UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

OSCAR SALAZAR, *et al.*,	)	
Plaintiffs,	)	
	)	**C.A. No. 93-452 (GK)**
v.	)	
DISTRICT OF COLUMBIA, *et al.*,	)	
Defendants.	)	

THE DISTRICT OF COLUMBIA'S REVISED[1] OPPOSITION TO PLAINTIFFS' MOTION TO ENFORCE THE DENTAL ORDER OF OCTOBER 18, 2004

INTRODUCTION

Almost twelve years ago, on October 18, 2004, this Court entered an order imposing numerous obligations on the District of Columbia (the District) to provide dental services to children enrolled in Medicaid. (ECF No. 1033 (Dental Order).) Many of the requirements in the Dental Order, including the target utilization goals, exceeded obligations imposed by federal law. Since 2004, the Dental Order's target utilization goals have proven to be unattainable by the District and every other jurisdiction in the United States. Nevertheless, the District has made significant improvements in the provision of dental services to Medicaid-eligible children since the entry of the Dental Order, and especially since January 1999 when the parties entered into the Settlement Order which first established judicial oversight of the District's obligations, including the provision of dental services under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services benefit required by federal Medicaid law. (ECF No. 663.)

As set forth in the accompanying Declaration of Colleen Sonosky (Ex. A), Associate

[1] The District submits this Revised Opposition to correct the dental utilization percentages in light of the District's revised CMS-416 for the 2015 Fiscal Year, submitted to the Court on August 9, 2016. (ECF No. 2172.)

Director of the Division of Children's Health Services in the Department of Health Care Finance, the District exceeds federal requirements in the provision of mandatory and most optional dental services for Medicaid-eligible children, and the District's dental service utilization rates have ranked above national averages for over five years. Indeed, the District has made notable progress in providing quality dental care to Medicaid-eligible children, including the implementation of measures to improve children's oral health through the District's State Oral Health Action Plan (SOHAP), which was developed in consultation with the United States Centers for Medicare and Medicaid Services (CMS) and other national experts.

Recognizing the difficulty of complying with the Dental Order's target utilization goals and the District's improved dental delivery system and dental provider network, the parties engaged in extensive mediation for over two years, from July 2012 to August 2014. Mediation was ultimately unsuccessful and formally concluded in 2015 following the parties' inability to reach final agreement on a revised dental order that set forth achievable goals and requirements and would allow compliance and exit from judicial supervision.

On February 16, 2016, plaintiffs filed a Motion to Enforce the Dental Order of October 18, 2004. (ECF No. 2094.) Plaintiffs allege violations of the Dental Order target utilization goals and contend that the District's 2015 and 2016 Dental Corrective Action Plans (CAPs) violate the "scope and specificity" of the Dental Order. (*Id.* at 1, 22-26.) Plaintiffs seek an order requiring the District to take specific steps to comply with the six performance goals enumerated in Paragraph 2(e) of the Dental Order by September 30, 2020. (*Id.* at 1.) Although styled as a "motion to enforce,"[2] 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

[2] Plaintiffs fail to identify any standard of review for the Court to apply in considering their motion to enforce.

forth specific requirements … 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." (*Id.*) Notably, plaintiffs completely disregarded the requirements under Paragraph 80 of the Settlement Order, which requires that the parties negotiate in good faith prior to seeking the Court's intervention. And, as explained below and in the Declaration of Ms. Sonosky, the District already has undertaken many of the measures proposed by plaintiffs. Imposing additional obligations and Court oversight will only serve to hinder the District's noteworthy progress to provide quality dental care to Medicaid-eligible children. Plaintiffs' motion to enforce should be denied.

BACKGROUND

I. Relevant Procedural Background

Plaintiffs filed this case in 1993 alleging violations of the Medicaid Act, 42 U.S.C. §1396, *et seq.*, in connection with the District's administration of its Medicaid program, including access to EPSDT services that must be provided to Medicaid-eligible children up to age 21. (ECF No. 1.) Following a bench trial in 1996, this Court held that the District violated the Medicaid Act by failing to provide Medicaid-eligible children with EPSDT services, including dental services. *Salazar v. District of Columbia*, 954 F. Supp. 278, 330-31 (D.D.C. 1996). Thereafter, in 1999, the parties entered into the Settlement Order, memorializing the District's obligations to remedy the violations. (ECF No. 663.) Under the Settlement Order, the District was obligated to provide dental services as required under the EPSDT provisions of federal Medicaid law. (*Id*. at ¶ 36.)

Following entry of the Settlement Order, plaintiffs filed several motions seeking to enforce the District's obligations to provide EPSDT dental services. (ECF Nos. 885, 1010.) As a

result, on October 18, 2004, the Court entered the Dental Order, imposing further specific requirements on the District in connection with the provision of dental services, many of which exceeded obligations under federal law. (ECF No. 1033.)

In May 2006, the District filed a motion to vacate the Dental Order on grounds that the Court had exceeded its authority by imposing requirements that went beyond the four corners of the Settlement Order. (ECF Nos. 1153, 1219.) The Court denied the motion to vacate on February 18, 2010, ruling that the motion was untimely because it was filed nineteen months after the Dental Order was entered. *Salazar v. District of Columbia*, 685 F. Supp. 2d 72, 75 (D.D.C. 2010). The District appealed and, on February 8, 2011, the United States Court of Appeals for the District of Columbia Circuit affirmed the Court's entry of the Dental Order, concluding the District had failed to show "extraordinary circumstances" under Fed. R. Civ. P. Rule 60(b)(6). *Salazar v. District of Columbia*, 633 F.3d 1110 (D.C. Cir. 2011). The D.C. Circuit noted, however, that the District was not without remedies under paragraph 71 of the Settlement Order, which provides for modification at "any time for any reason." *Id*. at 1122.

