Report to the Governor on the University of Wyoming Family Medicine Residency Programs

Preface

This document constitutes the report requested by the Governor of Wyoming pertaining to UW's Family Medicine Residency Programs (FMRP) in Casper and Cheyenne. Governor Mead, in his budget recommendations to the legislature for the 2013-2014 biennium, stated: "I recognize the importance of the services both clinics provide in these communities and I have asked the University to explore other delivery options with the Department of Health that may be more efficient. I recommend that the University be required to evaluate both programs and submit a plan that addresses the services provided to both students and community members and to provide options for a more efficient delivery system."

This document is the result of those explorations. It provides an overview of the programs, their histories, a description of fiscal and administrative challenges, an examination of various delivery options and a recommendation on how to proceed.

In developing the report, UW had discussions with officials from the state Department of Health, specifically Mr. Thomas Forslund and Dr. Wendy Braund. Additionally, drafts of the report have been circulated to the administrations of the sponsoring hospitals, the Wyoming Medical Center and Cheyenne Regional Medical Center, for their review.

Overview of Residency Programs

The University of Wyoming Family Medicine Residency Programs were established in Casper and Cheyenne in the 1970s as part of an overall plan to address the shortage of primary care physicians in Wyoming and to provide access to medical education for Wyoming citizens. Family medicine requires three years of training beyond the MD or DO. The program in Casper has 8 residents per year, and the program in Cheyenne has 6 residents per year, for a total of 24 and 18 residents in training, respectively. A timeline for the residencies is included in Appendix I.

The residency programs have three main purposes. The fundamental purpose is educational – to provide a medical education to family medicine residents through direct patient care. Both residency programs have been and continue to be successful in meeting this goal. The residency programs combined have graduated close to 400 board-certified family medicine physicians since their inception. Many of these graduates practice in Wyoming and the Rocky Mountain region. Although it is difficult to calculate exact state retention numbers, it is estimated that between 35-40% of graduates over the past 30 years have practiced in Wyoming. The Casper program alone has over 20 graduates practicing in Casper and over 50

graduates currently practicing across Wyoming. The Cheyenne program has 30 graduates currently practicing in Wyoming and has had a total of 71 physicians who have practiced in Wyoming at some point in their careers.

A second purpose is to provide clinical training for students pursuing other health professions and a resource for college research and service. Many College of Health Science professional students (nurses, pharmacists, etc.) and medical students from WWAMI and other programs have received some of their experiences in direct patient care in the team-based, "patient-centered medical home" environment of these facilities. Unlike states with major metropolitan areas, the residencies are the only teaching sites in Wyoming that offer this educational environment in ambulatory care. They are an integral component of UW's medical education program, the other components being strong pre-medicine academic preparation and the WWAMI medical school affiliation, and they are important to the training of other health professional students from UW and Western Interstate Commission on Higher Education (WICHE) programs. Additionally, the two residencies provide research laboratories and service to the state for testing new methods of providing health care delivery, such as the "patient centered medical home" with the Wyoming Integrated Care network and the "virtual pharmacist" with the Cheyenne Regional Medical Center CMS Innovation grant. It is expected that the residencies will house translational (bench to bedside) research endeavors in the future.

The third purpose is safety-net health care. Since their establishment, the FMRPs have provided essential medical care for citizens, regardless of their ability to pay. Both residencies are the safety-net providers for their communities and provide medical care access to patients who are financially less attractive to other providers. These include patients covered by Medicare or Medicaid, uninsured or underinsured, and the indigent. Previous program directors estimated that seeing these patients in the clinic as opposed to the emergency room results in substantial cost savings to Medicaid. Uncompensated care is a constant challenge for the community hospitals, and the residencies decrease the impact on local hospitals in providing services for which they will not be compensated.

This issue is one of the factors for the strong support the hospitals have shown the residencies. The Casper residency had 33,000 patient visits last year: 7000 inpatient visits, 24,000 clinic visits and nearly 2000 nursing home visits. They delivered nearly 200 obstetrical patients. The Cheyenne Residency had 28,700 patient visits last year: 7400 inpatient visits, 18,000 Cheyenne clinic visits, 500 nursing home visits and 1700 patient visits at the Pine Bluffs clinic.

The residencies are the largest safety net primary health care providers in Wyoming. In recognition of this key role in the provision of health care, the legislature removed the funding of the residency programs (as well as WWAMI, WYDENT, the accelerated nursing program and psychiatric nurse practitioner loan repayment program) from the UW block grant and created a related but separate budget account – Agency 167, Medical Education. This budget recognizes the missions of the FMRPs as being both educational and direct service. It is a reminder that

the funding of these programs is the result of public policy decisions pertaining to both higher education and health care delivery in Wyoming's two largest cities.

The safety-net mission of the residencies has important fiscal implications. While clinic revenues constitute an important source of funding for the programs, the patient mix makes it difficult to generate the more robust revenues that hospitals or other clinics must depend on for their survival as businesses. We review the residencies' funding profiles below.

Both residencies enjoy strong community relationships with their respective hospitals, physicians and most other healthcare providers in their communities. Many of these providers help teach FMRP residents and other students. The expectation is that residents can and do contribute to their practice sites, underscoring the mutually beneficial relationship of having the FRMPs in these communities. This has become a standard philosophy in healthcare education. Benefits to the host site include the satisfaction of giving back to the profession and learning new and updated information about the profession and the specific facts relating to advances in medicine. The activity of teaching alone increases the quality of care in the community.

Funding of Residency Programs

Most family medicine residency programs in other states receive funding from three primary sources: state appropriation, clinic income, and Medicare Graduate Medical Education (GME) reimbursement.[1] Each of these three revenue sources typically makes up roughly one-third of a residency's total funding. Wyoming is unique in that only two of these funding sources support its Casper and Cheyenne residencies. By its own choice, Wyoming is the only state in the nation that does not receive any federal GME support, and this fact, together with the patient mix associated with the safety-net mission, continues to create funding challenges.

GME support is comprised of two distinct pieces: Part A - Direct Medical Education (DME), and Part B - Indirect Medical Education (IME). DME provides support for residency operations, and IME provides support to the hospital for hosting a residency program. In general terms, DME is calculated as the Medicare proportion of total allowable educational costs. If the residency programs were eligible to receive DME support, they could receive approximately $1 million/year per residency program. The residencies do not receive either direct GME support from CMS nor indirect GME from a hospital pass-through.

On the other hand, IME is derived from a complex formula based in part upon total physician resident FTE's operating within the hospital. Wyoming Medical Center (Casper) and Cheyenne Regional Medical Center (Cheyenne) have financially benefitted through receiving IME payments of approximately $850,000/year each. The current view of both hospitals is that this is an expense incurred by the inefficiency of educating residents and no money should be returned to the residency programs. Given the financial realities facing hospitals in rural states, UW does not expect the local hospitals to agree to forward IME payments to the FMRPs. While there is

[1] American Academy of Family Physicians, Residency Program Solutions, Review, Cheyenne, December 5, 2011

compelling evidence to suggest that UW residencies are at least as productive (if not more so) and actually less expensive than comparator external physicians with hospital privileges in these communities, UW is not suggesting a change in the current distribution of IME payments to the hospitals.

