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NOTE

EVERYONE HATES GOING TO THE DENTIST! ARE DENTAL SERVICE ORGANIZATIONS TAKING THE BITE OUT OF MANAGING A DENTAL PRACTICE IN INDIANA?

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I. INTRODUCTION

As with most beautiful summer days at local state fairs, the smells and sounds of celebrating summertime would entice most people to munch on some yummy caramel corn or taste the latest salt-water taffy flavors. Upon doing so, one fairgoer in particular regrets the decision to indulge in such tasty delights as they feel a surge of pain shoot through one of their teeth as they bite down. Immediately, feeling the injury with their tongue, a portion of their tooth has sheared off and they instantly know—it is time to see their dentist. As the pain sharply increases, the main concern for this unfortunate fairgoer is how quickly they can access a dentist and how much is this going to cost them. After a few phone calls to check appointment availability, the fairgoer strikes gold: a nearby dentist has an opening the same day! Soon they are patiently sitting in the waiting room of a nicely decorated dental office, holding an ice pack to their jaw for some temporary relief. Upon looking around, the office is organized, extremely clean, and welcoming. The waiting room has a TV with dental education videos playing, free Wi-Fi, and professionally designed marketing materials. It truly looks like this dentist really knows the business side of owning and operating a dental practice. As the pained patient sits in the waiting room, thoughts of who actually owns this dental practice enter their mind as they are pretty sure they have seen commercials for similarly designed practices. Who actually maintains and runs this practice—is it even this dentist? Is this practice owned by an entrepreneur who is not a dentist? If a person goes to a fine restaurant, most people do not ask the highly skilled chef if they own the establishment; in fact, most chefs do not, and yet the food is usually amazing; is this the same type of situation? Thoughts of quality, safety and the legality of a non-dentist owning a dental practice enter the injured fairgoer's mind.

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A. The Issue

The control of the practice of medicine, including dentistry, is well-established among lawmakers. Volumes of regulation regarding medical and dental graduation requirements, the scope of practice, drug prescribing, and patient privacy laws, just to name a few, are heavily enforced in each state. Whatever the deemed area, government agencies are happy to step in and regulate, even if they are not regulating an actual medical or dental function. Proposed legislation is at issue for the recent rise of a newer type of business management company, which some states believe falls within the dental scope of practice and therefore must be regulated. This type of business is called a Dental Service Organization (“DSO”) and recently has become a controversial issue for many state legislatures.

A DSO is not a dentist (although dentists can be part of the management team), but rather a group of individuals with business backgrounds and entrepreneurial drive who run the administrative duties of a dental practice.¹ DSOs contract with dentists to provide business services in their dental practices; the end goal is for the dentist to be able to focus on dental work while the hired DSO can focus on the administrative work.² For example, DSOs usually provide such administrative services to the dentist’s information technology, marketing, human resource management, supply chain management, financial support, legal team access, and repairs and maintenance, while the dentist focuses on clinical procedures with the patient.³ The issue is if the dentist hires a management company to help them with their business affairs, why is the government and its agencies stepping in and trying to regulate the private management company? This Note will argue and delineate between the services a dentist provides, which are and should be regulated, and the services a DSO provides, which should not be regulated.

Another issue to consider is the health and welfare of the patients affected by DSOs in states that allow operation of such management companies. If a state legally allows DSOs to operate within their borders, are patients better taken care of? Customarily, the Iron Triangle of healthcare—access, cost and quality—is “used to assess healthcare systems of all kinds.”⁴ This Note will thoroughly examine and argue that DSOs do improve access for patients, help control costs through leveraged bargaining, and improve the quality of patient care through standardized training practices.

1. *About DSOs*, ASS’N DENTAL SUPPORT ORGS., <http://theadso.org/about-adso/dso-industry> [<https://perma.cc/NZT2-5WC8>].

2. *Id.*

3. *Id.*

4. Tom Godfrey, *What is the Iron Triangle of Health Care?*, PENN SQUARE POST (Mar. 3, 2012), <http://pennsquarepost.com/what-is-the-iron-triangle-of-health-care/> [<https://perma.cc/Q9ML-FK5Q>].

B. Roadmap

This Note discusses the upsurge of the DSO in various states and addresses whether they should be government regulated and how some states have treated this recent management style. Section II discusses the background of the corporate practice of medicine and how it applies to dentistry. This section also shows the historical trends of solo dental practices versus DSO managed practices and includes arguments for and against DSOs. The background section will illuminate the need for this Note, as it will show DSOs are here to stay and highlight the significant impact DSOs are making in the dental market. Section III will discuss a national sampling of how some states have already begun to regulate DSOs within their borders. This sampling includes heavily regulated states, states with some regulation, and states with virtually no regulation. Section III will provide an in-depth analysis of the Indiana statutory language regulating DSOs. Section IV will look at the impact of states that already have the presence of DSOs within their borders. Specifically, looking at the Iron Triangle, this section analyzes how DSOs provide better access to dental care, how costs are lowered, and how quality is improved. Section V concludes the Note, with a summary and delineation of dentist responsibilities versus DSO responsibilities. With the issue being clearer, this Note argues throughout that statutory regulation for administrative duties in a dental office is not needed. Last, for states that have DSOs, regulated or not, the benefits outweigh any proposed negatives, and states need to allow these types of business management companies to function like other business entities within their borders.

II. BACKGROUND OF THE ISSUE

A. The Corporate Practice of Medicine and its Application in Dentistry

For most in the medical community, it makes sense that there are laws limiting the practice of medicine to licensed individuals who graduate from credentialed institutions.⁵ These types of laws are often codified in state licensing laws or in common law doctrine and are collectively known as the Corporate Practice of Medicine (“CPM”) doctrine.⁶ In the early 1900s, the CPM doctrine was largely used to prevent companies from hiring physicians to care for workers in factories.⁷ Today, the CPM doctrine still has a profound effect on a corporations’ ability to hire physicians. Although there are benefits and efficiencies of medical group practices, “many believe that when corporations entangle themselves in the practice of medicine and are in a position to control

5. Jennifer Brunkow, *3 Steps to Navigate Through the Corporate Practice of Medicine*, BECKER’S HOSP. REV. (Mar. 26, 2012), <https://www.beckershospitalreview.com/legal-regulatory-issues/3-steps-to-navigate-through-the-corporate-practice-of-medicine.html> [http://perma.cc/V44H-3EAL].

6. HUBERFELD ET AL., *THE LAW OF AMERICAN HEALTHCARE* 507 (2017).

7. *Id.*

physicians' compensation, they may also negatively influence patient care.”⁸ A state will use its CPM doctrine to regulate four main areas:

1. Some states prohibit business entities from employing physicians to provide medical care.
2. Certain states require entities that provide medical services be owned and operated by licensed medical doctors.
3. Some states prohibit professional fee splitting between licensed medical professionals and non-licensed individuals or business entities.
4. The management fees stated within management services agreements must be set at fair market value.⁹

In most states, there are a number of exceptions to the CPM doctrine. The most widely known exception is that of hospitals. In the 1997 *Berlin v. Sarah Bush Lincoln Health Center* case, the Supreme Court of Illinois held that “a duly-licensed hospital possesses legislative authority to practice medicine by means of its staff of licensed physicians and is accepted from the operation of the corporate practice of medicine doctrine.”¹⁰ Although a common thought today, the concept of hospitals employing doctors was quite a leap from the stoic days of the early 1900s, where no layperson could possibly employ a physician. This leap has also occurred in the dental realm, but in a much quieter fashion.

Dentistry falls under the umbrella of a state's CPM doctrine because dentists are considered health care providers. For example, in 2010, the U.S. Department of Health and Human Services (“HHS”) released a Health Insurance Portability and Accountability Act (“HIPAA”) information sheet discussing a list of providers who must follow the updated HIPAA policy.¹¹ Under the section of who must follow the law, the answer was “[m]ost health care providers. . .including most doctors, clinics, hospitals, psychologists, chiropractors. . .and dentists” must follow all new HIPAA regulations.¹² Therefore, given that DSOs are not hospitals, it becomes apparent that they are illegal in every state adopting CPM policies. In other words, the law looks bleak for a layperson (a non-dentist) owning and operating a DSO. Keeping this in mind, how are there mega DSOs like Heartland, Aspen, Kool Smiles, and Pacific Dental, just to name a few, operating in states that have a CPM doctrine in place? Simply put, some state legislatures have stepped in and added to their existing CPM laws exceptions so that DSOs can operate within their boundaries. These exceptions, warranted or not, have been and currently are the controversial issues on many state legislature floors and are further discussed in the statutory analysis section below.