On March 18, 2009, the District moved to terminate the Settlement Order, including the requirements under the Dental Order, but the motion was denied on August 5, 2010. (ECF No. 1618.) Plaintiffs sought to modify the Dental Order on September 3, 2010, alleging violations of the Settlement Order and specific provisions of the Dental Order. (ECF No. 1627.) Following the District's Opposition (ECF No. 1649), plaintiffs filed a motion for leave to conduct limited discovery (ECF No. 1661), which the Court granted in part on February 3, 2011 (ECF No. 1706). In January 2012, in light of the parties' settlement discussions at the time, the Court granted plaintiffs' consent motion to stay briefing on the September 2010 motion to modify the Dental Order. (ECF No. 1771.) Plaintiffs subsequently withdrew their pending motions to enforce and

modify the Dental Order on April 19, 2012. (ECF No. 1789.) The following day, the Court entered an order referring the case for mediation (ECF No. 1790) under the direction of Amy Wind, Chief Circuit Mediator for the District of Columbia Circuit, and the parties engaged in mediation from July 2012 to August 2014. The parties were unable to reach a final agreement during the course of mediation, which formally concluded in 2015. On February 16, 2016, without complying with the notice and good faith negotiation provisions under Paragraph 80 of the Settlement Order, plaintiffs filed the instant motion to enforce the Dental Order, seeking to impose additional obligations on the District, including interim performance goals and the submission of a five-year CAP in an effort to achieve compliance with the Dental Order by 2020. (ECF No. 2094.)

II. The Dental Order Provisions

The Settlement Order addresses dental services in broad terms as part of the District's obligations to provide EPSDT services to Medicaid-eligible children, which includes preventive and therapeutic dental services. (ECF No. 663, at ¶ 36) ("Defendants shall 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"); *see also* 42 U.S.C. §1396d(r)(3). As noted above, plaintiffs moved to enforce the Settlement Order in 2004, alleging that the District had failed to meet the requirements of a separate February 28, 2003 order regarding the provision of dental services. (ECF Nos. 928, 1010-1.) On October 18, 2004, the Court entered the Dental Order, imposing detailed obligations for the provision of dental services under the EPSDT benefit. (ECF No. 1033.)

Among other requirements, the Dental Order provides that the District must create a detailed dental periodicity schedule that sets forth the ages and frequency that dental services

should be provided to children, and to distribute this schedule to all managed care organizations (MCOs), dentists, and pediatric health care providers. (*Id.* at ¶ 1.) In addition, the Dental Order requires the District to submit a yearly CAP with detailed information concerning the provision of EPSDT dental services. (*Id.* at ¶ 2(a)-(e).) In the CAP, the District must address the current number of providers of dental EPSDT services and the District's efforts to maintain a sufficient number of those providers who are willing and able to provide dental services to EPSDT-eligible children. (*Id.* at ¶ 2(a).) The CAP also must address reimbursement rates and streamlining of administrative procedures to encourage greater provider participation. (*Id.*) The District must include detailed information concerning available providers, including names, addresses, and telephone numbers. (*Id.*) Moreover, the District must report steps taken to ensure training, skills, and knowledge of providers to deliver EPSDT dental services. (*Id.* at ¶ 2(b).) Under the CAP, the District annually must distribute a provider bulletin to licensed dentists and pediatric health care providers describing dental health education and discussing guidance regarding oral hygiene for various ages and categories. (*Id.*) The District must describe its efforts to coordinate activities and communication among the Department of Health Care Finance (DHCF), MCOs, dentists, pediatric care providers, and the Department of Health's (DOH) Oral Health Program. (*Id.* at ¶ 2(c).) The District also must identify methods in the CAP to assist EPSDT enrollees in making and keeping dental appointments, including the establishment of a hotline to answer basic oral health questions and provide assistance in scheduling appointments and following up to ensure that appointments are kept. (*Id.* at ¶ 2(d).)

A significant element of the Dental Order requires the District to meet, and report on, specific goals for the provision of EPSDT dental services. The Dental Order requires the District to meet the following utilization goals:

(i) at least 80 percent of EPSDT-eligible children from 6-12 months of age must receive at least one oral risk assessment by a medical provider;

(ii) at least 80 percent of EPSDT-eligible children from 12-24 months of age must receive at least one oral risk assessment by a medical provider;

(iii) at least 85 percent of EPSDT-eligible children entering school must receive an oral health screening by a licensed dentist;

(iv) at least 70 percent of EPSDT eligible children from 8-14 years old must receive sealants on their permanent teeth;

(v) at least 80 percent of EPSDT-eligible children 3 years and older must receive "any dental services" as defined by CMS; and

(vi) at least 80 percent of EPSDT-eligible children 3 years and older must receive "preventive dental services" as defined by CMS.

(*Id*. at ¶ 2(e).) The Dental Order also requires the District to provide yearly reports to the Court and plaintiffs regarding the number of children receiving dental services. (*Id*. at ¶ 3.)

ARGUMENT

I. Plaintiffs Have Failed to Comply With Paragraph 80 of the Settlement Order.

In filing their latest motion to enforce the Dental Order, plaintiffs failed to comply with Paragraph 80 of the Settlement Order, which requires that:

> Before any party moves the Court to enforce or construe this Order . . . it shall give the other party 10 days' notice of its intention. During that 10-day period, the parties shall negotiate in good faith in an effort to resolve the dispute without seeking a decision from the Court.

(ECF No. 663, at ¶ 80.) On February 5, 2016, plaintiffs advised the District that they intended to file a motion to enforce the Dental Order, citing the unsuccessful mediation and stating that the District's 2016 CAP "does not contain adequate and concrete steps to reach the goals in paragraph 2(e) of the Dental Order in the near future." *See* Letter from Plaintiffs' Counsel (Feb. 5, 2016), attached as Ex. H. On February 12, 2016, the District responded and stated that it was

prepared to consider plaintiffs' proposals regarding how to increase the effectiveness of its CAP for dental services. *See* Emails between Bradford C. Patrick and Plaintiffs' Counsel (Feb. 12-16, 2016), attached as Ex. I. The District noted that plaintiffs had not proposed any improvements for the CAP beyond alleging that it was insufficient, and invited a discussion with plaintiffs to better understand their position and determine whether the parties could agree to implement any additional measures. *Id*. In response, plaintiffs stated that they would be prepared to negotiate once the motion was filed and the District had an opportunity to review the terms of a proposed order. *Id*. The same day, the District responded by once again inviting negotiations under Paragraph 80, and plaintiffs stated their belief that Paragraph 80 only requires plaintiffs to "offer to negotiate," but does not require a delay in the filing of any enforcement motion. *Id*. The District finally responded that, without knowing what relief plaintiffs intended to seek, it was not possible to determine whether any negotiation would be worthwhile. *Id*. Plaintiffs did not respond to the District's final email on February 16, and proceeded to file their motion to enforce the Dental Order that same day. (ECF No. 2094.)

