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OFFICE OF HEALTH CARE ACCESS
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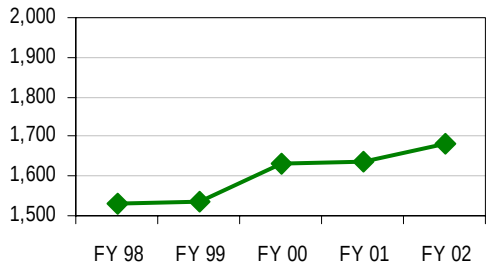
Graduate Medical Education in Connecticut (FY02)

INTRODUCTION

Graduate medical education, a period of three or more years of post-medical school clinical training, typically occurs in teaching hospitals or other health care settings which provide the clinical environment for the advanced education of physicians and other health professionals. Resident physicians in teaching hospitals receive specialized training and provide patient care under the supervision of a teaching physician.

The federal government is the primary payer of the costs associated with Graduate Medical Education (GME) through the Medicare program. States voluntarily support graduate medical education through their Medicaid programs. In Connecticut, Medicaid provides direct graduate medical education (DGME) payments only, using the same formula used by Medicare. Remaining GME costs are financed by a variety of sources, including the Department of Veterans' Affairs, the Department of Defense, state and local government appropriations, faculty practice plans and philanthropies, and other public and private third-party payers' payments for patient care services.

Figure 1: Number of Residents (FTEs), FYs 1998 - 2002



This report focuses on the financing by Medicare and Medicaid only, since the contributions from third party payers cannot be tracked.

In accordance with Public Act 99-172, this publication is the Office of Health Care Access' (OHCA's) fourth report on GME. Unless otherwise noted, all data cited in this report are from the Office of Health Care Access Hospital Budget System and are by hospital fiscal year (FY) (October 1 through September 30). These filings are reported by the hospitals and reviewed and verified by OHCA.

GRADUATE MEDICAL EDUCATION PROGRAMS IN CONNECTICUT

There were a number of residency programs in different medical specialty areas in 17 Connecticut teaching hospitals across the state, with 1,683 resident and intern full time equivalent (FTE[1]) positions during fiscal year 2002 (excluding Connecticut Children's Medical Center). **Figure 1** shows the number of resident and intern FTEs from 1998 through 2002. Data reported to OHCA on Connecticut teaching hospital interns' and residents' salaries, fringes and other program costs totaled $182 million in both 2001 and 2002, at an average of $111,117 and $108,122 per FTE, respectively.

Overall, there has been a 10% net increase in the number of FTE positions during the five-year period. While each hospital can increase the number of residents it employs, it will not receive GME payments for residents in excess of 1996 levels; the number of FTE residents eligible for federal funding was capped at 1996 levels under the Balanced Budget Act of 1997 (BBA).

Due to unforeseen delays in receiving Medicaid Cost Report data from the Department of Social Services, this publication updates information for both fiscal years 2001 and 2002.

FACTORS INFLUENCING GME PAYMENTS

Historically, two factors have had significant implications for how GME programs are operated and financed. First, teaching hospitals tend to have higher costs that place them at a competitive disadvantage with non-teaching hospitals when competing for managed care contracts. In the past, private payers have subsidized the educational missions of teaching hospitals through higher payments. However, the growth of managed care, coupled with increased competition within health care markets, has eroded private payer subsidies for teaching. In addition, changes in Medicare and Medicaid funding for GME have added to the fiscal constraints on teaching institutions.

Second, Medicaid managed care growth has reduced Medicaid revenues and payments to teaching hospitals that serve a disproportionate share of low-income patients.

Congress has provided some relief in recognition of the costs of training medical residents through several legislative initiatives. The Balanced Budget Refinement Act of 1999 (BBRA) increased Medicare DGME payments for those institutions below the national average to 70 percent of the average. Beginning in 2001, primary care and non-primary care per-resident amounts were combined and adjusted according to a "corridor" bracketing a weighted standardized national average per resident payment amount. That amount was modified by the same geographic adjustment factor used to adjust physician payments. A "floor" and "ceiling" were calculated for each hospital with a floor set at 70 percent and a ceiling of 140 percent for the locally-adjusted national average per resident amount. If above 140 percent, no payment increases were made in FY 2001-02. If the per resident amount fell below 70 percent, it was adjusted up to the floor. Further, the Medicare, Medicaid and State Health Insurance Program (SCHIP) Benefits Improvement Act of 2000 (BIPA) increased payments to 85 percent of the national average, effective FY 2003.

