

State of Connecticut



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Office of
Health Care Access

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**An Analysis of
Graduate Medical
Education
in Connecticut**

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INTRODUCTION

Public Act No. 99-172 mandated the Office of Health Care Access (OHCA) to develop an annual study on graduate medical education (GME) and its impact on Connecticut hospitals. This legislation cited three specific areas to be addressed: the financial impact of GME; its effect on the sufficiency of the health care provider workforce; and its effect on access to health services. It also called for a council to be established to advise the Commissioner on the report. The Office of Health Care Access gratefully acknowledges the contributions made to this report by the members of this advisory council. The council members and their organizational affiliation are listed in the Appendix.

The purpose of this first report is to briefly describe the background of graduate medical education and how

it is financed, outline recent changes in the financing of health care that have an impact on GME, describe graduate medical education programs in Connecticut, and address the three issues (financial impact, workforce sufficiency, and access to care) noted in the enabling legislation. Future reports will update the information in this report and address additional questions about GME that the Public Health Committee may have.

The data in this report comes from the Office of Health Care Access unless another source is noted. The majority of the financial data comes from the Office of Health Care Access Financial Stability reports. These filings are reported by the hospitals and reviewed by OHCA and verified as final. This data has been reported to OHCA through the hospital fiscal year of 1998 (October 1997 to September 1998).

GRADUATE MEDICAL EDUCATION: BACKGROUND INFORMATION

At the beginning of this century, a model was established for American medical education: preparation in a baccalaureate program for the study of medicine; a university-based medical school for undergraduate medical education; and direct clinical experience or graduate medical education. It is in the graduate medical education phase that the provider acquires specialty and possibly sub-specialty training. This model creates a link between teaching, research, and health care during graduate medical education.

Graduate medical education typically occurs in teaching hospitals or other health care settings, which provide the clinical environment for the advanced

education of physicians, as well as nurses and other allied health professionals. The majority of these teaching institutions are tertiary care hospitals, providing the most advanced and complex level of treatment available. Resident physicians in teaching hospitals receive specialized training and provide patient care under the supervision of a teaching physician. Teaching physicians are faculty members who train and supervise residents by providing classroom instruction, making rounds with residents, examining specific patients, and discussing courses of treatment. Most teaching hospitals not only train physicians, but also care for a higher proportion of poor and uninsured patients, engage in research, and provide specialized services.

FINANCING GRADUATE MEDICAL EDUCATION

The federal government pays a significant portion of the costs associated with GME through the Medicare program, while state governments contribute through the Medicaid program. 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. This report focuses on the financing by Medicare and Medicaid, as the majority of GME payments are made to Connecticut by these programs, and because there is no way to specifically track the contribution from third party payers.

The Medicare program was enacted in 1965 to improve access to health care for the elderly, and later for disabled individuals. Because a major effect of this new program would be to expand the demand for medical services, and a subsequent need for more physicians, the Medicare program also established a mechanism to help pay for physician training. Medicare is the largest payer of graduate medical education. In fiscal year 1999, the Congressional Budget Office anticipates these additional payments will account for \$6.2 billion in program spending.¹

Medicare GME payments are made in two components - - direct medical education (DGME) and indirect medical education (IGME). DGME pays for the salaries and fringe benefits of residents and faculty who supervise the residents, other direct costs and allocated institutional overhead costs, such as maintenance and electricity. DGME is paid on a per-resident basis to the teaching hospital. The rate paid per resident is specific to each hospital; the formula to determine that rate is based on the hospital's calculated GME expenses in 1984 and 1985, annually updated by an inflation factor set by Medicare.

There are two basic rates for DGME. A slightly higher rate is given for residents in primary care specialties (family practice, general internal medicine, general pediatrics, osteopathic general practice, and obstetrics and gynecology); a slightly lower rate is based on the number of residents in sub-specialties programs. Residents are paid in full for a set number of years, then partially funded for additional years. Finally, the number of residents for which a hospital can get payments is capped at the number of residents in training at that hospital in 1996.

IGME costs, which are more difficult to measure, are intended to cover the cost of inefficiencies created by having residents in a facility. Some of these expenses are the costs of extra tests ordered by residents and longer patient stays caused by extra tests, residents' inexperience, and conflicts between educational goals and service needs. Analysis has shown that the presence of residency training programs is associated with an increase in providers' per diem patient costs, and the amount of the increase is associated with the intensity of the facility's resident training activity as measured by its number of residents per bed. The IGME is calculated as a percent "add-on" to the base of the prospective payment system price for every Medicare case. Part of the calculation uses the ratio of residents to the average number of occupied beds. As the number of residents per beds increases, the percent of the "add-on" also increases.

In addition to Medicare, states pay a voluntary payment to graduate medical education through their Medicaid programs. Unlike Medicare, state Medicaid programs have no statutory obligation to support GME. Most states have made GME payments under their fee-for-service program. In Connecticut, Medicaid pays DGME payment only, using the same formula used in the Medicare program.

CURRENT FACTORS INFLUENCING GME PAYMENTS

Two recent trends in health financing have had a significant effect on GME payments to teaching hospitals -- the federal government's efforts to control health care costs and the growing managed care market.

In order to reduce its health care expenditures, the federal government made changes to the Medicare payment structure. Several of these changes had a direct impact on the amount of payments that go to teaching hospitals. These changes were made in the Balanced Budget Act (BBA) of 1997 (P.L. 105-33). Prior to the BBA, this IGME adjustment was increased approximately 7.7% for each 10% increase in a hospital's ratio of residents to occupied beds. The 1997 legislation reduced the IGME adjustment to 7.0% in fiscal year 1998, 6.5% in 1999, 6.0% in 2000, and to 5.5% in 2001 and subsequent years.

