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*

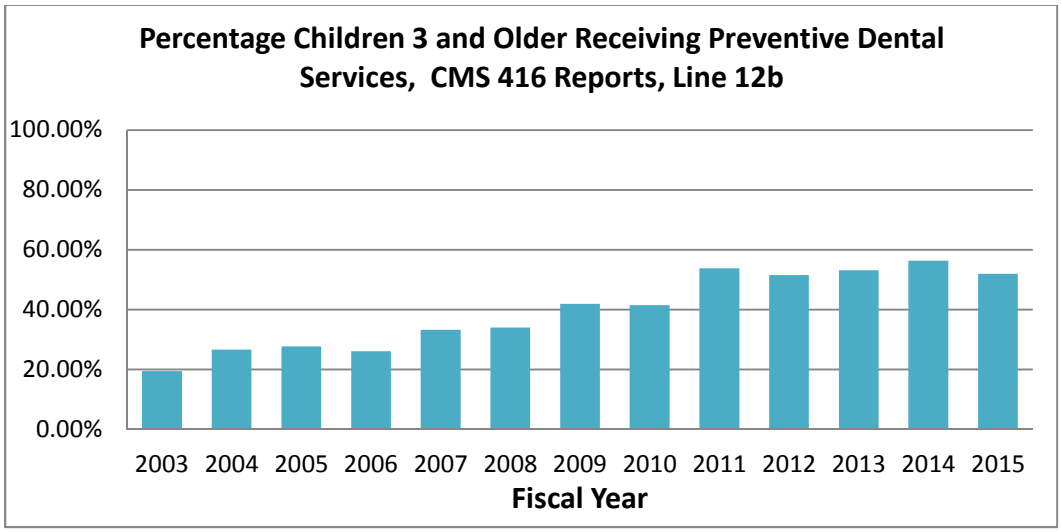
PLAINTIFFS' REPLY MEMORANDUM IN SUPPORT OF THEIR MOTION TO ENFORCE THE DENTAL ORDER OF OCTOBER 18, 2004

INTRODUCTION

In October 2004, this Court found defendants in violation of paragraph 36 of the Settlement Order with respect to dental services for children, because the District of Columbia ("the District") failed to provide or arrange for Early and Periodic, Screening, Diagnostic and Treatment Services (EPSDT) as required by 42 U.S.C. 1396d(r)(3) to "the vast majority of children in the class covered by this litigation * * *." Memorandum Opinion, ECF No. 1034, p. 2, 8. In response, the Court entered a comprehensive order requiring defendants to undertake specific activities to ensure EPSDT-eligible children in the District received the dental services to which they were entitled under federal law, imposing six specific performance goals, which were to be met by September 30, 2007.[1] *See* Order of October 18, 2004, ECF No. 1033 ("Dental Order"), para. 2.

[1] The six numerical 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 in line 12a of the CMS Form

Twelve years after the Dental Order was entered and, despite the many advantages that the District possesses due to its size, urban location, relatively high dentist-to-child ratio (State Oral Health Plan, Pl. Ex. 13, pp. 2-3),)[2] and adequate dental reimbursement rates (Declaration of Colleen Sonosky ("Sonosky Decl."), para. 110), the District has been unable to comply with any of the six performance goals in the Dental Order. In the first few years of the Dental Order, and especially after 2006, when the District increased dental reimbursement rates pursuant to the Order, the District doubled the number of children ages 3-20 receiving preventive dental services (26.10% in 2006 to 53.74% in 2011). *See* D.C. Preventive Dental Services, 2003-2015, Pl. Ex. 33, attached.



However, after 2011, the pace of improvement has slowed considerably. In the four years since 2011, defendants have been unable to make gains of more than 3% in the number of children receiving preventive dental services and are now beginning to lose earlier gains. *Ibid.* For the second time in the most recent four years, defendants provided fewer children ages 3-20

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

[2] Based on FY 2013 data provided in the District's State Oral Health Action Plan, there were 86,211 children enrolled in managed care (ECF No. 2094-14, p. 2), and 108 active dentists serving these same children (*id.*, p. 3). The ratio of dentists to children in managed care, was therefore 798 children for every dentist (86,211/108).

with preventive dental services than the prior year. *Ibid*. (56.32% in FY 2014 decreased to 52% in FY 2015). Defendants also provided fewer sealants to children in 2015 than they did in 2014. Sonosky Decl., para. 28 (20.54% in FY 2014 compared to 19.58% in FY 2015). This downward trend is occurring despite the measures that the District has taken to expand access to dental services.

To address defendants' continued violation of the Dental Order, and after an unsuccessful two-year effort at mediation, on February 16, 2016, plaintiffs filed a motion seeking an order from the Court to enforce the 2004 Dental Order by requiring defendants to impose interim performance goals and submit a five-year Corrective Action Plan ("CAP") setting forth specific requirements, including concrete steps and measurable, interim deadlines and goals, designed to reach full compliance with each of the paragraph 2(e) performance goals by September 30, 2020. Plaintiffs' Motion to Enforce the Dental Order of October 18, 2004, February 16, 2016, ECF No. 2094 ("Pl. Br.").

In response, defendants first claim plaintiffs have failed to comply with paragraph 80 the Settlement Order by failing to negotiate in good faith following plaintiffs' notice to defendants of their intent to enforce the Dental Order. The District of Columbia's Opposition to Plaintiffs' Motion to Enforce the Dental Order of October 18, 2004, ECF No. 2142 ("Def. Opp."), 7-9. We show below that paragraph 80 does not apply to the 2004 Dental Order. Nonetheless, plaintiffs gave defendants notice prior to filing this motion to gauge whether defendants were willing to negotiate a consent order and avoid the need for a litigated motion. Defendants responded that they wished to negotiate about their 2016 Dental CAP. However, plaintiffs reasonably determined that, after the two-year unsuccessful mediation effort, because defendants were not

willing to negotiate an order, further discussions would have been futile.[3]

As to the merits, defendants oppose both the five-year CAP and the September 30, 2020, deadline to reach full compliance, claiming that a CAP is unnecessary because the District has already "implemented significant measures to improve dental services," many of which plaintiffs' expert, Dr. William Maas, has suggested, and which have placed the District above national averages on several dental measures. Def. Opp. 9-14, 21. Indeed, plaintiffs recognize that some of defendants' efforts, as described in the District's current five-year State Oral Health Action Plan ("SOHAP"), and in more detail in the Declaration of Colleen Sonosky (Def. Ex. A), are a step in the right direction. However, they do not go nearly far enough either in concrete measures or in numerical goals to comply with the six performance goals in paragraph 2(e) of the Dental Order within a reasonable timeframe.

