UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

OSCAR SALAZAR, *et al.*, on behalf of themselves and all others similarly situated, Plaintiffs, v. THE DISTRICT OF COLUMBIA, *et al.*, Defendants.	Civil Action No. 93-452 (GK) *In Forma Pauperis*

PLAINTIFFS' MOTION TO ENFORCE THE DENTAL ORDER OF OCTOBER 18, 2004

Plaintiffs hereby move this Court to enforce the Dental Order of October 18, 2004.

As set forth in the accompanying Memorandum of Points and Authorities, defendants are in significant violation of the Court's Dental Order of October 18, 2004 ("Dental Order")(ECF No. 1033). Plaintiffs seek an order from the Court requiring defendants to take specific actions designed to bring about compliance with the six performance goals in paragraph 2(e) of the Dental Order by September 30, 2020.

Plaintiffs also request that this Court impose interim performance goals and the submission of a five-year Corrective Action Plan ("CAP") that sets forth specific requirements, including concrete steps and measurable, interim deadlines and numerical goals, designed to reach full compliance with each of the paragraph 2(e) performance goals by September 30, 2020.

STATEMENT PURSUANT TO LOCAL CIVIL RULE 7(m)

As explained in the accompanying Memorandum of Points and Authorities, the parties spent approximately two-and-a-half years in negotiations and mediation regarding much needed improvement in the delivery of dental services to children. In 2015, the parties reached an

impasse. Pursuant to paragraph 80 of the January 25, 1999 Settlement Order and Local Civil Rule 7(m), on February 5, 2016, plaintiffs' counsel notified defendants' counsel, Bradford Patrick, of plaintiffs' intention to file this motion. Plaintiffs have waited the requisite ten days under paragraph 80 before filing this motion. It is plaintiffs' understanding that defendants intend to oppose this motion.

Respectfully submitted,

/s/ Zenia Sanchez Fuentes

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February 16, 2016

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INTRODUCTION

As the Court recently recognized, "[t]he provision of dental services to the plaintiff class has been a long-standing problem." *Salazar v. District of Columbia*, 991 F. Supp. 2d 39, 60 (D.D.C. 2014). Defendants are in significant violation of the Court's Dental Order of October 18, 2004 ("Dental Order"). The parties' efforts to arrive at a solution through mediation have been unsuccessful. Through this motion, plaintiffs seek to enforce the Dental Order.

Plaintiffs request that this Court impose interim performance goals and the submission of a five-year Corrective Action Plan ("CAP") that provides detailed and verifiable steps toward full compliance with the Dental Order by 2020.[1] As explained below, several of the interim performance goals that plaintiffs seek are the same as the requirements imposed by the Centers for Medicare & Medicaid Services ("CMS") except that plaintiffs seek satisfaction of these goals by the end of FY 2016 instead of FY 2015 due to the fact that defendants were unable to meet these goals by the end of FY 2015.

BACKGROUND

In 1993, plaintiffs filed this class action, alleging that defendants were administering the District of Columbia (the "District") Medicaid program in a manner that systematically deprived plaintiffs of various rights under Title XIX of the Social Security Act (42 U.S.C. 1396, *et seq.*) and accompanying regulations (42 C.F.R. 430, *et seq.*). The subclass of all Medicaid-enrolled children alleged that defendants were depriving the subclass members of their right to receive the early and periodic screening, diagnosis, and treatment ("EPSDT") services required by federal law. In 1996, following a seven-day bench trial, this Court agreed that "[d]efendants ha[d]

[1] On January 15, 2016, defendants submitted their 2016 CAP. ECF No. 2078-1 (attached here as Pl. Ex. 30). The Five-Year CAP would replace the 2016 CAP and defendants would be relieved of their obligation to submit annual CAP's under paragraph 2 of the Dental Order.

violated [the EPSDT statute and regulations] * * * and the accompanying HCFA guidelines, by failing to provide EPSDT services to eligible children in the District of Columbia." *Salazar v. District of Columbia*, 954 F. Supp. 278, 331 (D.D.C. 1996).[2]

While that judgment was pending on appeal by defendants, the parties reached a comprehensive settlement agreement, which this Court approved and entered as the January 25, 1999 Settlement Order (hereafter "Settlement Order"). ECF No. 663. Paragraph 36 of the Settlement Order requires that "[d]efendants shall provide or arrange for the provision of early and periodic, screening, diagnostic, and treatment (EPSDT) when they are requested by or on behalf of children." The federal Medicaid Act, 42 U.S.C. 1396d(r)(3), provides that EPSDT services include preventive and therapeutic dental care.

Since entry of the Settlement Order, the parties have filed numerous motions concerning defendants' obligations to provide EPSDT dental services. Plaintiffs began with two motions to enforce paragraph 36 of the Settlement Order with respect to EPSDT dental services, the first of which was filed on July 3, 2002. *See* ECF No. 885 (Motion to Enforce the Settlement Order of January 25, 1999, Concerning Lead and Dental Services). On February 28, 2003, the Court found that "the vast majority of children within the class covered by this litigation who should receive * * * dental services are not getting them." ECF No. 928, p. 1. The Court then ordered the Court Monitor, Dr. Henry T. Ireys, to prepare a report on the effectiveness of the methods used by the District's Medicaid agency and the managed care organizations ("MCO's") for informing Medicaid recipients about EPSDT dental services. ECF No. 928, para. 3. Filed on June 17, 2003, Dr. Ireys' report found that most Medicaid-enrolled children were "not receiving

[2] The Health Care Finance Administration ("HCFA") was a division within the U.S. Department of Health and Human Services when this Court wrote its 1996 merits opinion. In has since been replaced by CMS.

adequate dental care" and recommended strategies for the District to address the situation. ECF No. 1010, Pl. Ex. 1, p. 1.

On April 23, 2004, plaintiffs filed a second motion to enforce. ECF No. 1010 (Motion to Enforce the Settlement Order of January 25, 1999 and the Order of February 28, 2003, Concerning Dental Services). On October 18, 2004, the Court held that defendants were in violation of paragraph 36 of the Settlement Order and 42 U.S.C. 1396d(r)(3) and granted plaintiffs' motion in part. ECF No. 1034. That same day, the Court entered an Order (hereafter "Dental Order") requiring that defendants undertake specific activities to ensure that EPSDT-eligible children in the District receive the EPSDT dental services to which they are entitled under federal law. ECF No. 1033. It is this Dental Order that plaintiffs now seek to enforce.