Because of concerns expressed that these and other adjustments in the 1997 BBA placed an unintended burden on teaching hospitals, the **Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999** (signed into law on November 29, 1999) has delayed these reductions to 6.5% in fiscal year 2000 and 6.25% in FY 2001, after which the rate becomes 5.5%.

The BBA of 1997 also made changes to DGME payments. It placed limits on the number of "full-time equivalent" (FTE) residents that hospitals can count for DGME payments, and required that residents be counted using a three-year rolling average method. In addition, the BBA allowed Medicare to make DGME payments to entities other than hospitals. Finally, hospitals have been allowed to count the time that residents spend in settings outside the hospital, such as

freestanding clinics, nursing homes, and physician offices, subject to certain agreed-upon conditions between the hospital and the outside entity.

As a result of the 1997 BBA, certain "non-hospital providers," such as federally qualified health centers, rural health clinics, and Medicare+Choice organizations may now receive DGME payments.

The second major trend in health financing that has influenced GME is the growth of managed care in publicly paid health plans. Because IGME rates are based on the number of Medicare or Medicaid cases that are paid by the federal or state government, it is based on a fee-for-service model of health care financing. As the federal government and the states enroll their eligible populations in managed care, support for GME becomes less clear and in the opinion of many, is even put at risk.

Generally, under a managed care plan, the state pays the managed care company a per-patient fee determined in advance; the managed care company in turn negotiates a payment plan with hospitals to determine how much will be paid for covered health services. The historic rates upon which managed care contracts are negotiated included GME funds for teaching hospitals. That is, GME funding is distributed to HMOs as part of the capitation rate. But HMOs are not bound to distribute these dollars to hospitals with GME programs. And unlike payments for fee-for-service Medicaid or Medicare, there is no way to track the amount that goes to teaching hospitals for the purpose of GME payments from managed care plans. Although in Connecticut, a higher proportion of Medicaid recipients are in a managed care plan as compared to Medicare recipients, the use of managed care plans is also growing for Medicare.

GRADUATE MEDICAL EDUCATION PROGRAMS IN CONNECTICUT

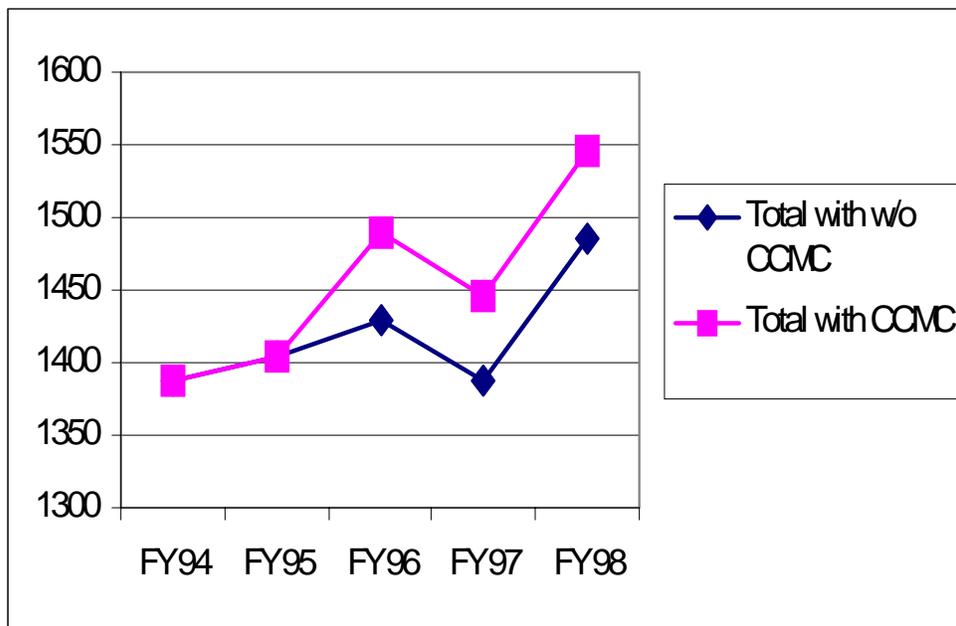
Connecticut has two medical schools -- The University of Connecticut School of Medicine and Yale University School of Medicine. There are four medical schools that are also affiliated with the residency programs in the state's hospitals: Dartmouth College; New York Medical College; Finch University of Health Sciences at the Chicago Medical School; and Columbia University College of Physicians and Surgeons. A resident is hired by a hospital to work in a residency program that is affiliated with a medical school. Among these six schools, there are more than 80 residency programs in 18 hospitals around the state.

There were 1,545 full time equivalent (FTE) residents and interns positions in Connecticut hospitals during fiscal year 1998. **Graph 1** shows the numbers of residents and interns from 1994 through 1998. (Data for

The Connecticut Children's Medical Center is shown separately in the total figures because there are no GME payments associated with the residents from The Connecticut Children's Medical Center. Hospitals have not received GME payments for residents that are in pediatric services, because funding is based on the number of Medicare discharges. **The Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999** allows for GME payments to children's hospitals.) Overall, there has been an increase of more than 10% in the number of resident FTE positions during the five-year period.

Some hospitals have a much higher ratio of staff beds per resident. This density of residents to beds is relevant to the indirect GME payments, because a part of the formula for the indirect payment takes this into

Graph 1
Number of Residents (FTEs)



account. An example of the effect of this change in the density between beds and residents can be seen in the trend of indirect GME payments (**Table 7 in Appendix**) and the number of resident FTEs (**Table 11 in Appendix**). For each hospital but Yale-New Haven, the amount of indirect GME payments has declined between fiscal year 1997 and 1998, following the rate change specified in the BBA. A probable reason for this difference is that for Yale-New Haven, the ratio of residents to beds increased in 1998.

