonable promptness requirement regarding children's services, stating: "Setting reimbursement levels so low that private dentists cannot afford to treat Medicaid enrollees effectively frustrates the reasonable promptness provision by foreclosing the opportunity for enrollees to receive medical assistance at all, much less in a timely manner."

The Court found that inadequate access also violated the EPSDT requirements. The Court noted that its holding did not rely on the equal access requirement (which it had earlier held could not be privately enforced). Instead, the judge relied on the evidence of inadequate and inaccurate materials about EPSDT dental services, the high volume of customer complaints, and the "shockingly low" number of children enrolled in Medicaid versus children enrolled in private insurance who received dental services.

The Court entered a Joint Remedial Plan agreed to by the parties on February 3, 2006 which includes:

(a) a program of member assistance, which includes assistance in making and keeping appointments and with transportation;
(b) developing and maintaining a provider network, including instituting a practice of contacting any provider announcing intent to withdraw from Medicaid and attempting to discover why and to convince them not to do so;
(c) appropriations in FY 2007 to increase reimbursement rates using the most current and accurate date available, followed by annual assessment of whether further increases are needed;
(d) instituting a practice of sending information about dental services at six month intervals, 60 days after eligibility determinations and re-determinations, and sending targeted information to individuals for whom there has been no Medicaid claim in the past year;
(e) authorizing the State to proceed with implementing a state law that allows dentists to limit the number of MassHealth patients in their practices; and
(f) appointing an independent monitor to assess implementation and effectiveness of the remedial program, including measuring the receipt of: dental sealants, dental screenings, dental prophylaxis, fluoride treatment and restorative care.

Michigan

*_Westside Mothers v. Olszewski_, 454 F.3d 532 (6th Cir. 2006), _aff'g in part and rev'g in part,_ 368 F. Supp. 2d 740 (E.D. Mich. 2005), _same case sub nom. Westside Mothers v. Haveman,_ 289 F.3d 852 (6th Cir. 2002) (denying motion to dismiss), _rev'g in part and aff'g in part,_ 133 F. Supp. 2d 549 (E.D. Mich. 2001)

Background: This case was filed by parents and pediatric providers of children who are experiencing difficulties accessing EPSDT services, including dental care. The case includes claims based on § 1396a(a)(30)(A) (equal access), § a(a)(8) (reasonable promptness), and § 1396u-2(b)(5) (adequate number, mix, and geographic distribution of managed care providers), and EPSDT provisions.

Outcome: The most recent district court ruling, in 2005, held that the reasonable promptness and EPSDT-related provisions could be enforced by the plaintiffs but the equal access requirement could not. The Court also held that the plaintiffs had not proven their claims because it decided that "medical assistance" under the Medicaid Act does not include the provision of medical services but only payments; nor does it include a right to force the State to ensure 100% participation by all potentially eligible individuals. On appeal, the 6th Circuit dismissed the plaintiffs' (30)(A) claim but remanded to allow them to continue with other claims.

Settlement of this case is pending.

New Hampshire

Hawkins v. Commissioner, No. C-99-143-JD, 2004 DNH 23 (D.N.H. 2004)

Background: This class action case was filed by a parent on behalf of her Medicaid-eligible children in 1999. A number of Medicaid Act violations were alleged, including: 42 U.S.C. § 1396a(a)(43) (inform beneficiaries of EPSDT benefits), 42 C.F.R. § 441.62 (provide transportation and appointment scheduling assistance)), § 1396a(a)(43)(B) and 1396d(r) (provide or arrange for dental screening services and needed treatment, including case management and transportation services), § 1396a(a)(30)(A) (equal access), § 1396a(a)(1) (statewideness), and § 1396a(a)(8) (reasonable promptness).