On May 26, 2006, after abandoning their appeal of the Dental Order before the court of appeals,[3] defendants filed an unsuccessful motion to vacate the Dental Order. ECF No. 1153 (Motion to Vacate the Court's Order Granting Injunctive Relief Dated October 18, 2004).[4] On June 8, 2006, following defendants' repeated failures to meet the Dental Order's deadlines, plaintiffs filed a motion to impose penalties on defendants. ECF No. 1159 (Motion for an Order

[3] Defendants initially appealed the Dental Order to the court of appeals in November 2004 (ECF No. 1036; D.C. Cir. No. 04-7200), but they filed a motion to hold the appeal in abeyance shortly thereafter in January 2005 (ECF No. 1171, Pl Ex. 2) and voluntarily dismissed the appeal in March 2006 (ECF No. 1588-6).

[4] On February 18, 2010, the Court denied defendants' Motion to Vacate the Dental Order. *Salazar v. District of Columbia*, 685 F. Supp. 2d 72 (D.D.C. 2010). The court found that "[v]irtually all the arguments made by Defendants * * * were made, examined, and rejected in the Court's Opinion of October 18, 2004" and there was "no justification – no change in the law or the facts, no unforeseen obstacles which have made the Order unworkable, and no evidence that its enforcement would be detrimental to the public interest – that would support vacating the Dental Order." *Id.* at 79, 81. After appealing this decision, defendants filed a motion in this Court to stay the Dental Order pending the appeal (ECF No. 1574), which the Court denied (ECF No. 1599). On February 8, 2011, the court of appeals affirmed this Court's denial of defendants' Motion to Vacate. *Salazar v. District of Columbia*, 633 F.3d 1110 (D.C. Cir. 2011).

Imposing Penalties for Defendants' Failure to Comply with the Order of October 18, 2004) (hereafter "2006 Enforcement Motion"). In that motion, plaintiffs sought, *inter alia*, an order that all of defendants' future corrective action plans comply with the Dental Order and that the Court set forth new deadlines for various Dental Order requirements and a schedule of penalties to be imposed if defendants failed to comply with them. ECF No. 1159.[5]

In September 2010, plaintiffs filed a Motion to Modify the Court's Dental Order (hereafter "2010 Motion to Modify") (ECF No. 1627), which was never fully briefed.[6] In

[5] The court dealt separately with the penalty and non-penalty issues in plaintiffs' 2006 Enforcement Motion. First, on July 10, 2006, the Court partially disposed of plaintiffs' 2006 Enforcement Motion by entering a Memorandum Opinion and Order (hereafter "Penalties Order") that granted plaintiffs' request for a schedule of stipulated penalties and required plaintiffs to file a praecipe after any calendar quarter in which defendants accrued penalties. *See* ECF Nos. 1175, 1176. Accordingly, plaintiffs filed praecipes for the third and fourth quarters of 2006 (ECF Nos. 1234, 1261), the second and third quarters of 2007 (ECF Nos. 1296, 1317), and the first quarter of 2008 (ECF No. 1354). On August 13, 2008, the Court adjudicated these five praecipes, assessing $931,050 in penalties against defendants for a variety of missed deadlines and other violations of the Court's orders, of which $50,000 in penalties stemmed from violations of the Dental Order. *See Salazar v. District of Columbia*, 570 F. Supp. 2d 105, 109-110 (D.D.C. 2008) (assessing $38,500 in 2006 penalties against District for its failure to meet original Dental Order deadline and multiple subsequent extensions for distributing the Dental Brochure); *id.* at 110 (admonishing District that its "enormous data problems" provide no excuse for its 2007 decision to "simply ignor[e]" the Dental Order's requirement that the Annual Oral Health Summary Report include data regarding utilization of dental services by child fee-for-service beneficiaries); *id.* at 112-114 (assessing $11,500 in 2008 for failure to submit a timely Dental Corrective Action Plan as required by the Dental Order). Throughout the opinion, the Court reserved particular criticism for defendants' repeated decisions to "simply ignor[e]" deadlines and other express requirements of court orders when defendants thought they might not be able to comply, instead of moving for relief or an extension of time. *Id.* at 110.

Second, as to the non-penalty issues raised in the 2006 Enforcement Motion, plaintiffs filed supplemental briefs and praecipes in January 2007 (ECF No. 1268), April 2007 (ECF 1284), April 2008 (ECF No. 1349-2), and March 2009 (ECF No. 1447-2). On March 23, 2011, the Court issued an order denying the remainder of plaintiffs' 2006 Enforcement Motion, without prejudice, in light of the fact that plaintiffs had filed a subsequent motion on the same subject in September 2010. ECF No. 1731.

[6] In November 2010, defendants filed their Opposition to Plaintiffs' 2010 Motion to Modify (ECF No. 1649), which raised issues necessitating plaintiffs filing in December 2010 a motion for leave to conduct limited discovery (ECF No. 1661). The Court granted plaintiffs' motion in (continued…)

December 2010, after defendants allowed the MCO's to reduce the rates that they paid dentists to treat Medicaid-enrolled children, which plaintiffs argued violated paragraph 2(a)(2) of the Dental Order, plaintiffs filed a motion to hold defendants in contempt (ECF No. 1667). This motion was also not fully briefed. In November 2011, the parties entered into settlement discussions concerning both pending motions, which led to a January 2011 consent motion to stay briefing in both pending motions (ECF No. 1771), followed a few months later by plaintiffs' notice withdrawing both motions (ECF No. 1789).[7]

In April 2012, the parties requested that the Court refer the case to mediation, which the Court granted. ECF No. 1790. From July 2012 to August 2014, the parties engaged in extensive mediation under the direction of Chief Circuit Mediator for the District of Columbia Circuit, Amy Wind. During this time, plaintiffs abstained from filing motions related to the Dental Order and withdrew their pending motions. *See* ECF No. 1789. Mediation formally concluded in 2015 after the parties reached an impasse.

Plaintiffs now move to enforce the Dental Order to rectify defendants' long-standing violations of the requirements of that order.

ARGUMENT

Paragraph 36 of the Settlement Order requires that defendants "provide or arrange for the provision of early and periodic, screening, diagnostic and treatment services (EPSDT) when they are requested by or on behalf of children." ECF No. 663. Under federal Medicaid law, EPSDT services include comprehensive preventive and therapeutic dental care, "which shall at a

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part in February 2011 (ECF No. 1706). Plaintiffs ultimately filed motions to stay briefing (ECF No. 1771) and then to withdraw the motion (ECF No. 1789).