Much of the District's Opposition is dedicated to explaining measures the District already has undertaken to improve dental services, or to correct plaintiffs' mistaken assumptions concerning dental service delivery for Medicaid-eligible children in the District. If plaintiffs had negotiated in good faith, the briefing on this motion, at a minimum, may have been more circumscribed. Instead, contrary to the requirements under Paragraph 80, plaintiffs failed to negotiate in good faith in an effort to resolve this dispute without the need for the Court's intervention. This is evident in plaintiffs' Statement Pursuant to Local Civil Rule 7(m) (ECF No. 2094, at 1-2) in which they state they "waited the requisite ten days under paragraph 80 before filing this motion." Plaintiffs' treatment of the ten days as a mere waiting period violates the

directive and spirit of Paragraph 80 that the parties negotiate in good faith. On these grounds alone, plaintiffs' motion to enforce should be denied.

II. The District Has Implemented Significant Measures to Improve Dental Services to Medicaid-Eligible Children Since the Entry of the Dental Order.

As set forth in the Declaration of Colleen Sonosky, the District has made notable progress in providing quality dental care to Medicaid-eligible children since the entry of the Dental Order in 2004. (Declaration of Colleen Sonosky at ¶¶ 28-30, June 3, 2016, attached as Ex. A (Sonosky Decl.).)

A. CMS Oral Health Initiative and Learning Collaborative

In 2010, CMS created national and state goals for preventive dental services by 2015 through a national Oral Health Initiative (OHI). (*Id*. at ¶ 31.) The OHI worked with states, including the District, to set a baseline and goals to be achieved over a five-year period, including: (1) an increase by 10 percentage points of the proportion of children ages 1 to 20 covered under Medicaid and the Children's Health Insurance Program (CHIP) (enrolled for at least 90 days) who receive a preventive dental service; and (2) an increase by 10 percentage points of the proportion of Medicaid and CHIP children ages 6 to 9 (enrolled for at least 90 days) who receive a sealant on a permanent molar tooth. (*Id*.) CMS recently extended the deadline for the OHI preventive dental services goal to 2018[3] and permitted the District to use either the 2011 or 2013 dental utilization rates as the SOHAP baseline. (*Id*. at ¶ 32.) The District's SOHAP uses its 2013 dental utilization rates as a baseline and its five-year goal consists of the following, to be achieved by FY 2018: (1) an increase from 50% to 60% for children ages 1 to 20 enrolled in Medicaid and CHIP (for at least 90 days) who receive a preventive dental service; and (2) an increase from 17% to 27% for children ages 6 to 9 enrolled in Medicaid and CHIP (for at least

[3] CMS was never able to set a baseline for its OHI sealant goal and will not be tracking states' progress on that goal for OHI. (Sonosky Decl. ¶ 32.)

90 days) who receive a sealant on a permanent molar tooth. (*Id*. at ¶ 33.)

In 2014, the District was selected to be one of five participants in the second cohort of the CMS OHI Learning Collaborative along with four other states: Florida, Kansas, Michigan, and Utah. (*Id*. at ¶ 34.) Of the five states, the District was the highest performing jurisdiction for children receiving preventive dental services in FY 2014. (*Id*.) The Learning Collaborative works with CMS, the Center for Health Care Strategies (CHCS), Mathematica Policy Research, and other national experts to develop, implement, and assess strategies for improving children's oral health. (*Id*. at ¶ 35.)

In a recent five-state call, CMS reported that only one state, Iowa, surpassed its four-year preventive dental service goal and is on track to meet its FY 2015 goal. (*Id*. at ¶ 37.) In FY 2014, the District was one of eleven states to see a 3% increase in preventive service utilization since FY 2011, whereas 25 states reported less than a 3% increase. (*Id*.)

B. The District's State Oral Health Action Plan (SOHAP)

CMS encouraged states to develop and submit a State Oral Health Action Plan (SOHAP) as part of the OHI. (*Id*. at ¶ 38.) The District's SOHAP is a five-year plan that sets forth specific measures to achieve the OHI goals, using the guidance from the Learning Collaborative and CMS guidelines and recommendations. (*Id*.) In developing and implementing the measures in the SOHAP, the District collaborates with MCOs and other stakeholders to discuss strategies for improving children's oral health. (*Id*. at ¶ 39.) In an effort to enhance oral health services and increase dental utilization, the District identified strategies to reduce barriers and those strategies are incorporated in the District's SOHAP. (*Id*. at ¶ 40; *see also* Pls.' Ex. 13.) The District finalized its SOHAP in consultation with CMS, and it was submitted to CMS in June 2015. (Sonosky Decl. at ¶ 41); D.C. SOHAP, *available at* https://www.medicaid.gov/medicaid-chip-

program-information/by-topics/benefits/downloads/sohap-dc.pdf. As set forth in the SOHAP, the District's two major areas of focus are oral health integration into primary care and well-child visits, and preventive dental utilization, including dental sealant utilization. (Sonosky Decl. at ¶ 42.) The SOHAP describes opportunities and resources, identifies key barriers to utilization, and outlines specific steps to achieve the District's OHI goals. (*Id*. at ¶ 43.)

The SOHAP has specific action items for consulting with the District Board of Dentistry to determine the feasibility of changing the scope of practice to increase dental sealant utilization and using data from the School Health Memorandum of Agreement (MOA) to determine which schools and children to target for preventive dental health care, including dental sealant assessments and applications. (*Id*. at ¶¶ 44-45.) In connection with oral health integration, the SOHAP describes the District's work with pediatric primary care providers who serve children under age three to encourage the service delivery of fluoride varnish treatments, as well as dental referrals for this population. (*Id*. at ¶ 46.) The SOHAP also describes the work of DOH's Community Health Administration to implement a Perinatal Oral Health Initiative. (*Id*. at ¶ 47.) These action items, and various other measures set forth in the SOHAP, are designed to increase dental service utilization and sealant placement among the EPSDT-eligible population. (*Id*. at ¶ 48.)

