

Financial Defense for Your Residency

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Number of Slides

- No, we are not going to read all these slides.
- The number of slides and amount of narrative is to decrease your need for notetaking, and provide you with resources and methodology to take home.

Methodology

Literature search – through January 2016

Determining the True Value of a Family Practice Residency Program

The financial model enables directors to begin to quantify the intangible contributions that traditional financial reports don't consider.

Perry A. Pappas, MD, MPH, William R. Glendon, MD, Richard Lerner, MD, E.D. Lane, MHA, Amy Socha, MD, and George C. Zaballa Jr., MD, MBA

There are financially challenging times for academic programs. Many are being cut across or merged into reduced medical laboratories for postgraduate medical education and the National Budget has cut 10% across the board for all non-core federal funding spending.

Family practice residency programs are particularly vulnerable as a result of their specific design. Since they are practice based in community hospitals, where most of the only graduate medical education program financing comes. They typically serve dual functions: patient programs and trainees both come to a common link "high-intensity" medical residents and specialty trainees.

For example, an academic medical center program. Clinical criteria, curriculum, productivity generate the training, making time and high operating expenses that are not always high budget.

Key Points

- Academic programs determine their own financial contribution to the institution.
- The financial model makes the comparison of the program value to the institution's budget.
- The financial model is not a substitute for the institution's financial data.

As a result of their specific design, family practice residency programs are particularly vulnerable as a result of their specific design. Since they are practice based in community hospitals, where most of the only graduate medical education program financing comes. They typically serve dual functions: patient programs and trainees both come to a common link "high-intensity" medical residents and specialty trainees.

With limited operating budgets, many programs are under increasing pressure from governing institutions and their governing bodies to find a greater contribution to the bottom line.

Reassessing true value
While traditional reports are the standard, a special job of quantifying the intangible contributions...

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ORIGINAL ARTICLES

Ten-year Trends in the Financing of Family Medicine Training Programs: Considerations for Planning and Policy

Richard Lerner, MD, MPH, Amy Socha, MD, George C. Zaballa Jr., MD, MBA

BACKGROUND AND OBJECTIVES: The need to determine the true value of family medicine training programs is critical to the development of a sustainable program. This study examines the financing of family medicine training programs over a ten-year period. The objectives of this study are to determine the financing of family medicine training programs over a ten-year period and to identify the factors that influence the financing of family medicine training programs.

DESIGN: This was a retrospective study of the financing of family medicine training programs over a ten-year period. The study was conducted in a large academic medical center.

SETTING: The study was conducted in a large academic medical center.

PARTICIPANTS: The study included all family medicine training programs in the institution.

MEASUREMENTS AND MAIN RESULTS: The study found that the financing of family medicine training programs has increased significantly over the ten-year period. The study also found that the financing of family medicine training programs is influenced by a number of factors, including the size of the program, the number of residents, and the number of faculty.

CONCLUSIONS: The study found that the financing of family medicine training programs has increased significantly over the ten-year period. The study also found that the financing of family medicine training programs is influenced by a number of factors, including the size of the program, the number of residents, and the number of faculty.

Subsequent grant programs, including the Family Practice Training Grant, provided funding for the program. The program was able to secure funding from a number of sources, including the National Endowment for Family Practice, the National Endowment for Family Practice, and the National Endowment for Family Practice.

CONCLUSIONS: The study found that the financing of family medicine training programs has increased significantly over the ten-year period. The study also found that the financing of family medicine training programs is influenced by a number of factors, including the size of the program, the number of residents, and the number of faculty.

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Reference Articles

- *Ten-year Trend in the Financing of Family Medicine Training Programs: Considerations for Planning and Policy.* Lesko S, Pauwels J., et al; *Fam Med* 2011;43(8):543-50
– Follow up of longitudinal studies released in 2000, 2003, 2006, 2011, and referred to in the 2014, Carney, P below referenced article)
- *The Cost of Residency Education,* Saultz J; *Fam Med* 2011; 43(8):541-2. Accompanying editorial of Lesko article.

Reference Articles

- *Financing Residency Training Redesign,* Carney P et al.; *Journal of Graduate Medical Education,* December 2014.
 - *Accompanying editorial – Family Medicine is only specialty which has specifically published on costs of a residency program and the impact of new accreditation requirements.*

Reference Articles

- RAND – 2013
- IOM – 2014
- Don't be surprised if finance offices refer to these

RAND 2013

Wynn BO, Smalley R, Cordasco KM; Does It Cost More to Train Residents or to Replace Them? A Look at the Costs and Benefits of Operating Graduate Medical Education Programs; RAND Corporation, 2013

RAND 2013

- The impact should include **both the costs** associated with operating the residency program and the **benefits** that the hospital and its educational partners derive from operating the programs.
- Understanding the financial impact would allow Medicare to distribute its GME funds more efficiently (MedPAC, 2010).
- **“We were unable to develop a consistent comparison metric—impact per resident—that could be used to quantify the results and generate an overall measure of financial impact for each type of program.”**

Opening the “Black Box” of GME Costs and Benefits: A Conceptual Model and a Call for Systematic Studies; JGME; March 2015