Outcome: The case settled in early 2004. The consent decree contemplates a five-to-six year period of court jurisdiction overseeing implementation. Among other things, the State agreed to:

(a) allocate $1.2 million each year in additional state funds for the EPSDT dental program;
(b) maintain dedicated toll-free numbers for individuals to obtain information;
(c) arrange for periodic dental screening, beginning at age three (or earlier upon physician referral);
(d) establish a procedure for providing scheduling assistance, to include referrals to specific dentists;

(e) periodic written and oral informing of recipients of EPSDT and the need for dental care, to include targeted outreach to non-users;
(f) provide transportation to dental appointments; and
(g) provide data and reports on program measures, including the number of children, by age group, using sealants, preventive services, dental visits, topical fluoride, and a dental home (defined as at least three examinations under continuous enrollment).

Swain v. Gregg, Civ. No. 90-91-D (D.N.H.) (Consent decree, May 5, 1991)

Background: The plaintiffs claimed dental payment rates were too low.

Outcome: The parties settled this case when the state agreed to:

(a) increase dental reimbursement rates;
(b) review the adequacy of rates annually;
(c) make needed adjustments to rates;
(d) update its periodicity schedule for dental screening under EPSDT,
(e) use "pay and chase," rather than "cost avoidance," third party liability collection practices when dealing with EPSDT claims; and
(f) engage in regular contact and meetings with the New Hampshire Dental Society to resolve problems early and encourage provider participation in Medicaid.

New Jersey

Pelletier v. Waldman, Civ. No. 2:93-cv-02488-HAA (D.N.J.) (Voluntary dismissal, April 21, 1995)

The complaint in this case, filed on June 9, 1993, alleged that the State was violating mandatory EPSDT provisions by failing to provide preventive dental services to children. Claims for relief included: 42 U.S.C. § 1396a(a)(1) (statewideness), § a(a)(8) (reasonable promptness), § a(a)(10)(B) (comparability), § 1396a(a)(23) (free choice of providers), § a(a)(30) (quality and equal access), § a(a)(37) (prompt and efficient claims payment), and §§ a(a)(43), d(a)(4)(B), d(r) (EPSDT). This case was dismissed following settlement; however, the terms of the agreement are not published or posted on electronic case filing systems.

New York

Dental Society of New York v. Pataki, Civ. No. 99-C-0156 (N.D.N.Y.) (Stipulation, May 24, 2000)

Claims: This class action case was filed by the New York State Dental Association, individual dentists, and Medicaid beneficiaries in February 1999. It charged the state Medicaid agency with failure to adhere to 42 U.S.C. § 1396a(a)(1) (statewideness), § a(a)(8) (reasonable promptness), § a(a)(10)(B) (comparability), § a(a)(23) (free choice of providers), § a(a)(30) (quality care and equal access), and § a(a)(37) (prompt and

efficient claims payment). Among other things, the complaint pointed out that dental rates had not increased appreciably from the inception of the Medicaid program in 1966.

Outcome: The parties entered a stipulated settlement on May 24, 2000. This agreement required dental expenditures to be increased each year for the next four years for selected service fees. In addition, a Medicaid Dental Advisory Committee would be established to make recommendations to the Medicaid agency for improving access (to sunset March 31, 2004).

Dental Society of New York v. Carey, 61 N.Y.2d 330, 462 N.E.2d 362, 474 N.Y.S.2d 262 (Ct. App. 1984)

This case challenged New York's dental rates as violating federal comparability and equal access regulations. The published decision deals with procedural challenges and does not address the substance of the case. The court held the Dental Society had standing to bring the case on behalf of its members and that the claims were within the court's competence to decide.

North Carolina

**Antrican v. Buell*, Civ. No. 4:00-CV-173-H (E.D.N.C.) (Settlement agreement, March 2003), *same case*, 158 F. Supp. 2d 663 (E.D.N.C. 2001), *aff'd,* 290 F.3d 178 (4th Cir. 2002) (denying motion to dismiss)

Background: This complaint was filed on behalf of Medicaid beneficiaries under age 21, who alleged that dental services were not adequately available and accessible. Some plaintiffs were traveling more than three hours, each way, to obtain dental care. Plaintiffs alleged violations of: 42 U.S.C. §§ 1396a(a)(43) and 1396d(r) (EPSDT benefits and informing), § 1396a(a)(30)(A) (equal access), § 1396a(a)(1) (statewideness), § 1396a(a)(8) (reasonable promptness), § 1396a(a)(23) (free choice of providers), and § 1396a(a)(10) (comparability).

