UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

CIVIL ACTION NO. 00-10833-RWZ

HEALTH CARE FOR ALL, INC., *et al.*

v.

GOVERNOR MITT ROMNEY, *et al.*

MEMORANDUM OF DECISION

July 14, 2005

ZOBEL, D.J.

Plaintiff Virgin Torres complains that she cannot find an oral surgeon for her daughter. Plaintiff Patricia Meaney says that she cannot locate a dentist of adequate quality for her sons. Plaintiff Sharleen Campbell's child saw a dentist only after Ms. Campbell called approximately fifty other providers. These experiences illustrate the frustration and failure that plaintiffs in the instant case claimed to confront in seeking Medicaid-covered dental care in Massachusetts. Medicaid is a nationwide medical assistance program operated on a state-by-state basis pursuant to individual state plans. States that participate in Medicaid may receive cooperative federal funding if their state plans comply with certain federal criteria. These requirements include provision of dental care and services to Medicaid enrollees under the age of 21. States may elect to provide dental care and services also to adults, and the Medicaid program of the Commonwealth of Massachusetts (commonly known as "MassHealth") does so only for a discrete class of adult beneficiaries who meet regulatory guidelines for

severe chronic disabilities or certain clinical conditions and are therefore known as "special circumstances" enrollees.

According to plaintiff Health Care For All, Inc. ("HCFA"), the Commonwealth and MassHealth have fallen far short of meeting statutory and assumed obligations to serve the dental needs of children and adult MassHealth enrollees. HCFA is a nonprofit, tax-exempt organization that represents the interests of Massachusetts residents who seek quality, affordable health care. Together with numerous MassHealth enrollees, HCFA filed suit against several Commonwealth and MassHealth executives in order to procure improved dental care and services. Two subclasses comprise the plaintiff enrollees – those under the age of 21 who are fully eligible for dental and early and periodic screening, diagnostic and treatment ("EPSDT") services, and those who are adults with special circumstances that qualify them for MassHealth coverage. State defendants in this suit include Mitt Romney, Governor of Massachusetts; Ronald A. Preston, Secretary of Health and Human Services; Eric Kriss, Secretary of Administration and Finance; Beth Waldman, Director of the Office of Medicaid; and Steve Kadish, Assistant Secretary for Health.

Plaintiffs originally alleged seven statutory violations by defendants. They have since voluntarily dismissed Counts I and IV, and this Court allowed defendants' motion to dismiss Count V. Two of the four remaining allegations, Counts II and III, respectively assert unsatisfactory provision of dental care by defendants for lack of "reasonable promptness" and comparatively inequitable "amount, duration, [and] scope" of care, in violation of 42 U.S.C. §§ 1396a(a)(8) and 1396a(a)(10)(B). The

other two, Counts VI and VII, concern the provision of EPSDT services and the requirement to inform eligible individuals under the age of 21 of the availability of such services, as required by 42 U.S.C. §§ 1396a(a)(43), 1396a(a)(10)(A), 1396d(a)(4)(B) and 1396d(r). Intended specifically to address the health needs of children on Medicaid, EPSDT services include preventive, diagnostic and treatment services that all state Medicaid programs must provide to enrollees under the age of 21. In defending against summary judgment earlier in the proceedings, plaintiffs successfully argued that the statutory underpinnings of these allegations constitute enforceable rights, the deprivation of which may be remedied through a civil action under 42 U.S.C. § 1983.

The parties presented evidence on these claims at a bench trial followed by closing arguments. The issues at trial centered on whether defendants, in fact, deprived MassHealth enrollees of their rights to obtain medical assistance with reasonable promptness (Count II), to receive such assistance with comparable equity in amount, duration and scope (Count III), to receive notices about EPSDT screening and preventive services (Count VI) and to access such services with periodic regularity (Count VII). Although plaintiffs sought certification as a class, this motion was withdrawn, as defendants stipulated that any "remedial relief ordered or agreed to pursuant to a judgment in favor of the named plaintiffs shall benefit all similarly eligible MassHealth members." Stipulation of Parties Agreed to in Open Court on Day One of Trial. Defendants stipulated further that the testimony by four plaintiff enrollees – Elizabeth Curtis, Sharleen Campbell, Sharon Liberty and William Liberty – was relevant

to all named plaintiffs whose own experiences were outlined in the Third Amended Complaint and to other similarly eligible but unnamed MassHealth beneficiaries. See id.

I. Facts

1. Plaintiff Enrollees: Hardships in Accessing Dental Care

Plaintiffs Elizabeth Curtis, Sharleen Campbell, Sharon Liberty and William Liberty described their family's and their own experiences in trying to obtain dental care as MassHealth enrollees. Each testifying plaintiff confronted hardships in identifying MassHealth participating dentists, obtaining appointments for dental care and receiving quality services. Ms. Curtis and Ms. Campbell's testimony related to the plaintiff subclass of enrollees under the age of 21, while Mr. and Mrs. Liberty spoke as members of the plaintiff subclass of adult enrollees with special circumstances.