History

In establishing the residency programs in the late 1970s, Wyoming elected not to participate in GME. The factors in that decision included a strong state financial picture and a desire for independence from federal mandates. When the residencies were established, the legislature prohibited them from seeking GME funding. Once this decision was made, the programs became "established" in the view of Medicare, and therefore, ineligible for any current or future GME support.

Several attempts at the state level have subsequently been made to obtain GME support, most notably in the early 1990's by Wyoming Medical Center and in the early 2000's by the Community Health Center of Central Wyoming. Both efforts failed to prevail at the federal level. The Centers for Medicare and Medicaid Services (CMS, the federal program administrator) ruled that Wyoming's FMRPs are ineligible because they were not new programs. Wyoming, therefore, continues its reliance on just two funding sources: state appropriations and clinic income.

With the renewed national emphasis on increasing the number of primary care physicians and training in community-based settings, the rules for GME funding may be revised, which could allow funding of Wyoming's programs. However, this outcome hinges on federal policy and is far from certain. Any future attempt to acquire GME funds would more likely require a change in the CMS interpretation of the rules and would require the support of the Wyoming congressional delegation to develop legislation favorable to enabling the UW FMRP's obtaining DME.

The lack of DME funding has required the state to provide much more than a third of the funding for the FMRPs for the past thirty years. Additionally, the residency programs' business models have relied on unrealistically high estimates of clinic revenue streams in an attempt to balance their budgets. Given the residencies' responsibilities as safety-net providers, the limited ability of their patients to pay, and the relatively low number of high-revenue producing procedures done in family medicine, the actual revenues have seldom met projections.

This situation has created fiscal and administrative problems. The reliance on state funds and clinic revenue has understandably precipitated concerns at both the state and university levels with respect to the financial stability of the FMRPs. "Why are these programs so expensive?" is a question frequently asked by legislators and others. In turn, this financial uncertainty leads to programmatic instability and uncertainty, manifested in the low faculty physician salaries

compared with market averages, accreditation citations, the low faculty and staff morale, and concerns about program quality. This pattern creates a downward spiral that could be the undoing of the programs if it is not averted. At one time, these programs were known nationally as top programs for rural family medicine. This is no longer the case. The university would like them to return to that status.

There have been different but significant changes at each of the residency programs that have had financial consequences. In Cheyenne, in 2008, UW requested an increase of $4.79 million in the biennial budget authorization. The plan, developed in an effort to overcome fiscal shortfalls prevalent at the time, was to generate these monies in the form of increased clinic revenues enabled through the hiring of 20 additional full-time and 6 additional part-time employees. This request was made under the state's B-11 process, in which the Governor may approve increased expenditures where additional revenues are anticipated. In 2009 the Cheyenne clinic revenue increased by 50% over the previous year; nevertheless, this increase fell short of the projections reflected in the B-11 request.

There were several reasons for the shortfall. One was a decreased number of paying patients due to the national recession. Compounding this problem were issues associated with business practices — especially billing, conversion to an electronic medical record and the management of accounts receivable — and the methods used to make financial projections. Finally, patient volume has decreased with the opening of new private clinics in Cheyenne..

UW took corrective steps to address these issues, including removing the Cheyenne program director and business office manager, eliminating two specialty physician positions, and outsourcing the clinic's billing. Collections remained an issue, and the former billing agency was dismissed and replaced by the same billing company used at the Casper residency. These corrective steps have helped address some of the fiscal and administrative problems. However, in the University's estimation, clinic income alone will never be sufficient to fill the fiscal gap created by the absence of GME funding. Without access to GME funding, the normal business model for residency programs that operate elsewhere in the nation does not work in Wyoming.

The Casper program faced a more difficult issue, because it involved governance as well as fiscal problems. In 2000, as part of an effort to address the structural funding shortfall and seek GME revenues, the residency entered into an affiliation agreement with a newly established Community Health Center of Central Wyoming (CHCCW) that operates under its own Board of Directors. Under this agreement, CHCCW managed the daily medical clinic and facilities operations, while UW continued to provide graduate medical education. The CHCCW was given all of the clinic's medical equipment and received all of the income generated in the clinic, much of it by the residents and faculty in the hospital. CHCCW also rented space in the UW clinic at a favorable rate. The state and university remained responsible for the educational components of the residency program including all faculty, resident and staff salaries.

The relationship was problematic for most of the time it existed. The contention centered on conflicts between the respective missions: education for UW's residency program and income generation through patient care for the CHCCW. In 2010 the CHCCW received federal funding to build a new clinic; this introduced a new dynamic in the relationship and the need to renegotiate the arrangement. However, attempts to renegotiate the contract were unsuccessful. The major concerns centered on the refusal of the CHCCW to alter business practices that UW regarded as detrimental to the residencies' accreditation and to disagreements over how much of the residency program's state budget UW should forward to CHCCW. To mitigate these issues, UW proposed merging the functions under an Educational Health Center — a federally defined structure that allows for increased rates of Medicare and Medicaid reimbursement. The CHCCW Board of Directors rejected this proposal. After lengthy discussions, UW and the CHCCW agreed to dissolve their affiliation agreement effective July 1, 2011.

UW estimates that the transition to independent clinic operations required $1.22 million in one-time new equipment purchases and $3.09 million/year in staffing (32 positions) and support, to offset the loss of staffing and support provided by CHCCW. The UW administration allocated $2.31 million in one-time, non-appropriated funds[2] to cover the equipment costs and that portion of the staffing and support costs that estimated clinic revenues for FY 2012 would not cover. UW also requested and received permission from the state to collect and spend clinic revenues formerly collected and spent by CHCCW, up to $2 million/year. UW will use limited internal funding to continue covering the shortfall of approximately $800,000 in FY14 but may need to request additional state funding assistance for the FY15/16 biennium.

Compounding the financial issues at the residency programs are the continual changes occurring in healthcare nationally. It is well known that healthcare costs in the U.S. continue to increase unabated. There are numerous reasons for this increase, including federal mandates. For example, to maintain Medicare reimbursement at current levels, the providers must use an electronic medical record system. Another example is the requirement to maintain compliance with the Health Insurance Portability and Accountability Act; the residencies have recently spent over $20,000 on this issue alone. Medicare, Medicaid and private insurance billing has become much more complex and can no longer be accomplished in-house, requiring outsourcing. Additionally, there have not been any increases in salaries for residency center employees for several years, yet average salaries for the same professionals have increased dramatically in the private sector. Information from the Wyoming Health Resource Network indicates that it takes a minimum of $220,000/year in salary to recruit a family physician to Wyoming. Salaries for new hires at the residency programs are budgeted in the $150,000/year range, thus increasing the challenge of recruiting and retaining faculty. Additionally, the university has been recruiting for program directors for each of the programs for over a year, and the low salaries have been the main reason the searches have been unsuccessful.