[7] *See also Salazar v. District of Columbia*, 991 F. Supp. 2d 39, 60-61 (D.D.C. 2014) (recounting the procedural history).

minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health." 42 U.S.C.1396d(r)(3).

In the Memorandum Opinion accompanying the Dental Order, this Court held that defendants were in violation of paragraph 36 because their record of providing EPSDT dental services was "abysmal." ECF No. 1034, pp. 8-9. The Court held that the federal EPSDT statute "places affirmative obligations on states to assure that [EPSDT] services are actually provided * * * in a timely and effective manner." *Id.*, pp. 5-6. This includes an obligation to "'aggressively notify, seek out and screen'" children to detect health problems and provide treatment. *Id.*, p. 6.

Accordingly, the Court imposed interim and final performance goals in its Dental Order. The six performance goals imposed under paragraph 2(e) are the heart of the Dental Order. *See* ECF No. 1033, para. 2(e). *See generally* ECF 1034, pp. 9-11 (finding such goals to be "appropriate" for various reasons). The court of appeals recognized the goals as enforceable requirements. *Salazar v. District of Columbia*, 633 F.3d 1110, 1113 (D.C. Cir. 2011)("The District government was ordered to * * * meet specific participation goals * * *").

The goals are (ECF No. 1033, para. 2(e)(i)-(vi)):

(i) an oral health risk assessment by a primary care provider ("PCP") for 80% of children age 6-12 months;

(ii) an oral health risk assessment by a PCP for 80% of children age 12-24 months;

(iii) an oral health screening by a licensed dentist for 85% of children entering school for the first time;

(iv) placement of protective sealants on the permanent teeth of 70% of children age 8-14 years;

(v) any dental service for 80% of children age 3-20 years as reported at line 12a of the CMS Form 416; and

(vi) any preventive dental service for 80% of children age 3-20 years as reported at line 12b of the CMS Form 416.

The Court ordered that defendants comply with these "final goals no later than **September 30, 2007**" (emphasis in original), and that defendants "shall include [in the CAP] the specific interim goals and deadlines that Defendants shall meet" on their way to achieving the final performance goals.[8] ECF No. 1033, para. 2(e). The Court said that the importance of having "specific goals and deadlines" is that they are "designed to focus Defendants' efforts on concrete steps to meet their overall EPSDT obligations." ECF No. 1034, p. 9.

I. DEFENDANTS ARE IN VIOLATION OF THE REQUIREMENT TO PROVIDE PROTECTIVE SEALANTS

Paragraph 2(e)(iv) of the Dental Order requires that no later than September 30, 2007, "[a]t least **70 percent** of all EPSDT-eligible 8-14 year-olds receive protective sealants on their permanent teeth" (emphasis in original).[9] Only 21 percent received protective sealants in FY 2014.[10] Pl. Exs. 5, 7; *see also* Pl. Ex. 6.

[8] Paragraph 2 of the Dental Order requires defendants to develop and submit a CAP annually.

[9] Sealants are thin plastic coatings applied to the chewing surfaces of teeth, especially to permanent molars, which are the teeth most likely to develop cavities. Sealants act as a barrier against bacteria that causes decay. Affidavit of William Maas, DDS, MPH, MS (hereafter "Maas Aff."), Pl. Ex. 14, para. 6. It only takes a few minutes to apply a sealant. *Ibid*. Dental sealants reduce decay in permanent molars by 81% approximately 2 years after placement and continue to be effective up to 4.5 years after placement. *Ibid*.

[10] Paragraph 3 of the Dental Order requires compliance reporting using the same age categories as reported on CMS Form 416. The relevant age categories in CMS Form 416 are 6-9 and 10-14. *See* Pl. Exs. 1-4. Using these age categories, instead of ages 8-14 as set forth in the Dental Order, the percentage of eligible children receiving sealants is 20.5 percent. Pl. Ex. 5.

(continued…)

The 2015 CAP fails to acknowledge this noncompliance. *See* Pl. Ex. 9. The 2015 CAP also fails to provide any details as to the steps defendants plan to take to achieve compliance with the sealant goal. *See ibid.* In fact, other than including the sealant goal in the list of all of the goals at the top of the first page, the 2015 CAP is silent about sealants.[11] The 2016 CAP acknowledges the noncompliance and sets an interim goal of increasing the percentage to 27 percent through a 2 percent increase every year.[12] Pl. Ex. 30, p. 1. The 2016 CAP does not

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These percentages overstate the number of eligible children receiving sealants under the Dental Order. The CMS Form 416 data are limited to eligible children who received a sealant on a single permanent molar. Pl. Ex. 4, line 12d. The Dental Order requirement is for "sealants on their permanent teeth." ECF No. 1033, para. 2(e)(iv). In other words, the requirement is for sealants on all permanent molars, not just a single molar.

Under paragraph 3 of the Dental Order, defendants are required to submit an "Annual Assessment of Oral Health." These annual reports do not provide data in a manner that permits assessment of defendants' compliance with paragraph 2(e)(iv). The annual reports provide gross data and do not provide for the calculation of percentages for comparison to the goals in paragraph 2(e)(iv) or any of the other goals in paragraph 2(e).

Thus, the CMS Form 416 data are the best data available to assess defendants' compliance with paragraph 2(e)(iv). Even with the deficiencies in these data, they show a significant violation of the sealant goal.

In order to establish consistency between the Dental Order and the CMS Form 416 reporting, plaintiffs suggest that the Court use the 6-14 age group rather than the 8-14 age group to measure defendants' compliance with paragraph 2(e)(iv). As plaintiffs' expert, Dr. Maas, explains in this affidavit, the critical ages for the application of sealants are 6 and 7 for the initial permanent molars and 12 and 13 for the secondary or second set of permanent molars. Maas Aff., para. 6. Thus, the CMS age group is better suited to evaluating that sealants are provided to the optimal ages.

Furthermore, as discussed below (p. 13), defendants should be required to conduct a survey to obtain the data to assess compliance with this requirement, but, more importantly, to aid in the development of strategies that are targeted to improving the delivery of this extremely important preventive oral health measure.

[11] As discussed in Part VI below, the 2015 CAP discusses only three of the six performance goals.

[12] The 2016 CAP merely states "2 percentage points every year"; it does not specify the number of years it is expected to take to satisfy this interim goal -- a goal that is far below the long-overdue sealant goal of 70 percent. *See* Pl. Ex. 30, p. 1.

provide concrete steps as to how sealants will be delivered to more children and how defendants will overcome their significant noncompliance with the Dental Order. As addressed in Part VI below, the 2016 CAP violates the Dental Order in both scope and specificity.

