Corporate Dentistry Task Force Report

By Shelly Fritz, DDS

October 2012

The purpose of this report is to find out what we know about corporate dentistry so that we can have a basis to make decisions in regard to corporate dentistry's role in the future of dental care. There are no recommendations in this report. However, after the Board of Trustees and House of Delegates of the New Mexico Dental Association and the Members of the New Mexico Board of Dental Health Care read the report, hopefully, recommendations and action will take place.

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What and who are corporate practices?

The people who study, research or work in what many of us think of as corporate dentistry use other terms in describing practices. According to Matt Warren, Senior Manager, Policy Analysis and Analytics, Health Policy Resources Center ADA, there are three types of dental practices as determined by size. Solo or collaborative practices have one to four dentists.

Group Practices have five to nineteen dentists with a sole owner with several or many associates. They are in single or multiple locations with single or multiple dentists in the various locations. More often than not they are groups of general practitioners but many do have specialty practices. They are focused in towns with local satellite offices and are the precursors to large group practices.

There are large group practices that have over twenty dentists. These are large specialty or multi-specialty practices, regional general practitioner practices and corporate practices that are the largest. They have many offices with a large dentist workforce with hundreds of offices and even more dentists. The dentist workforce can consist of employees, owners and part time owners. Ownership can be concentrated in one entity, shared with dentists by some formula, or be of no consideration such as Dental Management Service Organizations (DMSO’s). These entities implement management strategies associated with achieving economies of scale such as selection and optimization of location, management of supply chain costs, and manipulation of demand.

There are three types of large group practices. Group Practice Organizations are referred to as Franchise Dentistry such as Comfort Dental in Albuquerque with seven independently owned office locations. Each office is independently
owned and operated by the dentist (LLP) and they typically have four dentists in a practice.

The Dental Management Services Model (DMSO) is an administrative arrangement. The practice pays a fee for administrative, financial, marketing and information service aspect of their practices. There is no corporate ownership stake in the practices. Growth is by adding solo, small and large groups in the administrative arrangement. Perfect Teeth managed by Birner Dental Management Services has a presence in New Mexico as well as Arizona and Colorado.

Other group practices are composed of two business units: a DMSO and an Equity Group which may be shared with the dentists. Growth occurs through acquisitions and new practice locations in the form of small and large groups.

The third is called the Geographic/Multi-Specialty Model. They have fewer locations focused in the same geographic area. Each location has multiple dentists and may include specialists along with GP’s. Some dentists may split time among several locations. Growth occurs by acquisition and new (organic) locations. This model can become very large. Modern Dental run by Pacific Dental Services is an example in New Mexico. Pacific Dental Services is a large group practice with over 300 offices in California, Nevada, Arizona, Colorado, Texas, New Mexico, Utah and Oregon. They have two practices in New Mexico.

New Mexico non-dentist licensed owners are Modern Dentistry with three offices, Family Dental Health Care with five offices, Panda Smiles, Smiles for Miles, and Santa Fe Modern Dentistry and Orthodontics. There are seven licenses and Pacific Dental Services holds three of them.

There are a number of group practices owned by dentists. They are Adventure Dental and Orthodontics in Albuquerque and Santa Fe, Comfort Dental in Albuquerque, Gentle Dental in Albuquerque, Kids Choice Dental in Albuquerque, Kids Care in Alamogordo, Albuquerque, Anthony, Carlsbad, Clovis, Farmington, Las Cruces and Roswell, Peppermint Dental in Albuquerque, and Perfect Teeth in Albuquerque and Santa Fe. In Clovis,
Espanola, Hobbs, Roswell and there is Familia Dental. Cottonwood, Winrock Mall, Uptown Park and Santa Fe Place Family Dental Practice Centers in Albuquerque and Santa Fe are owned by a dentist.

The greatest number of large group practices in New Mexico are our non-profit clinics. Eileen Goode, RN BSN, Director of Operations/Clinical Programs for the New Mexico Primary Care Association writes: They are partially funded by community, state and federal government grants/agreements and may have line items in budgets. They must treat all patients but usually treat the poor and underserved. These providers see a large portion of those with Medicaid. They are in urban and rural communities throughout the state. These clinics are in areas identified as Health Professional Shortage Areas and/or they provide services to Medically Underserved Populations. Thirty-nine (39) non-profit large group practices are associated with Federally Qualified Health Centers (FQHCs) also known as Health Center Program Grantees or Community Health Centers. There are fifteen non-profit organizations operating as FQHCs in thirty-one of the thirty-three counties of New Mexico. The FQHC associated dental sites are located in twenty-one of the counties in New Mexico. FQHC dental sites serve large geographic areas and in 2011 these sites provided services to 72,234 patients (unduplicated) during 196,821 visits. The New Mexico FQHCs employ 59.64 FTE dentists, 36.12 FTE Dental Hygienists, and 140.71 Dental Assistants & other support personnel. There are also non-profit large group dental clinics funded by the Indian Health Service (IHS) and 638 clinics which are tribally operated clinics funded by IHS. At least three other non-profit dental clinics are located in New Mexico and, providing services in Bernalillo, Santa Fe, Lea and Lincoln counties.