8. Brunkow, *supra* note 5.

9. *Id.*

10. *Berlin v. Sarah Bush Lincoln Health Ctr.*, 179 Ill. 2d 1, 19 (1997).

11. *What is HIPAA?*, OFF. FOR C.R., U.S. DEPT. HEALTH & HUMAN SERV., <https://medicalboard.iowa.gov/images/pdf/HIPAA.pdf> [<https://perma.cc/Q63M-SBXD>] (last updated Aug., 2010).

12. *Id.*

B. The Dental Field Follows the Medical Field: A Look at Consolidation

Business consolidation is common practice these days: “[c]onsolidation in the general economy is occurring more often Lately, the economy has experienced a wave of consolidations in the banking industry, retail sales organizations and in the automobile manufacturing and airline industries.”¹³ The healthcare sector has also seen consolidations, specifically in the early 1990s with the development of Management Service Organizations (“MSOs”) for doctors, and then again in the late 2000s with large-scale employment by hospitals.¹⁴ Medicine leads the way in the health care field and predicts what other health care professionals will be doing ten to twenty years down the road.¹⁵ It is common news these days that small and large hospitals are consolidating to ensure future viability.¹⁶ In fact, all types of medical facilities are consolidating or already have consolidated to save on costs and improve patient care.¹⁷ In October of 2015, the U.S. Department of Veterans Affairs consolidated their medical programs in order to improve access to care.¹⁸ In a recent 2015 study, only 17% of today’s physicians are in solo practice, compared to 54% in 1980.¹⁹ Doctors who described themselves as solo practitioners dropped from 62% in 2008, to the dramatic figure of 35% in 2014.²⁰ Physicians who are employed by hospitals or medical groups increased from 38% to 53% over the 2008-2014 period.²¹ The same type of consolidation is happening now in dentistry.²² Solo dental practices are shrinking at an unprecedented rate; “[a]ccording to the American Dental Association, solo practices represented 68% of all dental practices in the U.S. in

13. Albert Guay et al., *Considering Large Group Practices as a Vehicle for Consolidation in Dentistry*, AM. DENTAL ASS’N, 2, (Apr. 2016), http://www.ada.org/~media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0416_1.pdf [https://perma.cc/643J-AUNB].

14. *Id.* at 3.

15. Steven J. Holm, *The Changing Face of Dentistry*, 94 J. IND. DENTAL ASS’N 6, 7 (2015), <http://www.jida.news/jida2015winter#page=6>.

16. *Indiana Health System and Hospital Complete Merger*, BECKER’S HOSP. REV. (Jan. 7, 2010), <https://mail.beckershospitalreview.com/news-analysis/indiana-health-system-and-hospital-complete-merger.html> [https://perma.cc/SP6Q-8WP4].

17. *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*, U.S. DEP’T VETERANS AFF. (Oct. 30, 2015), https://www.va.gov/opa/publications/VA_Community_Care_Report_11_03_2015.pdf [https://perma.cc/WN6B-3SDD].

18. *Id.*

19. Richard Gunderman, *Will Independent Physicians Go Extinct?*, THE HEALTH CARE BLOG (Apr. 1, 2015), <http://thehealthcareblog.com/blog/2015/04/01/will-independent-physicians-go-extinct/> [https://perma.cc/7KW4-LHXE].

20. *Id.*

21. *Id.*

22. *Is Dental Following Medical?*, PLANET DDS (Oct. 28, 2015), <https://www.planetdds.com/2015/10/28/is-dental-following-medical/> [https://perma.cc/SR57-QEBY].

2014, down from 76% in 2008.”²³ Dentists are choosing to practice with groups and DSOs rather than taking the risk of trying a solo dental practice and “[t]his trend appears to be pronounced among recent dental school graduates who don’t want to deal with the business aspects of running a practice and would prefer to focus exclusively on patient care.”²⁴ In a recent 2017 report, the growth and market share capture of DSOs is becoming very obvious.²⁵ According to the American Dental Association (“ADA”), while DSOs have an annualized growth rate of 14%, solo practices are becoming less and less common, shrinking at a growth rate of 7% per year.²⁶ In the same report, it is predicted that DSOs will continue to grow at 15% annually over the next five years, making market share at 30% by 2021.²⁷

Understanding the trends of the medical field, and how the dental field usually follows close behind in these trends, is critical to this Note because, legally, one could predict with some degree of accuracy how group practice dentistry—the DSO—will be treated. When states first adopted the CPM doctrine, there was a general sense of negativity towards the doctrine.²⁸ Then, with the expansion of medical conglomeration, there was also widespread negativity towards corporate medicine.²⁹ Over time, and with experience and strategies in place, physicians and state legislatures became friendlier towards the idea and even saw some positive outcomes from consolidation.³⁰ One could then also predict that public opinion will shift in favor of DSOs in the dental arena.³¹ This is a key part of the issue at hand because dental consolidation is newer, and there are those who are opposed to the idea and think regulation is the key.³² Dr. Steven Holm, DDS, former president of the Indiana Dental Association, said, “I am not opposed to large group practices...I think there will be a place for both solo practices and large group practices to succeed side by side. First, however we must tear down the fences.”³³ Dr. Mark Cooper, DDS, shared that, “most dentists and their political organizations are resisting the obvious—that DSOs are the future. Rather than figuring out how to optimize their values and assets within

23. *Id.*

24. *Id.*

25. Marc Cooper, *Why the Future is DSOs*, DPR’S MOD. DENTAL NETWORK (Apr. 19, 2017), <http://practicemanagement.dentalproductsreport.com/article/why-future-dsos?page=0,0> [<https://perma.cc/N9CG-FSEQ>].

26. *Id.*

27. *Id.*

28. Brunkow, *supra* note 5.

29. *Id.*

30. *Id.*

31. Holm, *supra* note 15.

32. *Sound Off: The Dental Community Talks ‘Corporate Dentistry’*, DENTISTRY IQ (Apr. 7, 2016), <http://www.dentistryiq.com/articles/apex360/print/volume-3/issue-4/special-focus-corporate-dentistry-2-0/sound-off-the-dental-community-talks-corporate-dentistry.html> [<https://perma.cc/7323-ZJG9>].

33. Holm, *supra* note 15.

a DSO ecology, most dentists are up in arms about DSOs, trying to stop their growth and expansion and digging in their heels.”³⁴ Dr. Holm pleaded in his article, “If you look at history...dentistry always follows medicine—always. Bottom line is we need to talk.”³⁵ Let the discussion truly begin.

C. Why States Want to Regulate DSOs

As briefly discussed, DSOs have non-dental—also known as non-clinical—functions.³⁶ DSOs provide “critical business management and support including non-clinical operations.”³⁷ Some of these operations include human resource management, information technology services, supply chain management, bill payment and financial services, operation management, and revenue cycle services. These services are provided to the dentist in a few ways. First, a solo-practicing dentist could hire a DSO via contract to help manage their practice. Second, a group of individuals could form a company and hire dentists as their employees, building and acquiring practices through mergers or new practice build outs. Depending on the state laws the company is operating in, the DSO may have a professional service agreement with a licensed dentist in that particular state.³⁸ Third, in combination of the first two services, a solo practice dentist could sell their non-clinical assets to the DSO and become their employee.³⁹ Whichever method is chosen, the DSO has the same role each time, which is non-clinical management of the practice’s business aspects.⁴⁰

In contrast, a solo dentist without a DSO will perform: patient examinations, treat diagnosed issues, teach prevention, find or attend training for licensure, and perform all the management duties needed to run a successful business.⁴¹ Dentists will have to “hire, evaluate, promote and fire employees including . . . receptionists, dental hygienists and assistants...order equipment and supplies for the practice . . .check bookkeeping and accounting and handle tax, paycheck and insurance payments, as well as pay for repairs and maintenance of their offices.”⁴² Dentistry has one of the highest suicide rates among professionals.⁴³ One

34. Cooper, *supra* note 25.

35. Holm, *supra* note 15, at 7.

36. *About DSOs*, *supra* note 1.