The Court should require that the Five-Year CAP set forth specific requirements, including concrete steps and measurable, interim deadlines and numerical goals, designed to reach full compliance with the sealant goal by September 30, 2020.[13] Essentially, the Five-Year CAP should be a plan that explains how defendants will move from their current level of significant noncompliance to full compliance with the sealant goal.

As an interim goal, the Court should impose a deadline for defendants to achieve the increase in sealants called for under the CMS Oral Health Initiative. The CMS Oral Health Initiative set a national goal for all states and the District of Columbia to increase by ten percentage points the proportion of children ages 6-9 who annually receive a sealant on a permanent molar by the end of FY 2015. Pl. Ex. 12. The ten percentage points are measured from the baseline year FY 2011. *Ibid.* The District did not adopt its plan for satisfaction of the CMS Oral Health Initiative goal until the summer of 2015. Excerpt of Transcript of July 1, 2015 Status Conference, pp. 29-30 (Ms. Sonosky reported that the plan was not final yet)(Pl. Ex. 24); E-mail from Ms. Sonosky, July 20, 2015, reporting that the plan was available (Pl. Ex. 25). Thus, it was not possible for defendants to meet the ten percentage point goal by September 30, 2015. Defendants acknowledge that their plan does not use the FY 2011 and FY 2015 baseline

[13] To ensure compliance with the September 30, 2020, deadline, the Court should impose civil penalties pursuant to the July 10, 2006, Civil Penalty Order (ECF No. 1175) for each day defendants fail to meet the September 30, 2020, deadline for any of the requirements in paragraph 2 of the Dental Order. Such advance notification of the consequence of non-compliance is much more likely to spur defendants to compliance than the present situation where defendants have violated the Dental Order with impunity.

and goal years of the national initiative. *See* Pl. Ex. 13, p. 1 ("Increase the proportion * * * who receive a dental sealant on a permanent molar by 10 percentage points over five-year period (baseline year TBD)"). Although the initiative goal does not extend to the full range of children covered by the sealant requirement in the Dental Order,[14] this Court, at a minimum, should require defendants to meet the 10 percentage points increase by the end of FY 2016 as measured from the baseline of FY 2011.

To meet the initiative goal and the long-overdue sealants goal of 70% in the Dental Order, defendants should be required to adopt a number of strategies. For example, defendants should improve the sealants percentage by ensuring that children ages 6-14 are referred to a Dental Home for the application of sealants as part of a pediatric health check.[15] Maas Aff., para. 8. Currently, the DC Medicaid HealthCheck Periodicity Schedule has no oral health recommendation for children older than 6 years. *See* Pl. Ex. 21, p. 1. The Periodicity Schedule is a reference list for physicians of the recommended health checks for children based on age. Maas Aff., Pl. Ex. 14, para. 8. The Periodicity Schedule should be modified for ages 6-14 to add Oral Health Assessments designed to refer these patients to a Dental Home for application of sealants. *Ibid*. Such referrals are likely to increase the number of children receiving sealants. *Ibid*.

Defendants should be required to improve the percentage of children who receive sealants by expanding school-based sealant programs to high-need schools. Maas Aff., Pl. Ex.

[14] The initiative goal applies only to children ages 6-9 whereas the Dental Order applies to children 8-14. However, as discussed above, the Initiative's goal targets the critical ages 6 and 7 for the application of sealants to the initial permanent molars. Maas Aff., para. 6.

[15] "A Dental Home is where all aspects of a child's oral health care is delivered in a comprehensive, continuously accessible, and coordinated way by a single dental practice." Pl. Ex. 21, n. 8.

14, para. 9. School-based dental sealant delivery programs, according to Dr. Maas, "provide sealants to students either onsite at schools (using portable dental equipment or mobile dental facilities) or offsite in dental clinics with transportation between the school and clinic provided." *Ibid.* School-based sealant programs have been proven highly effective in preventing tooth decay and improving dental health. *Ibid.* For this reason, they are recommended by the U.S. Community Preventive Services Task Force, an independent, non-federal, unpaid panel of public health and prevention experts that provides evidence-based findings and recommendations about community preventive services, programs, and policies to improve health. *Ibid.* In 2013, as part of its children's dental health campaign, The Pew Center on the States released a report on all 50 states and the District of Columbia on their performance in sealing the teeth of low-income children. Pew Center on the States, "Falling Short Most States Lag on Dental Sealants," January 2013 (hereafter "2013 Pew Report"), Pl. Ex. 15. In 2015, The Pew Center on the States released a follow-up report on the states' progress toward meeting the recommended actions in the 2013 report. Pew Center on the States, "States Stalled on Dental Sealant Programs," April 2015 (hereafter "2015 Pew Report"), Pl Ex. 16. The 2013 and 2015 Pew Reports found that fewer than 25% of the high-need schools in the District of Columbia have sealant programs.[16] Pl. Ex. 15, p. 8; Pl. Ex. 16, p. 6; *see* also Pl. Ex. 17.[17]

In conjunction with such an effort, defendants need to overcome the parental concern and fear about this dental procedure that likely suppresses the number of children who receive

[16] Defendants have indicated that they plan to develop school-based health centers, but do not have a timeline for doing this. *See* Oral Health Initiative, Pl. Ex. 13, p. 12.

[17] The 2013 and 2015 Pew Reports refer to a school as "high need" when a majority of the students at a school participate in the federal free or reduced price lunch program. Pl. Ex. 15, p. 8; Pl. Ex. 16, p. 19.

sealants by convincing the children that sealants are desirable and painless. Maas Aff., para. 11. This should be accomplished through school-based educational programs. *Ibid*. "Teachers should be trained to present information on sealants as part of health curriculums in first, second, fifth, and sixth grades when students are at the critical ages for the application of sealants on permanent molars." *Ibid*. This information should be designed to convince students that they want sealants.[18] If teachers and students are convinced of the value of sealants, parents will be more likely to arrange for or consent to the application of sealants.