Defendants' rejection of the September 30, 2020, deadline to reach the numerical goals in the Dental Order by "the District or any other State in the Nation" as "unattainable" (Def. Opp. 15) is contradicted by the performance of other states, which like the District, have been or are subject to federal court oversight concerning the provision of dental services to Medicaid-eligible children. Calculation of States' Preventive Services, FY 2015, Pl. Ex. 35, attached. These states, including Texas and Connecticut have far outperformed the District in their provision of preventive dental services to Medicaid-eligible children ages 3-20. *Ibid*. (Compare 66.92% in Texas and 61.58% in Connecticut with 52% in the District). Moreover, in fiscal year 2015, the most current reporting year, 20 other states, many of whom have much fewer advantages than

[3] In addition, plaintiffs strongly object to defendants' submission of electronic-mail messages setting forth the views of counsel regarding the reasons that the Dental Order mediation failed. ECF No. 2142-9. The provision of such information to the Court is contrary to Local Rule 84.9(a)(1) and the specific instructions of Court Mediator Amy Wind concerning the confidentiality of mediation. *See* Pl. Ex. 34, attached. Defendants should promptly withdraw the exhibit.

the District, have been able to provide a larger percentage of their Medicaid-eligible children with preventive dental services than the District. *Ibid*.

The Court's intervention is needed to ensure that the purpose of the Dental Order is carried out, namely, to ensure that the policies implemented by defendants are effective at achieving increases in dental services for children to the levels required by each of the numerical goals in paragraph 2(e) of the Dental Order. *See DL v. District of Columbia*, -- F. Supp.3d – (2016), 2016 WL 340306 at *13 ("While the District thoroughly details the policies it has enacted * * *, the Court must consider the *effectiveness* of those policies in achieving compliance * * *")(emphasis in original; internal citations omitted).

We note that defendants make no objection to plaintiffs' proposal for the imposition of civil penalties for each day they fail to meet the September 30, 2020, deadline or the use of the *Salazar* escrow fund to improve the delivery of sealants. Def. Opp. 1-28.

ARGUMENT

I. COURT INTERVENTION IS NECESSARY TO ENSURE FULL COMPLIANCE WITH THE DENTAL ORDER

Defendants reject the imposition of a five-year CAP to set forth how defendants will achieve full compliance with each of the numerical goals in paragraph 2(e) of the Dental Order, claiming that the District has already made notable progress and ranks above average among the states in the delivery of dental services to children; that its SOHAP and annual CAP's sufficiently detail the steps that the District will take to improve dental services; and that, in any event, the numerical goals in the Dental Order are not achievable.[4] Def. Opp. 9-27. Plaintiffs respond to each of these arguments.

[4] Defendants imply that plaintiffs are not truly moving to enforce the Dental Order because "plaintiffs request that the Court impose *additional* obligations upon the District, including 'interim performance goals' and the submission of a five-year CAP 'that sets forth specific requirements * * * designed to reach full compliance with each of the paragraph 2(e)

A. Defendants' Current Measures Are Insufficient to Ensure Compliance with the Sealant Goal by September 30, 2020

1. Plaintiffs' Final Sealant Goal Is Attainable

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). ECF No. 1033. In order to achieve consistency between the 2004 Dental Order and the CMS Form 416, plaintiffs proposed that compliance be determined using the age group of 6-14 instead of 8-14 (as is currently in the Dental Order). ECF No. 2094-1, para. 1. Defendants do not oppose this proposal. Def. Opp. 16-20.

In FY 2015, the District provided sealants to 19.58% of children ages 6 to 14, an almost one percent decrease from the previous year (Def. Opp. 16) and 50 points below the requirement of paragraph 2(e)(iv). Plaintiffs proposed that defendants submit a five-year CAP that explains in detail, how defendants will meet the 70% sealant goal by September 30, 2020. Pl. Br. 9. Defendants reject this proposal because "no state has been able to achieve this utilization rate."

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performance goals * * *'" (emphasis in original). Def. Opp. 2. However, under the relief sought by plaintiffs, defendants' obligation is the same—to comply with the six performance goals in paragraph 2(e) of the Dental Order. *See* Modified Proposed Order, paras 1, 4, 6-8, attached. Plaintiffs propose to enforce compliance with these goals by requiring defendants to show how they will comply with the Dental Order within a reasonable time period through the submission of a detailed 5-year CAP, to comply with interim goals that would show that defendants are on track towards compliance with the final requirements in the Dental Order, and to pay civil penalties for failure to comply. *Id*..

These actions are well within the Court's power to fashion a remedy to enforce a prior order when the prevailing party has shown noncompliance with it, as is the case here. *See Heartland Hospital. v. Thompson*, 328 F.Supp.2d 8, 11 (D.D.C. 2004), *affirmed sub nom. Heartland Regional Medical Center v. Leavitt*, 415 F.3d 24 (D.C. Cir. 2005) ("Courts grant motions to enforce judgments when a prevailing plaintiff demonstrates that a defendant has not complied with a judgment entered against it * * *")(internal citations omitted). *See also Madden v. Grain Elevator, Flour and Feed Mill Workers, International Longshoremen Ass'n, Local* 418, AFL-CIO, 334 F.2d 1014, 1020 (7th Cir. 1964) ("in enforcing its orders, the district court may adapt the form of the application of its power according to the resistance to enforcement with which it is confronted"); *Armstrong v. Brown*, 939 F.Supp.2d 1012, 1018 (N.D. Cal. 2013) ("A district court has the authority to make an enforcement order to secure compliance with its earlier orders and governing law").

