

COMMITTEE PRINT" !113TH CONGRESS

1st Session

S. PRT.

113–16

U.S. GOVERNMENT PRINTING OFFICE

WASHINGTON :81–510 2013

JOINT STAFF REPORT ON

THE CORPORATE PRACTICE OF DENTISTRY

IN THE MEDICAID PROGRAM

PREPARED BY THE STAFF OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

MAX BAUCUS, Chairman

AND

COMMITTEE ON THE JUDICIARY

UNITED STATES SENATE

CHUCK GRASSLEY, Ranking Member

JUNE 2013

Printed for the use of the Committee on Finance

For sale by the Superintendent of Documents, U.S. Government Printing Office

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I. Preface

The United States Senate Committee on Finance has jurisdiction over the Medicare and Medicaid programs. As the Chairman and a senior member and former Chairman of the Committee, we have a responsibility to the more than 100 million Americans who receive health care coverage under these programs to oversee their proper administration and ensure the taxpayer dollars are appropriately spent. This report describes the investigative work, findings, and recommendations of the Minority Staff of the Senate Committee on the Judiciary and the Majority Staff of the Senate Committee on Finance regarding the corporate practice of dentistry in the Medicaid program. The issues are analyzed primarily in the context of one company, Small Smiles. We received whistleblower complaints about the company, it has been the subject of a False Claims Act lawsuit, and it has been under a corporate integrity agreement with independent monitoring by the Department of Health and Human Services Office of Inspector General since January 2010. In addition, we briefly examined complaints received regarding ReachOut Healthcare America (ReachOut).

At the outset of this investigation, Church Street Health Management (CSHM), the parent company of Small Smiles, cooperated with Committee staff until it emerged from bankruptcy. After emerging from bankruptcy and hiring new counsel, CSHM ceased cooperating. Under the old ownership, Committee staff was able to obtain reports by the Independent Monitor, a private, independent

oversight entity whose services were mandated as part of CSHM's settlement agreement with the U.S. Department of Justice (DOJ). However, the new owners and counsel refused to give Committee staff access to on-going reports from the Independent Monitor. ReachOut cooperated with the Committees' investigation. More than 10,000 pages of documents were obtained from CSHM, ReachOut, whistleblowers, and Federal entities. The Committee staff conducted six meetings with Small Smiles, six meetings with the U.S. Department of Health and Human Services Office of Inspector General, one site visit, and various stakeholder meetings throughout the course of the investigation. Likewise, the Committee staff met with ReachOut three times in addition to meeting with various stakeholders.

II. Executive Summary

Across the country, there are companies that identify themselves as dental management companies. These organizations are typically organized as a corporation or limited liability company. They work with dentists in multiple states and purport to provide general administrative management services. In late 2011, whistleblowers and other concerned citizens came forward with information that some of these companies were doing more than providing

management services. In some cases, dental management companies own the dental clinics and have complete control over operations, including the provision of clinical care by clinic dentists.

While there is no Federal requirement that licensed dentists, rather than corporations, own and operate dental practices, many states have laws that ban the corporate practice of dentistry. In those states where owners of dental practices must be dentists licensed in that state, the ownership structure used by some dental management companies is fundamentally deceptive. It hides from state authorities the fact that all rights and benefits of ownership actually flow to a corporation through contracts between the company and the “owner dentist.” These contracts render the “owner dentist” an owner in name only.

Notably, these clinics tend to focus on low-income children eligible for Medicaid. However, these clinics have been cited for conducting unnecessary treatments and in some cases causing serious trauma to young patients; profits are being placed ahead of patient care.

In one case, the corporate structure of a dental management company appears to have negatively influenced treatment decisions

by over-emphasizing bottom-line financial considerations at the expense of providing appropriate high-quality, low-cost care. As a consequence, children on Medicaid are ill-served and taxpayer funds are wasted.

Our investigation into these allegations began by examining five corporate dental chains which were alleged to be engaged in these practices:

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Church Street Health Management (CSHM), which at the time owned 70 Small Smiles dental clinics in 22 states and the District of Columbia;

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NCDR, LLC, which owns 130 Kool Smiles clinics in 15 states and the District of Columbia;

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ReachOut Healthcare America (ReachOut) which operates mobile clinics that treat children at schools in several states;

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Heartland Dental Care, Inc. (Heartland), which operates more than 300 clinics in 18 states; and

-

Aspen Dental Management, Inc., (Aspen) which operates more than 300 Aspen Dental clinics in 22 states.

While we initially looked broadly at all five companies, the focus

shifted primarily to CSHM and ReachOut, due to similarities between the patient populations of these two companies. Both treat Medicaid-eligible children almost exclusively and therefore are reimbursed using taxpayer dollars.

A. CSHM

CSHM has management services agreements with dental clinics which extend far beyond providing typical management services. Through its agreements, CSHM assumes significant control over the practice of dentistry in Small Smiles clinics and is empowered to take substantially all of a clinic's profits.

CSHM has management services agreements with "owner dentists" who typically work at one of the Small Smiles clinics and also "own" several clinics nearby. These "owner dentists" are paid a sal

ary by CSHM as well as a flat fee when they sign state paperwork declaring that they own other clinics. In a glaring departure from industry practice, some “owner dentists” have never visited clinics that they purport to own, are not allowed to make hiring decisions, and do not even control the scheduling of patients. Moreover, Small Smiles dentists are required by their parent company, CSHM, to treat a high volume of patients daily, which subsequently has a significant impact on the quality of care delivered.

Defenders of this corporate structure are quick to claim that without their organizations, the under-served Medicaid population would not have access to dental care. Countless news reports cite low Medicaid reimbursement rates as the principal cause for the lack of access to dental care for low-income families. However, if states and Medicaid are having difficulty recruiting good dentists to serve such a vulnerable population due to lack of reimbursement, how are private investors so successful at producing huge profits from those allegedly inadequate Medicaid reimbursements? Do short-term profits come at the cost of quality care and a sustainable business model in the long run? Local dentistry practices should be able to provide quality care to the Medicaid population and still be profitable. Fortunes should not be made on Wall Street by sacrificing proper care for the underprivileged.

B. ReachOut Healthcare America

The troubling case of Isaac Gagnon illustrates the concerns relating to the quality of ReachOut's care and a pattern of treatment without parental consent. A then 4-year-old "medically fragile" boy, Isaac received invasive dental work in October 2011 from a mobile services unit that held a contract with ReachOut Healthcare America.

1 Notably, Isaac's mother said that while she permitted ReachOut to review dental hygiene education with Isaac, she also expressed her wishes that no procedures be performed.²

On the day treatment was provided, the mobile dental unit visited Isaac's special needs preschool. During treatment that lasted approximately 40 minutes, three adults held down a screaming, kicking, and gagging Isaac.³ This disturbing conduct violated ReachOut's own internal policy that a patient is never to be physically restrained in any manner, except by holding a patient's hands when the patient "presents [an] imminent danger of harm to themselves."⁴ In the aftermath, Isaac was severely traumatized, and according to his mother, a "complete mess, emotionally."⁵ Moreover, since the treatment, Isaac has exhibited increasingly aggressive behavior—namely, kicking, screaming, and punching.⁶

Ultimately, after Isaac's mother informed the school superintendent, the school board voted to sever contractual ties with ReachOut, and issued a cease and desist order.⁷ Isaac's mother was

referred to a pediatric dentist who concluded after examining Isaac

1 Interview with Stacey Gagnon, by Moriarty Leyedecker, PC at 2 (Nov. 11, 2011) (Exhibit 36).

2 See id.

3 See id. at 3.

4 Letter from Reginald Brown, Attorney at WilmerHale, to Senators Baucus and Grassley at
5 (Feb. 23, 2012) (Exhibit 31).

5 Interview with Stacey Gagnon, by Moriarty Leyedecker, PC at 4 (Nov. 11, 2011) (Exhibit 36).

6 See id. at 5.

7 See id. at 4.

that the two pulpotomies (root canals) and two silver crowns administered were both unnecessary, and in the case of the former, performed incorrectly.⁸

Another troubling case occurred in December 2011. Nevada's Clark County School District, with a student population of almost 400,000, severed contractual ties with ReachOut after receiving complaints from parents who alleged ReachOut did not give proper notification before proceeding with serious procedures such as fillings and crowns.⁹ According to Amanda Fulkerson, spokesperson for the Clark County School District, "They [ReachOut] were going well beyond what we consider preventive care."¹⁰

The allegations against ReachOut that its dental practices were abusing children and billing Medicaid for unnecessary procedures were serious and disturbing, but we found that those practices were not necessarily widespread. Unlike CSHM, ReachOut's management services agreements truly provide only administrative and scheduling support, and do not constitute de facto ownership and control of its mobile dental clinics.¹¹

In its Administrative Agreements with dentists, ReachOut uses language similar to the following example, which ensures that the

sole authority to practice dentistry remains with the licensed dentist:

Sole Authority to Practice. Notwithstanding any other provision of this Agreement, Provider shall have exclusive authority and control over the healthcare aspects of Provider and its practice to the extent they constitute the practice of a licensed profession, including all diagnosis, treatment and ethical determinations with respect to patients which are required by law to be decided by a licensed professional.¹²

ReachOut maintains administrative services agreements with local dentists, or principal shareholders (PCs), who largely provide mobile services to schools, but also the military and in some states, nursing homes.¹³ At the time of this report, ReachOut has contracts with 23 dental practices in 22 states. The contracts between ReachOut and dental practices relate only to nonclinical aspects.¹⁴ ReachOut is paid set fees by the dentists for facilitating the mobile dentistry services. These services include providing equipment and supplies, maintaining inventory, and providing information systems, financial planning, scheduling, reporting, analysis, and customer service.¹⁵

⁸ See *id.*

⁹ See Ken Alltucker, *Mobile dental clinics drawing scrutiny*, AZCentral.com (Aug. 18, 2012)

<http://www.azcentral.com/business/articles/20120810mobile-dental-clinics-scrutiny.html>.

10 Id.

11 See, e.g., Administrative Agreement between ReachOut and [REDACTED] DDS, PC (July 2, 2006) (bates RHA 0000007–0000021) (Exhibit 32).

12 Administrative Agreement between ReachOut and [REDACTED], DDS at 9 (Apr. 23, 2009) (bates RHA 0000030) (Exhibit 33). Small Smiles has what is arguably similar language to that found in ReachOut’s administrative agreement. However, ReachOut’s language appears to be focused

more on limiting its liability. Moreover, our investigation found that Small Smiles’ contractual language is at odds with actual practice. See report Section IV(a); see Management Services Agreement, Small Smiles Dentistry for Children, Albuquerque, PC and FORBA, LLC at 2 (Oct. 1, 2010) (Exhibit 6).

13 See Administrative Agreement between ReachOut and Big Smiles Colorado at 2–3 (July 1, 2009) (bates RHA 0000051–0000065) (Exhibit 34).

14 See Letter from Reginald Brown, Attorney at WilmerHale, to Senators Baucus and Grassley at 2 (Feb. 23, 2012) (Exhibit 31).

15 See id.

The basic plan behind the Administrative Agreement between ReachOut and the mobile dentists is “to provide administrative and financial services as set forth herein, so that the PC can focus on furnishing high-quality dental care directly and through third-party dentists to needy, primarily low-income, children in schools and out-of-home placement agencies needing mobile dentistry through the services of the PC’s dentist(s).”¹⁶ The compensation for ReachOut is divided into two categories: direct expenses and administrative services. Administrative services are billed at a fee of \$500 per visit for all services provided.¹⁷ Direct expenses are billed at the actual cost plus 15% of the entire professional corporation (PC)’s employee salaries and expenses paid from the PC’s account.