Defendants should also improve the percentage of children receiving sealants by authorizing the application of sealants in school-based programs by dental hygienists. The District presently has one of the most restrictive rules in the country concerning the services that dental hygienists may perform. Maas Aff., para. 10; Pl. Ex. 16, pp. 3, 7, 15. It requires examination by a dentist prior to the placement of a sealant by a hygienist. Maas Aff., para. 10; Pl. Ex. 16, pp. 3, 7. As explained by Dr. Maas (para. 10), experts have determined that a visual assessment by a dental hygienist is acceptable before the placement of sealants. *See also* Pl. Ex. 16, p. 3.[19] A bill providing for sealant application by dental hygienists and assistants under the supervision of a dentist but without a prior examination by a dentist has been pending before the

[18] For the younger students, a video similar to that offered by the Columbus Ohio Department of Health could be used to explain this painless procedure to students. Maas Aff., para. 12. The video is available at http://mchoralhealth.org/seal/video.html. Such a video could also be made available online for the students to show their parents. Such a video could also be made available through other venues designed to increase exposure to the information about the benefits of sealants.

[19] The District of Columbia received an "F" rating from Pew in 2015 due to its lack of a sealant program in high-need schools and its requirement of an examination by a dentist before a dental hygienist could administer a sealant. Pl. Ex.16, p. 3; Pl. Ex. 17. The District received the same failing grade in the 2013 Pew Report. Pl. Ex. 16, p. 3. According to Pew, the prior examination requirement "runs counter to growing evidence that a dentist's exam is not necessary before a sealant is put in place." *Ibid*.

City Council since April 2013. Children's Oral Health Care Amendment Act of 2013, B20-0227, Pl. Ex. 29. Defendants have acknowledged that passage of this bill would increase delivery of dental sealants. Pl. Ex. 13, p. 6. Rather than wait for the passage of this bill, which is not limited to schools and may incur some opposition from dentists, defendants should authorize sealant application in school-based programs by a dental hygienist without prior examination by a dentist.

Critical to assessing compliance and improving the delivery of sealant services is determining how many children have received sealants and which populations should be targeted for sealant application. Maas Aff., para. 13. Defendants should conduct surveys every five years to obtain these data with the first survey to be completed by September 30, 2016. *Ibid*. The District's dental director should be able to design and conduct such a survey. *Ibid*. Defendants should also conduct school-based screening for sealants. *Id.*, para. 14. To ensure that more students participate, an opt-out approach, rather than an opt-in one, should be used for such screenings. *Ibid*. From such screenings, students without the appropriate number of sealants should be referred promptly to school-based sealant delivery programs.[20] [21] *Ibid*.

Strategies such as these with very concrete steps and deadlines should be required in the Five-Year CAP.[22]

[20] Parental consent for the application of the sealants becomes much more likely if educational programs, as discussed above, have convinced students of the value of having this painless procedure performed.

[21] All requirements for school-based programs should also apply to charter schools.

[22] Plaintiffs acknowledge that during the December 10, 2015, Status Conference, defendants generally indicated that they were taking steps to improve the delivery of sealants and other dental services. *See* Pl. Ex. 31, pp. 17-18. Whatever steps defendants are taking or planning can be built into the Five-Year CAP.

In addition to these strategies, plaintiffs believe that the delivery rate of sealants would benefit from the use of the monies in the Penalty Escrow Fund. Accordingly, plaintiffs urge the Court to require all parties to submit a proposal for use of escrow funds to improve the delivery of sealants. Each proposal should provide specific information as to how the escrow fund monies would be expended. The Court should select the proposal(s) most likely to improve the delivery rate and allocate the funds.

II. DEFENDANTS ARE IN VIOLATION OF THE REQUIREMENT TO PROVIDE PREVENTIVE DENTAL SERVICES

Paragraph 2(e)(vi) of the Dental Order requires that no later than September 30, 2007, "[a]t least **80 percent** of all EPSDT-eligible children 3 years of age and older receive 'preventive dental services' as reported in line 12b of the CMS Form 416" (emphasis in original). ECF No. 1033. Only 56 percent of these children received preventive dental services in FY 2014. Pl. Ex. 18. If all eligible children ages 1-20 are included, as defendants have done in their reporting to the Court, the percentage is 53%. Pl. Ex. 7, p. 2; Pl. Ex. 18.

The 2015 and 2016 CAP's acknowledges this noncompliance implicitly by setting an interim goal of increasing the percentage by two percent. *See* Pl. Exs. 9, 30. A two percent increase falls far short of the long-overdue 80 percent requirement. The Court should require that the Five-Year CAP set forth specific requirements, including concrete steps and measurable, interim deadlines and numerical goals, designed to reach full compliance with the preventive services goal by September 30, 2020.

As an interim goal, the Court should also impose a deadline for defendants to achieve the increase in preventive services called for under the CMS Oral Health Initiative. The CMS Oral Health Initiative set a national goal for all states and the District of Columbia to increase by ten percentage points the proportion of children ages 1-20 who receive an annual preventive dental

service by the end of FY 2015. Pl. Ex. 12, p. 2. The ten percentage points are measured from the baseline year FY 2011. *Ibid*. The District did not adopt its plan for satisfaction of the CMS Oral Health Initiative goal until the summer of 2015. Excerpt of Transcript of July 1, 2015 Status Conference, pp. 29-30 (Ms. Sonosky reported that the plan was not final yet)(Pl. Ex. 24); E-mail from Ms. Sonosky, July 20, 2015, reporting that the plan was available (Pl. Ex. 25). Thus, it was not possible for defendants to meet the ten percentage point goal by September 30, 2015.[23] This Court should require defendants to meet the 10 percentage point increase by the end of FY 2016 as measured from the baseline of FY 2011,[24] so that at least 60% of children ages 1-20 have received a preventive dental service by that time.

In order to meet this interim goal and to put them on track to satisfying the long-overdue final preventive services goal, defendants should be required to adopt a number of strategies. By increasing the number of children who receive sealants, defendants increase the number of children receiving preventive services. This is because the reporting for sealants on line 12d of CMS Form 416 is included in the reporting for preventive services on line 12b. Instructions for Form CMS 416 Annual EPSDT Participation Report, pp. 6-7 (HCPCS Code D1351 for sealants is within the range of codes for preventive services (HCPCS Codes D1000 - D1999))(Pl. Ex. 19).

[23] Unlike for the sealants goal, defendants did utilize the goal and baseline years of FY 2015 and FY 2011, respectively, from the CMS Oral Health Initiative. *See* Pl. Ex. 13, p. 1. The FY 2011 baseline for ages 1-20 was 49.7%. Pl. Ex. 18.

