UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

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

MEMORANDUM OPINION

Plaintiffs have filed a Motion to Enforce the Settlement Order of January 25, 1999, and the Order of February 28, 2003, Concerning Dental Services. Upon consideration of the Motion, Opposition, Reply, the exhibits submitted, and the entire record herein, and for the reasons stated below, Plaintiffs' Motion is **granted in part** and **denied in part.**

I. Background

Pursuant to paragraph 36 of the Settlement Order of January 25, 1999 ("Settlement Order"), which modified the Amended Remedial Order of May 6, 1997 and vacated the Order of March 27, 1997, 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." Settlement Order, ¶ 36. Under the Medicaid Act, EPSDT services include preventive

and therapeutic dental services. See 42 U.S.C. § 1396d(r)(3).[1]

According to Defendants' own reports, the vast majority of children in the class covered by this litigation who should be receiving dental services under both the Medicaid Act and paragraph 36 of the Settlement Order are not getting them. In 1992, the District of Columbia reported that only 26.6 percent of the EPSDT-eligible children received dental services. See Salazar v. District of Columbia, 954 F.Supp. 278, 307 (D.D.C. 1996). By 1999, that number had dropped even lower to 23.14 percent. Salazar v. District of Columbia, 93cv452 (D.D.C.), February 28, 2003 Mem. Op. at 2. By 2003, that number had dropped even further to 19.80 percent. Pl.s' Mot. at 2.

On February 28, 2003, the Court granted Plaintiffs' first Motion to Enforce the Settlement Order of January 25, 1999, Concerning Lead Blood Screenings and Dental Services. See Salazar v. District of Columbia, 93cv452 (D.D.C.), February 28, 2003 Mem.

---

[1] Early and periodic, screening, diagnostic and treatment services include

> [d]ental services ... which are provided ... at intervals which meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care, and ... at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and ... which shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health.

42 U.S.C. § 1396d(r)(3).

Op.. Pursuant to paragraph 3 of the February 28, 2003 Order, the Court ordered Court Monitor, Dr. Henry T. Ireys, to "prepare and submit a report evaluating the effectiveness of the methods used by the District of Columbia and each of the managed care organizations (MCOs) for informing Medicaid recipients about EPSDT dental services. Said report shall describe what methods are now being employed, as well as present recommendations for improving the methods being used." In footnote 1 of the Order, the Court stated, "Upon completion of Dr. Ireys' report, the Court will consider imposition of other remedies contained in Plaintiffs' proposed Order."

On June 17, 2003, Dr. Ireys issued his report entitled "Methods Used by the District of Columbia and the Managed Care Organizations to Inform Medicaid Recipients about Preventive Dental Services." See Pl.s' Ex. 1 ("Report"). In the Report, Dr. Ireys recommended that Defendants (1) "[i]ncrease coordination between the MCOs, the MAA [Medical Assistance Administration], and the Oral Health Program;" (2) "[e]ncourage each MCO to broaden methods for informing and educating members about dental health;" (3) "[d]evelop and evaluate a systematic approach to the use of incentives" to enhance utilization rates of preventive care under EPSDT; and (4) "[d]evelop additional informational and educational

strategies."[2] Report at 6-7.

On April 23, 2004, Plaintiffs filed the instant Motion.

II. Analysis

Plaintiffs contend that "[D]efendants are in violation of paragraph 36 of this Court's January 25, 1999 [Settlement Order] in that with respect to dental services for children, they have failed to provide or arrange for the provision of [EPSDT services] as required by 42 U.S.C. § 1396d(r)(3) and the CMS State Medicaid Manual, Sections 5123.2.G, 5124.B.2." Pl.s' Proposed Order at 1. They request that, "pursuant to footnote 1 of the Order of February 28, 2003, the Court consider additional remedies to compel defendants to comply with paragraph 36 of the Settlement Order based on Dr. Ireys' report." Pl.'s Reply at 5.

