B

THE STATE OF WISCONSIN

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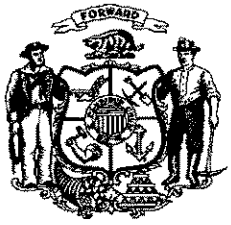

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JOINT COMMITTEE ON FINANCE

MEMORANDUM

To: Members
Joint Committee on Finance

From: Senator Alberta Darling
Representative Dean Kaufert
Co-Chairs, Joint Committee on Finance

Date: March 6, 2003

Re: DHFS Report on WIC

Attached is a copy of a report from the Department of Health and Family Services, as required by 2001 Wisconsin Act 16, section 9123 (9h). It provides information on the feasibility of an Electronic Transfer System under the Supplemental Nutrition Program for Women, Infants and Children (WIC).

The report is for your information only. No formal action is required by the Committee. Please feel free to contact us if you have any questions.

Attachment

AD:DK:dh

State of Wisconsin
Department of Health and Family Services

Jim Doyle, Governor
Helene Nelson, Secretary

March 4, 2003

The Honorable Alberta Darling
Senate Co-Chair
Joint Committee on Finance
Room 317 East, State Capitol
Madison, WI 53702

The Honorable Dean Kaufert
Assembly Co-Chair
Joint Committee on Finance
Room 308 East, State Capitol
Madison, WI 53702

Dear Senator Darling and Representative Kaufert:

As required by 2001 Wisconsin Act 16, section 9123 (9h), I am enclosing the Department's report on the feasibility of an Electronic Transfer System under the Supplemental Nutrition Program for Women, Infants, and Children (WIC).

Sincerely,

Helene Nelson
Secretary

Attachment

WIC Electronic Benefit Transfer System

The Supplemental Nutrition Program for Women, Infants and Children (WIC) provides supplemental food, health screening and nutrition education to approximately 100,600 low- and moderate-income participants in Wisconsin. The WIC program is federally funded by grants from the U.S. Department of Agriculture (USDA), Food and Nutrition Services. 2001 Wisconsin Act 16, section 9123 (9h), requires the Department to study the feasibility of implementing an electronic benefits transfer system in the WIC program. This report provides information on the following:

1. Information system requirements for administering an electronic benefit transfer system under the supplemental food program for women, infants and children.
2. Compatibility of an electronic benefit transfer system under the supplemental food program for women, infants and children with existing electronic benefit transfer systems.
3. The costs and benefits of implementing an electronic benefit transfer system to the department of health and family services, participants and vendors under the supplemental food program for women, infants and children.
4. Possible funding sources for the implementation of an electronic benefit transfer system under the supplemental food program for women, infants and children.

INFORMATION SYSTEM REQUIREMENTS

The major WIC Electronic Benefit Transfer (EBT) components and their associated infrastructure include the EBT card (which provides the necessary authentication for accessing benefits) and the local clinic, EBT processor, and retailer point-of-sale (POS) terminal systems. The local clinic and the retailer POS terminal system interface with the EBT card and the EBT processor system. The local clinic system provides recipient account setup and issues benefits. The EBT processor receives and maintains demographic and benefit issuance information from the local clinic system, authorizes redemption claims submitted by the retailer, and produces daily and monthly financial reports of benefit activity. The retailer system facilitates the exchange of food items with the benefits conveyed on the EBT card. For the entire system to work, each component must communicate effectively as well as process data consistently.

The following is a list of the major components. For each of these components, the corresponding infrastructure must be coordinated to administer an EBT System.

Local Clinic System

- Account Setup
- Benefit Issuance
- Card Issuance
- Card Replacement
- Conversion to Category and Subcategory

- Access Daily Transaction History
- System User Accounts and Privileges
- Interface with the Card
- Interface with the EBT Processor

EBT Processor System

- Interface with the Local Clinic System
- Account Setup
- Benefit Issuance
- Online Account Setup and Benefit Issuance
- Card Issuance
- Card Replacement (This may include test of the process to replace hybrid cards for WIC/FS and/or other program partnerships. For example, there will have to be an interface with the FSP EBT system.)
- PIN Management
- UPC Database Maintenance
- Card and Account Status Maintenance
- "Hot" Card List Maintenance
- Daily Transaction Processing – Transaction Authorization
- Transaction Validation
- Daily and Monthly Reports Generation
- Rebate Tracking
- Settlement and Funds Movement
- Call Center Support

Retailer System

- Card Holder Authentication (e.g. PIN)
- Card Validation
- WIC Approved Item Validation
- Period of Benefit Access Validation
- Insufficient Benefits on the Card
- Interface with the EBT Processor

- POS Management Functions (User, Manager Ids and Passwords)
- Backroom PC (if applicable)
- Third-party processors (TPPs).

Smart Card

- Benefits Storage and Retrieval
- Benefits Debit and Credit
- Card Holder Authentication
- Transaction History Log
- Card/Program Lock and Unlock
- PIN Selection and Change

COMPATIBILITY

EBT systems will most likely involve partnerships with other programs such as the Food Stamp Program (FSP), Medicaid, Head Start, Temporary Assistance for Needy Families (TANF), and Immunization to share client data. It is anticipated that WIC State agencies will coordinate their plans with other State officials, including the Food Stamp Program and EBT Directors. Through joint projects, WIC and Food Stamps may be able to reduce costs by using the same EBT contractor to perform functions that are similar in both programs, such as retailer settlement, bank processing, and help desk services. Integration of farmers' markets into States' electronic benefit delivery plans is a challenge, and work still needs to be done on resolving the problems presented by this unique type of integration.

Functionally, there are three points of intersection for the WIC Program and the Food Stamp Program: (1) shared benefit redemption at the retailer; (2) shared client population (up to 60 percent of WIC participants also receive food stamps in some States); and, (3) a shared goal to protect program integrity, achieved by facilitating the sharing of authorization and disqualification data on retailers to minimize fraud and abuse.

Regarding the sharing of point-of-sale (POS) terminals at the grocery store, it is important to emphasize that WIC both delivers and measures its benefits differently than the FSP and may require different technology at the point of sale. WIC delivers a food package of specific, nutritious foods, targeted for the individual health needs of at-risk pregnant, postpartum, and breastfeeding mothers, infants and children. It is a food prescription that specifies amounts and brands of foods, not simply the dollar amount (as does food stamps). It is crucial that this part of the WIC Program mission be addressed in EBT system plans and that grocery stores understand that WIC EBT will involve additional design features beyond those that enable the basic financial transaction used by the Food Stamp Program.

Sharing client data is a special challenge; however, EBT can serve as a catalyst to improve the exchange of client data between WIC clinics, food stamps and other programs. The exchange of client data could be especially helpful with regard to WIC's performing adjunct income eligibility determinations; i.e., eligibility in other programs such as Medicaid or Food Stamps provides automatic income eligibility for WIC. However, it is understood that linking with other health and welfare data systems may present a challenge, for both confidentiality and technology. Thus, while it is desirable to put WIC, Food Stamp Program and other program client data on one EBT card, differences in each program's issuance systems may present integration difficulties. Therefore, this objective is dependent on each State's circumstances and resources.

Finally, the WIC and Food Stamp Programs have similar interests in ensuring the integrity of the grocery store transactions. While strengthened coordination is not a requirement of a WIC/FSP EBT project, such a project provides an opportunity for EBT to facilitate increased interaction and efficiency between both programs concerning retailer integrity responsibilities.