[2] This money was from one-time funds dedicated to medical education which remained from the payback of medical students not returning to Wyoming from the contract program that UW once had with Creighton University.

Consultants' reports

The financial and administrative challenges described above are not new. They have plagued the residency programs for years, and UW has attempted to address them in numerous ways based upon internal and external reviews.

There have been a number of consultants who have reviewed the residency programs over the past three years. Each accreditation visit is a thorough external review, and each of these is customarily preceded by a WWAMI external review. Maintaining accreditation is extremely important for a number of reasons, the foremost being that it ensures a quality program. Accreditation is also necessary for residents to enter professional practice: residents must graduate from an accredited program to sit for board certification, and board certification is needed for practice. While both residency programs remain accredited, concerns about their future ability to meet accreditation standards have led the Accreditation Council for Graduate Medical Education to recommend reviews on a more frequent basis than the normal 5-year cycle. The following is a list of the reviews over the past three years.

Date	Reviewer	Recommendations
November 2, 2009	American Academy of Family Physicians, Residency Program Solutions Review - Cheyenne	• Outsourcing billing and collection functions • Address accounts receivable • Address staffing issues in the clinic business office • UW should maintain regular active engagement in the fiscal management of the practice • Investigate FQHC (Educational Health Center) model • Discuss GME funding possibilities with CRMC
January 27, 2010	WWAMI Internal Review - Casper	• Address leadership issues • Address major financial issues around the lack of financial flow from the CHCCW. "if there is no margin, there is no mission and there must be a wider margin for the program to grow, evolve and be sustainable going forward." • Improve both internal and external communications, including the community health center and their medical director • Improve teamwork including committees with the CHCCW • Residents need to see more CHCCW patients • Community Health Center tensions: "This is a major problem for the program. Either the program must tighten up its affiliation agreement/contract with the Community Health Center to get the financing and relationships straight between the two entities or contemplate a separation from the Community Health Center. … Basically, he Community Health Center has to come to recognize the value of the residency, not only in the terms of seeing patients but also growing its workforce for not only the community of Casper but also the state of Wyoming." • Increase community physician teaching
February 24, 2010	WWAMI Internal Review - Cheyenne	• Program demonstrates solid compliance with ACGME accreditation guidelines

		• Access UW resources regarding curriculum development • Continue to improve internal communications • Improve intraining exam scores and Board Certification Exam results
March 23, 2010	ACGME Accreditation - Casper	• 16 citations including: high rate of resident attrition, Faculty/sufficient time devoted to program not ensured, goals and objectives not competency-based, lack of program evaluation by residents, lack of documentation of procedures, continuity of care not ensured, minimum number of total and continuity deliveries not ensured and poor performance on board scores. • Accreditation continued for 2 years (full accreditation is 6 years)
April 28, 2011	Community Link Consulting (CLC) – Casper	• CLC explored and delivered three primary options and two alternative options to develop an EHC • One option was not accepted by the CHCCW - "As outlined by UWFMRC, merging with CHCCW would require modification of CHCCW's mission and bylaws and reconfiguration of Board of Directors to support the educational mission of the residency. Recent conversations between CHCCW's Board of Directors and UWFMRC indicate that CHCCW is not open these modifications. In the agreement letter dated April 19, 2011, CHCCW stated that it will not transition its current operations into an EHC. As a result, both parties agreed to retain a consultant to assist a transition committee comprised of representatives of both organizations." • CLC strongly recommends beginning the process to become an EHC as soon as possible to take advantage of the increased reimbursement rates. • CLC reviewed the proposed bylaws for an EHC and had no material changes. • CLC recommended they provide an FQHC Look Alike Application that includes an umbrella organization for the UWFPR-Cheyenne, meet all HRSA guidelines, and develop the appropriate administrative relationship between the EHC and UW. • CLC explored the potential for qualifying for GME funding with the Wyoming Medical Center.
August 5, 2011	ACGME Accreditation - Casper	• Accreditation visit was accelerated due to concerns regarding last accreditation visit. • 10 citations • Accreditation continued for 2 years (full accreditation is 5years)
August 5, 2011	ACGME Accreditation - Cheyenne	• 11 citations • Accreditation continued for 3 years (full accreditation is 5 years)
December 5, 2011	American Academy of Family Physicians, Residency Program Solutions Review - Cheyenne	• Programmatic restructuring/realignment that may include development of a faculty practice plan and/or realign program structure in partnership with CRMC • Recruit a visionary and effective program director • Address billing and collections issues

		• Fill faculty and staff vacancies • Access feasibility of joining the CRMC EPIC electronic health record • Address accreditation citations • Pursue Patient Centered Medical Home (PCMH) Certification
May 24, 2012	WWAMI – Internal Review - Casper	• Need for a permanent program director • Address funding model with Direct Graduate Medical Education funds or establishing an Educational Health Center • Doing well in addressing accreditation issues

To date, UW has been able to address the most critical of these recommendations. However, these reviews have revealed some common, persistent problems:

- The programs are underfunded when compared with other programs in the region.
- Faculty salaries are low.
- There are detailed accreditation issues at both programs (which UW is addressing).
- Finding stable, experienced leadership for the programs is a challenge at existing salary levels.
- There are educational quality issues connected with the problems listed above.
- There are business models that may increase clinic income, such as a Federally Qualified Health Center (FQHC) structure — in particular an Educational Health Center — or a faculty practice plan, as discussed in more detail below.
- While obtaining federal GME funding may be possible, it is unlikely to come from the hospitals, and current federal regulations exclude the UW residencies from this funding stream.

Substantial progress has been made by both residencies in addressing the accreditation and the educational quality issues. Leadership issues for medical education remain but are currently being addressed.

Options

A premise underlying all of the options examined here is that the FMRPs serve critical functions for Wyoming. They provide medical education to residents, offer medical care to low-income patients, and recruit and prepare primary care and family medicine physicians to practice in Wyoming. Based on this premise, we do not examine the option of eliminating the programs altogether.

The need for primary care physicians will become even more critical in the future. Nationally, the Affordable Care Act (ACA) will extend insurance coverage to many more people, which will escalate the physician shortage[3]. Wyoming is already facing a shortage of physicians due to retirement of an estimated half of the physicians in the state within 10 years of age 65. The Wyoming Department of Workforce Services estimates that the state will have an average

[3] New York Times, July 28, 2012

annual opening of 56 positions for just the category of "Family & General Practitioners" for the 2010 to 2020 time period.[4]

Below are various options for bringing fiscal and administrative stability to the FMRPs. The report is then concluded with a recommendation for a course of action.