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Before children can receive treatment during school hours, they must obtain parental approval. ReachOut America maintains that all offered services must be pre-approved by the child’s parents or legal guardians. Verification of the legal guardianship of the child is the responsibility of the school. However, per contractual agreement, ReachOut facilitates the delivery of the Provider consent forms and coordinates the completion of the consent forms:

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Arrange for the delivery of the Provider consent forms to the proper school employee in each school for each student to take home.

-

Coordinate that each school obtains completed consent forms by the students and that they are provided to the Administrator [ReachOut].¹⁹

In ReachOut's case, the reported problems of unnecessary procedures, lack of parental consent, and patient abuse appear to be the result of ReachOut having management agreements with several unscrupulous dentists. Given the administrative nature of their arrangement, ReachOut lacks ability to police such bad actors. As of last year, the company had no standards for dentists with whom they contract to obtain parental consent for treatment—leaving each mobile clinic to devise its own forms and procedures. While these factors appear to have contributed to many of the problems reported to us involving the company, it is also evidence that ReachOut does not significantly control the operations of clinic dentists, and simply contracts with dentists to provide support services.

¹⁶ Administrative Agreement between ReachOut and [REDACTED] DDS, PC at 1 (July 2, 2006) (bates RHA 0000007–0000021) (emphasis added) (Exhibit 32).

¹⁷ See id. at 9.

¹⁸ See id.

19 Administrative Agreement between ReachOut and [REDACTED] D.D.S., Big Smiles
Maryland

PC, at 5 (Apr. 1, 2009) (bates RHA 0000246) (Exhibit 35).

III. Key Findings

1. Through management services agreements with dentists, CSHM is the de facto owner of all Small Smiles clinics. It retains all the rights of ownership, employs all staff, recruits all staff, makes all personnel decisions, and receives all income from each Small Smiles clinic.
2. CSHM entered into a Corporate Integrity Agreement (CIA) with the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) as part of the company's settlement with the U.S. Department of Justice (DOJ). As part of the agreement, an Independent Monitor (IM) conducts extensive audits of CSHM's clinics. During the last 3 years, the IM has found massive amounts of taxpayer dollars being recklessly spent on unnecessary procedures on children in the Medicaid program by Small Smiles clinics.
3. After 2 years of intense scrutiny by HHS OIG through the CIA, and attempting to follow newly prescribed rules, CSHM went bankrupt.
4. After 3 years of monitoring by the HHS OIG and emerging from bankruptcy with new ownership and leadership changes, CSHM has repeatedly failed to meet quality and compliance standards set forth in the CIA with HHS OIG. Breaches in quality and compliance include: (1) unnecessary treatment on children; (2) improper administration of anesthesia; (3) providing care without

proper consent; and (4) overcharging the Medicaid program.

5. Despite CSHM's repeated violations of the CIA, resulting in both monetary fines and an HHS OIG-issued Notice of Intent to Exclude the company from Medicaid, HHS OIG has allowed Small Smiles to continue to participate in the program.

6. Despite state laws against the corporate practice of dentistry, numerous states have allowed companies such as CSHM to operate dental clinics under the guise of management services agreements. These practices appear contrary to the purpose of state law requiring clinics to be owned and operated by licensed dentists. The result is poor quality of care, billing Medicaid for unnecessary treatment, and disturbing consumer complaints.

7. Access to dental care is a problem in certain parts of the country, particularly rural areas for the dual reasons of fewer employment opportunities and lower reimbursement rates than urban counterparts. It is also a problem for some patients served by the Medicaid program due to the number of dentists who are unwilling to accept patients on Medicaid. Access is complicated by the burden of extremely high student loans of dentists graduating from dental school that makes serving rural or Medicaid populations problematic.

IV. Church Street Health Management and Small Smiles Dental Centers

Church Street Health Management was the successor company of an organization called FORBA (For Better Access). FORBA was founded in Pueblo, Colorado on February 9, 2001 by Dan DeRose.²⁰ At the time of incorporation, FORBA operated only a handful of Small Smiles clinics in Colorado and New Mexico.²¹ Eventually, the company grew and expanded to a nationwide chain with more than 60 clinics, and benefitted from an influx of private equity dollars, including investments by The Carlyle Group and Arcapita.²² Today, Small Smiles' mission is "to provide the highest quality dental care to low-income children in the Medicaid and [S]CHIP populations."

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An investigative report in 2008 by the ABC-7 I-Team in Washington, DC revealed serious abuses at Small Smiles clinics. Featured clinics prohibited parents from accompanying their children during treatments and excessively used a device called a papoose board, which is used to strap down young patients and immobilize them during treatment. The clinics performed a high number of crowns and pulpotomies on children who did not require such aggressive treatment and engaged in improper X-ray billing. The quality of care was significantly below any recognized medical

standard according to independent pediatric dentists interviewed by ABC—7.²⁴

This explosive report was triggered by several qui tam actions²⁵ initiating the investigations by the Department of Justice and the Department of Health and Human Services Office of Inspector General.²⁶ Acting Associate Attorney General Tony West went so far as to describe the conduct of Small Smiles as “really horrific stuff,” and further stated, “[T]he behavior in that [clinic] was so egregious that we had to—I think we were compelled to be very aggressive about going after [the] fraud in that case.”²⁷ The company eventually settled with the government and entered into a CIA, which provided for extensive audits by an Independent Monitor.²⁸ On February 20, 2012, after struggling to comply with the CIA, Church Street Health Management filed for Chapter 11 Bankruptcy protec

²⁰ Articles of Incorporation of FORBA, Inc., Secretary of the State of Colorado, signed by Dan DeRose (Feb. 9, 2001) (Exhibit 1).

²¹ See Small Smiles History, <http://www.smallsmiles.com/small-smiles-history.php> (last visited Mar. 22, 2013).

²² Press Release, Arcapita, Arcapita Completes Largest US Corporate Transaction (Jan. 15, 2007) (<http://www.arcapita.com/media/presslreleases/2007/01-15-07.html>); Sydney P. Freedberg, Dental Abuse of U.S. Poor Dodges Ejection from Medicaid, BLOOMBERGBUSINESSWEEK,

June 26, 2012, <http://www.businessweek.com/printer/articles/268590?type=bloomberg>; Dr. Steven

Adair Joins FORBA Dental Management as Chief Dental Officer, BUSINESS WIRE, Sept. 19, 2008 (on file with author).

23 See Small Smiles FAQs, <http://www.smallsmiles.com/faqs.php> (last visited Mar. 22, 2013).

24 I–Team: Small Smiles Investigation, <http://www.youtube.com/watch?v=ploMaw4zC9Q> (last visited Mar. 22, 2013).

25 See BALLENTINE’S LAW DICTIONARY (2010) (“An action to recover a penalty brought by an informer in the situation where one portion of the recovery goes to the informer and the other portion to the state”).

26 Civil Settlement Agreement, FORBA and Dep’t of Justice (Jan. 15, 2010) (Exhibit 2).

27 Interview with Tony West, Acting Associate Attorney General, Department of Justice, in Washington, D.C. (Mar. 18, 2013) (on file with authors).

28 Corporate Integrity Agreement, Department of Health and Human Services and FORBA Holdings, LLC (Jan. 15, 2010) (Exhibit 3).

tion.²⁹ The company emerged from bankruptcy under the moniker CSHM, which is how we will generally refer to the company in this report.

A. Corporate Structure

CSHM argues that it does not own any dental clinics, but rather that it has management services agreements with dentists who own the clinics.³⁰ However, courts have voided management services agreements with similar characteristics to the agreements between CSHM and their dental clinics.³¹ Based on our review of several management services agreements, employment contracts, and the payment structure, it appears that these arrangements are designed to give the appearance of complying with state laws requiring that dental clinics be owned by licensed dentists.³² However, in practice, dental clinics are not owned by dentists in any meaningful sense.

Typically, an agreement between the owner of a business and a third-party management company would simply involve the business owner paying a fee to the management company in return for services. The arrangements between CSHM and its dental centers, however, are much more complex. Like traditional third-party management agreements, dental clinics are obligated to pay CSHM

a management fee under the terms of their management agreements.

However, in that the benefits of the dental operations are heavily weighted toward CSHM, this fee is unlike traditional agreements on account of the sheer asymmetry benefitting CSHM. Specifically, each calendar month, a dental clinic must pay CSHM the greater of: (i) \$175,000; or (ii) 40% of the “Gross Revenues”;³³ or (iii) 100% of the “Residual.”³⁴ “Residual” is defined as “the Gross Revenues and income of any kind derived, directly or indirectly, from the Business . . . based on the net amount actually collected after taking into account all refunds, allowances, and discounts.” Notably, “residual” excludes “owner dentist” or staff compensation and benefits (and other expenses).³⁵ Therefore, at a minimum for any given month, CSHM is collecting a \$175,000 management fee from dental clinics, even if the clinic loses money. However, for banner months CSHM is poised to reap 100% of a clinic’s gross revenues and income, minus “owner dentist” and staff salaries and benefits.

²⁹ Bankruptcy Filing, Case 3:12–bk–01573 (Feb. 2, 2012) (Exhibit 4).

³⁰ Letter from Theodore Hester, Attorney at King & Spalding, to Senators Baucus and Grassley (Nov. 29, 2011) (Exhibit 5).

³¹ See, e.g., Consent Order Granting Permanent Inj. at 4, N.C. State Bd. of Dental Exam’rs

v. Heartland Dental Care, Inc., 11 CVS 2343 (N.C. Gen. Court of Justice Super. Ct. Div. 2011)

(rescinding the Management Services Agreements between Heartland and Drs. Cameron & Son)

(Exhibit 61).

32 See Appendix A. See generally Jim Moriarty, Survey of State Laws Governing the Corporate Practice of Dentistry, Moriarty Leyendecker 2012, at 10–11, <http://moriarty.com/content/documents/MLIPDFs/cpmdl4.10.12.pdf>.

33 See Management Services Agreement, Small Smiles Dentistry for Children, Albuquerque, PC and FORBA, LLC at 8 (Oct. 1, 2010) (Exhibit 6). (“Gross Revenues shall mean all fees and charges recorded or booked on an accrual basis each month by or on behalf of Practice as a result of dental services furnished to patients by or on behalf of [dental] Practice as a result of dental services furnished to patients by or on behalf of [dental] Practice or the Clinic, less a reasonable allowance for uncollectable accounts, professional courtesies and discounts.”).

34 See *id.* (emphasis added).

35 *Id.* at 9.