COST/BENEFITS

Since WIC EBT is in the process of being piloted nationally, there is, as yet, no final information on which to base a cost/benefit analysis. Preliminary information from other states indicates that EBT costs in WIC are much higher than the current food delivery system. States piloting EBT are doing so with grants from USDA; it is unlikely that states would be able to pilot EBT without these additional EBT federal development funds.

For example, Ohio is a pilot state that has a current WIC food delivery system similar to Wisconsin's (paper vouchers issued and processed through the Federal Reserve System like a check). According to Ohio's "EBT Cumulative Cost Report," the cost of its EBT project development and testing was $1,331,807. The pilot project serves 11,199 participants, with a project operation cost per casemonth of $1,069,077 (see Attachment A). This is a cost of $95.46 per person just to issue and redeem the food benefits. In contrast, Wisconsin currently pays its bank and data processing contractor $98,000 a month for 104,000 participants, resulting in a cost of $.94 a person per month for the entire data system maintenance, voucher issuance and bank processing. Even though this amount includes more than just the voucher-related costs, the cost per person is still a much less expensive method of food benefit delivery than EBT at this time.

Michigan's pilot WIC EBT program, with a pilot caseload of 4,200, has a budget of $2.8 million. Of this, $1.873 million is budgeted for development costs. The EBT Contractor, Citicorp, will also receive a $2.50 per client, per transaction charge, which will pay for the cost of the card, any transaction fees, and client training in the use of the card. In addition to the funding provided to Citicorp, Michigan has allocated $.5 million for modifications to the current WIC system, $.2 million for a program/quality assurance manager, $80,000 for staff support and $90,000 for an evaluation.

Based on information from pilot states, the Department has developed preliminary estimates for some of the costs associated with the development of a WIC EBT system in Wisconsin. These estimates are summarized below.

- System development: $ 925,000

- "Architectural" changes to the current mainframe system: $1 million for a magnetic stripe card system. It is assumed that smart card changes would be higher.

- Units to encode cards: $274,092. This estimate assumes 91 units at $3,012 each and includes the costs of installation and PC interface. The cost is dependent upon whether or not smart cards or magnetic strip are chosen. WIC currently has 91 full-time sites and this estimate will change if the number of sites changes.

- Point-of-sale terminals at stores: $1,394,800. The cost of one POS terminal for smart cards is currently $1,268 and there are approximately 1,100 contracted WIC stores. This estimate assumes that the WIC EBT program does not use existing POS terminals, which may not be able to be adapted to the WIC program. If the Department is able to adapt existing devices to the WIC EBT program, POS costs could possibly be lowered.

- PC for network LAN control: $450,000. It is assumed that most stores will require POS terminals for more than one cash register line. To accommodate this, a PC server will be needed that will connect the state's IT system and the systems used by grocery stores.

- An on-going maintenance fee for POS terminals: $209,220. This fee is 15% of the cost of all POS devices and assumes the lowest possible numbers of devices installed.

- Staff costs: $200,000. This estimate assumes that two to three project staff will be required to act as project manager and to provide quality assurance and IT assistance.

Other potential costs, which have not been estimated, include the initial card issuance, new card issuance for those new to the program, replacement card costs, mailings or communications with participants, and transaction fees charged by the EBT Contractor.

These costs will be offset by efficiencies that will result in savings to the program but that cannot be quantified at this time.

- Food vouchers currently may be rejected by the bank due to lack of signature, expired vouchers, early redemptions and invalid dates, lack of store stamp number, invalid food instrument, which results in additional processing costs to the Program and the vendor. EBT would reduce or eliminate these situations. For example, the WIC program pays banks approximately $2,200 per month for processing returned vouchers. If these costs were eliminated, there would be a savings of $26,400 annually.
- WIC currently pays $600/month for paper food voucher stock, and approximately $21,000/month to process redeemed drafts through a bank. If these costs were eliminated, there would be a savings of $259,200 annually.
- EBT provides timely and accurate redemption information that will assist in the control of food costs to the Program.

- EBT provides intrinsic benefits to the participant, such as eliminating the stigma associated with using paper vouchers at the store.
- EBT provides immediate cash flow to the retailers.
- Because program-approved food items are programmed into the EBT system, there will be fewer unintentional mistakes, such as giving unauthorized foods to a customer.

There are some state and federal issues, however, which should be resolved before the EBT program becomes operational nationwide.

- There are no national standards/regulations for food stamp or WIC EBT, making it virtually impossible for clients to cross state lines and use their EBT benefits in another state.
- There is no national UPC database or a method for keeping a database updated. As a result, each state is responsible for updating its own data base containing hundreds of foods.

FUNDING FOR EBT

Funds to develop and implement EBT systems will come primarily from the state's Nutrition Services and Administration (NSA) grants, which are the source for the current funding for WIC ADP systems and other capital investments, including regional office discretionary funds and the annual WIC multi-purpose grant. States are encouraged to share expenses through cost sharing agreements with EBT project partners (e.g., Food Stamp, TANF, Immunization) to the extent that this also benefits the WIC Program.

EBT will offer additional benefits to the WIC Program; however, these additional benefits carry a price. While the costs of implementing and operating EBT continue to decline, initial operational costs exceed the current paper-based system (see Cost/Benefits above). Additional federal funding for the maintenance and operation of a State's EBT system is not likely to be provided. States will have to pay these costs from their annual NSA grants.

With regard to new states starting a WIC EBT initiative, Food and Nutrition Services will support only WIC State agencies currently planning, developing and evaluating EBT systems. These states are being used as pilots. Once the pilot states have completed their development and testing of the different technology approaches, there will be more information about the cost/benefits of WIC EBT. (See Attachment B for a recent summary of pilot status.) As more states use WIC EBT, and more providers are connected to the system, EBT costs are likely to decrease. Results from the WIC EBT pilots to date, however, indicate that cost neutrality has not yet been achieved for EBT. The pilot systems are currently more costly than existing state paper instrument and banking services. FNS will continue to evaluate costs for all projects to identify cost savings achieved through various technological solutions and procurement strategies.

SUMMARY

Food and Nutrition Services will continue to pursue the expansion of WIC EBT through support and evaluation of current state WIC EBT projects, while testing the feasibility of alternative technologies that are in line with current trends in commercial retail transaction processing. By 2008, FNS expects to have a technically and financially viable national model for retail transaction processing for WIC EBT.

At this time, it would not be cost effective for Wisconsin to pursue a WIC EBT system without additional federal funds. The Department will continue to monitor progress of other state WIC Programs in their development of WIC EBT systems. In the meantime, the Department is planning for a new participant data system that will also issue paper food instruments. This is necessary due to the age and outdated technology of the current system. In developing the new system, the Department will ensure that it will be "EBT-ready." In the event that the State decides to pursue an EBT program, the new data system will be able to accommodate an electronic benefit transfer process.

Attachment A

EBT Cumulative Cost Report

Project Name/State: _____Ohio_____ **Report Period Beginning** **10/1/98**
Report Period Ending Da **7/24/02**

General Instructions: *The following cost information will be shared with WIC State agencies interested in developing EBT projects. This report will reflect the total cumulative project costs and will be updated throughout the project period and submitted to FNS 30 and 180 days after the end of the State fiscal year until all costs are identified. Please show all funds spent, including funds not provided specifically through infrastructure grants. The attached cost definitions are provided to assist States in the completion of this report. It is desirable to have costs broken out as listed below. However, if this is not possible, please use the "Other" categories to show where costs are broken out differently. Do not include costs that are a part of normal State agency operations. Use the comments sections to further explain the breakdown of costs, as needed.*

A. Project Planning. Include all costs associated with planning this project. Costs incurred that are not listed below should be specified under "Other." For example, these other costs may include travel, project management software, consultant fees, office space, staffing, supplies, miscellaneous or other costs not included in the cost of the deliverables listed. (NOTE: Do not include equipment costs here. All equipment should be reported under section E below.) If costs incurred in development of an FRD are part of the total PAPD costs, show the costs under PAPD and note in the comments section below that PAPD costs include development of the FRD.

