How Much is Your Residency Worth?

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APPD 2011 National Meeting

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Does a medical center gain or lose money on its residents?

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How Did We Get Into This Mess?

I. **Prior to 1940**
   - Housestaff lived in “the house”. Salary paid directly by the hospital. Room and board included.

II. **1945-1965: GI Bill**
   - Residency positions increased 6-fold
   - GI Bill supports subsidizes residency positions for servicemen, and subsidizes hospital expenses

III. **1966-1981: Medicare**
   - Congress acknowledges need to support GME. Medicare and private payers contribute “customary and reasonable expenses”

iv. **1982-1986 DME & IME**

- Special subsidies to teaching hospitals. Complex calculations based upon resident-to-bed ratios, Medicare's share of total hospital inpatient days, etc.
- Additional subsidies for classrooms, clerical support, faculty teaching efforts,
- Subsidies to teaching hospitals for additional testing and increased technology in teaching centers

v. **1986-1996 Start of "adjustments"**. Increase subsidies for "disproportionate share payments" with new calculations accounting for care of indigent patients.

Government begins to pull back on IME payments.

Modern Era- Balanced Budget Act (*BBA*)

BBA acts of 1997, 2001

- Markedly increased attention on cutting costs
  - 5-year annual progressive decrease in IME
  - **Cap** on total resident-to-bed ratios
  - GME payments “carved out” of reimbursements sent to hospitals that care for Medicare HMO patients

Health care reform-2012?

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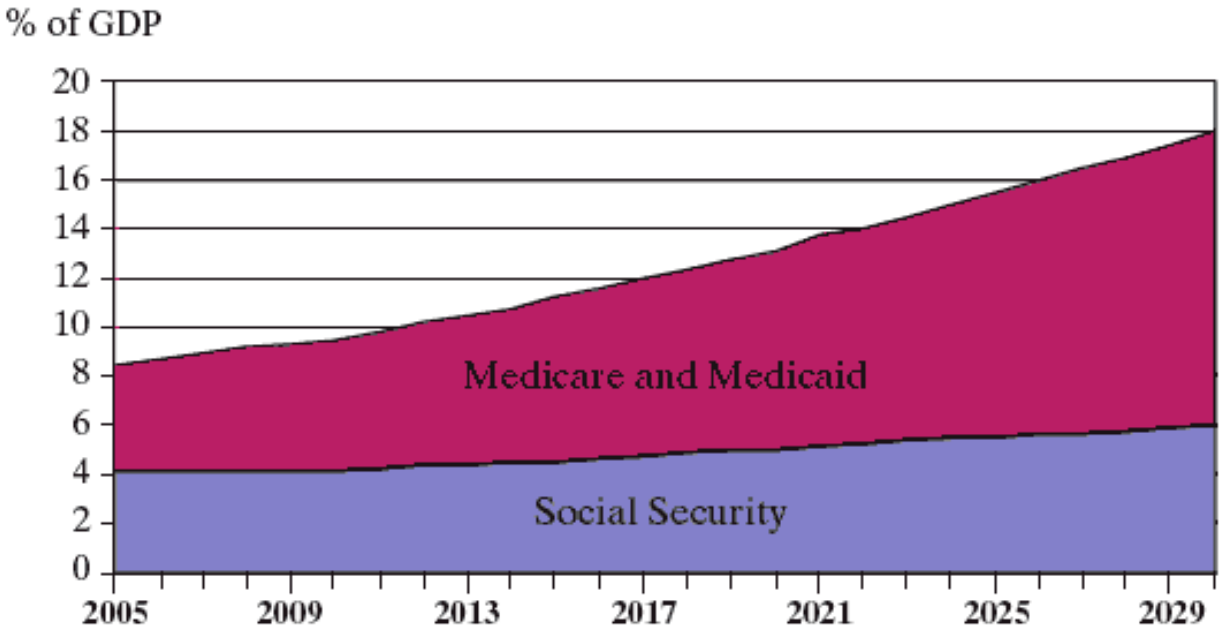
Why Worry Now?

Figure 1

SOCIAL SECURITY, MEDICARE, AND MEDICAID AS A PERCENTAGE OF GDP



Source: Congressional Budget Office.

Will There be Any Money Left at All?