Option 1: Relocate the Oversight to Another Agency.

The residencies have the dual missions of education and direct patient care services, which makes providing oversight complex. The University of Wyoming has extensive expertise in the management of advanced educational ventures but does not have the same degree of expertise in the management of a highly complex medical care facility. However, the university has been doing this for over 30 years. There is no other state entity with UW's level of experience in managing a medical residency program.

We concluded from our discussions with the Wyoming Department of Health that it would not be an appropriate agency to provide oversight for the residencies and that the university remains the only appropriate state agency. Our discussions also made it clear that any state agency running the residency programs would ideally have a business officer devoted to the medical education budget. The University Medical Education (Agency 167) budget does not currently have this position.

Other than state agencies, the hospitals in Casper and Cheyenne could provide the expertise needed for managing the clinics and the services they provide, but for business-related reasons they have been reluctant to assume this fiscal responsibility in the past. Additionally, they would not have the expertise in graduate medical education to provide the educational services; hence, this function would most logically remain with the university. This type of arrangement could have the potential for conflict relating to inherent discrepancies in missions and governance, perhaps not with the current administrations but quite possibly in the future. Similar considerations arise in contracting with a for-profit entity to run the residency programs.

Option 2: Establish an Educational Health Center.

The Educational Health Center is a relatively new federal program through the US Department of Health and Human Services, Health Resources and Services Administration (HRSA), designed to support primary care education. The program provides access to financial benefits and grant opportunities available to Federally Qualified Health Centers (FQHC) as defined in federal statute.[5] During the past 16 months, UW has explored the possibility of the FMRPs becoming Educational Health Centers (EHCs). The premise of these explorations has been that it might be possible to structure an EHC that would both meet federal FQHC guidelines and possess an acceptable system of governance. . UW's desire for appropriate control over the budget and

[4] Health Care Workforce Needs in Wyoming: Advancing the Study, Occasional Paper No. 6, Fall 2011, Research & Planning Wyoming DWS, Wyoming Workforce Services.

[5] Public Health Services Act of 1996 (PHSA, 42 U.S.C.).

personnel matters would have to be balanced with HRSA requirements for a governing board independent of the university's Board of Trustees. As discussed below, this balance is difficult to achieve and has significant implications.

EHC designation would increase clinic income and have other financial benefits but would not provide direct federal funding. It is estimated that the clinic income would increase by approximately $1,000,000 at each residency, through the following mechanisms: (1) increased Medicare and Medicaid reimbursement, (2) access to grant funding, (3) National Health Service Corporation Loan Repayment for faculty physicians, (4) increased patient access, and (5) Federal Tort Claim Act malpractice coverage. Additionally, patients would receive access to less expensive medications through federal pharmacy pricing provisions. These benefits are considerable and extend beyond just a financial benefit for UW.

Still, as indicated above, there are tricky governance issues associated with this option. The federal law[6] governing FQHCs in general, and EHCs in particular, mandates that these centers come under the authority of governing boards having prescribed structures. In UW's case, the constitutionally established governing board — the Board of Trustees — cannot fulfill this function. This constraint allows conflicts to arise between the clinical mission and the educational mission.

Understanding the UW/CHCCW relationship in Casper is critical to this discussion because of the parallels between that relationship and the EHC option. The CHCCW — a health center meeting the FQHC governance guidelines — was formed by UW to gain access to additional revenues that would help augment state appropriations. It was assumed that CHCCW would also be an educational partner. During this partnership, UW provided, in aggregate, $10 million in direct grants and $20 million in clinic income to the CHCCW, without significant financial benefit to the university. The CHCCW's bylaws, governance and mission statement were not developed to support graduate medical education; they were structured to support revenue generation through clinical operations. This context set the stage for repeated conflicts between UW and the CHCCW Board during most of the 10-year partnership. Because federal statute requires that health centers answer to governing boards different in nature from the university's constitutionally established governing board (the Board of Trustees), conflicts between the revenue-generating mission and the clinical education mission are virtually unavoidable and can be nearly intractable under this structure. The resulting separation in 2011 required UW's Casper program to re-assume clinic operations on its own. After one year and considerable expense on the university's part, the Casper FPR program is experiencing increasing patient volume, clinic income, and educational opportunities for the residents.

The point of the previous paragraph is that governance-related concerns are far from abstract. They can impose serious barriers to the educational mission, and they cost a lot to fix.

[6] PHSA, 42 U.S.C.254b, especially §330.

UW has undertaken great effort to mitigate the governance-related concerns, including the writing of draft bylaws and agreements. However, these drafts have not had legal review, nor have they received approval by HRSA. They have been modeled after the Richmond Clinic in Portland, Oregon, a functioning EHC family medicine residency. There will need to be other drafts to address remaining governance-related concerns or differing federal interpretations of the complex rules.

There are other hurdles that will need to be overcome. The residencies would need to be functioning as an EHC prior to any HRSA review. HRSA will critically look at overlap of services and the governance structure of each model. In Casper, the CHCCW will probably oppose the establishment of an EHC, which they would understandably regard as competition. However, the Wyoming Primary Care Association has stated they would support such an application.[7] From UW's perspective, the key issue is whether it is possible to design a viable governance structure — one compatible with the educational mission as well as the clinical mission.

The UW and College of Health Sciences administration is currently contracting with Community Link consultants to evaluate the feasibility of establishing an EHC at both residencies. If this option is viable — an outcome that is still uncertain — it has the capacity to increase clinic revenues by increasing the rate of reimbursements from Medicare and Medicaid. Whether such increases would suffice to eliminate the programs' funding shortfall remains uncertain.

Option 3. Create a Teaching Health Center.

The Teaching Health Center (THC) is another relatively new FQHC-based program through HRSA, designed to provide federal funding for the expansion of family medicine residencies within community health centers. It does not provide increased funding for existing operations but would bring FQHC status to clinic operations. It is a demonstration project in the Affordable Care Act and is authorized only for five years.

UW's Dean of the College of Health Sciences and the Director of Medical Education have worked with consultants regarding the possibility of establishing a THC at the residencies. The efforts regarding establishing a THC at the Cheyenne residency have been supported operationally and financially by both the Cheyenne Regional Medical Center (CRMC) and Cheyenne Health and Wellness. The THC designation provides federal funding but only for additional new residents. Additionally the holder of the FQHC authorization, Cheyenne Health and Wellness, would have to be the applicant for a THC designation. To be able to qualify CHW would have to be the fiscally responsible party for the residency. This would create the potential for a situation similar to the one UW experienced in Casper with the CHCCW; the university would have responsibility

[7] Email, Patrick Monahan, MBA, MPA, Executive Director, Wyoming Primary Care Association.

for resident education but may not have a stake in the clinic operations necessary to provide that education.