According to a December 2011 letter from CSHM, “owners typically pay themselves a fixed administrative fee from the practices they own.”³⁶ However, when Senate staff interviewed a Small Smiles “owner dentist,” a different story emerged. After claiming that she owned five clinics in Maryland and Virginia, the interviewee stated that she was paid a flat fee by the company, as opposed to paying herself a fixed administrative fee.³⁷ Claiming that she had no input in choosing the amount of said fee, the “owner dentist” further indicated she did not know if she was entitled to additional payments based on the number of clinics she supposedly owned, but was currently receiving one flat fee as if she owned only one clinic.³⁸ When asked why she chose to tell state authorities that she owned additional clinics for no additional compensation, the “owner dentist” stated that CSHM told her the clinics would close if someone else could not be found to list as the owner.³⁹ This arrangement is in direct contradiction to the representations made by CSHM in its December 16, 2011, letter to Senators Grassley and Baucus.⁴⁰

At Small Smiles, “owner dentists” enjoy none of the traditional benefits normally associated with ownership. The “owner dentist” has no equity in the practice in any meaningful sense of the word. According to the Buy-Sell Agreement, CSHM can replace the

“owner dentists” at will, and the “owner dentist” has no right to sell the practice without consent from CSHM.⁴¹ Furthermore, the Buy-Sell Agreement states that should an Event of Transfer occur, a Small Smiles representative is then entitled to buy all of the “owner dentist’s” ownership interests.⁴² Event of Transfer includes (but is not limited to) the following: owner’s death, owner’s loss of license to practice dentistry, owner’s ineligibility to participate in Medicare or Medicaid, loss of owner’s professional liability insurance, or owner’s termination or end of employment with CSHM or Small Smiles.⁴³ In the event of an Event of Transfer or Involuntary Transfer,⁴⁴ the “owner dentist” is only entitled to the purchase price of \$100.⁴⁵ Notably, pursuant to stock pledge agreements with CSHM, “owner dentists” are prohibited from issuing additional shares of capital stock in the dental clinic without first obtaining

36 Letter from Graciela M. Rodriquez, Attorney at King & Spalding, to Senators Baucus and Grassley (Dec. 16, 2011) (Exhibit 7).

37 See Interview with Gillian Robinson-Warner, DDS, Lead Dentist of Small Smiles Clinic Oxon Hill, Md. (Mar. 7, 2012).

38 See *id.*

39 See *id.*

40 See Letter from Graciela M. Rodriquez, Attorney at King & Spalding, to Senators Baucus

and Grassley (Dec. 16, 2011) (Exhibit 7).

41 Id; see, e.g., CSHM/Small Smiles Dentistry for Children, Albuquerque, PC, Buy-Sell Agreement

with [REDACTED] at 1 (Oct. 1, 2010) (CSHM-00000950) (Exhibit 8).

42 CSHM/Small Smiles Dentistry for Children, Albuquerque, PC, Buy-Sell Agreement with [REDACTED] at 1 (Oct. 1, 2010) (CSHM-00000950) (Exhibit 8).

43 CSHM/Small Smiles Dentistry for Children, Albuquerque, PC, Buy-Sell Agreement with [REDACTED] at 2-3 (Oct. 1, 2010) (CSHM-00000950) (Exhibit 8).

44 See id. at 3 (“involuntary transfer” is an event “in which Owner shall be deprived or divested of any right, title or interest in or to any Ownership Interest, including, without limitation, upon the death of Owner, transfer in connection with marital divorce or separation proceedings, levy of execution, transfer in connection with bankruptcy, reorganization, insolvency or similar proceedings. . . .”).

45 See Interview with Gillian Robinson-Warner, DDS, Lead Dentist of Small Smiles Clinic Oxon Hill, Md. (Mar. 7, 2012); see, e.g., CSHM/Small Smiles Dentistry for Children, Albuquerque, PC, Buy-Sell Agreement with [REDACTED] at 2-3 (Oct. 1, 2010) (CSHM-00000950) (Exhibit 8).

CSHM's discretionary express written consent.⁴⁶ Additionally, "owner dentists" may also not amend, alter, terminate or supplement the clinic's Articles of Incorporation, corporate Bylaws, and/ or other vital documents without first obtaining CSHM's express written consent.⁴⁷

All lease agreements for the clinic buildings, property, and equipment are with CSHM, not the "owner dentist." ⁴⁸ The "owner dentist" cannot determine the schedule or number of patients that they or their dentists see each day.⁴⁹ Furthermore, the "owner dentist" cannot hire or fire employees or purchase new equipment without receiving approval from CSHM.⁵⁰

The purpose of these arrangements is made abundantly clear in a 2006 memorandum assessing CSHM's (formerly FORBA) value:

Due to the state regulations prohibiting the corporate practice of dentistry, FORBA does not technically provide dental care to the patient, own any interest in its affiliated practices, or employ the dentists in the clinic. However, FORBA selects the new sites, negotiates the lease, oversees construction of the clinics, purchases the equipment, installs the IT and billing infrastructure, employs the staff, recruits the dentists and receives

all of the income. Thus, it effectively owns and manages the clinics.⁵¹

Thus, by this description, it is clear that the dental management company actually maintains ownership and control over Small Smiles clinics. Moreover, the facts and circumstances surrounding the creation and implementation of the CIA illustrate that this particular ownership structure undermined the independent, professional, and clinical judgment of Small Smiles dentists. That is precisely the harm that state laws requiring that dentists own dental practices are designed to prevent.

In addition to the many other ways that CSHM limits the exercise of professional judgment by its dentists, the CIA requires CSHM to ensure compliance with quality of care standards,⁵² perform regular audits,⁵³ and establish, implement, and distribute a Code of Conduct articulating consequences for non-complying dentists.

⁵⁴ For example, the agreement requires CSHM's board to "ensure that each individual cared for by [CSHM] and in [CSHM] facilities receives the professionally recognized standards of care."⁵⁵

While the CIA provisions to ensure CSHM follows recognized standards of care are well-intentioned, it creates an affirmative duty for CSHM to exercise control over the professional judgment

⁴⁶ CSHM/Small Smiles Dentistry for Children, Albuquerque, PC, Stock Pledge Agreement with [REDACTED] at 3 (Oct. 1, 2010) (CSHM-00000959) (Exhibit 65).

47 See id.

48 See Interview with Gillian Robinson-Warner, DDS, Lead Dentist of Small Smiles Clinic Oxon Hill, Md. (Mar. 7, 2012).

49 See, e.g., e-mail from Dr. [REDACTED] to Dr. [REDACTED] (May 19, 2011, 4:57 pm) (Exhibit 9).

50 Id.; see also Interview with Gillian Robinson-Warner, DDS, Lead Dentist of Small Smiles Clinic Oxon Hill, Md. (Mar. 7, 2012).

51 MIC Memorandum, FORBA, LLC, Arcapita at 6 (June 2006) (FORBAI0046011) (Exhibit 10) (emphasis added). Arcapita was the private equity firm that owned FORBA, LLC.

52 Corporate Integrity Agreement Between the Office of Inspector Gen. of the Dep't of Health & Human Serv. and Forba Holdings, LLC, at 13–14 (Jan. 14, 2010) (Exhibit 3).

53 Id. at 10–11.

54 Id. at 11–12.

55 Id. at 8.

of dentists in states that do not allow a corporation to own dental clinics or interfere with dentists' professional judgment. Therefore, the CIA has the effect of enhancing control over dental clinic operations by CSHM which is a corporation that is not licensed to practice dentistry.

B. The Influence of Private Equity

Venture capital and private equity deals are central to economic growth and innovation. However, the interest of private equity targeting dental practices within the Medicaid system is alarming—especially considering the regular complaints of private dentists and doctors about low Medicaid reimbursement rates. If a dentist in a small family practice cannot afford to take Medicaid patients because of low reimbursement rates, why would private equity invest capital in this business model? What can firms backed by private equity investment do to make money from Medicaid patients that locally owned and operated practices cannot or will not do? The answer is “volume.”

Through various meetings—both with CSHM executives and employees at the Small Smiles Oxon Hill facility—Committee staff were told that CSHM's business model was to increase patient volume as much as possible. In order to do this, CSHM executives and

staff claimed that due to the population the clinics are serving, they must over-book appointments. This means, at times, two to three patients will be scheduled for a single time slot. CSHM claims that Medicaid patients tend to be unreliable, often not showing up for scheduled appointments. This is confirmed by a 2006 memorandum assessing FORBA's (CSHM's precursor) value:

Importantly, FORBA's unique business model mitigates the 33% broken appointment challenge in that patients are not scheduled to have appointments with specific dentists. Instead, any one of four dentists at a clinic can see a patient. Therefore, since FORBA employs a minimum of three to four dentists per clinic, FORBA can leverage its critical mass of dentists and over-schedule appointments by 25%.⁵⁶

CSHM has also employed the use of bonuses as a way to incentivize their employees, both dentists and non-dentists, to maximize volume and profit. Under FORBA's leadership, employees received both a salary and productivity-based bonuses based on contests amongst dental clinics. Bonuses were based on: (1) daily average productivity, (2) broken appointment rates, (3) number of patients seen per day, and (4) number of patients converted from providing simple hygiene to operative dental work (at a higher reimbursement rate).⁵⁷ Based on a clinic's productivity level, employees could receive up to \$1,000.⁵⁸ FORBA would hold these contests multiple times throughout the year.

56 MIC Memorandum, FORBA, LLC, Arcapita at 26–27 (June 2006) (FORBAI0046011) (Exhibit 10) (emphasis added). Arcapita was the private equity firm that owned FORBA, LLC.

57 See FORBA, March Madness at 1 (FORBA 0236082/CSHM–00002086) (Exhibit 11).

58 See FORBA, The Road to the Super Bowl (FORBA 0230059/CSHM–00002004) (Exhibit 45).

Under management by CSHM, compensation is based on the revenue of that dental clinic as well as the collections of each dentist.

59 This productivity-based compensation arrangement prioritizes volume, operative procedures over preventive care, and encourages unnecessary care.⁶⁰ In fact, when asked what aspects of her job were the most dissatisfying in an exit interview with CSHM, one Lead Dentist disclosed, “Only after doctors were converted to production[-]based compensation. This conversion caused distractions and realignment of priorities. Inability to concentrate only on dentistry and patient needs.”⁶¹ [sic]

If dentists in a CSHM clinic feel the schedule is unmanageable, they are not permitted to hire additional employees to handle the increased workload without approval from CSHM executives. Nor do they have the authority to reduce their own patient load. For example, in a May 2011 e-mail from a Lead Dentist to CSHM management, the Lead Dentist complained to CSHM management that staffing was not at the appropriate level to handle the patient load they were carrying.⁶² CSHM replied that, “As we discussed yesterday, the patient load will not be reduced without collaboration from CSHM.”⁶³ The Lead Dentist replied, “I will not be [held] responsible for errors in my center when we have asked for help numerous times.”⁶⁴

C. Federal Government Intervention

In 2010, after a lengthy investigation into the company by the United States Department of Justice, CSHM entered into a CIA with the United States Department of Health and Human Services,⁶⁵ as well as settlement agreements with the United States Department of Justice and 22 states.⁶⁶ The Department of Justice settlement cites conduct by FORBA (now CSHM) from the time period of September 2006 through June 2010.⁶⁷ Specifically, the conduct noted in the agreement includes submitting Medicaid reimbursement claims for medically unnecessary pulpotomies, crowns, extractions, fillings, sealants, x-rays, anesthesia, and behavior management; failing to meet professionally recognized standards of care; and provision of care by unlicensed persons.⁶⁸ CSHM's CIA with the Department of Health and Human Services required CSHM to institute rigorous compliance procedures and programs, as well as submit to regular audits and reviews by an Independent Monitor.⁶⁹

To date, the Independent Monitor has audited and reviewed 60 Small Smiles clinics through an onsite review or desk audit since 2010. Consistently, the Independent Monitor reports reveal that

⁵⁹ See CSHM/Small Smiles Dental Center of Holyoke, LLC, Lead Dentist Employment Agreement

with Dr. [REDACTED] at 4–6 (Aug. 30, 2010) (Exhibit 12).

