Is Government Adequately Protecting Taxpayers from Medicaid Fraud

Written Congressional Testimony of Christine Ellis DDS, MSD

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Good morning and thank you for inviting me to testify to the committee about the Medicaid funding of orthodontic treatment in Texas. I will do my best to clarify my perspective of the events that have taken place and to answer any questions that you have for me. I have a unique understanding of Medicaid funded orthodontics, thanks to my rather unconventional orthodontic career. In 1995, I graduated from St. Louis University with my masters in Orthodontics and began working with my father in his private orthodontic office in Altamonte Springs, Florida. After marrying a Texan, I continued to work part time with my father but moved to Texas, where I joined the cleft team at Children's Medical Center of Dallas. In 2003, I joined the faculty of the division of Oral and Maxillofacial Surgery at UT Southwestern. I currently see patients funded by Medicaid in both the faculty practice in Texas and the private practice in Florida.

In Texas, Medicaid has provided funding for the orthodontic treatment of severe handicapping malocclusions which are defined by an HLD index score of 26 points. In plain English, a severe handicapping malocclusion is found in the mouth of a child with teeth so far out of position that they cannot do normal things like eat and talk without difficulty. Everyone who knows them knows that these kids desperately need braces. Children born with cleft lip and palate as well as children born with other craniofacial anomalies such as Crouzon's or Apert's Syndrome develop a handicapping malocclusion as a result of their medical diagnosis and are in need of orthodontic treatment as they mature. Similarly, children born with other medical conditions such as Down Syndrome, Muscular Dystrophy, connective tissue disorders and developmental delay also frequently develop a handicapping malocclusion that results from their medical diagnosis.

In many cases, these children depend on Medicaid for funding of their orthodontic treatment. It has been my great pleasure to have worked with this patient population over the past 12 years. I have had the opportunity to participate in the life changing results that dedicated physicians and dentists are able to provide, and find no higher professional calling than caring for these children. At the same time, I have also provided routine orthodontic care for children, adolescents and adults, and recognize the value of an attractive healthy smile.

It is important to recognize the differences between these patient populations. Orthodontic treatment of children with a handicapping malocclusion is quite different from that of a straightforward case of crooked teeth. Unlike crooked teeth, children with a handicapping malocclusion must be treated as they are developing. Frequently their orthodontic care is provided in concert with surgeons who are intervening at specific developmental landmarks. Postponing orthodontic care until adulthood does not meet the standard of care. It risks devastating consequences, including compromised speech, pre-mature loss of teeth and increased surgical risk. The importance of maintaining

adequately reimbursed Medicaid funding for orthodontic treatment for handicapping malocclusions cannot be understated. Due to a series of problems, Medicaid funding in Texas for the orthodontic treatment of these children has been put at risk. It is my intention to explain the problems that have developed in Texas and to suggest corrective actions that can be taken to safeguard both taxpayer's money from fraudulent Medicaid activity and qualifying children's access to high quality orthodontic care.

In May 2011, Byron Harris of WFAA ran a story that exposed the likelihood that Texas was experiencing massive fraudulent billing of Medicaid for routine orthodontic care. In 2010, Texas Medicaid paid out over $184 million in orthodontic care. For comparison, during the same year California paid $19.4 million. In fact in 2010, Texas paid more than the top 10 most populous states combined. Texas has been leading the nation for several years in orthodontic payments under Medicaid. In 2008, Texas Medicaid paid over $102 million in orthodontic treatment and in 2009, over $133 million was paid.

Until recently, orthodontic treatment funded by Medicaid has been administered by TMHP and guided by the policies published annually in provider handbooks. Orthodontic treatment has always only been available for children demonstrating a severe, handicapping malocclusion which is defined as a score of 26 points on the Handicapping Labio-lingual Deviation (HLD) index. Orthodontic treatment for children with unaesthetic, crooked teeth has never been a benefit covered by Medicaid, which specifically excludes orthodontic treatment for cosmetic or self esteem purposes. Orthodontic fees have been paid on a per visit / per orthodontic appliance basis instead of the set global fee typical found in most fee for service orthodontic contracts. The Medicaid orthodontic policies were written to give the provider wide discretion in the management of difficult cases as well as to avoid limiting providers to any particular orthodontic treatment philosophy.

Since joining the faculty at UT Southwestern, I have been asked to consult with our surgeons on many cases undergoing Medicaid funded orthodontic treatment by a variety of orthodontists in the Dallas area. Specifically, I was asked to provide orthodontic advice on how to properly prepare these cases for surgery, as there were many complications that would have occurred had the surgeons taken these cases to surgery in their presenting condition. After seeing case after case of poorly handled orthodontic treatment, I became concerned that these children were frequently receiving orthodontic care that was of such poor quality that it was detrimental to the child's dental health. My concern led me to offer my assistance to WFAA's Byron Harris after his first story aired. Several months later, I was contacted by Texas OIG and asked to participate in audits of high volume Medicaid orthodontic offices, which I immediately agreed to undertake.

