AAMC
Tomorrow's Doctors, Tomorrow's Cures®

Learn
Serve
Lead

The Changing Academic Medical Center: Ophthalmology Success/Strategic Planning

Janis M. Orlowski, MD, MACP
Chief Health Care Officer, AAMC

January 28, 2021

Association of American Medical Colleges

1

At the Heart of AMCs Are 4 Missions

They Function Together Like a 4-Chambered Heart

AAMC

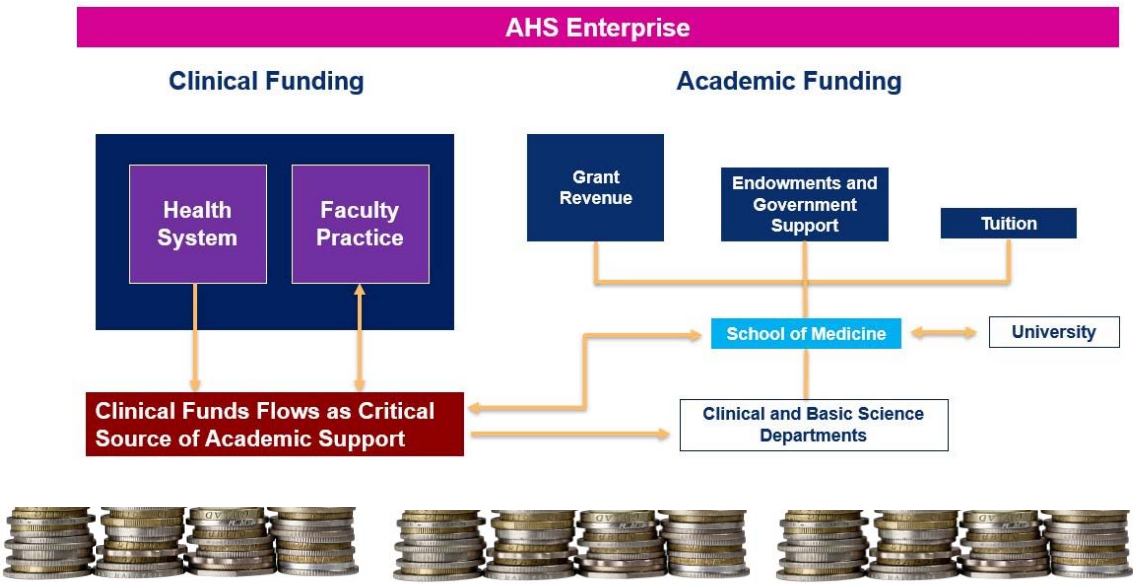
2

Funds Flow Overview

AAMC

3

Who earns the money? Who spends the money? How is it allocated among the three mission areas – education, research, and clinical – at an institution?



AAMC

4

Organizational Alignment

Strategic Plan **Clinical Enterprise**

Health System **FPP**

School of Medicine **Department**

Clinical Faculty

AAMC

5

Low Organization Alignment

- Ad hoc agreements with limited centralized structure
- No enterprise-wide incentive model between AHS and SOM
- Limited service line alignment model with health system
- Generally "historical" funding arrangements; may have standard agreements for some services
- Embedded cross-subsidization in compensated service agreements

AAMC

6

Medium Organization Alignment

- Formal funds flow oversight ("governance") process
- Explicit recognition of academic investment by health system and concomitant enterprise-wide incentive model
- Strong service line alignment model with health system
- Standardized agreements for compensated services

AAMC

7

High Organization Alignment (Enterprise Aligned)

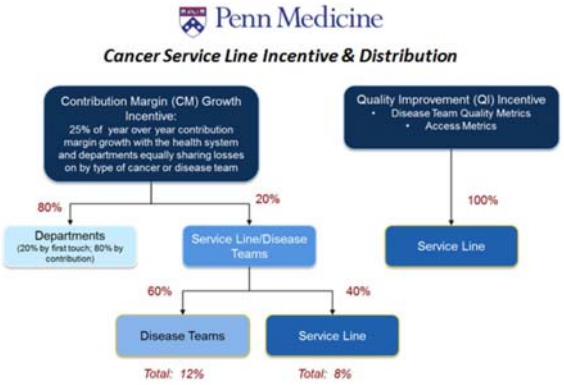
- Enterprise goals and metrics that are comprehensive for all missions (e.g. volume, financial, quality, engagement, impact)
- Alignment model for service lines between health system and FPP
- Omnibus and standardized agreement for compensated services

AAMC

8

Why Enterprise Alignment?

- Create value through the use of the AHS brand
- Implementation of clinical research and innovation networks
- Access to specialty programs
- Extension of educational programs to community sites