Each year approximately 175 physicians enter the residency programs sponsored by the University of Connecticut, and each year the programs graduate between 150 and 160 physicians. Approximately half of these graduates begin practice, while the remainder enter other training programs (clinical and/or research). The University does not routinely track practice locations of graduates from the residency

and fellowship programs. However, a review of results from a recent exit survey showed that of 52 graduates entering practice: twelve (23%) were remaining in the greater Hartford area; ten were staying in Connecticut (19%); and nine (17%) were going to practice somewhere in New England.

If these numbers are representative, it is estimated that each year, University of Connecticut-sponsored residency and fellowship programs train 20-25 physicians who practice in the state of Connecticut. This represents approximately 40% of those that enter practice immediately after completion of their training program². In this academic year, 350 physicians entered the Yale University residency programs. A recent survey of Yale New Haven Hospital graduates from 1929 to 1994 showed that 34% of survey respondents lived in Connecticut. The number of trainees in the various residency programs of both schools are listed in the Appendix.

There are more than eighty residency programs in eighteen hospitals in the state of Connecticut.

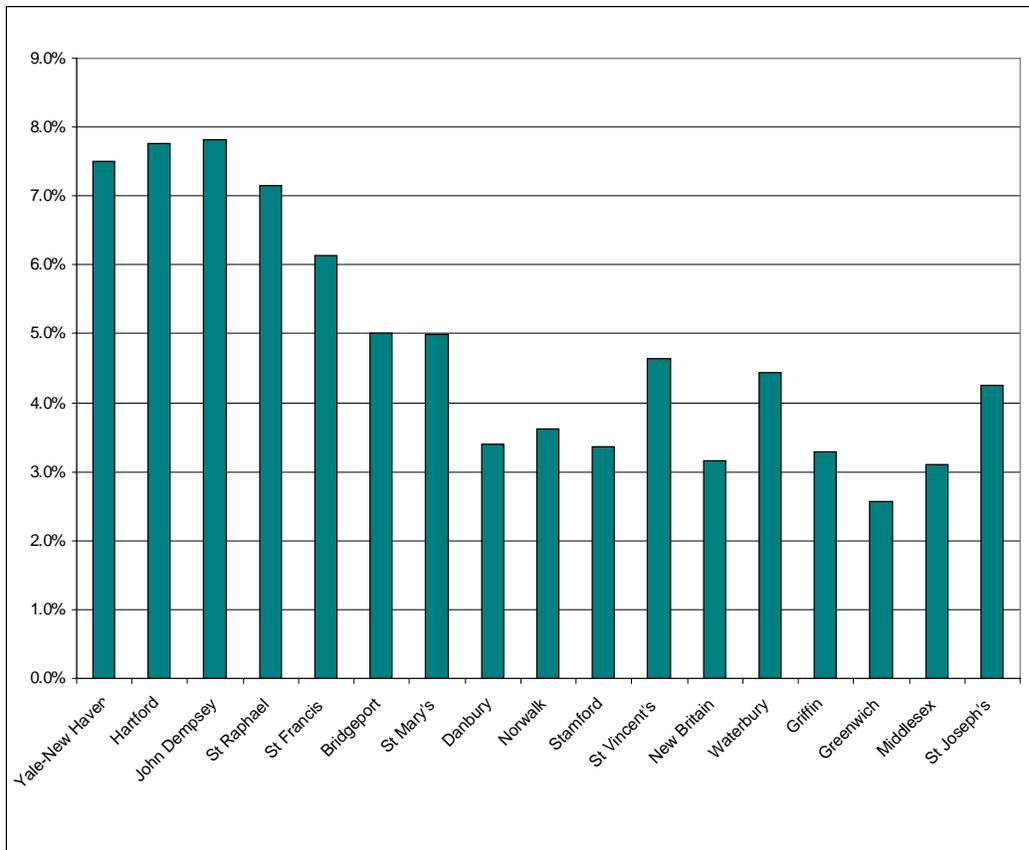
FINANCIAL IMPLICATIONS OF GME FUNDING ON CONNECTICUT HOSPITALS

Seventeen hospitals received GME payments as a part of their gross revenue in 1998. For most of these hospitals, this contributes five percent or less of their total operating revenues (**Graph 2**). Four hospitals in the state got more than 7% revenue from GME payments in fiscal year 1998 – John Dempsey, Hartford, Yale-New Haven, and St. Raphael.

In fiscal year 1998, approximately \$164.5 million in

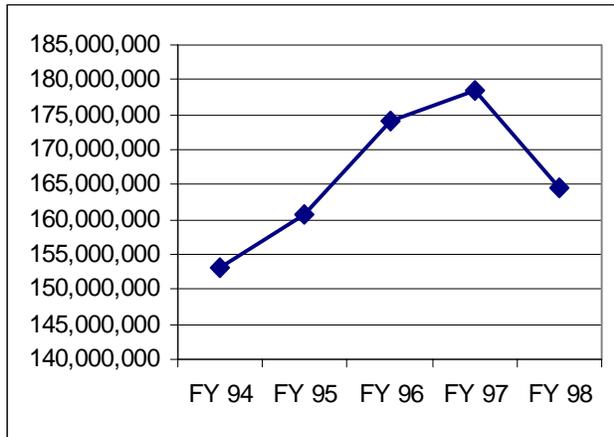
GME payments was received from Medicare and Medicaid. This amount is more than seven percent lower than 1997, the year with the highest level of GME payments between 1994 and 1998 (**Graph 3**). The majority of this decline is largely due to reductions in Indirect GME (IGME) payments (**Graph 4**). The reduction between 1997 and 1998 is small in proportion to the total amount of IGME, however, since the IGME payments represent the majority of total payments, any decrease in this has a large effect.