37. *Id.*

38. See Kevin Cain, *What You Should Know About DSOs*, DRBISCUSPID.COM (June 29, 2015) <http://www.drbcuspide.com/index.aspx?sec=ser&sub=def&pag=dis&ItemID=318109> [<https://perma.cc/JDU8-8Q9P>].

39. *Id.*

40. *About DSOs*, *supra* note 1.

41. Irene Blake, *General Dentist’s Duties*, CHRON, <http://work.chron.com/general-dentists-duties-11094.html> [<https://perma.cc/G5DP-S67N>].

42. *Id.*

43. *Top 11 Professions with Highest Suicide Rates*, MENTAL HEALTH DAILY, <http://mentalhealthdaily.com/2015/01/06/top-11-professions-with-highest-suicide-rates/> [<https://perma.cc/4MQM-Y2YD>].

contributing factor may be the balancing act a solo dentist has to do each day trying to administratively run their dental practice yet still focus on the clinical patient side.⁴⁴ It makes sense that a dentist would want to shed some of this stress by hiring a DSO or become an employee of a DSO. So what is the real conflict then?

Similarly, when the medical community started to consolidate, “there [was] a bias among some towards those that work in large group practices, that this business concept is less than ideal.”⁴⁵ As experts in business, DSOs have been accused of focusing on the bottom line rather than the patient in the chair.⁴⁶ The conflict occurs between a dentist and a DSO because dentists are typically paid based on what they produce, so to be paid higher wages, a dentist might feel the pressure “to over diagnose to meet production goals.”⁴⁷ An example of this type of situation occurred in 2010, when a national chain known as “Small Smiles Centers” was fined \$24 million to resolve fraud allegations, which the Department of Justice said stemmed from medically unnecessary dental services performed on children.⁴⁸ The company paid the fine, agreed to sign a Corporate Integrity Agreement, and assisted “the government’s continuing investigation of individual dentists.”⁴⁹ Allegations of billing and procedure abuse continued at Small Smiles Centers until the final blow occurred in 2014, when the Office of Inspector General notified the company they would no longer be allowed to use Medicaid, Medicare, or other government sponsored health programs.⁵⁰ In another example, in 2012, Indiana’s Office of Inspector General released a report investigating dentists for questionable Medicaid pediatric billing practices, implying many dentists under review were from dental chains.⁵¹ No further reports were generated from the Office of Inspector General’s 2012 initial claim. Also, as recent as January 2018, a fine of \$23.9 million was announced by the Department of Justice against Kool Smiles dental clinics for allegedly submitting false claims.⁵² With large fines and thousands of patients being affected, questions

44. *Id.*

45. Holm, *supra* note 15.

46. *Id.*

47. *Id.*

48. *National Dental Management Company Pays \$24 Million to Resolve Fraud Allegations*, U.S. DEP’T JUSTICE (Jan. 20, 2010), <https://www.justice.gov/opa/pr/national-dental-management-company-pays-24-million-resolve-fraud-allegations> [<https://perma.cc/PL48-DB8D>].

49. *Id.*

50. Talesha Reynolds, *Firm That Manages Dental Clinics for Kids Excluded from Medicaid*, NBC NEWS (Mar. 12, 2014, 12:44 PM ET), <https://www.nbcnews.com/news/investigations/firm-manages-dental-clinics-kids-excluded-medicaid-n50416> [<https://perma.cc/5H7G-T3EU>].

51. DEP’T HEALTH & HUMAN SERVS., QUESTIONABLE BILLING FOR MEDICAID PEDIATRIC DENTAL SERVICES IN INDIANA 12 (2014), <https://oig.hhs.gov/oei/reports/oei-02-14-00250.pdf> [<https://perma.cc/YCN5-FFPR>].

52. *DOJ: Kool Smiles Dental Clinics to Pay \$23.9 Million, Allegedly Submitted False Claims*, ABC15 ARIZONA (Jan. 10, 2018, 6:50 P.M.), <https://www.abc15.com/news/state/doj-kool-smiles-dental-clinics-ordered-to-pay-239-million-knowingly-submitted-false-claims>

about regulations and oversight of large dental groups have certainly been addressed on most state congressional floors. Big dollar fines produce big headlines, but that does not mean that all DSOs are depraved and all solo dentists operate with full integrity.

The dental industry should be regulated to ensure the best patient care possible so that huge headlines, like those discussed above, do not happen. These regulations should apply to all clinically related items because it is the dentist who holds responsibility for clinical decisions—not common business practices found in every industry.⁵³ Every state regulates the practice of dentistry differently, but “there exists a demarcation between clinical activities, which are regulated by a state’s dental board (or equivalent state body), and non-clinical activities which are not considered professional matters (and over which the dental board has no authority).”⁵⁴ Some states have done a great job at distinguishing between a clinical area and a normal business management area. A sampling of how various states have handled this type of regulation will be discussed next.

III. STATE DSO REGULATIONS

A. National Sampling of State DSO Regulations

As previously discussed, the conflict between dentist and DSO regulation seems to stem from the concern of overbilling and pressures for high production to meet the bottom line.⁵⁵ State regulation of dental clinical functions is appropriate, but regulation of non-clinical normal business activities, which occur in other industries, is an over-reach of regulators. In sum:

State dental boards guard and enforce their existing statutes prohibiting non-licensed individuals from performing or even attempting to perform a clinical function reserved for licensed professionals. What is equally clear is that activities on the nonprofessional side of the clinical/nonclinical line do not involve the practice of dentistry and, as such, do not require a license to practice dentistry to perform. The sanctity of the clinical/non-clinical line also applies in alternative practice arrangements[.]⁵⁶

States have handled the delineation of clinical dental duties versus non-clinical duties in a variety of ways, but mostly through adding to their own states corporate practice of medicine doctrines.

[<https://perma.cc/9PXU-EH34>].

53. ASS’N DENTAL SUPPORT ORGS., TOWARD A COMMON GOAL: THE ROLE OF DENTAL SUPPORT ORGANIZATIONS IN AN EVOLVING PROFESSION 7 (2014), <https://www.theadso.org/wp-content/uploads/2018/04/ADSO-White-Paper.pdf> [<https://perma.cc/RJL8-CL9M>].

54. *Id.* at 9 (emphasis omitted).

55. Holm, *supra* note 15.

56. ASS’N DENTAL SUPPORT ORGS., *supra* note 53, at 9.

1. States with little-to-no DSO regulations

Some states have little regulations regarding the operation of DSOs within their borders. States like Arizona, Mississippi, New Mexico, North Dakota, Ohio, and Utah are states that permit full or partial ownership of dental practices by business entities through their corporate practice of medicine laws.⁵⁷ In Utah, for example, the statutory code allows dental practice through a business corporation.⁵⁸ The Utah legislature uses the following language to regulate dental practices: “[a] dentist licensed under this chapter may engage in practice as a dentist, or in the practice of dentistry only as an individual licensee, but as an individual licensee, he may be: . . . a lawfully formed professional corporation . . . a lawfully organized limited liability company . . . a lawfully organized business corporation . . .”⁵⁹ Utah Code provides that there are some limitations to a non-licensed dentist to “participate in, or interfere in the licensee’s practice of dentistry.”⁶⁰ Utah’s language is a very good example of how the State has recognized the delineation between the clinical practice of dentistry and the normal business constructs of managing any type of company. In Utah, a dentist must focus on the clinical side of dentistry and maintain their license. Other business entities, including DSOs, are not to interfere with the clinical decisions of the practice but can be hired to help with the day to day non-clinical operations of the practice.

