Knowledge is Power:
Understanding Your True Residency Program Financial Picture

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Educational Objectives

- Recognize the value of financial knowledge
- Define revenue, expenses, and margin
- List common sources of residency program revenue and expenses
- Understand the ramifications of positive and negative financial margins

Why Does This Matter?

Knowledge is Power

- Everyone has perceptions of your program's financial contribution (or lack thereof) to your institution
- Different people see different parts of the picture and therefore have differing perceptions
- If you truly understand the entire picture you will be best positioned to both make good decisions and manage impressions

Speaking the Language Helps

- Administrators don't expect doctors to understand finance
- If you speak their language you can open doors
- You create the opportunity to be part of decisions that affect you
- You may have best understanding, especially in single program institutions

It's a Valuable Tool

- Organizations respond best to business plans
- If you can build a solid financial argument for something you want you have the best chance of getting it
- In education return on investment can take time- you need to be able to advocate for a long-term view of success

Key Concepts

Your Residency Program

- Should be the unit of study
- Should include only those people and activities core to the program
  - Administration and education
  - Faculty time attributed to your program
  - Residents
  - Clinical activities of faculty, residents and other staff
- Recognize that each program will be different

Revenue

- Income generated by or intended to support the residency program
  - Medicare DGME and IME
  - Medicaid DGME and IME
  - THC HRSA support
  - Professional Fees
  - Grants and contracts
  - State support

Expenses

- Costs associated with doing business as a residency program
  - Administrative and educational costs
  - Salaries and benefits
  - Clinic operational expenses
  - Malpractice insurance
  - Miscellaneous

Margin

- Revenue minus expenses
- May be positive or negative
- Outcome is heavily influenced by what is (or isn't) included in revenue and expenses
- There will be differing perceptions of margin within your institution- you need to know the "truth"

Revenue

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Medicare DGME

- Medicare pays teaching hospitals for Medicare's share of the direct cost of the residency operations
  - Resident salaries, faculty teaching, administration, etc.
- Per Resident Amount (PRA) calculated based on 1984 base year adjusted for inflation

How DGME is Calculated

1. PRA set base year (1984 unless newer)
2. Inflation adjustment annually
3. PRA multiplied by program resident cap (1996), discounted 50% for residents beyond primary period of training
4. Medicare share of total DGME calculated based on proportion of total inpatient days

Medicare IME

- Theoretically, IME payments cover teaching hospital's "excess costs" of care due to residents' inefficiency (more tests, longer LOS, sicker patients)
- In reality, IME makes up for lack of education funding by other payers
- IME supports the expensive indigent care system in many localities (NY, LA)

How IME is Calculated

- Percent added to each DRG payment from Medicare. Hospitals with more residents per bed get a higher percent added to their DRGs (0- 40%)
- Includes DRGs for both traditional Medicare and Medicare Advantage patients
- IME typically double DGME

Medicaid DGME and IME

- Provided by a (shrinking) number of states
- Mechanisms and amounts vary
- Medicaid expansion has resulted in growing payments to some programs

Professional Fees

- Your largest source of clinical revenue
- Gross vs. net revenue
  - Gross = charges
  - Net = $ collected (typically 60% of gross)
- Largest determinants:
  - Patient mix
  - Number and clinical activity of faculty
  - Number of residents

Grants

- May come from a variety of sources
- Activities being supported vary widely
- Are seldom general program support

Contracts

- Payments for delivery of services by program staff to other organizations
- Clinical examples
  - Nursing home director
  - Student health services
- Non-clinical examples
  - Research consultation
  - Medical school teaching

State Funding

- Direct state support of GME
- Common in some states (TX, CA, WA)
- Non-existent in others
- May be direct to programs or indirect

HMO and Population Health Payments

- Currently growing and can be sizable
- Per-member-per-month contracted payments
- Shared savings rewards
- Meaningful Use payments

The Reality of Revenue Credit

- Just because your program generates revenue doesn't mean it will all appear on your balance sheet
  - Some or all of IME may be kept by institution
  - QI Department may claim population health payments to support infrastructure
  - Grant revenue or charitable gifts may go elsewhere

Expenses
Personnel

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Things to Consider

- People are probably 80% or more of your total expenses
- People and Full Time Equivalents (FTEs) are two different things
- Direct costs
  - Salary
  - Benefits (20-50% of salary)
- Academic vs. clinical time allocation

Faculty

- Director
- Associate/Assistant Directors
- Full-time faculty
- Part-time faculty
- Community preceptors
  - How many FTE's does the pool add up to?

Residents

- Salary
  - On your website
- Benefits
  - May be different from other employees

Residency Administrative Staff

- Administrator/Manager/Coordinator
- Other professional staff
  - Evaluation
  - Finance
  - Recruitment
- Administrative Assistants

Practice Staff

- Manager
- Physician Assistants and Nurse Practitioners
- RNs and LPNs
- Patient care technicians and Medical Assistants
- Front desk staff
- Billing staff
- Social workers, care coordinators, pharmacists, etc.
- Dedicated IT support

Contracted Services

- On call coverage (eg. OB)
- Specialist teachers (eg. Geriatrician)
- External billing service
- IT support

Expenses

Non-Salary

Malpractice Insurance

- Payments to insurance company
- Hospital self-insured trusts

Practice Expenses

- Lease payments
- Utilities, maintenance, cleaning and service contracts
- EHR licenses
- Drugs
- Lab supplies
- Translation services
- Miscellaneous

Residency Administrative Expenses

- Recruitment and advertising
- Travel and faculty CME
- Tuition, fees, subscriptions and licenses
- Educational expenses
- Consulting
- Miscellaneous

Capital Equipment

- Typically items costing more than $1,000-5,000 expected to last more than 1 year
  - Furniture, carpets, painting
  - Computers, servers, projectors and routers
  - US machines, surgical equipment, colposcopes, sigmoidoscopes
- Typically administered in separate budget
- May also be special project funds

Support of Other Entities

- Hospital Director of Medical Education (DME)
- Graduate Medical Education Office (DIO)
- Department of Family Medicine
  - Clinical Chair
  - Administrative support
- Dean's Taxes

Margin

Margin- The Bottom Line

- You need to know the real number
- Others will have their own, often varying, perspectives
- Playing to perceptions or dispelling myths may open doors

Positive or Negative?

- If you are positive
  - Who knows?
  - What's the trajectory? Is it sustainable?
  - Where is your margin going?
- If you are negative
  - Who knows?
  - Is it transient or expected to continue?
  - Who is making up your deficit?

Thinking Beyond Margin

- Downstream revenue to sponsoring institution
  - Hospital admissions, surgery, lab, and radiology
  - May exceed $10,000,000 annually
- Non-monetary contributions
  - Institutional leadership
  - Cost savings (important in ACOs)
  - Primary care workforce
  - Community benefit

Take Home Messages

Take Home Messages

- Knowledge is power, and can open doors
- Revenue – Expenses = Margin
- Everyone at your institution will have a different perception of your margin
- You must understand the entire picture- no-one else likely does!

During the break…

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


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