



A Legal and Policy Analysis of the Impact of Traditional Federal Graduate Medical Education (GME) Funding on Pediatric Dentistry Programs

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With respect to federal graduate medical education (“GME”) funding ², pediatric dental residency programs have two possible options. First, for a program operating in a freestanding Children’s Hospital, there is the Children’s Hospitals Graduate Medical Education Payment Program (“CHGME PP”). Second, for those pediatric dental programs training residents in a non-hospital setting or in a general hospital setting (i.e., non-children’s hospital), there is the traditional federal Medicare GME (M-GME)³ funding. This analysis will briefly describe the CHGME PP, for comparison purposes, and the balance of the analysis will focus on the traditional federal M-GME program, its background, recent policy changes and clarifications, and how pediatric dental programs might best utilize traditional M-GME funding in the future given these recent regulatory changes.

Children’s Hospitals Graduate Medical Education Payment Program

The CHGME PP was enacted by Congress in 1999 as part of the Health Research and Quality Act (Public Law 106-310). The program was first announced in a June 19, 2000 *Federal Register* notice.

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² Throughout this analysis, GME will refer to both direct and indirect graduate medical education payments.

³ While funded through Medicare Part A, as explained in this analysis any type of approved resident may be counted under M-GME, even pediatric medical and dental residents.

Congress designed this program specifically to provide adequate graduate medical education funding for Children's Hospitals. Children's hospitals had been effectively marginalized by the traditional federal M-GME program, because the hospitals' low Medicare patient census resulted in very few traditional GME dollars flowing to them. A children's hospital receives the same direct GME ("D-GME") and indirect medical education ("IME") funding for a dental resident as for a medical resident.

In contrast to the traditional GME program, the CHGME program is administered by the Health Resources and Services Administration ("HRSA") and is dependent each year on Congress appropriating funds to run the program and distribute to Children's Hospitals. In its first year of implementation, Congress appropriated \$40 million to be divided among the 74 freestanding children's hospitals with their own Medicare provider number. For fiscal year 2005, Congress appropriated \$301 million to distribute to the hospitals. Funding for fiscal year 2006, which began on October 1, 2005, is still up in the air, as Congress struggles with passing both the funding bills to keep the federal government operating and legislation to pay for the War in Iraq and assistance to hurricane victims.⁴

Traditional Federal Medicare GME Program

The traditional federal M-GME funding program is administered by the Centers for Medicare and Medicaid Services ("CMS"). Significantly, the traditional program is not dependent on Congress appropriating funding for the program each year. Rather, the traditional program is an entitlement program, with the hospitals submitting cost reports each year, listing the number of residents qualifying to be counted towards D-GME and IME funding. CMS then pays the hospitals D-GME and IME based on the numbers in the cost report and not based on how much money Congress has set aside for the program each year.

Children's hospitals do not fare well under the traditional GME program because the funding formula for this program is based on the HOSPITAL'S share of Medicare patients, and clearly children's hospitals do not treat many Medicare patients. It is significant to note that the lynch pin is the HOSPITAL'S Medicare patient load and not how many Medicare patients any individual resident or residency program treats. Therefore, a hospital receives the same amount of D-GME or IME for a dental resident who treats very few Medicare patients as it does for an internal medicine resident who may treat many.

⁴ For more information on CHGME see the separate **Children's Hospitals GME Fact Sheet for Pediatric Dental Educators**, also available on the AAPD web site (www.aapd.org) in the Members-only Advocacy Section.

1997 Legislative Changes to Traditional M-GME Program

Congress enacted two significant changes to graduate medical education policy in the Balanced Budget Act (“BBA”) of 1997 that impacted dental residency programs. These changes enabled hospitals to newly receive both direct graduate medical education (D-GME) payments and indirect medical education (IME) payments for dental residents training in non-hospital locations, such as dental school clinics or Federally Qualified Health Centers (“FQHCs”) ⁵

With the first change, Congress exempted dental residents from the 1996 cap imposed on the number of residents a hospital could claim for D-GME or IME funding. In the second change, hospitals were able to include the time residents train in non-hospital settings in determining their full-time equivalent (“FTE”) counts for both D-GME and IME payments. Prior to the BBA, hospitals could include training time in non-hospital settings only for D-GME funding.

