

COLUMBIA UNIVERSITY

SCHOOL OF DENTAL AND ORAL SURGERY

OFFICE OF THE DEAN

June 10, 2003

Mr. Thomas Scully
Centers for Medicare & Medicaid Services
Department of Health and Human Service
P.O. Box 8010
Baltimore, MD 21244-1850

RE: Medicare Program; CMS-1470-P

Dear Administrator Scully,

In response to Part IV F of the *Proposed Changes to the Hospital Inpatient Prospective Payment System for FY 2004* (42 C.F.R. Parts 412 and 413), the following comments are provided in my role as Dean of the Columbia University School of Dental and Oral Surgery. These comments specifically address graduate medical education (GME) funding to hospitals for residents in a non-provider setting.

Paula Friedman, President of the American Dental Education Association (ADEA) recently wrote to you concerning the ADEA's views on the May 19th proposal, urging you to withdraw it in its entirety. I, too, am urging you to withdraw the May 19th proposal as its implementation would destabilize the financing of resident training at Columbia and would force us to drastically curtail or eliminate our community-based service programs in the HPSA designated communities of Harlem and Washington Heights. My comments address the specific issue of what role dental GME programs in a non-provider setting play in the provision of care to those patients served by the Columbia University School of Dental and Oral Surgery.

As you are aware, training in dental schools is quite different than what occurs in medical schools. Both medical and dental school curricula are four years in length, but differ in what is expected at the conclusion of the four years. In medical schools the first two years consist of basic science and preclinical courses, and the final two years are clinical rotations. During this time, the medical students identify their area of interest, and then proceed on to three or more years of residency before they can directly provide care to patients. Dental schools have a different responsibility, as dental school graduates are allowed to practice at the conclusion of their four-year curriculum. The first two years of the dental curriculum are similar to those of a medical school, being comprised of basic science and preclinical courses. The last two years are clinical years, with students providing patient care in a controlled and monitored setting. Afterward, students can, after completing state licensure procedures, practice dentistry.

Although not required as with medical school graduates, many dental school graduates do

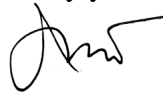
go on to do a one-year or more residency in either general dentistry or a specialty. During this time the residents further their training and also continue to work in a clinical setting. As they have their dental degree, the residents can see more patients and perform more complex treatment than their pre-doctoral counterparts. I raise this point to emphasize the three equal missions of a dental school, including research, education and patient care. Dental schools across the United States have become providers of care for those individuals who are most in need of dental services. Many of the schools are located in major cities, and serve the neediest members of society. These schools have become the safety net for dental care for hundreds of thousands of people in the United States. Furthermore, these schools offer care for all, which in many cases means serving the uninsured, as well as providing emergency services 24 hours a day, seven days per week. In fact, in New York State alone, in the last fiscal year the dental schools provided more than \$45 million dollars in uncompensated care. In addition, dental schools have become leaders in provision of services at off-site locations (i.e. away from the main clinic). As an example, our school maintains dental clinics in local public schools and residents provide care at local community health centers. We also have a mobile dental van. The total number of off-site visits provided by our School in the last fiscal year was more than 25,000.

If the proposed CMS rule were to be finalized, Columbia and the other dental schools across the country will be forced to reevaluate their dental GME programs. Without the GME stipend we are able to provide to residents, many will choose to forgo residency and go directly into private practice. This will lead to dentists with less training in private practice, but just as importantly, it will mean fewer dentists working at dental school clinical facilities, treating the poor, Medicaid beneficiaries, the uninsured, minorities, and other underserved populations. In fact it is very likely that many residency programs will have to be discontinued, leaving no one to perform more complex dental services in the school's clinics.

The issue of oral health disparities was clearly identified in the 2000 Surgeon General's report "Oral Health in America". These disparities are of primary concern to the dental schools in the United States, and these institutions are leaders in addressing the oral health care needs of those that are most in need of care. The proposed changes to the rule governing residents training in non-hospital settings would have a major adverse impact on Columbia's ability to provide care to those who have difficulty accessing dental services. Much of the care at the Columbia University School of Dental and Oral Surgery is provided by dentists at our institutions in postdoctoral training. Consequently, I urge you to withdraw the proposal.

Thank you for your consideration of these comments.

Sincerely yours,



Ira B. Lamster, D.D.S., M.M.Sc.
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