Planning Phase	In-House	Contracted	Total Cumulative Planning Costs
Planning Advanced Planning Document (PAPD)	See Comments	See Comments	See Comments
Request for Information (RFI)			
Functional Requirements Document (FRD)			
Request for Proposals (RFP)			
Imple. Advanced Planning Docu. (IAPD)			
Notable Staff Time at State Level	$173,761.64		$173,761.64
Compuware		$7,395.00	$7,395.00
Other_____	$1,235.86		$1,235.86
Total Planning Phase	$174,997.50	$7,395.00	$182,392.50

Comments: Other costs of the above items were not tracked.

B. Project Design. Include all costs associated with project design. Costs incurred that are not listed below should be specified under "Other." For example, these other costs may include travel, software, consultant fees, office space, staffing, miscellaneous or other costs not included in the cost items listed. (NOTE: Do not include equipment costs here. All equipment should be reported under section E below.)

Design Phase	In-House	Contracted	Total Cumulative Design Costs
System Design		$66,045	$66,045.00
System Acceptance Plan			
WIC UPC Database Design			
Functional Demonstration Plan		7,437.50	7,437.50
Data Conversion			
Functional Design Document		44,800.00	44,800.00
Other_____			
Total Design Phase		118,282.50	118,282.50

Comments:

EBT Cumulative Cost Report

C. Project Scope. Please provide information on the scope of the project.

Project Scope	Number
Number of WIC Participants in Project	11,199 (4/02 closeout participation)
Number of Participants Per Household	1.6
Total Number of Households in Project	7,188 (4/02)
Number of Authorized Retailers	43
Number of WIC Clinics	5
Duration of EBT Current Contract	July 1, 2001- June 30, 2003

D. Project Development and Testing. Include all costs associated with project development and testing. Costs incurred that are not listed below should be specified under "Other." For example, these other costs may include travel, consultant fees, office space, staffing, miscellaneous or other costs not included in the cost items listed. Under "Retailer Agreements" include all associated costs, e.g., staff time, printing, mailing, training, etc. (NOTE: Do not include equipment costs here. All equipment should be reported under section E below.)

Project Development & Testing Phase	In-House	Contracted	Total Cumulative Development Costs
Application Software: WIC Clinic			
Application Software: Interface/EBT-State Information System		$322,650.00	$322,650.00
Application Software: Interface/Retailers			
Food Stamp Integration (WIC costs only)			
Other Program Integration			
Acceptance Testing		$19,218.50	$19,218.50
Acceptance Report		$6,426.00	$6,426.00
Implementation Plan		$24,854.00	$24,854.00
Functional Demonstration		$3,213.00	$3,213.00
Functional Demonstration Report		$2,380.00	$2,380.00
Disaster Recovery Plan			
Risk Analysis		$18,275.85	$18,275.85
Retailer Agreements		$12,409.15	$12,409.15
Training Manuals and Materials (including tutorials and videos)		$138,200.65	$138,200.65
User Manuals for System Documentation		$12,665.65	$12,665.65
Other_____		$597,380.00	$597,380.00
15% Holdback for deliverables		$174,134.55	$174,134.55
Total Development and Testing Phase		$1,331,807.35	$1,331,807.35

Comments: Acceptance Testing includes the Acceptance Test Plan ($6,426) and the Acceptance Test ($12,792.50)

E. Project Equipment. Include all project equipment purchases and/or leases. Do not include installation and maintenance costs here. Installation and maintenance costs are to be included under section F. See attached definitions. Equipment that is not listed below should be specified under "Other."

Equipment	Unit Costs (Lease/Purchase)	# of Units (Lease/Purchase)	Total Cumulative Costs (Lease/Purchase)
Retailer Equipment - Backroom PC	See Comments	See Comments	See Comments
Retailer Equipment - POS Card Reader			
Retailer Equipment - Cabling			
Retailer Equipment - Mounting Equipment			

EBT Cumulative Cost Report

Retailer Equipment - Inquiry Terminal & Printer						
Retailer Equipment - Scanners		$1,534.65		60	$78,267.15(less 15%)	
Retailer Equipment - Receipt Printers						
WIC Clinic Equipment (List all EBT equipment in Comments section)						
Equipping Offices in Planning Phase						
Electronic Cards						
Other_____						
Other_____						
Total Equipment				$78,267.15		$78,267.15
Comments: Equipment Costs were included in the the CCM or are part of the cost sharing with Food Stamps. Ohio WIC utilizes the Food Stamp retailer equipment with the exception of "WIC only" required equipment. The above scanner costs were negotiated for retailers added after the original bid.						

F. Project Operation. Include all costs associated with project operations. Costs incurred that are not listed below should be specified under "Other." See attached definitions. Show the "cost per casemonth," if applicable, and provide a definition of "cost per casemonth" in the comments section below.

Project Operation	In-House	Contracted	Total Cumulative Operational Costs
Authorize Issuance			
Clinic Worker Training			
Participant Training			
Retailer Training			
Training Materials			
Clinic System & Equipment Maintenance			
Retail System & Equipment Maintenance			
Maintain WIC Information System			
Maintain UPC Database			
Customer Service Charges for participant, retailer, WIC clinic toll-free services			
Customer Service Charges from toll-free pay phone calls **(#of calls placed: _____)**			
Data processing at EBT Host			
Telecommunications		$1,027.26	$1,027.26
ACH Fees			
Fund WIC settlement account			
Evaluation			
Cost Per Casemonth (Define in Comments)		$1,069,077.54	$1,069,077.54
State Personnell for 10/1/99 to 9/30/2001	$403,055.17		$403,055.17
Other_____			
Total Operations	$403,055.17	$1,070,104.80	$1,473,159.97
Comments: CCM is for 10/2000- 5/2002 Telecommunication costs through 5/2002 are included. Estimated payroll costs for State Personnell were established using the WIC Time Study. FY00 Personnel Costs -$180,314.17 FY01 Personnel Costs-$222,741.00			

G. Statewide Operation. Include all costs associated with statewide operations. Costs incurred that are not listed below should be specified under "Other." See attached definitions. Show the "cost per casemonth," if applicable, and provide a definition of "cost per casemonth" in the comments section below.

EBT Cumulative Cost Report

Statewide Operation	In-House	Contracted	Total Cumulative Operational Costs
Authorize Issuance	This section is not applicable in Ohio.		
Clinic Worker Training			
Participant Training			
Retailer Training			
Training Materials			
Clinic System & Equipment Maintenance			
Retail System & Equipment Maintenance			
Maintain WIC Information System			
Maintain UPC Database			
WIC clinic toll-free services			
phone calls **(#of calls placed: _____)**			
Data processing at EBT Host			
Telecommunications			
ACH Fees			
Fund WIC settlement account			
Evaluation			
Cost Per Casemonth (Define in Comments)			
Other_____			
Other_____			
Total Operations			
Comments:			
Grand Total for EBT Project	$578,052.67	$2,605,856.80	$3,183,909.47

version 7/26/2000

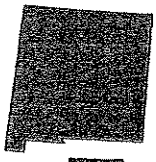
Attachment B

September 30, 2002

WIC EBT STATUS REPORT - STATE PROJECTS

Michigan has selected Citibank for an 18-month pilot which will demonstrate a new hybrid approach for WIC electronic service delivery, using on-line magnetic stripe card technology for food benefit delivery at authorized WIC retail locations. The State has finalized a functional design document and detailed design document and is finalizing the retailer and EBT-MIS interface specifications. The proposed WIC pilot will be conducted in Jackson County, and will involve 4200 participants, 21 retailers, and 1 permanent clinic site. Pilot implementation is slated to begin in the spring of 2003 and Michigan hopes to have a specific date selected within the month.