Chart 1-11. Medicare HI trust fund is projected to be insolvent in 2017 *(HI=hospital insurance)*

Estimate	Year costs exceed income	Year HI trust fund assets exhausted
High	2008	2014
Intermediate	2008	2017
Low	2018	2028

Note: HI (Hospital Insurance). Income includes taxes (payroll and Social Security benefits taxes, railroad retirement tax transfer), income from the fraud and abuse program, and interest from trust fund assets.

Source: 2009 annual report of the Boards of Trustees of the Medicare Trust Funds; CMS, Office of the Actuary.

How Does the Money Get to Our Trainees?

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CMS Speak 101-**DME**

Direct Medical Education Payments

- **DME** *(also DGME)* This is the Medicare determined payment for each resident.
- **PRA** The "Per Resident Amount"
- **FTE** Full Time Equivalent

How is it calculated?

DME =

PRA x FTE (weighted) **x Medicare share of inpatient days.**

This rate was frozen 12/31/96

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CMS Speak 201- **IME**

IME-Additional payment for a Medicare discharge to reflect higher patient care costs for teaching hospitals relative to nonteaching

R = IME Adjustment Factor-Calculated by using ratio of hospital's residents to beds

C = Multiplier- Random factor set by congress

$$IME = C \times [(1 + R).405-1]$$

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What the??????????????

Translation Please?

- IME payment is dependent upon your number of residents and a congressionally determined IME multiplier.
- Multiplier has been 1.35 since 2003
- That translates into a 5.5% increase in IME payments for every 10% increase in the resident to bed ratio...(*it used to be 7.7% increase*)
- This translates into a disincentive to increasing residency program size.

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PPS Payments

PPS=Prospective Payment System

PPS is a pre-determined fixed amount of reimbursement made up of the following…

- $ Base payment
- $ Wage index (local costs)
- $ MS-DRG (accounts for differences in patient mix from one hospital to the next)
- $ Add on for "disproportionate share of indigent patients"
- $ Add-in for IME
- $ Add on for cases that use approved eligible technologies
- $ Outlier payment for "exceptional" cases
- $ **Reduced payments for hospitals that don't report on quality data.**

What's the Bottom Line for the USA?

American DGME & IME payments:
estimates for fiscal year 2010

DGME Payments	=	$3.0 billion
IME Payments	=	$6.54 billion
Total	=	$9.54 billion

SO… How Much Per Resident?

2010 estimates

- $9,540,000,000 in GME funds
- 90,000 residents funded under the cap for….
- $**106,000 per resident**

- *110,000 residents total in USA 2010 (i.e. 20,000 over cap) or final average of $**86,700 per resident***

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Calculations- Part I

- Resident Salary= $50,000 per year
- Fringe of 27% = $13,500 per year
- **Total costs = $63,500 per year**
- *DGME/IME = $106,000 per year*

- Net Profit to Institution**= $42,500 per resident/year!**
- For our categorical residency of 50 **= $2,125,000**

- *Remember… if your residency is already capped, additional residents will **NOT** bring in additional DGME or IME from Medicare!*

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Calculations-Part II

- **But how much does it cost to teach?**
  - **Time for faculty effort when they're not billing?**
    - Direct supervision, Observed H & P, didactics, advising, remediation, program directorship, procedural training, etc.
  - **Ancillary staff**
    - Coordinator, chiefs, assistants, DIO, etc.

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Can we estimate minimum FTE faculty to calculate cost of teaching?

	Cty	ED	IP	PICU	NICU	NNN	Subsp Ad/DBP	**FTE**
x1,000$	*120*	*150*	*140*	*180*	*180*	*120*	*130*	
SM	4	4	4	2	4	1	8	=27
MD	8	8	6	4	8	2	16	=52
LG	12	12	10	8	10	3	32	=87

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Now add in minimum FTE admin

	Fac	PD	APD	Coord	Chief	Asst	**FTE**
SM	27	0.5	0.25	1	1	0.25	=30
MD	52	0.75	0.5	1	2	1	=57
LG	87	1	1	1	4	2	=96

Our best guess – **Price Tag** for Faculty-Pediatric Residency Training.

SM = **$4,740,000**

MD = **$7,840,000**

LG = **$16,500,000**

(Assumption of 27% fees for benefits)

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Calculations- Part III

- What about the intangibles and “goodwill”?
- Academic medical centers often have potent advantages in
  - grants, research support, up to date providers, recruitment of specialists, intellectual stimulation, community prominence

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Calculations Part IV

- Balance Sheet-
- Do residents bring money in, or cost us?
  - Generally more testing?
  - Increased length of stay?
  - Increased errors?
  - Diminished billing?
  - Patient satisfaction?
  - Mandates to expand faculty to meet ACGME requirements in money losing programs?