Graph 2
Total GME as a Percentage of Revenue from Operations -- FY 1998

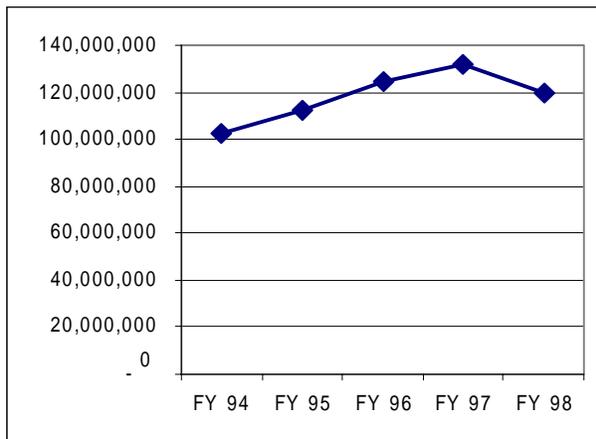


The amount of Direct GME payments has also declined in recent years ³ (Graph 5). Medicaid GME payments have decreased each year since 1994 (Graph 6). This is largely due to the fewer number of people who are enrolled in Medicare and the larger number of people who are enrolled in the Medicare managed care program (Graph 7).

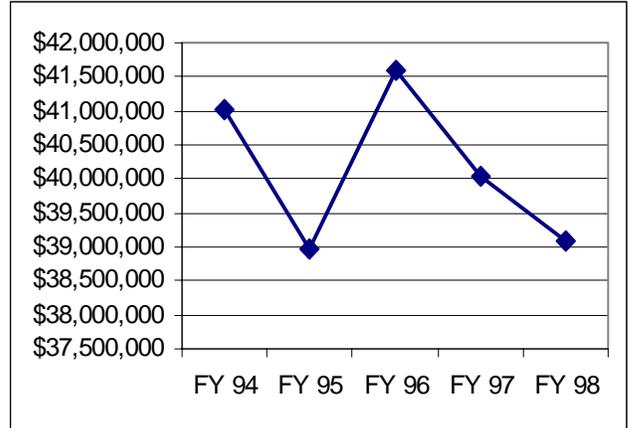
**Graph 3
Total GME Payments**



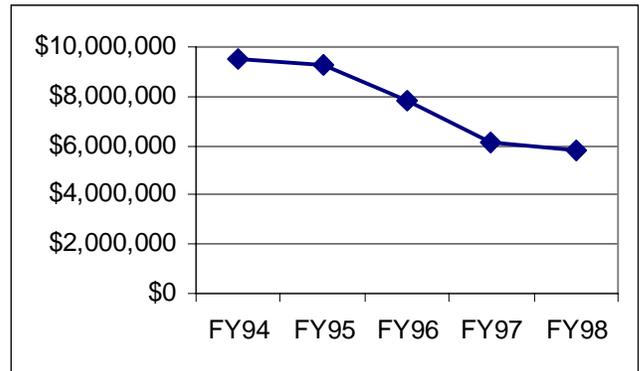
**Graph 4
Indirect GME Payments (Medicare)**



**Graph 5
GME Direct Payments (Medicare)**



**Graph 6
GME Medicaid Fee-for-Service Payments**



**Graph 7
Medicare Fee-for-Service Discharges**

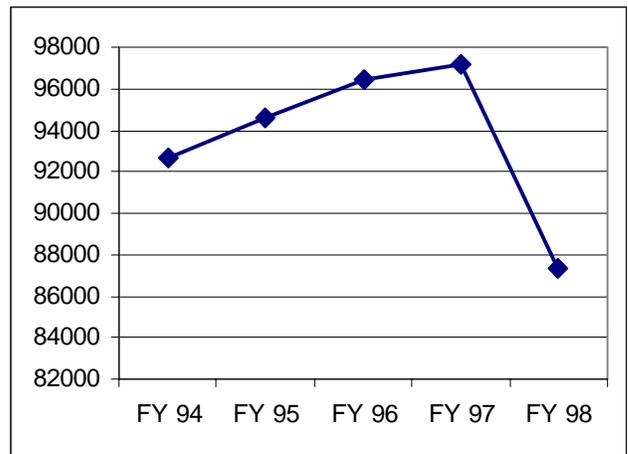


Table 1 shows GME Medicare payments as projected from the **Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999**, signed into law on November 29, 1999. This projection shows Medicare GME payments being reduced approximately 2.5% as a proportion of all Medicare payments, and less than 1% as a proportion of all revenue from operations.

Finally, the cost of graduate medical education is a question that is frequently raised, but difficult to answer. Hartford Hospital studied this question in 1992, and a recently updated analysis of these costs put the estimate at approximately \$98,500 per resident FTE. (This amount does not include tests that might be ordered as part of the education process.) Understanding the costs of GME as compared to the payments is an area in which many in the hospital community have

strong feelings. Non-teaching hospitals believe they have additional costs that teaching hospitals do not, such as offering services 24 hours-a-day with staff paid at full market value, rather than with residents paid at a lower rate. Teaching hospitals are concerned that the current payment structure, and in particular the reduction of payments from Medicare, puts them at an increasing financial disadvantage. Given the time constraints of this first report, we hope to more fully explore this issue in the second report.

In summary, the amount of a teaching hospital's revenue that comes from GME payments is a small part of its overall gross revenues, but one that has declined more than seven percent in the past year and is expected to continue to decline over the next several years.

