

RESIDENT COMPLEMENT INCREASES – WHY IS IT SO HARD IF THERE IS A WORK FORCE SHORTAGE?

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DISCLOSURES

- No relevant disclosures
- I am not an expert on CMS regulations



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OUTLINE

- Define current/projected workforce shortage issue
- Historical perspective of residency spots
- Options for funding
- Rural Track Program

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2022 AUA CENSUS

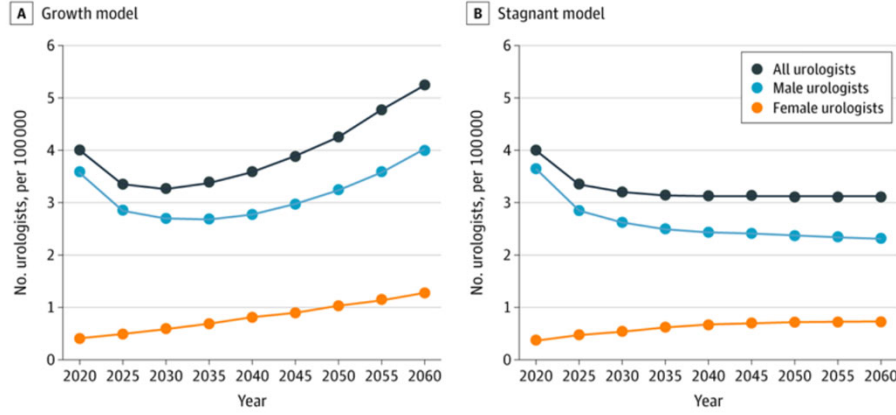
Median age is 54

28.5% aged 65 or older

Planned retirement age 68 (men) and 65 (women)

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Figure 1. Projected Number of Urologists per Capita From 2020 to 2060



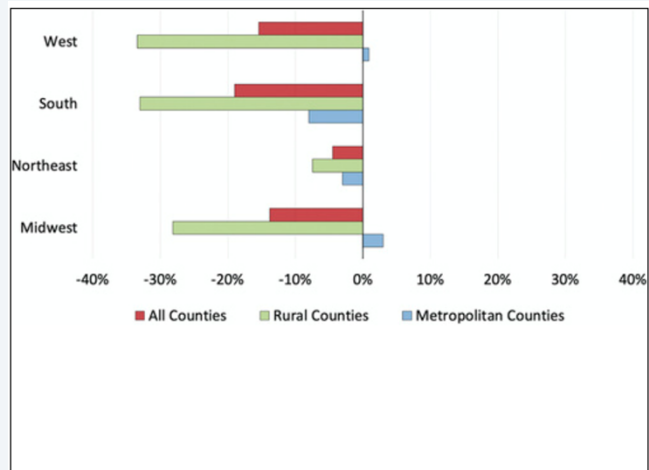
Using 2019 AUA
Census data and
2017 US Census
Bureau
projections

Nam et al. 2021JAMA Network

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RURAL AREAS AFFECTED MOST

- From 2000 – 2018:
 - Metropolitan counties had 4.5% decrease in urologists
 - Rural counties had 24.5% decrease



Pittman et al. 2022 Urology Practice

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UROLOGY WORKFORCE SHORTAGE



→ Access to care



→ Delay in treatment



→ Increased demands on practicing urologist

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AAMC

- In 2006, in response to growing concerns of a likely future physician shortage, the AAMC recommended a 30 percent increase in U.S. medical school enrollment by 2015
 - Increasing capacity of current medical school classes
 - Opening new schools

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U.S. Medical School Matriculants, 2013-2023

Year	Total	Percent Change from Prior Year
2013	20,055	+2.8%
2014	20,343	+1.4%
2015	20,631	+1.4%
2016	21,030	+1.9%
2017	21,338	+1.5%
2018	21,622	+1.3%
2019	21,869	+1.1%
2020	22,239	+1.7%
2021	22,666	+1.9%
2022	22,710	+0.2%
2023	22,981	+1.2%

**MEDICAL
STUDENT
PIPELINE**

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PIPELINE ISSUE?