Commentary JGME, March 2015

- **Barbara Wynn, MA**, is a Senior Health Policy Researcher, RAND Corporation
- “Seemingly simple question, how much does it cost hospitals and other health care providers to participate in GME?”
 - Information needed to answer it is lacking
 - Referred to the 2014 IOM Report

Commentary JGME, March 2015

- **Institute of Medicine's (IOM) 2014 report**, *Graduate Medical Education That Meets the Nation's Health Care Needs* (Washington, DC: National Academies Press; 2014.)
 - There is little understanding of the bottom-line financial impact of programs
 - **Costs and benefits** of providing resident education are a “**Black Box.**”

Fort Wayne Medical Education Program (FWMEP) Family Medicine Residency

- 10/10/10
- Dually accredited
- Only residency in town
- Community-based consortium – three tertiary hospitals and Medical Society
- 501(c)3, self-contained silo
 - **No stepdown cost methodology – FWMEP knows its expense to the penny**
- FMC – ours/owned and operated by us (not FQHC/CHC etc.)
- RPS Criteria for Excellence
- NCQA Level 3 PCMH and MU

NIPDD Finance Projects

- NIPDD (National Institute for Program Director Development) Academic Medicine Fellowship finance projects
 - FWMEP has four graduate fellows
 - 135 family medicine residencies for comparison which represents ~30% of nation's FM residencies
 - *Carney, et.al.; Financing Residency Training Redesign; JGME; Dec 2014, pp. 686-693.*

Lesko & Pauwels, et. al. Articles

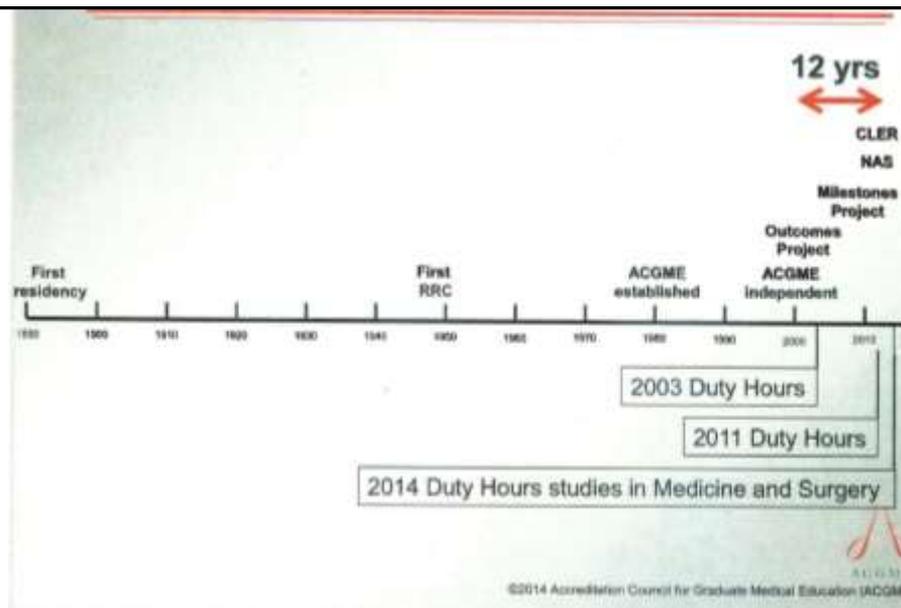
- Importantly, a **10-year longitudinal study**
 - Worked with residency programs directly and sought clarifications when there were data discrepancies or missing data.
 - Hospitals and medical schools have **varied stepdown cost methodologies and not tracking all costs.**
 - **Lack of finance standardization** regarding costs and benefits

Lesko & Pauwels, et. al. Articles

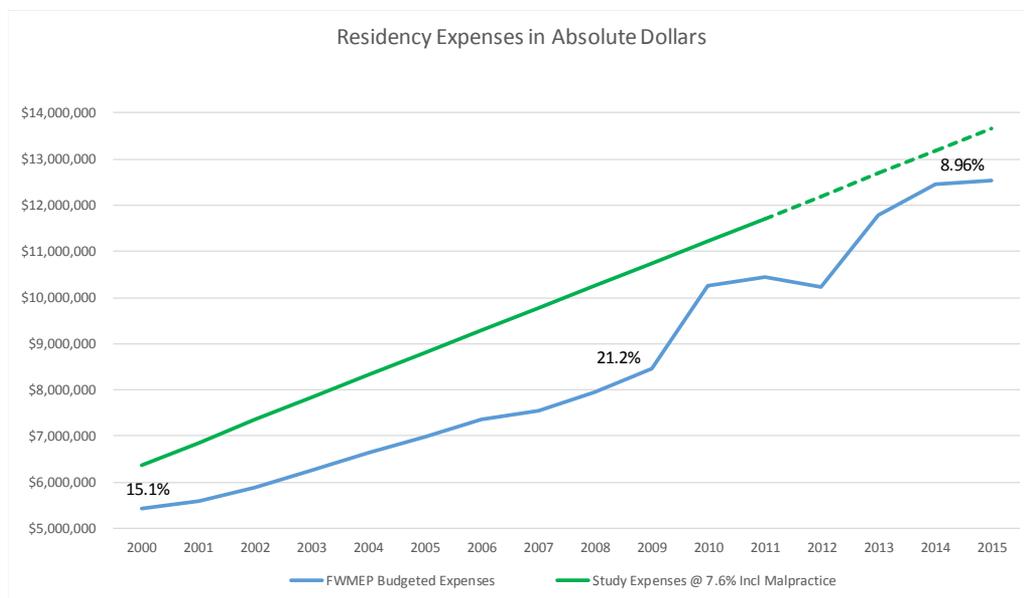
- **2010-2010 residency costs increased 79.6% (7.96% annualized). Inflation rate for same time period – 26.9%**
 - *During this time period the study residencies increased residency size by 5.1% = one resident. This is factored out of expense on the following graph by applying an annualized increase of 7.6% rather than 7.96%.*
- *Employees increased 26.5% over the 10 years*
- **Average # faculty – 21% increase** over 2000-2010.
- **Salary support – 79.3%** of expenses. FWMEP = 81.4% (includes full PCMH NCQA Level 3)