C. Partnerships with Children's Oral Health Stakeholders

As noted above, the District works closely with MCOs and numerous providers and advocacy groups to identify and address potential barriers to access and utilization. (*Id*. at ¶ 49.) For example, DHCF collaborates with MCOs to discuss the improvement of dental service utilization, focusing on issues such as dental provider capacity, oral health education, outreach, and access to care. (*Id*. at ¶¶ 49-50.) DHCF has worked with CMS and CHCS on the Learning

Collaborative, and also leads the District's Oral Health Initiative Working Group to implement the SOHAP. (*Id*. at ¶¶ 51-52.)

In February 2016, DHCF released a provider transmittal on the state of children's oral health in the District and an overview of reimbursable dental services delivered in primary care and dental health care settings, including oral health assessment, fluoride varnish application, and dental sealants. (*Id*. at ¶ 52.) Also in February 2016, DHCF published a brochure highlighting District Medicaid dental services, including fluoride varnish and dental sealant services, and information concerning a dental home. (*Id*. at ¶ 53.) The brochure was shared with the MCOs for distribution and is available for download on the DC HealthCheck Website. (*Id.* at ¶ 54.) Moreover, in partnership with the MCOs and DOH, DHCF hosted a dental provider training on February 24, 2016. (*Id*.) Two dental providers presented at the training: Dr. Ron Brown of Howard University focused on dental care for pregnant women and Dr. Brigitte Zivkovic of Mary's Center focused on dental care for very young children. (*Id*. at ¶ 55.) Forty-one providers registered for the training, and 31 dental providers attended it. (*Id*.)

In April 2016, DHCF updated the oral health toolkit on DC HealthCheck. (*Id*. at ¶ 56.) Providers can access the District's latest Medicaid resources, including information on Medicaid reimbursable oral health services (including dental sealants, fluoride varnish, and oral health assessments), the DC Medicaid dental benefits brochure, fluoride varnish training for primary care providers, and links to oral health practice tools and resources. (*Id*.)

In addition, DHCF, DOH, and the District of Columbia Public Schools (DCPS) have worked together for several years to increase school-based health education and service delivery. (*Id*. at ¶ 57.) In 2014, the agencies entered into an MOA to collect and share data among the three agencies and the District's MCOs to develop targeted lists of students in schools that are in

need of outreach for dental service utilization and sealant placement. (*Id*.)

DHCF also is a member of the D.C. Pediatric Oral Health Coalition, a community-driven alliance of multi-disciplinary public and private stakeholders comprised of pediatric and general dental professionals, medical providers and clinicians, government and public health specialists, health educators, community improvement leaders, and other health and social service related professionals. (*Id*. at ¶ 58.) The Coalition's purpose is to increase access to children's oral health services, which includes training professionals on how to increase oral health literacy among families and caregivers, helping to identify and streamline administrative processes for providers, and working with stakeholders to address barriers among providers. (*Id*. at ¶ 60.) For example, the Coalition helped to confirm with the D.C. Board of Medicine that physicians' scope of practice did not prohibit fluoride varnish or basic preventive oral health services in the District. (*Id*. at ¶ 61.) As a result, DHCF was able to gain approval from CMS for fluoride varnish reimbursement, which now allows primary care providers to bill for fluoride varnish up to four times per year for children up to age 3. (*Id*.)

The DOH's Oral Health Program also will begin to develop a formal Oral Health Surveillance System in FY 2016, which will allow the District to collect, analyze, and distribute information related to oral health conditions, health behavior, oral health care service utilization, and oral health workforce trends. (*Id*. at ¶ 62.)

D. The District's School-Based Initiatives

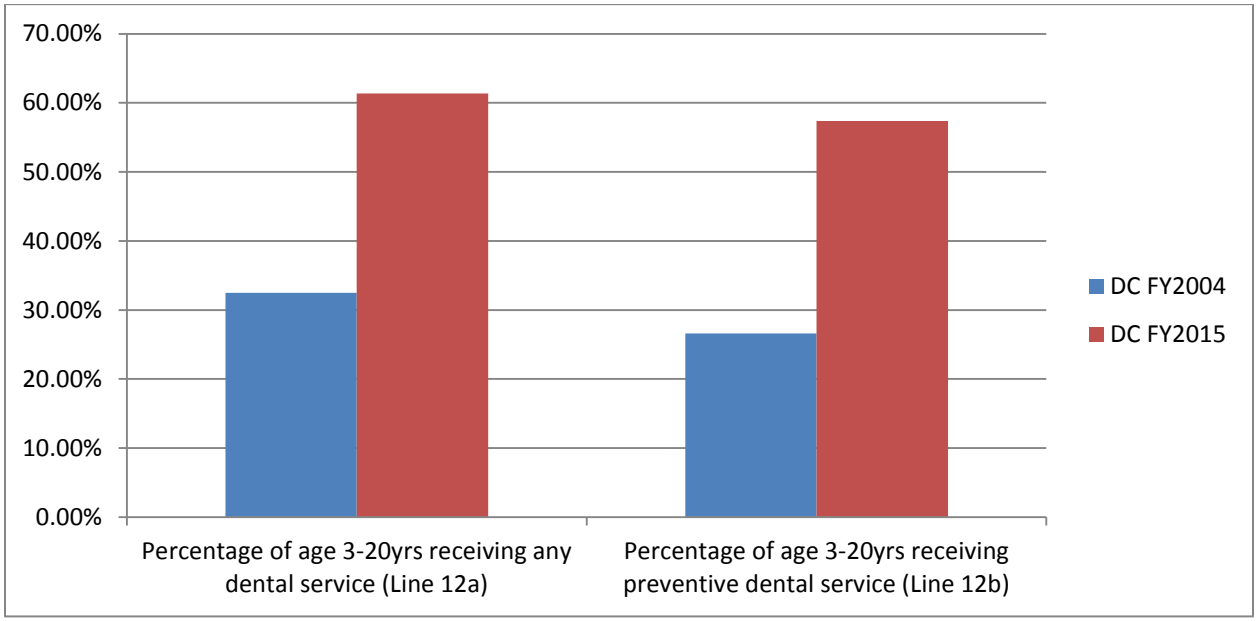
Through DOH's Oral Health Program, DOH has contracted with two Medicaid providers to furnish services in schools through which students receive dental assessment and services, including sealants. (*Id*. at ¶ 65.) In FY 2015, DOH provided preventive dental services in over thirty schools, which included oral health education and promotion, dental screenings and