The flagrancy of the fraud that I have found in the course of auditing for OIG is truly unbelievable. It is highly likely that it was intentional. Quite simply, providers submitted falsified HLD index forms in order to obtain pre-approval for orthodontic care. Providers did not appear to screen prospective orthodontic patients to find the children that Medicaid was designed to help. Not one patient with a craniofacial anomaly or medical compromise was found during the audit. Submitted HLD scores weren't off by

just a point or two. They were inflated by all 26 points in some cases. If scored accurately, at best only 10% of the cases would have qualified.

Examination of individual billing incidence revealed troubling trends as well. Providers found creative ways to bill for services that were either not provided or not medically necessary. Offices tracked orthodontic visits to ensure that braces were not removed until all 26 visits had been billed. Patients with documented poor oral hygiene remained in orthodontic treatment despite multiple warnings that braces would be removed. My general conclusion was that providers delivered inefficient orthodontic care and a whole lot of additional unnecessary appliances with the main goal of increasing their payment from Medicaid, not providing competent patient care.

One of the largest billers for Medicaid funded orthodontic treatment is All-Smiles, based in Dallas and majority owned since 2009 by Valor Equity, a private equity firm. All Smiles received over $10 million for Medicaid orthodontic services in 2010. In addition to Medicaid orthodontics, All-Smiles provides both office based and mobile pediatric dental services to a target base of Medicaid patients. Dr. Richard Malouf, who remains a 30% owner of All-Smiles, recently settled allegations of orthodontic Medicaid fraud from 2004-2007 for $1.2 million with the Texas Attorney General. The Texas Dental Practice Act (TDPA) clearly states that only dentists can own dental practices. In September 2011, I filed a complaint against Dr. Richard Malouf with the Texas State Board of Dental Examiners (TSBDE) for facilitating the illegal practice of dentistry by a corporation. My complaint was dismissed by the TSBDE without action. The TSBDE claimed that they did not have jurisdiction over corporations practicing dentistry, only individual dentists possessing a Texas dental license. Recent Texas State House and Senate committee hearings investigating the corporate practice of dentistry reveal continued resistance from the TSBDE to enforce the TDPA by sanctioning corporations owning and operating dental clinics within the state. It begs the question that if the TSBDE will not defend the TDPA against the illegal corporate practice of dentistry, who will?

The fifth circuit Court of Appeals in Texas has maintained that business service agreements or Management Agreements entered into with corporations by orthodontist are illegal under Texas law (see OCA vs. Jordan No. 07-30430). This precedent directly applies to the non-dentist owned corporations currently conducting business in Texas and other states. Much has been written about the inherent conflict of interest that arises when a for-profit enterprise owns a medical provider business. Correctly in their Dental Practice Acts, states have prohibited the corporate (non-dentist) ownership of dental offices to avoid conflict of interest problems.

As demonstrated by All-Smiles in Texas, corporations are not only illegally practicing dentistry, but are using fraudulently authorized orthodontic Medicaid claims to boost profits. The evidence found in the recent bankruptcy of private equity owned Small Smiles (FORBA) indicates that similar fraudulent Medicaid activity exists in pediatric dental claims as well. It is imperative that Texas as well as other states Attorneys General actively prosecute corporations found to be in violation of the law. A white

paper summarizing the laws in every state and the District of Columbia has been provided by well respected lawyer, Martin Siegel and has been made available to this committee. The dental board of North Carolina has been particularly proactive in this area and should serve as a model for other state boards to follow.

Amazingly, in their attempt to reduce orthodontic Medicaid fraud, Texas is making a bad problem worse. In March, the administration of dental Medicaid was outsourced to three dental managed care companies. The Department of Health has increased the complexity of the approval process for orthodontic treatment and has cut reimbursement. This is the wrong response. The corrective measures needed are 1) ensure that only the children who qualify for orthodontic care are approved and 2) ensure that they are adequately funded. Adding complexity and reducing funding will not attract the highly skilled orthodontic providers necessary to best care for the most challenging orthodontic patients.

While I encourage increased reimbursement for the orthodontic care of eligible children, I am in no way advocating for greater amounts of public money to be spent on braces. Elective orthodontic treatment should not be funded by Medicaid. Eligibility for orthodontics should be limited to children with a medical diagnosis and accompanying dental deformity. This is not just my opinion, but also that of the American Association of Orthodontists. By doing so, children truly needing treatment will be ensured that access to high quality orthodontic care will be available.