⁶⁰ Id.

61 CSHM Exit Interview, Medrina Gilliam at 1 (July 1, 2011) (CSHM-00006826) (Exhibit 13).

62 See E-mail chain from Dr. [REDACTED] to Dr. [REDACTED] (May 19–20, 2011) (Exhibit 9).

63 Id.

64 Id.

65 Letter from Dep't Health and Human Services, OIG, to Senators Baucus and Grassley, re: Corporate Integrity Agreement with CSHM, w/attach. at 2 (Oct. 4, 2012) (Exhibit 14).

66 CSHM/FORBA Holdings, LLC, State Settlement Agreement with the State of N.Y. (Jan. 20, 2010) (Exhibit 15).

67 See Civil Settlement Agreement, FORBA and Dep't of Justice (Jan. 15, 2010) (Exhibit 2).

68 See id.

69 See Letter from Dep't Health and Human Services, OIG, to Senators Baucus and Grassley, re: Corporate Integrity Agreement with CSHM, w/attach. at 2 (Oct. 4, 2012) (Exhibit 14).

clinic employees had little awareness of the new compliance procedures, and that CSHM was giving its dentists passing grades on chart audits which the Independent Monitor says they clearly failed.⁷⁰ In fact, of the 14 reports that graded the clinic doctors on a 100-point scale, CSHM gave their doctors grades that were on average 44% higher than the grade that the Independent Monitor awarded.⁷¹

D. Committee Staff Site Visit to Small Smiles of Oxon Hill, Maryland

On March 7, 2012, Committee staff arranged a site visit at a Small Smiles Dental Center in Oxon Hill, Maryland, during an audit by the Independent Monitor.⁷² The center was large, reasonably well kept, and clinic employees were friendly and welcoming. Signs informing parents of their right to join their children in the treatment area were prominently displayed in both English and Spanish: ⁷³

⁷⁰ See Independent Monitor Report, Oxon Hill, Md. at 11 (Apr. 20, 2012) (Exhibit 16).

⁷¹ See Independent Monitor Report, Worcester, Mass. at 5 (Jan. 4, 2011) (Exhibit 46); Independent

Monitor Report, Thornton, Colo. at 6 (Feb. 4, 2011) (Exhibit 47); Independent Monitor

Report, Santa Fe, N.M. at 6 (Mar. 7, 2011) (Exhibit 48); Independent Monitor Report, Albuquerque, N.M. at 5 (Apr. 8 2011) (Exhibit 49); Independent Monitor Report, Myrtle Beach, S.C. at 6 (May 9, 2011) (Exhibit 50); Independent Monitor Report, Augusta, Ga. at 6 (July 1, 2011) (Exhibit 51); Independent Monitor Report, Austin, Tex. at 6 (July 29, 2011) (Exhibit 52); Independent Monitor Report, Mattapan, Mass. at 6 (Sept. 6, 2011) (Exhibit 53); Independent Monitor Report, Manassas, Va. at 8 (Sept. 22, 2011) (Exhibit 23); Independent Monitor Report, Youngstown, Ohio at 5 (Oct. 14, 2011) (Exhibit 27); Independent Monitor Report, Oklahoma City, Okla. at 6 (Nov. 4, 2011) (Exhibit 54); Independent Monitor Report, Mishawaka, Ind. at 6 (Oct. 5, 2012) (Exhibit 40); Independent Monitor Report, Brockton, Mass. at 6 (Nov. 9, 2012) (Exhibit 55); Independent Monitor Report, Denver, Colo. at 7 (Dec. 7, 2012) (Exhibit 56). The 44% figure was calculated by averaging the CSHM score and the Independent Monitor score for each doctor in the listed reports. The difference was found between each score, which resulted in 44% higher average in CSHM scores than Independent Monitor scores.

72 *Id.* at 8.

73 See Small Smiles Clinic, Oxon Hill, Md. Photograph of signs (Exhibit 37).

Committee staff was given the opportunity to sit in with the Independent Monitor during the interview of three employees of the clinic and ask supplemental questions.

The first employee interviewed was the clinic's Office Manager/ Compliance Liaison.⁷⁴ The role of the Compliance Liaison is to keep up-to-date with CSHM compliance policies and ensure that staff is knowledgeable and well-trained in compliance policies.⁷⁵ For example, the Compliance Liaison is responsible for regularly checking the company's web portal to see if there are any new compliance trainings on topics such as X-ray safety, record management, and billing practices.⁷⁶ During questioning, it became increasingly clear that the Compliance Liaison was simply too busy running the clinic to keep up with his compliance duties. This particular clinic treats as many as 70 children each day, and makes appointments for well over 100.⁷⁷

The Compliance Liaison also indicated that he was previously the Office Manager and Compliance Liaison at yet another troubled Small Smiles clinic in Manassas, Virginia.⁷⁸ When asked whether he thought there were any problem areas with the Manassas clinic, he responded that he did not think so.⁷⁹

The next employee interviewed was the Clinical Coordinator. The Clinical Coordinator is typically a facilitator—making certain that the busy treatment area operates efficiently. The Clinical Coordinator maintains and orders supplies, monitors patient flow, and keeps things moving. During the interview, it was clear that the Clinical Coordinator was not knowledgeable about important safety and compliance policies. For example, when the Independent Monitor asked what should be done when a child has evidence of tooth decay, but will not sit still for X-rays, the Clinical Coordinator responded that the dental assistant or available staff should sit with the child in the X-ray area and hold the child still.⁸⁰ However, pediatric dental education literature emphasizes that given “associated risks and possible consequences of [protective stabilization], the dentist is encouraged to evaluate thoroughly its use on each patient and possible alternatives.”⁸¹ A dentist must consider the following factors prior to using protective stabilization: “1. alternative behavior guidance modalities; 2. dental needs of the patient; 3. the effect on the quality of dental care; 4. the patient’s emotional development; [and] 5. the patient’s medical and physical considerations.”

⁸² The Clinical Coordinator was terminated.

Finally, Committee staff questioned the “owner dentist” of Oxon Hill Small Smiles, who was also the Lead Dentist. The “owner dentist” appeared nervous when speaking with the Independent Monitor and Committee staff, but appeared genuinely passionate about

74 See generally Interview with Marty Reyes, CDA, EFDA, Office Manager and Compliance Liaison

of Small Smiles Clinic Oxon Hill, Md. (Mar. 7, 2012).

75 See CSHM Office Manager's Manual, v. 06–2011, at 15 (Dec. 17, 2010) (Exhibit 17).

76 See Interview with Marty Reyes, CDA, EFDA, Office Manager and Compliance Liaison of Small Smiles Clinic Oxon Hill, Md. (Mar. 7, 2012).

77 See Daily Patient Flow at 5 (Apr. 13, 2011) (Exhibit 18).

78 Interview with Marty Reyes, CDA, EFDA, Office Manager and Compliance Liaison of Small Smiles Clinic Oxon Hill, Md. (Mar. 7, 2012); see discussion at Parts E.2.

79 Id.

80 Id.

81 34 AM. ACAD. OF PEDIATRIC DENTISTRY, REFERENCE MANUAL: GUIDELINE ON BEHAVIOR

GUIDANCE FOR THE PEDIATRIC DENTAL PATIENT 176 (1990) (emphasis added) (Exhibit 19).

82 Id.

dental care for underprivileged children. When asked about the details of her compensation, the “owner dentist” stated that she receives a salary, and an additional flat payment for being the “owner dentist.”⁸³ When asked how many Small Smiles Dental Centers she owned, she stated that she owned five clinics and had just recently become the owner of the Manassas, Virginia clinic.⁸⁴ She was then asked if she received an additional flat fee payment for each clinic that she owned, and she stated that she did not.⁸⁵ Following up on that question, she was asked why she chose to become the owner of the troubled Manassas⁸⁶ clinic for no additional compensation, and she stated that she was told it would have to close if she did not agree to become the owner.⁸⁷ The “owner dentist” was then asked if she could name any of the dentists under her employ at the Manassas clinic she purported to own.⁸⁸ She could not name a single dentist at that facility. When asked if she had ever been to the Small Smiles clinic in Manassas, she replied that she had not.⁸⁹ When asked whether she knew the names of any of the dentists at another Maryland clinic she purported to own, she struggled for some time before recalling one dentist’s first name.⁹⁰

The next line of questioning for the “owner dentist” was regarding her control over operations at the clinics she supposedly owns.

She was adamant that all medical decisions remain under her control.

However, she conceded that CSHM receives 100% of the proceeds of the business, pays all of the staff salaries at her clinic, pays her salary, dictates the number of patients to be scheduled for each day, sets the budget for supplies, rents the space the clinic uses, and has complete control over all hiring and firing decisions.

91 When pressed further regarding her ability to hire additional staff should the clinic need an additional dentist to keep up with demand and provide quality care, she did not wish to engage in the hypothetical discussion, but conceded that she had never hired or fired anyone without the permission of CSHM.⁹²

Despite the language in the management services agreement regarding the payment structure and management fees paid to CSHM, it is clear that the “owner dentists” have no idea where the money from the procedures for which they bill Medicaid actually ends up. “Owner dentists” are merely paid a salary by CSHM and receive a flat fee to assert ownership to their respective state, but they exercise none of the traditional elements of ownership.

83 Interview with Gillian Robinson-Warner, DDS, Lead Dentist of Small Smiles Clinic Oxon Hill, Md. (Mar. 7, 2012).

84 Id.

85 Id.

86 See discussion at Parts E.2.

87 Id.

88 Interview with Gillian Robinson-Warner, DDS, Lead Dentist of Small Smiles Clinic Oxon Hill, Md. (Mar. 7, 2012).

89 Id.

90 Id.

91 Id.

92 Id.

E. CSHM Repeatedly Fails to Meet Quality and Compliance Standards

The Department of Health and Human Services Office of Inspector General and the Independent Monitor have closely monitored Small Smiles clinics and their corporate owners since 2010. Monitoring has included audits, site visits, fines, penalties, and changes to management, and yet CSHM repeatedly fails to meet basic quality and compliance standards. According to Independent Monitor reports, the company is still rushing through dental treatments, providing substandard and in some cases dangerous care, performing medically unnecessary treatments, and risking the safety of children—all of which are ultimately financed by taxpayers through the Medicaid program.⁹³

Each time the company fails to meet its obligations or the Independent Monitor uncovers problems, the company promises to do better, and HHS OIG gives CSHM another chance. The following sections outline the major failures of CSHM during the monitoring period, and the seemingly endless capacity for the government to grant the company more chances.