Figure 2:
Total GME as a Percentage of Revenue from Operations, FYs 2001 and 2002

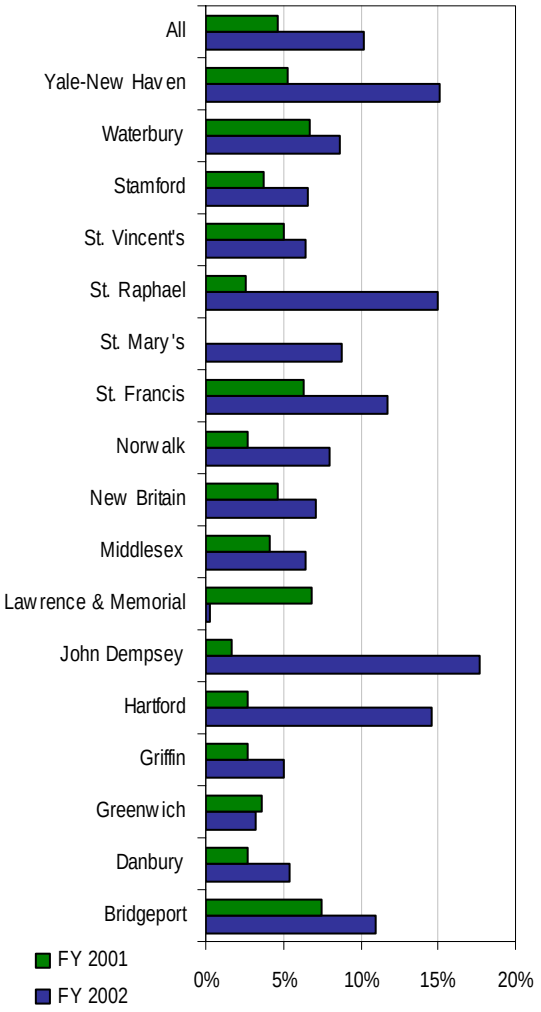
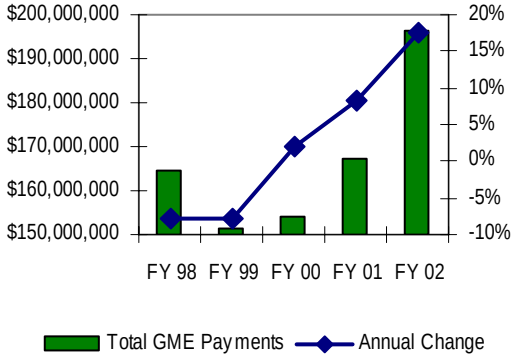
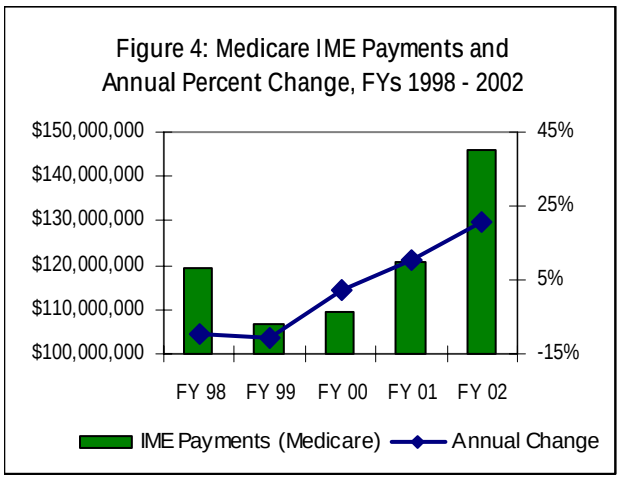
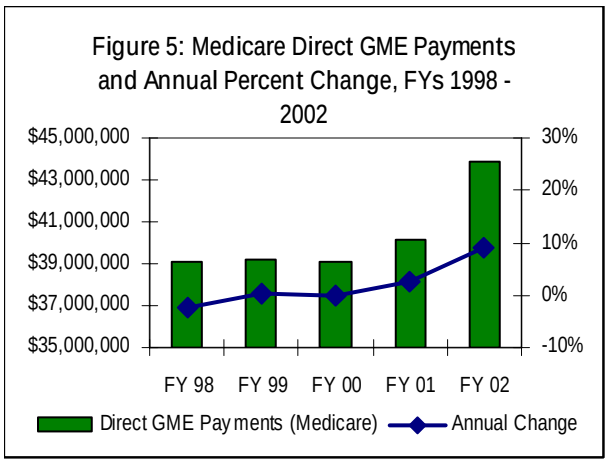
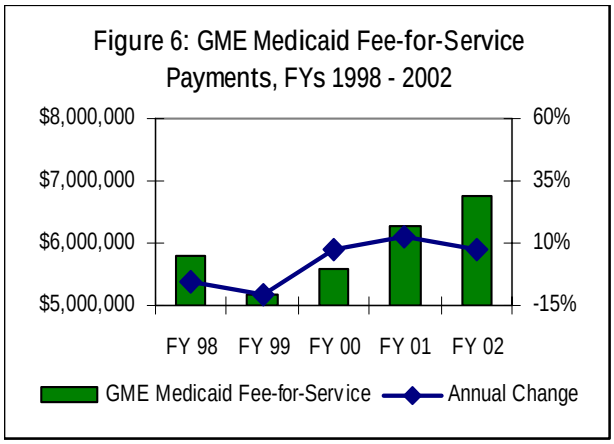