The FQHC clinics are in Alamogordo, Albuquerque, Anthony, Artesia, Columbus, Cuba, Clovis, Dona Ana, Deming, Edgewood, El Rito, Espanola, Farmington, Ft Sumner, Hatch, Jal, Las Lunas, Las Cruces, Las Vegas, Lordsburg, Mora, Ojo Caliente, Pecos, Penasco, Pine Hill, Portales, Reserve, Silver City, Tierra Amarilla, Santa Fe, Sunland Park, Torreon, and Truth or Consequences.

The IHS clinics serve the Acoma-Canoncito-Laguna area, Albuquerque, Jicarilla in Dulce, Mescalero, Santa Fe, and Zuni-Ramah in Pine Hill. Many of the pueblos have 638 clinics: Cochiti, Isleta, Jemez, Sandia, Santo Domingo, Taos, and Zia.
**Prevalence**

Various forms of corporate practices have added 662 offices from Q3, 2009 to Q3, 2011 in the US. This amounts to 75 offices per quarter at a 36% growth rate. Twenty-five large group practices have over 2,500 offices in the US. However, in analyzing its data on individual dentists, the ADA Health Policy Resource Center concludes that the rate of solo practitioners is falling. In 2010, 69 percent of dentists were solo practitioners compared to 76 percent in 2006.

Pacific Dental Services (that has a small presence in New Mexico) is a member of the Dental Group Practice Association. Several DGPA members in January 2012 attended a meeting with ADA leaders and staff to discuss areas of mutual interest. Representatives from DentalOne Partners, SmileBrands, Aspen Dental Management and Heartland Dental Care were also in attendance. The DGPA represents about 30 members, which are dental service organizations that provide business management and support services to owner dentists for a fee. DGPA has about 7,000 affiliated dentists or dentist owners involved in large group practices. Aspen Dental, DentalOne Partners and Heartland Dental Care are largest groups and do not have a presence in New Mexico.
Why do dentists choose to work in corporate practices?

The ADA New Dentist Committee identified a number of reasons why large group dental practices may appeal to new graduates:

- Student indebtedness is a barrier to early practice ownership.
- Traditional practices are not absorbing new graduates due to the recession. There are fewer jobs for new grads, but large group practices are hiring.
- There are more dual profession families, and married professionals may require mobility that practice ownership does not allow.
- Other lifestyle choices are being considered, such as the desire to help others, and the quest for work/life balance leads to practice choices that do not focus on the responsibility of growing a small business.
The residents of the University of New Mexico Dental Residency Program were surveyed shortly after they entered the program in the summer of 2012. Eight of the ten residents responded. Gender and practice preference was split in half with practice preference (private or public) split within the genders. One was married with an infant and the rest were single. The average educational debt was $263,000 with only two having a small amount of personal debt. They all wanted health insurance as a benefit and other benefits such as retirement and vacation were desired. The residents who aspire to a private practice model were less likely to desire benefits. The four who wanted to go into public health noted that they wanted to serve the public or underserved. The four who wanted to go to private practice had connections or stated they wanted to be the "boss".

Another facet that challenges solo practices is stated in an article in the AGD Impact, July 2012 Vol 40, No 7 issue, The Future of Dental Practice by Mason Kostinsky, DMD and Andrew Koenisberg, DDS. They state using ADA Survey Center information:

Dental School Debt: $150,000 to $300,000

Female Dentists:

1920: 3%  1975: 3.5%

2003: 17.2% of all dentists

2003: 34% of all dentists practicing less than 10 years

Reimbursement and Billing Models: Out-of-Pocket Dental Expenditure on Dental Care:

1960: 97%

2002: 47%

2013: 44.2% (Predicted by Centers for Medicare and Medicaid Services)

Based on estimates from various sales representatives of market leading software and hardware new technology costs to remain competitive:
Yearly Digital Practice Management Fees. $5,000+
Digital Radiography $52,000
CAD/CAM $120,000
CBCT $125,000
Total $302,000+

Digital patient management and clinical systems have a 25% market penetration. Digital radiography has more than 50%. Digital impressioning has less than 5%. The cost of these technologies is the main reason that they are not pervasive in the dental industry. However, large group practices can pool their resources and provide these services less expensively.

Solo practitioners ready to retire, change practice settings, or practice modality see corporate options in a positive manner willing to sell their practices to these entities. The reason for choosing to work in a large group practice or a solo practice are as varied as the dentists who choose to work in these various entities.

Another reason for group practice care is it may be more cost efficient. Arthur Laffer in his recent study on corporate practices study indicates 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. He concluded, "Competition, new business models, and increased services are good things. As consumers and taxpayers, we should embrace innovation."