Different Hospital CEO/CFO Paradigm

- 2000-2010 – residency costs increased 7.6%/yr. vs. typical hospital CEO/CFO expectation of 2%
- HR (Human Resource/labor) costs 79% vs. typical hospital CEO/CFO expectation of 50%



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Residency Expense Graph

- 2000 - 2010 - from Lesko et. al. article
- 2010 - 2013 – extrapolated from NIPDD info
- 2013 - 2015 – unlikely cost curve bent secondary to MU (Meaningful Use) expenses, implementing PCMH, and new supervision requirements in July 2011 and NAS in 2014.
 - 12/31/2014 – Nationally 26% of FMR were PCMH and 2% MU 2
 - 2-3% increase in costs: \$118k - \$175k/program/yr secondary to training redesign (P⁴). 2011 data
 - Carney, et.al.; *Financing Residency Training Redesign*; JGME; Dec 2014, pp. 686-693.

PCMH

- Gill J., Bagley B, Practice Transformation? Opportunities and Costs for Primary Care Practices; *Annals of FM*, Vol. 11, No. 3, May/June 2013
 - \$117,000/physician/year
 - 2008 dollars – Baron R, *Implementing PCMH: The Practice Experience*. Washington, DC: PCPCC Stakeholders' Working Meeting 2008.
 - 8.25 FTE resident and faculty physicians in FWMEP's FMC = \$965,250 plus 2.5% annualized inflation since 2008 = \$1.13M = \$37,800/training cost of resident/year.
- Pennsylvania Chronic Care Initiative (PACCI), a statewide multi-payor medical home pilot
 - \$64,768 per clinician (\$18,585 to \$93,856)
 - *Cost of Transformation among Primary Care Practices Participating in a Medical Home Pilot; Journal of General Internal Medicine; Grant R. Martsolf (RAND), 29 December 2015*

PCMH

- \$105k/FTE Physician/yr
 - Magill M et al.; *The Cost of Sustaining a Patient-Centered Medical Home: Experience From 2 States; Annals of FM Sept/Oct 2015;vol. 13, no. 5, 429-435*
- FWMEP FMR is provided PCMH NCQA Level 3 in 2015 for \$655k/yr = \$80.6k/FTE Physician = \$22.2k/training cost of resident/yr.
- PCMH extra expense contributes to FWMEP's decreased net training revenue/expense per resident/year in 2014.