1. Phoenix, Arizona Independent Monitor Report

The Independent Monitor visited a Small Smiles clinic in Phoenix,

Arizona on December 23, 2010, relatively early on in the monitoring period. At this clinic, the Lead Dentist informed the Independent Monitor that she automatically performed pulpotomies on primary anterior teeth that received a NuSmiles crown.⁹⁴ A NuSmiles crown is a stainless steel crown (SSC) with a natural-looking, tooth-colored coating.⁹⁵ According to the Lead Dentist, “the amount of tooth structure removal necessary to prepare the teeth for the crowns endanger the pulp and necessitated pulpotomies.”⁹⁶ However, a pulpotomy is only necessary when the nerve is exposed, and is typically only indicated in one-third of patients.⁹⁷ Therefore, if the patient population is typical, two-thirds of the pulpotomies that the Lead Dentist in Phoenix performed were potentially unnecessary, at a total cost of approximately \$5,300 per 100 Medicaid patients.⁹⁸ Not only is this a quality of care issue, with children receiving unnecessarily prolonged treatments, but it is also a drain on the Medicaid system. When dentists perform unnecessary pulpotomies, it is the Medicaid system that initially foots the bill, and then ultimately the taxpayers. It is unclear whether outside influence or information compelled the dentist to do pulpotomies every single time, but this case illustrates that the trainings and compliance programs necessitated by the CIA were largely ineffectual.

Of the 30 records reviewed by the Independent Monitor, 15 documented children being strapped down to a papoose board during

93 See IMR Oxon Hill, Md. at 27 (Exhibit 16).

94 Independent Monitor Report Phoenix, Ariz. at 3 (Dec. 23, 2010) (Exhibit 20).

95 NuSmile, Pediatric Crowns, <http://www.nusmilecrowns.com> (last visited Mar. 22, 2013).

96 IMR Phoenix, Ariz. at 3 (Exhibit 20).

97 Thikkurissy, Sarat, et al., Pulpotomy to Stainless Steel Crown Ratio in Children With Early Childhood Caries: A Cross-sectional Analysis *Pediatric Dentistry*, *Pediatric Dentistry*, vol. 33 n. 7, 496, (Nov./Dec. 2011) (Exhibit 21).

98 Arizona Health Care Cost Containment System—Schedule of Dental Rates (Jan. 1, 2007) (Exhibit 22). Each pulpotomy costs \$81. *Id.* at 2.

treatment.⁹⁹ However, none of these patients received nitrous oxide/oxygen anesthesia, which is the preferred method of calming young dental patients.¹⁰⁰ Furthermore, one child was documented as being on the papoose board for 1 hour and 45 minutes, without monitoring of vital signs or a bathroom break.¹⁰¹ This is a clear violation of CSHM's policies and is dangerous and distressing for the child.¹⁰²

This early Independent Monitor report demonstrates that many of the problems identified in prior news reports and flagged by DOJ in 2007 and 2008 were still common practice at Small Smiles in late 2010, including unnecessary procedures, overuse of the papoose board on distressed children, and a general lack of understanding by Small Smiles dentists regarding how children should be treated.

2. Manassas, Virginia Independent Monitor Report

The Independent Monitor visited a Small Smiles clinic in Manassas, Virginia on September 22, 2011—nearly one year after the initiation of compliance programs, training, and monitoring by the government. The Independent Monitor found many of the same problems, and nearly an identical case involving the misuse of a papoose board. Both dentists at the clinic scored lower on the Independent

Monitor's evaluation than on a previous internal audit conducted by CSHM. These dentists did not follow proper protocols for implementing and documenting dental procedures, and this ultimately resulted in one dentist receiving an automatic failure from the Independent Monitor.¹⁰³ This fact is critical. The purpose of the monitoring period is that, at the end of 5 years, CSHM should be able to use its own internal monitoring and compliance programs. In numerous Independent Monitor reports, however, CSHM's audits have given dentists passing grades, while the subsequent Independent Monitor's review found that these same dentists clearly failed.¹⁰⁴ Therefore, despite the passage of time and ample guidance from the government, CSHM is still unable to rely on its own internal monitoring and compliance programs.

Just like the Phoenix clinic, one dentist at the Manassas clinic utilized a papoose board on a patient for 1 hour and 45 minutes, a violation of CSHM use of restraint policy,¹⁰⁵ and in violation of generally recognized standards from the American Academy of Pediatric Dentists.¹⁰⁶

⁹⁹ IMR Phoenix, Ariz. at 17 (Exhibit 20).

¹⁰⁰ Id. at 18.

¹⁰¹ Id. at 17.

102 Id. at 17–18.

103 Independent Monitor Report Manassas, Va. at 2 (Sept. 22, 2011) (Exhibit 23).

104 Independent Monitor Report, Worcester, Mass. at 5 (Jan. 4, 2011) (Exhibit 46);
Independent

Monitor Report, Thornton, Colo. at 6 (Feb. 4, 2011) (Exhibit 47); Independent Monitor

Report, Santa Fe, N.M. at 6 (Mar. 7, 2011) (Exhibit 48); Independent Monitor Report,
Albuquerque,

N.M. at 5 (Apr. 8 2011) (Exhibit 49); Independent Monitor Report, Myrtle Beach, S.C.

at 6 (May 9, 2011) (Exhibit 50); Independent Monitor Report, Augusta, Ga. at 6 (July 1, 2011)

(Exhibit 51); Independent Monitor Report, Mattapan, Mass. at 6 (Sept. 6, 2011) (Exhibit 53);

Independent Monitor Report, Manassas, Va. at 8 (Sept. 22, 2011) (Exhibit 23);

Independent Monitor Report, Youngstown, Ohio at 5 (Oct. 14, 2011) (Exhibit 27); Independent

Monitor Report,

Oklahoma City, Okla. at 6 (Nov. 4, 2011) (Exhibit 54); Independent Monitor Report,

Mishawaka, Ind. at 6 (Oct. 5, 2012) (Exhibit 40); Independent Monitor Report, Denver, Colo.

at 7 (Dec. 7, 2012) (Exhibit 56).

105 CSHM Policy on Protective Stabilization at 3 (Jan. 14, 2012) (Exhibit 24).

106 Guideline on Behavior Guidance for the Pediatric Dental Patient, American Academy of
Pediatric

Dentistry, vol. 33 no. 6, 167–68 (2011/2012) (Exhibit 25).

Another example includes one dentist automatically failing due to the lack of documentation for medical necessity.¹⁰⁷ Manassas clinic dentists billed Medicaid for reimbursement of X-rays even though the Independent Monitor's audit found no evidence that the X-rays were actually performed.¹⁰⁸ Five records revealed patients receiving treatment for 8 to 12 teeth during a single visit without the proper amount of anesthesia being administered. Of 244 pulpotomies performed, 104 "were not medically necessary,"¹⁰⁹ costing taxpayers and the Medicaid program a total of \$8,391.¹¹⁰ This audit also revealed that CSHM's chart audit tool failed to uncover several documentation errors and improper anesthesia use.¹¹¹

Allegations of abuse plagued the Manassas clinic, leading to its eventual closure by CSHM. The Committee staff have received information that the Virginia Department of Health Professions will be reviewing the dentists who practiced at the Manassas clinic. Contrary to assertions that a vulnerable population would go un

¹⁰⁷ See IMR Manassas, Va. at 2 (Exhibit 23).

108 Id.

109 Id. at 3.

110 Virginia Smiles for Children—Schedule of Allowable Fees (Exhibit 66). Each pulpotomy costs \$80.69.

111 Id.

treated without Small Smiles, the patients of the Manassas clinic and other clinics closed by CSHM have been absorbed into other practices with little difficulty.¹¹²

3. Oxon Hill, Maryland Small Smiles Clinic

The report issued by the Independent Monitor after the site visit at the Oxon Hill Small Smiles confirms the findings of the Committee staff who observed the clinic with the Independent Monitor.

First, the Independent Monitor discovered numerous quality of care issues. It found that the clinic was inappropriately documenting and administering local anesthetics and nitrous oxide.¹¹³

Notably, the Independent Monitor observed that “[t]he maximum dose of local anesthetic was not calculated for patients treated by the Lead Dentist before she administered local anesthetic.”¹¹⁴

Rather, local anesthetic calculations were performed and filled in after the fact.¹¹⁵ Moreover, the clinic was found to be substituting the papoose board for anesthesia or nitrous oxide.¹¹⁶ This means that the child was both experiencing pain while also being restrained.

Out of 30 records, there were six instances in which a child younger than 5 years old was restrained during treatment without the use of local anesthetic, and seven instances in which primary teeth fillings on children younger than 7 years old were

administered without local anesthesia or nitrous oxide.¹¹⁷

Second, the Independent Monitor found alarming practices that had threatened patient safety at Oxon Hill, Maryland clinic. One notable incident involved a child treated with a pulpotomy and a stainless steel crown who was restrained using a patient stabilization device (PSD):

[C]hild screamed and fought the entire time. The patient kept moving her head, making it difficult to keep it secured. She vomited approximately half way through the procedure. The dentist immediately turned the patient on her side and suctioned her mouth and throat. This child's airway was in jeopardy because the mouth prop opened her mouth so wide it restricted her ability to swallow and protect her airway. The patient was screaming and gasping, leaving her airway open and vulnerable. Cotton pellets used during the pulpotomy were placed and removed while SSC's were fitted and removed on a moving, combative, and hysterical child with no methods employed to protect the airway.¹¹⁸

Notably, the dentist resumed treatment despite the child's vomiting. Most shocking was the Independent Monitor's final observation regarding the clinic:

Treatment was provided to restrained children who were fighting,

crying, and basically hysterical, using large mouth props

112 See Interview with Church Street Health Management, in Washington, D.C. (Feb. 21, 2012).

113 See IMR Oxon Hill, Md. at 27 (Exhibit 16).

114 Id. at 36.

115 Id.

116 Id.

117 See id. at 27.

118 Id. at 36 (emphasis added).

that overextended their mouths, compromising their ability to swallow and protect their airways. Water spray from hand pieces, cotton pellets used for pulpotomies, and stainless steel crowns (SSCs) that are fitted and removed all presented potential risk to these children's airways.

Preparedness and anticipation was lacking on the part of the dental assistants during procedures on uncooperative young children.¹¹⁹

Third, the Independent Monitor found instances in which no medical necessity was provided for treatments performed. In 9 of the 30 records reviewed by the Independent Monitor, no documentation or X-rays were provided to support the medical necessity of treatments provided to patients.¹²⁰ Therefore, in 30% of the records reviewed, the Medicaid program was billed for unjustified and potentially unnecessary treatments. Larger sampling at this and other clinics could reveal massive overpayments by the government to CSHM.

4. Oxon Hill, Maryland Small Smiles Overpayment

At the Oxon Hill Small Smiles Center, mentioned above, HHS OIG was alerted to an \$852,492.74 overpayment.¹²¹ Not only was

this clinic providing substandard care, according to the Independent Monitor, it was also providing unnecessary treatments and getting excessive payments from Medicaid. Shortly after the overpayment was identified, CSHM satisfied its obligations under the CIA to refund the overpayment.¹²²

5. Youngstown, Ohio Clinic

Similar problems occurred at the Youngstown, Ohio clinic, where the Independent Monitor found that the clinic provided unnecessary care and also had billing, reimbursement, and records management issues. HHS OIG even went as far as to demand that Small Smiles pay a \$100,000 stipulated penalty and issued a Notice of Material Breach and Intent to Exclude to the Youngstown clinic. Such notices signal that HHS OIG intends to exclude a facility from the Medicaid program. Exclusion would prohibit a facility from treating Medicaid beneficiaries and seeking state and Federal reimbursement. HHS OIG cites the Independent Monitor report findings as the primary reason to exclude the Youngstown facility from participating in the Medicaid program.¹²³

Specifically, 7 of the 15 records reviewed by the Independent Monitor revealed a lack of documentation or radiographic evidence to support medical necessity for treatments provided by Small Smiles.¹²⁴ Of those 7 records, 6 revealed pulpotomies were performed without medical necessity, while one record showed no X-

119 Id. at 5.

120 Id. at 29.

121 See Letter from CSHM to HHS OIG, re: Reporting of Substantial Overpayment to Small Smiles Dental Centers of Oxon Hill at 2 (May 22, 2012) (Exhibit 57).