Ohio law provides definition for occupations and professionals in relation to their CPM doctrine. Ohio Code provides that “a corporation may be formed under this chapter for the purpose of carrying on the practice of any profession, including, but not limited to, a corporation for the purpose of providing . . . medical and hygienic treatment of patients . . .”⁶¹ In Ohio, therefore, corporations are allowed for the purpose of providing medical and hygienic services. In Ohio’s revenue code, “[n]o person, being a manager, proprietor, operator, or conductor of a place for performing dental operations, shall employ a person who is not a licensed dentist to perform dental operations or shall permit such person to practice dentistry in his office.”⁶² All states have similar language restricting clinical practice of dentistry to licensed dentists.⁶³ Notably, however, this does not restrict a DSO from operating within Ohio state boundaries. Finally, one of the few restrictions Ohio statutes have potentially placed on DSOs comes with the naming (marketing) of the dental practice. In a recent 2015 language update from

57. MARTIN J. SIEGEL & JIM MORIARTY, SURVEY OF STATE LAWS GOVERNING THE CORPORATE PRACTICE OF DENTISTRY (2012), <https://oversight.house.gov/wp-content/uploads/2012/04/4-25-12-Survey-of-State-Laws-Governing-the-Corporate-Practice-of-Dentistry.pdf> [<https://perma.cc/95C7-8PZS>].

58. UTAH CODE ANN. § 58-69-804 (LexisNexis 2018).

59. UTAH CODE ANN. § 58-69-804(1) (LexisNexis 2018).

60. UTAH CODE ANN. § 58-69-804(2) (LexisNexis 2018).

61. OHIO REV. CODE ANN. § 1701.03 (LexisNexis 2018).

62. OHIO REV. CODE ANN. § 4715.19 (LexisNexis 2017).

63. ASS’N DENTAL SUPPORT ORGS., *supra* note 53.

Ohio's House Bill 64, "[a]ny person practicing or offering to practice dentistry or dental surgery shall do so under the person's name, the name of a professional association, professional partnership, corporation-for-profit, or limited liability company that includes the person's name."⁶⁴ This language states that dentists can name their practice using their name personally or the corporation's name, but if dentists use the corporation name, then they must also include their personal name on the business registration as well.

Although this is a small sampling of statutory language from states with little-to-no DSO regulations, the sampling of CPM doctrine shows how most state legislatures have still considered the presence of DSOs within their borders and solved the delineation issues between a clinical dental provider and a business management provider.

2. States with a moderate level of DSO regulation

States with moderate regulation typically have some statutory language that restricts DSOs in areas that are clearly non-clinical or areas that are typically not regulated in the normal course of business. Florida and Indiana are good examples of moderate legislation.⁶⁵ In Florida, statutes provide that

no person other than a dentist . . . a professional corporation or a limited liability company composed of dentists may employ a dentist or dental hygienist . . . control the use of any dental equipment or material . . . or direct, control or interfere with a dentist's clinical judgment.⁶⁶

In Florida, if there are any leased dental equipment or materials involved, there must be a provision in the DSO contract establishing that the dentist maintains custody and control of the equipment.⁶⁷ Florida code specifically addresses and prevents a non-dentist from influencing a dentist's "independent professional judgment."⁶⁸ Florida also lists items that a DSO cannot exercise control over, including: selection of treatment for patients, patient records, policies and decisions for pricing, credits, refunds, warranties and advertising, along with decision relating to office personnel and hours of the practice.⁶⁹ Ordinary business decisions in most industries of a non-clinical nature typically include the ability to hire personnel for the office, market for the practice, and select the hours of operation. Florida has made these decisions illegal and penalizes such behavior of DSO operators with a third-degree felony.⁷⁰ Thus, if a DSO in Florida sets business hours for a practice from 9:00 a.m. to 5:00 p.m., the non-dentist owners could be liable for a felony in the third degree. This does seem heavy-handed,

64. OHIO REV. CODE ANN. § 4715.18(B) (LexisNexis, 2017).

65. Noting that Indiana will be discussed in-depth later in this Note.

66. FLA. STAT. ANN. § 466.0285 (LexisNexis, 2017).

67. *Id.*

68. FLA. STAT. ANN. § 466.0285(2) (LexisNexis 2017).

69. FLA. STAT. ANN. § 466.0285(2)(a-d) (LexisNexis 2017).

70. FLA. STAT. ANN. § 466.0285(3) (LexisNexis 2017).

but, in Florida, it is the law.

3. States with prohibitions or heavy regulation of DSOs

States with strict regulation or complete restriction of DSOs with their borders are not that common. States that fall under the heavy-handed approach require DSOs to register their business with the dental board, give increased power to their state licensing board or prohibit DSOs within their borders all together. Missouri, Wisconsin, Texas, and Iowa are examples of states with increased regulations against dental management businesses. In Missouri, a 2017 house bill proposal includes language that allows the state dental board to regulate DSO non-clinical services, such as information technology and billing support.⁷¹ In Wisconsin, a 2016 amendment prohibits a person from owning or operating a dental practice in Wisconsin unless the dental practice is registered by the dental examining board.⁷² This bill also gives power to the state's dental board to stop operations of any DSO at any time, even if the DSO had nothing to do with other events.⁷³ Dentists in the state of Wisconsin who are opposed to this type of legislation claim the board is given too much unchecked power, stating they “can’t imagine a heart surgeon having to worry about payroll or if the hospitals [sic] quarterly returns are in, they have to stop focusing on patients.”⁷⁴

Proposals similar to Wisconsin’s have recently been passed and signed into law in Texas.⁷⁵ As of February 2016, registration of DSOs must occur annually and must disclose names, addresses, non-clinical individuals who hold more than ten percent ownership, and all support services that a DSO provides to the dentist.⁷⁶ The requirement of DSOs to register “continues the trend in Texas

71. ASS’N DENTAL SUPPORT ORGS., MISSOURI STATE PROFILE (2017), <http://theadso.org/wp-content/uploads/2017/05/ADSO-State-Profile.pdf> [https://perma.cc/72AR-U4N7]. See also H.B. 815, 99th Gen. Assemb., 1st Reg. Sess. (Mo. 2017).

72. ASS’N DENTAL SUPPORT ORGS., ASSEMBLY BILL 368 RELATING TO: REGULATION OF DENTAL PRACTICES: PROBLEMS PRESENTED BY ASSEMBLY SUBSTITUTE AMENDMENT 1, <http://theadso.org/download/repulican-one-pager-on-assembly-bill-368/?wpdmdl=4837> [https://perma.cc/85B7-6XMH].

73. ASS’N DENTAL SUPPORT ORGS., ASSEMBLY BILL 368 RELATING TO: REGULATION OF DENTAL PRACTICES: DSOs INCREASE ACCESS TO DENTAL CARE AND LOWER COSTS, <http://theadso.org/download/democratic-one-pager-assembly-bill-368/?wpdmdl=4832> [https://perma.cc/DHD4-RK9M].

74. Tim Quirt, *Don’t Add Red Tape to My Dental Practice*, WAUSAU DAILY HERALD (Nov. 10, 2015, 4:50 PM), <http://www.wausaudailyherald.com/story/opinion/columnists/2015/11/10/don-t-add-red-tape-my-dental-practce/75514290/> [https://perma.cc/3Y4S-KT94].

75. Alexis Reynolds, *Texas to Require Registration of Dental Support Organizations*, MCGUIREWOODS (Jul. 23, 2015), <https://www.mcguirewoods.com/Client-Resources/Alerts/2015/7/Texas-Require-Registration-Dental-Support-Organizations.aspx> [https://perma.cc/8ZLW-TS38].

76. *Id.*

toward somewhat tighter regulation of DSOs.⁷⁷ DSOs are non-clinical business management companies.⁷⁸ These types of services can be performed by business entity and include:

Bookkeeping, accounting and tax preparation, payroll administration and processing, payor relations, billing and collections, banking and financing, creation and placement of dentist approved advertising, promotion (social media), marketing, information technology, human resources, general office management, property management, housekeeping, risk management: legal and regulatory, compliance, insurance.⁷⁹

Regulating a DSO entity to the extreme measures as discussed above, is comparable to mandating anyone Southwest Airlines contracts with for outside services, registers with the FAA for scrutiny. Regulation of clinical functions makes complete sense and fulfills the missions of state police powers under the Tenth Amendment, but to regulate normal industry business behavior in this manner is too intrusive and needlessly drains taxpayers' money and government time.