<table>
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<th>Provider</th>
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<th>Total Procedures per patient</th>
<th>Cost per patient per year</th>
<th>Cost per procedure</th>
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(All Texas Medicaid Providers, FY 2011)
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<th>11.94</th>
<th>$665.83</th>
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Arthur Laffer was a member of President Reagan's Economic Policy Advisory Board from 1981 to 1989, and was the first chief economist at the White House Office of Management and Budget. He is the author of the "Laffer Curve," one of the main theoretical constructs of supply-side economics.

Arthur Laffer's study was sponsored by Kool Smiles, the largest Medicaid focused DSO in Texas. The study of publicly available data of 25.9 million Medicaid procedures in Texas in 2011 is available at:


Laffer maintains the independence of the study results and his opinions...
Why do dentists dislike working in corporate practices?

The following comments are from a New Mexico dentist:

“I worked Kidskare a number of years ago then Perfect Teeth just about a month, then
turned in my resignation but had to stay a couple more months to avoid as per contract. So that being a while back, take my comments for what they are and in that time period. I do doubt things have changed much.

The money at Kids was always known to be in the hygiene program. I was in favor immediately because of 20+ years of experience and the ability to manage offices and employees at their start-up. I left because of the layers of non-dentist supervisors who felt they could control the dentists, etc. A hygienist would be scheduled 40 patients a day.... and the hope was to treat 30 for approximately a $4500 day. She would make $450+ per day for a four day week. Hours were not so long back then at Kids.... we were told we could be done by 3 - 3:30 (and I was on the golf course for a standing 3:15 tee time every day). That has changed I understand. The hygienist would have an assistant or two to clean up operators, etc. There were 6 -8 operators just for hygiene. I would run four ops minimum with an assistant per op most days. I know at the time Kids had over ten dentists working, and for a base $175K salary, you were expected to produce $2,500 a day.... young guys and gals right out of school. Dentists with experience could produce $7 - 10K a day.... and be earning base $200K + bonuses (I mean nice ones of anther $5-10 K per month). Some of the guys I still keep in touch with, thus being at Kids for 10 years now, are great dentists, and do a good job in all aspects. They have made great livings. Some young dentists got in over their heads at times, and when problems arose, it was easy to transfer them elsewhere. Two young
guys that I helped train for a month or two each, during my time were sent to Farmington, and I understand there were some problems there; but the company had a great executive who would try to settle patient problems quietly. I do believe this was an enormous business and profit for the owner and his family... and family members did work offices routinely... and were good employees. I do also believe quality of care could be less than ideal just due to the environment and skill level of some of the dentists. At future times, when business may have slowed, I have been told dentists were expected to produce more... but for all but newer dentists, it is not hard to produce a lot of work with the setup Kidskare has. I cannot say it was a bad experience, but as an older guy with my own ideas and goals, it was just not my future to be in that corporate setting.

Perfect Teeth was a transition time for me, after moving to Albuquerque, and I was fortunate to fine IHS tribal situation almost immediately after. Now there in my short time I am sure that there was so much selling of endo/fixed/etc that was not necessary that I just was not going to do it. My starting salary was still over 12K a month, and there are decent bonuses also. The top producers in the Albuquerque area make a real killing but I do feel they are really over treating. Examples were treatment plans that I saw with twelve facial restorations, most had fallen off (if applied) within a year, and radiographs that showed no need for endo, p/c & crowns, but certainly were done. Dentists (some of us) did report this to the corporate team, but I really feel this was condoned generally as long as the DDS was producing the big money, and would be protected. Perfect Teeth did offer various "insurances" etc, to build patient base, etc. I just did not want to be associated with such a company. Then IHS offered employment and I have been here since.

Hope this helps a bit. I am sure you will know much more than I would ever, in regard to corporate DDS. I would enjoy seeing what comes out of it.”

The dentist who wrote these remarks compare to all the dentists and employees who told me similar and other reasons why they left various large group practices. In summary, they talked of pushed production, using labs they didn't like, fraudulent billing practices, OSHA violations, infection control violations, could not use materials they preferred and that they were not allowed to use their professional judgment on some matters. However, many others love the opportunity to practice dentistry without the business aspects
of the practice as one of their responsibilities. Those dentists worked out the problems described above with the business people and were able to practice what they felt was ethical.

To be fair, many employees complain of the same things in private practices.

The greatest complaints voiced were about turf protection and infringement. Private practice dentists complain that community clinics take away their livelihood by treating not only the indigent (who they can’t treat because they can’t afford to) but others who they view should be in their practices because they can afford their dental care.

Various offices, organizations and agencies treat children in the schools. Most of these programs involve exams, radiographs and sometimes sealants but rarely restorative and urgent care. Therefore, the dentists who provide the post exam care provide new radiographs or an exam gratis to treat these children because they have no access to the records taken at the schools. Also these various groups will go into a school without knowing that another entity is present and preform the same services.

They all want someone to provide coordination so that these same services are not provided multiple times, but more important, that the children get restorative and urgent care.
Regulations Regarding Practice Ownership

(The following information was copied from ADA sources.)