Def. Opp. 16. Plaintiffs do not dispute this fact (though nine states have achieved a higher rate than the District). Calculation of States' Sealant Provision, FY 2015, Pl. Ex. 36, attached. However, as the Pew Center on the States found in its April 2015 report, this is because (ECF No. 2094-17, p. 2) "most states are failing to enact policies that provide sealants to low-income and at-risk children"—not because a significant increase in the percentage of children receiving sealants is unattainable, as the District contends (Def. Opp. 15-20).

Few states are in a better position to meet the 70% sealant goal by September 30, 2020, than the District. The District has begun taking a number of measures to increase the number of children ages 6-14 who receive sealants, including implementing some of the suggestions made by plaintiffs' expert, Dr. William Maas. For example, the District has increased its education and outreach to dentists, primary care providers, and school nurses concerning the importance of dental sealants; has started to offer dental services to a limited number of children at schools; intends to request the D.C. Board of Dentistry to revise its scope of practice so that dental hygienists can apply sealants without a prior examination and presence of a dentist; and to participate in the National Oral Health Surveillance System by conducting a five-year survey about the number of children who have received sealants and the populations that should be targeted. Def. Opp. 11-14, 18-19. These steps are important and set the District on a path towards compliance. However, in several important areas, the District has not gone far enough.

(a) Expansion of School-Based Sealant Programs

Dr. Maas suggested, as recommended by a panel of public health and prevention experts, that the District expand its school-based sealant programs to high-need schools targeting children ages 6 to 14.[5] Maas Aff., ECF No. 2094-15, para. 9; *see also* 2015 Pew Report, Pl. Ex. 16, ECF No. 2094-17, p. 5 ("Sealant programs based in schools are an optimal way to reach children * *

[5] High-need schools are those with a majority of the students participating in the federal free or reduced price lunch. Pl. Ex. 15, ECF No. 2094-16, p. 8.

*"). Defendants state that they already provide school-based sealant services. Def. Opp. 18. The District explains that under an agreement, which has been in place since 2014, several of its agencies have worked with MCO's to identify target lists of schools "for dental outreach, utilization, and sealant placement." Sonosky Decl., para. 57. According to defendants, "since 2014 [the District] has contracted with two Medicaid-enrolled provider groups to offer services in schools through which students receive dental assessment and services, including sealants." *Id*., para. 65; *see also id*., para. 79. However, despite these efforts, the District provided sealants to only 622 students at schools in the first half of the 2015-2016 school year. Def. Opp. 18. This figure represents a mere 1.55% of the 40,141 Medicaid-eligible children ages 6-14 needing sealants in their permanent molar teeth. *See* FY 2015 CMS Form 416, ECF No. 2118-1, Line 1b.

Defendants assert that "DHCF has focused on providing education and outreach to encourage families to see their dentists * * * in a medical setting, not a school setting, given the District's high rate of Medicaid coverage and the right to obtain EPSDT services." Def. Opp. 18. However, since "school-based dental sealant delivery programs [can] 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" (Maas Aff., para. 9), there is no basis for defendants' concern. The critical point is that school-based sealant dental programs have a captive audience of 6 to 14 year olds that no other environment provides. No opportunity should be wasted to take advantage of this fact. The benefit of receiving preventive sealants far outweighs the District's desire to have a child's regular dentist involved in every preventive dental procedure that the child receives. Def. Opp. 18.

In any event, school-based sealant programs can serve as a safety net for those children who do not go to the dentist. Defendants' position, that Medicaid-eligible children should be

seen in a medical setting, does not address the reality that many poor working parents[6] face real, practical constraints that force them to choose between taking time off work to take an otherwise healthy child for a preventive dental service and taking time off work to address more urgent matters, such as a sick child or because they are themselves sick.[7] When parents work several jobs, go to school, or take evening and weekend shifts, dental office hours may not provide the flexibility that parents need, even when they and their children receive outreach and are aware of the importance of dental sealants. Unless the District directly faces this challenge, by enacting policies that assist all parents and children, not just those that have the capacity and time to take their children to the dentist, it will be extremely difficult to improve the number of Medicaid-eligible children ages 6-14 receiving sealants.

Finally, the District's position (Def. Opp. 18) that dental services should be provided at a dentist's office by a regular dentist is also inconsistent with efforts within the District of Columbia City Council, supported by the D.C. Pediatric Oral Health Coalition, to pass the Children's Oral Health Amendment Act (SOHAP, ECF No. 2094-14, p. 6), which would require all elementary schools "at which 50% or more of the student body is eligible for a free or reduced-price lunch program" (high-need schools) to have a school-based sealant program (ECF No. 2094-30, p. 3). Thus, defendants themselves recognize the importance of the school-based programs that Dr. Maas recommends. They must take effective actions to implement such school-based programs.

[6] Plaintiffs refer to parents throughout their motion as a shorthand for all caregivers.

[7] The District of Columbia's sick leave statute, DC Code Ann. § 32-131.02, has limitations which are likely to affect working parents of Medicaid-eligible children. For instance, under the law, employers with 24 or fewer employees are only required to allow employees a maximum of 3 sick days per year. The law excludes independent contractors, health care workers, and employees in the construction industry under particular circumstances.

(b) Oral Health Assessments and Referrals to Dentists for Placement of Sealants

Defendants argue that they cannot modify the District's HealthCheck periodicity schedule used by primary care providers to include oral health assessments and referrals to dentists for children 6-14 as part of a well-child visit, as recommended by Dr. Maas, because it "is not in accordance with guidance" from the national pediatric medical and dental associations. Def. Opp. 18. As one of the last states in the county to pay primary care providers for fluoride varnish applications, the District has a history of lagging behind other states with regard to implementing common sense preventive dental policies, adopted by the national pediatric medical and dental associations.[8] In this case, the District should lead and not wait for common sense policy to be recognized and adopted by the majority of states and the national pediatric medical and dental associations.

The current Medicaid periodicity schedule for primary care providers recommends oral health assessments and referrals to dentists for children up to 6 years old. DC Medicaid HealthCheck Periodicity Schedule, ECF No. 2094-22. Accordingly, the District requires all primary care providers to provide oral health assessments to young children as part of a well-child visit and refer the child to a dentist if she does not have one. DHCF Transmittal to Dentists and EPSDT Providers, ECF No. 2142-4, Def. Ex. D, p. 2. Plaintiffs' expert, Dr. Maas, recommends that the same procedure should apply for children up to 14 years of age; if the child does not have a dentist, she should be referred to a dentist for care, including the application of sealants. ECF No. 2094-15, para. 8; *see also* Proposed Order, ECF No. 2094-1, para. 1(e)).