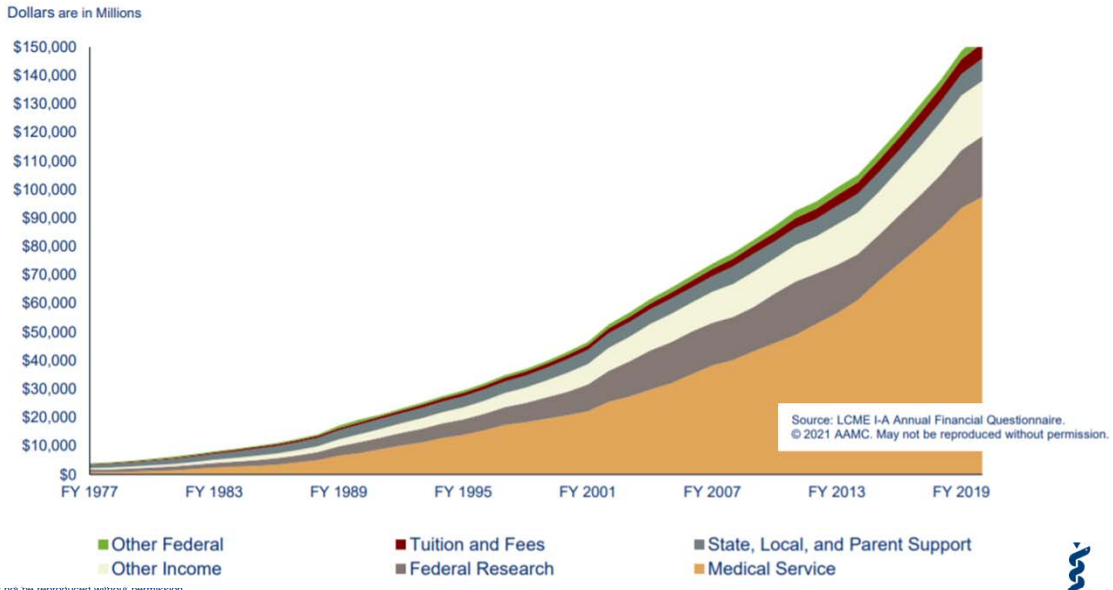


Ensuring the vitality of the academic missions through the ongoing investment of clinical margins in research and educational programs is fundamental to the long-term health of every AHS.

AAMC

9

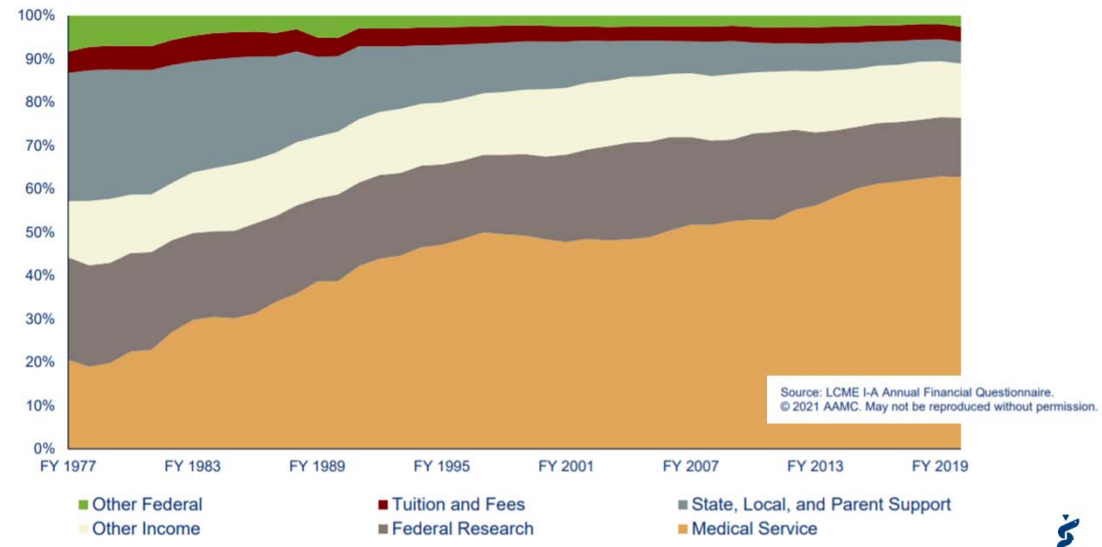
Figure 8: Revenue by Source for Medical Schools with Full Accreditation, FY 1977 through FY 2020



AAMC

10

Figure 9: Revenue by Source as a Percentage of Total Revenue for Medical Schools with Full Accreditation, FY 1977 through FY 2020

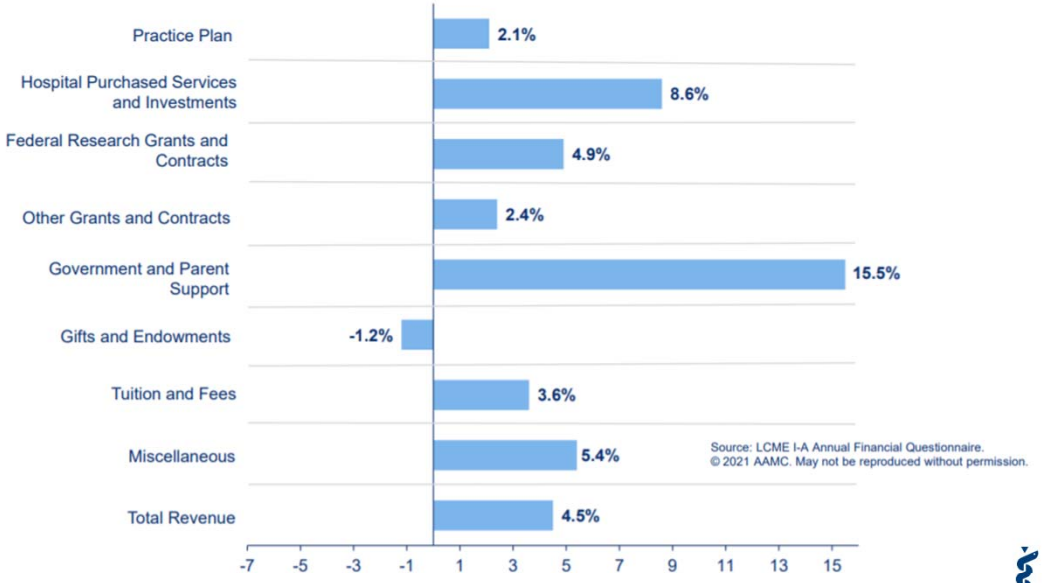


11

AAMC

11

Figure 3: Percent Change in Revenue by Source Fully Accredited Medical Schools, FY 2019 to FY 2020 in Current Dollars

