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The Balanced Budget Act of 1997: Implications for Medicare Reimbursement and Graduate Medical Education

In August 1997, as a result of the Balanced Budget Act of 1997, Congress made changes of significant magnitude in the reimbursement of graduate medical education (GME) to the nation's teaching hospitals.[1] These changes have sizable implications for the Jefferson Health System and each of its teaching hospitals. This article reviews salient features of current GME payment mechanisms; summarizes the relevant components of this legislation; and outlines the initial response of the Jefferson Health System to these changes.

Direct GME Reimbursement (DME) - DME is provided to reimburse teaching institutions for the costs of resident and faculty salaries and fringe benefits, administration of residency programs, and institutional overhead allocated to the educational programs. The DME is paid on a per resident basis, is institution-specific, and is based on 1984 (cost report identified) direct costs, which are increased each year by an inflationary factor.

Under the new legislation, Medicare fixed the maximum reimbursed DME resident count at the number of residents present in the fiscal year beginning on or after October 1, 1997. Thus, institutions will not receive additional DME payments if they increase their number of trainees. Additional counting regulations were included in this legislation. Medicare will also investigate, with the purpose of adjusting, the DME payments of institutions in the top 25% of per resident DME payments.

Indirect GME Reimbursement (IME) - IME is provided to teaching institutions to offset the costs of higher technology mix, higher acuity, larger percentage of indigent care, and the inefficiencies inherent in a teaching environment. This payment is based on a formula which augments the DRG payment, which is based on the ratio of residents to beds in the institution, and the IME adjustment factor. Thus, an institution with 10 residents and 100 beds (Resident:Bed Ratio 1;10) would receive approximately 7.7% additional reimbursement for that DRG payment.

Three adjustments have been made to IME. First, the resident count applicable to the Resident:Bed Ratio has been capped at the number present in the fiscal year beginning on or after October 1, 1997. Thus, institutions will not receive additional reimbursement related to an increase in "countable residents." This situation is true whether the increase in "countable residents" is related to an increase in number of trainees, or to a change in curriculum which increases "countable months" per existing resident. Second, institutions may now count resident months in non-hospital settings for which the hospital bears all or substantially all of the costs of the training program at that site. However, this is subject to the cap on resident IME count noted above. Third, and most important to academic health centers from a fiscal impact perspective, Medicare will progressively decrease the IME adjustment factor from 7.7% (Fiscal Year 1997) to 5.5% in Fiscal Year 2001 (a five-year period phased reduction). With a stable IME count, Resident:Bed Ratio, and mix of Medicare patient discharges, institutions will experience a 28.57% reduction in the IME adjustment. On average nationally, IME accounts for two thirds of GME

reimbursement, thus the magnitude of this reduction approaches 20% of total GME reimbursement.

Adjusted Area Per Capita Cost (AAPCC) - The AAPCC payment used for calculation of the per Medicare enrolled payment made to risk contracting Medicare HMO programs contains the GME dollars and "disproportionate share" dollars which had previously flowed to teaching hospitals on a per discharge basis. Under the new legislation, DME and IME will be paid to teaching hospitals based on a to be determined mechanism, and phased in over the same five-year period as the phase in of reductions in IME. Phased Resident Reduction Payments (PRRP) - This is a new concept as proposed by the legislation, under which a payment mechanism will facilitate a reduction in the number of residents and fellows of 20 to 25% over five years. Although the final rules regarding these reductions have not yet been published, the basic tenets are outlined in the legislation. The sponsoring institution would receive a decreasing percentage (100% to 0% in 20% increments) of the difference between the actual Medicare GME payments and the projected payment had the institution's resident count remained unchanged.

Direct Payment of DME to GME Consortia - The legislation will result in rules regarding the eligibility of GME consortia to receive DME funds directly (IME funds would continue to flow directly to the teaching hospitals). Currently, GME consortia receive no direct funding from Medicare; all DME and IME funds flow to the participating or sponsoring teaching hospitals.

The response of the Jefferson Health System to this legislation has three major dimensions:

Fiscal Impact Analysis - The fiscal impact of the changes in IME and caps on IME and DME counts will have a significant impact on all teaching hospitals within the JHS. Estimates of the impact of resident caps plus the IME rate changes range from $5 to $10 million reduction in payments per year in each of the JHS teaching hospitals after full phase-in of reductions. The JHS, its founding members, and alliance partners could see a reduction of $30-40 million per year in GME payments based on current Medicare reimbursement patterns.

Organization of GME Programs - The GME programs of the teaching hospitals of JHS are currently organized around the needs of the sponsoring departments and institutions, with little centralized organization or coordination of these programs. As fiscal pressures mount due to diminishing GME revenue and as community need for additional physicians wanes, a System-wide approach to organization of educational programs and sharing of resources will be essential.

The Master Academic Agreement of JHS charges the Education and Research Committee of the Board of Trustees with the oversight of all educational programs. The Education and Research Committee is structuring the organization of GME and other educational programs in the form of an educational consortium.

Evaluation of Phased Residency Position Reduction - Under the direction of the author, the senior JHS leadership will evaluate the feasibility of application for the aforementioned Phased Residency Reduction Payment (PRRP) program. This process will evaluate the fiscal impact, the programmatic implications, and the needs of the community for physicians in determining whether JHS and its educational consortium should take advantage of this program.

References

1. Iglehart JK. Medicare and graduate medical education. Health Affairs 1998, 338(6): 402-7.

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