



A Monthly Newsletter from Executive Director Richard W. Valachovic, D.M.D., M.P.H. The views and opinions expressed in this letter are those of the author and do not necessarily reflect those of the American Dental Education Association.

*In this month's letter, Dr. Rick Valachovic, Executive Director of the American Dental Education Association, considers the latest challenges to Graduate Medical Education (GME) funding.*



### **A Haircut? A Makeover? Threats to GME Could Be More Than Cosmetic.**

*Voices inside and outside of government argue that GME recipients need to be more accountable for and cost effective in their use of public dollars.*

Unless you've been on a desert island these last six months, I don't need to tell you that the U.S. government has been locked in a spirited, and unfortunately partisan, battle over how to reduce the federal deficit. When it became clear that Congress as a whole would be unable to reach an agreement this summer, the task of slashing up to \$1.5 trillion from the deficit over the next 10 years was punted to a newly created [Joint Select Committee on Deficit Reduction](#) known inside the Washington beltway as the "Super Committee."

The committee is scheduled to present its proposal for budget cuts to Congress later this month, and many observers are predicting a repeat of the kick-the-can-down-the-road scenario we witnessed in August. If the Super Committee does not agree on a proposal, or if Congress fails to pass a committee proposal, automatic, across-the-board cuts of \$1.5 trillion over 10 years to the nation's discretionary domestic and defense programs will be triggered. Either way, Medicare is almost certain to take a haircut because, as Willie Sutton responded when asked why he robbed banks, "because that's where the money is!" Since Graduate Medical Education (GME) is funded entirely through the Medicare Trust Fund, it is also likely to be affected.

Our colleagues at the [Association of American Medical Colleges](#) (AAMC), whose members stand to lose the most from any GME contraction, have responded to this threat with an incisive media campaign. The slogan is "Careful What You Cut." My counterpart at the AAMC, Dr. Darrell Kirch, issued a statement in September pointing out that "the long-term cost to the nation's health will far outweigh the near-term savings" to be gained by cutting GME to meet deficit-reduction targets. I couldn't agree more.

ADEA President Dr. Leo Rouse and I sent [letters](#) to the 12 members of the Super Committee in September asking them to protect and preserve programs and services that underpin oral health care. We emphasized that programs and research are essential for the oral health of the nation and cannot withstand reduced funding and still carry out their critical mandates. Although we continue to hope that Congress will not eviscerate GME funding for medical and dental residency programs, GME may fall victim to the same intransigence that has plagued the current Congress. If nothing

else, I fear that the Medicare program, and the GME program in it, could get a trim before the deficit reduction process comes to a close. Even if program budget cuts are minimal, GME may ultimately receive a makeover. The Centers for Medicare and Medicaid Services (CMS), the principal underwriter of GME, is already undergoing changes, and voices inside and outside of government are arguing that GME recipients need to be more accountable for and cost effective in their use of public dollars.

A [2011 report of the Josiah Macy Jr. Foundation](#) calls for substantial reforms to U.S. Graduate Medical Education. The report argues that graduating skilled health care professionals is no longer a sufficient goal for GME. The authors repeatedly assert that GME must be accountable to the public as well as to the residents and institutions it serves. "The GME system must also be a responsible steward of public funds," the report states, "and ensure that the process of education is efficient, cost-effective, and evidence-based."

The report makes recommendations aimed specifically at medical educators, but dental educators must also remain alert to changes that may be coming down the pike. While the health professions community remains adamant that GME must be preserved, others seem to be receptive to seeing the program evolve. At a meeting of the Council on Graduate Medical Education (COGME), Dr. Paul H. Rockey, Director of the Division of Graduate Medical Education at the American Medical Association (AMA), proposed that the argument for funding GME be reframed in terms of access, appropriateness, and accountability, adding his voice to those who have urged policymakers to think of GME as a medical workforce rather than a hospital funding issue.

My counterpart at the [American Association of Colleges of Osteopathic Medicine](#) (AACOM), Dr. Steve Shannon, made similar remarks in his October newsletter. He asserted, "Current and projected physician shortages should be a primary factor in any discussion regarding changes to GME funding." AACOM supports innovations that target professional shortage areas, such as the Teaching Health Center Graduate Medical Education (THC) Program. In 2010, this new program, authorized by the Affordable Care Act (health care reform) and funded by the [Health Resources and Services Administration](#) (HRSA) rather than CMS, awarded 10 grants to train primary care physicians in underserved communities. [Penobscot Community Health Care](#) (PCHC) a nonprofit federally qualified health center (FQHC) in Bangor, Maine, was the sole recipient of a THC dental residency grant.