Offsetting Revenues

FORT WAYNE MEDICAL EDUCATION PROGRAM
Analysis of Offsetting Revenue vs. Expenses

	2011	2012	2013	Projected 2014	Projected 2015
CME & related revenue to consortium members:					
Medicare Direct GME	\$ 1,173,979	\$ 1,251,389	\$ 1,478,901	\$ 1,595,931	\$ 1,385,511
Medicare Indirect (IME)	2,708,005	2,596,005	2,851,674	2,766,834	2,786,634
Medicaid Capital (IME)	118,408	134,817	134,894	111,349	113,148
Medicaid (Fixed) (IME)	518,813	371,879	637,384	703,763	703,763
Disproportionate Share (Residency portion)	180,318	53,719	44,264	64,269	64,269
Rebate from FWMFP	1,000,000		1,400,000	548,921	2,242,448
Subtotal - CME & related revenue to consortium members	\$ 5,000,523	\$ 4,307,810	\$ 6,557,066	\$ 5,991,067	\$ 7,295,633
Hospital revenue, attributable to FWMFP:					
Net revenue attributable to FWMFP (11.75 FTE) @ \$7,267,597 per FTE (source: HealthWeek article dated 5-08-13)	\$ 21,261,139	\$ 23,261,179	\$ 21,266,119	\$ 25,285,379	\$ 23,266,119
Subtotal - Hospital revenue attributable to FWMFP	\$ 21,261,139	\$ 23,261,179	\$ 21,266,119	\$ 25,285,379	\$ 23,266,119
Overriding cost and depreciation @ 83.2% for 2011; 75.2% for 2012; 75.8 % for 2013. Source = BIP, Hospital Fiscal Report	\$ 17,300,940	\$ 18,410,042	\$ 17,693,049	\$ 17,699,849	\$ 17,639,949
Subtotal - Qualified contribution to hospitals, net/offsets to FWMFP	\$ 4,961,191	\$ 6,844,087	\$ 6,625,179	\$ 5,993,379	\$ 5,015,179
Revenue to FWMFP:					
Net indirect financial activities	\$ 1,812,196	\$ 1,896,791	\$ 1,800,456	\$ 1,812,582	\$ 2,008,052
Regional Associates Support	490,291	212,501	288,448	411,159	469,601
County - State of Indiana	190,000	225,000	175,000	192,000	175,000
County - State of Indiana	220,134	205,779	195,009	373,141	330,796
Grant - Indiana University	39,739	35,412	54,600	41,400	36,930
Allen County Clinic - net	104,408	138,871	109,977	18,144	-
Educational fees (SAB) & contributions	7,460	8,493	4,100	5,440	4,400
Subtotal - Revenue to FWMFP	\$ 2,590,727	\$ 2,595,857	\$ 2,713,200	\$ 2,897,870	\$ 2,994,547
Total - Net revenue attributable to FWMFP	\$ 11,842,438	\$ 11,755,232	\$ 10,844,497	\$ 13,674,610	\$ 15,988,438
FWMFP Budgeted Operating Expenses	\$ 10,332,498	\$ 10,349,854	\$ 11,051,240	\$ 11,884,610	\$ 11,746,958
Excess of Revenue over Expenses (Total)	\$ 1,509,940	\$ 1,405,378	\$ 2,094,257	\$ 890,000	\$ 2,003,270
Excess of Revenue over Expenses (Per Resident)	\$ 43,801	\$ 48,583	\$ 64,475	\$ 23,853	\$ 54,409

Note on 2014 & 2015 projections: 2014 CMS DME/IME dollars are carried over to 2015 pending hospitals' CMS cost report filing. The 2013 Medicaid IME and modified contribution dollars are carried over to 2014 & 2015 pending hospitals' fiscal report filing.

FWMEP Resident Training Cost

- 8.97% less training costs compared to average residency
- Positive contribution (not a loss for the hospital)
 - 2011: \$43,001/resident/yr
 - 2012: \$48,185
 - 2013: \$96,475 (Thank you ACA and MU!)
 - 2014: \$33,003 - *projected (decreased secondary to full PCMH implementation cost)*
 - 2015: \$94,409 – *projected (we decreased cash on hand on Balance Sheet – rebate back to hospitals)*
 - Comparative: (-)\$27,260 (loss) Range: (+)\$167k to (-)\$411k in 2010 (Lesko 2011)

Revenue

- CMS Direct and Indirect (DME and IME) - In 2014: \$165,048/CMS slot
- Medicare Capital IME – adds 3-5%
- Medicaid DME and/or IME
- State Grants
- Other Grants (HRSA, community foundation, etc.)
- FMC and Inpatient Professional Fees
- Educational Fees for teaching medical students
- DSH (Disproportionate Share Hospital)
- Merritt Hawkins hospital net revenue per FTE family physician
- Contribution Margin (modified) to Hospital
- Incentives: ACA and Meaningful Use
- Regional Associate Hospitals contributions
- VA Funding

State Grants: Indiana GME Task Force

- 2016 – 500 new funded slots for new residency programs or expansion of existing residencies. Focus on primary care
- \$45k/resident/yr. Minimum of 8 years of funding with understanding needs to be perpetual
- Joint effort of Indiana's two medical schools, Indiana State Medical, and Indiana Hospital Association.
- Legislation passed in 2015: House: Yes 95 No 1 Senate: Yes 48 No 0

CMS DME & IME Information

- Contact Hospital finance department
- Graham Center: Now updated to 2013!!: <http://www.graham-center.org/online/graham/home/tools-resources/data-tables.html>
- Or: <http://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports/Hospital-2010-form.html>
 - Line # 31 on cost report (Form – CMS-2552-10) on worksheet E-4 for DGME
 - Line # 29 on cost report (Form – CMS-2552-10) on worksheet E, Part A for IME
 - Line # 6 on cost report (Form – CMS-2552-10) on worksheet L, Parts I-III for Capital IME
- Or: <https://www.cms.gov/center/freedom-of-information-act/regional-contacts.html>
- Try State Department of Health (Hospitals in Indiana required to report annually)

Medicaid Go To for Info/Websites

- 40 states and Washington DC pay Medicaid DGME and/or IME
 - *To determine if your state pays Medicaid GME: Refer to AAMC Henderson article referenced below*
- Average payment - **\$35k/resident/yr in 2009** **Wynn BO**, Smalley R, Cordasco KM; *Does It Cost More to Train Residents or to Replace Them? A Look at the Costs and Benefits of Operating Graduate Medical Education Programs*; RAND Corporation, 2013; Pages 41, 65, 66
 - *Henderson, T. M., Medicaid Direct and Indirect Graduate Medical Education Payments: A 50-State Survey, AAMC, 2010*
 - *Brotherton, S.E., and Etzel, S.I., Graduate Medical Education, 2008-2009, JAMA, Vol. 306, No. 9, 2009, pp. 1015-1030.*
- Ask for amount from hospital finance department