B. Indiana Regulations regarding DSOs

1. First major CPM case regarding dentist practice ownership in modern times

As previously stated, Indiana statutory regulations tend to fall into the moderate category of DSO regulation. There is both case law and statutory language that govern what a DSO can and cannot do within its borders. The first indicator of change for CPM laws and dental practice ownership occurred in a landmark case in 2002, which is still valid law today.⁸⁰ In the 2001 case *Orthodontic Affiliates P.C. v Orthoalliance Inc.*, Ortho Affiliates were a group of orthodontists who merged their professional corporation with the DSO Orthoalliance.⁸¹ Some of the doctors became “dismayed because their profits failed to meet projections; the loss of autonomy over certain business decisions bothered others.”⁸² In order to get out of their practice management agreements with Orthoalliance, the orthodontists sued, claiming their service agreements, merged together, violated Indiana Code §25-14-1-23 of the Indiana Dental Practice Act (“IDPA”).⁸³ In 2001, this section of the Indiana code read:

[a] person is practicing dentistry within the meaning of this chapter if the person . . .

77. *Id.*

78. ASS'N DENTAL SUPPORT ORGS., *supra* note 53.

79. *Id.* at 9.

80. *Orthodontic Affiliates P.C. v. Orthoalliance Inc.*, 210 F. Supp. 2d 1054 (N.D. Ind. 2002).

81. *Id.* at 1056.

82. *Id.*

83. *Id.* at 1058.

- (13) exercises direction or control over a dentist through a written contract concerning . . .
- (F) final decisions relating to the employment of dental office personnel.⁸⁴

Ortho Affiliates then pointed to seven areas of the service agreement which fell within the provisions of the statute, arguing because Orthoalliance practiced medicine without a license, the contract was invalid and unenforceable, releasing the dentist from their obligations thereunder.⁸⁵ First, the court looked at the contract language between the parties to sort out clinical versus non-clinical duties.⁸⁶ If the DSO had performed clinical duties, the DSO would be in violation of Indiana law. However, if the DSO performed only non-clinical duties, then it would not be within the confines of the CPM law.⁸⁷ The court ruled that the plain text of the contract was clear:

Defendant [Orthalliance] has the contractual obligation to render business services and provide the business personnel necessary to discharge this duty. Moreover, the contractual obligation to render these services is *explicitly subject* to the regulation of dental practice in Indiana. So, if a certain course of conduct constitutes unlawful practice of dentistry under Indiana law, the Service Agreement requires that Defendant refrain from engaging in that proscribed conduct.⁸⁸

The court explained that Orthoalliance purposefully refrained itself contractually from performing duties that were contrary to Indiana law, meaning performing clinical functions, and found no violation of the law.⁸⁹

Next, the court looked at the actions of Orthalliance regarding “staff.”⁹⁰ Ortho Affiliates claimed that Orthalliance exercised control over employment decisions of “dental office personnel” in opposition of Indiana law.⁹¹ If “staff” included people who actually worked on patient’s teeth, such as the dental hygienist or dental assistant, there would be a violation as defined by the IDPA.⁹² The parties titled the paragraph “Personnel and Payroll,” and stated that Orthalliance “shall be responsible for the performance of all payroll and payroll accounting functions.”⁹³ Further, the term “dental office personnel...refers to person employed to work on patients teeth...staff related to business personnel and thus, the company’s control over the staff pursuant to the service agreement did not

84. *Id.*

85. *Id.*

86. *Id.* at 1060.

87. *Id.*

88. *Id.*

89. *Id.*

90. *Id.*

91. *Id.*

92. *Id.*

93. *Id.*

permit the company to exercise control over employment decisions of ‘dental office personnel’ in contravention of the IDPA.”⁹⁴ The court ruled that payroll services are “clearly *not* the sort of activity within the purview of dentistry,” and it was Ortho Affiliates that made statements that the “orthodontists retained exclusive control over the plaintiff’s dental practice.”⁹⁵ Looking at the totality of the claims, the court ruled that the defendant was not practicing dentistry by providing such services.⁹⁶

Last, the court looked at the ability of the defendant, Orthalliance, a DSO, to employ dentists as employees and compared this act to the CPM doctrine of Indiana.⁹⁷ The plaintiff argued that by entering into an employment agreement with the defendant, a non-dentist, it “constitutes unauthorized practice of dentistry.”⁹⁸ The court held “even assuming that entering into employment contracts with orthodontists construes unauthorized practice of dentistry, it was [the Ortho Affiliates] who agreed to engage in the unlawful act.”⁹⁹ The culpable party was therefore Ortho Affiliates in this case, “and as a result, it ha[d] no remedy.”¹⁰⁰ Interestingly, the court pointed out that if anyone had broken the law, it was the dentist who willingly and willfully entered into the contract.¹⁰¹ The court did not state that when a DSO employs a dentist, it violates state statute; it stated that even if it did, the culpable party would be the dentist who entered the agreement.

In sum, this case ushered in an era where DSOs could operate in Indiana, as long as the clinical versus non-clinical line was clearly delineated in the contract and in the actions of the parties. Regulation of the medical-clinical lines and not regulating normal business practices with the same heightened control shows a proper level of governmental control. This case supports the main argument of this Note, that DSOs perform normal business management functions of a non-clinical nature and do not need to be regulated by legislation. This case also illuminated several issues that were brought to the forefront about a decade later.

2. Proposed changes to Indiana CPM Dental Laws

In January 2013,¹⁰² the issue of DSOs arose once again in Indiana with the proposal of new statutory language regarding who can and cannot operate a dental practice.¹⁰³ In the first regular session of the 118th General Assembly, language sponsored by then-Senator Ryan Mishler that would “[p]rohibit a person

94. *Id.* at 1054.

95. *Id.* at 1060.

96. *Id.*

97. *Id.*

98. *Id.*

99. *Id.*

100. *Id.*

101. *Id.*

102. S.B. 590, 118th Gen. Assemb., 1st Reg. Sess. (Ind. 2013).

103. *Id.*

other than a licensed dentist from owning, operating, conducting, or maintaining a dental practice, office, or clinic, and makes exceptions” was read on the floor.¹⁰⁴ The proposal included changes to Indiana Code pertaining to CPM doctrine for dentistry, statutory language wanted to add the language “except as provided in subsection (i), owns, operates, conducts, or maintains a dental office, or clinic, or...” to the existing language of “...is the employer of a dentist who is hired to provide dental services.”¹⁰⁵ Sections (j) and (k) were also proposed, which included language for DSOs: (j)(1) to register with the dental board, (j)(2) name an active licensed dentist as dental director responsible for clinical functions, (j)(4) maintain current list of licensed dentists and make these records available to the board upon request, (k)(1) preclusion of any non-licensed entity from ownership tangible assets used in the dental office, (k)(2) employment of services personnel other than licensed dentists, and (k)(3) management in a dental office that are not related to clinical practice of medicine.¹⁰⁶

These proposals were not initially accepted, but were then amended favorably and referred to the Committee on Health and Provider Services on February 14, 2013.¹⁰⁷ In April of the same year, the conference committee report digest for the Engrossed Senate Bill 590 added language to study the “delivery of dental practices by persons other than dentists” further.¹⁰⁸ The date for the study to be completed was by December 31, 2013.¹⁰⁹ On October 22, 2013 the Health and Finance Commission met and heard testimony from different Indiana dentistry representatives regarding the management of DSOs.¹¹⁰ This testimony included myths and realities of DSOs; dentists who praised the fact that DSOs helped them manage their practices administratively; how Medicaid services are expanded due to DSOs, issues regarding credentialing of dentists via DSO management; second opinions for work possibly over diagnosed; and the Indiana Attorney General’s Office requesting clarification on the ambiguity of the current law that should be addressed by statute or the state dental board as regulatory authority.¹¹¹ The commission ended the meeting and inserted into the final report recommended preliminary drafts of the issues presented that day.¹¹² Notably, no preliminary draft recommendations for the management of DSOs in Indiana were presented by the commission.¹¹³ In late November 2013, the Health Finance Commission

104. *Id.*

105. *Id.* at (a)(10).

106. *Id.* at (j)-(k)(3).

107. Ind. S.B. 590.

108. COMMON HEALTH & PROVIDER SERV., CONF. COMM. REP. DIGEST FOR ESB 590, S. 118-590, 1st Reg. Sess., at 1 (Ind. 2013).

109. *Id.* at 12.

110. HEALTH FIN. COMM’N, MEETING MINUTES (Oct. 22, 2013), <http://www.in.gov/legislative/interim/committee/minutes/HFCOGAM.pdf> [<https://perma.cc/JYR2-XSER>].