Calculations-Part V

- **Replacement Cost**
- how many FTE's would be required to fill the role of one resident FTE
- *Assumption*: 50% inpatient, 50% ambulatory
- Inpatient replacement FTE: 3-4 for one resident x 50%
- Ambulatory-1 FTE replacement x 50%
- **SUM**: Need 2.5 FTE per resident per year
- **=$425,000 per year for each replacement**

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Calculations- Part VI

- **Expansion Costs**
- Unless there is a new source of billing or revenue, residency expansion will generally appear as a net loss!
- *Caveat: Winning new cap positions from recently closed institutions*

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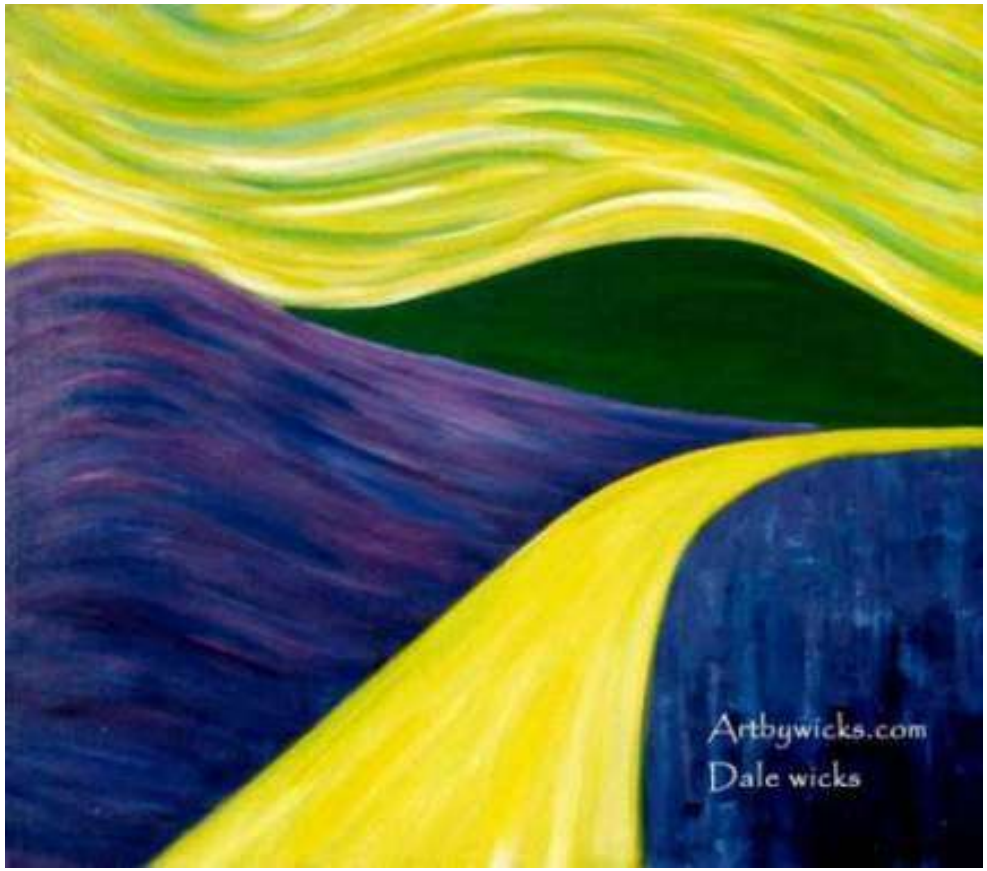
Many Possible Futures



Freestanding Children's Hospitals
a group at particular risk?

CHGME

Children's Hospital GME Payment Program

- Freestanding children's hospitals don't have a significant Medicare source of funding
- Congress appropriated $300 million dollars for ONE year of GME funding including DME/IME
- **Obama budget 2012 would eliminate that funding.**

CONGRESS

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Who Will Pay For All of the Training?

Huge numbers in the medical student pipeline

- Medical schools awarded **16,468** MD Degrees in 2009
- A total of **18,390** students entered medical schools in 2009
- AAMC **and** COGME calling for increase in students to offset projected shortages

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Watch MedPAC!