[8] In 2011, the District was one of 11 states who did not reimburse primary care providers for preventive dental care to young children. *See* American Academy of Pediatrics Oral Health Initiative, Caries Prevention Services Reimbursement Table, April 6, 2011 ("2011 State Reimbursement Table"), Pl. Ex. 37. By 2013, the District was only one of 7 states remaining that was still not reimbursing primary care providers. *See* American Academy of Pediatrics Oral Health Initiative, Caries Prevention Services Reimbursement Table, Updated June 2013 ("2013 State Reimbursement Table"), Pl. Ex. 38.

Since pediatricians are or should be providing oral health assessments for young children as part of a well-child visit, expanding the age range to 14 does not represent a radical change in their scope of practice.

(c) Inclusion of Sealants in Health-Related Education of Students

Dr. Maas recommends that defendants overcome parental concern and fear about sealants by convincing their children, through school-based education programs, that they are desirable. ECF No. 2094-15, para. 11. In particular, Dr. Maas recommends that (*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.

Defendants' response is that school nurses receive such training. Sonosky Decl., para. 108(d)("school-based health programs already cover * * * the benefits of sealants * * * in its school nurse training"). However, while school nurses should receive this training, defendants do not have a policy of educating teachers or students about sealants in specific grades. *Ibid*.

(d) Authorization for the Application of Sealants in School-Based Programs by Dental Hygienists

Defendants take an ambiguous position concerning Dr. Maas' recommendation that the District authorize sealant application in school-based programs by dental hygienists without a prior examination by a dentist. Defendants minimize the effectiveness of such a practice, arguing that unlike in rural areas, there is no shortage of dentists in the District to apply sealants. Def. Opp. 19. Although there are many dentists in the District of Columbia, all children on Medicaid who should receive the important preventive service of sealants are not receiving them. Moreover, according to the Pew Center on States, "if the outdated prior exam rule were removed, dentists working with school-based programs could instead use their time to care for students with more complex needs." Pl. Ex. 15, ECF No. 2094-16, p. 12. Defendants state that the issue of allowing dental hygienists to deliver sealants "is governed by the District's Board of

Dentistry, not DHCF." Def. Opp. 19. However, the responsibility of defendants to improve dental services for children on Medicaid is not limited to DHCF – that organization is not a defendant in this lawsuit. To deliver more sealants to children, defendants, *i.e.*, the Mayor and the District of Columbia, should actively work to change the District of Columbia's own rules governing practice by dental hygienists.

2. Plaintiffs' Proposed Interim Sealant Goal Is Attainable

In June 2015, defendants submitted a SOHAP to CMS, as part of its voluntary participation in CMS's Oral Health Initiative, in which it set an interim five-year goal for the District to increase by 10 percentage points "the proportion of children ages 6-9 enrolled in Medicaid * * * who receive a dental sealant on a permanent molar tooth by FFY 2018[,]" using FY 2013 as a baseline year. ECF No. 2094-14, p. 11. In order to meet its voluntary interim goal, the District would have to provide sealants to 22% of children ages 6-9 by FY 2018, or September 30, 2018.[9] Defendants aim to meet this interim goal with annual increases of two percent, an increase which is based on the use of the "Plan-Do-Check-Act" cycle model, which defendants describe as a "60-year-old model that provides a defined and well-tested process to achieve lasting improvement in health care delivery." Def. Opp. 17, 26.

In their motion, plaintiffs proposed a more ambitious interim goal using the same CMS measure: that defendants increase by at least 10 percentage points the number of children ages 6-9 who receive a dental sealant on a permanent molar by the end of FY 2016, as measured from the baseline of FY 2011. ECF No. 2094-1, para. 2.[10] The main reason that plaintiffs' proposal is

[9] The percentage of Medicaid-eligible children ages 6-9 in the District receiving a sealant in FY 2013 was 17.10 percent. FY 2013 CMS 416, ECF No. 2094-4 (of 18,129 children ages 6-9 in Line 1b, 3,100 children ages 6-9 in Line 12d received a sealant).

[10] In order to comply with plaintiffs' interim goal, defendants would have to provide sealants to 28.24 percent of children ages 6-9 by FY 2016, or September 30, 2016. Since briefing on the instant motion will be finalized in late July and an order may not issue in FY 2016, plaintiffs

more ambitious than defendants is that defendants' performance declined from FY2011 to FY2013. *See* Pl. Ex. 5, ECF No. 2094-6. With the FY2013 as a baseline, less improvement is required under defendants' plan. Defendants oppose plaintiffs' interim goal because the District has already "set interim goals through its SOHAP in a manner that will realistically allow improvement of dental utilization, while permitting the District to routinely assess its performance and make any necessary adjustments * * *." Def. Opp. 17.

Defendants' voluntary interim sealant goal is "realistic" only in that very low expectations are much easier to meet than ambitious ones. Such low expectations are not appropriate in the context of an existing court order that has the requirement to provide sealants to 70% of children ages 8-14 by 2007. In order to meet the 70% goal by September 30, 2020, defendants should have an interim goal that challenges the District to stretch itself beyond the status quo. However, such a goal is inherently inconsistent with the "Plan-Do-Check-Act" (PDCA) cycle model used by defendants for increasing the use of dental sealants.

According to the Agency for Healthcare Research and Quality, an agency within the U.S. Department of Health & Human Services, the PDCA works by continuously repeating the same four steps: plan the change or improvement, conduct a pilot test, gather data on the pilot test, and implement the change. *See* AHRQ IT Webpage, downloaded on July 17, 2016, Pl. Ex. 39. Under this model, no change would be implemented without going through the full four steps. *Ibid*. Thus, if defendants must pilot test every policy change, even those evidence-based policies that have been proven effective, the changes will take an extremely long time to be implemented and have a widespread impact. While such a process may be appropriate under different circumstances in the healthcare context, it is not here, where proven and common-sense measures exist to increase the provision of sealants to children. *See* Maas Aff., ECF No. 2094-

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have modified their proposed order to require compliance by September 30, 2017. *See* Modified Proposed Order, attached.