[24] In order to establish consistency between the Dental Order and the CMS Oral Health Initiative goal, plaintiffs suggest that the Court use the 1-20 age group from the Initiative (*see* Pl. Ex. 12, p. 2; Pl. Ex. 13, p. 1) rather than the 3-20 age group from paragraph 2(e)(vi) of the Dental Order to measure defendants' compliance with this interim goal.

Another strategy is for defendants to increase their efforts to encourage the delivery of fluoride varnish treatments through pediatric primary care providers.[25] Maas Aff., para. 16; *see* Pl. Ex. 7, p. 2; Pl. Ex. 13, p. 6. As we show below, defendants are not providing the compensation needed to encourage primary care providers to deliver fluoride varnish treatments or other oral health services. This Court has previously recognized that low compensation rates suppress dental provider participation. *See* ECF No. 1034, pp. 11-12. The same is true of primary care providers, except that defendants' practice in this regard not only lacks incentive, it provides a disincentive. It is not enough for defendants to encourage pediatric primary care providers to incorporate fluoride varnishes into well-child visits, the providers must be properly compensated to provide the needed incentive to incorporate this additional function into well-child visits. Instead many providers are being asked by defendants to provide these additional services without any additional compensation.

In 2014, defendants instituted a new billing practice for primary care providers who provide well-child care visits. Pl. Ex. 22, p. 1. That new practice provides separate screening codes and increased compensation for the provision of oral health services as part of well-child care visits. *Id*., p. 2. Separate screening codes allow defendants to track compliance under the Periodicity Schedule and under the Dental Order. Increased compensation provides much needed incentives to increase the delivery of these oral health services by providers. However,

[25] The U.S. Preventive Services Task Force, an independent, volunteer panel of national experts in prevention and evidence-based medicine, "recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption."

See http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/dental-caries-in-children-from-birth-through-age-5-years-screening.

this new coding practice and its increased compensation do not apply to the pediatric primary care providers serving the majority of eligible children.

First, the new practice and compensation do not apply to MCO's where compensation is on a capitated basis. Pl. Ex. 23, p. 3. Nearly 94% of the EPSDT-eligible beneficiaries are cared for by MCO's. *See* Pl. Ex. 4.[26] These MCO-providers are expected by defendants to add the training, time, and personnel needed to offer fluoride varnish services for the same level of compensation provided for a well-child visit without fluoride varnish services. *See* Pl. Ex. 23, p. 3. It is highly unlikely that these pediatric primary care providers will add services and effectively reduce their compensation. Instead, these pediatric primary care providers should receive separate reimbursement for performing fluoride varnishes and other dental-related services so there is sufficient incentive for them to undertake the necessary training and to incorporate the necessary time and personnel into their well-child appointments. Defendants should apply the same or comparable compensation and coding to MCO-providers as fee-for-service providers in order to increase the percentage of eligible children receiving preventive dental services under the Dental Order.[27]

Second, federally qualified health clinics (FQHC's) are likewise excluded from the new levels of compensation. Pl. Ex. 23, p. 3. Although their rates are bundled rather than capitated, the impact is the same. Defendants expect them to provide these additional oral health services without additional compensation. FQHC's, such as Mary's Center and Unity Health Care, Inc.,

[26] Line 1a of the overall CMS Form 416 states that there are a total of 98,350 eligible children (Pl. Ex. 4) and line 1a of the Fee-for-Service CMS Form 416 states that there are 5,934 individuals in fee-for-service (Pl. Ex. 26). Thus, there are 92,416 MCO children, or nearly 94% of the overall number of eligible children.

[27] In addition, two of the four MCO's have had "significant declines in the[ir] 'well child' visit rate." Pl. Ex. 32, p. 19. Such declines result in fewer opportunities to provide fluoride varnishes.

which are two of the four largest pediatric provider practices in the District of Columbia, provide services to a significant percentage of eligible EPSDT children. ECF No. 2049, pp. 1-2. Defendants should apply the same or comparable compensation and coding to FQHC's as fee-for-service providers in order to increase the percentage of eligible children receiving preventive dental services under the Dental Order.

III. DEFENDANTS ARE IN VIOLATION OF THE REQUIREMENT TO PROVIDE ANY DENTAL SERVICES

Paragraph 2(e)(v) of the Dental Order requires that no later than September 30, 2007, "[a]t least **80 percent** of all EPSDT-eligible children 3 years of age and older receive 'any dental services' as reported in line 12a of the CMS Form 416" (emphasis in original). ECF No. 1033. Only 60.5 percent of these children received any dental services in FY 2014. Pl. Ex. 20.

The 2015 CAP acknowledges this noncompliance implicitly by setting an interim goal of increasing the percentage by two percent. *See* Pl. Ex. 9. A two percent increase falls far short of the long-overdue 80 percent requirement. The 2016 CAP does not include a specific interim goal for this requirement although its interim goals for sealants and preventative services advance this goal. *See* Pl. Ex. 30; Pl. Ex. 19, p. 6. The Court should require that the Five-Year CAP set forth specific requirements, including concrete steps and measurable, interim deadlines and numerical goals, designed to reach full compliance with the preventive services goal by September 30, 2020.

The interim goals that plaintiffs urge this Court to set for sealants and preventive services advance this goal as well. By increasing the number of children who receive sealants and other preventive services, defendants increase the number of children receiving any dental services. This is because the data for sealants on line 12d of CMS Form 416 and for preventive services on line 12b are included in the reporting on line 12a for any dental services. Pl. Ex. 19, p. 6.

IV. DEFENDANTS ARE IN VIOLATION OF THE REQUIREMENT TO PROVIDE SCHOOL-AGED CHILDREN AN ORAL HEALTH SCREENING BY A LICENSED DENTIST

Paragraph 2(e)(iii) of the Dental Order requires that no later than September 30, 2007, "[a]t least **85 percent** of all EPSDT-eligible children entering school programs for the first time receive an oral health screening by a licensed dentist" (emphasis in original). ECF No. 1033. Less than 60% percent of these children received such screenings in FY 2014. Pl. Ex. 27. To plaintiffs' knowledge, defendants do not report data specific to this requirement of the Dental Order. Defendants do report data as to the number of eligible children receiving preventive dental services. Since an oral health screening is a preventive dental service, plaintiffs have used these data as it relates to children ages 3-18 and 6-18 to measure defendants' compliance.[28] *See ibid*. However, the preventive dental services data overstates the level of compliance with the oral health screening requirement because what constitutes a preventative dental service may not be as significant a level of care as an oral health screening by a licensed dentist.[29] Nevertheless, defendants are significantly below the 85% required for compliance with the Dental Order.