Ms. Curtis needed to find Medicaid-covered dental care for herself, her disabled husband and three of her six children. Although the most convenient provider would have been the Ellen Jones Community Dental Center on Cape Cod, she could not schedule any appointments there in advance of the year-long wait on the list for new patients. Thus, Ms. Curtis consulted the participating provider list supplied by MassHealth. Because only one of the five listed providers in fact accepted MassHealth for children, she drove her children forty minutes to an hour to Centerville Dental for their appointments. In the meantime, she and her husband lacked dental care except for urgent services received at the Falmouth Hospital Emergency Room and covered by MassHealth. When Falmouth Hospital informed Ms. Curtis of a local dental clinic,

Tatakut Dental Clinic ("Tatakut"), that would accept MassHealth coverage for her entire family, she moved the family to this new provider. At Tatakut, however, she observed what she believed to be poor quality care, and the clinic eventually closed after a fire. Centerville Dental was no longer accepting MassHealth patients, so the Curtis family paid out-of-pocket to receive dental services from a solo practitioner. By this time, one of Ms. Curtis's sons had over thirteen cavities. Tatakut then re-opened under new ownership but showed little improvement in quality. The children complained of mouth discomfort during and after cavity fillings, and some of the fillings fell out within a month.

Ms. Campbell experienced similar difficulty in locating a participating dentist. Her daughter suffered an infected molar and could not attend school, eat or sleep due to the pain until they found a dentist who accepted MassHealth and extracted the tooth. Ms. Campbell then searched for two months to find an oral surgeon who accepted MassHealth and would perform extractions for her son whose permanent teeth were not developing properly. A friend informed her of a dental clinic, Cranberry Dental, that would treat the entire family, and they obtained services at this clinic for about a year until Ms. Campbell received ill-fitting dentures. They saw another dentist, but only briefly because his office appeared cluttered, dingy and unclean. The Campbell family subsequently located Unident Dental Care and have been receiving MassHealth-covered services there.

Sharon and William Liberty are wheelchair-bound enrollees who both received services from the Harvard Faculty Practice until it ceased accepting MassHealth. They

then received dental care at the Tufts Dental Facility for the Handicapped ("Tufts Dental"). Both found the quality of care delivered by Tufts Dental to be unacceptable, because the practitioners often refused to lift them from their wheelchairs into a dental chair. Instead, the dentists tried to treat Mr. and Mrs. Liberty while they remained seated in their wheelchairs and received examinations with only a light and a mirror. Mr. Liberty has searched for other dentists who accepted MassHealth and could treat him in a more appropriate physical setting but, so far, has not found any.

Defendants raised several points during cross examination of these witnesses. First, although plaintiffs encountered challenges in obtaining appropriate dental care that would be covered by MassHealth, none of the plaintiffs took full advantage of procedures available to notify MassHealth of such challenges and seek assistance. Although MassHealth offered transportation services, Ms. Curtis never inquired as to the availability of such services. While MassHealth offered a complaint line, neither Ms. Campbell nor Mr. Liberty ever filed a complaint regarding the quality or type of services covered by MassHealth. Moreover, the plaintiffs acknowledged that in most cases, they eventually obtained needed services that, with limited exceptions, were paid for by MassHealth.

2. Reports and Data: Research Regarding Enrollee Access to MassHealth Dental Services and Their Health Outcomes

While plaintiffs may not have pursued all avenues for obtaining care, additional evidence corroborated their reports of impeded access. In response to national statistics showing that not enough children on Medicaid received preventive care

services, the Massachusetts legislature commissioned the Report of the Special Legislative Commission on Oral Health (the “Commission”), entitled Oral Health Crisis in Massachusetts and published in February of 2000 (the “Legislative Commission Report”). The Access Committee that supervised the project was chaired by Robert Compton, D.M.D., an expert in dental insurance program operations and Chief Dental Officer of Delta Dental Plan of Massachusetts (“Delta Dental”), the largest private insurer of dental services in the Commonwealth. The Legislature ordered the Commission to report on the status of access to dental services by Commonwealth residents, particularly by high-risk and low-income populations. Statistics presented in the Legislative Commission Report that address MassHealth enrollees portrayed a dire situation for their dental care. Of the over 4,500 practicing dentists in the Commonwealth, 86% at the time of the Legislative Commission Report did not accept MassHealth patients, and this percentage was growing as more dentists left the program, “citing inadequate reimbursement rates.” Legislative Commission Report, p. 5. As explained by the Legislative Commission Report, “[t]he primary barrier to improving utilization of dental services by MassHealth members is the critical and growing shortage of participating dentists.” Id. at 6. In exploring the genesis of this shortage, the Commission found that

> [o]ne of the most significant factors is the longstanding inadequacy of the MassHealth fee schedule. Present reimbursement rates are so dramatically below current market levels that dentists who choose to treat MassHealth patients receive fees that cover only about 75% of their direct costs of providing the service.

Legislative Commission Report, p. 7.

Both parties cited another survey of dental health in the Commonwealth published by the Massachusetts Oral Health Collaborative (the “Collaborative”), a group of academics, public officials, state representatives and delegates from dental professional societies, public interest groups and health insurers. The Collaborative conducted in-person oral health screenings of several thousand third-grade students in the Commonwealth and developed key findings set forth in the 2004 Massachusetts Oral Health Report (the “Oral Health Report”). According to data from 1999 and 2002, “[w]hile 73% of children ha[d] a dental visit on average, only a third of children with MassHealth ha[d] a dental visit.” Oral Health Report, p. 4. During the same time periods, “[w]hile 79% of Massachusetts’ residents ha[d] a dental cleaning visit on average, less than a third of children with MassHealth ha[d] a dental cleaning visit.” Id. At the same time, however, the Oral Health Report presented statistics that over 73% of MassHealth children had a checkup in the prior year, and over 71% of MassHealth children listed a dentist.