15, paras. 9-15.[11]

B. Defendants' Current Measures Are Insufficient to Ensure Compliance with the Preventive Dental Services Goal by September 30, 2020

1. Plaintiffs' Final Preventive Dental Services Goal Is Attainable

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 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. In FY 2015, the District provided preventive dental services to 52% of Medicaid-eligible children ages 3 and older, a four percent decrease from the previous year. Def. Opp. 20.

In their motion, plaintiffs propose that defendants submit a five-year CAP that explains in detail how defendants will meet the 80% preventive services goal by September 30, 2020. ECF No. 2094-1, para. 4. Defendants reject this proposal because "no state has been able to achieve this utilization rate." Def. Opp. 20. While this is true, this does not mean that a state could not meet the goal by September 30, 2020. Defendants state that in FY 2014, the District provided 56.32% of Medicaid-eligible children ages 3-20 with preventive dental services, earning a fourth place rank among the states. Def. Opp. 20. This is no longer the case. In FY 2015, the District provided 52% of children ages 3-20 with preventive dental services, but 20 other states ranked higher than the District. Calculation of States' Preventive Services, FY 2015, Pl. Ex. 35. Connecticut and Texas provided 62% and 67% of children ages 3-20, respectively, with preventive dental services in FY 2015. *Ibid*. These two states are less than 18 and 13 points away from reaching the 80% goal by 2020.

Like the District, Connecticut and Texas have been defendants in class action litigation and under federal court oversight concerning dental services for Medicaid-eligible children. *See*

[11] Contrary to defendants' claim that "the PDCA is similar to the S.M.A.R.T. criteria advocated by plaintiffs," the S.M.A.R.T. criteria do not require that each planned change be pilot-tested before being widely implemented. *See* Pl. Br. 23-26, and articles cited therein.

Frew ex rel. Frew v. Hawkins, 540 U.S. 431 (2004); *Carr v. Wilson-Coker*, 203 F.R.D. 66 (D. Conn. 2001). In these two cases, court intervention and those states' commitment to take the needed steps to increase dental services have led to favorable results. In the past, the Court's Dental Order requiring an increase in dental reimbursement rates to dentists made a significant impact in increasing the number of children receiving preventive dental services. From 2006 to 2011, the percentage of Medicaid eligible children in the District ages 3-20 more than doubled from 26.10% to 53.74%. D.C. Preventive Services Calculation, 2003-2015, Pl. Ex. 33. However, in late 2010, the District of Columbia allowed the MCO's to pay dental reimbursement rates to dentists lower than the fee-for-service scale that was enacted pursuant to the 2004 Dental Order. *See* Pl. Ex. 40 (March 10, 2006, Final Rulemaking on Increased Dental Rates); Pl. Ex. 41(Letter from Colleen Sonosky to Judge Kessler, Oct. 27, 2010, stating that in response to MCO complaints "we have agreed to grant the MCOs an optional one year's relief from the existing fee schedule"). Since 2011, the District has decreased the delivery of preventive dental services in two years (FY 2012 and FY2015) and has not surpassed a 3% increase in the preventive services goal in the other two years. Pl. Ex. 33.

The District argues that it has undertaken many of the strategies for compliance with the preventive services goal proposed by plaintiffs and Dr. Maas. Def. Opp. 21. However, although the District has taken some steps to increase preventive dental services (Sonosky Decl., paras. 108-110), it has not gone far enough. Court intervention is needed to enforce the 2004 Dental Order and compel all necessary actions to be taken to reach the 80% preventive dental services goal by September 30, 2020.

In their motion, plaintiffs showed that defendants were not providing the compensation needed to encourage pediatric primary care providers (*i.e.*, doctors) paneled with managed care organizations and federally-qualified health centers (FQHC's) to provide preventive dental

services to young children because payments for well-child visits were either capitated or bundled. Pl. Br. 16-17. Defendants respond that "the District not only reimburses for fluoride varnish applications, but its reimbursement rate is by far the most generous in the region."[12] Def. Opp. 22. According to defendants, when the rates were implemented in 2014, "the MCOs were required to adjust their reimbursement rates to providers accordingly." *Ibid*.

However, pre-existing contracts containing capitated or bundled fee agreements between the major pediatric primary care providers and the managed care organizations do not permit these providers to be paid separately for fluoride varnish applications. At the August 21, 2014, status conference, defendants informed plaintiffs that Children's National Medical Center (CNMC) received a capitated rate and FQHC's received a bundled fix rate for well-child visits. Letter to Defendants, Oct. 14, 2014, Pl. Ex. 42, p. 2, attached. Defendants sent plaintiffs an e-mail in September 2014, stating that CNMC had negotiated a fee arrangement with Chartered Health Plan, and then with AmeriHealth, in which it received a capitated amount for primary care visits. *Ibid*. Plaintiffs were concerned that given these existing fee arrangements, the new rates in the District's billing policy, including the rate for fluoride varnish applications, would not apply to any pediatric primary care practice with pre-existing fee arrangements with managed care organizations.[13] In an e-mail to plaintiffs dated December 1, 2014, in response to questions as to how the capitated fee arrangements would affect the payment to pediatric primary care providers under the District's new billing policy, defendants stated (ECF No. 2094-24, p. 3):

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[12] As mentioned in note 8 above, for many years, the District was an outlier among the states in recognizing the value of reimbursing pediatric primary care providers for preventive dental services. The District finally authorized reimbursement to primary care providers for preventive dental services in 2014. Sonsoky Decl., para. 109.

[13] Plaintiffs' review of the contracts between the MCO's and major pediatric providers confirmed defendants' statements that AmeriHealth paid CNMC a capitated fee and that it paid a bundled rate to Mary's Center and Unity Health Clinics for well-child visits. Defendants produced the contracts to plaintiffs in response to a Freedom of Information Act request made on October 21, 2014 (Pl. Ex. 43, attached).