**Table 1
Projections of GME Payments**

Revenue from operations	\$2,954,495,010
1998 Medicare inpatient payments	\$1,037,053,122
1998 IGME payments	\$119,524,503
1999 IGME payments	\$110,987,039
2000 IGME payments	\$110,987,039
2001 IGME payments	\$106,718,306
2002 IGME payments	\$93,912,110
Drop in IGME Between 1998-2002	\$25,612,394
Drop as % of Medicare Inpatient payments	2.47%
Drop as % of Revenue from Operations	0.87%
 (All dollar amounts are in 1998 dollars. Based on 1998 level of residents per bed.)	

THE EFFECT OF GME ON WORKFORCE SUFFICIENCY

Establishing the effect of the financial structure of GME payments on hospitals is relatively straightforward; asserting the effect of graduate education on the sufficiency of the health care provider workforce is less so. Even the notion of “workforce” can have different boundaries or dimensions. In discussing this issue, the advisory council determined that, for this and future reports, “workforce” would include physicians, advance practice nurses, and physician assistants. Most of the discussion in this report focuses only on physicians, as there is currently little funding for the advanced education of nurses and physician assistants.

To consider workforce sufficiency, three issues will be examined: the number of providers in the state; the effect on the workforce of residents in training and after graduation; and the effect on the workforce of the faculty in the teaching hospitals.

Table 2 displays the number of health care providers in Connecticut during the past four years.⁴ Connecticut has 3.75 physicians per 1,000 population, making it the fifth highest state in the nation for number of physicians per population (the District of Columbia, Massachusetts, Maryland, and New York are higher)⁵.

Table 2
Number of Licensed Nurses, Physician Assistants and Physicians in Connecticut

	1996	1997	1998	1999
Registered Nurses	48,342	48,778	49,312	49,769
Advanced Practice Registered Nurses	1,123	1,384	1,599	1,932
Physician Assistants	493	578	632	754
Physicians and Surgeons	12,105	12,223	12,441	13,181

Overall, Connecticut has a large number of physicians. However, the distribution of primary and specialty practices can be out of proportion to the need. Currently there are no data sources readily available to provide evidence about that issue in Connecticut. The sufficiency of the nurse workforce is less clear. There is evidence that the nation is beginning to experience a shortage of nurses.⁶

There is little evidence to assess whether the number of residents in GME programs has a significant impact on the sufficiency of the physician workforce, that is, whether Connecticut has too few or too many physicians. But because Connecticut has a high number of physicians per capita as compared to other states, it is unlikely that the number of residents contributes in a practical way to the sufficiency of the work force. In addition, the majority of graduates of Connecticut's two schools of medicine leave the State after graduation, making graduate medical education an "export industry" for Connecticut. This is not to say that the "industry" does not provide significant service

while residents are in their graduate education program. (The next section on access to care will describe this issue more fully.)

Another workforce effect of a GME program is its ability to attract highly qualified people and clinical programs. Although it is difficult to quantify this effect, advisory council members and other hospital representatives attribute to their teaching programs the ability to attract clinicians in difficult to fill, specialty

clinical fields. Because these hospitals offer the challenges of a teaching environment, they can attract more doctors, particularly in sub-specialty areas, who prefer a teaching environment.

At any given time, graduate medical education programs provide for more than 1,500 of the state's physicians serving primarily in hospitals. In addition, teaching programs made possible by GME payments have the estimated effect of attracting highly experienced clinicians in sub-specialty areas to the state's hospitals. Connecticut, however, is a state with a large supply of physicians.

Therefore, current evidence suggest that GME programs may have little effect on the sufficiency of the workforce in Connecticut.

Advisory council members and other hospital representatives attribute to their teaching programs the ability to attract clinicians in difficult to fill, specialty clinical fields.

EFFECT ON ACCESS TO HEALTH CARE

The relationship between GME and access to health care is, like the issue of the workforce, unclear. Treatment is provided, regardless of ability to pay, at all Connecticut hospitals. However, it is likely that without GME programs in our hospitals, this provision of health care to the uninsured and underinsured would be more costly to Connecticut taxpayers. Without the significant contribution of the Medicare payments in the form of direct and indirect payments, Connecticut citizens might be faced with higher health care costs to continue the current standard of hospital treatment to all. Thus, GME programs do not directly alter the level of access to inpatient care in Connecticut as much as they affect how this access to care is financed.

That said, it is important to consider the amount of service provided through these GME programs, in both

inpatient and outpatient settings, regardless of the insurance status of the patient. We can estimate the amount of service because the Accreditation Council for Graduate Medical Education has established regulations on the minimum and maximum hours of education and patient care activities that residents must have in each year of their graduate education. The amount of patient care activities required for the residency programs of Internal Medicine, Family Practice, General Pediatrics, and Obstetrics-Gynecology are summarized below.

Residents provide a significant amount of patient services while enrolled in Connecticut GME programs. This does not directly expand access to care to those who would otherwise not have an opportunity to have hospital services, but it may lower the cost of those services to Connecticut taxpayers.

**Table 3
Patient Encounters for Selected Residency Program
For Total Years in Program**

	General Internal Medicine	Pediatric	Obstetrics & Gynecology
Continuity Clinics	798	874	1,090
Specialty Clinic	na	280	264
Ambulatory Care Blocks	606	4,800	240
Emergency Room	1,958	na	na
Inpatient	1,872	7,236*	8,568*
Intensive Care	2,392	na	na
Total	7,626	12,930	10,162

*Includes patient encounters for whom resident acts as a supervisor and may not have direct patient responsibility.

CONCLUSION

Connecticut has eighteen hospitals that participate with medical schools in graduate medical education, and received \$164.5 million dollars from Medicare and Medicaid in 1998. The amount of a teaching hospital's revenue that comes from GME payments is a small part of its total revenues, but one that has declined in the past year and is expected to continue to decline in the future. Between 1998 and 2002, the estimated reduction in GME payments from Medicare, the major funding source, will be .86 % of total operating revenue for all Connecticut teaching hospitals combined.