Figure 3: Total GME Payments from Medicare and Medicaid and Annual Percent Change, FYs 1998 - 2002









Source: Connecticut Department of Social Services, Medicaid Cost Settlement Reports

GME DOLLARS TO HOSPITALS — FINANCIAL IMPACT OF GME FUNDING ON HOSPITALS

Overall, GME as a percentage of total revenue (which includes revenue from direct patient services and indirect revenue from sources such as parking lots, cafeterias, philanthropies, etc.) rose from 4.7% in 2001 to 10.2% in 2002 **(Figure 2, page 2)**. In fiscal year 2002, Connecticut hospitals received approximately $196.5 million in GME payments from Medicare and Medicaid **(Figure 3, page 2)**. In general, GME payments rose by 20 percent between 1998 and 2002. The payment increases were largely due to growth in Indirect GME (IME) payments[2] **(Figure 4)**, the result of rising resident-to-bed ratios.

Direct GME (DGME) payments,[3] a small part of hospitals' gross revenues, also increased in the last two years by 3% and 9%, respectively **(Figure 5)**. The increases were largely due to growth in both the number of full-time residents and interns and the proportion of non-managed care Medicare inpatient days.

Since FY 1999 (the lowest point in the five year period), Medicaid GME payments have risen by 30%, with the largest year-to-year increase occurring between 2000 and 2001 **(Figure 6)**.

Prior to fiscal year 2000, pediatric services residents did not receive GME payments because funding was based on the number of Medicare discharges and children's hospitals treat few, if any, Medicare patients. Congress created the Children's Hospitals Graduate Medical Education (CHGME) program in 1999 as part of the Healthcare Research and Quality Act, to provide independent teaching hospitals with support similar to that provided to other teaching hospitals. The program supports GME training of pediatric and other interns in freestanding children's hospitals.[4] Connecticut Children's Medical Center (CCMC) received $3,034,377[5] and $4,139,233[6] in fiscal years 2001 and 2002, respectively.

SUMMARY

Seventeen[7] teaching hospitals in Connecticut received approximately $196.5 million in graduate medical education funding from Medicare and Medicaid in 2002, with Medicare direct and indirect GME payments totaling $43.8 and $146 million, respectively. Medicaid contributed an additional $6.7 million in 2002. This is an overall increase of 18 percent over FY 2001.

As mentioned in the past three reports, while assessing the financial impact of GME on Connecticut's hospitals is relatively straightforward, determining its effect on the sufficiency of the health care provider workforce and access to health care services is difficult to measure. Data that might be useful to OHCA in assessing GME's effect on the provider workforce and access to health care services is not currently available to the agency.

OHCA will continue to publish GME-related financial data, however the agency is currently reviewing its reporting requirements within the GME policy context and is examining ways to make this report more relevant to today's GME environment.

NOTES

[1]FTE is the derived number of full time equivalent positions rather than a count of actual individuals.

[2]IME costs include those associated with providing additional tests, longer hospital stays, sicker patients, technological requirements and lack of contributions from private insurers for training residents.

[3]DGME payments cover physician compensation such as resident salaries and fringe benefits, and attending physician compensation.

[4]http://newsroom.hrsa.gov/NewsBriefs/1999.childrensgme.htm

[5]http://newsroom.hrsa.gov/releases/2001Releases/childhospgrants1.htm

[6]http://newsroom.hrsa.gov/releases/2002releases/childrenGME.htm

[7]Excludes Connecticut Children's Medical Center GME funds