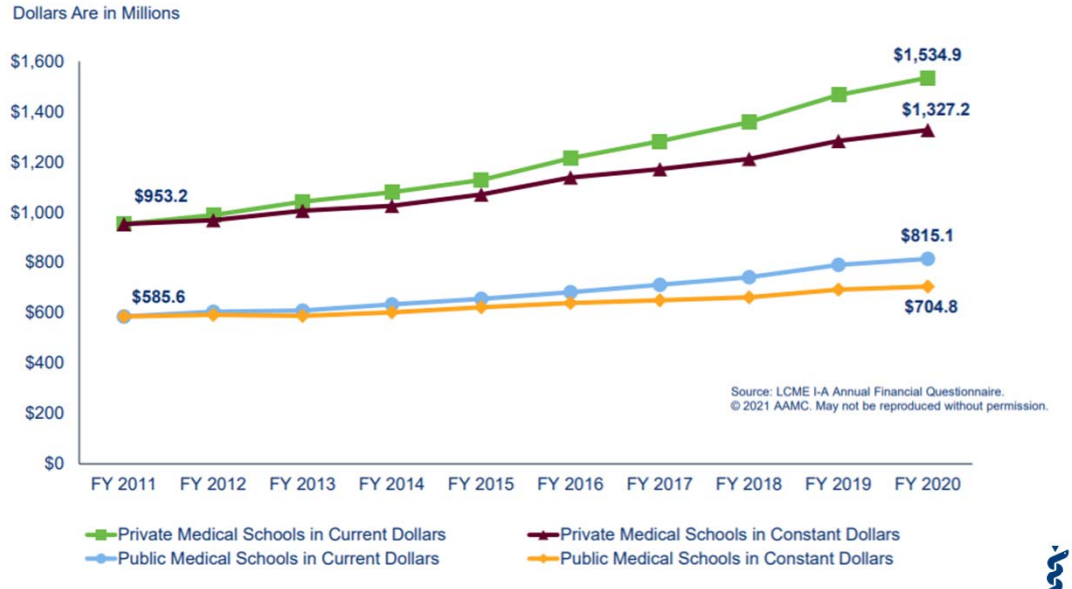


12

AAMC

12

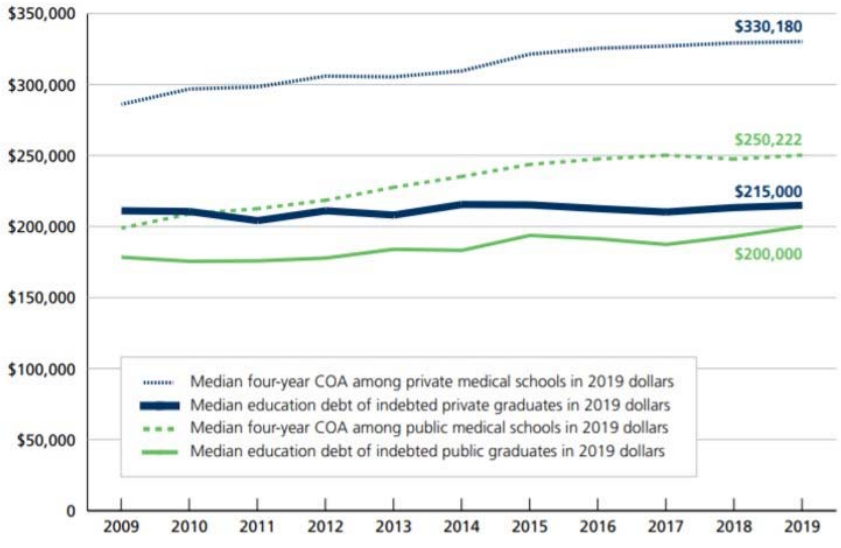
Figure 5: 10-Year Trend of Average Total Revenue, Fully Accredited Medical Schools, Public vs. Private



Source: LCME I-A Annual Financial Questionnaire.

AAMC

13



Source: AAMC Medical School Graduation Questionnaire (GQ) and Tuition and Student Fees Questionnaire (TSF).

Figure 2. Median four-year cost of attendance (COA) and education debt of indebted medical school graduates by public or private school, 2009-2019 (in constant 2019 dollars).

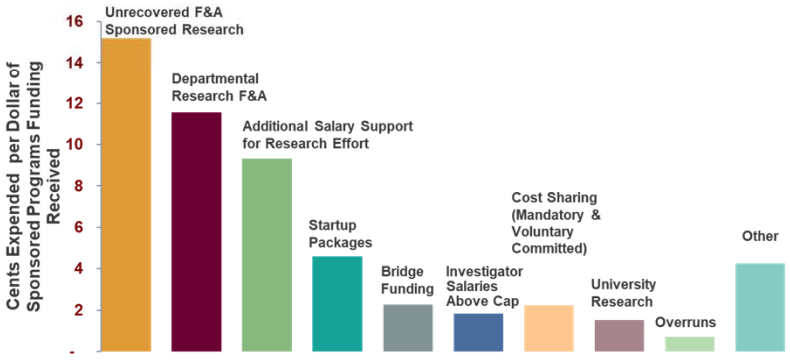
Student tuition and debt are at their limit.