122 See id.

123 Letter from HHS OIG to CSHM, re: Demand for Stipulated Penalties and Notice of Material Breach and Intent to Exclude (June 22, 2012) (Exhibit 26).

124 Id. at 4–5.

rays or photographs were taken to support the medical necessity for treatment provided.” 125

The Independent Monitor report found “poorly performed fillings and stainless steel crowns, undiagnosed recurrent decay or faulty restorations, lack of rationale for extractions, no use of local anesthesia for placement of fillings in teeth with deep decay, use of multiple surface fillings without any substantiation as to why stainless steel crowns were not used.” 126 In perhaps the most troubling violation observed by the Independent Monitor, the report describes:

A combative 4-year-old child received a cut to the tongue while three teeth were being treated with fillings, a pulpotomy and a [stainless steel crown]. The documentation in the patient’s record did not record the size of the cut and reported the patient was “very strong and vocal.” Four people were required to help manage the patient. Documentation also showed that a protective stabilization device (PSD) was used and the patient was “double wrapped” in order to provide treatment. The e-mail communication related with this case did not show that X-rays were requested; therefore, it appeared there was no evaluation to determine whether the treatment rendered was medically necessary.¹²⁷

On July 3, 2012, HHS OIG received confirmation that CSHM paid the \$100,000 stipulated penalty.¹²⁸ On August 23, 2012, HHS OIG sent a letter to CSHM stating that it determined that CSHM “cured the breaches identified in the OIG’s Notice, and will not proceed with an exclusion action against CSHM’s Small Smiles Dental Centers of Youngstown at this time.”¹²⁹ CSHM advised HHS OIG of its effort to cure the specific breaches through various actions, including: (1) evaluation and termination of nine staff people; (2) the temporary, 2-day closure to conduct training; and (3) the development of an ongoing oversight and monitoring plan by the Chief Compliance Officer, Chief Dental Officer, the Regional Director, and the Senior Vice President of Operations.¹³⁰

F. Health and Human Services Office of Inspector General

Notice of Intent to Exclude

On March 8, 2012, HHS OIG sent a Notice of Material Breach and Intent to Exclude to CSHM. HHS OIG states in its letter that due to CSHM’s “repeated and flagrant violation of certain provisions” of the CIA, the OIG is exercising “its right under the CIA to exclude CSHM from participation in the Federal health care programs.”

¹³¹ HHS OIG largely cites violations occurring at the Manassas, Virginia clinic as primary reasons for its intent to exclude.

Specifically, HHS OIG points to five main areas in which CSHM

¹²⁵ Id.

126 *Id.* at 5.

127 Independent Monitor Report Youngstown, Ohio at 11 (May 25, 2012) (Exhibit 27) (empha

sis added).

128 See Letter from HHS OIG, to CSHM, re: Resolution of the Stipulated Penalties and Notice

of Material Breach and Intent to Exclude Matter at 2 (Aug. 23, 2012) (Exhibit 28).

129 *Id.* at 1.

130 See *id.*

131 Letter from HHS OIG to CSHM, re: Notice of Material Breach and Intent to Exclude at

1 (Mar. 8, 2012) (Exhibit 29).

violated the terms of the CIA: (1) management certifications and accountability; (2) policies and procedures requirements; (3) change to termination policy and procedure; (4) CSHM review of pulp-to-crown ratios and provision of medically unnecessary services at other CSHM facilities; and (5) quality of care reportable event requirements.

132

Part of complying with the CIA requires CSHM to certify that each employee knows and understands his/her responsibilities and duties under Federal law, state dental board requirements, and professionally recognized standards of care. The certification also requires the employee to “attest that his/her job responsibilities include ensuring compliance with regard to the area under his/her supervision. . . .” 133 On March 15, 2011, CSHM submitted a report to the HHS OIG, including a certification for LaTanya O’Neal, the Lead Dentist in the Manassas, Virginia clinic. On November 16, 2011, HHS OIG conducted a site visit to the Manassas Clinic to gauge if the clinic was in compliance with its obligations under the CIA. During this site visit, the OIG interviewed Ms. O’Neal to ascertain her level of compliance and discuss her oversight role as Lead Dentist. Unfortunately, Ms. O’Neal was not able to address “any compliance-related obligations that she oversaw at Manassas Center.” 134 Additionally, Ms. O’Neal could not “recall signing an

annual certification or any specific steps that she took to evaluate compliance at Manassas Center for purposes of signing that certification.”

135 Ultimately, HHS OIG found Ms. O’Neal’s certification to be false.¹³⁶ CSHM responded that it could not cure the breach of having submitted a false certification, but indicated that the Certifying Employee who signed the false certification is no longer employed by CSHM. Additionally, CSHM “implemented significant training and revamped [its] process for certifications.”¹³⁷ These two actions were enough to satisfy HHS OIG.

Section III.B.2.u of the CIA requires CSHM to have written Policies and Procedures in place to terminate employees who have been found to have violated professionally recognized standards of health care.¹³⁸ In January 2012, CSHM revised its “Adverse Events, Quality of Care Reportable Events, and OMIG Patient Care Matters” policy which states the following:

Practitioners who have violated professionally recognized standards of healthcare, including the AAPD Guidelines, the CSHM Clinical Policies and Guidelines for CSHM Associated Dental Centers, and any applicable state or local standards or guidelines, and whose violation has been deemed by the Chief Dental Officer to be a Quality of Care reportable event will be terminated or will undergo a remediation plan developed by the Chief Dental Officer with approval of the OIG.¹³⁹

132 Id. at 2–8.

133 Id. at 2.

134 Id. at 3.

135 Id.

136 See Letter from HHS OIG to CSHM, re: Notice of Material Breach and Intent to Exclude at 3 (Mar. 8, 2012) (Exhibit 29).

137 Letter from HHS OIG, to CSHM, re: Notice of Material Breach and Intent to Exclude at 2–3 (Mar. 13, 2012) (Exhibit 30).

138 Id.

139 Id. at 6 (emphasis added).

The CIA does not allow for the Chief Dental Officer to dismantle the termination process with a remediation plan. Therefore, HHS OIG found this revision to directly contradict the requirements of the CIA because it allowed the Chief Dental Officer to avoid the termination requirement with his/her own remediation plan.¹⁴⁰

Part of every audit conducted under the CIA includes a desk audit report. Included in each desk audit is a review of all of the dental work associated with that clinic. The Manassas, Virginia clinic desk audit report “indicated that of 244 pulpotomies reviewed by the Monitor, 104 were medically unnecessary.”¹⁴¹ The desk audit also found that as a result, CSHM improperly billed the Medicaid program. CSHM issued a response to the findings on October 31, 2011, stating that it “agrees that pulpotomies were performed that were not medically necessary . . . [and that] CSHM’s systems were ineffective in identifying this issue.”¹⁴²

Included in the October 2011 response, CSHM also identified 13 dentists with high pulp-to-crown ratios similar to those at the Manassas Clinic in its response to the desk audit.¹⁴³ CSHM was planning on addressing these 13 dentists by “monitor[ing] the pulp-to-crown ratio for each of these 13 individuals” and providing “indirect pulp therapy as an alternative to pulpotomies.”¹⁴⁴ After its

October 2011 response, CSHM clarified that it had identified 12 dentists, and not 13 dentists, who exhibited high pulp-to-crown ratios.¹⁴⁵ However, HHS OIG was not able to determine whether CSHM “had performed or planned to perform a financial review of claims it submitted on behalf of the 12 identified dentists to determine whether CSHM had any overpayment or other liability for claims that were associated with high pulp-to-crown utilization.”¹⁴⁶ HHS OIG determined this was a breach of CSHM’s duty to develop and implement a policy to promptly and appropriately investigate compliance issues.¹⁴⁷

CSHM had 30 days to demonstrate to HHS OIG that its material breach had been cured. CSHM submitted a written response on March 12, 2012, and met with HHS OIG on March 13, 2012.¹⁴⁸ Later that day, on March 13, 2012, HHS OIG sent CSHM a letter formalizing the terms of the agreement with CSHM whereby the OIG would not proceed with an exclusion action for the CIA breaches identified in the March 8, 2012 notice.¹⁴⁹

With respect to the Manassas facility, HHS OIG agreed not to pursue an exclusion action that would apply to the entire company if CSHM agreed to: (1) a voluntary exclusion of Manassas Center within 90 days of the date of March 13, 2012, letter; and (2) comply with additional program integrity-related obligations that will be

¹⁴⁰ Letter from HHS OIG to CSHM, re: Notice of Material Breach and Intent to Exclude at

6 (Mar. 8, 2012) (Exhibit 29).

141 Id.

142 Id.

143 Id. at 7.

144 Id.

145 See id.

146 Letter from HHS OIG to CSHM, re: Notice of Material Breach and Intent to Exclude at
7 (Mar. 8, 2012) (Exhibit 29).

147 Id. at 7–8.

148 Letter from CSHM, to HHS OIG, re: Notice of Material Breach and Intent to Exclude (Mar.
12, 2012) (Exhibit 64).

149 Letter from HHS OIG, to CSHM, re: Notice of Material Breach and Intent to Exclude (Mar.
13, 2012) (Exhibit 30).

incorporated as an amendment to the CIA by the March 13, 2012 letter. On June 4, 2012, CSHM sold the Manassas Clinic to a third party buyer, satisfying the first requirement.

The additional integrity-related provisions HHS OIG placed on CSHM include the following:

1. Compliance Program Onsite Reviews of CSHM Facilities.

“Within 30 days CSHM shall develop and implement a process by which the Chief Dental Officer, the Compliance Officer, and Regional Dentists shall conduct at least one onsite review each month to a CSHM facility for the purpose of evaluating and ensuring compliance with all Federal health care program requirements, state dental board requirements, and the obligations of the CIA. The OIG will require CSHM to recruit Regional Pediatric Dentists who will assist with the Onsite Reviews.

...” 150

CSHM has completed its hiring of Regional Pediatric Dentists.

151

2. Quality Improvements Initiatives. “Within 30 days, CSHM shall develop and implement a process by which CSHM identifies specific risk areas and relevant quality benchmarks, taking

into account the recommendations of the Independent Monitor.

...” 152

CSHM fulfilled this requirement within the allocated time

frame set forth by the HHS OIG.¹⁵³

3. Referral Process. “Within 30 days, CSHM shall develop and implement guidance for each CSHM facility regarding patient referrals from CSHM facilities to other facilities better equipped to treat a patient in specific circumstances involving concerns for patient safety, including but not limited to anesthesia requirement[s] and behavior guidance techniques.” 154

CSHM fulfilled this requirement within the allocated time

frame set forth by the HHS OIG.¹⁵⁵

4. Certifying Employee Certifications. “Within 30 days, CSHM shall develop a process by which Certifying Employees shall perform a comprehensive assessment of the areas of his/her responsibility under Federal law, state dental board requirements, and the obligations under the CIA.” 156

150 Id. at 3.

151 E-mail chain between Committee Staff and HHS OIG re: Reporting Substantial Overpayments

to Small Smiles Dental Centers of Oxon Hill (Mar. 7, 2013) (Exhibit 59).