OWNERSHIP OF DENTAL PRACTICES, EMPLOYMENT OF DENTISTS, AND INTERFERENCE WITH THE PROFESSIONAL JUDGMENT OF A DENTIST BY A NON-DENTIST

Legal provisions prohibiting or restricting non-dentists from owning or participating in the ownership of dental practices or from interfering with the clinical judgment of a dentist appear primarily in state dental practice acts, and to a lesser extent in the rules and regulations of the dental board. Some states address the issues of ownership and control in their Dental Corporation Act (if they have such an Act), Professional Corporation Act; business practices laws, or insurance laws. In California, for example, an exception to the restriction on non-dental ownership appears in the Knox-Keene Act; in Illinois, the Insurance Code permits the employment of providers by limited health service organizations. These laws, which are not reflected in this document, may complement, conflict with, or supersede the Dental Practice Act, and, therefore, it is important to review them.

The information below is limited to what is contained in state dental practice acts and regulations. Due to diverse state treatment of these issues, there may be dental board policies of which we are not aware that may impact on how the states have been categorized. If you determine any revision in how a state is categorized please contact the ADA Department of State Government Affairs.

Ownership defined as dentistry

An examination of the dental practice laws and regulations reveal that, as a general rule, states attempt to restrict non-dentist interference or ownership by making the act of owning (managing, operating, leasing, etc.) a dental practice, a defining element of practicing dentistry.
Twenty-six (26) states define the ownership of a dental practice as an element of practicing dentistry.

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<thead>
<tr>
<th>Alabama</th>
<th>Minnesota</th>
<th>Oklahoma</th>
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<td>Maryland</td>
<td>Ohio</td>
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</tr>
</tbody>
</table>

**Non-dentist operation of a dental practice prohibited**

Five (5) states, *Alaska, Massachusetts, New York, North Carolina,* and *Vermont* prohibit non-dentists from operating dental practices. The New York State Dental Association reports that the statutory exceptions to this provision and the enforcement policies of the attorney general have eroded the law's effectiveness.

**Uncertain Status**

Four (4) states, *Iowa, Louisiana, Michigan, Pennsylvania,* and the *District of Columbia,* either have no laws addressing the issues of ownership and control, or have provisions that provide no guidance on how to classify those states within this summary. For example, *Louisiana* has a provision preventing dentists from sharing fees with non-dentists.
Non-dentist’s Participation in Ownership of Private Practices

Eleven (11) states, Arizona, California, Colorado, Indiana, Kentucky, Maine, Minnesota, New Mexico, North Dakota, Washington and Wisconsin, allow non-dentists to participate in the ownership of a private dental practice. California-2003 law allows physicians, surgeons, hygienists, and assistants to own up to 49% of a practice.

Colorado - The CDA reports that the dental practice act is preempted by a law allowing non-dentist ownership if the dental practice is part of a provider network. Kentucky's Board of Dentistry interprets the Dental Practice Act as permitting a non-dentist to own a dental practice. Maine allows denturists to hold a non-controlling stockholder interest in an incorporated dental practice. Minnesota allows health care professionals to form a corporation for the provision of multidisciplinary services. North Dakota permits non-dentists to own and control up to 49% of a private, as opposed to non-profit, dental practice. Wisconsin, however, does prohibit interference with the professional judgment of a dentist per WDA.

Exceptions to Ownership / Operation Restrictions upon Dentist’s Death or Disability

Seventeen (17) states, Kansas, Louisiana, Missouri, Montana, Massachusetts, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Dakota, Ohio, Oklahoma, Oregon, Tennessee, Texas, and Vermont permit the estate or spouse of a deceased or incapacitated dentist to own or operate a dental practice, or to employ a dentist. Montana, for example, limits the period of such ownership to 12 months and Ohio limits it to 90 days; however, some states do not specify any time limit. New Mexico allows spouses or hygienists to own the dental practice for up to a year after the death of the dentist.

Enforcement of Ownership Restrictions
Despite statutory or regulatory restrictions on ownership, there is little case law to provide guidance on the subject. In some states, there is a lack of enforcement, for a variety of reasons; in other states, the restrictions are interpreted differently. The Ohio Attorney General issued an opinion stating that Ohio law does not prohibit a non-dentist from furnishing certain business and management services in operating a dental practice. The Maryland Attorney General concluded that a non-dentist is prohibited from owning or operating a dental practice, but that some forms of business arrangements may be permissible.

Many states also have restrictions on the use of trade names, such as “Smiling Dentistry,” for a dental practice. They require the name of individual dentist(s) to appear prominently in the name of the practice. The effect of the trade-name regulation is to prevent public deception as to the identity of the responsible owner.

**Non-Dentist’s Ownership of Dental Facilities & Employment of Dentists**

In an effort to increase access to dental care, there has been a trend in recent years to allow facilities, other than dental schools or governmental entities, to own and operate dental practices and employ dentists. The most common types of these facilities are federally qualified health centers and nonprofit corporations that provide dental care to underserved populations. Fifteen (15) states, California, Connecticut, Florida, Kansas, Maine, Missouri, Montana, New Hampshire, New Mexico, North Dakota, Oregon, South Carolina, South Dakota3/, Texas, and Washington1/, allow dentists to be employed by non-profit health facilities owned and operated by non-dentists. The Florida, New Mexico and Texas Boards of Dentistry have authority to approve or disapprove entities that employ dentists. These entities must register with the dental board and are subject to the same disciplinary rules as dentists in Missouri.