These apparently competing statistics illustrate a fundamental and pervasive problem with the figures presented by both parties throughout the trial. Too often, the parties failed to establish an apples-to-apples comparison between their statistics – for instance, presenting figures based on the total MassHealth population instead of focusing on the two subclasses at issue in this case – thereby preventing the opportunity for a meaningful understanding of the relationship between these numbers. This irreconcilability severely undermined the utility of both parties’ statistics.

3. Participating Dental Providers: Insufficient Reimbursement

Several dentists and administrators in various positions of responsibility in the Massachusetts dental community and government agencies further substantiated plaintiffs' testimony and the Legislative Commission Report statistics regarding barriers to access and identified inadequate reimbursement as a source of these barriers. For example, according to Stephen Schusterman, D.M.D., the former Dentist-in-Chief at the Children's Hospital Dental Clinic ("CHDC") in Boston, MassHealth children constitute 65 to 70% percent of CHDC's average patient caseload and many CHDC patients travel distances from Worcester, Springfield and other parts of the state for treatment of cavities and similarly mundane dental problems. New patients often wait one to two months for an initial appointment. He explained that, MassHealth pays CHDC significantly less than CHDC's usual and customary fee, and CHDC operates at a loss. Mary Foley, Director for the Commonwealth's Office of Oral Health, discussed state funding for programs that support children's dental health, including the Essential School Health Services Program and school-based health centers ("SBHC"). She testified that the grant money provided by this program to school systems for developing such health centers has decreased by one-third since 2002, and only one of the over 50 centers offers dental services.

Another witness, Mark Doherty, D.M.D., served as Director of Oral Health Services at several community health centers ("CHCs"), including ones in Dorchester and Taunton, that cared for the MassHealth population as safety net providers. He testified that state funding cuts for MassHealth devastated these CHCs' budgets, as MassHealth enrollees and uninsured individuals composed about 90% of their dental

patient base. As noted by the Legislative Commission Report, “most safety-net providers also serve many MassHealth members and are struggling under the same inadequate reimbursement rates as are dentists in private practice.” Legislative Commission Report, p. 8. The wait for both new and follow-up patients at the Dorchester and Taunton CHCs is about 50 days, although emergency care is usually available on a same-day basis for patients who are willing and able to wait. CHCs rarely refer to private dentists, Dr. Doherty said, because very few accept either MassHealth or uninsured patients. Similar testimony was provided by Timothy Martinez, D.M.D, a dentist who served as Dental Director for several community health clinics, including the Ellen Jones Community Dental Center on Cape Cod and the Mid-Upper Cape Community Health Center. According to Dr. Martinez, MassHealth enrollees comprise over 90% of the patient bases at these centers, and the wait for a new appointment is six months to a year. Dr. Martinez also maintained two private practices but did not accept MassHealth patients, because the payment for services was insufficient. The burden of low reimbursement is further compounded by state law that prohibits dentists who agree to accept MassHealth coverage from limiting the number of MassHealth patients they see, by characterizing any such limitation as discriminatory. As explained by Dr. Martinez, however, the unintended consequence of this law is that a private dentist who chooses to participate in MassHealth risks financial instability if too many MassHealth patients join the practice, since MassHealth reimbursements would be a completely inadequate source of primary income. Thus, a dentist who is willing to accept a limited number of such patients accepts none.

4. Delta Dental: Perspectives from Private Insurance

Plaintiffs also presented testimony by Dr. Compton who led Delta Dental, the largest private insurer of dental services in the Commonwealth with approximately 1.8 million members and a participating provider list that included 97% of the approximately five thousand dentists currently in practice. Of these approximately 4,850 Delta Dental dentists, Dr. Compton said only about 675 accept MassHealth coverage, and there are approximately 500,000 children on MassHealth. He explained that the federal agency responsible for administering the Medicare and Medicaid programs, the Centers for Medicare and Medicaid Services, required every Medicaid program to summarize utilization by enrollees who receive EPSDT services, including dental services. The reports prepared and submitted by MassHealth indicated that only slightly more than 30% of MassHealth children received at least one dental visit each year for the years 2001, 2002, and 2003 and, as clarified by Dr. Compton, these numbers did not reflect the degree or full range of services that a child may actually need and did not receive.[1] In contrast, 80 to 85% of children covered by Delta Dental across all plans accessed care, and as an expert, Dr. Compton opined that an appropriate benchmark for access to dental services by all children would be 70 to 75%, with initial appointments available within four to six weeks. With respect to palliative care, or care delivered in

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[1] Defendant challenged the accuracy of these figures on the basis that not all enrollees remained eligible for MassHealth for an entire year. A child who enrolled for three months and had no dental visit during that time would not necessarily reflect a problem with access to dental care. Thus, for purposes of evaluating access to care, the percentages may be artificially low. However, for the years 2001, 2002 and 2003, the period of eligibility for all EPSDT enrollees was around 0.80, or between nine and ten months, and thus allows a reasonable annual approximation.

order to relieve pain, Dr. Compton said that he reviewed both MassHealth and Delta Dental utilization reports to find that children covered by MassHealth receive about ten times more palliative care than those covered by Delta Dental, likely because the lack of preventive care for MassHealth enrollees allowed dental disease to progress to severe stages.