Specifically, Plaintiffs request that the Court require Defendants (not the MCOs) to (1) "adopt a [separate] dental periodicity schedule which complies with the schedules for children under age 21 as recommended by the American Dental Association and

---

[2] According to Dr. Ireys, these efforts could include:

> 1) educational videotapes that help to lessen fear of dental services, 2) radio and television advertisements that link preventive care to culturally-valued health and social outcomes, 3) a sustained media campaign that includes celebrities whose opinions or endorsements will be valued by families of Medicaid-enrolled children, and 4) innovative programs that involve parents and community leaders in communicating the importance of preventive dental care.

Report at 7.

the American Academy of Pediatric Dentristy," Pl.'s Proposed Order, ¶ 2; (2) "develop a corrective action plan ["CAP"] for ensuring that all Medicaid-eligible children receive dental services," which sets forth specific goals and deadlines for improving access to dental care by EPSDT-eligible children, describes specific actions to be taken to meet those goals and deadlines, and addresses provider participation, training of providers, coordination of dental services, and outreach; id., ¶ 1; and (3) conduct an annual assessment of oral health and submit an annual report setting forth the number of EPSDT-eligible children in the District of Columbia who received particular dental treatments. See id., ¶ 3.

A. Plaintiffs Have Established that Defendants Are in Violation of Paragraph 36 of the Settlement Order

Defendants argue that "plaintiffs' motion does not, in fact, seek to enforce the settlement order of January 25, 1999 but instead seeks to impose new requirements on the District not contemplated in that order nor mandated by federal law." Def.s' Opp'n at 1. Specifically, they contend that Plaintiffs have failed to establish a breach of the Settlement Order because they have "provide[d] no evidence that the District has systematically failed to provide dental services when requested by or on behalf of a Medicaid eligible child. ... Rather, plaintiffs read the term 'when requested' out of the Settlement Order and seek to require the District to meet certain dental participation goals as a matter of strict liability." Id. at 2-3.

This argument is totally unpersuasive. "Whatever might be discerned about the goals of the founders of EPSDT, one may fairly assume that they did not intend to create a means by which states that fail to inform poor and unhealthy children about the program might turn around and use this ["request" language] as a defense to their failure to provide services." Frew v. Gilbert, 109 F.Supp.2d 579, 609 (E.D. Tex. 2000). The EPSDT statutory mandate does not merely provide access to services; rather, "the Medicaid statute places affirmative obligations on states to assure that these services are actually provided to children on Medicaid in a timely and effective manner." Memisovski ex rel. Memisovski v. Maram, 2004 WL 1878332, *50 (N.D. Ill.) (citing Stanton v. Bond, 504 F.2d 1246, 1250 (7th Cir. 1974) ("The mandatory obligation upon each participating state to aggressively notify, seek out and screen persons under 21 in order to detect health problems and to pursue those problems with the needed treatment is made unambiguously clear by the [EPSDT amendments to the Medicaid Act] and by the interpretative regulations and guidelines.")). See Mitchell v. Johnston, 701 F.2d 337, 348 (5th Cir. 1983) (same). See also Dajour B. v. City of New York, 2001 WL 830674, *9 (S.D.N.Y.) (concluding that the "EPSDT provisions of the Medicaid Act are sufficiently mandatory to support a Section 1983 claim"); Westside Mothers v. Haveman, 289 F.3d 852, 863 (6th Cir. 2002) (same).

B. The Court Has Discretion to Order the Relief Plaintiffs Request

Defendants argue that neither federal law nor Dr. Ireys' recommendations provide any basis for the relief Plaintiffs request and, therefore, that such relief is not within the Court's discretion to order. This argument is unconvincing.