Medicaid Dollars per Resident

- If a “no go”, then access the two below articles which are updated each year:
 - *Google search: AAMC Medicaid GME payments Henderson (most recent 2013)*
 - *Provides amount of Medicaid dollars paid for GME per state*
 - *Google search: Brotherton, S.E., and Etzel, S.I., Graduate Medical Education, JAMA (Most recent 2014)*
 - *Provides total number of residents in each state*
 - *Calculation: Take Total Medicaid GME dollars in your state / Total number of residents in your state = Medicaid dollars per resident*
- 2016 update by FWMEP: Average Medicaid payment in US per resident = **\$33k in 2012 dollars**

DSH

- Disproportionate Share Hospital
- Based on Medicaid and uninsured inpatient and outpatient hospital uncompensated costs
- Particularly relevant if some years hospital receives DSH and some years it doesn't - much more likely than that FMR contributes to securing DSH dollars

Merritt Hawkins 2013 Inpatient/Outpatient Revenue Survey

- Purpose: Stats to be used for quantitative analysis for hospital recruiting programs, as defined by IRS, to establish the financial benefits which newly recruited physicians bring to the hospital to help support the hospital mission.
- Combined net direct inpatient and outpatient revenue/FTE physician (hospital employed or independent practice).
- Direct revenue only (indirect revenue from specialty referral is not included). Direct revenue includes admissions to hospital, labs, diagnostics, therapies, and procedures.

Merritt Hawkins 2013 Inpatient/Outpatient Revenue Survey

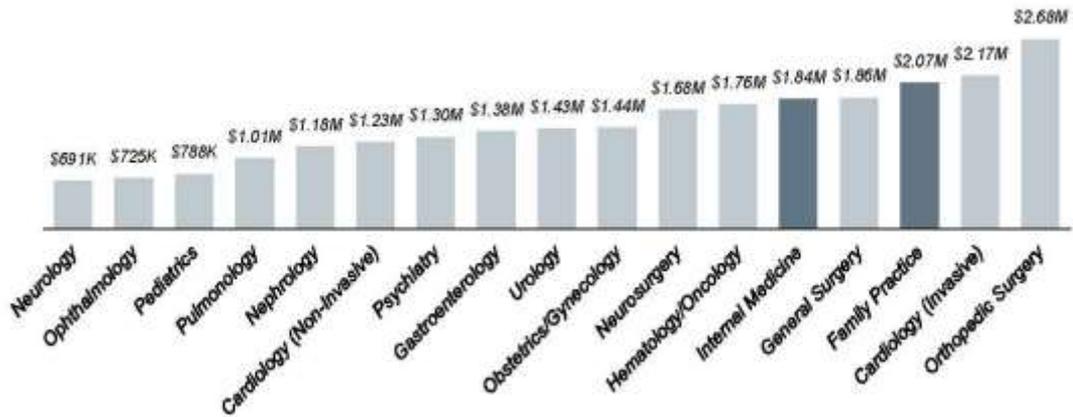
- Hospital CFO survey
- Study being quoted/used by: Advisory Board, Modern Healthcare, Becker's Healthcare/Hospital Review, Medical Economics, and AAFP.
- Blogs and peer review since published have not refuted these numbers.

Merritt Hawkins 2013 Inpatient/Outpatient Revenue Survey

- **Family Medicine:**
 - 2002: \$1,559,482
 - 2004: \$2,000,329
 - 2007: \$1,615,828
 - 2010: \$1,662,832
 - **2013: \$2,067,567**

Physician-Driven Hospital Revenue, by Specialty

Includes admissions, procedures, and tests conducted in hospital inpatient and outpatient facilities
(Reproduced with permission from Merritt Hawkins)



Merritt Hawkins 2013 Inpatient/Outpatient Revenue Survey

(Reproduced with permission from Merritt Hawkins)



#FTE Residents & Faculty

- Total FTE count – 11.25
 - FMC – 8.25 FTE (almost exact proportion as Lesko study for a 10/10/10 residency)
 - OB service – 1.0 FTE – 325 deliveries for local FQHC and private FMC patients (plus small FM inpatient service 3-4 patient census)
 - Inpatient FM service – 2.0 FTE (ultraconservative) Represents one hospitalist pod run solely by FMR

Modified Contribution

- The dollars attributed to the hospital from the residency.
- Since one cannot accurately identify all hospital variable costs to determine contribution margin (let alone the national controversy and lack of standardization in categorizing fixed vs. variable costs in hospitals), we have instead modified and are using margin (profit) plus depreciation.
- This represents the residency contributing revenue to offset non-controversial fixed expenses, which the hospital would have incurred, even if residency did not exist. This represents a very conservative approach.

Modified Contribution

- Contribution towards Fixed Costs and Profit
 - Sponsoring Hospitals' blended rate in 2013 - **\$187,339/resident** - *conservative estimate*.
 - Does not include an estimate for contribution margin for hospitals' fixed expenses of general administrative support, personnel management/human resources, security, housekeeping, marketing, legal, IT, finance, compliance, risk management, negotiations, strategic development, physical plant utilities, phone, maintenance, etc., which would still be incurred if resident services were not in the hospital.