He later testified that Delta Dental sought to add dentists to its network when the waiting time for a dental cleaning appointment exceeded four weeks and opined that the industry generally considered four to six weeks to be an appropriate waiting time for such appointments. To add and retain dentists, Dr. Compton explained that Delta Dental marketed aggressively and employed licensed dentists to interact with participating providers, two approaches to developing a provider network that MassHealth has not adopted. Also different from MassHealth, Delta Dental simplified billing practices by implementing the standard billing form designed by the American Dental Association instead of a proprietary form as used by MassHealth.

5. MassHealth Regulators: Reimbursement and Policy

In addressing more specifically the derivation of reimbursement rates for dental services under MassHealth, defendants offered testimony by Phyllis Peters, Deputy Assistant Secretary for the Office of Acute Services in the Executive Office of Health and Human Services ("EOHHS"). Ms. Peters explained that the Division of Health Care Finance and Policy ("DHCFP") held direct responsibility for establishing and re-evaluating rates on a biannual basis, and MassHealth participated in such discussions including those regarding dental rates. The most recent rate review in 2002 resulted in

increased dental rates for MassHealth children but elimination of dental services for MassHealth adults. Defense witness Lucinda Brandt, Pricing Policy Manager of EOHHS, explained that MassHealth dental rates are based on Delta Dental charge data because it was available and was specific to Massachusetts. According to Ms. Brandt, MassHealth usually set reimbursement at 80% of the Delta Dental median, as MassHealth believed that amount to be in an acceptable range for participating dentists. However, even MassHealth's efforts to use Delta Dental data as a benchmark were not entirely successful, as Ms. Brandt did not realize that Delta Dental updated its rates every six months, not annually, with the result that MassHealth rates failed to reflect current Delta Dental fees. For example, the most recent Delta Dental rates presented at trial were based on Delta Dental's fee data from April of 2003 fees. Ms. Brandt testified that obtaining updated fee data now might further delay the MassHealth reimbursement review process.

As mentioned by plaintiffs' witness Zoila Feldman, Executive Director of the Great Brook Valley Health Center in Worcester, an enhanced reimbursement fee also became available to MassHealth CHCs that implemented a plan to improve access to dental care, for example by subcontracting with private dentists, increasing hours of operation, or adding specialty services. Both Ms. Feldman and plaintiffs' witness Dr. Doherty discussed the availability and benefit of infrastructure and loan forgiveness grants to community health centers for expanding services and recruiting more dentists with broader skills. Defense witness David Noel, D.M.D., Chief Dental Program Consultant for the State of California, further testified to the beneficial impact of

infrastructure grants and loan forgiveness programs. Ms. Peters confirmed that in spite of these efforts MassHealth still received more complaints by enrollees about dental care than about any other service, on the order of thousands of complaints per month, and she recalled no significant decrease in these complaints over time. See also, Legislative Commission Report, p. 6. Dr. Noel emphasized the relevance of employing licensed dentists to interact with, retain and recruit MassHealth providers. Neither Maximus, Inc. nor Unisys Corporation, the third-party entities that administer the beneficiary and provider enrollment and billing portions of MassHealth, employed any licensed dentists on staff to advise or directly handle provider or beneficiary concerns.

Some of the evidence presented by defendant attributed the differences in dental health as observed between MassHealth enrollees and individuals with private insurance to pre-existing cultural and educational differences. For example, Dr. Noel opined that lack of educational awareness may lead to a poor diet that, in turn, leads to higher incidence of tooth decay. Both he and Dr. Compton also noted that MassHealth enrollees often compose a disproportionately large percentage of patient “no-shows” where a scheduled patient fails to appear for his appointment. Defendant’s underlying point posed a “chicken and egg” scenario by challenging whether insufficient dental care caused MassHealth children’s bad health outcomes or, instead, whether the outcomes resulted from poor education and absence of cultural importance placed on proper dental care. Additionally, Dr. Noel explained that dentists themselves frequently harbored a bias in favor of patients with private insurance, as these patients typically represent increased revenue for the practice. He testified that while some providers

easily integrated MassHealth patients into their practices, generally it took years to establish a change in perspective across the majority of dentists.

Defendants also highlighted the fact that by the time of trial, all eligible plaintiffs had successfully obtained access to dental services covered by MassHealth. Although plaintiffs experienced appointment delays, individual providers controlled their own scheduling policies and received no instruction from MassHealth with respect to waiting lists or the allocation of services to MassHealth enrollees or as between MassHealth and non-MassHealth patients. Defendants noted that all patients in general experienced waits for appointments regardless of insurance status, and participating providers always delivered priority care to all patients with emergencies. Moreover, while plaintiffs focused on the percentage of enrolled children who obtained dental care as hovering around 30% for several years, defendants cited an over 12% net increase in the number of such children who received dental care from FY2001 to FY2004.

II. Standard of Review

One of defendants' ongoing positions with respect to this litigation regards the role of the Centers for Medicare and Medicaid Services as the proper evaluator of defendants' conduct. Defendants assert that any shortcoming on their part should be assessed and remedied not by plaintiffs or the judicial system but by the Centers for Medicare and Medicaid Services, as the federal agency charged with administration and oversight of the Medicaid program. To this end, defendants argue that any review of its conduct in connection with the instant case should address whether "there is a failure to comply substantially with any such provision [of the statutory requirements for

state Medicaid plans set forth in 42 U.S.C. § 1396a].” 42 U.S.C. § 1396c. In other words, defendants believe their conduct should be held to the standard of substantial compliance, not full or perfect compliance as urged by plaintiffs. Defendants maintain that plaintiffs have failed to show any such deficiencies and, thus, have failed to establish any sufficient factual bases for the claims at issue.