referrals, fluoride treatment, and sealant application. (*Id*. at ¶ 80.) In the first half of the 2015-2016 school year, 1,516 students received preventive dental care (fluoride, sealant, or cleaning) and 622 students received sealants through the Oral Health Program. (*Id*. at ¶ 81.) These services were provided at 33 DCPS schools, 26 public charter schools, and 3 Early Childhood Centers. (*Id*.) In fact, DOH has operated three school-based health centers at DCPS high schools since 2010 and now has expanded the program to seven high schools and is working to increase the utilization of these health centers. (*Id*. at ¶ 66.) To implement this effort, DOH has issued Requests for Applications to continue its School-Based Health Center Program and School Health Services Program until 2020. (*Id*. at ¶ 67.) Although DOH 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, DOH is working with DCPS to ensure the form reaches an adult caregiver and is collaborating with other stakeholders to increase oral health literacy and outreach among families. (*Id*. at ¶ 68.)

The District is involved in several school-based initiatives designed to increase dental utilization through greater collaboration between DHCF, DOH, and DCPS. (*Id*. at ¶ 70.) Through the MOA referenced above, the agencies share data on Medicaid claims, school enrollment, and submission of school health forms to promote outreach and target resources in schools. (*Id*. at ¶¶ 70-72.) Once again, through this "cross-system collaboration" and data analysis, the District will identify schools in need of dental services and anticipates more accurate reporting and increased dental utilization among the EPSDT-eligible population. (*Id*. at ¶ 71.)

III. Although the Target Utilization Goals in the Dental Order Have Been Unattainable by the District or any State in the Nation, the District Has Implemented Measures to Increase its Dental Utilization Rates, and Consistently Ranks Above National Averages.

Since the entry of the Dental Order in 2004, the target utilization goals have been unattainable by the District and every other jurisdiction in the United States. However, as discussed above and in the context of specific performance goals below, the District has made significant improvements in the provision of dental services to Medicaid-eligible children, and its dental service utilization rates consistently rank above national averages. (*Id*. at ¶¶ 28-29.) As compared to FY 2004, the chart below illustrates the District's improved utilization rates for any dental services (line 12(a)) and preventive dental services (line 12(b)) for ages 3 to 20:[4]



(*Id*. at ¶¶ 28-29.) In fact, in FY 2014, the District ranked fourth highest in the nation for preventive dental service utilization for ages 1 to 20. (*Id*. at ¶ 30.)

[4] CMS did not establish the line 12(d) sealant reporting until 2010. (Sonosky Decl. at ¶ 28.) In 2010, the District reported 11.92% on Line 12(d) for sealants for ages 6 to 14. (*Id.*) In FY 2015, the District reported that 22.67% received protective sealants for ages 6 to 14. (*Id.*)

Plaintiffs now seek to impose additional obligations on the District, including "interim performance goals" and the submission of a five-year CAP that would, in essence, replace the SOHAP that was developed in consultation with CMS and other national experts. This would only serve to frustrate the District's laudable efforts to improve dental services for children and increase dental utilization. Indeed, the District is acting in good faith to comply with the requirements of the Dental Order. (*Id*. at ¶¶ 2-3.) Thus, plaintiffs' request for additional obligations, and the suggestion that the District be subject to civil penalties if those obligations are not met by September 2020, should be rejected summarily. Notably, as set forth in the Declaration of Ms. Sonosky, the District has implemented many of the recommendations proposed by Dr. William Maas.

A. The Requirement to Provide Protective Sealants

Paragraph 2(e)(iv) of the Dental Order requires that at least "70 percent of all EPSDT-eligible 8-14 year-olds receive protective sealants on their permanent teeth." (ECF No. 1033, at ¶ 2(e)(iv).) As of FY 2015, the most complete national data available from CMS,[5] no state has been able to achieve this utilization rate. In FY 2014, the District reported on line 12(d) of the Form CMS-416 that 20.54 percent of children ages 6 to 14 received protective sealants, compared to the national average of 14.88 percent. (Sonosky Decl. at ¶ 28.) In FY 2015, the District reported that 22.67 percent received protective sealants, compared to the national average of 14.70 percent. (*Id*.)

Plaintiffs contend that the District's 2015 CAP fails to acknowledge "noncompliance" with the Dental Order, and that it is silent on any detailed steps to meet the sealant goal. (ECF

[5] As of August 3, 2016, all states have submitted their CMS-416 reports for FY 2015. *See Early and Periodic Screening, Diagnostic, and Treatment*, Medicaid.gov., https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html (last visited August 5, 2016).

No. 2094, at 8.) However, as stated above, the District's SOHAP, which was developed and submitted to CMS after the 2015 CAP, provides an entire section devoted to sealants, including information on enrollee outreach and education, provider education, and DOH's Oral Health Program. The SOHAP provides for a ten percentage point increase to 27 percent by FY 2018 for children ages 6 to 9, as reflected in the District's 2016 CAP. (Pls.' Ex. 30.) The two percent increase every year, measured from FY 2013 to FY 2018, is based on a nationally-recognized quality tool referred to as the "Plan-Do-Check-Act" cycle, which is used by CMS. Plaintiffs seek the imposition of a five-year CAP designed to reach full compliance with the Dental Order by September 30, 2020, including an "interim goal" of a ten percentage point increase for children ages 6 to 9 by the end of FY 2016. (ECF No. 2094, at 9.) Plaintiffs' request should be rejected. The District has set interim goals through its SOHAP in a manner that will realistically allow improvement of dental sealant utilization, while permitting the District to routinely assess its performance and make any necessary adjustments to ensure quality dental care to Medicaid-eligible children.