The state's two medical schools, The University of Connecticut and Yale University, are affiliated with the majority of the 1,545 FTE residency positions in hospitals and other health care settings. In addition to residents, programs made possible by GME payments attract highly experienced clinicians into the state's hospitals, particularly in difficult to recruit sub-specialty areas. Connecticut, however, has the nation's fifth highest ratio of physicians to population. Therefore, current evidence points to the fact that GME programs have little effect on the sufficiency of the physician workforce in Connecticut.

Residents provide a significant amount of patient services while enrolled in Connecticut GME programs. Having residents on staff may reduce the waiting time for services in teaching hospitals, but it is unclear that they directly expand access to care to those who would otherwise not have an opportunity to have hospital services. Service expansion occurs in outpatient clinics that are staffed by residents, a topic that will be explored in greater depth in the second report on Graduate Medical Education. It is likely, however, that GME payments made to teaching hospitals lower the cost of those services to Connecticut citizens.

American health care delivery systems are experiencing a time of instability, largely due to the changing nature of their financing systems. Ever-increasing costs have resulted in attempts by public and private payers to rein in these costs. As with other revenue sources, payments for graduate medical education programs are decreasing. Public policy makers are likely to be called upon to address the reduction in revenue that supports these programs. Continued study of this issue will be needed to fully inform the debate.

REFERENCES

¹ Medicare Payment Advisory Commission, *Report to Congress: Rethinking Medicare's Payment Policies for Graduate Medical Education and Teaching Hospitals*. August 1999. p. 4.

² Dr. Bruce Koeppen, M.D. Dean, Academic Affairs and Education, University of Connecticut. Communication to Advisory Council.

³ The dip in the 1995 amount is due to a reporting error in the Waterbury Hospital financial filing.

⁴ Rural Policy Research Institute, *Can Medicare Graduate Education Policies Better Address Rural Provider Shortages*. Volume 1, :Number 3 (PB97-3) October 1997.

⁵ Buerhaus, P. I. and D. O. Staiger. *Trouble in the Nurse Labor Market? Recent Trends and Future Outlook*. Health Affairs. Volume 18, Number 1. 1999.

⁶ Connecticut Department of Public Health. These numbers do not take into account the number of practitioners who are working in patient care settings in Connecticut.

APPENDIX 1: GRADUATE MEDICAL EDUCATION STUDY ADVISORY COUNCIL

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St. Mary's Hospital

Keith Stover
Government Relations
CT Association of HMOs

APPENDIX 2: ADDITIONAL TABLES

Table 4A	
University of Connecticut Health Center	
Number and Size of Sponsored Residency	
& Fellowship Programs (1999/2000)	
Program	# Trainees
Internal Medicine	115
Primary Care Medicine	57
General Surgery	45
Pediatrics	43
Emergency Medicine	29
Psychiatry	29
Ob/Gyn	24
Orthopedic Surgery	20
Family Medicine	19
Anesthesiology	16
Cardiology A	10
Cardiology B	10
Diagnostic Radiology	8
Medicine/Pediatrics	8
Neurology	8
Otolaryngology	8
Urology	8
Geriatrics	7
Oral Maxillofacial Surgery	7
Gastroenterology	6
Child Psychiatry	5
Neonatal/Perinatal	5
Pulmonary/Critical Care	5
Hematology/Oncology	4
Infectious Disease	4
Surgery/Critical Care	4
Endocrinology	3
Maternal/Fetal	3
Addiction Psychiatry	2
Nephrology	2
Nuclear Medicine A	2
Nuclear Medicine B	2
Occupational Medicine	2
Reproductive Endocrinology	2
Rheumatology	2
Surgical Research	2
Academic Pediatrics	1
Blood Banking/Transfusion	1
Hand Surgery	1
Pediatric Endocrinology	1
Pediatric Orthopedic Surgery	1
Sports Medicine	1
Vascular Surgery	1
TOTAL	533

Table 4B	
Yale University School of Medicine	
Number and Size of Sponsored Residency	
& Fellowship Programs (1999/2000)	
Program	# Trainees
Internal Medicine Traditional	93
Internal Medicine Primary Care	76
Psychiatry	72
Anesthesiology	66
Surgery	56
Pediatric	48
Emergency Medicine	39
Obstetrics and Gynecology	24
Pathology	24
Cardiovascular Disease	20
Orthopedic Surgery	20
Neurology	14
Gastroenterology	12
Ophthalmology	12
Children & Adolescent Psychiatry	12
Laboratory Medicine	10
Otolaryngology	9
Infectious Diseases	9
Nephrology	8
Plastic Surgery	7
Dermatology	7
Neurosurgery	7
Urology	6
Radiation Oncology	6
Medical Oncology	6
Neuroradiology	5
Endocrinology, Diabetes, Metabolism	5
Pediatric Cardiology	5
Pediatric Critical Care	5
Addiction Psychiatry	5
Thoracic Surgery	4
Preventive Medicine	4
Rheumatology	4
Pediatric Infectious Diseases	4
Dentistry	3
Medical Genetics	3
Allergy and Immunology	3
Geriatrics	3
Nuclear Medicine	3
Neonatal-Perinatal Medicine	3
Pediatric Gastroenterology	3
Critical Care Surgery	2
Vascular Surgery	2
Pediatric Nephrology	2
Forensic Psychiatry	2
Pediatric Surgery	1
Plastic Surgery of the Hand	1
Critical Care	1
Pain Management	1
Pediatric Anesthesiology	1
Clinical Cardiac Electrophysiology	1
Hand Surgery	1
Sports Medicine	1
Blood Banking	1
Medical Microbiology	1
Pediatric Endocrinology	1
Geriatric Psychiatry	1
TOTAL	745

**Table 5A
University of Connecticut
School of Medicine
Distribution of Residents by Hospital
(1999/2000)**

School of Medicine	
John Dempsey Hospital	93
Hartford Hospital	162
St. Francis Medical Center	135
New Britain General Hospital	53
Veteran's Administration	12
Connecticut Children's Medical Center	50
TOTAL	505

Other residents are assigned to following institutions: Danbury Hospital; St. Mary's Hospital; Capitol Region Mental Health Center; Masonic Geriatric Healthcare Center; Hebrew Home and Hospital; Hospital for Special Care; and McLean Home.

