Nuclear Medicine Could Face Decrease in Residents

GOVERNMENT BUDGET CUTS REDUCE FUNDING FOR GRADUATE MEDICAL EDUCATION

The budget compromise reached by the United States Congress, and new Medicare rules issued in July, will take millions of dollars away from graduate medical education (GME) programs in this country.

Nuclear medicine residencies could face a decrease in the number of available positions as Medicare funds shrink and Congress considers new laws to exert more control over physician training programs. Of three bills introduced this year in Congress with cost containment measures for GME, two give priority to primary care residencies.

Medicare now pays for about 30 percent of all GME programs, including direct and indirect costs. The remaining costs are covered by other third-party payers and patient charges.

Direct costs include salaries of interns and residents and administration costs. Medicare now reimburses these expenses as 100 percent "pass-through" costs with no limit.

Freeze on direct costs

Indirect costs cover additional patient care expenses inherent in a teaching hospital, such as the increased number of diagnostic studies ordered by interns and residents. Medicare now reimburses these expenses as an "add-on" to each payment of 11.59 percent, following a formula that is based on the ratio of residents to hospital beds.

The Health Care Financing Administration (HCFA), which controls Medicare expenditures, published a new rule that limits annual Medicare payments for direct GME costs to each program at its 1984 level (*Federal Register*, July 5, 1985, pp. 27722–27732). This reimbursement freeze will save an estimated $125 million, of a projected $1.56 billion, for Medicare GME direct costs during fiscal year 1986, according to HCFA.

The congressional budget proposal includes several changes, expected to save $10.2 billion over the next three fiscal years, in the Medicare system. With respect to GME, the budget reduces the indirect teaching adjustment from 11.59 to 8.7 percent, saving an estimated $1.65 billion over the next three fiscal years. The proposed budget did prohibit, however, a freeze on direct costs.

The Reagan Administration originally proposed that the indirect adjustment be reduced to 5.79 percent, which would save $2.9 billion over the three-year period. [The indirect adjustment rate was 5.79 percent before the introduction of Medicare's prospective payment system (PPS), when the rate was doubled to compensate for an anticipated decline in GME reimbursement to teaching hospitals.]

Congress ties strings to GME

Congress is considering three bills that would curb Medicare GME spending while encouraging medical graduates to enter primary care fields (family, internal, pediatric, preventive, and geriatric medicine, and public health). These bills would also put limits on Medicare support for graduates of foreign medical schools.

All three bills are proposed amendments to the Social Security Act of 1965, which provided that Medicare support GME. After 20 years of this open-ended funding, with few incentives to economize, legislators now feel that state and local governments, medical schools, and private philanthropies should bear more of the costs of GME.

On April 15, Senator Dan Quayle (R-IN) introduced a bill (S.1210) which would establish set percentages of primary care versus specialty residencies, limiting the number of federally funded specialty residents.

Sen. Quayle first proposed that all teaching hospitals affiliate with accredited medical schools and establish training programs to meet the legislated percentages. He is now considering state or regional affiliations instead for teaching hospitals. Every four years, a council would review the percentages, which cannot vary more than 5 percent from the previous year.

On May 16, Senators Robert Dole (R-KS) and David Durenburger (R-MN) introduced a bill (S.1158) that would freeze direct GME costs for one year. Beginning in 1987, Medicare would place a five-year limit on residency support and no longer pay for graduates of foreign medical schools who are not U.S. citizens.

The Dole-Durenburger bill also

(continued on page 974)

(continued from page 973)

calls for studies to determine the fiscal and administrative relationships between hospitals and medical schools, and the cost differences between teaching and nonteaching hospitals.

On June 6, Representative Henry A. Waxman (D-CA) introduced a bill (H.R.2699) that calls for an assessment of variations in indirect GME costs. It also reduces the rate of reimbursement for indirect GME costs in phases, from 11.5 percent in 1985 to 10 percent in 1986, 9 percent in 1987, to 8 percent in 1988.

"It is my understanding that, although reliable data are virtually nonexistent, there are considerable variations among hospitals in the costs they incur, on the average, for a resident in training," said Rep. Waxman. "While some variations are undoubtedly legitimate and should be recognized, it is appropriate to examine whether those who are incurring extraordinarily high costs, in comparison to the average spent by all hospitals, are administering these programs in an appropriate and efficient manner," he added.

The Waxman bill would standardize direct GME costs based on a national average paid to full-time residents. Medicare would pay direct costs for only the first three years of any residency, and salaries would be weighted to encourage medical students to enter primary care fields. Over a three-year period, salaries of primary care residents would increase to 105 and then 135 percent of the national average, while salaries of specialty residents would decrease to 96 and then 65 percent of that average.

Lee Grindheim, a health policy analyst for The Society of Nuclear Medicine and the American College of Nuclear Physicians, pointed out that all these amendments are still under negotiation, and the numbers could change before Congress votes on the bills.

Since a nuclear medicine residency requires four years, the proposed three-year limit on reimbursement will curtail funds substantially. James W. Fletcher, MD, chairman of the Society's Academic Council, said he has heard suggestions of charging fourth-year residents tuition to cover these costs.

Impact on nuclear medicine

B. Leonard Holman, MD, chairman of the Residency Review Committee for Nuclear Medicine, noted that 35 percent of all residents in nuclear medicine programs are graduates of foreign medical schools, compared to 8 percent in diagnostic radiology programs. "We could lose these slots unless they are filled by U.S. medical graduates," he said.

In addition, the first two years of nuclear medicine training are spent in a preparatory program, usually internal medicine, radiology, or pathology. "Those programs are going to be financially squeezed, and less inclined to accept candidates who plan to go on to nuclear medicine," said Dr. Holman.

To lessen the impact from preparatory residencies, Dr. Holman said that he would like to see the nuclear medicine field tailor its own training programs and take financial control of three instead of two years. According to Dr. Holman, a more ideal nuclear medicine residency program would begin with a one-year internship, followed by two years of nuclear medicine training and a third year of training in cardiology, oncology, radiology, etc.

AMA responds to GME cuts

Testifying in Congress, the American Medical Association (AMA) said that it opposed the one-year freeze on direct Medicare GME payments unless it is part of a freeze on all domestic and defense federal spending.

The AMA also said that it supported eliminating Medicare GME reimbursement for foreign medical school graduates who are not U.S. citizens, although it recommended that provisions be made for an orderly transition for hospitals that rely on these residents for current patient needs.

At its meeting in July, the Council of Medical Specialty Societies (CMSS) discussed the GME budget cuts. Its members "expressed deep concern that the health and public policy implications of the proposed legislation will not be considered sufficiently as Congress hastens to resolve its pressing budgetary problems," according to the CMSS.

In a health policy report published in the *New England Journal of Medicine* (May 23, 1985, p. 1400), John K. Inglehart agreed with the CMSS: "The government may well establish a legislatively mandated process leading to long-range changes in federal medical-education policies—not unlike the trigger in the Tax Equity and Fiscal Responsibility Act [TEFRA] of 1982, which produced Medicare's prospective payment system—while accepting short-term spending reductions in the context of the 1986 budget."

The Inglehart report also noted that the parties who provide GME funding want more influence in the accreditation and certification process. As Robert M. Heyssel, MD, president of Johns Hopkins Hospital, said in his testimony to a congressional committee:

"Payers for medical care, who support GME, have no clear voice in decisions that affect the design and content of GME programs—decisions that have ramifications for the cost of health care and for the financial status of teaching hospitals." ■