Relying upon the Affidavit of Dr. William Maas (Pls.' Ex. 14), plaintiffs also propose that the District adopt a number of strategies to meet the sealant goal in the Dental Order. These strategies include referring children ages 6 to 14 to a Dental Home for the application of sealants as part of a pediatric health check; expansion of school-based sealant programs to high-need schools; changes to the District's dentistry regulations; overcoming parental concern and fear regarding dental sealants; convincing children that sealants are desirable and painless; conducting surveys to obtain data on how many children have received sealants; "opt-out" school-based screening to assess the need for sealants; and educating teachers and students regarding the value of sealants. (Pls.' Ex. 14, ¶¶ 8-15 (Maas Aff.).)

The District has largely implemented Dr. Maas's suggestions and is working closely with CMS, DOH, DCPS, MCOs, and other stakeholders to collect and analyze data, assess current strategies, and make any required improvements. (Sonosky Decl. at ¶ 107.) However, the suggestion that the District's HealthCheck periodicity schedule for well-child visits be modified to include oral health assessments by primary care providers for children ages 6 to 14, and the referral of this population to a Dental Home for sealants (Maas Aff., ¶ 8), is not in accordance with guidance from the American Academy of Pediatrics (AAP) and the American Academy of Pediatric Dentistry (AAPD). (Sonosky Decl. at ¶ 108.) The District's HealthCheck and dental periodicity schedules are based on guidance and recommendations from the AAP and AAPD, highlighting the importance of oral health integration in primary care. (*Id*.)

Plaintiffs propose that the District expand school-based sealant programs to high-need schools. (Maas Aff., ¶ 9.) DOH already provides dental services, including sealants, through its school-based Oral Health Program. (Sonosky Decl. at ¶ 108.) As noted above, DOH provided sealants to 622 students in the first half of the 2015-2016 school year. (*Id*.) DHCF has focused on providing education and outreach to encourage families to see their dentists and health care providers on a regular basis in a medical, not school setting, given the District's high rate of Medicaid coverage and the right to obtain EPSDT dental services. (*Id*.) The MOA described above permits the District to collect and analyze data to target high-need schools for preventive dental services and sealant utilization. (*Id*.) The Pew Center on the States reports cited by plaintiffs, to argue that there are few school-based oral health programs, are based on data from 2013 and do not address any of the District's efforts since that time. (*Id*.)

Plaintiffs also propose that the District change its dentistry regulations to allow the application of sealants by dental hygienists without a prior examination and the physical

presence of a dentist. (Maas Aff., ¶ 10.) Although dental hygienists are used to a greater extent in rural areas experiencing a shortage of dentists, that is not the case in the District. (Sonosky Decl. at ¶ 108.) Moreover, this issue is governed by the District's Board of Dentistry, not DHCF. (*Id*.) As reflected in the District's SOHAP, legislative efforts have been taken, and a request will be made to the Board of Dentistry to revise the scope of practice, but the dentist examination requirement serves to advance the overall goal of providing beneficiaries with a primary dental provider. (*Id*.)

In addition, plaintiffs suggest that the District should employ measures to overcome parental concern and fear about the dental sealant procedure by convincing children that sealants are desirable and painless. (Maas Aff., ¶ 11.) DOH's school-based health programs cover the importance of oral health, including the benefits of sealants, as well as the overall health needs of students through school nurse training. (Sonosky Decl. at ¶ 108.) Regarding the suggestion that the District use the video presented by the Ohio Department of Health to explain the sealant procedure, Maas Aff., ¶ 12, this content is covered by the DOH's school nurse and other school-based health programs. (*Id*.) Moreover, the proposal of a five-year survey to obtain data on the number of children receiving sealants and the populations that should be targeted for sealants, Maas Aff., ¶ 13, is a step that the District has undertaken, except that the data analysis is conducted on a more frequent basis. (Sonosky Decl. at ¶ 108.) As part of the District's SOHAP, DHCF reviews annual data on sealant services received by Medicaid-enrolled children as reported on the Form CMS-416. (*Id*.) And as described above, DOH's Oral Health Program will begin developing a formal Oral Health Surveillance System in FY 2016 for the District to collect, analyze, and distribute information related to oral health, including sealant placement application. (*Id*.)

Plaintiffs propose that the District conduct an opt-out school-based screening process to assess the need for sealants. (Maas Aff., ¶ 14.) But DOH's Oral Health Program does provide dental services, including screenings and assessments, through its school-based programs, and the District will be able to analyze data to target schools and children for dental services through the MOA. (Sonosky Decl. at ¶ 108.) An opt-out approach is untenable given that parental consent is needed for screening. (*Id*.) Furthermore, as to the suggestion that the District educate teachers and students about sealants in an effort to improve the likelihood that parents will consent to the application of sealants, Maas Aff., ¶ 15, the District also is undertaking these measures through DOH's school-based health programs. (Sonosky Decl. at ¶ 108.) In addition, DOH has collaborated with principals and school leaders to provide education and resources on the importance of oral health in schools. (*Id*.) This includes increasing outreach among teachers, students, and families. (*Id*.)

B. The Requirement to Provide Preventive Dental Services

Paragraph 2(e)(vi) of the Dental Order requires that at least "80 percent of all EPSDT-eligible children 3 years of age and older receive preventive dental services as reported in line 12(b) of the CMS Form 416." (ECF No. 1033, at ¶ 2(e)(vi).) As of FY 2015, the most complete national data available from CMS, no state has been able to achieve this utilization rate. In FY 2014, the District reported that 56.32 percent received preventive dental services for ages 3 to 20, compared to the national average of 48.14 percent. (Sonosky Decl. at ¶ 28.) In FY 2014, the District ranked fourth in the percentage of children ages 1 to 20 who received a preventive dental service, behind only Vermont, Connecticut, and Washington. (*Id*. at ¶ 30.) In FY 2015, the District reported that 57.38 percent received a preventive dental service for ages 3 to 20, compared to the national average of 48.24 percent. (*Id*. at ¶ 28.)