AAMC

14

Universities Already Make A Significant Investment in Research

For Every $1 of Federal Support, on Average, Med Schools Contribute $0.53 More of Own Funds to Research Mission



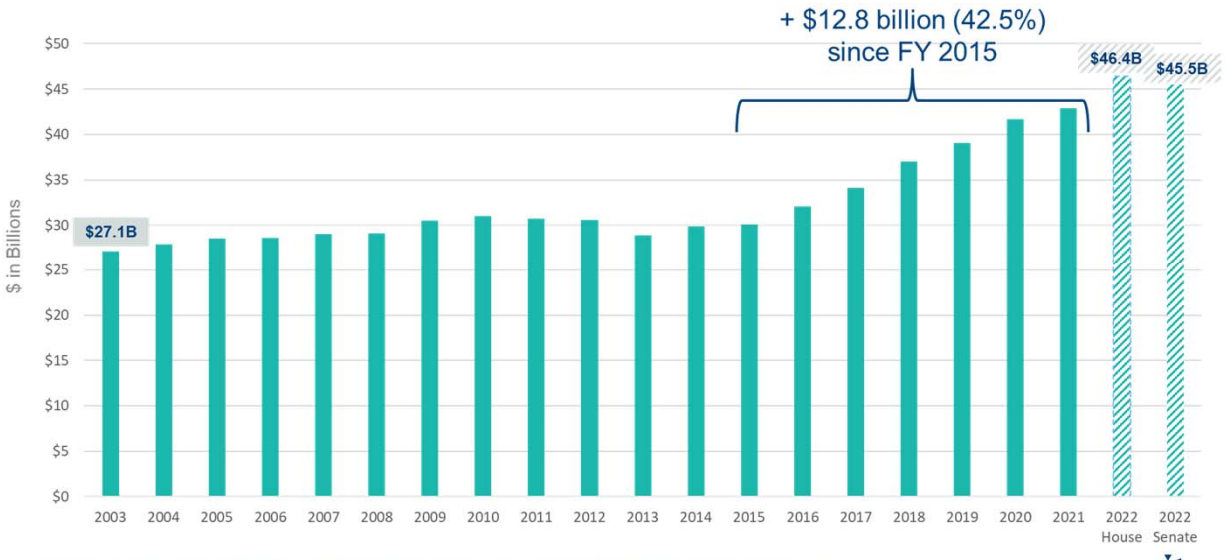
Average Expenditure by Category

https://www.aamc.org/what-we-do/mission-areas/medical-research

AAMC

15

Where We Have Been: NIH Funding



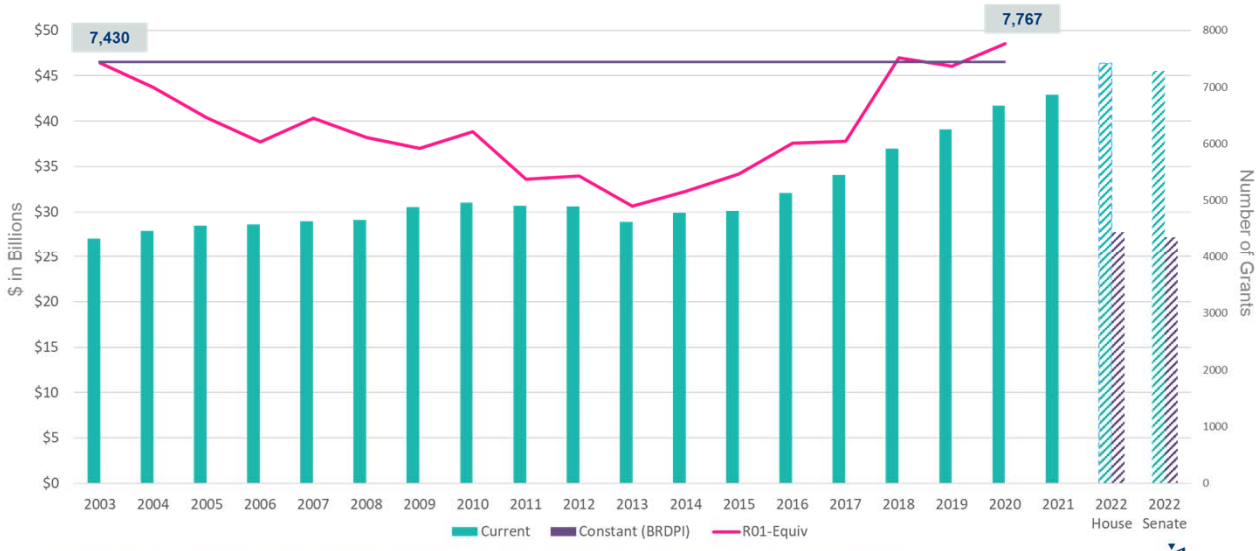
Sources: NIH Office of Budget; White House Office of Management and Budget; H. Rept. 117-96. Senate Draft Labor-HHS Report. Updated 12/8//21.
Note: Funding levels do not include emergency supplemental funding.

7

AAMC

16

Despite Recent Funding Increases, Total Number of NIH R01-Equivalent Grants Only Slightly Above 2003 Level



Sources: NIH Office of Budget; White House Office of Management and Budget; H. Rept. 117-96. Senate Draft Labor-HHS Report. NIH Data Book. Updated 12/8//21.
Note: Funding levels do not include emergency supplemental funding.

8

AAMC

17

Outlook Remains Negative

Moody's
INVESTORS SERVICE

Research Announcement: Moody's - 2021 outlook for US not-for-profit and public healthcare sector remains negative on constrained revenue, rising costs

New York, December 11, 2020 --

- Median operating cash flow will drop 10%-15% in 2021 from Moody's annualized third-quarter 2020 estimate
- Softer demand for certain services due to coronavirus fears will continue until pandemic ends

The outlook for the US not-for-profit and public healthcare sector in 2021 remains negative, Moody's Investors Service says in research published today. Volume and service mix disruption, reduced commercial insurance revenues from elevated unemployment, and higher expenses will weigh on hospitals amid the coronavirus crisis. The pace and sustainability of recovery from last spring's nationwide mandatory elective shut down will be influenced by containment of the virus and widespread vaccination.