Seven (7) states, Connecticut, Hawaii, Illinois, Kansas, Maine, Virginia, and Washington, allow dentists to be employed by employers who provide health care services for employees at work. Oregon allows labor organizations to own and operate dental practices to treat its members.
Interference with the Professional Judgment of a Dentist

Eighteen (19) states, Alaska, Arizona, Arkansas, California, Florida, Georgia, Illinois, Indiana, Mississippi, Missouri, Montana, Nebraska, New Mexico, North Carolina, Oklahoma, Rhode Island, South Carolina, Texas, and Utah, prohibit non-dentists from interfering with the professional judgment of a dentist. Florida expressly regulates the relationship between dentists and dental managed services organizations. The Mississippi Board of Dentistry is not concerned with the form or type of business arrangements entered into by dentists as long as there is no interference with clinical judgment. The Indiana attorney general has issued an opinion that the Dental Practice Act provides that non-dentists may not be involved in the direction, control, and treatment of patients but are not prohibited from owning dental practices. Georgia enacted 1999 H 295 giving the board of dentistry authority to promulgate rules of prohibition. Texas - a 1999 law prohibits interference and expressly prohibits the board of dentistry from prohibiting dentists from contracting with DMSOs.

1/Washington-dentists may join partnerships or other business association with, and be employed by denturists provided that there is no impairment of independent professional judgment.

2/Indiana-an Attorney General Opinion may be construed as allowing non-dentists to own dental practices if there is no interference with the professional opinion of the dentist.

3/ South Dakota allows nonprofit entities affiliated with nonprofit dental service organizations to own and operate mobile dental units. Community Health Centers CHCs and Migrant Health Centers may also employ dentists.

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Department of State Government Affairs
Non-Dentist Owner Licensure in the State of New Mexico
Pacific Dental Services, Inc., Colorado/Utah Regional Dental Services, LLC, Albuquerque Modern Dentistry, LLC and NE Heights Modern Dentistry, LLC are licensed to practice as Non-Dentist Owners in the State of New Mexico. The below information is provided to aid others in understanding the statutory basis of the Non-Dentist Owner license in New Mexico and the benefits attained by the State of New Mexico as a result of the Non-Dentist Owner licensure. Additionally, this document responds to various questions about Non-Dentist Owners that have been raised.

1. **What is a non-dentist owner?**
   
   a. Previously, it was “unlawful for any person or persons to practice dentistry or dental surgery under the name of any company, association or corporation.” NMSA § 61-5-17 (Repealed).
   
   b. Now, New Mexico law specifically permits the ownership of a dental practice by a “non-dentist owner,” so long as that owner is licensed by the New Mexico Dental Health Care Board. NMSA § 61-5A-5.1(A).
   
   c. With limited exceptions, a “non-dentist owner” is defined by the Board as “an individual not licensed as a dentist in New Mexico or a corporate entity not owned by a majority interest of a New Mexico licensed dentist that employs or contracts with a dentist or dental hygienist to provide dental or dental hygiene services.” NMAC 16.5.9.7(C).
   
   d. Under this definition, while a non-dentist owner in New Mexico may employ a dentist or dental hygienist for the provision of dental services, the non-dentist owner is expressly prohibited from having “direct control or interfer[ing] with the dentist’s or dental hygienist’s clinical judgment.”

2. **What are the obligations and liabilities of a non-dentist owner in New Mexico?**
   
   a. Among other things, a non-dentist owner is required to ensure that its employee licensees follow all of the requirements for New
Mexico licensed dentists and dental hygienists. See NMAC 16.5.9.8(B). They are also required to ensure continuity of care of patients when an employed dentist or dental hygienist leaves the non-dentist owner’s practice, NMAC 16.5.9.8(C); notify the Board of certain changes in among those they employ and ownership, NMAC 16.5.9.8(D) & (E); and maintain patient records for a minimum of six years, NMAC 16.5.9.8(M).

b. Failure of a non-dentist owner licensee of the Board to ensure that its employee dentists follow the requirements for licensed dentists under NMAC 16.6.16 can result in disciplinary options ranging from a small fine to loss of licensure. NMAC 16.5.16.9.

c. Non-dentist owners are also responsible, under general principles of New Mexico law, for the negligence of their licensed employees. This concept is called respondeat superior, and it applies to all employers of licensed professionals, even if the employers—like non-dentist owners—could not have intervened in the employee’s exercise of her clinical judgment.