Once again, plaintiffs argue that the Court should require a five-year CAP designed to reach full compliance with the preventive services goal by September 30, 2020, in addition to an "interim goal" of a ten percentage point increase (measured from the baseline of FY 2011) so that at least 60 percent of children ages 1 to 20 have received a preventive dental service by the end of FY 2016. (ECF No. 2094, at 14-15.) The District's SOHAP, which was developed and submitted to CMS after the 2015 CAP, provides a goal of a ten percentage point increase (measured from the baseline of FY 2013) so that at least 60 percent of children ages 1 to 20 receive preventive dental services by FY 2018. (Sonosky Decl. at ¶ 33.) Once again, the two percent increase every year is based on the "Plan-Do-Check-Act" cycle. (*See* Section IV below.) The Court should reject plaintiffs' request for measures that the District has determined are not achievable by FY 2016.

Plaintiffs also rely upon Dr. Maas's Affidavit to propose strategies for compliance with the preventive services goal in the Dental Order, many of which the District has undertaken. (ECF No. 2094, at 16.) For example, plaintiffs suggest that the District increase its preventive dental service utilization by encouraging delivery of fluoride varnish treatments through pediatric primary care providers. (Maas Aff., ¶ 16.) Indeed, in FY 2014, the District implemented pediatric primary care billing for fluoride varnish application for children under age 3. (Sonosky Decl. at ¶ 109.) In addition, DHCF partnered with the D.C. Chapter of AAP, the D.C. Pediatric Oral Health Coalition, key pediatric oral health champions at Children's National Medical Center and Georgetown University, and other stakeholders to promote this service and offer training on fluoride varnish application for primary care providers. (*Id*.) Moreover, the DHCF transmittal to pediatric primary care providers and dental providers in February 2016 addresses the importance of fluoride varnish and oral health service delivery for children enrolled in

Medicaid. (*Id*.) The District's SOHAP also focuses on the fluoride varnish service, and the District continues to monitor the number of pediatricians who are trained and able to bill for this service. (*Id*.) The District also is working closely with the D.C. Pediatric Oral Health Coalition on a technical assistance program to further implement this service in the District. (*Id*.)

Plaintiffs recommend that the District compensate primary care providers for the delivery of fluoride varnish treatments, asserting that only fee-for-service providers are compensated for this service. (ECF No. 2094, at 16-17.) That is not accurate. (Sonosky Decl. at ¶ 110.) In FY 2014, the District implemented pediatric primary care billing for fluoride varnish application for children under age 3. (*Id*.) As explained in a recent DHCF transmittal, primary care providers may bill for oral health assessments and fluoride varnish applications for children under age 3 by using the appropriate code. (*Id*.; *see also* DHCF Transmittal No. 16-07, Feb. 16, 2016, attached as Ex. D.) The District not only reimburses for fluoride varnish applications, but its reimbursement rate is by far the most generous in the region. (Sonosky Decl. at ¶ 110.) The District reimburses primary care providers $29.00, Virginia reimburses $20.79, and Maryland does not cover the service at all. (*Id*.) The federally qualified health clinics (FQHCs) referenced by plaintiffs present a more complex issue because they are compensated through a federally required prospective payment system. (*Id*.)

C. The Requirement to Provide Any Dental Services

Paragraph 2(e)(v) of the Dental Order requires that at least "80 percent of all EPSDT-eligible children 3 years of age and older receive any dental services as reported in line 12(a) of the CMS Form 416." (ECF No. 1033, at ¶ 2(e)(v).) As of FY 2015, no state has been able to achieve this utilization rate. In FY 2014, the District reported that 60.51 percent received any dental services for ages 3 to 20, compared to the national average of 52.66 percent. (Sonosky

Decl. at ¶ 28.) In FY 2015, the District reported that 61.38 percent received any dental services for ages 3 to 20, compared to the national average of 52.72 percent. (*Id*.) Although the 2016 CAP does not include a specific interim goal for this requirement, plaintiffs recognize that the interim goals for sealants and preventive services advance this goal. Indeed, by increasing the number of children who receive sealants and other preventive services, the number of children receiving any dental services increases because the reporting for line 12(a) in the Form CMS-416 includes data for sealants (line 12(d)) and preventive services (line 12(b)). In their discussion of the requirement relating to any dental services, plaintiffs simply refer to their proposed five-year CAP and strategies for improving and attaining compliance with the sealants and preventive services goals set forth above. Thus, for the reasons explained above regarding plaintiffs' proposals surrounding the sealant and preventive services goal, the Court should reject plaintiffs' recommendations relating to any dental services. The SOHAP's focus on increasing utilization for sealants and preventive services will advance the goal of providing any dental services under Paragraph 2(e)(v) of the Dental Order.

D. The Requirement to Provide An Oral Health Screening

Paragraph 2(e)(iii) of the Dental Order requires that at least "85 percent of all EPSDT-eligible children entering school programs for the first time receive an oral health screening by a licensed dentist." (ECF No. 1033, at ¶ 2(e)(iii).) Plaintiffs allege that less than 60% of Medicaid-eligible children received such screenings in FY 2014, relying upon data for preventive dental service for children ages 3 to 18 and 6 to 18 to measure the District's compliance. (ECF No. 2094, at 19; Pls.' Ex. 27). As reflected in the 2015 CAP, the District has identified action items to encourage the submission of oral health assessment forms. (Pls.' Ex. 9.) Through the MOA, the District hopes to collect accurate data on the submission of Universal Health Certificates

(UHCs) and Oral Health Assessments (OHAs) to create a more accurate report on the District's compliance with Paragraph 2(e)(iii) of the Dental Order. (Sonosky Decl. at ¶ 77.)

Through its partnership with DCPS and DOH, DHCF is committed to identifying disparities in the utilization of EPSDT services, including preventive dental services and well-child visits for children attending public schools. (*Id*. at ¶ 73.) On a bi-annual basis, DHCF and DCPS share data to identify DCPS children enrolled in Medicaid who are in need of a well-child visit and preventive dental visit, as well as a completed UHC and OHA. (*Id*. at ¶ 74.) The most recent data analysis was completed in February 2016 and the information was shared with each MCO in March 2016. (*Id*. at ¶ 75.) DCPS has developed school-level reports on the number of enrolled students and the percentage of students submitting the UHCs and OHAs, which will allow the information to be shared with school leaders. (*Id*.) In March 2016, DHCF developed MCO-level and District-wide reports on the number of DCPS Medicaid children who need a well-child visit or dental visit, and those who need to submit UHCs and OHAs. (*Id*. at ¶ 76.) This information was shared with the MCOs and members of the School Health Requirements Interagency Committee, as described in the 2016 Dental CAP. (*Id*.; Pls.' Ex. 30.) However, the District does not believe that this information should be reported on each school's website, as plaintiffs suggest, because the MOA data at this juncture is best used for programmatic decision-making by District agencies to improve outreach and dental service delivery. (*Id*. at ¶ 76.)