"The negative outlook for the not-for-profit and public healthcare sector assumes that COVID-19 vaccines won't be widely available before the middle of next year," said Moody's Vice President Diana Lee. "Meanwhile, soft demand for some services and the ongoing shift toward lower-cost settings will contribute to median operating cash flow dropping 10%-15% in 2021 from our annualized third-quarter 2020 estimate."

Patient volumes will remain constrained due partly to fears about coronavirus exposure, Lee says. At the same time, labor and supply costs will increase, especially amid new COVID-19 surges. Moody's outlook assumes there will be no additional federal aid similar to CARES Act grants.

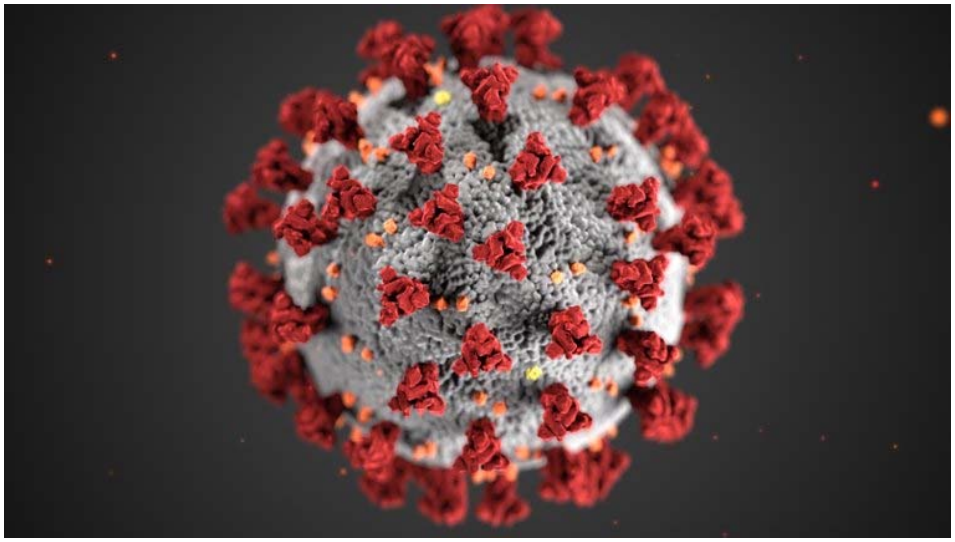
Meanwhile, elevated joblessness will lead to growth in the Medicaid and uninsured population as individuals lose employer-sponsored commercial insurance, which is usually more profitable than government-provided coverage. Additionally, as baby boomers move out of commercial healthcare plans, hospitals will become more dependent on Medicare revenue.

The not-for-profit and public healthcare sector's recovery from the effects of the pandemic will be uneven and differ by region and by facility, Moody's says. Overall, large, diverse healthcare systems and/or those with more cash will be best positioned to resume growth, while smaller standalone hospitals will likely consider partnerships. Hospitals also stand to lose revenue if the Affordable Care Act is overturned in the absence of a replacement plan, and if there are cuts to Medicaid funding.

AAMC

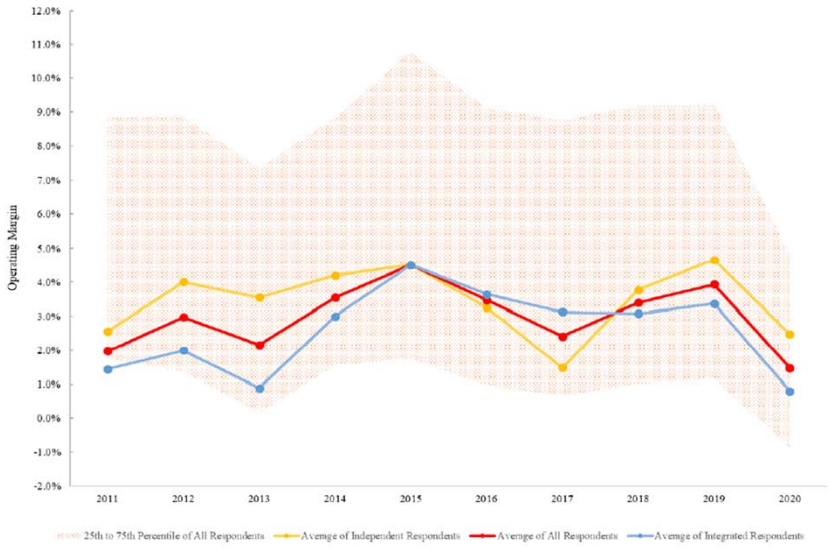
18

Impact of COVID



19

AAMC Member Teaching Hospital Operating Margins: FY2011-2020



Source: 2020 Council of Teaching Hospitals and Health Systems Survey of Hospital Operations & Financial Performance Autumn 2021 Databook

20

Graduate Medical Education (GME)

21

Who Finances Resident Education and Teaching Hospitals' Special Missions?

- Medicare (largest explicit payer – today's focus)
- Medicaid (last tally – 43 states + DC)
- HRSA (Children's GME and Teaching Health Centers)
- Private patient care revenues
- VA/DoD
- Other federal and state programs

22

Two Payments With an "Education" Label

Direct Graduate Medical Education (DGME)

Partially compensates for residency education costs.

Indirect Medical Education (IME)

Partially compensates for higher patient care costs due to many factors

Graduate Medical Education*

AAMC

23

Medicare Funding is Significant

Estimated federal fiscal year 2019 (payments made to approximately 1,100 teaching hospitals):

DGME payments = $4.24 billion

IME payments = $11.20 billion

Total = $15.44 billion

AAMC

24

Medicaid Funding for GME

43 states and DC

Total of $5.58B

- 52% under managed care
- 48% under fee for service

Most payments went to teaching hospitals but

- In MN, FL, and TN medical schools were eligible to receive payments directly
- FL, IA, NV, VT and SC made GME payments directly to teaching physicians

AAMC

25

How are DGME Payments Calculated?