3. How are non-dentist owners structured?

a. The corporate structure of a non-dentist owner in New Mexico could vary widely. Under the regulations, a non-dentist owner could be a single, individual non-dentist who owns a dental practice; it could be a group of individuals, one or more of whom are dentists, but with the majority ownership held by non-dentists; it could be a single corporation, without any individual owners; or a limited liability company (LLC).

b. Currently, there are 7 non-dentist owners licensed to practice in New Mexico. Of those, three are Pacific Dental Services-supported practices, with a fourth being a part-owner of certain of those practices. PDS-supported practices are typically jointly owned by limited liability companies and New Mexico licensed dentists.
c. Pacific Dental Services is committed to full compliance with New Mexico law and regulations and, as such, solely serves to support Owner Dentists in the business aspects of the practice with the Owner Dentist having complete responsibility for all aspects of the dental practice. Owner Dentists are engaged with Associate Dentists at the dental practices and often look to partner with an Associate Dentist as a second owner of the dental practice.

4. What is the purpose or mission of non-dentist owners?

a. There is no single “mission statement” or “purpose” for or among non-dentist owners. To the contrary, while one non-dentist owner may be a non-profit corporation, another may be the brother of an employee dentist.

b. Pacific Dental Services’ own mission, and that of the practices it supports, however, is to be the provider of choice in the markets they serve. To PDS, this means providing successful business support services to dentists and dental hygienists who provide excellent and affordable dental health care to their communities.

c. Like any dental practice owner, non-dentist owners recognize the operating necessity of their practice’s economic viability. Just as dentist-owned practices must assure that their income exceeds their expenses in any given year, non-dentist-owned practices similarly seek to operate in an efficient and sustainable manner.

5. What are the benefits to New Mexico of having non-dentist owners?

a. Non-dentist ownership of dental practices reduces the barriers to entry into the practice for new dentists, thereby improving the diversity of dentists and the number of dentists, thus improving access to care.

   i. For most dentists entering the market today, opening up a solo-practice is simply not feasible.
1. Dental students now leave school with significantly higher debt than their father's generation. Indeed, the average dental student’s debt reached nearly $200,000 in 2010, representing an increase of over 230% since just 1996.¹

2. Add to dentist’s high debt the current tightening of financing, in which creditors are increasingly reluctant to lend, especially to new dentists with no track record of performance and high school debt. Without financing, the costs of starting up a dental practice as a solo practitioner – estimated at between $150,000 to over $1 million in 2011² - simply are not feasible for the average new dentist.

3. Additionally, due to the economic downturn, many older dentists are choosing to continue practicing rather than selling their practice to enter retirement.³ This, in turn, means that more new dentists are left with only the options of opening a new practice, incumbent with the financing woes described above, or becoming employees of larger practices. Not surprisingly, many dentists are choosing to begin their careers – and sometimes continue on in their careers – as employees of non-dentist owned practices.


ii. Without non-dentist owned practices, dentists entering the field would face fewer options for practicing in New Mexico. Having the option of partnering with non-dentist owners in New Mexico creates a space for these dentists to practice and provide health care to the residents in our State.

iii. The ability to forego the high barriers to entry of opening one’s own practice, and instead choose to work for a non-dentist owned practice, has an important added benefit of improving diversity of the dental practice in our State. It is the same added benefit that results when a female dentist cannot afford to take maternity leave as a solo-practitioner, but could as a dentist in a non-dentist owned or co-owned practice. That is, the allowance and formation of non-dentist owned practices in New Mexico has the very real ability to improve diversity among dentists.

1. Unfortunately, New Mexico does not track the gender or ethnicity of its licensed dentists. However, based on a review of the names of actively licensed dentists in New Mexico, it appears that women make up no more than 25%.

2. This calculation was reached through a review of the first names of the Board’s publically available information on actively licensed New Mexico dentists, of which there are around 1320 currently. Of those 1320, 990 can be identified as male, 235 as female, and the remaining 95 cannot be identified based on their first name. If we exclude the 95 unidentified dentists altogether, the number is more troubling, with 81% of actively licensed dentists being male and 19% female.

3. Compare these general statistics to those within PDS-supported practices. Within these practices, 58% of
the practicing dentists are male, and 42% are female. This represents a 23% improvement in representation for female dentists, and further supports the proposition that non-dentist owned practices, and practices supported by dental service organizations, help improve the representation of women, and likely other historically underrepresented groups of people within dentistry, in the dental practice.

4. This conclusion is further bolstered when you take into account the success of female dental hygienists in New Mexico. Dental hygienists, unlike dentists, are almost exclusively employees, not owners, of the dental practice in which they work. Of around 1120 active dental hygienist in New Mexico, 40 can be identified as male, 1053 as female, and the remainder 27 cannot be identified based on their first name. With these numbers, even assuming all unidentified hygienists are male, female hygienists still represent 94% of the field in New Mexico. This is a clear example of the benefits, indeed necessities, which cause many women to work as an employee of a practice rather than continuing their education to become a dentist and, likely, a dentist practice owner.

b. Non-dentist ownership of practices also improves the access to and quality of dental care in New Mexico.

i. As the Board knows, New Mexico has a critical shortage of dental health care, which has been identified through at least two federal designations. First, there are Health Professional Shortage Areas (HPSAs) in dental care within 29 of the 3 counties in New Mexico. Similarly, there are