DHCF has requested that each MCO invite its dental benefit manager to the June 2016 quarterly EPSDT meeting to discuss strategies for increasing dental utilization for children ages 1 to 20. (*Id*. at ¶ 82.) Each MCO will be instructed to target its dental outreach efforts to children in the Head Start program ages 3 to 5 and children ages 6 to 14 attending Title I schools in an effort to increase the delivery of dental services and the submission of OHAs. (*Id*.) The goal of

these outreach efforts is to ensure students schedule a visit with a dentist, receive the appropriate dental service (including dental sealants if appropriate), and submit a completed OHA form. (*Id.* at ¶ 83.) By undertaking these measures and instituting these programs, the District is committed to encouraging the submission of the OHA forms and increasing oral health screenings. (*Id.*)

E. The Requirement to Provide Oral Health Assessments

Paragraphs 2(e)(i) and (ii) of the Dental Order require that at least 80 percent of EPSDT-eligible children 6 to 24 months "receive at least one oral risk health assessment by a primary care provider as part of the HealthCheck visit." (ECF No. 1033, at ¶¶ 2(e)(i), (ii).) Plaintiffs once again request that the District be required to submit a five-year CAP that sets interim goals designed to reach compliance with these requirements of the Dental Order. Yet, as plaintiffs acknowledge, the 2015 CAP sets forth a five percent increase as an interim goal to increase utilization for health assessments in the 6 to 24 month age range. (Pls.' Ex. 9.) The 2015 CAP also provides action items to improve provider education on the importance of oral health in young children, and to implement training and billing capabilities for fluoride varnish applications and oral assessment for children under three years of age. (*Id.*) Contrary to plaintiffs' assertion, these are specific steps aimed to increase compliance with the goals for oral assessments. Moreover, as described above, the 2016 Dental CAP outlines action items to encourage the submission of the OHA forms, coupled with data collection and analysis through the MOA. (Pls.' Ex. 30.)

Under Form CMS-416 reporting, dental visits computed in line 12(b) for preventive services include oral health assessments by a dentist or other dental professional under the supervision of a dentist. On the Oral Health Assessments furnished during well-child visits by primary care providers, the District's well-child visit utilization for the 6 to 12 month and 12 to

24 month age groups is 88 percent and 78 percent, respectively. (*Id*. at ¶ 102.) The District is working with its providers and stakeholders to increase oral health education and training among pediatric providers. (*Id*.) Pediatricians may be conducting oral health assessments as part of each well-child visit, but not reporting it. (*Id*. at ¶ 103.) DHCF began requiring separate billing for separate components of a well-child visit to better track the services provided during well-child visits. (*Id*.)

Finally, the notion that the District has created compensation "disincentives" for MCO-providers or FQHCs in the provision of oral health assessments by primary care providers is simply not true, as explained above in the discussion relating to preventive dental services.

IV. The District's Dental CAPs Do Not Violate the Dental Order.

Plaintiffs contend that the District's Dental CAPs violate the Dental Order "in scope and specificity" because they purportedly lack specific and measurable goals and deadlines. (ECF No. 2094, at 22-26.) As discussed above, the District's 2015 Dental CAP (Pls.' Ex. 9) was created prior to the District's SOHAP, and the 2016 CAP (*Id*.) was based on action items developed in the SOHAP in consultation with CMS and other children's oral health stakeholders. (Sonosky Decl. at ¶ 96.) Contrary to plaintiffs' assertion, the 2016 CAP provides specific goals and deadlines regarding provider engagement, beneficiary outreach, and administrative oversight and collaboration in an effort to achieve the interim goals described in the CAP and increase dental utilization. (Pls.' Ex. 30.)

In setting its OHI goal for a two percent increase per year for preventive dental services and sealants, the District used a nationally recognized quality tool called the Plan-Do-Check-Act (PDCA) cycle, a 60-year-old model that provides a defined and well-tested process to achieve lasting improvement in health care service delivery. (Sonosky Decl. at ¶ 98.) Used in the OHI

Learning Collaborative, PDCA serves as a foundation to develop and monitor quality improvement activities for state Medicaid agencies and public health departments. (*Id*. at ¶ 100.) CMS routinely uses PDCA in its programs with state Medicaid agencies, such as the OHI. (*Id*.) Under the PDCA, organizations are encouraged to set achievable goals over short timeframes, implement desired changes, and routinely evaluate performance to determine progress. (*Id*. at ¶ 99.) If progress is achieved, a more aggressive goal is instituted, and the cycle is repeated. (*Id*.) In accordance with PDCA, the District set an initial goal of improving preventive dental service and dental sealant utilization by two percent, which can be increased upon quarterly evaluation of the rates. (*Id*. at ¶ 101.) The District will evaluate the initial goal on a quarterly basis in an effort to achieve increased dental utilization for Medicaid-enrolled children. (*Id*.)

The PDCA is similar to the S.M.A.R.T. criteria advocated by plaintiffs because it promotes manageable objectives over a defined period of time. For example, plaintiffs acknowledge that the 2016 CAP sets an interim goal for increasing the delivery of sealants to Medicaid-eligible children. Indeed, the 2016 Dental CAP identifies specific barriers and action items to eliminate those barriers, along with a timeframe for implementation and completion, and provides information on responsible parties, deliverables, and anticipated results. (Pls.' Ex. 30.) Finally, plaintiffs' contention that the CAP fails to address the importance of school-based sealant delivery systems is not accurate. The District, through its SOHAP, has undertaken several school-based initiatives designed to increase dental services, including sealants, through greater collaboration between DHCF, DOH, and DCPS. (*See* Section II, above.)

CONCLUSION

For the foregoing reasons, plaintiffs' Motion to Enforce the Dental Order of October 18, 2004 should be denied.

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Respectfully submitted,

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