Financing of pediatric dental postgraduate programs

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There are severe financial challenges to academic health centers in the 1990s. These are brought about by increasing competition for patients in a managed care environment, decreasing indirect recovery from NIH grants and threats to Medicaid and Medicare reimbursements. Such fiscal pressures on universities and hospitals trickle down, sooner or later, to individual programs. As the pressure becomes more severe, survival of the health center and its components, such as a dental postgraduate program, is based on financial independence.

Pediatric postgraduate programs in this environment must anticipate these pressures and become innovative with regard to producing revenue. Besides the goals of scholarship, community involvement, and providing high-quality patient care, programs must be considered commercial enterprises whose existence depends on profits. In this scheme, the postgraduate program needs to be considered an economic cost center, producing service and income, as well as consuming resources. Income opportunities must be realized by improving efficiency, as well as adopting innovations. Deficits will not only limit the ability to initiate or expand programs, but will erode the quality of an existing program, producing further inefficiencies that threaten the program as hospitals and health centers "reengineer".

Below are several suggestions that we have found to elevate the financial position of a pediatric postgraduate program without dramatically altering the scholarship and educational missions of a program:

Produce timely financial information

One of the first improvements to financial performance of a dental clinical operation can be the distribution of monthly income reports that are specific for each provider (Table 1). Such reports should contain information on all providers at all locations in which treatment is being performed. In this way providers become more involved in income production, and may actually become competitive with regard to monthly and yearly income. A public recognition, either orally or by a gift, of the highest income producer also provides incentive to increase financial productivity.

Improve performance

Goal setting and performance feedback should be utilized to improve resident income performance. Goal setting involves discussing with each resident his/her personal academic and clinical performance. These conversations could also include monthly or yearly clinic income. Performance feedback provides positive or negative reinforcement of performance. If goals are not being met, the program director must take a problem-solving approach, asking the resident, for example, what might be the constraints to improving performance and what steps could be taken to solve the problems.

Upsize

In the last several years it has become prevalent for industry to downsize in order to increase profits. The

Table 1. Resident income by month in a clinic in which the residents spend 20% of their time

Residents	*July*	*Aug*	*Sept*	*Oct*	*Nov*	*Dec*	*Total to Date*
First Year A	0.00	275.75	0.00	528.00	949.00	252.00	2004.75
First Year B	0.00	579.00	1061.50	1284.00	1996.00	1608.00	6528.50
First Year C	0.00	399.00	1823.50	2285.50	1555.00	1390.00	7453.00
First Year D	0.00	881.00	724.00	1121.00	1519.00	602.00	4847.00
Second Year A	1817.50	2648.00	1106.75	1474.25	785.00	1893.00	9724.50
Second Year B	2009.00	1114.25	1453.45	-6.00	0.00	0.00	4570.70
Second Year C	3076.00	1784.50	2308.50	0.00	0.00	386.00	7555.00
Total	6902.50	7681.50	8477.70	6686.75	6804.00	6131.00	42,683.45

opposite, that is upsizing, may increase profits for a dental clinic operation provided there is sufficient patient flow, sufficient clinic space, and an adequate fee structure. With such favorable conditions, providers (especially fellows and hygienists) should be able to bill more than twice their salary, a margin that should increase net clinical income. Besides increasing profit, "economies of scale" dictate that upsizing will increase overall efficiency of the clinic while decreasing overhead. Table 2 shows the effect of upsizing by adding a hygienist to a clinical operation. In the first year (93/94) the individual billed approximately $68,000. In the second year, billing was $86,000. Besides the monetary flow attributed to this one individual, a "re-engineering" of the overall clinic operation was possible because residents and fellows were freed from doing exams and preventive procedures.

Convert from comprehensive care to modified block clinic model

There are academic and patient care advantages for patients to be assigned to a provider with all the care and follow-up appointments performed by the same person. However, such a clinic model generally produces less clinical income because the provider is responsible for making the appointments and providing all the care irrespective of experience level, and is idle when the patient cancels.

In a block clinic model patients are not assigned to any one provider. The receptionist makes the appointments and reminder calls, generally schedules the patients for shorter visits, and commonly overbooks the clinic assuming that not all patients will show. The preceptor increases efficiency by giving procedures to providers with appropriate experience level. A modified block model encourages the receptionists to schedule the patient for the same provider, if calendars permit. This variation maintains efficiency of the clinic while allowing for some patient/provider continuity.