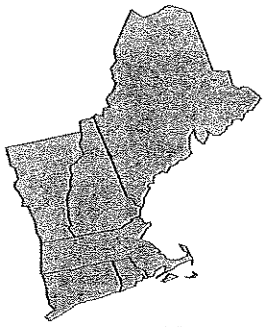
New Jersey This project has been terminated, effective July 2002.



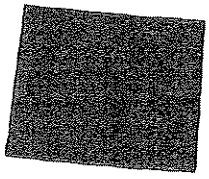
New Mexico and **Texas** have completed a joint procurement for WIC EBT services. The States released a joint Request for Offers (RFO) for smart card integration services on June 12, 2000, and selected GovConnect as the WIC EBT "card integration" contractor. New Mexico plans to pilot its commercially developed stand-beside system in March 2003. Texas plans to pilot its commercially developed integrated system and its "home grown" stand beside system in September 2003. Texas and New Mexico will operate their own clinic systems. Texas is developing its clinic system in-house using contracted Programmers. New Mexico is developing its clinic system using an outside contractor, PDA, for the programming effort.

Ohio launched its off-line, smart card WIC EBT pilot on October 16, 2000, in conjunction with existing off-line chip card technology already in place for the OH Food Stamp Program. The Ohio WIC EBT pilot includes 11,000 WIC participants, 43 retailers, and 5 clinics. The WIC pilot may operate under current contract through July 2003. Ohio staff is currently finalizing their in-house pilot project evaluation and have indicated that the evaluation is very positive and most respondents to the evaluation survey prefer EBT over paper food instruments. The State is currently assessing whether it will continue its current pilot operations or expand the pilot beyond the Dayton area.

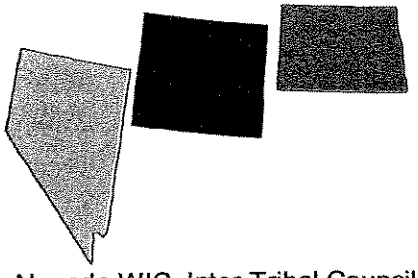
September 30, 2002



New England PARTNERS (NEP) (ME, NH, VT, MA, RI, and CT), continues planning for a multi-state, multi-program procurement for pilots in all six States. NEP plans to utilize hybrid card technology (on-line magnetic stripe and off-line integrated circuit chip/smart card) to deliver WIC food benefits as well as maintain and exchange health services information in partnership with a variety of health service providers. NEP selected Burger, Carroll and Associates, Inc. as the Project Management/Quality Assurance Contractor for the duration of the pilot projects. The project plan for NEP is to procure the services of a Contractor for the design, development, and implementation of the pilots, and to procure a Contractor for an independent evaluation of the pilot projects. An Implementation Request for Proposals was issued on November 1, 2001 and a formal mandatory bidders conference was held on January 3, 2002. Five viable bids were received by February 15, 2002. On May 7, 2002, a tentative ESD contractor was selected by the Evaluation and Executive Committees and notified in writing. Contract negotiations have finalized and the contract submitted to FNS for approval in August 2002.



In **Wyoming**, both WIC and Food Stamps share the same smart card for off-line benefit delivery and transaction processing at authorized retail locations, and the EBT system is operating statewide for both programs. The Wyoming EBT unit supporting both WIC and FSP operates as its own Prime Contractor, securing processing, customer service, networking and banking from Stored Value Systems, equipment installation and maintenance from Modern Electric, equipment from IVI-Checkmate, cards from Orga, training materials from the University of Wyoming, and retailer management and client conversion and training from contracted staff.



The **Health Passport Project** Field Demonstration of the Western Governor's Association is designed to demonstrate the use of an individual, secure, portable electronic health record using smartcard technology. Seventeen programs for mothers and children including WIC, Medicaid, Maternal and Child Health, Immunization, and Head Start are linked together through an application program interface to manage the 500 "common data" elements across programs on a smartcard. Pilots began in Bismarck, North Dakota and Cheyenne, Wyoming in June 1999. Bismarck has issued 1500 cards and Cheyenne has issued 1000. The HPP application in Reno for Nevada WIC, Inter-Tribal Council of Nevada, Head Start and Immunization began in June 2000, and is currently serving over 6000 participants. North Dakota and Wyoming are planning 2002 as a transition year to consider additional partners including Medicaid in Wyoming. The Nevada demonstration is scheduled to operate through 2002.

Senator Moore
Representative Huebsch

HEALTH AND FAMILY SERVICES -- HEALTH

WIC Electronic Benefits Transfer Study

Motion:

Move to require DHFS to include the following in its study of the program and operational requirements of establishing an electronic benefit transfer (EBT) system under the supplemental food program for women, infants and children (WIC): (1) information system requirements for administering a WIC EBT system; (2) the compatibility of a WIC EBT system with existing EBT systems in Wisconsin; (3) the costs and benefits of implementing a WIC EBT system for the WIC program, WIC participants and food retailers; and (4) possible funding sources;. Require DHFS to report on the findings of the study to the Joint Committee on Finance by January 1, 2002.

Note:

As passed by the Legislature, the 1999-01 biennial budget bill included a provision requiring DHFS to conduct a study of the EBT systems under the supplemental food program for women, infants and children (WIC). The study was to include: (1) program and operational requirements of establishing and EBT system for WIC; (2) information system requirements for administering an EBT system under the WIC program; (3) compatibility of an EBT system under WIC with existing EBT systems; (4) the costs and benefits of implementing an EBT system to DHFS, participants and vendors; and (5) possible funding sources for implementation of an EBT system under WIC. A report on the findings of the study was to be submitted to the Joint Committee on Finance by January 1, 2002. The Governor vetoed all of these provisions, except the requirement that DHFS study the program and operational requirements of establishing an EBT system for WIC.

This motion would restore the provisions included by the Legislature in the last biennial budget bill, except for the provision relating to recommendations for reducing fraud in the WIC program, and require DHFS to report on the findings of the study to the Joint Committee on Finance by January 1, 2002.

28. EARLY IDENTIFICATION OF PREGNANCY [LFB Paper 1046]

PR	- $200,000

Joint Finance/Legislature: Delete $100,000 annually to eliminate temporary assistance for needy family funds (TANF) support for outreach activities for the early identification of pregnancy program. The funds were provided in 1999 Wisconsin Act 9 to make low-income women aware of the importance of prenatal and infant health care and the availability of medical assistance and other programs to support prenatal and infant care and family planning services.

29. WOMEN, INFANTS AND CHILDREN SUPPLEMENTAL FOOD PROGRAM -- ELECTRONIC BENEFITS TRANSFER STUDY

Joint Finance: Require DHFS to include the following in its study of the program and operational requirements of establishing an electronic benefit transfer (EBT) system under the supplement food program for women, infants and children (WIC): (1) information system requirements for administering a WIC EBT; (2) the compatibility of a WIC EBT system with existing EBT systems in Wisconsin; (3) the costs and benefits of implementing a WIC EBT system for the WIC program, WIC participants and food retailers; and (4) possible funding sources. Require DHFS to report on the findings of the study to the Joint Committee on Finance by January 1, 2002.