Modified Contribution

- Form IRS 990 for non-profit hospitals – Can get to through www.guidestar.org....free sign up and use.
- For-profit hospitals – In Indiana, all including for-profit hospitals are required to submit their annual fiscal report to the State Department of Health.
- Calculation:
 - Step 1:
 - $$[\text{Net Revenue} - (\text{Operating Expenses} - \text{Depreciation})] \div \text{Net Revenue}$$
 - Net Revenue (called Total Revenue on Form 990) located Part VIII, line 12
 - Operating Expenses (called Total Functional Expenses on Form 990) located Part IX, line 25.

Modified Contribution Continued

- Step 2:
#FTE residents and faculty x \$2.07M (from Merritt Hawkins) = Net Revenue to hospital attributed by the residency
- Step 3:
[Step 1 answer] x [Step 2 answer] = Modified Contribution dollars to hospital

Older Studies – Leverage Principle

- Four studies identified from 1989 – 2001 demonstrated a **leverage/multiplier** of family medicine center revenue to sponsoring health system revenue. (1989 - 6.4x; 2001 - 6.0x; 1991 - 5.9x; 1995 - 10.3x) There have not been any recent updated studies, so the multiplier effect may be significantly higher, secondary to the new diagnostics and procedures presently utilized which were not available during the timeframe of these studies.
- Do not recommend using as old data and significantly less revenue than provided by 2013 Merritt Hawkins study.

Resident Retention Rate

- National consulting firm secured by FWMEP to optimize CMS GME revenue, September 2014 - Normal resident retention rate is 29-31% in market share area.
- AAMC study, 2009, from AMA Masterfile: 56% family medicine within 100 miles of residency, 19% within 5 miles, 39% within market share area.
- IU School of Medicine and Marian University have provided references to IHA/ISMA Residency Expansion Task Force for 39%/41%/45% retention rate within 100 miles of residency training or retained within state of Indiana post-residency graduation.

Cost per Retained Resident

- FWMEP retains twice as many residents in the market share area as national stats
- **Cuts cost of retained physicians by 50%.**

Recruitment Cost Avoidance

Family Medicine is the number one recruited specialty in nation 9 years running - Merritt Hawkins 2015

The previous slides of revenue & expense spreadsheet and expense graph do not include **Recruitment Cost Avoidance**

- \$6,300 - \$18,467/res/yr. for FWMEP FMR
- Calculation: (avg. cost of recruitment/physician) x (# of residents retained/yr) ÷ Total # residents in residency

Recruitment Cost Avoidance

- Cejka/American Medical Group Association (AMGA) – 62 medical groups responded representing 17,624 physicians.
- Journal of ASPR (Association of Staff Physician Recruiters) 2012

Recruitment Expense Avoidance

Source: Cejka Search; Reproduction of material from www.cejkasearch.com without written permission is strictly prohibited.

AVERAGE INTERVIEW COSTS PER VACANCY	
Agency recruiting fees	\$0 - \$30,000
Sourcing/Advertising	\$0 - \$10,000
Interview: Travel cost ¹	\$0 - \$2,205
Interview: Entertainment ¹	\$0 - \$911
Signing bonus	\$0 - \$30,000
Moving cost	\$0 - \$15,000
Total	Up to \$88,116
1. AVERAGE INTERVIEW COST PER VACANCY. SOURCE: 2011 CEJKA SEARCH AND AMGA PHYSICIAN RETENTION SURVEY	

Recruitment Expense Avoidance

Source: Cejka Search; Reproduction of material from www.cejkasearch.com without written permission is strictly prohibited.

AVERAGE INTERVIEW COSTS PER VACANCY	
Avg. Candidates Interviewed x Avg. Visits per Candidate (3.1 x 1.7)	
Avg. # of Interviews Per Vacancy	5.3
Avg. Travel/Lodging + Avg. Entertainment (\$2,205 + \$911)	\$3,116
Avg. FTEs Involved x Avg. Projected Avg. Hourly Rate x 2 hours (5.5 x \$250 x 2)	\$2,750
Avg. Cost Per Interview	\$5, 866
Avg. Interview Cost Per Vacancy (5.3 X \$5,866)	\$31,090

Recruitment Cost Avoidance

- HealthLeaders, March 2012: \$50,000 - \$75,000
- Tripp Umbach, May 2014, IUSOM/Marian/IHA/ISMA Residency expansion Task Force - \$75K
- New England Journal of Medicine Career Center, Jan 2015 – references 2010 Cejka physician retention study of \$30K of interview costs – does not include agency recruitment fees.
- FWMEP Sponsoring Hospitals' blended rate - \$32,995

Recruitment Cost Avoidance

Retained resident graduates - already facile in the knowledge and pragmatic use of local and regional health care resources.