**Table 5B
Yale University School of Medicine
Distribution of Residents by Hospital
(1999/2000)**

School of Medicine	
Bridgeport Hospital	30
Connecticut Mental Health Center	36
Hospital of St. Raphael	18
St. Mary's Hospital	20
Waterbury Hospital	20
W. Haven Veteran's Administration	124
Yale-New Haven Hospital	424
Other outpatient and inpatient site	82
TOTAL	754

Additional residents are assigned to other affiliated institutions and to other settings such as public schools and private offices.

Table 6
Total GME Payments from Medicare and Medicaid

	FY94	FY95	FY96	FY97	FY98
Yale-New Haven	\$29,105,302	\$29,444,065	\$29,636,439	\$29,635,417	\$34,107,504
Hartford	\$27,686,143	\$31,275,523	\$31,898,882	\$32,752,498	\$28,358,286
John Dempsey	\$5,512,325	\$6,175,032	\$7,897,551	\$8,801,589	\$8,697,159
St Raphael	\$17,060,782	\$19,832,892	\$20,283,452	\$21,546,602	\$18,227,462
St Francis	\$13,900,304	\$14,201,754	\$18,753,147	\$18,537,698	\$18,271,431
Bridgeport	\$11,336,461	\$11,912,497	\$12,355,856	\$11,254,687	\$9,120,930
St Mary's	\$6,590,832	\$6,127,395	\$7,527,873	\$8,493,311	\$5,844,480
Danbury	\$5,676,127	\$5,704,768	\$5,679,119	\$6,019,860	\$6,022,702
Norwalk	\$5,931,948	\$5,489,687	\$5,748,988	\$5,749,512	\$5,245,853
Stamford	\$3,530,806	\$3,791,774	\$3,644,799	\$4,076,310	\$4,026,044
St Vincent's	\$6,238,883	\$6,601,878	\$7,339,927	\$8,135,146	\$6,753,611
New Britain	\$5,369,462	\$5,649,072	\$6,298,939	\$5,331,297	\$4,696,351
Waterbury	\$5,589,127	\$5,121,907	\$5,671,701	\$6,686,711	\$5,618,002
Griffin	\$1,880,798	\$2,245,229	\$2,541,743	\$2,083,660	\$1,904,124
Greenwich	\$1,752,615	\$1,966,536	\$2,773,591	\$2,884,856	\$2,580,414
Middlesex	\$4,754,653	\$3,957,910	\$4,359,596	\$5,071,538	\$3,928,964
St Joseph's	\$1,193,552	\$1,343,322	\$1,572,134	\$1,380,520	\$1,015,004
	\$153,110,121	\$160,841,242	\$173,983,740	\$178,441,209	\$164,418,321

**Table 7
Medicare Indirect Payments**

	FY94	FY95	FY96	FY97	FY98
Yale-New Haven	\$20,384,129	\$21,158,627	\$22,186,123	\$23,091,305	\$25,368,012
Hartford	\$19,120,721	\$22,357,851	\$23,660,039	\$24,756,495	\$20,657,297
John Dempsey	\$4,065,873	\$4,864,240	\$6,636,753	\$7,675,436	\$7,138,070
St Raphael	\$12,847,410	\$15,079,488	\$15,474,341	\$16,827,309	\$14,316,961
St Francis	\$10,151,227	\$10,758,452	\$13,852,444	\$14,473,255	\$15,065,134
Bridgeport	\$6,435,838	\$7,711,876	\$7,980,016	\$7,801,101	\$6,326,538
St Mary's	\$4,314,829	\$3,895,679	\$5,269,666	\$6,360,903	\$4,190,445
Danbury	\$3,795,455	\$3,850,361	\$3,827,706	\$4,397,806	\$4,207,491
Norwalk	\$3,182,014	\$2,895,012	\$3,194,290	\$3,751,632	\$3,236,965
Stamford	\$2,449,925	\$2,666,055	\$2,866,036	\$2,902,275	\$2,913,363
St Vincent's	\$3,720,010	\$4,140,052	\$4,308,094	\$5,046,312	\$3,748,188
New Britain	\$3,651,745	\$3,914,135	\$4,488,347	\$3,607,225	\$3,198,533
Waterbury	\$3,864,901	\$4,204,815	\$4,206,244	\$4,847,021	\$3,744,457
Griffin	\$1,360,426	\$1,686,726	\$1,794,647	\$1,456,373	\$1,192,477
Greenwich	\$1,017,890	\$1,121,067	\$1,926,860	\$2,047,793	\$1,720,077
Middlesex	\$1,568,981	\$1,580,022	\$2,025,974	\$2,384,223	\$2,029,812
St Joseph's	\$639,124	\$703,136	\$868,030	\$829,960	\$470,689
	\$102,570,499	\$112,587,595	\$124,565,613	\$132,256,421	\$119,524,509