1999 Wisconsin Act 9 requires DHFS to study the program and operational requirements of establishing an EBT system for WIC, but, as a result of the Governor's partial veto, includes no parameters as to what the study must include or a deadline for a report on the findings from the study.

Assembly/Legislature: Delay from July 1, 2002, to July 1, 2003, the date by which DHFS would be required to report on its study of an electronic benefits transfer (EBT) system for the supplemental food program for women, infants and children (WIC).

[Act 16 Section: 9123(9h)]

30. STATEWIDE TRAUMA SYSTEM

	Legislature (Chg. to Base)		Veto (Chg. to Leg)		Net Change	
	Funding	Positions	Funding	Positions	Funding	Positions
PR	$685,000	2.00	- $685,000	- 2.00	$0	0.00

Assembly/Legislature: Provide $185,000 in 2001-02 and $500,000 in 2002-03 from federal funds received by the Department of Transportation under the state and community highway safety grant program, and 2.0 two-year project positions, beginning in 2001-02, to fund and implement the statewide trauma system. This item includes: (a) $60,000 in 2001-02 and $80,000

State of Wisconsin Investment Board

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MADISON, WI 53707-7842

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MADISON, WI 53702
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March 11, 2003

Honorable Alberta Darling, Co-Chair
Joint Committee on Finance
PO Box 7882
Madison WI 53708-7882

Honorable Dean Kaufert, Co-Chair
Joint Committee on Finance
PO Box 8952
Madison WI 53708-8952

Honorable Carol Roessler, Co-Chair
Joint Committee on Audit
PO B9x 7882
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Honorable Suzanne Jeskewitz, Co-Chair
Joint Committee on Audit
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Mr. Donald Schneider
Senate Chief Clerk
PO Box 7882
Madison WI 53708-7882

Mr. Patrick Fuller
Assembly Chief Clerk
PO Box 8952
Madison WI 53708-8952

Members of the Legislature:

Pursuant to s. 25.17(14r), Stats., I have attached copies of SWIB's recently revised Investment Guidelines. The following summarizes the changes:

1. The Board of Trustees established two additional internal equity (stock) portfolios for the Fixed and Variable Trust Funds of the Wisconsin Retirement System – a Large Cap (capitalization) Diversified Portfolio and a Small Cap Diversified Portfolio. The portfolios were created to increase the diversification of our stock exposure in these market segments. The attached guideline revisions incorporate these portfolios and apply the same benchmarks, objectives and risk parameters that already apply to the existing Large Cap and Small Cap Equity Portfolios.

2. The Trustees approved the consolidation of the Intermediate Government/Corporate Bond Portfolio and the Long Term Government/Corporate Bond Portfolio, renamed it the Government/Credit Fixed Income Portfolio. These portfolios manage assets for the Fixed Trust Fund. The number of issues the portfolio may hold was increased to 200. This consolidation was done in conjunction with a reallocation of resources in the Fixed Income Group. A portion of the assets of the Long Term Government/Corporate Portfolio was transferred to our internally managed Global Fixed Income Portfolio to

build on the success of our global bond investments. The benchmark for the combined portfolio was changed to the Lehman Government/Corporate Index, which reflects all US public fixed income.

3. The Board of Trustees completed a comprehensive review of all benchmarks and changed the benchmarks for the following portfolios: Private Equity and Opportunity E Portfolios, Emerging Markets, and National and Wisconsin Private Placements Portfolios. These portfolios all manage assets for the Fixed Trust Fund. The Private Equity and Opportunity E Portfolios previously had an absolute annual return of 15% as their benchmark, and the Private Placements Portfolios were measured against a sector-weighted corporate bond index. Following the restructuring of these portfolios, it was necessary to establish new benchmarks that more closely reflected the purpose and structure of each portfolio. The new benchmarks are tied to an industry established index plus a premium that more responds to market behavior.

4. To comply with requirements of the Office of the Commissioner of Insurance (OCI), the Board amended the investment guidelines for the State Life Insurance Fund. As of January 1, 2003, the Fund may only invest in publicly traded fixed income obligations. It may, however, retain any privately placements that were in the portfolio on that date. In addition, the portfolio must maintain a minimum "A-" quality rating from a national rating agency.

I have attached a copy of the current guidelines plus a copy that shows where the changes were made. Additional information regarding the investment strategies associated with these changes will be provided in our annual performance and strategies report, which should be completed by the end of March. If you have any questions, please contact Sandy Drew (1-0182).

Sincerely,

Patricia Lipton
Executive Director

Enclosures

cc: Members of the Committees
Robert Lang, Legislative Fiscal Bureau
Janice Mueller, Legislative Audit Bureau

STATE LIFE INSURANCE FUND

Description: The State Life Insurance Fund offers low cost life insurance protection to Wisconsin residents in amounts not exceeding $10,000 per person. The State Office of the Commissioner of Insurance is responsible for administering the operations of the Life Insurance fund. The fund's securities are maintained by SWIB.

Investment Objective: To maintain a diversified portfolio of high quality publicly issued fixed income obligations that will preserve principle, maximize income while minimizing costs to policyholders, and approximate the expected life of the Fund's insurance contracts. Surplus income from the Fund is used to minimize the cost of insurance to the Fund's policyholders.

Investment Guidelines (exposure limits are to be applied at the time of purchase):

1. Portfolio is to be invested in publicly traded dollar denominated instruments, including government, agency, corporate and yankee securities. (Private placements purchased prior to January 01, 2003 will remain in the portfolio.)

2. The portfolio shall maintain a minimum quality rating from a national rating agency of "A-", using the lower of split ratings.

3. Portfolio maturity, including cash, shall be a minimum of 10 years.

4. Non-Investment Grade securities shall not exceed 5% of the fund.

5. No single issuer shall constitute more than 5% of the fund, with the exception of the US Government and its agencies.

6. Notwithstanding the above requirements, investments may be made in the Lehman Intermediate Government Index, the Lehman Intermediate Credit Index, the Lehman Long Government Index and the Lehman Long Credit Index.

7. Make any other legal investment that is specifically approved by the Board.

STATE LIFE INSURANCE FUND

Description: The State Life Insurance Fund offers low cost life insurance protection to Wisconsin residents in amounts not exceeding $10,000 per person. The State Office of the Commissioner of Insurance is responsible for administering the operations of the Life Insurance fund. The fund's securities are maintained by SWIB.

Investment Objective: To maintain a diversified portfolio of high quality publicly ~~or privately~~ issued fixed income obligations that will preserve principle, maximize income while minimizing costs to policyholders, and approximate the expected life of the Fund's insurance contracts. Surplus income from the Fund is used to minimize the cost of insurance to the Fund's policyholders.

Investment Guidelines (exposure limits are to be applied at the time of purchase):

1. Portfolio is to be invested in publicly traded dollar denominated instruments, including government, agency, corporate and yankee securities. (Private placements purchased prior to January 01, 2003 will remain in the portfolio.)

~~1~~2. The portfolio shall maintain a minimum quality rating from a national rating agency of "A-", using the lower of split ratings.

~~2~~3. Portfolio maturity, including cash, shall be a minimum of 10 years.

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~~5~~6. Notwithstanding the above requirements, investments may be made in the Lehman Intermediate Government Index, the Lehman Intermediate Credit Index, the Lehman Long Government Index and the Lehman Long Credit Index.

~~6~~7. Make any other legal investment that is specifically approved by the Board.