Need more physicians/urologists

Successful increase in medical student enrollment

0.85 residency positions/applicant.
(~2,500 unmatched applicants/year)

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UROLOGY RESIDENCY SPOTS

	Feb 2023	Feb 2022	Feb 2021	Jan 2020	Jan 2019
Programs					
Positions Offered	386	365	357	354	339
Not Matched	125	191	124	88	59

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INCREASING RESIDENCY SPOTS

- 1 Increasing complement of current programs
- 2 Starting new program

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INCREASING COMPLEMENT

- Temporary versus Permanent
- Options: Increase every year, Back fill PGY2, increase every other year
- Approval of DIO then submit to Review Committee through ADS
- Must have a status of Continued Accreditation (with or without warning)

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NEED TO CONSIDER...

Assess potential impact to current cohort and on Program as whole

Adding clinical sites

Favorable ACMGE survey from residents and faculty?

Board pass rate?

Citations?

Any duty hour concerns?

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HOW TO BE SUCCESSFUL WITH RC

- Compliance with ACGME Resident survey
- Resources: Adequate core faculty, facilities, patients
- Stable administrative and program leadership structure
- Education rationale
 - “desire and ability to educate increased number of residents”

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RC NARRATIVE

- Case numbers
 - Uncovered cases
 - Additional site case #s
 - Faculty growth
- **Should not be using complement increase to “correct” problems**
 - Need to correct existing issues prior to applying
 - Appropriate to address prior concerns and fixed in narrative though

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DIO APPROVAL

- \$\$\$
 - Stipends
 - Other costs associated with education residents
 - Malpractice
 - GME
 - Accreditation fees
 - Benefits

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FUNDING SOURCES



Medicare/CMS



Hospital/Health system makes up remaining



Private funding? Pharmaceutical/Device Manufacturers

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MEDICARE RESIDENCY FUNDING

- In 1965, Congress established federal funding for graduate medical education costs
- Balanced Budget Act of 1997, Congress established a 100,000 cap on number of residents funded
- Balanced Budget Refinement Act of 1999 increased rural hospital caps to 130% of the 1997 cap
- Affordable Care Act (2010) introduced a section that allows for additional CMS funding to create more permanent residency slots due to hospital closures

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MEDICARE RESIDENCY FUNDING (CONT.)

- The Consolidated Appropriations Act 2021
 - (Section 126) allowed some hospitals to adjust their FTE caps
 - Increase of 1,000 spots over 5 years
 - Preference to hospitals/specialties (primary care, psychiatry) in geographic areas in greatest need as determined by Health Professional Shortage Areas
 - Rural Training Program (RTP) (Section 127)- developed to increase access to and availability of healthcare in medically underserved areas and populations

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DGME: Direct graduated medical education payments

- Resident stipends, supervisory physician salaries, admin costs
- Medicare formula- part of % of Medicare patients being cared for

IME: Indirect medical education (not for resident training costs)

- Intended to cover the cost of “inefficient care” eg. more tests, more complex patients

\$16.2 billion in FY2020 (Approximately 1.7% of Medicare budget)

**MEDICARE
RESIDENCY
FUNDING**

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MEDICARE RESIDENCY FUNDING

Estimated in 2016 that 11,000 resident spots that were not covered due to cap limitations and 70% had more residents than Medicare funded spots

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FUNDING SOURCES



Medicare/CMS



Hospital/Health system



Private funding? Pharmaceutical/Device Manufacturers

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HEALTH SYSTEM PERSPECTIVE

- POSITIVES of increasing residency spots
 - Cheap labor, on call services
 - Pipeline to future local workforce
 - Increase faculty productivity and revenue

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HEALTH SYSTEM PERSPECTIVE

- NEGATIVES of increasing residency spots
 - Residents cannot “do” as much as they could in past
 - Work hour restrictions
 - Limited # of patients on service
 - Increased requirements for attending physician supervision of the residents
 - Cannot bill independently
 - Difficult to quantify profitability- “Proforma”

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Does It Cost More to Train Residents or to Replace Them?