1. Requiring Defendants to develop a dental periodicity schedule is appropriate relief to remedy Defendants' failure to comply with the Settlement Order

Plaintiffs request that the Court order Defendants to develop a dental periodicity schedule "which complies with the schedules for children under age 21 recommended by the American Dental Association and the American Academy of Pediatric Dentistry." Pl.s' Proposed Order, ¶ 2. They claim that, at a minimum, the schedule should (1) identify appropriate intervals for oral risk health assessments, including a definition of such, and the appropriate age/circumstances in which a primary care provider should refer a child to a dentist, and (2) require prophylaxes and flouride treatments and dental sealants. Such relief falls within the Court's discretion under 42 U.S.C. § 1396d(r)(3)(A)(i), which specifically states that EPSDT services, including dental services, should be provided "at intervals which meet reasonable standards of dental practice, as determined by the State after consultation with

recognized dental organizations involved in child care."[3]

2. Requiring Defendants to develop a comprehensive and detailed CAP is appropriate relief to remedy Defendants' failure to comply with the Settlement Order

Plaintiffs request that the Court order "[D]efendants (not the [MCOs]) [to] develop a corrective action plan ["CAP"] for ensuring that all Medicaid-eligible children receive dental services." Pl.s' Proposed Order, ¶ 1. They claim that the CAP should, at a minimum, (1) set forth specific goals and deadlines for improving access to dental care by EPSDT-eligible children, (2) describe specific actions to be taken to meet those goals and deadlines, and (3) address provider participation, training of providers, coordination of dental services, and outreach. See id. Such relief falls within the Court's discretion to order.

Defendants are clearly in violation of paragraph 36 of this Court's Settlement Order in that, with respect to dental services for EPSDT-eligible children, they have failed to provide or arrange for the provision of EPSDT dental services as required by 42 U.S.C. § 1396d(r)(3)(A)(i). Indeed, it is undisputed that only 19.80

[3] As Plaintiffs point out, the American Academy of Pediatric Dentistry recommends that (1) the primary care provider complete an oral health risk assessment between 0 and 12 months, and every six months thereafter, see Report, App. B at 52; (2) the primary care provider provide "topical flouride treatments" between 12 and 24 months, and every six months thereafter, see id.; (3) children receive dental sealants for primary and secondary teeth between 2 and 6 years of age, and every six months thereafter, id.; and (4) "[a]t an age determined by patient, parent and dentist, refer the patient to a general dentist for continuing oral care." Id.

percent of EPSDT-eligible children currently receive any dental services whatsoever. Notably, this is significantly less than the percentage of such children who received these services in 1992, four years before this Court issued its first Opinion in this case in 1996. The record of the District is abysmal.

It is well-established that "a trial court retains jurisdiction to enforce [] settlement agreements." Beckett v. Air Line Pilots Ass'n, 995 F.2d 280, 286 (D.C. Cir. 1993). See Frew v. Hawkins, 124 S.Ct. 899, 905 (2004) (In a case involving EPSDT, the Supreme Court stated that "[f]ederal courts are not reduced to approving consent decrees and hoping for compliance. Once entered, a consent decree may be enforced."). Accordingly, the Court has discretion to order Defendants to develop a CAP so as to ensure the District of Columbia's compliance with paragraph 36 of the Settlement Order.

The specific goals and deadlines which Plaintiffs request are designed to focus Defendants' efforts on concrete steps to meet their overall EPSDT obligations. Plaintiffs request that the CAP require that: (1) at least 80 percent of EPSDT-eligible children in the 6-12 months-old age-category receive at least one oral risk health assessment by a primary care provider as part of the Health Check visit, Pl.s' Proposed Order, ¶ 1(e)(i); (2) at least 80 percent of EPSDT-eligible children in the 12-24 months-old age-category receive at least one oral risk health assessment by a