The 2015 CAP implicitly acknowledges defendants' violation of this requirement since it identifies the need for further outreach to encourage the submission of oral health assessment forms to schools. *See* Pl. Ex. 9, p. 5. The 2016 CAP mentions nothing about increasing the submission of these forms; it is silent on this topic. *See* Pl. Ex. 30.

[28] Since a significant number of children between the ages of three and five attend school in the District, the calculations in Plaintiffs' Exhibit 27 include these children. Plaintiffs' Exhibit 27 also includes a calculation without these children.

[29] As discussed in Part II, the provision of fluoride varnishes by a primary care physician are included in preventative dental services. Obviously, such services are not being provided by a licensed dentist.

Defendants require annual submission of an oral health assessment form by each student, but submission is not mandatory for school attendance. DC Code 38-604. The form if provided by the student requires evaluation and signature by a dental provider. *See ibid*. Thus, based on these forms, defendants could provide data as to the level of compliance with paragraph 2(e)(iii) of the Dental Order. This Court should require defendants to provide annually the data as to the level of compliance with paragraph 2(e)(iii).

The Court should further require that the Five-Year CAP set forth specific requirements, including concrete steps and measurable, interim deadlines and numerical goals, designed to reach full compliance with this goal by September 30, 2020. The 2015 CAP provides no details as to how defendants intend to increase compliance with the requirement that school-aged children receive a screening by a dentist. *See* Pl. Ex. 9. Instead, it merely mentions provision of the form in school packets and "increased outreach through DCPS [District of Columbia Public Schools] to encourage submission." *Id*., p. 5. Provision of the form does not ensure that the screenings are conducted. The Five-Year CAP must provide specifics as to how defendants will increase the provision of screenings and will include the large number of children who attend charter schools. Such specifics are essential to the satisfaction of this goal.

As part of its Five-Year CAP, defendants should be required to establish incentive programs to encourage submission by each student of the oral health assessment form required by DC Code 38-604. Such programs should require defendants to modify the website maintained for the public school system to provide the following information on a per school, per school year basis: number of students enrolled; number of students submitting the oral health assessment form; percentage of students submitting the form. The same information should also be reported on each school's website. Annually, within 30 days of the of the submission to CMS

of the Form 416 for the applicable Fiscal Year, defendants should be required to report to the Court as to the level of compliance with paragraph 2(e)(iii) of the 2004 Dental Order.[30]

V. DEFENDANTS ARE IN VIOLATION OF THE REQUIREMENTS TO PROVIDE ORAL HEALTH ASSESSMENTS

Paragraphs 2(e)(i) and (ii) of the Dental Order require that no later than September 30, 2007, at least 80 percent of EPSDT-eligible children in the 6-24 month age range "receive at least one oral risk health assessment by a primary care provider as part of the Health Check visit." None of defendants' reporting permits calculation of the percentage of these children receiving an oral risk health assessment.[31]

However, in the 2015 CAP defendants acknowledge noncompliance implicitly by setting an interim goal of increasing the percentage by five percent. *See* Pl. Ex. 9. The 2016 CAP does not include an interim goal. *See* Pl. Ex. 30. The Court should require that the Five-Year CAP set forth specific requirements, including concrete steps and measurable, interim deadlines and numerical goals, designed to reach full compliance with the oral health assessment goal by September 30, 2020.

Although the 2015 CAP includes a 5 percent increase as an interim goal, the 2015 CAP lacks concrete steps as to how to achieve the interim goal or the long-overdue final goal of 80%. Other than the listing of the 5 percent interim goal, the 2015 CAP mentions assessments only

[30] These requirements should also apply to charter schools.

[31] Recently, defendants started requiring primary care providers to use a separate code to bill for oral health assessments conducted as part of a well-child visit. *See* Pl. Ex. 22, p. 2. The extent to which primary care providers have adopted defendants' new coding requirements is presently unknown. *See* Response of the District of Columbia to Notice Concerning Agenda for Status Conference Set for September 23, 2015, ECF No. 2063, item 7. If the new coding is generally adopted, compilation of the data from this coding would permit defendants to inform the Court and plaintiffs as to defendants' compliance with this goal. As addressed below, the Court should require such reporting.

once and in vague terms without any specifics as to what steps will be undertaken.[32] It states as an action item to eliminate a barrier related to the limited number of dentists willing to see children three or younger (Pl. Ex. 9, p. 2):

> 1.a.3. Implement training and billing capabilities for primary care providers to provide fluoride varnish along with assessment and education for children under 3.

This statement provides no specifics as to what steps will be taken to increase the number of oral health assessments performed by primary care providers. The Court should require defendants to take specific steps to improve the percent of children receiving oral health assessments. The Court should also require specific annual reporting that is targeted in such a manner as to allow assessment of defendants' compliance with this goal.

In order to increase compliance with this goal, defendants should be required to eliminate the disincentives for MCO-providers or FQHC's by providing them with compensation for the provision of oral health assessments that is comparable to that offered to fee-for-service providers. See pp. 16-18 above.

VI. DEFENDANTS' CORRECTIVE ACTION PLANS VIOLATE THE DENTAL ORDER IN SCOPE AND SPECIFICITY

In its Memorandum Opinion accompanying the Dental Order, the Court found that it "has discretion * * * to ensure the District of Columbia's compliance with paragraph 36 of the Settlement Order" by ordering defendants to prepare a corrective action plan or CAP. ECF 1034, p. 9. Defendants are required to "develop and submit" a CAP to the Court on or before January 15 of each year. ECF No. 1033, para. 2. The purpose of the CAP is "ensuring that all

[32] All other mentions of oral health assessments relate to school-aged children. *See* Pl. Ex. 9, pp. 5-6.

EPSDT-eligible children receive dental services." *Ibid*. The required contents of the CAP are as follows (*ibid.*):

> The CAP shall (i) identify all problems as to EPSDT-eligible children receiving dental services and the likely causes of those problems; (ii) develop a plan of action to eliminate the causes of those problems; (iii) establish a specified time frame for implementation of the plan; (iv) develop methods to prevent the problems from recurring; and (v) develop methods to monitor the plan to verify that the changes have been successful.

The Dental Order further specifies that the CAP must address at least five major problem areas: provider participation, provider training, coordination of dental services, outreach to beneficiaries, and performance goals. *See* ECF No. 1033, para. 2(a)-(e). In ordering the performance goals under paragraph 2(e), the Court intimated that their importance lie in the fact that they provide "specific goals and deadlines," both of which were "designed to focus Defendants' efforts on concrete steps to meet their overall EPSDT obligations." ECF No. 1034, p. 9.