A Look at the Costs and Benefits of Operating Graduate Medical Education Programs

2013 RAND Corporation

	General Internal Medicine	Cardiology	Family Medicine	Dermatology	General Surgery	Urology	Radiation Oncology
Direct GME Cost Impacts							
Resident compensation increases by postgraduate year of training. ¹	↑	↑	↑	↑	↑	↑	↑
Attending physician compensation							
Compensation levels vary across specialties. ²	↑	↑	↑	↑	↑	↑	↑
Attending physician time spent in administrative and teaching activities does not generate patient care revenues. ³	↑	↑	↑	↑	↑	↑	↑
RRC minimum requirements have economies of scale. ⁴	↑	↑	↑	↑	↑	↑	↑
Other direct costs							
Malpractice insurance varies across specialties. ⁵	↑	↑	↑	↑	↑	↑	↑
Single-program sponsors lack economies of scale. ⁶	↑	↑	↑	↑	↑	↑	↑
Multiple training sites require additional coordination. ⁷	↑	↑	↑	↑	↑	↑	↑
Outpatient hospital and other ambulatory training is less efficient than inpatient training. ⁸	↑	↑	↑	↑	↑	↑	↑
Nonhospital training sites require more coordination and oversight. ⁹	↑	↑	↑	↑	↑	↑	↑
Difficulty in filling slots increases recruitment and orientation costs for foreign medical school graduates. ¹⁰	↑	↑	↑	↑	↑	↑	↑
Indirect Financial Impacts							
Residents provide on-call services that benefit both the hospital and attending physicians. ¹¹	↓	↓	↓	↓	↓	↓	↓
Residents teach more junior residents and medical students. ¹²	↓	↓	↓	↓	↓	↓	↓
Some specialty programs have a larger cost impact on inpatient costs than others after controlling for hospital-level teaching effect. ¹³	↔	↔	↔	N/A	↑	↑	N/A
Resident training increases the cost of ambulatory care. ¹⁴	↑	↑	↑	↑	↑	↑	↑
Teaching affects attending physician productivity and revenues. ¹⁵	↑	↑	↑	↑	↓	↓	↓
Faculty practice plan collections and practice expenses differ. ¹⁶	↑	↓	↑	↓	↓	↓	↓
Resident research reduces time spent in patient care activities; pure research is not eligible for Medicare GME payments. ¹⁷	↑	↑	↑	↑	↑	↑	↑
Physicians in academic practices have lower compensation than physicians in academic practices. ¹⁸	↓	↓	↓	↓	↓	↓	↓

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TRAIN OR REPLACE?

- Urology had the highest profit per resident (compared to IM, cardiology, Fam Med, Derm, Gen Surg, Rad Onc)
- Conclusion: If the hospital has service needs, there is a marginal benefit to adding a resident, particularly in the more-lucrative specialty and subspecialty programs, before considering the additional benefits of any Medicare GME-related revenues.

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PRIVATE FUNDING

- Can affect residents' ability to qualify for Public Service Loan Forgiveness Program
- Ethical?
- AMA House of Delegates
- "Affirm that an institution or medical education training program academic mission should not be compromised by a clinical training site's fiduciary responsibilities to an external corporate or for-profit entity."
- "Support publicly funded independent research on the impact that private equity has on graduate medical education."

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CAA SECTION 126

- 1,000 additional resident FTE slots
- 200 phased in per year starting FY 2023
- Preference to primary care, psychiatry
 - Option to increase primary care cap to reduce health system funding burden for excess residents and transfer the health system funding line to sub-specialty?
- Hospital must qualify in 1 of 4 categories:
 - In rural area (or treated as such by under CMS laws)
 - Hospital training residents in excess of their CMS cap
 - Hospital in state with new medical school or branch campus
 - Hospital serving area designated as health professional shortage area

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RURAL TRACK PROGRAM (RTP) (SECTION 127)

- Train in both non-rural and rural setting
 - >50% in Rural
 - “Rural” defined within Prospective Payment System
 - Hospitals that are geographically urban may be able to re-classify to rural
- Programs could receive additional DGME and IME \$
- Track within an existing program (does not need separate accreditation) or a new program
- Not required to add sites if current program (but can)
- Not requirement to practice in certain area afterwards

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RURAL TRACK PROGRAM (RTP)

- Still need DIO and RC approval
- Also need to confirm with Medicare that “rules” are followed
 - And to understand amount of DGME and IME could qualify for

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AUA ADVOCACY

**Our Priority:
Address the Urologic
Workforce Shortage**

Active member of GME
Advocacy Coalition

Proposed Legislation:
- Specialty Physicians
Advancing Rural Care
Act
- Resident Physician
Shortage Reduction Act

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CONCLUSIONS

- No easy answer to urologic surgeon workforce shortage
- Funding remains the biggest barrier to increasing residency spots
 - Legislative limits on Medicare supported FTEs
 - Rural Track Program option
 - Health System supported funding
 - Average operating margin is <1%
- Get involved in advocacy- AUA, AAMC