Seek government assistance

You should acquaint the officials representing the area where your clinics are located as to the value of the clinic for the community. Most legislators will appreciate being informed of issues that should help them better represent their district. Words such as "underserved children", "crippled children", "access to care" and "quality of care" should be used to make the case that it is necessary for state or federal support of the pediatric dental clinic operations. It is important that you accompany visits to officials with written "fact sheets" that allow easy understanding of the points you wish to make (Fig 1). It is of great benefit to have a thorough understanding of the needs of the community you are serving. This may require a survey of the local needs that can be compared to national data (Table 3).

Fig 1. Example of a "fact sheet" used to convince state legislators that low Medicaid fees were reducing children's access to dental care.

Access to dental care for Medicaid children in Connecticut

- The State is in violation of EPSDT equal access provisions for child dental care. Utilization rate of dental services for Medicaid children is 25%.
- Unequal access to dental care is a direct result of inadequate provider reimbursement. Reimbursement rates are currently between 28 - 35% of usual fees. This is less than half the cost incurred by dentists for delivering services.
- Reimbursement rates for pediatricians recently have been upgraded to approximately 90% of usual fees to alleviate access barriers to medical services.
- The outcome for many Connecticut children is chronic pain, dysfunction, missed school days, reduced capacity to succeed academically, poor esthetics with decreased self image — a constellation of outcomes that promotes failure.

TABLE 2. CHANGES IN CLINIC INCOME BETWEEN 1992 AND 1996* DUE TO INCREASES IN MEDICAID REIMBURSEMENTS AND PROVIDER MIX

92/93	*# Providers*	*Total Income*	*Mean Income*	*% change*
Residents	9	123,872	13,768	NA
Fellows	2	35,031	17,515	NA
Hygienist	0	NA	NA	NA
Total/Mean	11	158,903	14,445	NA
93/94	*# Providers*	*Total Income*	*Mean Income*	*% change*
Residents	7	212,934	30,419	55
Fellows	3	112,026	37,343	53
Hygienist	1	67,749	67,749	NA
Total/Mean	11	392,709	35,701	54
95/96	*# Providers*	*Total Income*	*Mean Income*	*% change*
Residents	7	213,876	30,553	0
Fellows	3	151,271	50,423	26
Hygienist	1	86,552	86,552	22
Total/Mean	11	451,699	41,064	16

* Only includes individuals who have income for entire year; does not include handicapped program income

Successful communication with legislators in Connecticut resulted in an increase in Medicaid reimbursement rates from 35% of usual and customary fees to 80% in January 1994. Such successful lobbying efforts had a dramatic impact on the UConn's pediatric dental clinic operation. A 53% increase in resident and fellow income between 92/93 and 93/94 can be attributed to this Medicaid reimbursement increase (Table 2).

TABLE 3. INFLUENCING HEALTH CARE POLICY BY COMMUNICATION FACTS TO LEGISLATORS: CAVITY RATE AND THE NUMBER OF UNFILLED CAVITIES IN 3-YEAR-OLD CONNECTICUT CHILDREN AS COMPARED TO MISSISSIPPI

Location	*No. of Children*	*Mean No. of Cavities Per Child*	*% of Children With Unfilled Cavities*
Hartford	276	2.29	77%
Norwich/ New London	125	2.26	82%
Mississippi*	210	1.07	0%

* Trubman et al: Dental Caries Assessment of Mississippi Head Start Children. J Pub Health Dent 49:167–69, 1989.

Know the value of your program

There are several aspects of your residency program and clinic operation that should be of value to your institution and therefore should be exploited. These areas include service to various teams, effect of dental patient flow in other areas, and GME reimbursements. Although it is often difficult to place monetary value on some of these service roles, part of your program expenses should be attributed to the overall good citizenship of your program to the larger institution. You should make sure that hospital administrators are aware of the service your program gives to other aspects of the institution, such as the craniofacial, hemophilia, and hematology/oncology programs. Furthermore, because dental areas have high patient flow, they should be attracting these patients to other services of the hospital. A program should try to calculate or estimate the number of times dental patients use other hospital services. Finally, you should be aware of the large payments your hospital receives or should receive for your residents through GME reimbursement (see Appendix).