Plaintiffs contend that the substantial compliance standard measures an entity's performance to determine whether it deserves continued federal funding. A finding of insubstantial compliance means “that further payments will not be made to the State . . . until the Secretary [of Health and Human Services] is satisfied that there will no longer be any such failure to comply.” 42 U.S.C. § 1396c. The lower standard of substantial compliance, as opposed to full or perfect compliance, serves to balance the dire consequences of failure to comply in the context of funding. However, nothing merits or implies the use of a low standard with respect to a state Medicaid program's fulfillment of its statutory and regulatory obligations to serve beneficiaries. Nothing mitigates the traditional expectation that a regulated entity fully comply with its governing statutes and regulations, even if “absolutely perfect compliance is unattainable.” Withrow v. Concannon, 942 F.2d 1385, 1388 (9th Cir. 1991)(finding that while “[i]mpossibility of perfect compliance may be a defense to contempt . . . it does not preclude . . . requiring compliance with the regulations when a pattern of non-compliance has been shown to have existed.”). The Withrow plaintiffs sought enforcement of time constraints for state officials' “failure to issue timely decisions” in hearings under the Aid to Families With Dependent Children, Food Stamp and

Medicaid programs. See Withrow, 942 F.2d at 1386. The Withrow defendants advocated for the substantial compliance standard, but for the above-mentioned reasons, the Ninth Circuit required compliance "'as strict as is humanly possible.'" Withrow, 942 F.2d at 1388.

While absolutely perfect compliance by defendants in the instant case may not be feasible, this fact does not excuse them from striving to comply as much as possible. The Centers for Medicare and Medicaid Services applies the substantial compliance standard to balance the "virtual death sentence" of withheld funding, not because perfect compliance is impossible. Withrow, 942 F.2d at 1387. Defendants have not offered a compelling analogy to justify application of the substantial compliance standard in the instant case where federal funding is not at risk, much less a thoughtful rationale for why the conventional standard of full compliance is not an appropriate expectation. Accordingly, the standard to be applied in this case will be full compliance.

III. Count II: "Reasonable Promptness"

Plaintiffs' complaint seeks to establish a relationship between MassHealth reimbursement for dental care and access to such care by MassHealth enrollees. In Count II, plaintiffs accuse defendants of failing to provide medical assistance with "reasonable promptness" as required by statute:

> [a] State plan for medical assistance must – . . . provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished
> with reasonable promptness to all eligible individuals; . . ."

42 U.S.C. § 1396a(a)(8). Related federal regulation deems “delay caused by the agency’s administrative procedures” to be unacceptable. 42 C.F.R. § 435.930. Plaintiffs argue that MassHealth impeded enrollees’ access to and receipt of services by providing such low reimbursement for dental care that dentists in the Commonwealth could not afford to participate as MassHealth providers. As a result, only a few dentists offered appointments to enrollees, and the waiting period for dental care services grew. Before applying this law to the facts at issue, defendants challenge this claim by questioning the appropriate scope of the statutory obligation, while plaintiffs tender a contrary interpretation of the statutory language.

1. Scope of Statutory Obligation

According to defendants, the term “medical assistance” refers to payment for dental services and not the provision of treatment, as the statute defines this term to mean “payment of part or all of the cost of . . . care and services” covered by Medicaid. 42 U.S.C. 1396d(a). Defendants urge that “reasonable promptness” means “a prompt determination of eligibility and a prompt provision of funds to eligible individuals to enable them to obtain the medical services that they need.” Bruggeman v. Blagojevich, 324 F.3d 906, 910 (7th Cir. 2003)(explaining that “the statutory reference to ‘assistance’ appears to have reference to *financial* assistance rather than to actual medical *services”)(*emphasis in original). Otherwise, “a requirement of prompt *treatment* would amount to a direct regulation of medical services,” and Medicaid “is not a scheme for state-provided medical assistance, as through state-owned hospitals.” Bruggeman, 324 F.3d at 910(emphasis in original). Plaintiffs, on the other hand, press

the opposing view that a state Medicaid program should be held "ultimately responsible for ensuring the actual delivery of dental services to eligible persons." Pls'. Reply to Defs'. Proposed Findings of Fact and Conclusions of Law, p. 17. Characterizing this principle as the "gravamen of [their] Complaint," plaintiffs seek an expansive interpretation of "medical assistance" beyond payment to include the eventual furnishing of services. Id.