Hospitals must meet certain criteria in order to count the residents training time in non-hospital locations. First, the residents must be in duly accredited programs and involved in patient care related activities. Second, under the original regulations promulgated to implement the BBA provisions, there had to be a written agreement between the non-hospital setting and the hospital. Third, the hospital must incur all or substantially all the costs of the training program. Fourth, the written agreement must specifically indicate the supervisory teaching costs incurred. 42 C.F.R. 413.78(d).

Fortunately, CMS has defined through regulations what costs the hospital must incur in order to meet the requirement that it has incurred “all or substantially all” the costs. The hospital must incur the cost of the residents’ stipends and fringe benefits, if any, and any lodging and travel costs associated with training in the non-hospital location and the faculty costs for the time spent providing supervisory teaching services. 42 C.F.R. 413.75(b).

⁵ FQHCs and rural health clinics (“RHCs”) also are eligible to receive D-GME funding directly due to changes in the BBA. However, this rarely is a dental program’s best option. The FQHC’s and RHCs are eligible only for D-GME based on their actual direct costs and their percentage of Medicare patients. An FQHC or RHC with dental residents is not likely to have a large percentage of Medicare patients that it treats. Typically, even if a dental program rotates residents to an FQHC or RHC, it is better to have a hospital fund those rotations and have the hospital receive the GME funding. The hospital usually will have a higher Medicare share and is able to receive both D-GME and IME for the residents rotating through the FQHC or RHC.

These BBA changes created new opportunities for dental programs, such as pediatric dentistry, in programs with training occurring in non-hospital settings.⁶ These programs could enter into written agreements with hospitals so that the hospitals would fund the dental programs and in return the hospitals would receive D-GME and IME funding. These arrangements **appeared** to fulfill the intent of Congress in enacting these changes – an intent to make sure that GME policy encouraged and facilitated the training of residents in these non-hospital settings.

Many programs did enter into these GME arrangements with hospitals. With the influx of hospital money, dental residents could actually be paid stipends that might rival those stipends paid to medical residents. Since the hospitals receive the same D-GME and IME for dental residents as for medical residents, it only made sense that these residents should be paid the same stipend. (Medical residents typically work more hours, however, with regular weekend rotations or on call responsibilities. Therefore, there might be legitimate reasons to not pay dental residents the same stipend as medical residents.)

With dental residents receiving stipends and hospitals paying for faculty supervisory time, dental programs with these hospital arrangements were flourishing. There were plans drafted for many dental programs to expand given the new federal funding source.

2003 CMS Changes – Application of the Community Support Principle

Seemingly out of the blue, in 2003, CMS issued a significant blow to the expansion of dental post-graduate programs through traditional GME funding. **Effective October 1, 2003, a hospital is not able to receive D-GME or IME funding for residents training in a non-hospital setting, unless the hospital has incurred some costs of the residency program from its inception.** 42 C.F.R. 413.78(d)(4), 413.81. CMS based this position on existing regulations on redistribution of costs and community support that CMS itself clearly had never applied to residency programs in non-hospital sites until issuing this 2003 final rule.

However, bowing to significant political pressure, CMS did agree to “grandfather” in those residents who began their residency programs on or prior to October 1, 2003. Hospitals were allowed to continue to count those “grandfathered” residents on their cost reports until those residents finished their training in the

⁶ Of the current pediatric dental residency programs, numbering 68 as of the date of this memo, the AAPD indicates that vast majority have training in hospital-based settings - regardless of whether a dental school or hospital is the program sponsor for accreditation purposes.

specific program they were in as of October 1, 2003, or for three years, whichever comes first. 42 C.F.R. 413.81(c)(2).

For residents beginning their training program in a non-hospital site after October 1, 2003, a hospital will not be able to receive D-GME or IME for these residents, unless a hospital had provided some funding to the program from its inception. CMS assumes that for hospital-based residency programs, a hospital incurs some costs. Therefore, effectively the community support/redistribution of costs principles had no impact on these programs.⁷

Office of the Inspector General Audits

To compound the new challenges faced by dental programs, Congress in a letter and not through legislation requested that the Office of the Inspector General (“OIG”) conduct audits of dental arrangements and provide recommendations to Congress. Significantly, there appears to be no deadline to this Congressional request.

Towards the end of 2003 and the beginning of 2004, the OIG selected 10 hospitals at random to audit regarding their dental arrangements. The OIG has stated that the selection of the hospitals was random, but it does acknowledge that it wanted to review large programs.