> DHCF will not be changing any existing capitated fee arrangements between the MCO's and any facility. * * * [P]roviders that are paid a capitated or bundled fee for a well-child visit will not receive separate payment for performing oral health assessments or fluoride varnish" (emphasis added).

Defendants do not claim that the existing fee arrangements between the major pediatric practices in the District and the managed care organizations that were active in 2014 are no longer in place. Sonosky Decl., para. 110. While these agreements do not cover every Medicaid eligible child enrolled with an MCO, AmeriHealth, the MCO with the largest number of children, and CNMC, Mary's Center, and Unity health clinics, all major pediatric providers in the District, operate under capitated or bundled fee agreements which do not separately reimburse providers for fluoride varnish applications provided at well-child visits (ECF No. 2094-24, Pl. Ex. 23, p. 3). As the defendants recognize (Def. Opp. 22) "[t]he FQHCs [like Mary's Center and Unity] * * * present a more complicated issue because they are compensated through a federally required prospective payment system." Dr. Maas explains in his affidavit that the lack of a financial incentive is a serious barrier to increasing the delivery of fluoride varnish by physicians (ECF No. 2094-15, para. 17):

> 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.

Defendants should alter the Medicaid compensation system so that fluoride varnish is a separately paid service.

2. Plaintiffs' Interim Preventive Services Goal Is Attainable

In June 2015, defendants submitted a SOHAP to CMS, as part of its voluntary participation in CMS's Oral Health Initiative, in which it set an interim five-year goal for the District to increase by 10 percentage points "the proportion of children ages 1-20 enrolled in Medicaid * * * who receive a preventive dental service by FFY 2018[,]" using FY 2013 as a

baseline year. ECF No. 2094-14, p. 8. In order to meet its voluntary interim goal, defendants would have to provide preventive services to 60% of children ages 1-20 by FY 2018, or September 30, 2018.[14]

In their motion, plaintiffs propose a more ambitious interim goal using the same CMS measure: that defendants increase by at least 10 percentage points the number of children ages 1-20 who receive a preventive dental service by the end of FY 2016, as measured from the baseline of FY 2011. ECF No. 2094-1, para. 5. This results in the same interim goal, to provide a preventive dental service to 60% of children ages 1-20, but by an earlier date, FY 2016, or September 30, 2016.[15]

Defendants reject this interim goal because the District has set an annual two percent goal based on a "Plan-Do-Check-Act" cycle model. Def. Opp. 21. As with defendants' voluntary sealants goal, defendants' voluntary interim preventive services goal sets very low expectations that are not appropriate in the context of an existing court order which required defendants to provide preventive dental services to 80% of children ages 3 to 20 by 2007. ECF No. 1033. Moreover, the use of the PDCA model to set interim goals for preventive dental services is inappropriate for the same reason that it is inappropriate in the context of the sealants goal – it inhibits prompt, widespread adoption of proven effective policies. *See* p. 13 above. For example, defendants' delayed adoption of a policy to reimburse primary care providers for fluoride varnish applications for young children, a now well-established component of preventive dental services (which would count towards meeting this goal), has resulted in the District being one of the last states in the nation to implement this evidence-based practice. *See* n. 8 above. Notably, while

[14] The percentage of Medicaid-eligible children ages 1-20 in the District receiving a preventive dental service in FY 2013 was 49.55%. Preventive Services Calculation, ECF No. 2094-19.

[15] Since briefing on the instant motion will be finalized in late July and an order may not issue in FY 2016, plaintiffs have modified their proposed order to require compliance by September 30, 2017. *See* Modified Proposed Order, attached.

other states reimburse for physicians to apply fluoride varnish applications to the teeth of children above 3 years of age (*see* 2013 Reimbursement Table, Pl. Ex. 38), the District does not do so. Sonosky Decl., para. 110. Here again, defendants could increase the delivery of preventive dental services to children by altering their policies.

C. Defendants' Current Measures Are Insufficient to Ensure Compliance with the Oral Health Assessments Goal by September 30, 2020

Paragraphs 2(e)(i) and (ii) of the Dental Order require that no later than September 30, 2007, at least 80 percent of all 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 a HealthCheck visit." ECF No. 1033. Defendants do not contend that they have met these goals. Def. Opp. 25-26.

In their motion, plaintiffs first propose that defendants begin reporting to the Court as to the District's level of compliance with paragraphs 2(e)(i) and (ii) of the Dental Order (*see* ECF No. 2094-1, para. 8), using the coding for billing oral health assessments, which the District implemented in 2014 (Pl. Br. 21, n. 31). Defendants do not oppose plaintiffs' proposal for an annual report of the District's level of compliance with the oral health assessment goals using such a method. *See* Def. Opp. 25-26.

Second, plaintiffs propose that defendants develop a five-year CAP that explains in detail how defendants will meet the 80% oral health assessment goal by September 30, 2020. ECF No. 2094-1, para. 8. Defendants reject the imposition of a five-year CAP, claiming that the District's 2015 CAP sufficiently provided "specific steps aimed to increase compliance with the goals for oral assessments" and that the 2016 CAP "also outlines action items to encourage submission of the OHA [Oral Health Assessment] forms, coupled with data collection and analysis * * *." Def. Opp. 25. While these CAP's outline general efforts aimed at increasing oral health assessments, such as improving provider education training and paying primary care providers to provide preventive dental services to young children (ECF No. 2094-31, p. 1), and continuing to recruit

additional dentists who see young children (ECF No. 2094-10, p. 1), they do not provide concrete measures and actionable goals, such as the number of providers that will be trained by a certain date or the number of providers that will be recruited.[16]

Finally, plaintiffs propose to eliminate the disincentives that exist for certain primary care providers with MCO's and FQHC's by providing them with compensation for providing oral health assessments. Pl. Br. 22. Defendants dismiss these disincentives as "simply not true" (Def. Opp. 26), but as explained above (pages 15-17), according to the most recent information from defendants, capitated or bundled fee primary care providers are not separately paid to provide oral health assessments to young children. Defendants should alter the Medicaid compensation system so that an oral health assessment by a physician is a separately paid service.

D. Defendants' Current Measures Are Insufficient to Ensure Compliance with the Student Oral Health Screening Goal in the Dental Order by September 30, 2020

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. To date, defendants do not report data on paragraph 2(e)(iii), but do not dispute that they are in violation of it. Def. Opp. 23-25.