After much study, UW and the other agencies involved determined that this model would be unworkable for the residencies because of irresolvable fiscal responsibility, educational responsibility and governance issues.

Option 4: Seek Direct Graduate Medical Education (DGME) Funding Through Medicare.

As described above, GME funding is used by virtually all medical residency programs with the exception of those in Wyoming. There is the possibility that as healthcare provision and education evolve under the federal Affordable Care Act, the funding model for primary care will change allowing for direct funding of the Wyoming programs. UW has discussed this possibility with Representative Lummis and her staff, and she agreed to add her name as a cosponsor of a bill to change the distribution of GME funding to a model more favorable to the Wyoming residencies.

To receive DME funds under CMS's current regulations would require a program restructuring and realignment with respective hospitals. This would require the hospitals to become financially responsible for the residency programs. As adapted from a consultant's report, the roles of the university and the hospital may be similar to those detailed in the table below.

Differential Roles:

University Role	**Hospital Role**
• Provides Resident Stipends+ EPB	• Continues to support current resident recruitment, meals etc.
• Leases use of FMC to Hospital	• Leases FMC from university
• Provides teaching and administrative cost of the residency	• Provides FMC personnel and supply costs
• University transfers clinic management to hospital	• Practice is a part of the Hospital Community Practice Network
• Maintains high level of program accreditation and high quality graduates	• Receives clinic income
• Equal representation on a Program Governing Board	• Equal representation on a Program Governing Board

It is difficult to estimate how the flow of funds would change for each partner. However, with a representative governing board and opportunities for annual renegotiation, this model has potential benefits. Obviously, the hospital would have the greatest increase in financial contribution compared to the current situation. The hospital would be able to integrate the FMC into its practice group and would be able to help ensure the future stability and growth of the program.

One major disadvantage is that Wyoming Medical Center in Casper and, to a lesser extent, the Cheyenne Regional Medical Center in Cheyenne have in the past been reluctant, for business reasons, to assume any financial responsibility for the residency programs. The current financial situations of the hospitals and uncertainty created by the Affordable Care Act make a change in their interest in this model unlikely.

The other option to receiving GME funding would be to enlist the Wyoming's delegation support in seeking legislative authorization to allow these residencies to participate. There is currently discussion as to alternatives for federal funding of primary care residencies that do not rely on a hospital acting as the intermediate, so this may be a timely request. Additionally, some of the consultants have expressed the opinion that the Wyoming residencies obtaining GME funding is not as unobtainable as it was in the past.

Option 5: Establish a Faculty Group Practice

Currently, UW faculty physicians working at the residency programs bear no cost of the clinical practice and have no financial incentive to grow the practice. Establishing a group practice owned by the faculty — either under the auspices of the university or at arm's length as a Limited Liability Corporation (LLC) — could accomplish the following:

- The physician faculty members would become personally financially responsible for the clinic operations.
- Increased clinic revenues could possibly decrease the university's appropriation to the program over time.
- The new incentives would shift most of the responsibility for the success of the clinical practice to faculty and program administration.
- UW might acquire capacity to fund programmatic growth from increased income generated.

Under this model the faculty practice limited liability corporation (LLC) would receive all clinic collections. From that income they provide a percentage of their salaries and the salaries for clinic support. Because the faculty members and the clinic would still provide education, the university would still provide for the bulk of the faculty members' salaries, for some clinic support services and for all of the educational expenses, including the resident's salaries. This could then potentially leave a margin to fund new faculty and staff positions, improve billing and collecting even at an increased cost, and pay a clinical incentive to high quality and/or very productive clinicians.

A partnership or contract between UW and a faculty-driven LLC is very possible with the right leadership. The state would relinquish the clinic income and the LLC would assume a negotiated portion of the expenses. Net financial support by the state will probably not change initially, but the opportunity for financial growth and salary increases would rest with the LLC. A major challenge to this model will be malpractice coverage. Faculty members are currently

covered under the state's malpractice umbrella. With a LLC this would not be the case, and as a result the model might end up being more expensive that the current one.

A faculty practice plan will not replace current funding. State funding will still be necessary to form the base funding for the educational costs of the programs. It would be necessary to use the additional clinic revenues to bring faculty members' salaries up to market levels. This may improve the university's ability to recruit and retain faculty, which will in turn improve the quality of the residents' educational experiences.

However, there are downsides to this model. It may take away valuable teaching time, as faculty members would have increased incentives to spend more time in patient care activities that generate income. It may take patients away from the residents at a time when resident patient visit numbers are an accreditation concern. The current patient mix, resulting from the residencies' mission to provide safety-net health care, is not conducive to this model. As a consequence, patients with more ability to pay would be recruited, and this dynamic would place state employees — UW faculty members — in direct competition with local healthcare providers.

Option 6: Downsize

Downsizing the residencies to meet the current money allocated in the budget is the least attractive alternative. The residencies are currently under-funded, resulting in compromised quality. The overall program expense for the Cheyenne program is approximately $7.4 million/year, including employer paid benefits.[8] The mean expense of comparable family medicine residency in size similar to the Cheyenne program (18 residents) in the WWAMI states is $8.3 million per year.[9] "Thus the program is not over-resourced and is less costly than other similar sized programs."[10] A similar statement can be made for the Casper program (24 residents), where the cost of $7.6 million/year is actually even less on a per resident basis. It would be difficult to take smaller classes of residents, because patient coverage has to be maintained continuously and there must be a sufficient number of residents and faculty for 24 hours a day, 7 days a week.

Option 7: Consolidate the Two Programs

The only other option under downsizing would be to close one of the programs and shift most of the resources to the other residency. Consolidation does allow for continuation of a viable program at the current level of state funding, including the training of residents of which 35-

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[8] Because of accreditation issues, the Cheyenne program attempted to address inadequate funding in 2008 with a business plan and B11 request. When that business plan's income was not realized, UW cut the residency's budget with substantial savings. However, going back to pre-2008 funding would not provide sufficient financial support for the operation of the program.

[9] Lesko S, Fitch W, Pauwels J, Ten-year trends in the financing of family medicine training programs. Fam Med 011;43(8):543-50

[10] David AK. Confidential Residency Program Solutions Consultation Report on the University of Wyoming Family Medicine Residency Program, Cheyenne, Wyoming. December 2011.

40% will continue to practice in the state; the continued provision of health care to low-income patients, albeit at a lower level; and the ability to attract quality faculty and staff that would help address accreditation issues. This would not result in any cost savings but would allow the remaining residency to be funded at appropriate levels.