**Table 8
Medicare Direct Payments**

	FY94	FY95	FY96	FY97	FY98
Yale-New Haven	\$5,469,906	\$5,046,000	\$4,774,000	\$4,242,000	\$6,676,000
Hartford	\$6,645,524	\$6,906,165	\$6,805,409	\$7,020,340	\$6,814,452
John Dempsey	\$785,276	\$731,292	\$764,979	\$831,952	\$1,154,913
St Raphael	\$3,646,515	\$4,221,316	\$4,382,105	\$4,324,538	\$3,539,353
St Francis	\$3,300,000	\$3,010,738	\$4,304,046	\$3,618,430	\$2,746,163
Bridgeport	\$4,209,464	\$3,578,133	\$3,800,273	\$2,925,895	\$2,378,613
St Mary's	\$2,055,124	\$1,998,109	\$2,082,124	\$1,995,364	\$1,537,414
Danbury	\$1,619,815	\$1,581,923	\$1,653,864	\$1,456,930	\$1,625,458
Norwalk	\$2,443,230	\$2,319,249	\$2,278,111	\$1,809,832	\$1,809,832
Stamford	\$899,450	\$956,159	\$582,929	\$1,034,618	\$989,200
St Vincent's	\$2,247,982	\$2,270,635	\$2,819,340	\$2,924,723	\$2,820,510
New Britain	\$1,502,164	\$1,513,341	\$1,662,624	\$1,599,879	\$1,363,175
Waterbury	\$1,405,280	\$666,077	\$1,282,167	\$1,706,119	\$1,742,284
Griffin	\$507,819	\$507,819	\$690,419	\$592,684	\$690,419
Greenwich	\$720,000	\$810,484	\$797,356	\$814,297	\$843,751
Middlesex	\$3,053,301	\$2,258,806	\$2,244,151	\$2,614,448	\$1,838,478
St Joseph's	\$518,639	\$601,487	\$663,000	\$526,442	\$526,354
	\$41,029,489	\$38,977,733	\$41,586,897	\$40,038,491	\$39,096,369

Table 9
Medicaid Fee-for-Service Payments

	FY94	FY95	FY96	FY97	FY98
Yale-New Haven	\$3,251,267	\$3,239,438	\$2,676,316	\$2,302,112	\$2,063,492
Hartford	\$1,919,898	\$2,011,507	\$1,433,434	\$975,663	\$886,537
John Dempsey	\$661,176	\$579,500	\$495,819	\$294,201	\$404,176
St Raphael	\$566,857	\$532,088	\$427,006	\$394,755	\$371,148
St Francis	\$449,077	\$432,564	\$596,657	\$446,013	\$460,134
Bridgeport	\$691,159	\$622,488	\$575,567	\$527,691	\$415,779
St Mary's	\$220,879	\$233,607	\$176,083	\$137,044	\$116,621
Danbury	\$260,857	\$272,484	\$197,549	\$165,124	\$189,753
Norwalk	\$306,704	\$275,426	\$276,587	\$188,048	\$199,056
Stamford	\$181,431	\$169,560	\$195,834	\$139,417	\$123,481
St Vincent's	\$270,891	\$191,191	\$212,493	\$164,111	\$184,913
New Britain	\$215,553	\$221,596	\$147,968	\$124,193	\$134,643
Waterbury	\$318,946	\$251,015	\$183,290	\$133,571	\$131,261
Griffin	\$12,553	\$50,684	\$56,677	\$34,603	\$21,228
Greenwich	\$14,725	\$34,985	\$49,375	\$22,766	\$16,586
Middlesex	\$132,371	\$119,082	\$89,471	\$72,867	\$60,674
St Joseph's	\$35,789	\$38,699	\$41,104	\$24,118	\$17,961
	\$9,510,133	\$9,275,914	\$7,831,230	\$6,146,297	\$5,797,443

Table 10
Medicare Fee-for-Service Discharges

	Discharges 94	Discharges 95	Discharges 96	Discharges 97	Discharges 98
Yale-New Haven	8,763	9,281	9,797	9,970	9,067
Hartford	11,111	11,295	11,273	11,857	10,751
John Dempsey	1,806	1,988	1,996	2,299	2,098
St Raphael	9,542	10,444	10,656	11,085	10,158
St Francis	7,660	7,759	10,022	10,520	9,567
Bridgeport	6,173	5,983	5,784	5,521	4,227
St Mary's	5,288	5,353	4,976	4,688	4,143
Danbury	5,438	5,327	5,086	4,811	4,667
Norwalk	4,735	4,574	4,410	4,371	4,122
Stamford	3,185	3,388	3,296	3,384	3,504
St Vincent's	6,959	6,772	6,900	6,401	5,108
New Britain	5,101	5,159	5,400	5,353	5,027
Waterbury	4,938	4,917	4,878	5,006	4,349
Griffin	2,746	2,882	2,789	2,684	2,390
Greenwich	2,709	2,999	2,887	3,008	2,928
Middlesex	4,357	4,330	4,276	4,433	4,148
St Joseph's	2,172	2,156	2,010	1,736	1,075
	92,683	94,607	96,436	97,127	87,329

**Table 11
Number of Resident FTEs per Hospital**

	FY 94	FY 95	FY 96	FY 97	FY 98
Yale New-Haven	335	335	310	310	400
Hartford	238	238	225	209	209
John Dempsey	110	124	140	127	117
St Raphael	114	122	125	125	125
St Francis	103	100	130	116	131
Bridgeport	84	80	83	82	91
St Mary's	49	46	60	61	54
Danbury	60	60	56	54	56
Norwalk	47	43	47	50	48
Stamford	41	41	38	38	41
St Vincent's	43	46	46	52	53
New Britain	48	50	50	44	46
Waterbury	50	51	47	49	47
Griffin	19	20	21	19	19
Greenwich	19	19	23	21	20
Middlesex	14	16	16	17	16
St Joseph's	12	12	12	13	13
CCMC			60	59	59
Total with w/o CCMC	1,387	1,404	1,429	1,387	1,486
Total with CCMC	1,387	1,404	1,489	1,446	1,545