111. *Id.*

112. *Id.*

113. *Id.*

released their final annual report.¹¹⁴ Although the October 22, 2013, meeting regarding DSOs is recorded, the commission finalized its findings and no recommendations for action were given.¹¹⁵ Engrossed Senate Bill 590 was dead; the State of Indiana researched and heard the issues regarding DSOs and decided against further government interference and regulations.¹¹⁶ This in-depth discussion of Indiana's consideration of ESB 590 (DSO legislation) shows that after careful consideration of the issues, the Health Finance Commission did not choose to improve further regulations upon DSOs because DSOs perform non-clinical functions and do not need to be regulated by the CPM.¹¹⁷

3. Current Indiana CPM Laws for Dentistry and Recommendations

In Indiana, the current CPM law allows licensed dentists to have contractual relationships with other business management entities.¹¹⁸ Codified in Indiana Code § 25-14-1-23,¹¹⁹ a person is practicing dentistry within the meaning of this chapter if the person does any of the following:

- (2) Directs and controls the treatment of patients within a place where dental services are performed.
- (10) Is the employer of a dentist who is hired to provide dental services.
- (11) Directs or controls the use of dental equipment or dental material while the equipment or material is being used to provide dental services. However, a person may lease or provide advice or assistance concerning dental equipment or dental material if the person does not restrict or interfere with the custody, control, or use of the equipment or material by the dentist.
- (12) Directs, controls, or interferes with a dentist's clinical judgment.
- (13) Exercises direction or control over a dentist through a written contract concerning the following areas of dental practice:
 - (A) The selection of a patient's course of treatment.
 - (B) Referrals of patients, except for requiring referrals to be within a specified provider network, subject to the exceptions under IC 27-13-36-5.

114. STATE OF IND. LEGISLATIVE SERVS. AGENCY, ANN. REP. OF THE HEALTH FIN. COMM'N, GEN ASSEMB., (2013).

115. *Id.*

116. Ind. S.B. 590; *See* STATE OF IND. LEGISLATIVE SERVS. AGENCY, ANN. REP. OF THE HEALTH FIN. COMM'N, GEN ASSEMB., (2013).

117. STATE OF IND. LEGISLATIVE SERVS. AGENCY, ANN. REP. OF THE HEALTH FIN. COMM'N, GEN ASSEMB., (2013).

118. Eric J. Yetter, *Understanding Corporate Practice of Medicine Laws by State*, PHYSICIANSFIRST HEALTHCARE PARTNERS (Aug. 25, 2017, 3:10 PM), <https://www.physiciansfirsthc.com/blog/corporate-practice-of-medicine-laws-by-state/> [<https://perma.cc/65GB-J7M3>].

119. IND. CODE ANN. § 25-14-1-23 (LexisNexis, 2017).

- (C) Content of patient records.
- (D) Policies and decisions relating to refunds, if the refund payment would be reportable under federal law to the National Practitioner Data Bank, and warranties.
- (E) The clinical content of advertising.
- (F) Final decisions relating to the employment of dental office personnel.¹²⁰

Note that all the proposed language in ESB 590, previously discussed, is not present in the current Indiana Code. As discussed in case law, DSOs who provide management services and personnel to dentists are not considered practicing dentistry.¹²¹ As mentioned, Indiana is a moderately legislated state and DSOs do not have to register with the dental board like Texas, but there are still regulations that cross into the non-clinical aspects of dentistry like advertising and human resource management areas.

This Note recommends clarification of the language surrounding “dental office personnel” within section 13(F) of Indiana Code §25-14-1-23.¹²² The only language Indiana currently has concerns the word “staff” from the Orthoalliance case and leaves too much gray area to be interpreted.¹²³ DSOs should be able to assist the dentist by helping to recruit and manage all dental team members. Dentists do not need to be statutorily excluded or purposefully included on the hiring of a dental assistant; for example, if they choose to be directly involved in personnel management, dentists can ensure that detail is added in their contracts. Some dentists will not like having time they spend with their patients interrupted in order to attend to an interview or to participate in decision-making meetings as mandated by current legislation, yet some will. The law should not dictate this provision because it should be at the preference of the dentist and contractually bargained for between the parties.

Next, section 13(E), the “clinical content of advertising,” is also unclear.¹²⁴ Does this mean that a marketing team can design an ad but cannot indicate the current procedural terminology (“CPT”) code for the procedure or even mention it? Admittedly, statutory language will not cover all interpretations of possible meanings, nor is it intended to; however, “clinical content” is very ambiguous and adds confusion. Further, dental marketing is already covered by state administrative law,¹²⁵ and service provider agreements already restrict DSOs to act in accordance with the state law in which the contract is enacted. Section 13(E) clinical content language should be eliminated.

120. *Id.*

121. *Orthodontic Affiliates P.C.*, 210 F. Supp. 2d at 1060.

122. IND. CODE ANN. § 25-14-1-23 (LexisNexis, 2017).

123. *Orthodontic Affiliates P.C.*, 210 F. Supp. 2d at 1054.

124. IND. CODE ANN. § 25-14-1-23 (LexisNexis, 2017).

125. 828 IND. ADMIN. CODE 1-1-14 (2013), *invalidated by* Ind. Prof'l Licensing Agency v. Atcha, 49 N.E.3d 1054 (Ind. Ct. App. 2016) (holding 14(a) and 14(b) to be unconstitutional).

C. DSOs Can Legally Operate in Indiana

After careful review of the CPM case law in Indiana and statutory language regarding practicing dentistry, all indicate that DSOs can legally operate within the borders of Indiana. There must be a service provider agreement between the dentist and the DSO that specifically addresses the statutory language discussed to ensure that clinical and non-clinical areas are well defined. Indiana should regulate and create legislation for clinical function in a dental office. Indiana must fulfill the policing powers granted to it under the Tenth Amendment to ensure health, safety, and welfare for its citizens. However, these policing powers should not flow into areas that are customarily non-clinical business management tasks. Human resource management and marketing are great examples of normal business operations that are non-clinical. Over-regulation leads to vague statutory language, and vagueness hinders the efficiencies of professional business management and can reduce access to healthcare, increase costs, and lower quality.

IV. DSOS PROVIDE INCREASED ACCESS, LOWER COST, AND HIGHER QUALITY FOR PATIENTS

According to state statutory language and case law, DSOs are now able to operate within the border of most states. Just because a DSO can legally operate within the borders of a state does not mean it is an effective method for delivering healthcare. Methods of delivery in healthcare are customarily assessed using the Iron Triangle of healthcare.¹²⁶ Three areas are assessed and include: access, cost and quality.¹²⁷ The Iron Triangle states that access, cost, and quality are like a three legged stool, if you remove one of the legs the entire system becomes unstable and eventually fails.¹²⁸ However, if a new healthcare initiative improves one or two (or even all three) of these legs, the healthcare initiative becomes more stable and desirable.¹²⁹ Using the Iron Triangle of healthcare assessment, this section concludes that DSOs are improving the health and welfare of patients in states where DSOs are operating.