Productivity

- All 452 FM residency programs report productivity stats to webADS annually.
- Based on five survey results from 2000 to 2010, **resident productivity decreased over the 10-year interval, with resident total yearly patient visits down 17.2%**. (Fam Med 2012;44(2):83-9.)
- Electronic health records (EHRs), resident duty hour restrictions, and Patient Centered Medical Home (PCMH) innovations have all impacted the clinical practices of residency programs over the past decade

Productivity of Residents in FMC

FMC PGY1

	National	FWMEP
2012	239	276
2013	239	274
2014	238	272

FMC PGY3 Graduates

	National	FWMEP
2012	1803	1891
2013	1784	1773
2014	1766	1768

Graduates 1.4% over average residency

Productivity of Residents: Inpatient

Inpatient PGY1

	National	FWMEP	FWMEP + St Joe Service
2012	6.02	5.77	6.77
2013	6.05	6.11	7.11
2014	5.97	6.20	7.20

Inpatient PGY2

	National	FWMEP	FWMEP + St Joe Service
2012	7.16	7.29	8.29
2013	7.20	6.61	7.61
2014	7.17	8.10	9.10

Inpatient PGY3

	National	FWMEP	FWMEP + St Joe Service
2012	7.95	7.53	8.53
2013	8.48	7.79	8.79
2014	8.31	8.20	9.20

Combined PGY years: 13.4% over average residency

Productivity of Residents: OB

OB Graduates

	National	FWMEP
2012	68.2	86.5
2013	66.6	108.7
2014	66.2	107.6

62.8% over average residency

Community Benefit from Residents

- Residents provide **\$200K/year of economic benefit** to their community.
- Retained graduates provide **\$1.5M/yr** of economic impact, including 6 additional jobs, to the community served by the hospital

- Tripp Umbach, May 2014, IUSOM/Marian/IHA/ISMA for Indiana Residency Expansion Task Force.

“Hospital CEO/CFO Think”

- In thinking about revenue/expense, CEOs to consider what their subsidy is for each of their primary care physicians who are hospital employed.
- Average loss per primary care physician employed by hospital = **\$70K** (Physician Executive Journal, 2010)
- Kentucky Hospital Association study 2014/Medical Economics Jan, 2015 – 58% of hospitals losing more than **\$100K** per employed physician. Loss on employed specialists higher than family medicine.

“Hospital CEO/CFO Think”

- Average employed physician - **\$178k/yr** (2013) loss which is up from \$58k in 2004 (HFMA 12/8/2014 based on MGMA data)
- Hospitalist covering census of 15 patients – loss of **\$125k/yr** – IHA Annual Meeting Nov 2015
- Average FM - **\$115k – \$127k/yr** loss and average hospitalist - \$253k loss MGMA 2012

Decrease Expense or Increase Revenue

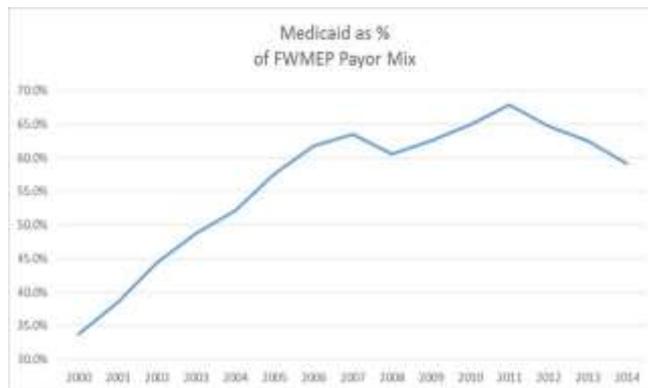
- Alter payor mix (Mission may alter....perhaps)
- Increase # FMC/FMP visits
- Enhance CMS GME Revenue

Mission Costs

RPS 2012 FWMEP consult – “Financially the program is doing well but its FMC financial performance reflects the high volume of uninsured patient care provided, as well as the care of complex ethnic group, i.e., Burmese, that require customization of their care processes.”

Consider two social workers in the FMC regarding complex, difficult to treat patients.

Mission: Service Medicaid Patients Hospital Subsidy of \$360,388



Medicaid Percentage

Source: *Ten-Year Trends in the Financing of Family Medicine Training Programs; Considerations for Planning and Policy; Fam Med 2011;43(8):543-50.*

	2000	2003	2006	2008	2010
% Medicare FFS (mean, range)	16.8% (9%–30.8%)	16.9% (6%–38%)	18.6% (5%–36%)	18.7% (4%–40.8%)	16.2% (3.2%–32.4%)
% Medicaid FFS (mean, range)	24.5% (14%–50%)	28% (5%–47%)	27.6% (3%–46%)	25.8% (7%–54%)	22.5% (3%–45.5%)
% self-pay or uninsured (mean, range)	8% (3%–17%)	7% (3%–24%)	11% (2%–63%)	11% (1%–59%)	12% (1%–51%)
% commercial FFS (mean, range)	30% (14.9%–55%)	28.2% (12.6%–58%)	30% (11%–64%)	29% (14%–63%)	26.2% (10%–52%)

Payor Mix

FWMEP's payor mix includes 64% Medicaid, 16% Medicare, 9% Self-pay, 10% various commercial insurers

\$360,388/yr mission subsidy to serve this vulnerable population (normalizing payor mix)

- Calculate by determining the difference of payment from Medicaid compared to Medicare and blended commercial insurance, and then normalizing to payor mix percentages in your local community or from published data such as the above referenced article.