In their motion, plaintiffs propose that defendants submit a five-year CAP explaining how defendants will comply with paragraph 2(e)(iii) by September 30, 2020. The District lists a number of measures in response. For instance, the District has begun to take measures, some of

[16] Moreover, the submission of the school OHA forms does nothing to advance the goal of increasing the number of oral health assessments provided to children ages 6-24 months at a well-child visit. OHA forms provide information about oral health assessments provided by a dentist, but not by primary care providers. *See* Oral Health Assessment Form, Pl. Ex. 44. In addition, since the forms are submitted by a caregiver to a child's school, they do not impact children ages 6-24 months, who have not yet started pre-school. *See* Excerpt of D.C. Public Health Requirements 2016-2017 School Year, Pl. Ex. 45 (requiring submission of forms from ages 3 to 12).

which were recommended by plaintiffs, including the collection of data on the submission of the Oral Health Assessment form, to enable an accurate report of the level of compliance with paragraph 2(e)(iii) of the Dental Order. Sonosky Decl., paras. 75-77.[17] Defendants also report that, through inter-agency collaboration, various District of Columbia agencies have "develop[ed] outreach strategies based on data sharing and target schools for delivery of oral health services." *Id*., para. 78. Some of these target schools appear to include charter schools, as plaintiffs suggested. Pl. Br. 20; Def. Opp. 14 (students at 26 public charter schools have received services). These are important steps towards compliance with paragraph 2(e)(iii), but they do not go far enough.

A critical barrier to ensuring that students entering a school program for the first time receive an oral health/dental screening remains the lack of parental consent to receiving school-based screenings. The District "recognizes that a key contributor to low utilization of school-based dental care is the low rate of consent forms completed and returned by parents" (Def. Opp. 14), but rejects Dr. Maas' recommendation that it use an "opt-out" approach, under which students would receive school-based screenings to determine the need for sealants, unless the parent affirmatively refuses to consent (*id*., p. 20). Defendants claim that "[a]n opt-out approach * * * is not appropriate given that parental consent is needed for screening." Sonosky Decl., para. 108(g). However, other states routinely provide health screenings at schools, including dental screenings for children, under an "opt-out" approach. *See, e.g*., Tennessee School Health Screening Guidelines, Pl. Ex. 46 (offering option to schools), p. 5; Utah School Vision Screening Guides, Pl. Ex. 47, p. 21; Iowa Department of Education School Screenings, Pl. Ex. 48

[17] Plaintiffs also suggested, as a way to provide an incentive to schools and students, that the website for the public school system provide information on a per school, per school year basis about the number of students enrolled, the number of students submitting the oral health assessment form, and the percentage of students submitting the form. Pl. Br. 20. Defendants do not object outright to this suggestion; instead defendants state that "at this juncture" the data are "best used for programmatic decision-making." Def. Opp. 24.

(providing for passive consent for dental screenings); Kan. Stat. Ann. § 72-5201, *et seq*. (2008)(requiring schools to provide dental screenings to all first and second grade classes in the state); Kansas School Dental Screening Toolkit, Pl. Ex. 49, p. 1 (parents may opt-out from their child receiving dental screening services).

Defendants' refusal to consider an opt-out approach to parental consent seriously constrains the delivery of dental services to children in District of Columbia schools. As with school-based sealant programs (pp. 8-9 above), school-based dental screenings serve an important function in ensuring that those students who cannot access a medical setting, nevertheless receive needed dental services.

E. Defendants' Current Measures Are Insufficient to Ensure Compliance with the Overall Dental Services in the Dental Order by September 30, 2020

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 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. In FY 2015, the District provided preventive dental services to 56.5% of Medicaid-eligible children ages 3 and older, a four percent decrease from the previous year. Def. Opp. 22-23.

In their motion, plaintiffs propose that defendants submit a five-year CAP that explains in detail, how defendants will meet the 80% overall dental services goal by September 30, 2020. ECF No. 2094-1, para. 6. Once again, defendants reject this proposal because "no state has been able to achieve this utilization rate." Def. Opp. 22. Defendants further state that "[i]n FY 2015, the District reported that 56.5 percent received any dental services for ages 3 to 20, compared to the national average of 52.50%. *Id*., p. 23. Given the advantages that the District enjoys of a small urban environment, a relatively high number of dentists (SOHAP, Pl. Ex. 13, p. 3), and relatively high dental reimbursement rates (Sonosky Decl., para. 110), the District should not be aiming at the national average; it should aim to be among the top states in the nation. However,

defendants' comparison with other states shows that the District is lagging behind many of its peers in the provision of dental services to Medicaid-eligible children. *See* Calculation of States' Preventive Services, Pl. Ex. 35.

In FY 2014, the District provided 60.51% of children ages 3-20 with any dental service. Def. Opp. 22. A 20-point increase to 80% by September 30, 2020, is attainable by taking concrete steps and utilizing measurable, interim deadlines and numerical goals, designed to increase the number of sealants and other preventive services to children ages 3-20. Court intervention is needed to enforce the 2004 Dental Order and compel all necessary actions to be taken to reach the 80% "any dental services" goal by September 30, 2020.

II. DEFENDANTS DO NOT OBJECT TO THE IMPOSITION OF PENALTIES FOR FAILURE TO COMPLY WITH THE NUMERICAL GOALS IN PARAGRAPH 2(e)

Plaintiffs proposed that defendants pay civil penalties pursuant to the July 10, 2006, Civil Penalty Order (ECF No. 1175) for each day they fail to meet the September 30, 2020, deadline for any of the requirements in paragraph 2 of the 2004 Dental Order. Pl. Br. 9, n. 13; ECF No. 2094-1, p. 6. While defendants oppose the deadline of September 30, 2020, they do not make any specific objection to the imposition of penalties under the 2006 Civil Penalty Order if the standards of the Dental Order are not met by 2020. Def. Opp. 1-27. Therefore, the Court should impose the civil penalties sought by plaintiffs to compel defendants' compliance with the standards that should have been met in 2007 by 2020.