Both parties' positions present problems. Defendants' myopic reading of the statutory language misses the forest for the trees. Timely payment for services does little to benefit enrollees who cannot find a provider willing to accept such payment. Because payment for services necessarily presumes delivery of services, state Medicaid programs may indirectly impede medical assistance through practices and protocols that delay the delivery of services. In Bryson v. Shumway, for example, the First Circuit recognized that a state Medicaid program may have interfered with the reasonable promptness of medical assistance by executing certain of its responsibilities in a sluggish manner. See 308 F.3d 79, 89 (1st Cir. 2002). The "medical assistance" at issue involved the state's administration of a wait list for certain services and whether New Hampshire Medicaid was "diligently filling the empty slots with reasonable promptness." Bryson, 308 F.3d at 89. Although not presented with enough facts to rule on the merits of the issue, the First Circuit opined that the untimely allocation of empty treatment slots to enrollees on a wait list for certain services may subject New Hampshire Medicaid to liability for "not being reasonably prompt in its provision of medical assistance." Bryson, 308 F.3d at 89. In other words, the First

Circuit recognized that actions and protocols of New Hampshire Medicaid that undermined the timeliness of medical assistance must be subject to review under 42 U.S.C. § 1396a(a)(8), if the reasonable promptness provision was to be enforceable in a meaningful way.

As a solution, plaintiffs propose that defendants be held "ultimately responsible" for delivery of services, but they offer no clarification of exactly what conduct would be covered by this umbrella of responsibility. For example, to the extent that state Medicaid programs govern participating providers through contractual and regulatory controls, plaintiffs' proposal may be read to hold defendants accountable for barriers to prompt medical assistance that individual providers independently erect. However, the theory of liability acknowledged by the First Circuit in Bryson concerned state Medicaid programs' actions and protocols and did not expand the timely payment obligation to cover actions by participating providers such as dentists. Moreover, plaintiffs have not offered a persuasive substantive legal basis for anchoring this potentially far-reaching obligation to the reasonable promptness provision.

Between the defendants and plaintiffs polar views lies an interpretation of the "reasonable promptness" provision that both upholds the underlying purpose of requiring punctual medical assistance and tailors the reach of this statute to those undoubtedly intended to be governed by it. A state may not circumvent a statutory duty for prompt payment by under-funding a mandatory Medicaid service to the degree that no health care practitioners can afford to provide the service. 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. To that end, the promptness standard set forth in 42 U.S.C. § 1396a(a)(8) may be reasonably understood to constrain actions and protocols by a state and its Medicaid administrative and rate-setting agencies that otherwise subvert the statute's intent.

2. Analysis

A. Plaintiff Subclass of Enrollees Under 21

Plaintiffs' evidence shows that enrollees encountered extraordinary difficulty in obtaining timely dental services. As plaintiff enrollees testified, the challenge began with identifying a dentist who accepted Medicaid payment. Because the provider list from MassHealth did not accurately represent current participating providers, enrollees often relied instead on word-of-mouth referrals or direct cold calls to private offices. In times when no available providers could be located, plaintiff enrollees said they either paid out-of-pocket for services that should have been covered by MassHealth or simply went without treatment. The fact that MassHealth received thousands of calls each month from enrollees regarding problems of access to providers further corroborated this obstacle.

Upon finding a participating provider, plaintiff enrollees next confronted the hurdle of scheduling an appointment. As confirmed by the testimony of several CHC administrators, the wait for new patient appointments at CHCs were as short as one and a half months and, at some clinics, as long as one year, although children with emergencies usually qualified for same-day appointments. Conditions short of an

emergency, therefore, went unattended for at least an additional six or eight weeks, often several months to a year, after scheduling an appointment.

It is clear that the difficulties encountered by enrollees who sought dental appointments resulted from a shortage of dentists participating in MassHealth. Defendants query whether the MassHealth population could be adequately served by the current number of participating dentists if enrollees took full advantage of MassHealth services such as free transportation to visits, but they never offered concrete data to support this proposal. Defendants do not emphatically challenge plaintiffs' assertion that insufficient reimbursement accounted for the shortage in participating providers, instead admitting at trial that MassHealth recognized that valid issues existed but asserting that defendants were taking internal measures to remedy these problems. CHC administrators and practicing dentists as well as data presented in the Legislative Commission Report all confirmed the inadequacy of MassHealth payments as the primary reason that private dentists refused to open their practices to enrollees. Although plaintiffs did not vigorously dispute defendants' competing culturally-based explanations for low utilization and high rates of disease, defendants do not explain why a program that intends to serve such populations should not be expected to develop measures designed to mitigate the negative impact of such potential influences. For these reasons, plaintiffs' evidence persuasively demonstrates that MassHealth established reimbursement levels so low that private dentists could not afford to treat enrollees who, thus, either received dental care only after much delay or not at all. Accordingly, as to the plaintiff subclass of enrollees under the age of 21,

defendants have failed to comply fully with their statutory obligation set forth in Count II.

B. Plaintiff Subclass of Enrollees With Special Circumstances

Direct testimony by Mr. and Mrs. Liberty constituted the only evidence offered specifically with respect to difficulties encountered by adult enrollees with special circumstances. Their testimony regarded the quality, not the promptness, of dental services. Nothing suggested that special circumstances enrollees encountered problems in obtaining appointments with participating providers at Tufts Dental, or that Tufts Dental practitioners believed the reimbursement for treating these enrollees to be insufficient. Rather, these enrollees objected to the manner in which they received treatment. Plaintiffs therefore have not shown that defendants violated the promptness provision at 42 U.S.C. § 1396a(a)(8) with respect to this subclass of plaintiff enrollees.

IV. Count III: Comparability Provision

In Count III, plaintiffs fault defendants for not providing equivalent medical assistance to all Medicaid enrollees, since:

> [a] State plan for medical assistance must . . . provide . . . that the medical assistance made available to any individual described in subparagraph (A) – (i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and (ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A); . . .