While this option appears feasible, it has disadvantages. It decreases the number of residents in training, which will decrease the number of family medicine physicians available to recruit and practice in the state. It will eliminate UW's safety-net health care for that community, potentially forcing those patients to seek medical care at the hospital's emergency room. Other community agencies are probably not available to fill the safety-net gap. That community hospital would have increased costs for indigent care, and state Medicaid costs would also rise because patients would be getting emergency care for more acute conditions rather than less expensive preventive care at the FMRP.

Consolidation would not be a quick solution: there would remain a contractual obligation to teach out the remaining two classes of residents. It would eliminate a much needed training site for some of UW's other health professional students. Additionally, it would have an impact on the physicians in the community and the quality of care. Many physicians chose a community to practice with a residency because of a desire to teach and, as mentioned above, the residents bring knowledge of current practice to the community.

Option 8: Increase State Funding

One option is increased state funding to stabilize the programs fiscally and administratively as well as continue providing the current level of primary health care in Casper and Cheyenne. Bringing the programs funding closer to the national level will help reach the goal of increasing the quality. The university and its FMRPs will continue to seek funds to offset expenses through increased clinic income and pursuit of federal funding through specific grant programs (see below). However, there is a limit to how much clinic income can be generated from serving low-income patients, and GME funding is highly unlikely without legislation at the federal level.

This option would entail the following amounts of additional state general fund support, starting in the FY15-16 biennium:

- continuing the funding of the Cheyenne residency at the current level by converting the $2.3 million in one-time state general funds appropriated during the 2012 legislative session into ongoing funding,
- providing an additional $800,000/year in state general funds ($1.6 million biennially) to support the Casper residency clinic operations, and
- Providing an additional $200,540/yr in state general funds ($401,080 biennially) for salaries and employer paid benefits to ensure that salary for key employees are competitive (Appendix B). Offering competitive salaries will ensure that quality faculty will be retained and hired and that the current level of patient care will not be diminished.

- This totals an additional $4.3 million/biennium in state general funds.

Of course, any increased state funding will be based upon weighing the value of the FMRPs against limited state revenues. As described above, the reality of the residency programs is that physician training is expensive, they are an important local source of care, they are a component of UW's medical education program, and they bring to Wyoming primary care and family health physicians that are in increasing demand. This option has the advantages of improving the quality of medical education, attracting more highly qualified student residents who in turn will make better physicians for the state and support for a Wyoming-based approach to resolving some of the health care issues facing the state.

Summary of Options:

Option	Advantages	Disadvantages
1. Relocate the Oversight to Another State Agency	• This option would use existing expertise in running a complex medical enterprise • Community hospitals have the expertise in providing oversight of medical clinics	• That expertise does not exist at another state agency • The university is the agency best suited to provide oversight of the educational operations • Community hospitals have been reluctant to join this endeavor in the past and there is potential for conflict of mission • This option would not increase outside funding
2. Establish an Educational Health Center	• This option could allow for increased clinic revenue through federal FQHC status • There are several other benefits (e.g. 340B "sliding-scale" pharmacy pricing, physician loan repayment, etc.)	• Establishing an EHC will take time (2 years) • HRSA guidelines for a separate governing board are difficult to meet • There is high potential for governance issues with a governing board separate from UW's Board of Trustees • Increased federal reimbursement rates would increase clinic income but would not replace state funding
3. Establish a Teaching Health Center	• Doing so would allow for new federal funding but only to support additional new residents and only for a maximum of 5 years	• There are irresolvable issues of fiscal responsibility, educational responsibility and governance. • The THC program provides for a demonstration grant, funded by HRSA only for 5 years
4. Seek Direct Graduate Medical Education (DGME) funding through Medicare	• If successful, this measure would bring federal GME funding used by virtually all other US residencies	• Wyoming residencies have been rejected for funding in the past • This option requires either new federal legislation or different CMS interpretation of current rules • The option would require a program restructuring or realignment with respective hospitals • Would require direct financial participation by the affiliated hospitals • Hospitals have been reluctant to establish this relationship in the past
5. Establish a Faculty Practice Plan	• This option would increase incentives for faculty physicians to generate additional clinic income. • Any increased revenues could address low faculty salaries and	• The option would not increase outside funding or current state support • There would be some reduction in the state's fiscal oversight • Faculty would lose state malpractice insurance,

	help with recruiting	probably resulting in increased malpractice costs • The current safety-net patient mix would generate limited additional revenues — perhaps enough to augment faculty physician salaries but probably not enough to offset state fiscal support • A practice plan would place the faculty in direct competition with local providers for paying patients • Faculty physicians would have incentives to reduce their teaching time
6. Downsize	• This option could make the spending match the budget, by reducing the payrolls and the number of residents trained in each of the existing programs	• The option would not substantially reduce current state support • It would decrease the pool of future family medicine physicians trained in Wyoming. • The option would not increase federal funding • The option would be difficult to implement quickly • The option may have negative accreditation consequences if the reductions result in narrower clinical experiences for residents
7. Consolidate the Two Programs	• The option would provide sufficient funds for one high quality residency program, by focusing all existing resources in either Casper or Cheyenne	• The option would decrease the pool of family medicine physicians trained in Wyoming • it would not increase federal funding • Consolidation would eliminate a safety net provider in one major Wyoming city • The option is not a quick solution; it would take at least 2 years to teach out current residents. • Would have a negative financial impact on the hospital without a residency • May increase Medicaid costs • Would eliminate an important training site for other healthcare students
8. Fund Residencies Adequately Through State Funding	• The option would provide sufficient funds for two high-quality residency programs • The option avoids constraints associated with federal funding	• The option increases permanent commitment from state budget • The option does not, by itself, increase non-state sources of funding

Summary

There is no simple fix to the financial issues of the residency programs. Essentially almost all residency programs receive funding through federal Graduate Medical Education allocations, but this was not taken at either of Wyoming's program's inception and is now not available under current Center for Medicare Services (CMS) opinion. Federal legislative action could change this. This is currently the only avenue for direct federal support.

The other options described above have been carefully investigated by members of the university administration and, in some cases, by the supporting hospitals. The university has investigated the concept of an Educational Health Center and has utilized a consultant in these discussions. While this option does not replace state funding, it is a viable option in increasing clinic income and other patient care benefits. Becoming a HRSA certified EHC would take time. The residencies could move in this direction while the state tries to obtain GME funding.

Consolidation may appear to be an attractive option, especially if sufficient funding is not secured for the long-term stability of both programs. The question may arise: would consolidation be preferable to the *status quo* or to completely closing both programs? Yes. However, there are three major disadvantages: fewer family medicine physicians will be trained in Wyoming decreasing the probability that they will establish a practice here, providing of safety net care in one community will be lost, and the opportunity for training of other health professionals in Wyoming will be greatly reduced.