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APPENDIX

GME Reimbursements for Pediatric Dentistry Graduate Programs

1. What are direct graduate medical education (GME) payments?
   These are the payments Medicare has made to hospitals since 1973 for the educational costs associated with approved residency programs.
2. What costs will GME cover?
   The allowable costs include:
   a. salaries and benefits of residents
   b. salaries of teaching physicians (dentists) attributable to their supervisory time
   c. other teachers' salaries
   d. indirect costs associated with institutional overhead.
3. How does a hospital determine its allowable GME costs?
   An annual amount is determined by multiplying the hospital's "base-period" per-resident costs by the weighted average number of FTE residents in an approved program(s) working in the hospital during the reporting period.
   The "base period" for determining costs was FY 1984 (Oct. 1, 1983 through Sept. 30, 1984) and has been adjusted annually according to the consumer price index or a percentage determined by the Department of Health and Human Services (HHS).
   An example of the amount of the dollars that might be paid per year would be: $50, 000 X 50 FTE dental trainees = $2.5 million.
4. Who is eligible to receive GME reimbursement?
   An intern, resident or fellow who participates in an approved medical residency program, including programs in osteopathy, dentistry and podiatry, as required to become certified by the appropriate specialty board. The approved programs for dentistry are those programs that have received specialty status and are accredited by the American Dental Association.
5. What approved dental specialties are listed in the federal regulations?
   Endodontics, Oral Pathology, Oral and Maxillofacial Surgery, Orthodontics, Pediatric Dentistry, Periodontics, Prosthodontics, and Maxillofacial Prosthodontics.
6. Must the training take place in the hospital?
   No. For purposes of determining FTEs, the hospital may count the time residents spend in patient care activities outside the hospital setting if the hospital incurs all or substantially all of the training costs in the outside setting. The regulation further states that, " Although providers other than hospitals may participate in approved GME programs that Medicare supports, the majority of these programs are concentrated in hospital and health care complexes", and "allowable costs of GME on which the per-resident amounts established by this rule are based include GME costs attributable to nonhospital portions of a health care complex".
7. How is an FTE determined?
   The regulations are written to ensure that residents are only counted once and therefore allow FTE status to be based on the total time necessary to "fill a residency slot." It is acknowledged that the number of hours worked will vary from program to program.
8. What if a resident works in more than one hospital?
   The resident's time should be prorated between hospitals and should total no more than one FTE.
9. What information does a hospital need in order to count a resident as an FTE for GME reimbursement?
   a. The resident's name and social security number.
   b. The type of residency program and the number of years required to complete it.

(cont.)

c. *The dates the resident was assigned to the hospital during the reporting period.*
d. *The dates the resident was assigned to another hospital.*
e. *The name of the medical, osteopathic, dental or podiatry school from which the resident graduated.*
f. *In the case of graduates of foreign medical schools, the resident's status concerning the Foreign Medical Graduate Examination must be reported or their certification by the Education Commission for Foreign Medical Graduates with the appropriate date.*

10. How long can a hospital be reimbursed for each resident's training?
Payments may be received for the minimum number of years of formal training necessary to satisfy the requirements for initial board eligibility in the particular specialty.

11. Does this mean that hospitals can increase their GME payments when the number of residents they train increases?
Yes. The Federal Register acknowledges that, "depending on the composition of GME costs during the base period, some teaching hospitals that later decide to change the financing of their GME programs could experience windfall profits." The regulations also suggest that "the Act (the Consolidated -Omnibus Budget Reconciliation Act of 1986) seems to assume that GME programs (will) remain relatively static except for upward and downward movements in the number of residents in a program."

12. Is there a need to change the postgraduate program name and structure for all dental postgraduate programs that seek to get reimbursements from graduate programs to residencies?
Although it is not specifically stated, calling the trainees "residents" would conform to the language of the regulation.

13. Is there a need to pay the residents that are counted in reimbursement formula?
It is not specifically stated, although the language implies that the money is to pay for residents' salaries.

14. What administrative unit of an academic health center receives the GME payment?
The hospital.

15. Why haven't dental schools taken advantage of GME payments?
It is unclear. However, it may be due to multiple reasons, such as:
- *lack of knowledge*
- *a reluctance because payments do not directly accrue to the dental school*
- *a perception that the program must be located in the hospital for reimbursement*
- *the traditional approach of dental education that postgraduate students pay for their education rather than receiving a stipend as do medical residents*
- *that the GME payment is a Medicare program in which dentistry does not participate.*

16. What are the negatives associated with seeking GME reimbursement for all postgraduate dental trainees?
a. *All dental trainees for whom the hospital receives payments must be appointed to the hospital instead of the dental school.*
b. *All dental trainees for whom the hospital receives payments probably will have to be paid a stipend instead of them paying tuition.*
c. *Because the GME payment requires that the hospital underwrite program costs, there may be a perception that the dental school will lose some control of its programs.*
d. *Perhaps the dental school will not be able to recover what it perceives to be its share of the GME payment.*
e. *Existing revenue sources may be redirected to other components of the academic health center.*

Reference: Federal Register Vol. 54, No. 118, September 29, 1989.