As you are aware, there is significant disagreement between dental policy makers on how best to ensure access to care. Policy groups like the Pew Dental Campaign and the Kellogg Foundation advocate for greater public spending for pediatric dental care. To these groups, numbers define success; they advocate for greater numbers of dental procedures performed, greater number of patients treated and greater number of dollars spent. I do not question their good intent. But as a boots on the ground provider, I am here to warn of the side effects that accompany some of their recommendations. Texas has learned a painful and expensive lesson in the folly of simply increasing public funding in hopes of improving access to care.

Several years ago, Texas finally settled the long running Frew class action lawsuit. It claimed among other things, that Medicaid children in Texas did not have the access to dental care mandated under EPSDT. Part of the Frew settlement required the increased spending of 1.2 billion dollars with the stated goal of improving access to care. When dental Medicaid spending took off, Texas looked at Medicaid's increasing dental numbers and believed that they had achieved success.

Things did not work out as planned. Five years and over half a billion dollars later, Texas has spent a lot of money straightening basically already straight teeth and has gained a lot of fraudulent orthodontic providers, including many private equity owned dental clinics engaged in the illegal practice of dentistry. The sad conclusion to this entitlement driven transfer of money is that in Texas we have used the mouths of children to enrich unethical providers and private equity investors. Access to quality care for

these children remains a problem. In fact, it is possible that these children are more at risk of receiving unneeded poor quality care now than they were before the changes mandated by Frew took effect.

In conclusion, we all realize that public dollars must be carefully allocated to the areas of greatest need. Even though I am an orthodontist, I know that crooked teeth do not prevent one from enjoying life, liberty and the pursuit of happiness. However, for a child with a true handicapping malocclusion, it is good and proper to craft public policy that addresses their deformity through Medicaid funded orthodontic treatment. You can ensure their public safety net by clearly defining these children as the only patients who are eligible for well funded Medicaid orthodontic treatment. You can ensure the public that their dollars are well spent by clearly defining dentists as the only people qualified to own a dental business.

I appreciate your time and attention to the details concerning Medicaid orthodontic fraud in Texas. Public awareness of Medicaid fraud results in the honest, necessary debate as to the best use of scare funds. Thank you for your service to the public by allowing me the opportunity to share the good, the bad and the ugly of my experience with Medicaid. I truly hope that my testimony has been helpful, and that it will assist you all as you work together to serve your constituents.

Respectfully submitted,

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PERSONAL AND PROFESSIONAL RECOGNITION AND AWARDS

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PUBLICATIONS

Buschang PH, Porter CL, Genecov E, Salyer KE. Face mask therapy of surgically corrected unilateral cleft lip and palate patients. Angle Orthod Dentofac Orthop 1993; Volume 64, Pages 145-150

Ellis, CP. Category 6: Class II division I malocclusion treated with the extraction of permanent teeth. AJODO Volume 128, Issue 2, August 2005, Pages 231-240

INVITED PUBLICATIONS

Invisalign and Changing Relationships – AJODO July 2004

Self Ligating Brackets – AJODO Volume 133, Issue 1, January 2008, Pages 4-5

Lack of evidence forces practitioners to make clinically based decisions – AJODO, January 2-11, Page 3.

LECTURES AND PRESENTATIONS

Dentofacial Deformity Conference at UT Southwestern
"Orthodontic Principles", November 2004

Dentofacial Deformity Conference at UT Southwestern
"The Etiology of Anterior Open Bites", August 2005

St. Louis University Graduate Orthodontic Residents
"Multidisciplinary Treatment", August 2006

Dentofacial Deformity Conference at UT Southwestern
"Multidisciplinary Treatment", November 2007

St. Louis University Graduate Orthodontic Residents
"Open Bite Malocclusion", February 2009

Dentofacial Deformity Conference at UT Southwestern
"Alveolar bone and orthodontic tooth movement", January 2010

Dentofacial Deformity Conference at UT Southwestern
"Cephalometrics", February 2012

POSTER SESSIONS

American Association of Dental Research – 1992, 1993

Committee on Oversight and Government Reform
Witness Disclosure Requirement – "Truth in Testimony"
Required by House Rule XI, Clause 2(g)(5)

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1. Please list any federal grants or contracts (including subgrants or subcontracts) you have received since October 1, 2009. Include the source and amount of each grant or contract.

None.

2. Please list any entity you are testifying on behalf of and briefly describe your relationship with these entities.

Self.

3. Please list any federal grants or contracts (including subgrants or subcontracts) received since October 1, 2008, by the entity(ies) you listed above. Include the source and amount of each grant or contract.

None.

I certify that the above information is true and correct.
Signature: Christine Ellis Date: 4/23/12