III. DEFENDANTS DO NOT OBJECT TO THE USE OF THE SALAZAR PENALTY ESCROW FUND TO INCREASE DENTAL SERVICES FOR CHILDREN

Plaintiffs proposed that within 30 days of the entry of an Order on this motion, the parties submit to the Court a proposal for the use of the escrow funds to improve the delivery of sealants. Defendants make no objection to plaintiffs' proposal. Def. Opp. 1-27. Therefore, the Court should order the parties to submit proposals for the use of the escrow funds.

IV. PLAINTIFFS CONSULTED WITH DEFENDANTS REGARDING WHETHER SETTLEMENT WAS POSSIBLE PRIOR TO FILING THEIR MOTION

Paragraph 80 of the Settlement Order requires that any party intending to move the Court to enforce or construe the Order give the other party 10 days' notice and that, during the 10-day period, the parties "negotiate in good faith in an effort to resolve the dispute without seeking a decision from the Court." ECF No. 663, para. 80. The Dental Order (ECF No. 1033) is a separate order from the Settlement Order and was entered by the Court following a litigated motion; it is not a consent order. Therefore, paragraph 80 of the Settlement Order does not apply to the instant motion to enforce the Dental Order.

Nonetheless, prior to filing this motion, as has been their practice, plaintiffs informed defendants of their intentions and of the type of Order they would be seeking from the Court. Defendants argue that, after plaintiffs sent the notice letter, they failed to comply with paragraph 80 because plaintiffs did not negotiate in good faith during the 10-day period. Def. Opp. 8-9. Defendants imply that plaintiffs refused to discuss their position and, that as a result, defendants did not know the relief that plaintiffs intended to seek and were thus prevented from determining "whether any negotiation would be worthwhile." *Ibid*. Contrary to defendants' claims, plaintiffs' notice letter explained plaintiffs' position in detail (Def. Ex. H, ECF No. 2142-8):

> Plaintiffs intend to seek an Order from the Court which will require defendants to prepare an effective plan for improving the delivery of children's dental services, and to monitor and report on their compliance with it, to set interim goals to meet the standards for preventive dental services and sealants for the District of Columbia set forth by the Centers for Medicare & Medicaid Services, to take necessary steps to ensure that primary care providers receive training to apply fluoride varnish to young children's teeth for which they are adequately compensated for it, and to ensure that children's access to sealants is expanded through the schools and not impeded by severe and unnecessary restrictions preventing hygienists from applying sealants in schools.

In response, defendants requested "proposals" from plaintiffs regarding "how it can increase the effectiveness of its Corrective Action Plan for dental services." ECF No. 2142-9, p.

3. Since defendants did not offer to negotiate concerning the court order that plaintiffs informed them they would seek, and considering the two and a half years that the parties had met in an unsuccessful attempt at mediation concerning the Dental Order, plaintiffs reasonably concluded that a motion was necessary and that a consent order could not be obtained in settlement.[18]

V. CONCLUSION

For these reasons, and for those set forth in plaintiffs' opening brief, the Court should grant plaintiffs' motion, as modified by the attached proposed order.

Respectfully submitted,

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July 27, 2016

[18] As noted above, n. 3, p. 4, plaintiffs strongly object to defendants' submission to the Court of electronic mail messages in which counsel set forth statements regarding why the Dental Order mediation failed. ECF No. 2142-9, pp. 1-2. Local Rule 84.9(a)(1) provides that "[t]he Court hereby prohibits * * * all counsel and parties * * * from disclosing any written or oral communications made in connection with * * * any mediation session." Court Mediator Amy Wind similarly directly admonished the parties at the conclusion of the mediation. Pl. Ex. 34.

LIST OF EXHIBITS

Number	Description
33	D.C. Preventive Dental Services, 2003-2015
34	Electronic Mail from Court Mediator to Parties, February 27, 2015
35	Calculation of States' Preventive Services, FY 2015
36	Calculation of States' Sealant Provision, FY 2015
37	Academy of Pediatrics Oral Health Initiative, Caries Prevention Services Reimbursement Table, April 6, 2011 ("2011 State Reimbursement Table")
38	American Academy of Pediatrics Oral Health Initiative, Caries Prevention Services Reimbursement Table, Updated June 2013 ("2013 State Reimbursement Table")
39	Agency for Healthcare Research and Quality, Health Information Technology, "Plan-Do-Check-Act-Cycle" Webpage, downloaded on July 17, 2016, available at https://healthit.ahrq.gov/health-it-tools-and-resources/workflow-assessment-health-it-toolkit/all-workflow-tools/plan-do-check-act-cycle
40	Final Rulemaking on Increased Dental Rates, March 10, 2006
41	Letter from Colleen Sonosky to Judge Kessler, October 27, 2010
42	Letter from Plaintiffs' Counsel to Defendants, October 14, 2014
43	Plaintiffs' FOIA Request for Provider Contracts, October 21, 2014
44	Oral Health Assessment Form, downloaded on July 17, 2016, available at http://doh.dc.gov/sites/default/files/dc/sites/doh/DC%20Oral%20Health%20Assessment%20Form.pdf
45	D.C. Public Health Requirements 2016-2017 School Year, Excerpt, downloaded on July 17, 2016, available at http://dcps.dc.gov/sites/default/files/dc/sites/dcps/publication/attachments/ALL%202016-17%20Health%20and%20Medical%20Forms.pdf
46	Tennessee School Health Screening Guidelines, Revised May 2015, Excerpt, downloaded on July 7, 2016, available at http://www.tennessee.gov/assets/entities/education/attachments/csh_school_health_screening_guidelines.pdf
47	Utah School Vision Screening Guides, 2013, Excerpt, downloaded on July 17, 2016, available at http://www.schools.utah.gov/charterschools/School-Resources/Guidance-and-Procedures/School-Vision-Screening-Guidelines-2013.aspx
48	Iowa Department of Education School Screenings, May 2012, downloaded on July 17, 2016, available at https://www.educateiowa.gov/sites/files/ed/documents/1112_sn_schoolScreenings_v3.pdf
49	Kansas School Dental Screening Toolkit, downloaded on July 15, 2016, available at http://www.kdheks.gov/ohi/download/screening_initiative/Kansas_School_Screening_Toolkit.pdf