DGME	=	Hospital's PRA	×	FTE resident count	×	Hospital's Medicare patient load

Step 1: Determine the hospital's Per-Resident Amount (PRA):

Determine per-resident base year costs (*i.e.*, how much the hospital spent per resident back in 1984)

Update (to current year) for inflation; different for primary vs. non-primary care

Step 2: Multiply the updated PRA by the number of *countable* full-time equivalent (FTE) residents in the current year, subject to:

FTE "cap" (more on this to come);

3-year rolling average (more on this); and

"Weighting" rules

Step 3: Multiply by the hospital's ratio of Medicare inpatient days to total inpatient days (the "Medicare share")

AAMC

26

"Weighted" FTE Count: Initial Residency Period (IRP) Affects DGME Payment

IRP = minimum accredited length for each specialty

- Residents training during their IRP are 1.0 FTE; can be a 1.0 FTE for maximum of 5 years
- Additional years as 1.0 FTE geriatric programs and preventive medicine fellowships
- Residents training beyond their IRP are 0.5 FTE

IRP is determined during a resident's first year of training and does not change

Limited exception for preliminary and transitional-year programs

AAMC

27

Examples of IME-Related Costs

"Indirect" *patient care costs* associated with having a teaching program

Higher inpatient operating costs because of the clinical environment where teaching occurs:

- Unmeasured patient complexity not captured by the MS-DRG system
- Increased costs of specialized services
- Other operating costs associated with being a teaching hospital (standby capacity, lower productivity, etc.)

AAMC

28

What Is the IME Formula?

Total IME	=	Multiplier	×	$[(1 + IRB)^{0.405} - 1]$	×	DRG Pymts

IME adjustment is based on statistical analysis

Critical factor is hospital's ratio of interns-and-residents-to-beds (IRB)

- Proxy for teaching intensity
- Capped at lesser of current or previous year's ratio

Exponent of 0.405 meant to account for effect of teaching activity on inpatient operating costs

For **FFY 2021**, Multiplier = 1.35

Note: There is no IME add-on to Medicare outpatient payments

AAMC

29

Mergers, Acquisitions, and Partnerships (MAP)

30

AAMC

30

What drives MAP activity?

proactive strategic vision

market

population health

financial improvement, access to capital

AAMC

31

Market Share

…the willingness to consider mergers, acquisition, and/or partnership activity may reflect a strategic plan by a teaching hospital to…

- *Assemble a larger population base*
- *Cover a specific geographic area*
- *Achieve "scale"*
- *Reach a certain market share and/or target revenue*

AAMC

32

33

The Lasting Impact of a Hospital Closure

Closing Hahnemann could deprive some struggling neighborhoods of a key safety net

by Tom Avril and Dylan Purcell, Updated: July 2, 2019

YONG KIM / STAFF PHOTOGRAPHER

The closure of Hahnemann has decreased the number of beds in the city of Philadelphia, which ultimately places the low socioeconomic population at risk. Issues such as access to health care and hospital overcrowding will begin to greatly affect the city's ability to provide health care to all populations.

AAMC

34

Patients and Families Were Not the Only Ones Affected

Medical students: The clinical rotation of medical students at Drexel University occurred at other sites with different clinical partners.

Faculty: 40% of clinical staff lost their jobs due to closure

Residents:

- Employees of the hospital
- Disruption to training
- Licenses are dependent on standing in the training program
- Designated institutional official (DIO) oversees the program but employed by the hospital

IN THE UNITED STATES BANKRUPTCY COURT
FOR THE DISTRICT OF DELAWARE

In re	Chapter 11
CENTER CITY HEALTHCARE, LLC d/b/a HAHNEMANN UNIVERSITY HOSPITAL, et al.,	Case No. 19-11466 (KG)
	(Jointly Administered)
Debtors.	Related D.I.: 142

LIMITED OBJECTION OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES AND THE EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES TO THE RESIDENT PROGRAM BID PROCEDURES MOTION

The Association of American Medical Colleges ("AAMC") and the Educational Commission for Foreign Medical Graduates ("ECFMG"), by and through their undersigned counsel, hereby submit this limited objection (this "Limited Objection")[2] to the *Debtors' Motion for Entry of Orders (I)(A) Establishing Bidding Procedures Relating to the Sale of the Debtors' Resident Program Assets, Including Approving a Break-up Fee, (B) Establishing Procedures Relating to the Assumption and Assignment of Certain Executory Contracts, Including Notice of Proposed Cure Amounts, (C) Approving Form and Manner of Notice Relating Thereto, and (D) Scheduling a Hearing to Consider the Proposed Sale; (II) A) Approving the Sale of the Debtors' Resident Program Assets Free and Clear of All Liens, Claims, Encumbrances, and Interests, and (B) Authorizing the Assumption and Assignment of Certain Executory Contracts; and (III) Granting Related Relief* [D.I. 142] (the "Bid Procedures Motion"). In support hereof, the AAMC and the ECFMG respectfully state as follows:

AAMC

35

Service Lines

AAMC

36

What is a Service Line?