42 U.S.C. § 1396a(a)(10)(B). Plaintiffs argue that this provision prohibits geographic variations in access to covered services, including dental care, and that defendants violated it through, in part, inadequate funding. See Sobky v. Smoley, 855 F. Supp. 1123, 1140-42 (E.D. Cal. 1994).

1. Plaintiff Subclass of Enrollees Under 21

In support of this claim, plaintiffs offered evidence at trial that many areas of the Commonwealth have no CHCs or other safety-net dental clinic, thereby requiring MassHealth patients to travel distances, often 50 miles or more, to obtain dental care. For example, Dr. Doherty testified that dentists at the Dorchester CHC often see Worcester patients (approximately a 50 mile trip) while Cape Cod patients obtain care at the Taunton CHC (approximately a 70 mile trip). The number of children treated at Children's Hospital Boston who live beyond greater Boston has increased in recent years, according to plaintiffs' witness Dr. Shusterman. Additionally, when Cape Code safety net CHCs cannot accommodate new patients, the dentists refer them to Boston-area providers and dental schools, 60 to 120 miles away.

Defendants counter by clarifying the intent of the statute in question as ensuring that access by and services to "categorically needy" beneficiaries was available "first and in amounts not less than" access by and services to other categories of Medicaid eligibles such as the "medically needy," for whom coverage is optional. See, e.g., Mass. Ass'n of Older Americans v. Sharp, 700 F.2d 749, 753 (1st Cir. 1983). This provision, claim defendants, does not require "uniform proximity" to services or "identical convenience of service everywhere in the state." See, e.g., Bruggeman, 324 F.3d at 911. Defendants also note that this provision is not intended to ensure comparable utilization of dental services between the Medicaid population and the non-Medicaid population.

While plaintiffs offered some information about travel times for enrollees and the

location of CHCs and other safety net providers, their assertion that dental services are inequitably distributed is overshadowed by their primary argument that access is generally poor for all enrollees. While plaintiffs have shown that some enrollees live in parts of the state where participating dentists are woefully lacking (e.g., Cape Cod), they have shown that plaintiffs living in areas of higher concentrations of dentists may also suffer long waits and impaired access (e.g., Boston). In other words, plaintiffs never established that MassHealth provides sufficient treatment to some enrollees and insufficient treatment to others and, thus, have not shown any actual discrepancy in access among enrollees.

Furthermore, as explained by defendants, the comparability provision applies specifically to protect categorically needy enrollees from inadequate service as compared to other such enrollees or to medically needy enrollees. See 42 U.S.C. § 1396a(a)(10)(B), and King by King v. Sullivan, 776 F. Supp. 645, 653-654 (D. R.I. 1991). Plaintiffs never addressed the relationship, if any, between the alleged geographic differences in access and whether MassHealth enrollees were categorically or medically needy. Additionally, "nothing in the statute prohibits a state from offering different services to persons in different categories of medical need or with different degrees of medical necessity," and plaintiffs never addressed, much less proved, whether the alleged differences may be explained by varying degrees of medical necessity in the MassHealth population. King by King, 776 F. Supp. at 654. Accordingly, plaintiffs have not shown that defendants violated the comparability provision set forth at 42 U.S.C. § 1396a(a)(10)(B).

2. Plaintiff Subclass of Enrollees With Special Circumstances

Again, direct testimony by Mr. and Mrs. Liberty constituted the only evidence offered specifically with respect to difficulties encountered by adult enrollees with special circumstances. Their testimony regarded the quality, not the comparable amount, duration and scope, of dental services. Nothing suggested that access to covered services by special circumstances enrollees varied according to geography or that such variance created problems. Plaintiffs did not address the distinction between categorically and medically needy individuals in the context of special circumstances enrollees, either. Plaintiffs therefore have not shown that defendants violated the comparability provision at 42 U.S.C. § 1396a(a)(10)(B) with respect to this subclass.

V. Count VI: Inform about and Arrange for EPSDT Dental Services

Federal Medicaid laws require state programs to provide information about and to provide or arrange for the delivery of certain services to enrollees under the age of 21. Specifically:

> [a] State plan for medical assistance must – . . . provide for – (A) informing all persons in the State who are under the age of 21 . . . of the availability of EPSDT services . . . and the need for age-appropriate immunizations against vaccine-preventable diseases, (B) providing or arranging for the provision of such screening services in all cases where they are requested, (C) arranging for (directly or through referral to appropriate [providers]) corrective treatment [as needed and indicated per the screening services], and (D) reporting to the Secretary [certain utilization
> data].

42 U.S.C. § 1396a(a)(43). Plaintiffs contend that defendants have failed to effectively inform plaintiffs of the EPSDT program; to ensure adequate provision, or arrangement

for the provision, of EPSDT dental screens and services; and to recruit and retain enough dental providers to meet plaintiffs' EPSDT needs.