152 Letter from HHS OIG, to CSHM, re: Notice of Material Breach and Intent to Exclude at 4 (Mar. 13, 2012) (Exhibit 30).

153 E-mail chain between Committee Staff and HHS OIG re: Reporting Substantial Overpayments

to Small Smiles Dental Centers of Oxon Hill (Mar. 7, 2013) (Exhibit 59).

154 Letter from HHS OIG, to CSHM, re: Notice of Material Breach and Intent to Exclude at 4 (Mar. 13, 2012) (Exhibit 30).

155 E-mail chain between Committee Staff and HHS OIG re: Reporting Substantial Overpayments

to Small Smiles Dental Centers of Oxon Hill (Mar. 7, 2013) (Exhibit 59).

156 Letter to CSHM, from HHS OIG, re: Notice of Material Breach and Intent to Exclude at 4–5 (Mar. 13, 2012) (Exhibit 30).

CSHM fulfilled this requirement within the allocated time frame set forth by the HHS OIG.¹⁵⁷

5. Pulp-to-Crown Medical Necessity Review. “Within 120 days, CSHM shall review claims by those dentists with high ‘pulp-to-crown ratios’ to determine whether such documentation supports the medical necessity of the services.”

The Independent Monitor will give CSHM the appropriate pulp-to-crown ratio and CSHM will compare all dentists to that standard.¹⁵⁸ HHS OIG has directed CSHM to conduct a new and more expansive review of the pulp-to-crown Medical Necessity Review requirement, due in part to the change in ownership in 2012.¹⁵⁹

During the course of the breach, CSHM emerged from bankruptcy in June 2012 and began operating under a new owner, a new Board of Directors, and a new senior management team. The new senior management team consists of a new Chief Executive Officer, Chief Compliance Officer, Chief Dental Officer, and new General Counsel. HHS OIG has stated that “The [Independent] Monitor has further indicated to OIG that the onsite visits to CSHM’s facilities under the new ownership structure have all been positive.”

G. Continuation of Abuses Following the Health and Human
Services Office of Inspector General Notice of Intent to
Exclude and New Ownership

The new owners have only been in place a relatively short time, but the issues involving quality of care and abuse of taxpayer dollars still remain. Time and time again, CSHM has demonstrated that its Small Smiles clinics do not operate in compliance with the CIA. The core of the problem appears to be structural. The new CSHM ownership acquired and has maintained their predecessors' flawed management services agreements, which remove traditional ownership authority from dentists. These agreements fundamentally limit the ability of the dentists to exercise independent clinical judgment.¹⁶¹ Despite management changes and assurances that the company is improving, the same problems that were uncovered in 2008 and ultimately led to the CIA persist. It is unacceptable that this type of activity has been allowed to continue for 4 years despite aggressive oversight by the Independent Monitor and HHS OIG.

As stated above, in October 2012 HHS OIG declared that "The Monitor has further indicated to OIG that the onsite visits to CSHM's facilities under the new ownership have all been posi

¹⁵⁷ E-mail chain between Committee Staff and HHS OIG re: Reporting Substantial Overpayments

to Small Smiles Dental Centers of Oxon Hill (Mar. 7, 2013) (Exhibit 59).

158 Letter from HHS OIG, to CSHM, re: Notice of Material Breach and Intent to Exclude at 5 (Mar. 13, 2012) (Exhibit 30).

159 E-mail from Hinkle of HHS OIG, to CSHM from re: Reporting of Substantial Overpayment to Small Smiles Dental Centers of Oxon Hill (Mar. 7, 2013, 11:22 a.m.) (Exhibit 58).

160 Letter from Dep't Health and Human Services, OIG, to Senators Baucus and Grassley, re: Corporate Integrity Agreement with CSHM, w/attach. at 5 (Oct. 4, 2012) (Exhibit 14).

161 See Letter from Theodore Hester, Attorney at King & Spalding, to Senators Baucus and Grassley, at 1–2 (Nov. 29, 2011) (Exhibit 5).

tive.” 162 However, a review of Independent Monitor Reports following the establishment of new CSHM ownership in June 2012 and the subsequent Notice of Intent to Exclude, paints a very different picture—the abuses that plagued Small Smiles clinics have yet to subside. Although documenting different locations, the Independent Monitor’s reviews of CSHM clinics under new ownership from late 2012 reveal findings of the same violations that plagued the Oxon Hill, Manassas, and other aforementioned clinics. Curiously, despite having previously received numerous Independent Monitor reports of misconduct at CSHM facilities, in October 2012 HHS OIG nonetheless proceeded to relay and seemingly endorse an inaccurate Monitor assertion that new CSHM ownership had begun to implement changes. Below are a few examples of the glaring errors that HHS OIG considers positive.

1. Florence, South Carolina Independent Monitor Report

In 2011, the Independent Monitor conducted a desk audit of the Florence, South Carolina Small Smiles clinic. A desk audit does not involve an onsite audit but instead involves an exchange of documents followed by a review. The desk audit report laid out a number of findings and recommendations for the staff.¹⁶³

On July 3, 2012, the Independent Monitor followed up with an

onsite visit of the Small Smiles clinic in Florence, South Carolina. This site visit occurred almost 4 months after HHS OIG issued its Notice of Material Breach and Intent to Exclude to CSHM. When the Monitor interviewed the staff and dentists, it was clear that none of them was aware of the findings or recommendations from the desk audit:

The Compliance Liaison reported she had been in communication with several members of CSHM's management team and determined from their questions there was a report. However, when she asked about it, she was told it had been divided and distributed by department.¹⁶⁴

Additionally, the Independent Monitor found that the clinic continued to perform unnecessary procedures, while failing to diagnose and treat other problems. In three recorded cases, pulpotomies were performed without removing the required amount of pulpal tissue, and two patients were fitted with oversized crowns.¹⁶⁵ The records also indicated that a patient's mesial decay went undiagnosed and a single surface occlusal amalgam filling was placed on the tooth leading to further decay and the need for a stainless steel crown.¹⁶⁶ Moreover, the Independent Monitor noted that one associate dentist administered Septocaine to a child younger than 4 years of age—a practice that has not been approved by the FDA.¹⁶⁷

162 Letter from Dep't Health and Human Services, OIG, to Senators Baucus and Grassley, re: Corporate Integrity Agreement with CSHM, w/attach. at 5 (Oct. 4, 2012) (Exhibit 14).

163 Independent Monitor Report Florence, S.C. at 2–3 (July 3, 2012) (Exhibit 38).

164 *Id.*

165 See *id.* at 3.

166 See *id.*

167 See *id.*

2. Lynn, Massachusetts Independent Monitor Report

A month after the Florence report, the Independent Monitor found similar issues with the Lynn, Massachusetts clinic. After reviewing the post-operative X-rays, the Monitor found five poorly performed pulpotomies, where the tissue from the pulp chamber was not properly removed.¹⁶⁸ There was also one record that showed a failure to use a local anesthesia when it was required, and two instances where the wrong anesthetic was used.¹⁶⁹

Similar to the report from Akron, the Monitor found that 10 records did not justify using surface fillings over stainless steel crowns.¹⁷⁰ The Monitor also found 11 records where the same teeth were treated multiple times.¹⁷¹ As was reported in Akron, failing to use the proper filling can result in further decay and multiple treatments to the same tooth.

Despite the continued attention from HHS, the clinic has yet to fulfill all of the recommendations from the initial 2011 Independent Monitor review. Following its interviews, document review, and treatment observations, the Independent Monitor determined that “CSHM had successfully met and implemented 19 of the 29 recommendations” from the Independent Monitor’s previous report.¹⁷²

3. Mishawaka, Indiana Independent Monitor Report

On October 5, 2012, the Independent Monitor's findings from its review of the Mishawaka Small Smiles clinic revealed evaluation discrepancies, patient safety concerns, and questions involving medical necessity. As part of its desk audit, the Independent Monitor examined a 2012 internal CSHM chart audit by replicating the testing parameters and initiating its own assessment.¹⁷³ The CSHM chart audit ultimately issued passing scores for all three audited dentists.¹⁷⁴ While concurring in the finding that two dentists passed,¹⁷⁵ the Independent Monitor issued an automatic failure to the third dentist based on a "lack of documentation and radiographic evidence to support the medical necessity for treatment."¹⁷⁶ Notably, prior to the Independent Monitor's replicated audit, CSHM had given this very same dentist a score of 100%, the highest score of all three audited dentists.¹⁷⁷

More disturbing than the discrepancies in the CSHM evaluations of dentists are the incorrect calculations for administering anesthesia. In 4 of 15 records reviewed, the Independent Monitor found miscalculations of the anesthesia dosage, and, while finding that the administered dosage never exceeded the prescribed maximum, the miscalculations "allowed for the possibility of patient harm."¹⁷⁸ Furthermore, in three of these four miscalculations, a review revealed the use of anesthesia "without the recognition of a total

¹⁶⁸ See Independent Monitor Report Lynn, Mass. at 3 (Aug. 2, 2012) (Exhibit 39).

169 See id.

170 Id.

171 Id.

172 Id. at 9–10.

173 Independent Monitor Report Mishawaka, Ind. at 6 (Oct. 5, 2012) (Exhibit 40).

174 See id.

175 See id. (“The Monitor also identified instances of under-treatment and over-treatment that resulted in lower scores for the Clinic and passing dentists.”)

176 Id.

177 See id.

178 Id. at 23.

maximum allowable dose . . . regardless of patient weight or age” and “no evidence of calculation adjustments for overweight patients based on their healthy weight range.” 179

The Independent Monitor’s findings also raised questions about the medical necessity of performed care. In 1 of 15 records reviewed, it was discovered that neither documentation nor X-rays were provided to justify the medical necessity for a performed pulpotomy. 180 In fact, the review found that along with a complete lack of X-rays to determine the depth of tooth decay, the patient’s file lacked a “descriptive narrative” and “the digital photographs did not support the need for a pulpotomy on [said] tooth.” 181 Approximately 6–7% of all pulpotomies performed by that clinic would be unnecessary if the records reviewed are a representative sample of the clinic’s business. Taxpayers needlessly spend \$100 in Indiana every time an unnecessary pulpotomy is performed on a Medicaid patient.182

4. Colorado Springs, Colorado Independent Monitor Report

As late as November 15, 2012, the Small Smiles clinic in Colorado Springs was committing violations resembling those found at numerous other Small Smiles clinics: under-utilization of X-rays, inadequate documentation of medical necessity, questionable procedure

rationale, and quality of care issues. First, out of 24 records reviewed, the Independent Monitor found 5 records containing medically unnecessary X-rays and 12 records revealed evidence of under-utilization of diagnostic X-rays.¹⁸³

Second, questions of medical necessity also emerged from the Colorado Springs Small Smiles clinic. Notably, the Independent Monitor observed a trend of treatment being provided without diagnostic X-rays and further found 5 out of 24 patient records lacked “documentation and/or radiographic evidence to support the medical necessity for treatment[s]” which included pulpotomies, a stainless steel crown, and a 4-surface filling.¹⁸⁴

Third, the Independent Monitor review exposed questionable rationales for performed procedures. Along with finding a trend of under-utilizing stainless steel crowns, the review revealed 5 out of 24 records lacked documentation for choosing to perform multiple surface fillings and not stainless steel crowns.¹⁸⁵

Fourth, the review confirmed that, much like its fellow Small Smiles clinics around the country, quality of care issues were evident in the Colorado Springs clinic. Out of 24 records reviewed, 2 patient records lacked an explanation as to why teeth with noted decay were left untreated.¹⁸⁶ Lastly, and of great concern, is that 3 out of 24 records revealed that treatment was administered without the requisite informed and documented consent.¹⁸⁷

These five clinic findings reflect that, despite HHS OIG's Intent to Exclude and the new ownership structure, CSHM has continued

179 Id.

180 See id.

181 Id.

182 Indiana Health Coverage Programs, IHCP Bulletin at 5 (Apr. 15, 2010) (Exhibit 62).

183 See Independent Monitor Report Colorado Springs, Colo. at 16 (Nov. 15, 2012) (Exhibit 41).

184 Id. at 18.

185 Id. at 19.

186 Id. at 20.

187 Id.

to leave patients with decaying teeth untreated, while performing needless surgery on other patients. In other words, CSHM continues to treat a high volume of patients while sacrificing quality care and benefitting from the Medicaid system. The needless procedures ensure higher reimbursements, while mismanaged treatments ensure return visits that require more intensive treatments.