Outcome: The parties settled the case in early 2003. The State agreed to:

(a) increase payment rates to 73% of the UNC-Chapel Hill Dental Faculty Practice's UCR charges for 40 of the dental procedures most commonly provided to children;
(b) establish a Medicaid Dental Advisory Committee, as part of the influential NC Physicians' Advisory Group;
(c) provide written materials to beneficiaries regarding Medicaid dental services and the importance of dental care;
(d) engage in targeted outreach to dentists, through newsletters and presentations at the UNC-Chapel Hill Dental School; and
(e) provide toll-free telephone assistance to individuals seeking a dentist.

Preliminary evaluations suggest that increased rates have coincided with improved participation and utilization levels; for example, active dentist participation increased

33% between 2001 and 2004 (Mofidi 2005). The state legislature increased dental rates again in the 2005 biennium session. Legislation was introduced on May 24, 2006 (S. 1863) to further increase dental payment rates. While the UNC Faculty rates were supported by providers and the State in 2003, both groups have more recently discussed the potential benefits of a market-based fee schedule.

Oklahoma

Okla. Chptr. of the Am. Acad. of Pediatrics v. Fogarty, 472 F.3d 1208 (10th Cir. 2007), *rev'g,* 366 F. Supp. 2d 1050 *(*N.D. Okla. 2006), *petition for cert. filed,* 75 U.S.L.W. 3622 (U.S. May 7, 2007) (No. 06-1482).

Background: The plaintiffs are children who alleged a lack of equal access to child health services. EPSDT dental services were a part of this broad case. The Court held that the State had failed to provide equal access to physician (especially pediatric) services and had also violated the reasonable promptness requirement. With respect to dental services, the Court said the State's program was "not a model" but found only one federal violation: that the State did not establish a dental periodicity schedule after consultation with dentists.

Outcome: Periodicity schedules were amended. At original, lengthy district court decision ordered the State to pay physicians who see Medicaid patients at 100% of the Medicare rate and to conduct a study to determine if that rate is sufficient. The rates were raised in the summer of 2005. In mid-May 2006, the State's report suggested a rate reduction; however, the judge said the report lacked sufficient information and has maintained the rates pending further evidence. Meanwhile, the State appealed the decision to the 10th Circuit, which ultimately reversed the district court and dismissed the case. The circuit court held that "medical assistance" is merely an obligation on the state for prompt payment for all or part of the service rendered and does not include obligations that services actually be available and provided.

Oregon

Gibson v. Concannon, Civ. No. 94-6306-HO/TC (D. Ore.) (Amended complaint, Sept. 20, 1994)

Background: This complaint was filed on behalf of poor Oregonians who alleged they were unable to obtain timely or adequate dental care. While the State had obtained a federal waiver to operate an experimental Medicaid program, the plaintiffs argued that, except for specifically waived Medicaid laws, the program has to operate within the existing framework of Medicaid laws and regulations. Thus, the plaintiffs alleged violations of provisions that were not waived: § 1396a(a)(1) (statewideness), § a(a)(8) (reasonable promptness), § a(a)(30) (equal access), and § a(a)(37) (prompt and efficient claims payment).

Outcome: The case settled when the state agreed to: (a) increase payments and (b) establish a toll-free line to help beneficiaries locate a dentist.

Pennsylvania

Clark v. Richman, 339 F.3d 631 (3d Cir. 2004) (Summary judgment granted in part and denied in part), *on remand*, No. 4:00-cv-1306 (M.D. Penn. Aug. 17, 2005) (judgment)

Background: A group of children and youth with disabilities claimed that the state Medicaid agency denied access to Medicaid-covered dental services, alleging violations: § 1396a(a)(8) (reasonable promptness), § 1396a(a)(30) (equal access), and § 1396a(a)(43) and § 1396d(r) (EPSDT).