primary care provider as part of the Health Check visit, id., ¶ 1(e)(ii); (3) at least 70 percent of all EPSDT-eligible 8-14 year-olds receive protective sealants on their permanent teeth, id., ¶ 1(e)(iv); (4) at least 80 percent of EPSDT-eligible children age 3 and older receive "any dental services" as reported in line 12a of the CMS Form 416, id., ¶ 1(e)(v); and (5) at least 80 percent of EPSDT-eligible children age 3 and older receive "preventive dental services" as reported in line 12b of the CMS Form 416. Id., ¶ 1(e)(vi). Such relief is appropriate because paragraph 45 of the Settlement Order requires MCOs "to meet an 80% participant ratio for fiscal year 1999 and thereafter for all children enrolled in the MCO."[4] In addition, the CMS (Centers for Medicare & Medicaid Services) State Medicaid Manual requires each state "to achieve an 80-percent EPSDT participant ratio within 5 years or by FY 1995." Pl.s' Ex. 22 at 33-34.

Plaintiffs also request that the CAP require that at least 85 percent of EPSDT-eligible children entering school programs for the first time receive an oral health screening by a licensed dentist. Pl.s' Proposed Order, ¶ 1(e)(5). Such relief is appropriate because it is less onerous than District of Columbia law, which requires all children in the District of Columbia to furnish a

[4] According to the CMS (Centers for Medicare & Medicaid Services) State Medicaid Manual, "participant ratio" "indicates the extent to which the number of eligibles who should be screened during the year receive at least one initial or periodic screening service." Pl.s' Ex. 22 at 33.

certificate showing that they have had a dental screening before they are permitted to enroll in school. See D.C. Code 38-602(a). Moreover, the requested relief mirrors a goal the District of Columbia has set for itself. See Pl.s' Ex. 12 (The District of Columbia Healthy People 2010 Plan) at 38 ("Increase to at least 85 percent the proportion of children entering school programs for the first time, who have received an oral health screening.").

Plaintiffs' request that the CAP address how the District of Columbia intends to increase provider participation is appropriate because it is the lack of such provider participation which contributes to Defendants' violation of paragraph 36 of the Settlement Order. The District of Columbia itself has recognized the "[i]nadequate number of dentists in the community" as a "contributing factor" to the problems EPSDT-eligible children experience in accessing dental services. Pl.s' Ex. 20 (FY 2001 Oral Health Plan of Action for the District of Columbia) at 2. See Report at 2 (identifying as an obstacle to increasing the rates of children who receive preventive dental care the "long waits for appointments or long travel times to dental offices (or both) because very few dentists in any one community are willing to see many Medicaid-enrolled children"). Since "[l]ow reimbursement rates have been identified as one of the major reasons dentists are reluctant to enroll as providers," it is particularly important that the CAP address with specificity how the District of Columbia

intends to increase those rates. Pl.s' Ex. 20 at 3. See Report at 2 (identifying the fact that "[m]any dentists do not want to accept Medicaid-enrolled children because Medicaid reimbursements are extremely low for most dental services" as an obstacle to increasing the numbers of children who receive preventive dental care).

Moreover, many courts have held that the use of low reimbursement rates, which invariably results in low provider participation rates, violates 42 U.S.C. § 1396(a)(30)(A)[5], the "equal access" provision of the Medicaid Act. See Clark v. Kizer, 758 F.Supp. 572, 577 (E.D. Cal. 1990) (A "major factor that may be used in assessing compliance with the equal access provision is the level of reimbursement."). See also Methodist Hosps., Inc. v. Sullivan, 91 F.3d 1026, 1030 (7th Cir. 1996) (the equal access provision obligates the state to pay rates sufficient to enlist enough providers so that plaintiffs have equal access to medical services); Arkansas Med. Soc'y v. Reynolds, 6 F.3d 519, 529-31 (8th

---

[5] 42 U.S.C. § 1396(a)(30)(A) states that a State plan for medical assistance must

> provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan ... as ... are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

42 U.S.C. § 1396(a)(30)(A).

Cir. 1993) (concluding that the state's reduction of reimbursement rate violates the equal access provision); Clark v. Coye, 60 F.3d 600, 603 (9th Cir. 1995) ("The equal access provision requires states to set reimbursement rates at a level sufficient to enlist enough providers so that services are available equally to recipients and to the insured general population within a defined geographic area."); Memisovski ex rel. Memisovski v. Maram, 2004 WL 1878332, *42 (N.D. Ill.) ("The starting point for the issue of equal access must be the rates Illinois Medicaid pays to medical providers for providing services to Medicaid patients. Rates and equal access simply cannot be divorced.").