Even though the audits have been ongoing for almost two years, it is believed that none of the 10 hospitals has received even a draft report of the audit results. However, a few of the hospitals have been given some idea by the OIG audit team as to projected findings. Once a draft report is issued to the hospitals, the hospitals will have an opportunity to comment on these findings prior to the OIG issuing a final report. Even after a final report is issued, it will be in the form of only recommendations to the fiscal intermediary regarding whether there has been any over- or underpayment of GME funds. The OIG also intends to issue a report to Congress with some recommendations based on its findings.

It appears that during this time period where the hospitals are awaiting the OIG results that the fiscal intermediaries are continuing to reimburse the hospitals based on their GME agreements with dental schools.

2004 CMS Changes – Elimination of Written Agreement Requirement

⁷ In an informal AAPD survey of pediatric dentistry residency programs in 2004, only nine reported that they were significantly impacted by the CMS community principle regulatory change.

In 2004, CMS decided to do away with the requirement that hospitals and non-hospital training sites have a written agreement confirming that the hospital is incurring all or substantially all of the costs of the non-hospital site's training program. The hospital must still incur these same costs. However, CMS now permits the hospital to demonstrate this commitment either 1) by a written agreement (as previously required); or 2) by the hospital paying the required costs associated with the non-hospital training program by the end of the third month following a month in which the training in the non-hospital site occurred. 42 C.F.R. 413.78(e)(3).

If there is a written agreement, CMS stated in the final rule implementing these changes that the written agreement must be signed prior to the hospital counting the residents on its cost report. This has been an ongoing issue for certain hospitals and CMS.

A limited number of hospitals and dental schools had entered into written agreements soon after the BBA changes were implemented in 1999 or 2000 and had signed these agreements toward the end of the hospital's fiscal year, while the agreements had a written effective date per the contract as of the beginning of the hospital's fiscal year. The hospitals have argued that in terms of generally accepted accounting principles ("GAAP") and general contracts law, the hospitals have complied with the CMS regulations because they have incurred the requisite costs from an accounting and legal liability perspective from the beginning of the fiscal year. CMS has failed to agree.

This issue will be presented before the Provider Reimbursement Review Board ("PRRB") in December 2005 and a decision should be rendered 6-9 months after that.

Supervisory Teaching Time

The Medicare rules require hospitals to pay "reasonable compensation" for the faculty "supervisory teaching activities" for a training program in a non-hospital setting, if the hospital wants to include those residents on its cost report. 42 C.F.R. 413.78(d)(2). What exactly constituted "supervisory teaching activities" had been somewhat up in the air.

However, a Question and Answer sheet that CMS issued on April 8, 2005 (see Attachment 1) entitled "Medicare Policy Clarifications on Graduate Medical Education Payments for Residents Training in Non-Hospital Settings" provides some guidance. This document is also available on the CMS web site at: <http://www.cms.hhs.gov/providers/hipps/nonhospQA.pdf>

CMS states that if there is a cost associated with teaching physician time, then the hospital must pay for it. If there are no such costs, then the hospital does not have to pay any amount in this category. CMS believes that typically there is a cost for teaching physician time. For example, if a physician receives a predetermined compensation amount, usually this compensation includes payment for teaching time. However, CMS states that if the physician's compensation is based directly on the number of patients he/she treats and for which he/she bills, then there is no compensation for teaching.

This CMS guidance is very clear that time physicians spend on billable patient care activities is NOT teaching time and does not need to be paid for by the hospital.

“[O]nly the costs associated with teaching time spent on activities within the scope of the GME program, but not in billable patient care activities, would be considered direct GME costs that would need to be incurred by the hospital.” Answer #3.

Therefore, even though there is clearly teaching going on when a resident is involved in billable patient care with a faculty member, this time is not included when the hospital is trying to calculate supervisory teaching time. For programs in such non-hospital sites as Community Health Centers, much if not all the time is spent providing direct patient care. The supervisory teaching costs would most likely be very minimal.

Some of the shortcomings of the CMS document are pointed out in analysis by the Association of American Medical Colleges in Attachment 2 (Selected Documents).

Prior Residencies

Recently questions have arisen in a few hospital cost report audits by the fiscal intermediary as to how to treat a prior GPR or AEGD residency. Every accredited specialty is listed in the *Federal Register* with an Initial Residency Period (“IRP”). The IRP is the minimum number of years required to be completed in a program to be eligible to sit for the Board for that program. For example, the Commission on Dental Accreditation accredits pediatric dentistry programs for two years, although a small number are accredited for three years.⁸ A resident needs to complete only a 2-year program to be eligible to sit for the Pediatric Dentistry Board. Therefore, pediatric dentistry has an IRP of two years.