Appendix 2

Specific Investment Performance Objectives

U.S. EQUITY

PORTFOLIO	BENCHMARK	UNIVERSE RANK OBJECTIVE
Total U.S. Equity	Russell 3000	Above Median
Large Cap	S&P 500	Above Median
Large Cap Diversified	S&P 500	Above Median
Mid Cap	S&P Mid Cap	Above Median
Small Cap Diversified	S&P 600	Above Median
Small Cap	Russell 2000	Above Median
Healthcare Sector	Russell 3000 Healthcare Index	N/A

INTERNATIONAL EQUITY

PORTFOLIO	BENCHMARK	UNIVERSE RANK OBJECTIVE
Total International Equity	ACWI ex US	Above Median
Developed Markets Portfolios	MSCI World ex US	Above Median

FIXED INCOME

PORTFOLIO	BENCHMARK	UNIVERSE RANK OBJECTIVE
Total Fixed Income	"Roll Up"	Above Median
Total U.S. Public FI	Lehman Govt/Credit	Above Median
Govt/Credit	Lehman Govt/Credit	Above Median

FIXED INCOME (Continued)

PORTFOLIO	BENCHMARK	UNIVERSE RANK OBJECTIVE
National Private Debt	Lehman Duration Adjusted Credit plus 20 bps	N/A
Wisconsin Private Debt	Lehman Duration Adjusted BAA Credit plus 20 bps	N/A
CMBS	Lehman Duration Adjusted BAA Credit	N/A
Global FI	Salomon World Govt Bond	Above Median
Emerging Debt	JP Morgan Emerging Markets Global Constrained	Above Median

OTHER ASSET CLASSES

PORTFOLIO	BENCHMARK	UNIVERSE RANK OBJECTIVE
Real Estate	National Council of Real Estate Investment Fiduciaries (NCREIF)	N/A
Private Equity	Cash flow adjusted Russell 3000 plus 250 bps	N/A
Private Biotech	Cash flow adjusted Russell 3000 plus 250 bps	N/A
Opportunity Legacy	Cash flow adjusted MSCI All Country World Index plus 200 bps	N/A

Appendix 3

SOFT PARAMETERS – ASSET CLASS AND PORTFOLIO

ASSET CLASS CHARACTERISTIC	ASSET CLASS	DISCUSSION TRIGGER
Maximum Small Cap Exposure	U.S. Equities	2.5 x Benchmark
Maximum Volatility	U.S. Equities	120% of Benchmark Over 5 Years
Maximum Volatility	Int'l Equities	120% of Benchmark Over 5 Years
Duration	U.S. Fixed	± 15% of Benchmark
Maximum Volatility	U.S. Fixed	120% of Benchmark Over 5 Years
Duration	Global Fixed	± 15% of Benchmark
Maximum Volatility	Global Fixed	120% of Benchmark Over 5 Years
PORTFOLIO CHARACTERISTIC	**PORTFOLIO**	**DISCUSSION TRIGGER**
ACTIVE U.S. EQUITIES		
Number of Holdings	Large	30-100
	Large Cap Diversified	100-200
	Mid	30-250
	Small Cap Diversified	150-350
	Small	30-500
	Healthcare Sector	75-150
Maximum Position Size	Large	10%
	Large Cap Diversified	10%
	Mid	10%
	Small Cap Diversified	10%
	Small	10%
	Healthcare Sector	20%
P/E Ratio	Large	50%-150% of Benchmark
	Large Cap Diversified	50%-150% of Benchmark
	Mid	50%-150% of Benchmark
	Small Cap Diversified	50%-150% of Benchmark
	Small	50%-150% of Benchmark
	Healthcare Sector	50%-150% of Benchmark

PORTFOLIO CHARACTERISTIC	PORTFOLIO	DISCUSSION TRIGGER
Maximum Industry Sector Exposure	Large	Greater of 10% or 3 x Benchmark
	Large Cap Diversified	Greater of 10% or 3 x Benchmark
	Mid	Greater of 10% or 3 x Benchmark
	Small Cap Diversified	Greater of 10% or 3 x Benchmark
	Small	Greater of 10% or 3 x Benchmark
Maximum Volatility	Large	133% of Benchmark Over 5 Years
	Large Cap Diversified	133% of Benchmark Over 5 Years
	Mid	133% of Benchmark Over 5 Years
	Small Cap Diversified	133% of Benchmark Over 5 Years
	Small	133% of Benchmark Over 5 Years
	Healthcare Sector	133% of Benchmark Over 5 Years
Maximum Cash	Large	10%
	Large Cap Diversified	10%
	Mid	10%
	Small Cap Diversified	10%
	Small	10%
	Healthcare Sector	10%

PORTFOLIO CHARACTERISTIC	PORTFOLIO	DISCUSSION TRIGGER
INTERNATIONAL EQUITIES		
Number of Holdings	Int'l Developed	30-100
Minimum Number of Countries	Int'l Developed	10
Maximum Country Exposure	Int'l Developed	Greater of 10% or 3 x Benchmark
Maximum Industry Sector Exposure	Int'l Developed	Greater of 10% or 3 x Benchmark
Maximum Volatility	Int'l Developed	133% of Benchmark Over 5 Years
Maximum Cash	Int'l Developed	10%
U.S. FIXED INCOME		
Number of Issuers	Govt/Credit	20-200
Maximum Industry Sector Exposure	Govt/Credit	Greater of 10% or 3 x Benchmark
Maximum Volatility	Govt/Credit	133% of Benchmark Over 5 Years
Maximum Cash	Govt/Credit	20%
GLOBAL FIXED INCOME		
Duration	Global Fixed	± 15% of Benchmark
Minimum Number of Countries	Global Fixed	5
Maximum Exposure to Individual Sovereign Issuer	Global Fixed	40%
Maximum Volatility	Global Fixed	133% of Benchmark Over 5 Years
Maximum Cash	Global Fixed	20%
PRIVATE PORTFOLIOS		
Maximum Industry Exposure	National Private Debt	20%
Maximum Outside Developed Mkts	Private Equity	20%
Venture Capital	Private Equity	10-30%
Max VC Strategic Partnering	Private Equity	10% of VC
Buyouts	Private Equity	70-90%
Direct Investments	Private Equity	20-40% of Buyouts
Funds	Private Equity	60-80% of Buyouts
Maximum Industry Sector Exposure	Private Equity	Data Not Available
Maximum Non-U.S. Country Exposure	Private Equity	Data Not Available
Maximum Development Risk (Direct Holdings Only)	Real Estate	10%
Maximum Single Property Type Exposure - Quarterly	Real Estate	40%
Minimum Core Holdings	Real Estate	40%
Maximum Non-Core Holdings	Real Estate	60%
Maximum Core Portfolio Leverage	Real Estate	50%
Maximum Core Fund/Deal Leverage	Real Estate	75%

Appendix 2

Specific Investment Performance Objectives

U.S. EQUITY

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Small Cap	Russell 2000	Above Median
~~Large Cap Diversified~~	~~S&P 500~~	~~Above Median~~
Healthcare Sector	Russell 3000 Healthcare Index	~~Above Median~~ N/A

INTERNATIONAL EQUITY

PORTFOLIO	BENCHMARK	UNIVERSE RANK OBJECTIVE
Total Portfolio	ACWI ex US	Above Median
Developed Markets Portfolios	MSCI World ex US	Above Median

FIXED INCOME

PORTFOLIO	BENCHMARK	UNIVERSE RANK OBJECTIVE
Total Fixed Income	"Roll Up"	Above Median
Total U.S. Public FI	Lehman Govt/Credit	Above Median
~~Intermediate~~ Govt/~~Corp~~Credit	Lehman ~~Intermediate~~ Govt/Corp	Above Median