Outcome: The Court allowed the plaintiffs to enforce the equal access and EPSDT requirements but it dismissed the claim under § 1396a(a)(8), finding that provision only guaranteed the right to reasonably prompt payment for services, not to the provision of services themselves.

After an eight-day trial on the remaining issues, the Court ruled in favor of the State, finding that the Medicaid beneficiaries had failed to prove violations of EPSDT and equal access. Among other things, the court held that the State had a proper periodicity schedule for screenings that had been formulated in consultation with the Pediatric Dental Association and the Academy of Pediatric Physicians; the State complied with the EPSDT informational requirements, evidenced by managed care organizations' compliance with the informing requirements in their contracts and the fact that the State mailed out informational letters, handbooks and brochures, made and fielded phone calls from recipients; and maintained a website with "a wealth of information." The Court said the testimony regarding a lack of access was too limited and only "tangentially related to EPSDT."

Scott v. Snider, No. 91-CV-7080 (E.D. Pa. Dec. 2, 1994) (Order and stipulation of settlement), *same case,* (E.D. Penn. Aug. 11, 1993) (Stipulated settlement) (requires EPSDT informing of Medicaid-eligible mothers and infants at birth and before the mother's discharge)

Background: This case challenged the lack of outpatient provider participation in the Medicaid program, including dental participation. Plaintiffs alleged numerous violations of the EPSDT requirements.

Outcome: This is one of the first cases dealing in depth with a Medicaid managed care delivery system. A number of provisions address decision making and approval processes within the managed care plans. The broad settlement included a number of performance measures directly affecting dental care. The State agreed to the following measures:

(a) attempt to maintain an 80% enrollment rate of Medicaid-eligible children;
(b) increase to 80% the proportion of children and youth receiving periodic dental services;
(c) by ages 8 and 14, 50% of enrolled children and youth will have receive protective sealants on the chewing surfaces of their molar teeth;

(d) submit a budget request to increase fees for pediatric dental services to 70% of usual and customary charge (with final budget within the Governor's discretion); and
(e) consultation with the Medical Care Advisory Committee on how to spend appropriated funds.

Tennessee

John B. v Menke, No. 3-98-0168, 176 F. Supp. 2d 786 (M.D. Tenn. 2001), unpublished memorandum order (Oct. 22, 2004)

Background: This case involves a broad challenge to the failure of the State to provide Medicaid EPSDT services to children in managed care settings. Allegations regarding inadequate dental services were included in the complaint. A ruling from the Court held the State responsible for compliance with EPSDT, even when it delegates delivery to managed care organizations.

Outcome: The case was settled with an agreement whereby the State would implement an EPSDT plan that calls for, among other things, (a) improving outreach and informing of beneficiaries about EPSDT, (b) updating and implementing statewide periodicity schedules, and (c) realizing enhanced measures of performance (including more accurate reporting on the EPSDT reporting forms). Monitors are assessing the status of EPSDT. On May 30, 2006, they notified the Court that a proposed draft of the report would be submitted to the parties by September 30, 2006.

Brittney W. v. Preferred Health Partnership of Tennessee and Commissioner Tennessee Department of Health, No. 3-98-0759 (M.D. Tenn.) (Settlement agreement, November 1999)

Background: This case was filed on behalf of a child who could not find a pediatric dentist to treat her progressing dental care needs. The complaint named a health plan and the Medicaid Commissioner as defendants. The claims included: § 1396a(a)(8) (reasonable promptness), § 1396a(a)(3) (notice and fair hearing rights when claims are not acted on with reasonable promptness), §§ 1396a(a)(43), d(a)(4)(B), and d(r) (EPSDT), and a third party beneficiary contract claim (on the contract between the Medicaid agency and health plan).

Outcome: The case settled when the defendants acknowledged that the child was entitled to dental services and the health plan agreed to pay a named dentist for all of the child's pediatric dental care. The health plan also agreed to survey participating dental providers periodically to assure that its dental network is adequate and to send enrollees a notification of the availability of dental services.