Increase Revenue by Increasing Resident Visits in the FMC

FORT WAYNE MEDICAL EDUCATION PROGRAM			
FMC Visits - potential revenue effect			
Average visits (June 2014 graduates)	1,768		
2014 Clinic revenue (net)	\$1,247,429		
	Increased	Percentage	Revenue
<i>Potential volume increases:</i>	Visits	Increase	Increase (net)
1. From 1,768 to 1,950 visits	182	10.3%	\$ 128,412
2. From 1,768 to 2,200 visits	432	24.4%	\$ 304,802

Additional Service Mission and Intangible Benefits

Ask, "What would you do without these services if residency not here?"

- HIV clinic
- Dermatology clinic
- Sickle cell clinic
- Rescue Mission – healthcare for homeless shelter
- Burmese and refugees
- IMPACT – concussion evaluation of local school athletes
- FQHC OB service
- Community Research Consortium
- Interprofessional Education Consortium

Optimized CMS GME Reimbursement

- Consultant estimates **\$246k** of revenue increase if consortium changes the way it **shares CMS GME funded slots**
 - Assign FMC longitudinal rotation to the hospital with the highest CMS GME reimbursement.
 - An additional **\$245k** may be garnered if hospitals improved cost report by optimizing funded 422 (redistribution) slot positions

Intangible Benefits

- Number of graduates practicing in underserved areas of the hospital's market share communities
 - Each physician in underserved area saves community ~\$3.6M/yr in unnecessary hospitalizations due to better care coordination – Tripp Umbach 2014
- Graduate referrals (both in city and outlying communities) to residency inpatient medicine team
- Resident-Hospitalist teams are economically more efficient than Hospitalist-Midlevel provider team
 - Iannuzzi, M., et. Al.; *Comparing Hospitalist-Resident to Hospitalist-Midlevel Practitioner Team Performance on Length of Stay and Direct Patient Cost*; JGME, March 2015; pp. 65-69

Intangible Benefits

- Unattached/marginalized patient admissions and OB deliveries at hospital
- Code Blue, Rapid Response, and precipitous OB delivery coverage
- Market differentiation – “We are the education and research hospital in your community”
- GME community-based research impacting health outcomes
- Residents and retained graduates as change facilitators/champions – EMR/MU, MOC II and IV, PCMH, QI and Patient Safety in hospital

Intangible Benefits

- Quality of care improved in hospitals with residency programs (VBP)
- Stable FWMEP FMR inpatient medicine – one full hospitalist pod (census of 15 patients = national average). Lending stability secondary to turnover from the commoditization of hospitalists at one of our three sponsoring hospitals.
- FWMEP FMR provides 85% of OB deliveries at downtown hospital providing care for underserved/marginalized

Intangible Benefits

- Community service provided by residents and faculty
- Providing AMA and AAFP CME accreditation
- Hosting UME (Medical Students) – Beginning of the physician workforce pipeline

Future Ongoing Revenues

- **Net Revenue to hospital from graduate retention - \$2.1M annually**.....year over year....for as long as physician retained.
 - Merritt Hawkins 2013
- Retained physicians post-graduation provide:
 - **Economic benefit to their community** via purchasing of goods and services, payment of wages, benefits, and taxes:
 - **\$2.2M/year** per Levin Group 2011
 - **\$1.5M** per Tripp Umbach, May 2014, IUSOM/Marian/IHA/ISMA Residency expansion Task Force

CME and UME

- 1.6% additional costs
- CME value of \$366,706 vs. \$138,347 expenses (2.6x)
- 370 physicians obtain $\frac{1}{3}$ - $\frac{1}{2}$ of their CME locally
 - 12.8 hours/yr
- 565 non-physician learners (team learning)
- Supports accreditation of service lines – trauma, tumor boards, cardiovascular

CME and UME

- Avoidance of costs of transportation, hotel, meals, etc.
- Avoids loss of physician productivity secondary to time off to attend.
- AMA and/or AAFP credits for team-based training, leadership, EMR, committee learning work.
- Hospital C-Suite sees value attributed to residency. Increases local physician support.

UME and Visiting Residents

- UME (Medical Students)
- 33 Universities
- Beginning of physician workforce pipeline
- \$1,692/med student/month rotation. Includes apartment/administrative personnel, credentialing
- Visiting Residents – various specialties
- Interprofessional education & research

Primary Cost Drivers

- Own one's FMC vs. FQHC
 - FMC runs efficiently with good business practices (overhead, revenue cycle management, volume)
- Payor mix/Service mission
- Optimization of CMS GME funding (slots funded well and not over cap)
- Program size (6/6/6 or more....sweet spot)
- Faculty compensation levels (community-based higher)
- Malpractice insurance

Primary Cost Drivers

Primary care residency programs are disadvantaged relative to other specialties because of lower physician revenues and a higher proportion of training in ambulatory clinics. (RAND 2013)

During the break...

- Discuss / think about how you might implement the information you just heard.
- Fill out a session evaluation.



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