To this end, plaintiff enrollees testified to the inadequacy and inaccuracy of written material provided by defendants. For example, the MassHealth member handbook provided to enrollees mentions dental benefits only generally as a covered service for certain enrollees and does not clarify the availability of EPSDT services. Plaintiffs did not dispute that MassHealth mailed notices to enrollees every six months to recommend services such as dental checkups, cleanings and other covered treatments. On the other hand, written literature and telephone customer service information provided by MassHealth about available dental providers was often incorrect and outdated. Notices that accurately inform an enrollee about the need for screening but then inaccurately explain the means to obtain such screening do not satisfy defendants' obligation to notify. Defendants contend that their duties to arrange or provide for EPSDT dental services are triggered by plaintiffs' request for such services, so any apparent shirking of these duties actually reflected a lack of enrollee requests for such services. However, defendants' explanation does not eliminate the real possibility that any shortfall in requests for services derived from misinformation in the notices about effective means for scheduling appointments and not from the absence of need for such services.

Reports filed by the Commonwealth with the Centers for Medicare and Medicaid Services indicated that just over 30% of MassHealth children received a dental visit. Defendants argue that the percentage of visits provided may accurately reflect the

demand for such services, that essentially only 30% percent of MassHealth children actually sought dental services. They suggest that socioeconomic and cultural norms, and not a lack of providers, compromised access, as such norms may have downplayed the importance of dental health and effectively undermined MassHealth's information campaign. As noted earlier, though, it remains unclear why a program designed to serve such populations should not be expected to develop measures to mitigate the negative impact of such potential influences. When 80% of the children covered by Delta Dental are obtaining dental visits, demand for services alone seems unlikely to account for this gulf between the haves and the have nots.

The fact that defendants' notices contained incorrect and outdated guidance on obtaining services, that plaintiff enrollees' testified to and confirmed the inability to find participating providers of covered services based on information provided in the notices, that thousands of calls daily flooded MassHealth's consumer hotline seeking supplementary advice on locating providers, and that the actual percentages of children enrolled in MassHealth who received dental services as reported to the Centers for Medicare and Medicaid Services is shockingly low all support the finding that defendants have failed to comply fully with the obligation to provide such notices and subsequently arrange for and provide EPSDT services as required under 42 U.S.C. § 1396a(a)(43). Although plaintiffs suggest that this violation by defendants resulted in part from inadequate reimbursement to providers, plaintiffs have not offered compelling evidence on this point, and the finding does not rely upon or endorse any such theory.

VI. Count VII: Provide EPSDT dental services at reasonable intervals

Additional statutory obligations govern defendants' provision of EPSDT services. Plaintiffs complain that MassHealth does not meet the requirement that:

> [a] State plan for medical assistance must – provide – for making medical assistance available, including at least the care and services listed in . . . section 1396d(a) of this title . . . ," which include "early and periodic screening, diagnostic, and treatment services . . . for individuals who are eligible under the plan and are under the age of 21 . . . ," such services defined to include ". . . Dental services – (A) which are provided – (i) at intervals which meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care, and (ii) at such other intervals, indicated as medically necessary to determine the existence of a suspected illness or condition; and (B) which shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health.

§§ 1396a(a)(10)(A), 1396d(a)(4)(B) and 1396d(r). Plaintiffs argue that violation of these provisions ensued from insufficient reimbursement to participating dental providers.

MassHealth's EPSDT periodicity schedule requires the screening provider to "encourage members to seek regular dental care from a dental provider, beginning at age three years, or earlier, if indicated, including examinations once every six months, preventive services, and treatment, as necessary." App. W to all Provider Manuals, EPSDT Services: Medical Protocol and Periodicity Schedule, Transmittal Letter ALL-113, Page W-3 (Apr. 1, 2003). Plaintiffs only minimally challenge the substance of this protocol through their expert, Dr. Compton, who testified that the American Dental Association and the American Association of Pedatric Dentists recommend that a child's initial dental screening occur at age 1, not at age 3. Based on this spare argument, defendants correctly contend that plaintiffs failed to demonstrate that the

protocol did not comply generally with EPSDT requirements.

Plaintiffs' dominant complaint is that defendants failed to implement this protocol. To the extent that the protocol governs defendants' role in ensuring appropriateness in the actual intervals of care provided, once an enrollee becomes a patient, neither party presented extensive evidence on the actual or average length of time between appointments experienced by enrollees who became patients of a practice. To the extent, however, that defendants' conduct impeded enrollees' ability to obtain an initial appointment and thus even fall within the scope of the protocol, the factual underpinnings of plaintiffs' argument strongly resemble those presented in Count II regarding the "reasonable promptness" provision. A child who cannot find a participating provider certainly cannot obtain dental care at the prescribed intervals.

Accordingly, plaintiffs have shown that defendants failed to implement their EPSDT periodicity schedule, because enrollees were unable to locate participating providers and thus avail themselves of the periodic treatment required by the schedule. This omission constitutes another way in which defendants breached the "reasonable promptness" provision and thereby also implicates inadequate reimbursement to providers as part of the offending conduct.

VII. Conclusion

Plaintiffs have demonstrated that defendants violated sections of the Medicaid Act that require prompt provision of services, adequate notice and treatment at reasonable intervals and that these violations resulted, in part, from insufficient reimbursement. Defendants agreed at the outset of the trial to be bound as to the entire "class" of MassHealth enrollees under the age of 21 who qualify for dental

services. The Court has not found any violations by defendants with respect to adult enrollees with special circumstances. The parties shall attempt to develop a joint remedial program and judgment and report to the Court thereon by August 31, 2005. The court will schedule a hearing thereafter to determine the appropriate course of action.

________________________ DATE

/s/ Rya W. Zobel
RYA W. ZOBEL
UNITED STATES DISTRICT JUDGE