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4 A HPSA is a geographic area, population group, or health care facility that has been designated by the federal government as having a critical shortage of health professionals within the categories of primary, dental and mental health services. This designation is made to identify areas where there is a disparity in access to health care services, and to guide federal funding and resources to improve access to care in these areas.
Medically Underserved Areas (MUA/Ps) within 32 of the 33 counties in New Mexico.  

ii. Naturally, dentists are drawn to open a practice in the most populous areas of our State. This is because, for many dentists, practicing in certain rural communities may not be feasible as they do not have a broader base through which to spread their expenses and income. A non-dentist owner with several locations throughout the State, however, would be able to better support the economic stresses of providing dental care in rural communities.

iii. Non-dentist owned practices often also utilize discount plans for the uninsured. PDS-supported practices, for example, offer a discount dental plan to support contracted fees and is particularly useful for those without other dental insurance options.

iv. Finally, because non-dentist owned practices are often part of a large group practice model, clinicians at these practices are often members of a team of dentists, rather than practicing alone or with only one other dentist. Having a team of available dentists amongst practices allows mentorship of junior dentists, provides additional quality assurance, and creates access to specialist knowledge through dentists at affiliated companies. Being a part of a large group practice can also improve clinician’s access to training, which can be tailored and provided at a lower cost.
when it is given to multiple dentists across affiliated companies.

c. Non-dentist owned practices also may increase the resources for dentistry in New Mexico.

i. PDS supported practices in New Mexico, for example, offer web registration, digital radiographs, digital charting and Cad-Cam technology. The digital radiographs reduce the levels of radiation for patients as compared to traditional radiographs by 90%. Also, Cad-Cam technology provides a convenience for patients in the availability for patients to receive a crown the same day the tooth is prepared eliminating the need for temporaries and waiting for laboratories. Web based registration is convenient for patients in that they can register for their appointment with the dentist from the convenience of their home.

d. Non-dentist owners can also ensure continuity of patient care when a dentist becomes impaired or otherwise leaves practice in a way that a solo-practitioner can only do through association with another dentist.

i. New Mexico law prohibits patient abandonment and regulates patient records. NMAC 16.5.16.10; 16.5.9.8. These laws apply to non-dentist owners as they are to dentists, hygienists and dentist-owned practices.

ii. There is currently no evidence to suggest that non-dentist owners are more likely to close their practices than dentist-owned practices. There is also no evidence to suggest that the very same practice policy and procedures to ensure availability of records and continuity of care in the event of a practice closure need be any different as between dentist-owned and non-dentist-owned practices.
iii. Anecdotal evidence is, in fact, to the contrary. With non-dentist owned practices, which are typically larger than dentist-owned practices, if a dentist leaves practice permanently or temporarily, a non-dentist owner can better offer continuity of care through another employed dentist and ensure continuing availability of records. Also, non-dentist owned practices, particularly when part of a group of practices, are often more likely to have robust written policies and procedures. This is primarily because non-dentist owned practices can spread the cost of creating these policies and procedures over multiple practices.

6. How do non-dentist owners oversee the care provided at their practice?

a. New Mexico regulation prohibits a non-dentist owner from having “direct control or interfer[ing] with the dentist’s or dental hygienist’s clinical judgment.” NMAC 16.5.9.8. As such, no non-dentist owner may interfere with an employed dentist’s or hygienist’s clinical judgment. If they do, they are subject to discipline.

b. Instead, non-dentist owners exercise a limited degree of supervision of their employees in order to comply with their common law duty as employers. New Mexico common law requires that all employers exercise due diligence in their hiring, retention and supervision of their employees. NM UJI 13-1647.

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Board of Dental Health Concerns

There are no published back-up plans if a corporation or one of its offices goes out of business other than they change locations or get another dentist into the location.

None of the published mission statements, policies or conversations with owners, lobbyists or lawyers stated that profit comes before the patient. Here are some examples:

Heartlands Mission Statement is: “To significantly improve the oral health in the communities we serve by delivering the highest quality dental care experience, while providing exceptional careers for all of our team members and maximizing value to our stakeholders.”

“The mission of Smile Brands is to deliver Smiles for Everyone®. Whether you call it our vision, mission or purpose, it is the reason for Smile Brands’ existence, and what each employee and affiliated dental provider strives for every day. It means ensuring that all the groups who interact with Smile Brands—patients, doctors and employees—are enriched by their experience.”

The Mission for Pacific Dental Services: “The quest for excellence inspires everything that defines us. Principles and beliefs govern the way we do business. Highly productive teams and powerful technologies strengthen our affiliated practices to better serve Dentists and their patients. Passion for the business and the future drives us to be the best.”

The Vision:
“Face every challenge as an opportunity to become even stronger and more efficient in our services, helping our affiliated Dentists to achieve success in every way they define it.”
Create an environment where we learn from each other and each individual performs at his or her best with teamwork, communication and shared values.