MEDPAC Medicare Payment Advisory Commission

Medicare Payment Advisory Commission

MedPAC is heavily influential and seeking complete reform of GME funding

- ❖Should Medicare be in the GME business at all?
- ❖Recommendation that Congress convene an expert group to come up with new standards to link payments with national incentives on quality and outcome.
- ❖Timeline to completion- 3 years.
- ❖Incentivize primary care and ensure high quality primary care experiences

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Key MedPAC Quotes -*NEJM 2/24/11*

- "Medicare (*should*) publish information about how much it pays each teaching hospital for GME-information that is sometimes not even available to the residency-program directors and teaching hospital faculty. GME payments…may be allocated as the institution's chief executive and board of directors see fit without regard to the GME mission"

- *NEJM, 364:8 p.694*

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More MedPAC Quotable Quotes

- ACGME has taken important steps in reorienting its residency-program accreditation standards to support needed change. We applaud that progress, but it has been slower than MedPAC and some members of the GME community would like”

- *NEJM 364:8, 2/24/11 Pg.693*

- “MedPAC like many others is also concerned about the declining proportion of U.S. medical students choosing careers in primary care. GME could help to address this problem-for example by expanding primary care programs and shrinking subspecialty programs or by investing sufficient resources in primary care programs to ensure that residents have high-quality experiences”

- *NEJM 364:8, 2/24/11 Pg.694*

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Opportunity Knocks

- Shall we increase pediatric residency slots, and if so, who pays?
- Shall we increase primary care exposure and incentives, and if so, who pays?
- Shall we (APPD) become more politically active as an advocacy group?

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Should We be Thinking Entirely Anew?

- Multidisciplinary medical home?
- Fewer pediatricians, but more extenders?
- Accountable care organizations?
  - Financial risks shared between hospitals and community practitioners?
- Let market forces reign?

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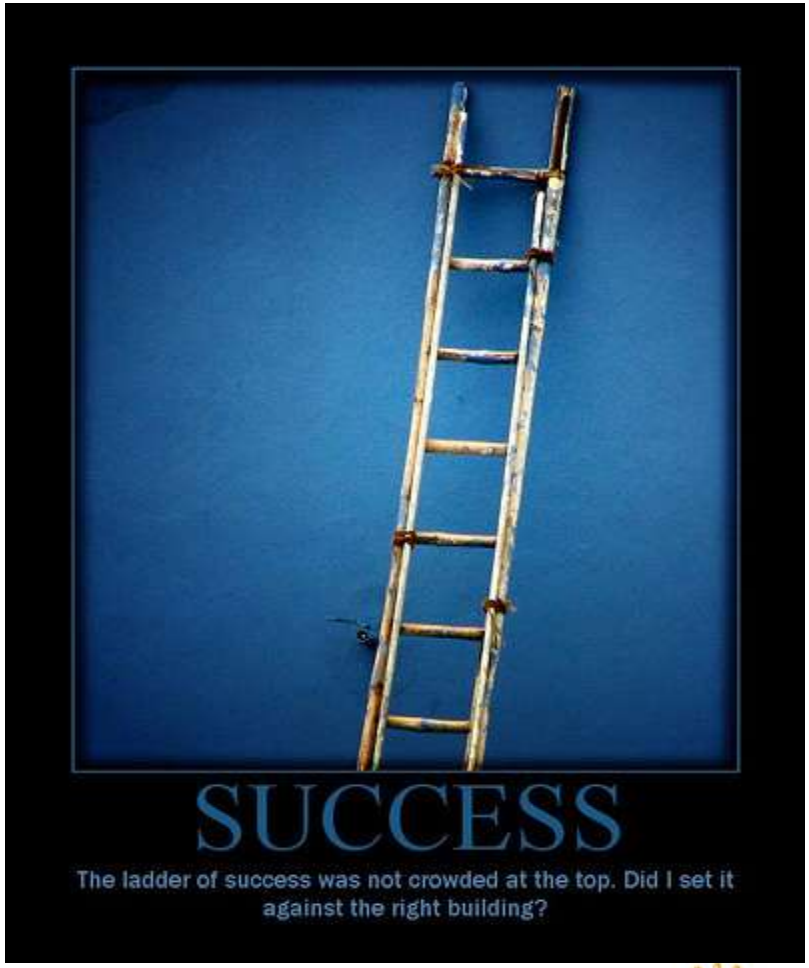
Where Shall We Go Next?

- More training programs or fewer?
- More residents or fewer?
- More primary care practitioners or specialists?
- More doctors or mid-levels and extenders?

What Will YOU do Next?



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