A. Increased Access to Dental Care

Rural communities, compared to urban centers, face real challenges in being able to access dental care.¹³⁰ Lack of access to dental care in rural areas results in

126. Godfrey, *supra* note 4.

127. *Id.*

128. *Id.*

129. *Id.*

130. Rebecca Singer Cohen & Julie Stitzel, *Improving Dental Care Access in Rural America*, THE PEW CHARITABLE TR. (Nov. 18, 2015), <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/11/18/improving-dental-care-access-in-rural-america> [<https://perma.cc/63V8-4ADY>].

higher rates of cavities and other serious dental issues.¹³¹ When a patient does not have access to a dentist, treatment is ignored until the pain becomes so severe that a visit to an already overburdened emergency room is sought.¹³² Although the emergency room visit will temporarily relieve the dental condition, it does not solve the problem long-term because emergency rooms are simply not designed to take care of dental needs.¹³³ In 2012, there were 4,438 total dental health shortage areas, areas in which there is no dentist for miles around.¹³⁴ In the United States, sixty percent of dental shortage areas are located in rural communities.¹³⁵ HHS predicts that over the next ten years, every state will face a rural dental shortage.¹³⁶

In the Crisis in Rural Dentistry report, both the Surgeon General and the Institute of Medicine “call for more dentists in rural locations.”¹³⁷ Possible solutions to increasing access of dental care in rural communities in the Crisis report include: admitting more dental students who are likely to have rural practices, providing rural experiences during dental school to attract more dentists post-graduation, and enhancing the ability of rural municipalities to recruit dentists through development efforts.¹³⁸ Another viable and positive solution is to encourage DSOs within states borders.¹³⁹ With dentists having record high student and practice debt, serving in a mostly rural area is simply not financially feasible.¹⁴⁰ DSOs are taking the bite out of this huge gap in access to dental care, for rural areas and urban areas too.¹⁴¹ DSOs have financial resources and business acumen to be able to operate in smaller markets, “[a]fter all, there is strength in numbers.”¹⁴²

An example of an effective DSO in a rural market can be found in Wisconsin, where “[o]ver the past 12 years, the Marshfield Clinic has opened 10 state-of-the-art dental centers to serve the rural poor.”¹⁴³ In Indiana, DSOs have dental

131. *Id.*

132. *Id.*

133. *Id.*

134. *Id.*

135. *Id.*

136. *Id.*

137. Mark P. Doescher, Gina A. Keppel, Susan M. Skillman, & Roger A. Rosenblatt, *The Crisis in Rural Dentistry*, RURAL HEALTH RES. CTR. POL’Y BRIEF (Apr. 1, 2009), http://depts.washington.edu/uwrhrc/uploads/Rural_Dentists_PB_2009.pdf [<https://perma.cc/TQ26-BYZP>].

138. *Id.*

139. Beth Miller, *DSOs Are Promoting Global Dentistry, Volunteerism, And Philanthropy*, GROUP DENTISTRY NOW (Nov. 28, 2017), <https://groupdentistrynow.com/dsos-are-promoting-global-dentistry-volunteerism-and-philanthropy/> [<https://perma.cc/Q5QV-ARXT>].

140. *Id.*

141. *Id.*

142. *Id.*

143. Alison Kodjak, *A Good Dentist is Hard to Find in Rural America*, NPR (Sept. 12, 2016, 6:50 AM), <https://www.npr.org/sections/health-shots/2016/09/12/488416888/a-good-dentist-is-hard-to-find-in-rural-america> [<https://perma.cc/4XVL-VKPT>].

practices in smaller rural communities like Franklin, Frankfort, Greenfield, Greencastle, Logansport, Marion, and Shelbyville—all underserved rural areas.¹⁴⁴ In addition to having dental practices in smaller communities, DSOs offer free dental care events, mission trips, community outreach programs, and service days.¹⁴⁵ Can a solo dentist spend time planning and administrating such events? Some can, but for the majority “solo practitioners are more focused on building their practice and paying their bills, including school loans.”¹⁴⁶ DSOs charitable efforts and small community practices reach “hundreds, or even thousands, of people” all over the United States of America.¹⁴⁷ DSOs are an excellent way to increase access to dental care and therefore improve the health of citizens overall.¹⁴⁸ If states want to solve the increasing shortage of dentists within their borders, they should welcome DSOs with open arms, as DSOs truly benefit citizen access. Access to dental care is only one leg of the stool; how costs affect patients is another area critical to assessing DSOs.

B. Lower Costs for Patients

When patients visit the dentist, the thought of “How much is this going to cost me?” often runs through their minds. The Centers for Medicare and Medicaid Services (“CMS”) reported healthcare spending of \$3.3 trillion or \$10,348 per person in 2016.¹⁴⁹ On average dental spending consists of approximately 4% of the overall health spending in the United States.¹⁵⁰ No wonder cost in dentistry is often overlooked by legislatures, as they consider dental care a non-essential health benefit.¹⁵¹ However, the ADA has reported that “cost [is] the number one reason for not visiting the dentist.”¹⁵² So what do patients do when they have a dental issue that has become a health priority and there is no access to a dentist or they cannot afford it? They go to the hospital emergency room, a medical

144. *Supported Locations*, HEARTLAND DENTAL, <https://heartland.com/who-we-support/supported-locations>.

145. Miller, *supra* note 139.

146. *Id.*

147. *Id.*

148. *Oral Health in Rural Communities*, RHIHUB <https://www.ruralhealthinfo.org/topics/oral-health> [<https://perma.cc/HM8W-Q33K>] (last updated Feb. 15, 2017).

149. *National Health Expenditure Data*, CTMS FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html> [<https://perma.cc/7ZA5-MSE3>] (last modified Jan. 8, 2018).

150. Marco Vujicic, *Dental Spending*, DENTAL ECONOMICS (Aug. 21, 2013), <http://www.dentaleconomics.com/articles/print/volume-103/issue-8/features/dental-spending.html> [<https://perma.cc/47LM-295K>].

151. *The Oral Health Care System: A State-by-State Analysis*, AM. DENTAL ASS'N, <https://www.ada.org/~media/ADA/Science%20and%20Research/HPI/OralHealthCare-StateFacts/Oral-Health-Care-System-Full-Report.pdf?la=en> [<https://perma.cc/WY8K-GDPK>].

152. *Id.* at 4.

facility completely untrained and unqualified as dentists, to get temporary relief from symptoms.¹⁵³ In 2015, \$1.6 billion dollars was spent on emergency room visits related to dental emergencies, equating to two million patient visits.¹⁵⁴ Most of these dental emergencies could have been addressed earlier and with a better prognosis than a prescription from an emergency room.¹⁵⁵ DSOs are typically run by individuals with strong business expertise and their companies have lower cost of operations than traditional dental practices by creating operational efficiencies through innovations that lower capital costs like bulk purchases and greater negotiating power.¹⁵⁶ A 2012 study, performed by economist Arthur Laffer, indicates that DSOs actually charge about \$225 less per patient than non-DSO dentists.¹⁵⁷ For example, in Texas, a non-DSO general dentist charged on average \$711.54 per patient per year, or \$57.41 per procedure.¹⁵⁸ DSO dentists, however, charged \$483.89 per patient per year, or \$47.69 per procedure, a significant reduction in actual costs to the patient.¹⁵⁹ Laffer says these cost-saving results are because “the DSO model enables the provision of dental services at a lower cost to consumers of all income levels by taking advantage of economies of scale.”¹⁶⁰ In addition to DSOs costing patients less, DSO practices are more efficient than a solo dental offices, and can even be profitable if they take state Medicaid dental programs.¹⁶¹ Although, also an argument for access to dental care, DSOs who take Medicaid are able to afford the pay-gap.¹⁶² Medicaid dental programs pay less than \$0.60 on the dollar, and traditional dental practices lose money without the business acumen to make this kind of a pay model profitable.¹⁶³ DSOs are able to leverage their operational efficiencies to close the Medicaid pay-gap and keep costs lower for patients and access continuous.¹⁶⁴ If DSOs are not allowed or are heavily regulated in a state, there will be increasingly fewer patients seen by

153. Cohen & Stitzel, *supra* note 130.

154. *Id.*

155. *Id.*

156. Wayne Winegarden & Donna Arduin, *DSOs Empower Dentists to Serve the Underserved*, GROUP DENTISTRY NOW (Sept. 9, 2015), <https://groupdentistrynow.com/dsos-empower-dentists-to-serve-the-underserved/> [<https://perma.cc/WS7M-9YTD>].

157. *Economist Finds Dental Service Organizations (DSOs) More Cost-Effective Than Average Independent Dentists*, DENTISTRYIQ (Sept 25, 2012), <http://www.dentistryiq.com/articles/2012/09/economist-finds-dsos-more-cost-effective-than-independent-dentists.html> [<https://perma.cc/TWT4-P9QF>].

158. *Id.*

159. *Id.*

160. *Id.*

161. Wayne Winegarden, *DSOs Illustrate How the Private Sector Can Solve Public Health Problems*, FORBES (Feb. 17, 2016, 2:05 PM), <https://www.forbes.com/sites/econostats/2016/02/17/dsos-illustrate-how-the-private-sector-can-solve-public-health-problems/#6d7c062e11f5> [<https://perma.cc/7ZTX-AZV7>].