This emphasis on specificity, both in the ultimate goal and the incremental steps necessary to get there, reflects an understanding long common in many fields: An ambitious goal is more likely to be achieved when expressed as a specific and measurable outcome with a deadline. *See* George T. Doran, There's a S.M.A.R.T. Way to Write Management's Goals and Objectives, 70 *Management Review* 35, 35-36 (1981) (seminal article advocating that goals and objectives be specific, measurable, assignable, realistic, and time-based).[33] The U.S. Centers for

[33] *See also* Goal Setting and Task Performance: 1969–1980, 90(1) *Psychological Bulletin* 125, 129 (1981), available at http://datause.cse.ucla.edu/docs/eal_goa_1981.pdf ("Previous research found that specific, challenging (difficult) goals led to higher output than vague goals such as 'do your best'. Subsequent research has strongly supported these results * * *" (internal citation omitted)); Gregory S. Ogrinc *et al*., Fundamentals of Health Care Improvement: A Guide to Improving Your Patients' Care, p. 52 (2d ed. 2012), available at https://ipecollaborative.org/uploads/EBPIMS111.pdf ("A stated time frame is an important element when chartering a [health care] quality improvement project. Stating a time frame gives (continued…)

Disease Control and Prevention ("CDC") is among the many public health organizations that have consistently emphasized the importance of selecting specific and measurable goals, which can then be broken down into a series of more manageable short-, medium-, and long-term objectives.[34]

According to the CDC, after establishing goals and a series of interim objective that meet the S.M.A.R.T. criteria, health care organizations should then identify the specific actions necessary to reach them, select quantitative indicators by which they can objectively measure the results of their efforts, collect data on those indicators, reach conclusions about the effectiveness of their efforts through periodic evaluation, and then recalibrate their efforts going forward based on the extent to which their current efforts are meeting their objectives and otherwise having the desired outcomes.[35] These are the key components of any serious plan to focus an individual or organization's attention on achieving a series of specific and measurable goals, to marshal and deploy the resources necessary to do so, and to create transparency and accountability.

Defendants' CAP's fail to satisfy these basic standards. They lack specific and measurable goals and deadlines. *See* Pl. Exs. 8, 9, 30. For example, defendants' Action Items lack quantification. The first Action Item in the 2015 CAP is "[c]ontinue to recruit additional

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a clear message to all involved that this is not a team that will stagnate but one that will reevaluate its goals at reasonable intervals").

[34] *See, e.g.*, CDC, Developing Program Goals and Measurable Objectives (Jan. 2007), available at http://www.cdc.gov/std/Program/pupestd/Developing%20Program%20Goals%20and%20Objectives.pdf; CDC, Introduction to Program Evaluation for Comprehensive Tobacco Control Programs, pp. 25-26 (2001), available at: http://www.cdc.gov/tobacco/tobacco_control_programs/surveillance_evaluation/evaluation_manual/.

[35] *See, e.g.*, CDC, Practical Use of Program Evaluation among Sexually Transmitted Disease (STD) Programs, pp. 2-3 (Jan. 2007), available at: http://www.cdc.gov/std/program/pupestd/Introduction.pdf.

dentists who see young children." Pl. Ex. 9, p. 1. This is neither specific nor measureable. Instead, this Action Item should be something like: "each year recruit 25 additional dentists who see young children." *See* CDC materials cited at footnotes 34 and 35 above.[36]

None of the Action Items identified in the 2015 CAP has a specific timeframe or deadline for completion. *See* Pl. Ex. 9. Instead, most the timeframes are listed as "on-going." The 2016 CAP is also deficient, but rather than listing "on-going," it just lists the last day of the year for most items. *See* Pl. Ex. 30. Concrete deadlines are needed so that the effectiveness of the Action Items can be evaluated.

Moreover, defendants' Action Items are too limited. This Court directed that the CAP must "identify all problems as to the EPSDT-eligible children receiving dental services and the likely causes of those problems" and "develop a plan of action to eliminate the causes of those problems." ECF No. 1033, para. 2. However, defendants' CAP's identify "Barriers to Achieving Compliance" and "Action Item(s) to Eliminate Barriers." Pl. Exs. 9, 30. While the identified barriers and actions to eliminate them are important, the identified barriers are a subset of the causes of the problems.

The 2016 CAP does not even attempt to "identify all problems as to the EPSDT-eligible children receiving dental services and the likely causes of those problems" and "develop a plan of action to eliminate the causes of those problems" as required by the Dental Order. ECF No. 1033, para. 2. It merely lists the provision of information in mailings and outreach to dental providers. *See* Pl. Ex. 30. More significantly, not all of the Dental Order's performance goals

[36] In other areas, defendants have shown their ability to prepare a professional plan for ensuring the delivery of critical preventive health care services. For example, the Department of Health's *DC Comprehensive HIV Prevention Plan for 2012-2015: Goals and Objectives*, although similar in purpose to DHCF's Dental Order CAP, sets forth a much more specific, measurable, and time-bound series of annual interim goals and action steps. *See* Pl. Ex. 28.

are addressed. For example, both the 2014 and 2015 CAP's mention sealants only once in the listing of the goals at the top of the first page. *See* Pl. Exs. 8, 9. Unlike the 2014 and 2015 CAP's, the 2016 CAP does mention sealants and sets an interim goal for increasing the delivery of sealants to eligible children. However, it fails to address the importance of and need for school-based sealant delivery systems as has been emphasized by The Pew Center on the States since its 2013 Report. Thus, defendants' CAP's fail to address the actions that need to be taken to address the problems associated with the delivery of sealant dental services to the EPSDT-eligible children. This is not what this Court intended when it imposed the performance goals and required annual CAP's designed to provide concrete steps for the satisfaction of the goals by the Court's deadlines.

Defendants' failure to submit and abide by CAP's that provide specific, measurable goals with concrete deadlines is not only a violation of the Dental Order; it likely explains the significant non-compliance with the Dental Order's performance goals. This Court must require that the Five-Year CAP set forth specific requirements, including concrete steps and measurable, interim deadlines and numerical goals, designed to reach full compliance with each performance goal. This Court should also require specific reporting that permits the Court and plaintiffs to verify defendants' compliance with each performance goal.

CONCLUSION

For the foregoing reasons, plaintiffs' motion should be granted.

Respectfully submitted,

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