⁸ According to the Commission on Dental Accreditation, only three Pediatric Dentistry programs are accredited for 3 years; two others are accredited for between 2 and 3 years (27 and 30 months respectively). The remaining 63 are 2 year programs.

The IRP is important because it is the maximum number of years that a hospital can count a resident as a full FTE for D-GME purposes. For any years of training beyond the IRP, the hospital can count the resident as only a 0.5 FTE for D-GME. The IRP has no impact on the FTEs for IME.

So for a pediatric dentistry resident in the third year of a three-year program, a hospital counts that resident as only 0.5 FTE for the D-GME and 1.0 FTE for IME. Another example as to how the IRP comes into play would be if a resident has completed a prior program that leads to board eligibility and then goes on to another residency program. For example, a resident might complete a year of dental public health and then go into a pediatric dental residency program. Because the dental public health program has an IRP of one year, the pediatric dental resident is counted as only 0.5 FTE for D-GME for the entire two years of the pediatric dentistry program. The policy reason for this is that the federal government wants to fully support residents only through their initial years of training and not for further specialty training.

A problem has arisen though regarding the GPR and AEGD residencies, because they are listed by CMS as having IRPs of one year and two years respectively. Therefore, based on this CMS listing, if a pediatric dentistry resident has completed a one-year GPR program, the entire two-year pediatric program could be treated by CMS as post the IRP. If that were so, the hospital should count the pediatric dentistry resident as only 0.5 FTE for D-GME for each of the two years of the pediatric program, as with the prior dental public health residency example.

However, the CMS listing of the IRPs for GPR and AEGD programs is not correct. The IRP is defined in the Medicare regulations as “the minimum number of years required for board eligibility.” 42 C.F.R. 413.79(a). Neither of these programs should have an IRP because the American Dental Association does not recognize a General Dentistry Board. See the April 15, 2004 letter from the American Dental Association provided in Attachment 2 (Selected Documents). Therefore, for these programs, there is no “minimum number of years required for board eligibility.”

These programs probably should be treated as transitional years. However, CMS has yet to provide definitive guidance in this area. If they were treated as transitional years, then completion of a one-year GPR program, for example, prior to entering a pediatric dental program would be counted as the first year of the pediatric program. The hospital could count the pediatric dental resident as a full 1.0 FTE for D-GME and IME for the first year of the pediatric program, but for the second year, the hospital could only count the resident as 0.5 FTE for the D-GME and 1.0 for the IME.

In practice, here is are the potential outcomes using the example of of a prior GPR:

- If GPR program has an IRP of 1 year:
 - For both years of the pediatric dentistry program, hospital counts resident as only 0.5 FTE for D-GME. IME is unaffected.
- If GPR program is a transitional year:
 - For 1st year of pediatric program, hospital can count 1.0 FTE for both D-GME and IME. For 2nd year, hospital can count only 0.5 FTE for D-GME. IME is unaffected.

So, it does make a financial difference to the hospital whether a GPR or AEGD program is considered to have an IRP or is a transitional year. As mentioned, CMS has not ruled on this issue yet; therefore, hospitals must check with their fiscal intermediaries and/or CMS on this issue. A hospital should definitely bring to the attention of the intermediary and CMS that there is no recognized Board for General Dentistry. Therefore, by regulation, there can be no IRP for these programs.

Graduates of Foreign Dental Schools

CMS recently has cleared up confusion in the area of the counting of dental residents who have graduated from a foreign dental school. **A foreign dental school is any dental school not located in the United States, Canada, and Puerto Rico.** A hospital can count graduates of foreign medical schools as full FTEs for D-GME and IME. However, there is a reduction in the D-GME count for the foreign dental school graduates.

An email that Rebecca Hirshorn, CMS technical analyst, sent to a hospital regarding this issue is provided in Attachment 3. In the email, Ms. Hirshorn points out that Section 1886(h)(4)(D) of the Social Security Act allows hospitals to fully count foreign medical graduates for D-GME if they have either passed the Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS) or received certification from the Educational Commission for Foreign Medical Graduates (ECFMG). Dental residents are subject to this same requirement through Section 1886(h)(5)(D) even though neither the FMGEMS nor the ECFMG have examinations or certifications with respect to dentistry.