Recommendation

University of Wyoming's leaders recognize that decisions about the Family Medicine Residency Centers involve state policy dimensions that transcend UW's educational mission. With that understanding, we offer the following recommendations, based on the institution's interest in offering high-quality education, maintaining a solid fiscal footing, and meeting the state's expectations for safety-net medical care. The recommendations take account of three observations: (1) few of the options listed above can, by themselves, resolve the fiscal issues; (2) the options are not mutually exclusive; and (3) the feasibility of several options will be uncertain until we have more information about the national policy setting and local healthcare markets. Therefore it makes sense to pursue a multipronged strategy involving several options, some of which involve uncertainties.

This recommended strategy includes the following four elements:

Element 1. UW will continue operating the residencies with the current levels of state funding through FY 2014.

- This element will require that UW continue to collect and expend all clinic revenues at the Casper residency and to fund the clinic operations formerly managed by CHCCW.
- UW will continue to pursue improvements in its business practices in the Cheyenne residency, including more effective billing.

Element 2. UW will seek changes in the federal regulations governing GME (Option 4).

- Changes to make the UW residency programs eligible for Direct GME funding would allow for a mix of program funding comparable to that available in virtually all other family medicine residency programs nationwide.
- This element will require work with Wyoming's Congressional delegation. UW will coordinate with the Governor's office in implementing this task.
- **Element 3.** UW will investigate the feasibility of establishing an Educational Health Center umbrella for both residency programs that is acceptable to the UW Board of Trustees (Option 2). A critical consideration in the feasibility study will be whether it is possible, under the Public Health Services Act cited above, to design a governance structure that will avoid conflicts between the clinical mission and the educational mission.

- Establishing an EHC may not be a panacea to all of the funding issues, but it may help address the need for additional funding, primarily by increasing Medicare reimbursement rates.
- UW has already contracted with Community Link Consulting to explore this option.
- UW plans to bring closure to this question by the end of FY 2013.

Element 4. UW will charge its faculty physicians and the appropriate medical education administrators to explore the logistics and fiscal viability of a faculty practice plan (Option 5).

- The purpose of this element is to investigate a possible vehicle for improving faculty salaries through appropriately managed mechanisms other than increased General Fund appropriations.
- The business constraints associated with UW's patient mix and the possible effects of such a plan on faculty incentives may make this option unrealistic.
- The deadline for this study will be the end of FY 2013.

Finally, we recommend that this report be used as a foundation for a Governor-convened summit of the major stakeholders, to discuss future legislative options. Among the stakeholders are:

- The University of Wyoming
- The Governor's office
- The Wyoming Medical Society
- A representative from the WWAMI medical program
- A representative of the Department of Health
- A representative of the Cheyenne Regional Medical Center
- A representative of the Wyoming Medical Center
- Representatives of the legislative delegations from Casper and Cheyenne.

The outcome that we seek from this summit is a multi-agency agreement regarding upcoming legislative measures, if any, needed to address the residencies' funding picture.

The university suggests that the summit and resulting recommendations could be completed in time for the Governor and legislators to consider them in developing the FY15-16 biennial budget.

It is often said that Wyoming should seek Wyoming solutions to providing healthcare. The two University of Wyoming Family Medicine Residency Programs have been a Wyoming solution for educating primary care physicians and for providing safety net medical care for over 30 years. Through their dual missions of providing healthcare and education they have served the state well. They are the safety-net provider for the populations of Wyoming's two largest cities and are often the only resource available to self-paying patients and those insured by Medicare or Medicaid. They educate medical school graduates to provide care in the rural and frontier environment of Wyoming and many of the graduates are located in the communities around the

state. Additionally, they offer a strong interprofessional, team-oriented practice opportunity for educating many other UW health professional students. Since they are the only sites in Wyoming that offer all of these benefits, the University of Wyoming remains committed to their future success and to the pursuit of constructive avenues to achieve it.

Appendix A. Timeline of UW Family Medicine Residency Centers (FMRC — formerly FPRC)

Date	Action
1976	-Legislative appropriation for establishing a Family Practice Residency Program as a component of a medical school; authorization and funding remained in Governor's Office until 1980 -Casper FPRC began training family physicians for practices in rural Wyoming -State general fund dollars covered all costs; clinical income revenue generated not used to support program -From inception, Casper program designed to support 24 resident physicians (8 in each three year class)
1977-79	-State appropriation from general fund for construction of FPRC facilities in Casper and Cheyenne which opened in 1977 and 1979respectively, with first graduates in 1979 and 1982, respectively. -State did not fund the medical school.
1978	-Cheyenne FPRC opened; supported 18 resident physicians (6 in each three year class)
1980	-UW assumed administrative responsibility for both Casper and Cheyenne FPRCs -FPRCs' funding also transferred to UW -State general fund dollars covered all costs; clinical income revenue generated not used to support program
1980s	-Attempts made by a minority group of legislators and some local physicians to reduce the size of the FPRCs. Multiple attempts throughout the 1980's were made by UW, some legislators and private entities to eliminate/reduce the size of the programs including suggested elimination of Cheyenne site -Board of Trustees maintained support for both FPRCs and efforts to close Cheyenne center did not succeed -FPRC funding folded into a UW block grant through the College of Human Medicine and subsequently the College of Health Sciences
1984-86	-Legislature, Board of Trustees, and independent studies called upon UW to consider phasing out the FPRCs based on state financial pressures and concerns about effectiveness in recruiting physicians to practice in rural areas of state
1991	-Both FPRCs established a "practice plan," allowing faculty to generate additional clinic revenues to augment their salaries
1993	-ACGME (medical education accrediting body) granted 'continuing full accreditation' to Cheyenne FPRC; raised questions about UW's sponsorship of the programs in graduate medical education, including financial support
1997	-FPRCs not generating enough in clinical revenues to meet budgeted expenses for operations -Undergraduate medical education contracts were changed from Creighton University to the University of Washington WWAMI program and the residencies became affiliated with a medical school for the first time.
1998	-With help from Legislature, UW increased investment in FPRCs by millions of dollars
2000	-Casper center entered into affiliation agreement with the Community Health Center of Central Wyoming (subject to yearly renewal): CHCCW assumed daily medical clinic and facilities operations; UW continued to provide graduate medical education. -By assuming all costs of the residency program, CHCCW was able to receive reimbursements for the direct costs of graduate medical education under the rules governing Medicare (later rescinded and the CHCCW began charging the University for medical education even while receiving all clinical income generated by faculty and residents)
2001	-ACGME accreditation review team proposed 'probation' for Casper FPRC; cited 15 areas of non compliance -Residency Assistance Program (RAP) review was conducted in response and provided to ACGME; apparently resulted in favorable accreditation status for Casper from the ACGME -RAP review (September) identified strengths and concerns; concerns included data reporting, faculty development, some missing curricular elements, numbers of faculty, external reviews,