~~Long Govt/Corp~~	~~Lehman Long Govt/Corp~~	~~Above Median~~
National Private Debt	Lehman Duration Adjusted Corporate ~~+~~plus ~~10 Bps~~ 20 bps	N/A
Wisconsin Private Debt	Lehman Duration Adjusted BAA Credit plus 20 bps~~Pending~~	N/A
CMBS	Lehman Duration Adjusted BAA	N/A
Global FI	Salomon World Govt Bond	Above Median
Emerging Debt	JP Morgan Emerging Markets ~~Plus~~Global Constrained	Above Median

OTHER ASSET CLASSES

PORTFOLIO	BENCHMARK	UNIVERSE RANK OBJECTIVE
Real Estate	National Council of Real Estate Investment Fiduciaries (NCREIF)	N/A
Private Equity	Cash flow adjusted Russell 3000 plus 250 bps	N/A
Private Biotech	Cash flow adjusted Russell 3000 plus 250 bps	N/A
Opportunity Legacy	Cash flow adjusted MSCI All Country World Index plus 200 bps	N/A

~~Real Estate Objective: A return in excess of NCREIF~~

~~Private Equity Objective: A net absolute return in excess of 15% per year.~~

Appendix 3

SOFT PARAMETERS – ASSET CLASS AND PORTFOLIO

ASSET CLASS CHARACTERISTIC	ASSET CLASS	Discussion Trigger
Maximum Small Cap Exposure	U.S. Equities	2.5 x Benchmark
Maximum Volatility	U.S. Equities	120% of Benchmark Over 5 Years
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PORTFOLIO CHARACTERISTIC	**PORTFOLIO**	**Discussion Trigger**
ACTIVE U.S. EQUITIES		
Number of Holdings	Large	30-100
	Large Cap Diversified	100-200
	Mid	30-250
	~~Small~~	~~30-500~~
	~~Large~~ Small Cap Diversified	~~100-200~~ 150-300
	Small	30-500
	Healthcare Sector	75-150
Maximum Position Size	Large	10%
	Large Cap Diversified	10%
	Mid	10%
	Small Cap Diversified	10%
	~~Large Cap Diversified~~ Small	10%
	Healthcare Sector	20%
~~Median Position Size~~	~~Large~~	~~2-3%~~
P/E Ratio	Large	50%-150% of Benchmark
	Large Cap Diversified	50%-150% of Benchmark

	Mid	50%-150% of Benchmark
	Small Cap Diversified	50%-150% of Benchmark
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	Small Cap Diversified	133% of Benchmark Over 5 Years
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Maximum Cash	Large	10%
	Large Cap Diversified	10%
	Mid	10%
	Small Cap Diversified	10%
	~~Large Cap Diversified~~ Small	10%
	Healthcare Sector	10%

PORTFOLIO CHARACTERISTIC	PORTFOLIO	Discussion Trigger
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Number of Holdings	Int'l Developed	30-100
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Maximum Cash	Int'l Developed	10%
U.S. FIXED INCOME		
Number of Issuers	Govt/Credit~~Intermediate~~	20-200~~20-100~~
~~—~~	~~Long~~	~~20-100~~
Maximum Industry Sector Exposure	Govt/Credit~~Intermediate~~	Greater of 10% or 3 x Benchmark
	~~Long~~	~~Greater of 10% or 3 x Benchmark~~
Maximum Volatility	Govt/Credit~~Intermediate~~	133% of Benchmark Over 5 Years
	~~Long~~	~~133% of Benchmark Over 5 Years~~
Maximum Cash	Govt/Credit~~Intermediate~~	20%
	~~Long~~	~~20%~~
GLOBAL FIXED INCOME		
Duration	Global Fixed	± 15% of Benchmark
Minimum Number of Countries	Global Fixed	5
Maximum Exposure to Individual Sovereign Issuer	Global Fixed	40%
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Direct Investments	Private Equity	20-40% of Buyouts
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Maximum Non-U.S. Country Exposure	Private Equity	Data Not Available
Maximum Development Risk (Direct Holdings Only)	Real Estate	10%
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THE STATE OF WISCONSIN

SENATE CHAIR
ALBERTA DARLING

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ASSEMBLY CHAIR
DEAN KAUFERT

308-E Capitol
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Phone: (608) 266-5719

JOINT COMMITTEE ON FINANCE

MEMORANDUM

To: Members
Joint Committee on Finance

From: Senator Alberta Darling
Representative Dean Kaufert

Date: March 11, 2003

Attached are copies of two reports from the University of Wisconsin – Madison Medical School, pursuant to s. 13.106(1) and (2), Stats.

The reports are being provided for your information only. No formal action is required by the Committee. Please feel free to contact us if you have any questions.

Attachment

AD:DK:dh

UNIVERSITY OF
WISCONSIN–MADISON
MEDICAL SCHOOL

March 6, 2003

Honorable Jim Doyle
Governor

Senator Alberta Darling
Co-Chair, Joint Committee on Finance

Representative Dean Kaufert
Co-Chair, Joint Committee on Finance

Dear Governor Doyle, Senator Darling and Representative Kaufert:

The enclosed reports are submitted in accordance with s. 13.106(1) and (2) that require:

(1) the Medical College of Wisconsin and the University of Wisconsin-Madison Medical School to biennially report to the Governor and the Joint Committee on Finance on the:

a. Minority student recruitment policies and programs of each medical school, and the number of minority students enrolled
b. Number and percentages of Wisconsin residents enrolled
c. Average faculty salaries compared to national averages
d. Development of cooperative educational programs with other institutions throughout this state
e. Placement of graduates of doctor of medicine and resident training programs

(2) the Medical College of Wisconsin and the University of Wisconsin-Madison Medical School to submit a biennial report containing financial summaries for the College and School to the Governor and the Joint Committee on Finance, in a consistent format and methodology to be developed in consultation with the Medical Education Review Committee under s. 39.16.

If you have any questions regarding the enclosed materials, please contact me.

Sincerely,

Philip M. Farrell, M.D., Ph.D.
Dean, UW Medical School and
Alfred Dorrance Daniels Professor on Diseases of Children

Attachment

Medical School Administration

1300 University Avenue Madison, WI 53706-1532

General Information 608/263-4900
Dean's Office 608/263-4910
FAX 608/262-2327
Office of Associate Dean for Students 608/263-4920

University of Wisconsin Medical School
Biennial Report for 2000-2002

State statutes (s. 13.106(1)) require the University of Wisconsin-Madison Medical School and the Medical College of Wisconsin to biennially report to the Governor and the Joint Committee on Finance on the:

a. Minority Student Recruitment Policies and Programs and the Number of Minority Students Enrolled

Recruitment Policies and Programs

The Medical School has a history of implementing programs to increase minority participation in medical education and is committed to increasing the number of minority physicians in the state and the nation. The Medical School has made efforts to attract and retain minority students by (1) developing and implementing pre-college science programs, (2) identifying target geographical areas to recruit prospective medical students, (3) developing programs and activities within the Medical School and forming linkages with other institutions and academic units to expand the minority student applicant pool, and (4) using national data bases to identify prospective medical students from under-represented minority groups.