What is most disconcerting from these reports is the timing in which these violations occurred. Although subpar dental treatment to children should never be tolerated, it is even more unforgivable when it follows admonishment from the Department of Justice and the Department of Health and Human Services Office of Inspector General.

V. Dental Demographics

When the Committee staff started investigating dental management companies, a common refrain emerged: if their businesses did not employ dentists to provide care to those in need, the Medicaid population would go untreated. As such, we began to take a closer look into the demographics of today's dentists. Although it is undeniable that certain parts of our country, particularly rural areas, have a shortage of dental providers, this same problem plagues all areas where Small Smiles Clinics are found. Ultimately, the current model is not sustainable, and dentists will not be able to meet

the growing demand for treatment. Thus, maybe it is time to begin discussing the incorporation of mid-level providers in order to alleviate the treatment needs of and provide dental care to patients.

Mid-level dental providers' education and skill level would place them between a dentist and dental hygienist. They would be qualified and licensed to perform relatively minor, but common procedures, such as cavity fillings and simple teeth extractions.¹⁸⁸

According to Oral Health America, the adequate ratio of dentists to population is 1 to 1,500.¹⁸⁹ Today, that ratio is 1 to 2,000 and in some states, such as Washington, the distribution is even greater having only one dentist for 12,300 people.¹⁹⁰ If this uneven distribution is not corrected, the problems will worsen. The U.S. Department of Labor, Bureau of Labor Statistics expects the dental profession to grow by 21% from 2010 to 2020.¹⁹¹ The potential for a large gap between the number of dentists needed and the number of dentists practicing is due to a number of variables. First, there will be a need for more complicated dental procedures for the baby boom generation.¹⁹² In addition, each generation is more likely to keep their teeth than the last, and studies continue to link dental

¹⁸⁸ See Phil Cauthon, National advocates for mid-level dental providers meet in Kan., KHI NEWS SERVICE (Dec. 5, 2012), <http://www.khi.org/news/2012/dec/05/national-advocates-mid-level-dental-providers-meet/>.

¹⁸⁹ Combating the Silent Epidemic: The Shortage of Dentists in America, Staff Care, at 4,

<http://www.staffcare.com/pdf/Dentistry-WhitePaper2007.pdf>.

190 U.S. Dep't of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook, Dentists Job Outlook, <http://www.bls.gov/ooh/Healthcare/Dentists.htm#tab-6> (last visited Mar. 22, 2013); Clair Gordon, Extreme Dentist Shortage Leads To 'Dental Therapists' Filling Cavities, AOL Jobs [hereinafter Gordon] (Apr. 16, 2012, 2:14 PM), <http://jobs.aol.com/articles/2012/04/16/extreme-dentist-shortage-leads-to-dental-therapists-filling-ca/>.

191 U.S. Dep't of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook, Dentists Job Outlook, <http://www.bls.gov/ooh/Healthcare/Dentists.htm#tab-6> (last visited Mar. 22, 2013). Nationwide there are 48.7 million Americans who live in areas with a shortage of dental care.

192 See id.

health with overall health.¹⁹³ Also, 5.3 million more children will qualify for dental services under the Affordable Care Act.¹⁹⁴ However, “without changes in state policies, expanded coverage is unlikely to translate into more dental care for every child in need.”¹⁹⁵ Children’s susceptibility to tooth decay is particularly problematic, because dental problems starting at a young age will compound into larger problems through adulthood.

The lack of care for both children and adults has resulted in 27 percent of children and 29 percent of adults having untreated cavities in 2003 and 2004.¹⁹⁶ The risks of untreated dental conditions are not confined to poor oral health, but can have devastating effects on overall health. Many Americans end up in the emergency room from tooth abscesses that keep them from eating or cause an infection that can travel to the brain and kill.¹⁹⁷ This horrifying result of tooth decay was the impetus for the ABC–7 I–Team investigative report into the Small Smiles clinics. The report identified a 12-year-old Maryland boy, Deamonte Driver, who died of a brain infection resulting from tooth decay that was not properly treat

ed.¹⁹⁸

In 2009, more than 830,000 visits to the emergency room nationwide were the result of preventable dental problems.¹⁹⁹ In Florida alone the bill exceeded \$88 million.²⁰⁰ Although many of these problems can be solved by preventive measures, the fundamental problems of lack of care and substandard care persist.²⁰¹

As more dentists graduate from school with an average debt of \$181,000, with one out of five exceeding \$250,000,²⁰² it is less economical for dentists to open practices in rural areas. Compounding the problem is available data which suggests low dentist participation in Medicaid,²⁰³ and the fact that some of those clinics that are providing care to Medicaid patients, such as Small Smiles, are doing so at a substandard level. The cost of correcting dental problems is much more expensive than the preventive measures, but

¹⁹³ See id.

¹⁹⁴ Dep't of Labor, Dentists Job Outlook; The State of Children's Dental Health: Making Coverage

Matter, The Pew Center on the States (May 2011), 208, 209, and 210; Louis W. Sullivan, Dental Insurance, but No Dentists, N.Y. TIMES [hereinafter Sullivan], Apr. 8, 2012, <http://www.nytimes.com/2012/04/09/opinion/dental-insurance-but-no-dentists.html?l=2&>.

¹⁹⁵ The State of Children's Dental Health: Making Coverage Matter, The Pew Center on the States (May 2011).

¹⁹⁶ Gordon. The 2003 and 2004 data is the latest available when the article was written.

197 Sullivan.

198 I-Team: Small Smiles Investigation, <http://www.youtube.com/watch?v=ploMaw4zC9Q> (last visited Mar. 22, 2013). In a similar news story a, 24-year-old single father, Kyle Willis died of a brain infection that was the result of untreated tooth decay. Gretchen Gavett, Tragic Results When Dental Care Is Out of Reach, PBS (June 26, 2012, 9:50 PM), <http://www.pbs.org/wgbh/pages/frontline/health-science-technology/dollars-and-dentists/tragic-results-when-dental-care-is-out-of-reach/>.

199 Sullivan.

200 Id. Dental disease is the number one chronic child disease that creates more children needing medical care than asthma. Id. In Maine a recent report has indicated that 55 percent of MaineCare children go without dental care even though they have insurance, resulting in more money being spent on fixing dental problems that preventing them. Report Details Dental Care Shortage in Rural Maine, Boston Globe (Feb. 5, 2013), <http://www.boston.com/news/local/maine/2013/02/05/report-details-dental-care-shortage-rural-maine/NkYZrj1bb1OEMKGFQZ1E5O/story.html>.

201 Sullivan.

202 Gordon.

203 See U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-11-96, ORAL HEALTH: EFFORTS UNDER WAY

TO IMPROVE CHILDREN'S ACCESS TO DENTAL SERVICES, BUT SUSTAINED
ATTENTION NEEDED TO

ADDRESS ONGOING CONCERNS 12 (2010) (Exhibit 60).

clearly the cost of providing preventive measures is not cheap or easy in certain parts of our country.

To address dental care access problems, two states have taken novel approaches to immediately address the lack of dental care. Alaska and Minnesota have been training dental therapists who provide fewer services than a dentist and more than a dental hygienist.²⁰⁴ These dental therapists are able to perform basic dental procedures that are in great demand, such as filling cavities and extracting childrens' primary teeth.²⁰⁵ These training programs are shorter than dentistry school, and the therapists receive pay that is roughly half of what a dentist would receive. This program has opened up dental care in rural areas of Minnesota and Native villages in Alaska. The ADA has opposed these positions out of fear that mid-level providers will provide substandard care.²⁰⁶

VI. Recommendations

Recommendation 1: HHS OIG should exclude from participating in the Medicaid program CSHM, Small Smiles clinics, and any other corporate entity that employs a fundamentally deceptive business model resulting in a sustained pattern of substandard care.

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Despite a change in ownership and repeated professed improvements, CSHM and Small Smiles clinics continue to operate under fundamentally deceptive contracts that circumvent state laws passed to ensure licensed dentists own dental practices, and thus, that the owners are held accountable to maintain a professional standard of care. As a result, Small Smiles clinics continue failing to meet basic quality and compliance standards, providing unjustified and deficient procedures, improperly withholding and recklessly administering anesthesia, and performing dubious internal audits. All of these actions strain the Medicaid system. Excluding CSHM and companies with similarly deceptive ownership structures from the Medicaid program would deter companies from engaging in similar egregious behavior in the future.

Recommendation 2: States should enforce existing laws against the corporate practice of dentistry and, where appropriate, take enforcement action against those that violate the law.

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State authorities have either ignored or been oblivious to dental management services agreements like those used by CSHM that allow companies to operate dental clinics under the guise of providing administrative and/or financial management support.

204 Sullivan. Kansas, New Mexico, and Vermont are also debating legislation that would cre

ate similar training programs; Gordon.

205 Gordon.

206 See AM. DENTAL ASS'N, BREAKING DOWN BARRIERS TO ORAL HEALTH FOR ALL AMERICANS:

REPAIRING THE TATTERED SAFETY NET 16 (2011); see also AM. DENTAL ASS'N, BREAKING DOWN

BARRIERS TO ORAL HEALTH FOR ALL AMERICANS: THE ROLE OF WORKFORCE 11 (2011) (“[A] critical

attribute that the ADA opposes unequivocally: Allowing non-dentists to perform surgical procedures, often with little or no direct supervision by fully trained dentists.”).

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In the 22 states and the District of Columbia that ban corporate dentistry, appropriate action should be taken to eliminate such circumvention of the law.

Recommendation 3: If states consider licensure of mid-level dental providers, such as dental therapists, the Federal Government should allow them to be reimbursed by the Medicaid program.

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According to GAO findings, the dental profession has low Medicaid participation rates and thus has failed to provide needed care and treatment to lower-income individuals in Medicaid.

While struggling to encourage the providers to adequately participate and serve the Medicaid program, the dental profession has done little to curb the abuses described in this report.

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States have already begun creating mid-level dental providers, such as dental therapists, and licensing them to practice in their states in order to better meet the unmet needs of their populations.

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Some in the dental profession argue that “low Medicaid reimbursement rates” are the root cause of the types of abuses described in this report. Yet, the dental profession has also opposed

allowing mid-level providers into the program who could provide much of the needed care at the current reimbursement rates.

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APPENDIX

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