Focus on everyone's distinctive talents and strengths, and work at optimum efficiency so there is no limit to what we can accomplish together.

We believe that joining the PDS™ team will provide the opportunity for you to maximize your individual and professional God-given potential. A life of service is the highest calling, and we live it every day as we help you promote excellent dentistry in the community and improve the quality of life for millions of people.”

All the other companies had similar statements.

Oversight: All of the companies investigated provide continuing education for their staffs directly or through reimbursement to seminars and lectures. They provide mentoring with dentists in the organization, and the very large ones have compliance officers.

Membership Recruitment

ADA large group practice initiatives, resources, recommendations and resolutions are as follows:

Council on Membership Workgroup on Large Group Practice was formed to evaluate the opportunity group practice membership represents for the ADA.

New Dentist Committee Workgroup on Large Group Practices is to collect information about new dentists working in corporate dentistry to obtain qualitative information regarding the potential value of ADA membership.

Interdepartmental ADA Staff Workgroup on Large Group Practice is to discuss ways to collect data on group practice dentists and enhance marketing efforts to this group.

ADA Office Level Database will place every member and non-member dentist into a dental office and associate every dental office with a dental practice organization and a set of associated attributes when applicable.
Council on Dental Practice will study changing trends and models affecting the delivery of dental care, including solo practice, group practice and dental service organizations.

Resources:
A. Large Group Practice Survey Information (Karen Burgess) June 2012
B. ADA News Article on Large Group Practice (Karen Fox) April 2012
C. Report on Consideration of Establishing New Membership Categories (Steve Rauchenecker) February 2012
D. New Dentist Committee Mega Issue Information (Chris Chico) January 2012
E. Agenda and Notes from the Large Group Practice CEO’s Meeting (Lalita Pittman) January 2012

Recent ADA Recommendations and Resolutions
- Resolved, that the New Dentist Committee recommends that the next ADA Survey of New Dentist Occupations, or other research as appropriate, include questions on corporate dentistry including income, basis for pay, benefits received, services provided and other topics in order to identify the percentage of dentists practicing in a corporate setting and establish benchmarks for this career option. (NDC: January 2012)
- Resolved, that the New Dentist Committee establish a workgroup to collect information about new dentists working in corporate dentistry to obtain qualitative information regarding the potential value of ADA membership (NDC: January 2012)
- The Council recommended repackaging current benefits and developing a benefits “package: for dentists in large group practices to reinforce the value of ADA membership and position itself as an advocate for employee dentists. This package will be developed by staff and the Council’s Subcommittee on Marketing, Communications and Benefits Issues and presented to the Council for review at its February 2012 meeting. (CM:2011)
- The Council recommended exploring ways to involve non-ADA group-practice dentists in future dialog with the Council regarding large group practices. ICM: June 2011)
• The Council recommended exploring ways to involve corporate leaders and group practice owners in future dialogue with the Council regarding large group practices. (CM: February 2011)

The ADA Council on Membership held a strategic discussion concerning the value of membership to corporate dentists on June 15, 2012 and was reported in the ADA News on August 20, 2012. The following are the outcomes of the meeting:

• Corporate dentists do not want to join an organization in which they are vilified.
• Most large group practices entities offer benefits so the benefit packages that ADA offers are not necessary.
• Peer review, a state program used to settle disputes between patients and dentists or third-party payers and dentists, is only available to members and would be an asset to corporate dentistry.
• The benefits of legislative advocacy was not mentioned in the report but is valuable to New Mexico dentists as changes in legislation affect all of our practices.

The New Mexico Delegation to the October ADA House Of Delegation presented a resolution for an Employee Dentist’s Bill of Rights. This resolution was referred to committee and will be reported back to the HOD next year.

The Employee Dentist’s Bill of Rights

1. An employee dentist has the right to not be penalized or terminated for exercising appropriate professional judgment in patient assessment, diagnosis and treatment.
2. An employee dentist has the right to refuse to deliver a prosthetic device that falls below the standard of care.
3. An employee dentist has the right to select a laboratory to fabricate the prosthesis for which they are responsible.
4. An employee dentist has the right to refuse to use materials and techniques which they find unacceptable or for this they feel unqualified.
5. An employee dentist has the right and responsibility to report unethical behavior by employers and other employees with the protection of whistleblower laws.

6. An employee dentist has the right to refuse provide care for which they will not be compensated.

7. An employee dentist has the right to expect appropriate and ethical billing practices by their employer.

8. An employee dentist has the right to expect employers to maintain facilities and equipment to the standard of care.

9. An employee dentist has the right to expect that OSHA and CDC guidelines are been enforced and adhered to.

10. An employee dentist has the right to perpetual access to the records of a patient they have treated, in the event of peer review, board complaint or lawsuit.

11. An employee dentist has the right to be a member of the professional organization of their choice.

12. An employee dentist has the right to abide by ADA Principles of Ethics and Code of Professional Conduct without obstruction by their employers.

13. An employee dentist has the right to refuse to perform treatment not justified by their own diagnosis.