Because dental residents who graduated from a foreign dental school cannot meet either of these requirements, a hospital cannot count them at all for D-GME. However, as Ms. Hirshorn points out in her email, these graduates of foreign dental schools may be counted fully for IME. Fiscal intermediaries appear to be following the guidance of this email. For further confirmation, hospital and or intermediaries could contact Eric Ruiz, technical analysis for CMS, at 410/786-0247. (Ms. Hirshorn is no longer handling GME issues for CMS.)

Didactic Training

As part of the OIG's audit of 10 hospitals, an issue has come up whether a hospital can include the time a resident spends in didactic training towards the hospital's FTE count for D-GME and IME. This issue was addressed directly in correspondence with CMS in 1999, where CMS clearly stated that a hospital could count didactic time towards both D-GME and IME. However, the OIG may not agree with CMS on this issue, and CMS has been unwilling to confirm that it will stand by its 1999 position.

The Medicare regulations are clear that residents training in non-hospital settings must spend their time in "patient care activities" in order for the hospital to include the time in its cost report. 42 CFR 413.86(f)(4)(i) and 412.105(f)(1)(ii)(C). In a letter (see Attachment 2, Selected Documents) dated June 24, 1999, to Rebecca Hirshorn of CMS from a lawyer representing a hospital, the lawyer asked CMS specifically what resident activities were included in the CMS definition of "patient care activities".

Tzvi Hefter, Director of the CMS Division of Acute Care, responded in a letter dated September 24, 1999 (see Attachment 2) that:

"HCFA interprets the phrase 'patient care activities' broadly to include any patient care oriented activities that are part of the residency program. As you stated in your letter, this can include resident participation in '1) the direct delivery of patient care, such as clinical rounds, discussions, and conferences, and (2) scholarly activities, such as educational seminars, classroom lectures, research conferences, patient care related research, as part of the residency program, and presentations of papers and research results to fellow residents, medical students, and faculty.' Therefore, as long as the residents are primarily involved in patient care oriented activities and other program requirements are met, a hospital may include other educational activities as part of the entire time spent by residents in non-hospital settings and include this time in its FTE count and GME/IME payment calculations."

Despite the fact that this 1999 CMS letter is so clear, CMS staff now point to a November 14, 2001 Administrator's Decision reversing a Provider Reimbursement Review Board ("PRRB") ruling as its latest position on didactic training. In Riverside Methodist Hospital (Columbus, Ohio) v. BCBS Association/AdminaStar Federal, Inc., ⁹ the PRRB ruled in favor of the hospital. The Riverside case involved a hospital-based family practice program. Residents in this program attended seminars, journal club, and had project management time. Because this was a hospital-based program, the PRRB found that there was no requirement that a resident's time had to be spent doing patient care activities. The PRRB noted that this was a requirement only for training programs in non-hospital settings.

However, the PRRB added a footnote mentioning that "The Board finds that the hours spent by the residents in the Family Practice Residency Program attending Seminars, Journal Club and Project Management are related to patient care and allowable in accordance with 42 C.F.R. 412.105(g)" Riverside Decision at page 5.

The CMS Administrator in an opinion dated November 14, 2001 stated that the residents' services had to be related to patient care activities and that seminars, journal clubs, and project management time do not, and so, this time should not be counted on a provider's cost report. The Administrator seemed to ignore totally the CMS response in 1999 that was exactly on point but reached a completely opposite conclusion on this issue.

The final word on this matter came from the federal district court in Riverside Methodist Hospital v. Thompson, 529 U.S. 576, 588 (2000). The District Court sharply overturned the Administrator's Decision holding:

"To insert a new requirement in the regulation – namely, that in counting the number of FTE residents, a hospital must exclude each and every hour spent by a resident fulfilling the resident's approved program that is not considered by the agency to be spent on individual "patient care" – would be to illegally change the regulation without the necessity of complying with the procedures mandated by the Administrative Procedure Act." Riverside at 588.

Significantly, CMS did not appeal the District Court's opinion.

Thus, we are left with a 1999 letter from CMS that directly states that patient care activities include didactic time and an Administrator's Decision that says the opposite but that was forcefully overturned by a Federal District Court. Moreover, if CMS and the OIG choose to disallow didactic time, they are left with

⁹ PRRB Hearing Dec. No. 2001-D50 (Sept. 7, 2001).

the seeming untenable position of requiring the hospital to incur the costs of faculty didactic time (See discussion above on what are supervisory teaching costs) but not letting the hospital count that time for residents.