A means of organizing physicians and clinical teams to advance the institution's goals

Physician-led, partnered with strong Chief Administrative Officer

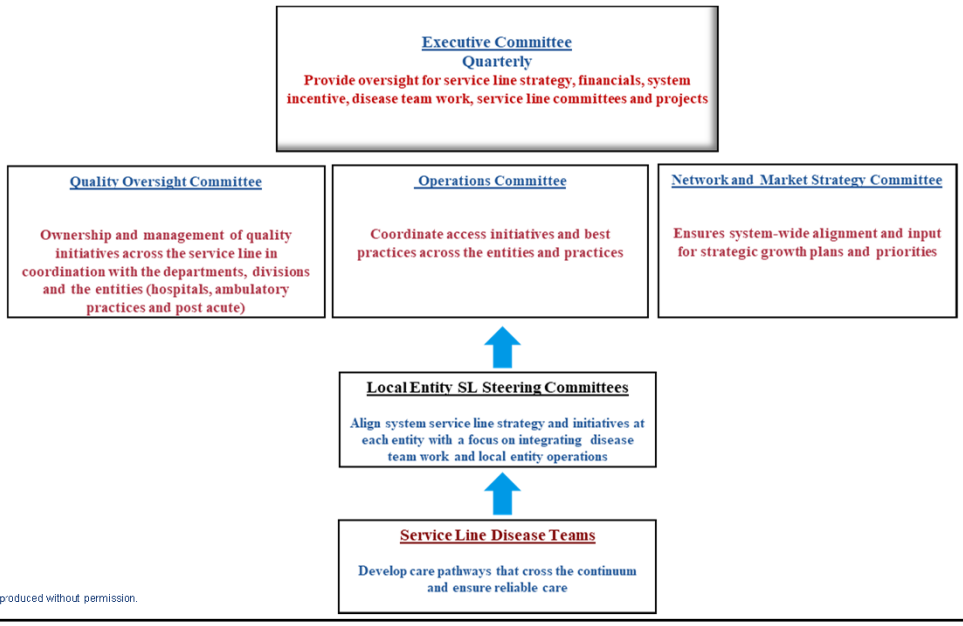
NOT intended to replace academic departments

37

Integration with Clinical Departments

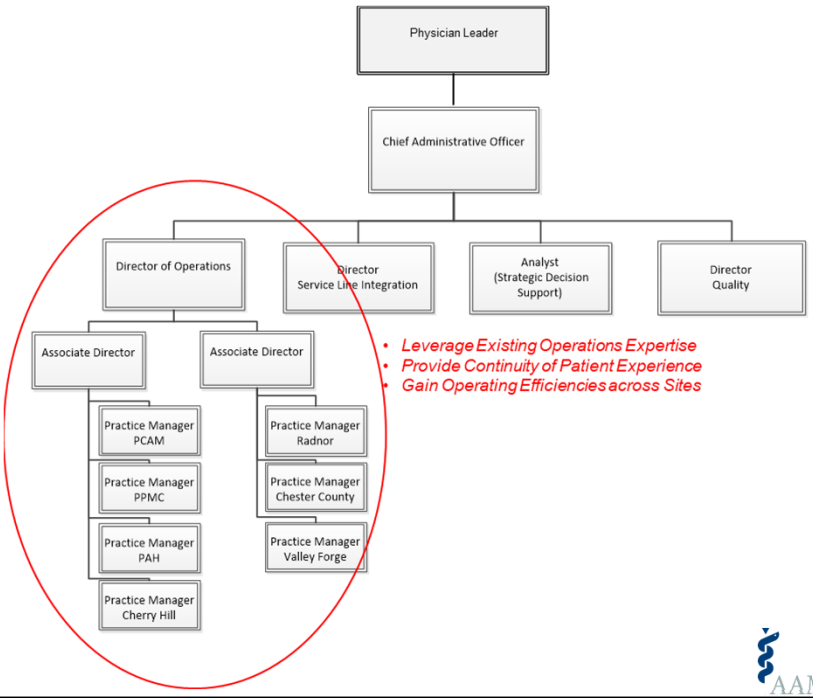
38

Service Line- Governance Structure



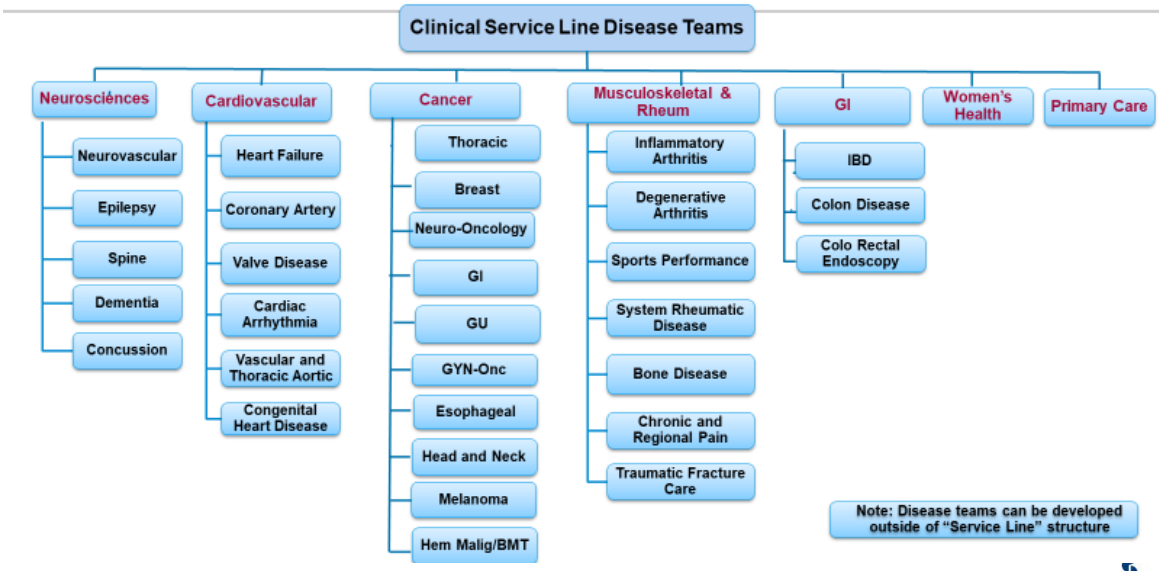
39

Service Line – Organizational Structure Example



40

Where could ophthalmology fit into the below structure?