	relationship with Wyoming Medical Center, residents' health insurance coverage, and some other issues
2002	-Consultant review of FPRCs: identified problems with administrative oversight and faculty, marginal-to-failing accreditation, poor utilization of available resources, and poorly identified financial resources (*Note: Maybe this refers to the RAP review conducted in late 2001, but I can't match this information specifically with that report and can't find another*.) -Explored option of transitioning Casper FPRC into a "community-based, university-affiliated program" and strengthening the FPRC in dual role of resident education and primary health care for Casper area (*Likewise I can't find information that documents this discussion.)*
2003	-Resignation of Cheyenne director, both Centers at 50 percent physician staff levels, 'scrambling' to fill programs, residents excluded from free health coverage, block grant insufficient to maintain programs
2004	-UW requested and Governor approved $2.067M in general fund appropriations for the 2005-2006 biennium to allow UW to continue at the current contract rate with the CHCCW. -ACGME granted continued full accreditation to Casper FPRC for five years; expressed some concerns, esp. resident attrition rate. Next site visit in September 2009.
2004-2005	-Rules for Medicare reimbursement changed, resulting in loss of reimbursement for direct costs of medical education by the CHCCW. -April 2005 the University accepted the full costs of the residency program and its educational mission, including costs of support services. CHCCW agreed to continue as a clinical services partner. -President requested a $780K FY2006 budget authority increase for the Casper Center; to pay CHCCW for support of clinical activities to cover costs of uncompensated care.
2005	-Board of Trustees reviewed proposal to extract medical education funding from UW's block grant and to create a new agency (#167) encompassing budgets for WWAMI and the two FPRC's. -Proposal would create operating budgets for the Cheyenne and Casper centers sufficient to cover costs of physician and other employee staffing (in accordance with ACGME minimum requirements for accreditation) and to adequately fund support services.
2006	Submission of 2007-2008 Biennium Budget request. Request cemented proposal for UW-Medical Education agency (#167) -Documented significant increases in patient visits and clinic revenues; projected continued increases -For Casper, UW requested and Governor recommended $9,370,732 in general fund appropriations for the biennium, 35 full-time and 9 part-time positions -For Cheyenne, UW requested and Governor recommended $7,381,291 in general fund appropriations for the biennium, $2M in other funds, 46 full-time, and 7 part-time positions
2008	-UW requested Cheyenne FPRC biennium budget authorization be increased by $4.79M to support salary and benefits for 20 additional full-time and 6 additional part-time positions -Request made under state's B-11 process under which the Governor may approve increased expenditures where additional revenues are anticipated.
2009	-Contract between UW and CHCCW rearticulated to provide for shared governance of Casper center and fiscal transparency -Competitive salary structures in place, physician retention issues addressed; Casper center has successfully matched its full complement of 8 residents per year without having to 'scramble' to fill slots.
2009	-Cheyenne FPRC received continued accreditation for 3 years by ACGE; but 16 citations -Cheyenne FPRC clinic revenue increased 50% over previous year, but fell short of projections in B-11 request -Not all authorized positions filled, so while clinic revenues were less than the estimates in the B-11, so were the expenditures -Financial shortfall was manageable 'in house' for FY 2009, but substantially less likely moving forward

	-All position vacancies and searches at Cheyenne FPRC frozen if offer(s) not already extended
2009	-Board of Trustees approved and UW submitted FY 2011-2012 budget request asking for additional state section 1 money to accommodate Cheyenne FPRC over-expansion to continue operation at same level ($3.2 million in General Fund for FY 2011-2012 biennium) -Budget request includes an explicit agreement that UW will pay down any of the state funds appropriated from the 2011-2012 request if clinic revenues allow -Request also included an additional faculty line for the Casper center to provide an accreditation buffer against loss of faculty
2010	-UW officials meet with Noridian, Inc., a Medicare-Medicaid intermediary, to discuss past and future Medicare billing practices at the Cheyenne center. At issue is the correct procedure for documenting UW's requests for federal Medicare reimbursement, since the Family Medicine Residency Center does not fit any model for which federal guidelines exist. In January 2011, Noridian relays a determination on the correct billing documentation and relieves UW of any obligations for billing done prior to the university's adoption of the new documentation procedures. -CHCCW announces plans to develop a new facility on the east edge of Casper, to operate independently of UW's residency program. UW notifies CHCCW of its desire to review the affiliation agreement between the two organizations in light of CHCCW's plans.
2011	-UW and CHCCW agree to dissolve their affiliation agreement, effective July 1, 2011. UW estimates that the transition to independent clinic operations will require $1.22 million in one-time new equipment purchases and $3.09 million/year in staffing (32 positions) and support, to offset the loss of staffing and support provided by CHCCW. UW administration allocates $2.31 million in one-time, non-appropriated funds to cover the equipment costs and a portion of the staffing and support costs that estimated clinic revenues for FY 2012 will not cover. UW also requests and receives permission from the state to collect and spend clinic revenues formerly collected and spent by CHCCW, up to $2 million/year. - ACGME notifies the Cheyenne FMRC that it has granted continued accreditation for 3 years. The accreditation report cites 11 areas in which the program is not in substantial compliance with accreditation standards. ACGME notifies the Casper FMRC that has granted continued accreditation for 2 years and cites 10 areas in which the program is not in substantial compliance.

Appendix B.

Casper	Current	WWAMI	Difference	
Program Director	$193,152	$223,374	$30,222	
Associate Program Director	$181,140	$172,401	($8,739)	
Clinical Assist Professor	$151, 008	$151,415	$407	
Clinical Assist Professor	$151, 008	$151,415	$407	
Clinical Assist Professor(0.75 FTE)	$120, 000	$113,561	($6,439)	
Clinical Assist Professor	$151, 008	$151,415	$417	
Clinical Assoc Professor	$153,900	$160,958	$7,058	
Clinical Assoc Professor	$171,792	$160,958	($10,834)	
Faculty Pharmacist	$88,068	$102,230	$14,162	
Business Manager	$50,184	$92,997	$42,813	
Clinic Director	$90,000	$86,592	($3,408)	
			$66,066	
Cheyenne				
Program Director	$179,700	$223,374	$43,674	
Associate Program Director	$175,574	$172,401	($3,173)	
Clinical Assist Professor	$145,908	$151,415	$5,507	
Clinical Assist Professor	$145,908	$151,415	$5,507	
Clinical Assist Professor (0.75 FTE)	$122,100	$113,561	($8,539)	
Clinical Assist Professor	$145,908	$151,415	$5,507	
Clinical Assoc Professor	$156,084	$160,958	$4,874	
Faculty Pharmacist	$88,068	$102,230	$14,162	
Clinical Assoc Professor	$160,668	$160,958	$290	
Business Manager	$50,916	$92,997	$42,081	
Clinic Director	$114,000	$86,592	($27,408)	
			$82,482	

Casper	$66,066
Cheyenne	$82,482
	$148,548
EPB at 35%	$51,992
Total	$200,540