Future of GME Funding for Pediatric Dentistry Programs

- For pediatric dental residents training in a children's hospital, the path is clear. The program should access the CHGME PP. These payments will be greater than what the children's hospital could receive under the traditional GME program. An existing or new pediatric dentistry program based in a general hospital setting should access the traditional M-GME funding stream.
- Existing non-hospital based programs that historically were funded by some source other than a hospital are essentially unable to tap any GME funds at this time.
- However, any brand new pediatric dentistry program that will have residents training in a non-hospital site should seriously consider having a GME arrangement with a hospital. The traditional M-GME funding is available for programs that are based in non-hospital settings if they have been funded by a hospital since the beginning of the program.
- Whether a hospital has funded a program from the beginning is determined program to program and not school to school. Therefore, if a Dental School had three existing programs – GPR, orthodontics, and periodontics – that had historically been funded by the Dental School, and then Dental School wanted to start a new school-based pediatric dentistry program that was fully funded by a hospital, the hospital could receive GME funding for the pediatric dentistry residents, but not others.
- If a hospital-based pediatric dental program decided today that it would like to rotate residents to a non-hospital site, the hospital could incur the cost of the residents' salary and fringe benefits and the faculty cost for supervisory teaching time and could count that training time on its cost report. The CMS adoption of the community support principle has not ended all GME funding of non-hospital site training programs. **Programs that have never been supported by the community before are still eligible for M-GME funding.**
- Programs that have historically been school-based may have a difficult time competing if a hospital in the community decides to start a new program in the same specialty as the dental school's program, and even have some rotations to non-hospital sites. The hospital will be able to access traditional M-GME funds, even for the non-hospital locations, making it difficult for the

school-based program to compete. If the school-based program were to close, it stands to reason that the hospital program might then draw on the dental school faculty to assist in running its program. However, if the chain of events occurred somewhat differently, i.e., that prior to a hospital program opening, the dental school closes its program, and THEN the hospital draws upon the dental school faculty to run its program, CMS has suggested in telephone conversations that it might not look favorably upon the hospital program as a NEW program. Rather, CMS staff have stated that this might be viewed as a sham arrangement just to get around the community support policy that is preventing the dental school-based program from receiving GME funds. In this situation, a hospital must simply consult with its fiscal intermediary and possibly CMS to obtain written confirmation that its program will be considered a new program and be eligible for GME funding.

Conclusion

Federal M-GME funding of dental programs had held out great hope of providing a stable base of support to improve and expand training programs until CMS applied the community support policy to this area in 2003. This has shut off GME funding for programs that have not been funded by hospitals since their inception.

Nevertheless, GME funding continues to be available for new programs with non-hospital training sites in which the hospital is the original funder. Hospital-based programs also have access to either traditional M-GME funding or, if a children's hospital, CHGME.

The OIG audits appear to be on hold indefinitely and recent CMS policy positions, or lack thereof, have arguably been favorable to dental programs. For example, graduates of foreign dental schools are at least eligible for IME funding. CMS has not clarified its position on whether hospitals can count resident didactic time. However, there is the 1999 letter directly on point and allowing this. Moreover, the CMS guidance in April 2005 stating that the supervisory teaching cost that hospitals need to incur is not billable patient care time, but rather time spent providing didactic training, weighs heavily in favor of hospitals being able to count this time, if CMS has stated they must pay for these teaching costs. The fact that CMS has clarified that supervisory teaching time does not include patient care time also should significantly reduce the faculty cost that a hospital must bear for training in a non-hospital setting.

CMS also has not taken a position on whether GPR and AEGD programs should be treated as transitional years. Yet its position that these programs have initial residency periods cannot be sustained as it is clear that an

initial residency period requires the program to lead to Board eligibility and that is not the case with general dentistry programs.

Lastly, it is clear that new dental programs training in non-hospital settings that are funded by hospitals are eligible for GME funding. Fiscal intermediaries are now more familiar with the dental programs and hospitals do not appear to have any difficulty getting GME for these new programs.

Therefore, there is a future for GME funding of dental programs. GME funding will not have the revolutionizing impact on graduate dental education that was once predicted. However, it will substantially assist new programs.

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