Plaintiffs' request that the CAP address how the District of Columbia intends to provide training to providers is appropriate because, pursuant to paragraph 41 of the Settlement Order, Defendants are required to "ensure that the MCO's train all EPSDT providers, during the first year of the contract and at least biannually thereafter, about the current requirements for EPSDT" and to "develop a monitoring program for the purpose of ensuring, on at least a biannual basis, that each physician providing EPSDT services has the necessary equipment and knowledge to perform such services in accordance with standard medical practice." Settlement Order, ¶ 41.

Plaintiffs' request that the CAP address how the District of Columbia intends to coordinate dental services is appropriate

because, as Plaintiffs point out, "[t]he result of not coordinating dental services with other child welfare programs is that opportunities to offer and encourage oral health care for children in a variety of settings are lost and children fail to receive EPSDT dental services." Pl.s' Reply at 14. Moreover, pursuant to paragraph 59 of the Settlement Order, Defendants are required to "develop and implement effective coordination of EPSDT notice and outreach with the Department of Health, the District of Columbia public school system, Headstart programs, the Women, Infants and Children nutrition program, public housing programs, Title XX programs, and the District's Part H early intervention program." Settlement Order, ¶ 59. See Report at 6-7 (recommending "[i]ncrease[d] coordination between the MCOs, the MAA, and the Oral Health Program").

Finally, Plaintiffs' request that the CAP address how the District of Columbia intends to improve outreach and incentive programs is appropriate for two reasons. First, "[t]he low participation rates among class members ... demonstrate that defendants' outreach efforts are ineffective. The fact that participation rates have declined is stark evidence of the ineffectiveness of defendants' outreach program." Frew v. Gilbert, 109 F.Supp.2d 579, 593 (E.D. Tex. 2000). Second, under 42 U.S.C. § 1396a(43), Defendants are required to "inform[] all persons in the State who are under the age of 21 and who have been determined

to be eligible for medical assistance ... of the availability of [EPSDT] services"). Third, pursuant to paragraph 4 of the February 28, 2003 Order, Defendants are required to "mail to all households in the District of Columbia, which have one or more children eligible for EPSDT, a written notice describing the EPSDT dental benefit."[6] Salazar v. District of Columbia, 93cv452 (D.D.C.), February 28, 2003 Order, ¶ 4.

3. Requiring Defendants to conduct an annual assessment of the oral health of EPSDT-eligible children is appropriate relief to remedy Defendants' failure to comply with the Settlement Order

Plaintiffs request that the Court order Defendants to conduct an annual assessment of oral health and submit an annual report setting forth the number of EPSDT-eligible children in the District of Columbia who received particular dental treatments. The Court clearly has discretion to order such relief. As Plaintiffs point out, "[i]f defendants do not know what EPSDT dental services need to be delivered, they cannot deliver them, in violation of paragraph 36 of the [January 25, 1999] Settlement Order." Pl.s' Reply at 23.

[6] No annual notice specifically targeted to dental services was sent in 2003. To date, it appears that the 2004 notice has not been sent. See Pl.s' Reply at 15-17.

III. Conclusion

For all the reasons stated herein, Plaintiffs' Motion is **granted in part** and **denied in part.**

An Order will issue with this opinion.

/s/
GLADYS KESSLER
U.S. DISTRICT JUDGE

November 15, 2004