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Understanding the Impact of the Medicare Balanced Budget Act

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The Medicare Balanced Budget Act (BBA) introduced on July 31, 1997, is likely to have the most dramatic effect on reimbursement in health care since the introduction of Diagnosis Related Groups (DRGs) in 1983. Facilities with Graduate Medical Education programs will be the hardest hit as a result of the BBA, with rate reductions to be phased in over a 5-year period.

The impact of the BBA will have long lasting implications for the future supply of Orthopaedic surgeons. Weakening support for physicians training, coupled with overall declines in third party reimbursement, create an unstable environment for training programs. Financial incentives once targeted toward increasing the pool of specialists have been reversed. Few academic centers will have the economic fortitude to expand training of specialties such as Orthopaedics and many may even look to pairing back their commitments.

Given the importance of the BBA to the future of the field, it is important for Orthopaedic surgeons to understand the key elements of this new law. The government, through the Medicare program, recognizes both Direct Medical Education Costs (DME) and Indirect Medical Education Costs (IME). DME costs are defined as the salaries and fringe benefits of residents, fellows and the physicians who teach the residents and fellows. In addition, malpractice and administrative expenses related to the residency programs are defined as direct expenses. IME costs are defined as additional expenses borne by the facility as a result of providing training to residents and fellows during the educational process. The additional expenses are primarily related to increased ancillary testing from physicians-in-training.

Prior to the implementation of the BBA direct costs of training residents and fellows were reimbursed based on a per resident amount developed from an audit of 1984 residency training costs. The per resident amount has since been adjusted annually by the Consumer Price Index (CPI), with the exception of Fiscal Years 1995 and 1996 when Congress enacted a two year freeze on the non-primary care residents per resident amount. (Primary Care residents are defined as General Medicine and OB/GYN residents while all other residents are referred to as non-primary care residents.) To calculate the total payment to a facility, the per resident amount is multiplied by the number of full-time equivalent (FTEs) residents and further multiplied by the facilities' Medicare utilization. Residents within the initial residency period are counted as a full FTE when applicable, whereas residents beyond the initial residency period are counted as half an FTE. The initial residency period is defined as the minimum number of years to become Board certified in the first specialty the resident chooses. In the case of Orthopaedic Surgery, the initial residency period is 5 years.

With the passage of the BBA, facilities will continue to receive the annual inflationary increase on the per resident amount based on CPI. However, the BBA instituted a cap on the unweighted number of residents as of December 31, 1996. The cap will apply to cost reports beginning on or after October 1, 1997. After the first year of the cap, the cap is compared to the average number of unweighted FTEs for the current year cost report and the two preceding years' cost reports. To the extent that the average unweighted FTEs exceed the cap, that percentage will be applied to the weighted FTEs. There are several residency programs that are excluded from the cap; they include Oral Maxillofacial Surgery, Podiatry, and any new program that received approval prior to August 31, 1997. New programs approved after August 31, 1997 will not be reimbursed. Facilities that employed residents beyond their initial residency period have the opportunity to replace the residents with other physicians-in-training who are still in their residency period. The facility will then be reimbursed for the number of residents up to the cap from Fiscal Year 1996 cost report.

In addition to making changes to DME funding, the BBA also affected payments for IME. Historically, the IME payment was designed to compensate facilities for the higher costs associated with training residents to care for patients. The formula used by Medicare provided an additional 7.7% in the DRG payment for each 10% increase in the hospital teaching intensity. The teaching intensity is defined as the resident to beds ratio. A key distinction in how HCFA counts residents for DME and IME is that residents are not weighted for IME purposes as they are for DME purposes. Therefore, residents beyond the initial residency period are still counted as a full FTE in the formula. In addition, beds in the resident to beds ratio are counted only if they are available. Therefore, beds closed due to renovations can be excluded from the denominator thus increasing the IME funding. The following represents an example of how the IME payment along with the DRG payment is calculated:

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Assumptions for this Example:

- Number of Residents: 530
- Number of Available Beds: 570
- Base Rate: $ 4,299.47
- Facility Medicare CMI: 1.85
- Number of Medicare Cases: 7,500

IME Formula: 1.89 * {(1 + 530/570) ^.405} − 1
= .57659 $4,299.47 * 1.85 × 7,500
= $59,655,146 × 1.57659
= $94,051,707

The implementation of the BBA made several changes to the IME Formula. First, the 7.7% will be reduced over a four-year period to 5.5% in Fiscal Year 2001. Second, the BBA instituted the same cap structure as the one used for DME. Third, the BBA instituted a cap on the resident to bed ratio. The cap allows beds to be reduced, thus increasing the IME reimbursement but delays the recognition by one fiscal year. The following represents an example of how the IME payment will be affected by the BBA using the same assumptions as in the prior example:

Assumptions:

- Number of Residents: 530
- Number of Available Beds: 570
- Base Rate: $4,299.47
- Facility Medicare CMI: 1.85
- Number of Medicare Cases: 7,500

IME Formula: 1.72 * <(1 + 530/570)ˆ.405> – 1
= .52473 $4,299.47 * 1.85 * 7,500
= $59,655,146 × 1.52473
= $90,957,991

In this example, reimbursement is reduced by $3,093,716 in the first year after the implementation of the BBA. The lost reimbursement increases to $9,682,103 in Fiscal Year 2001 based on the assumptions in this example.

Medicare has been one of the few third party payers who have shared in the responsibility of medical education costs. It is unlikely that other payers will voluntarily seek to subsidize training costs. Therefore, changes in federal reimbursement policies will most certainly create fundamental changes for academic training programs. Academic medical centers will increasingly examine the true costs involved in training physicians. There will be growing pressure to seek efficiency standards of community hospitals. Residents will be challenged to be more efficient than before by ordering fewer tests on patients. Even more important, these policy changes are designed to decrease the proportion of non-primary care residents. As facilities continue to see their revenue base erode they may begin to abandon non-primary care programs such as Orthopaedics and opt instead for primary care programs. Active monitoring of the impact of these policies on the field must be done. Physicians must take the time to understand reimbursement formulas and be active participants in the political and legislative processes.