162. *Id.*

163. *Id.*

164. *Id.*

dentists, forcing these patients into hospital emergency rooms, which will increase the already staggering and unnecessary costs in the billions of dollars.¹⁶⁵ In sum, taxpayers, consumers, and legislatures should embrace the innovation of the DSO that helps to reduce the direct cost to patients.¹⁶⁶

C. Higher Quality for Patients

Quality is the last area of the Iron Triangle analysis, which will be used to survey the benefits of the DSO healthcare system.¹⁶⁷ Peer review systems are used in the medical community to grant hospital privileges to applying physicians.¹⁶⁸ Peer reviews are the hospitals internal way of focusing on “quality care (e.g. education, experience, training, board certification, other appointments or affiliations, and references).”¹⁶⁹ In Indiana, the quality issue is of such significant importance that legislation has codified the duties of a peer review committee in Ind. Code § 34-6-2-99.¹⁷⁰ One of the main responsibilities of a peer review committee is to evaluate the “merits of a complaint against a professional health care provider . . . based on the competence or professional conduct of an individual health care provider.”¹⁷¹ A healthcare professional who is found liable under a peer review committee may be reprimanded, lose his or her privileges at a facility, or lose his or her license.¹⁷² In dentistry “[s]tate dental associations conduct peer review programs to settle disputes . . . that may be addressed through peer review involve appropriateness of care, quality of care...”¹⁷³ It is important to note that peer review, according to the ADA, evaluates “appropriateness of care, quality of care and . . . fees.”¹⁷⁴ Quality, one of the main branches of a state dental board peer review committee, tests the treatment provided by the dentist using standards that are generally accepted with the dental community by those practitioners who regularly perform those procedures.¹⁷⁵ Oftentimes by the time an offense has reached the peer review committee, the offense is serious and usually repetitive in nature. What DSOs are doing to increase quality of care is creating in-house peer-review models, called quality

165. Cohen & Stitzel, *supra* note 130.

166. *Economist Finds Dental Service Organizations (DSOs) More Cost-Effective Than Average Independent Dentists*, *supra* note 154.

167. Godfrey, *supra* note 4.

168. Huberfeld, *supra* note 6.

169. *Id.*

170. IND. CODE ANN. § 34-6-2-99 (LexisNexis 2017).

171. IND. CODE ANN. § 34-6-2-99(a)(1)(C) (LexisNexis 2017).

172. Huberfeld, *supra* note 6.

173. *Peer Review Resources*, AM. DENTAL ASS'N, <http://www.ada.org/en/member-center/member-benefits/practice-resources/peer-review-resources> [<https://perma.cc/TPR8-VKYK>].

174. *ADA Guidelines for Peer-Review*, AM. DENTAL ASS'N 10 (2017), https://www.ada.org/~media/ADA/Member%20Center/Files/2017_ADA%20Peer_Review_Manual.pdf?la=en [<https://perma.cc/MBC7-3SZY>].

175. *Id.*

assurance programs, to increase dentist accountability and prevent possible repetitive, low quality behavior.¹⁷⁶ This type of in-house measuring tool system monitors the dentists' failures and success rates, patient satisfaction levels, and treatment plan completion success.¹⁷⁷ When a dentist within an organization shows rates outside of normal parameters, the in-house dental peer committee reaches out to the dentist and helps by working with the dentist to correct the issue long before it turns into a habitual problem.¹⁷⁸ Establishing a clinical quality assurance program is a significant task not well suited for a solo dentist as they are already busy with running their own business.¹⁷⁹ Among lack of standardized measuring metrics and limited measuring systems,¹⁸⁰ solo dentists do not have anyone to self-report to. Until the patient formally complains to the state dental peer-review committee, the lack of quality of a solo dentist often goes unnoticed. In a DSO, which has a quality assurance program in place, metrics will allow for anomalies to be located sooner and corrective action can be taken quicker.

One of the best tools to prevent low quality care and correct dentist behavior is through training programs established by DSOs. DSOs love to hire experts in various dental fields to train and educate their dentists. A DSO dentist will "have access to new equipment, [and] they are provided continuing education" ("C.E.").¹⁸¹ In 2017, Heartland Dental, one of the industry's largest DSOs, recently held its annual winter conference where dentists came from all over the country to learn the latest technology, collaborate together, and build skills to better serve their patients.¹⁸² Heartland boasts that its dentists have access to over 200 hours of continuing education in clinical and leadership training.¹⁸³ Other successful DSOs, like Pacific Dental Services, have the same continuing education focus in mind with their dentists, providing hours of free C.E. business

176. Sean G. Boynes, *Clinical Quality Assurance in the Dental Profession*, DENTAL ECONOMICS (May 15, 2015), <http://www.dentaleconomics.com/articles/print/volume-105/issue-5/macroeconomics/clinical-quality-assurance-in-the-dental-profession.html> [<https://perma.cc/UG7U-38GN>].

177. *Id.*

178. *Id.*

179. *Quality Measurement in Dentistry: A Guidebook*, DENTAL QUALITY ALLIANCE 24 (2016), https://www.ada.org/en/~media/ADA/Science%20and%20Research/Files/DQA_2016_Quality_Measurement_in_Dentistry_Guidebook [<https://perma.cc/L4DV-6JAB>].

180. *Id.* at 12.

181. Holm, *supra* note 15.

182. GlobeNewswire, *Heartland Dental Holds 2017 Winter Conference Event Largest Dental Support Organization Hosts Hundreds of Supported Dentists for Two Days of Celebration and Education*, MARKETS INSIDER (Dec. 28, 2017), <http://markets.businessinsider.com/news/stocks/Heartland-Dental-Holds-2017-Winter-Conference-EventLargest-dental-support-organization-hosts-hundreds-of-supported-dentists-for-two-days-of-celebration-and-education-1012271330> [<https://perma.cc/Z437-9N4W>].

183. Pat Bauer, *Impacts of DSOs on the Dental Industry*, HEARTLAND DENTAL 42, <https://aadgp.org/wp-content/uploads/Pat-AADGP-Presentation-KM.pdf> [<https://perma.cc/FTW4-CPHR>].

training, and leadership training.¹⁸⁴ DSOs know that the nexus between high quality care and long-term standardized appropriateness of care comes from training their dentists. Solo dentists can access training, but the costs are higher as attending training usually requires them to temporarily close their practices and have no income. When DSOs provide internal peer-review committees and high-quality care through extensive training programs for dentists, patients win.

V. CONCLUSION

As the salt-water taffy injured fairgoer leaves his or her new dental home, feeling great relief from the morning's tooth injury, the fairgoer is impressed with the experience. The location of the office was easy to access, the dental operator was clean, and the dentist had the latest technology and communicated in a friendly, clear manner. The bill was thoroughly explained by the dental team and was actually less than expected for the level of trauma that occurred early in the day at the fair. The initial concern for how such a beautiful office could be run so well vanished, as the fairgoer had confidence in the clinical and business side of this new dental home. It is possible for more patients to have experiences like the fairgoer, but only if state legislatures are careful not to tread into regulation of non-clinical business management aspects of the dental world.

State legislatures do not need to regulate the non-clinical business affairs of a DSO. Regulation of clinical dental services is within the scope of a state's policing power. However, it is a slippery slope to enter into the regulation of non-clinical business efforts of a DSO, especially when similar business activities are not statutorily regulated in other industries. Indiana is a moderately statutorily regulated state, but no further legislation is needed to protect the citizens' dental health. Relaxing the statutory language would help foster positive dental care for patients within Indiana. When states allow DSOs to operate within their borders, DSOs actually improve all three areas of the Iron Triangle. DSOs provide increased access to high quality dentists, reduction in costs, and improved dental care quality through peer-review and training. DSOs are here to stay and policymakers should realize that "Dental Service Organizations exemplify the types of health care benefits private sector firms can create—but only if the policy environment does not impede their contributions."¹⁸⁵

184. *Lifelong Learning*, PACIFIC DENTAL SERVICES, <http://www.pacificdentalservices.com/approach/lifelong-learning/> [https://perma.cc/BE3D-8YUJ].

185. Wayne Winegarden & Donna Arduin, *The Benefits Created by Dental Service Organizations* (Oct. 2012), https://www.heartland.org/_template-assets/documents/publications/PRI-DSOFinal.pdf [https://perma.cc/4UVY-SX5F].