Under the traditional Medicare-funded GME program, FQHCs are only eligible for direct GME funding, which covers the actual cost of training residents. The THC model also makes FQHCs eligible for the indirect GME payments that hospitals receive in recognition of the fact that the cost of treating patients is higher in teaching environments.

Because PCHC hosts the nation's first and, so far, only THC dental residency program, ADEA sent a staff delegation to visit earlier this year. Our staff returned with high praise for the integrated interprofessional practice they witnessed there. "We hear sometimes about the limited administrative capacity of FQHCs to partner with dental schools," ADEA Associate Executive Director and Director of the ADEA Center for Educational Policy and Research Dr. Eugene Anderson told me after the visit, "but Penobscot shows that with the right leadership and management, FQHCs can be successful partners."

I subsequently contacted PCHC's Chief Dental Officer and Director of the General Practice Dental Residency, Dr. Chris Maller. He told me that, although technically a new model, PCHC's program mirrors general-practice and pediatric residencies offered in hospital settings. For one thing, PCHC provides its residents with access to an emergency room, anesthesia training, and operating room time through its affiliated hospital. Additionally, PCHC provides several opportunities afforded by its community-based comprehensive care setting.

"We can pull in a pediatric physician to do a seminar on physical examination," Chris told me, "or one of our pharmacists to talk to us about drug combinations and the clinical fallout we see. We've had a social worker educate us on the signs of child abuse and help us to discern the difference between abuse and neglect, and our in-house counsel is planning to speak to us about informed consent for minors."

Although these lectures are crafted specifically for its residents, PCHC opens them to both clinical and support staff and to dentists from the larger community. Everyone benefits, Chris points out, and most importantly, "by educating our providers to a higher standard, the program is benefiting our patients."

This experiment in funding community-based residencies dovetails nicely with the growing emphasis on community-based education (CBE) within our institutions. As of 2009, 94% of our dental schools required CBE, and the majority had students in the field for five weeks or more. That said, THC is just one example of the changes that may lie ahead. The [Medicare Payment Advisory Commission](#) (MedPAC), an independent Congressional agency established by the Balanced Budget Act of 1997 to advise the U.S. Congress on issues affecting the Medicare program, put forth recommendations in 2010 aimed at better aligning GME with delivery system reforms. According to a February 2011 perspective in the [New England Journal of Medicine](#) by the commission chair and a staff member, MedPAC has proposed that a portion of indirect GME payments be reallocated to fund incentive payments to hospitals that meet new performance measures aligned with delivery system reform goals. MedPAC advocates retaining the dollars currently allocated for GME, but it has not recommended expanding the number of residency slots for fear that perpetuating the current mix of GME recipients would impede system improvement.

Those of us who have been around for a while know that these challenges are perennial. But as the Macy Foundation report points out, there are signs this time around that changes to GME may actually occur. The report cites a convergence of forces including changing demographics, health reform, the growth in health care technology, the unsustainable growth in the cost of care, and "concerns that the GME system is not training the right specialty mix or number of physicians to

meet society's needs." The report also cites stimulants for reform from within GME, as educators struggle to retain curricular time against competing institutional demands.

Whatever the specific parameters of GME in the future, deep cuts to Medicare and Medicaid could have a devastating effect on resident training and patient care—a reality of which Chris Maller and his colleagues in Maine are all too aware.

"We may be able to continue when HRSA funding runs out because the residents are pretty productive," Chris told me, "but if the Medicaid and Medicare reimbursement rates are cut back, it could become impossible. There is little waste at PCHC. Almost everything goes to patient care and to resident education. I don't think PCHC could stand very much rollback of funding and stay in business."

The impact would undoubtedly be felt in traditional GME settings as well. Dr. Richard (Buz) Cooper, a Senior Fellow at the Leonard Davis Institute of Health Economics at the University of Pennsylvania, predicts that hospitals will respond to cuts in GME funding by simply eliminating residency positions. At a time of significant expansion in the number of medical and dental graduates seeking residency training, a reduction in federal funding for these residencies could become a major impediment to extending care to all Americans as the Affordable Care Act envisioned.

To quote Dr. Atul Grover, Chief Advocacy Officer at the AAMC, "Our nation's future strength will ... require continued investments in programs of demonstrated value to society. Medicare's support for physician [and I would add, dentist] training ... is one such program." As our own Jack Bresch, ADEA Associate Executive Director and Director of the ADEA Center for Public Policy and Advocacy, said to me recently, "Cuts to training programs may be more politically palatable than direct cuts to patient care, but, in the end, it is patients who suffer the consequences."



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