Texas

Frew v. Gilbert, 540 U.S. 431 (2004), *rev'g*, 300 F.3d 530 (5th Cir. 2002) (regarding federal court's authority to enforce consent decrees), *vacating*, 109 F. Supp. 2d 579 (E.D. Tex 2000), *same case*, 401 F. Supp. 2d 619 (E.D. Tex. 2005) (denying motion for relief from

judgment), *aff'd*, 457 F.3d 432 (5th Cir. 2006), *cert denied,* 127 S.Ct. 1039 (2007), *later decision,* No. 3:93CVO65WWJ (E.D. Tex. July 9, 2007) (settlement).

Background: This class action case, filed on behalf of Medicaid-eligible children on September 1, 1993, challenges the lack of EPSDT program activities and services.

Outcome: In a Consent Decree (approved February 16, 1996), the State agreed, among other things, to undertake numerous outreach and informing steps, to work to increase provider participation, and to monitor EPSDT performance. On August 14, 2000, the district court held the State had fallen short of its promises and ordered the State to comply with the Decree. The State argued that the federal court lacked authority to enforce the Consent Decree against the State, but the Supreme Court disagreed.

Meanwhile the plaintiffs' filed an amended complaint, alleging violations of equal access, caused by the failure of the defendants to assure access to necessary dental services. The State filed a motion to obtain relief from the judgment. The motion was denied by the district court on August 22, 2005. The Court refused to dissolve the Decree with respect to the dental program, finding that:

(a) the dental participation rates represented by the State on the uniform federal reporting form, Form 416, had over-reported participation and used different statistics over time, resulting in "apples to oranges" comparisons from year-to-year;
(b) the State's comparison of dental participation rates of time in Texas and relative to other states was fatally flawed because, among other things, states initiated dental screening at different ages); and
(c) the number of active dentists had "stagnated" while the number of Medicaid-eligible children was increasing.

On July 9, 2007, District Judge William Wayne Justice approved a settlement of the 14-year-old class action case. The approval followed a decision by the Texas Legislature to allocate more than $700 million over the next two years to improving children's health services. The settlement contains eleven corrective measures, including agreements by the state to improve transportation services, increase dental and physician payments, provide case management services to children who request them, and to improve outreach efforts to families. The state also agreed to hire more case workers. The corrective actions plans are posted at http://www.hhs.state.tx.us.

Mitchell v. Johnston, 701 F. 2d 337 (5th Cir. 1983)

Background: The plaintiffs claimed that cutbacks in services, including dental services, violated Medicaid's EPSDT requirements.

Outcome: The State's planned cutbacks were enjoined. As a result, the State could not reduce the number of periodic check ups; limit dental services to emergency, urgent situations; or exclude certain dental services altogether (topical fluoride, fixed space maintainers, and partial dental appliances).

Note: Congress recognized *Mitchell* with approval in legislative history to 1989 amendments to the EPSDT provisions of the Medicaid Act. H. Rep. No. 101-247, 101st Cong. 1st Sess. at 399 (1989), *reprinted in* 1989 U.S.C.C.A.N. 1906, 2125 (1989).

West Virginia

**Randolph v. Miller*, Civ. No. 2:91-0212 (S.D.W.Va.) (Settled and dismissed, Aug 7, 1992)

Background: This class action case, filed on behalf of Medicaid beneficiaries needing dental and other Medicaid services, challenged announced cut backs in Medicaid payment rates.

Outcome: The case settled when the State agreed to take a number of steps, including:

(a) development of a Medicaid services delivery plan;
(b) providing technical assistance to help clinics qualify as federally qualified health centers;
(c) providing unduplicated counts of beneficiaries, by county, utilizing services;
(d) develop a program to recruit providers to underserved areas, including loan forgiveness;
(e) improving dental screening rates to 80% over time;
(f) revision of dental periodicity schedules;
(g) establishment of an advisory board to the Medicaid Secretary;
(h) increasing payment rates on selected services; and
(i) assuring that 90% of "clean" claims (those needing no additional information) would be paid within 30 days of receipt; 99%, within 90 days.