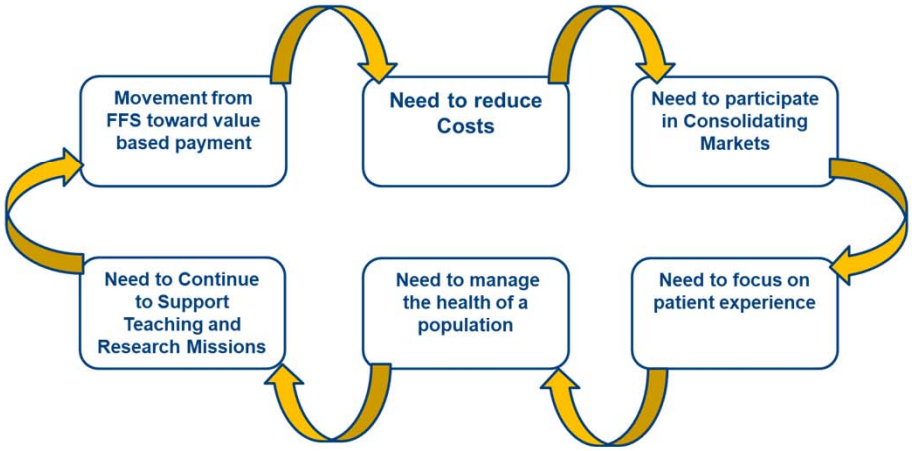
41

Value Based Care Payment Models

42

Times Are Changing

Payers are increasingly unwilling to continue to pay premium prices



AAMC

43

Medicare Increases Payment for Value

- The Center for Medicare and Medicaid Innovation (CMMI) designs and operates value based care (VBC) models, which link payment to quality and value
- As of 2020, 67% of Medicare beneficiaries were seen by Accountable Care Organizations—the most common form of VBC—or were enrolled in Medicare Advantage plans
- In 2021, CMS announced the goal that all Medicare beneficiaries will be in a care relationship with accountability for quality and total cost of care by 2030

Centers for Medicare and Medicaid. Innovation Center Strategy Refresh. Available at: https://innovation.cms.gov/strategic-direction-whitepaper

AAMC

44

CMMI Announced Strategic Priorities in 2021

Source: Centers for Medicare and Medicaid. Innovation Center Strategy Refresh. Available at: https://innovation.cms.gov/strategic-direction-whitepaper

AAMC

45

Where does ophthalmology sit in these models?

How can ophthalmology incorporate the value based payments model into practice?

AAMC

46

Community Impact

Breakdown of Economic Impact

Jobs

This is approximately 3.3% of jobs nationwide.

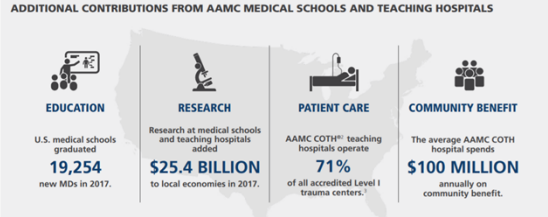
Wages, Salories, and Benefits

Average Wages, Salaries, and Benefits

ECONOMIC IMPACT OF AAMC MEDICAL SCHOOLS AND TEACHING HOSPITALS

This equates to about 3.1% of U.S. GDP and roughly $1,750 per person.

ADDITIONAL CONTRIBUTIONS FROM AAMC MEDICAL SCHOOLS AND TEACHING HOSPITALS



Health Equity

Health and health care inequities are deeply rooted in the conditions in which people are born, grow, live, work and age.

Medical schools and teaching hospitals play a singular role in ensuring all people have the same opportunity to reach their full potential—a state of health equity.

As pioneers in research and clinical best practices, these institutions create the evidence base that makes the case for policies, partnerships, and practices that facilitate health equity.

AAMC

49

The Future Academic Medical Center

AAMC

50

equity | transparency | culture | quality

leadership | system-based | alignment

AAMC

51

In this future, how can chairs be successful?

AAMC

52

How can new chairs be successful?

AAMC

53

How do we strengthen diversity and equity in academic medicine?

AAMC

54

What role can ophthalmologists play in evolving AMCs?

55

Organizational Alignment

Strategic Plan

Health System

School of Medicine

Clinical Faculty

Clinical Enterprise

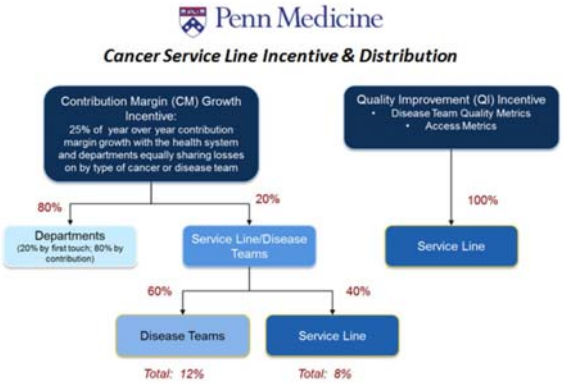
FPP

Department

56

Why Enterprise Alignment?

- Create value through the use of the AHS brand
- Implementation of clinical research and innovation networks
- Access to specialty programs
- Extension of educational programs to community sites



Ensuring the vitality of the academic missions through the ongoing investment of clinical margins in research and educational programs is fundamental to the long-term health of every AHS.

AAMC