A number of programs and initiatives have been implemented to increase minority student participation in the Medical School including:

High School Research Apprentice Program (RAP)
RAP is a seven-week summer program that provides research experiences for minority high school students from the Dane County area. Students apply to the program and selection is based on interest in science, high school academic record and teacher recommendations. The students work with Medical School faculty in a laboratory or clinic setting and receive a small stipend. In addition to the research apprenticeship component, students participate in academic enrichment activities that include (1) mathematics, computer science and writing workshops; (2) field trips to medical and research centers, and museums; (3) career presentations by physicians, research scientists, as well as graduate and medical school students; and (4) financial aid and college preparation workshops. At the end of the program, students must submit a research paper and give a presentation on their research findings. The Medical School maintains regular contact with these students throughout their high school and college careers in an effort to attract them into the field of medicine. While conclusive data are not available, preliminary data indicate that a large number of RAP participants tend to pursue a science major in their undergraduate studies. Furthermore, a sizeable number of the participants continue their education after completing undergraduate school by pursuing graduate study in the sciences and medical school.

NASA Sharp Plus Program
UW-Madison is one of 10 sites that host NASA Sharp Plus, an eight-week summer research program for high school students. NASA Sharp Plus is funded by National Aeronautics and Space Administration (NASA), and coordinated with other sites throughout the country by Quality Education for Minorities (QEM). QEM and NASA staff select program participants from a national applicant pool. This campus-wide initiative has been based on the Madison campus and run by the Medical School since 1996. The Medical School directs this program because more than half of the participants are interested in medicine or biomedical research. Students work in research laboratories with faculty and research scientists. Medical School faculty and staff who have volunteered their time as mentors are from the Neuroscience Training Program, Institute on Aging, and the Departments of Physiology, Surgical Pathology, Transplant Surgery, Otolaryngology, Psychiatry, Orthopedic Surgery, Hematology, and Ophthalmology and Visual Sciences.

At the end of the program, NASA Sharp Plus students are required to write a research paper and present their research findings. Additionally, they participate in weekly academic enrichment activities with RAP students and 3rd year PEOPLE Program participants who are interested in the medical sciences.

PEOPLE Program

Pre-college **E**nrichment **O**pportunity **P**rogram for **L**earning **E**xcellence (PEOPLE) is partnership that the University of Wisconsin-Madison has formed with the school districts in Milwaukee, Beloit, Racine, and Madison. Students apply to the program and are selected during the second semester of their 9th grade. This high school program provides students with a residential experience on the Madison campus for 4 summers. During the first summer, students participate in a 3-week enrichment program that focuses on writing skills and one week modules in the sciences. The Medical School offers students a one-week module in biomedical research and the health sciences. The second summer, the Medical School, working collaboratively with others in the sciences, engage students in hands-on problem-solving modules in the biological and physical sciences for 4-weeks. The third summer, PEOPLE program students participate in a 7-week summer research apprentice experience in different areas. Students who are interested in medicine and have a B average plus courses in biology and chemistry participate in biomedical research activities with RAP and NASA Sharp Plus students.

Health Professions Partnership Initiative (HPPI)

Since 1996, the UW Medical School has partnered with the Milwaukee Public Schools on the Health Professions Partnership Initiative (HPPI). HPPI is a pipeline program designed to increase the number of under-represented minorities interested in and qualified to pursue careers in the health professions. The program is based at the UW Medical School's Milwaukee Clinical Campus at Sinai Samaritan Medical Center. The Medical School in collaboration with other academic units at UW-Madison and UW-Milwaukee are working with the Milwaukee Public Schools, primarily Sarah Scott Middle School and Rufus King High School, in developing academic programs that will (1) introduce middle school and high school students to the sciences and health professions and (2) increase students' interest and proficiency in science. Some of the programs include after-school science programs and the four-week Rufus King Summer Prep Academy that focuses on science and math and field trips.

Originally funded by a five-year grant from the Robert Wood Johnson, Inc. and with matching dollars from the Medical School, HPPI has continued because of the commitment of this School to the project and its identification of various funding sources. Currently, HPPI is an integral part of the Center for Urban Population Health at the UW Medical School Milwaukee Campus.

Middle and High School Campus Visit Program

This program focuses on students from the Madison and Milwaukee area schools. One-day campus visits are conducted for middle and high school students with the cooperation of public school science teachers, representatives from the UW-Madison Admissions Office, and Medical School faculty, staff and students. Activities are designed to give students an overview of the requirements for undergraduate admissions, information on minority/disadvantaged student support programs, an introduction to different science majors and careers in the medical/scientific fields, and information on pre-college programs.

Pre-Medical Student Campus Visit/Advising Program

Campus visits are arranged for pre-medical student groups and for individuals seeking information about and admission to the Medical School. An annual one-day Pre-Medical School conference is conducted for students from UW System institutions and Wisconsin's private colleges. Also, special pre-medical school advising sessions are held for prospective students. From this pool of prospective applicants (primarily UW-Madison and UW-Milwaukee students), study groups have been formed to review biology, chemistry and physics in preparation for the Medical College Admission Test (MCAT).

Campus Visit/Interview Program

The Medical School has made a special effort to recruit a select group of minority students who, according to available data, have outstanding MCAT scores and/or strong science and cumulative grade

point averages. Each year, using information obtained from national data banks, approximately 30 academically outstanding minority applicants are invited to the Medical School for campus visits and interviews with the admissions committee. An array of activities is held to introduce applicants to the school's academic programs, services and facilities.

AHANA Pre-Health Professions Organization
The Medical School has played a critical role in the development of this UW-Madison undergraduate student organization. AHANA was founded by UW Medical School students and UW-Madison undergraduates to increase minority student participation and representation in the health professions. Medical School faculty and staff have been active on the AHANA advisory board and provided support for all activities including weekly study group sessions in core science classes; monthly lecture series; field trips; volunteer activities; summer opportunities in the health sciences; MCAT review sessions; and attendance at student specific medical health profession conferences.

University of Wisconsin-Milwaukee Liaison
The Medical School and the University of Wisconsin-Milwaukee continue to work together to identify ways to interest more minority students in the sciences, particularly medicine. Efforts include: joint advising; on-campus visits; formal presentations to pre-med student classes; and development of a formal educational partnership through HPPI with the Med-Prep Program in the College of Letters and Science at the UW-Milwaukee. Currently, the Med-Prep program and the Medical School jointly sponsor advising and informational sessions as well as a MCAT review session for Med-Prep students and UW-Madison undergraduates (the AHANA Pre-Health Professions Organization).

John Wesley Lawlah, Jr. Scholarship Program
This program was established in memory of the first minority student to attend the Medical School. Scholarships are awarded annually to two outstanding Wisconsin minority students on the basis of academic achievement and promise as future physicians. The School funds this four-year, full scholarship program.

Financial Aid
The Medical School provides scholarship dollars to supplement the Advance Opportunity Fellowship. The fellowship dollars support minority/disadvantaged students during their four-year program.

Special Outreach to Outstanding Minority Students
Special recruitment efforts are made to under-represented minority students who have exemplary MCAT scores. A special recruitment letter is sent during the latter part of August to this targeted group of students. This recruitment strategy has been useful in identifying outstanding applicants. The prospective applicants are identified through the Medical Minority Admissions Registry (Med MAR) which is a publication of the American Association of Medical Colleges (AAMC).

Recruitment Fairs
The Multicultural Affairs Office participates in a select number of recruitment fairs. These include: the National Association of Medical Minority Educators, Inc. (NAMME); the Association of American Medical College's (AAMC) Minority Student Medical Career Awareness Workshop; recruitment fairs at institutions in the Big Ten and those affiliated with the University's Inter-institutional Linkage Program; and at the alma mater of our successful minority students.

Summer Enrichment Program (SEP)
SEP - designed to introduce middle school students to careers in math, science, and health science - was discontinued in 2002 to eliminate duplicative pre-college program services at the University and for financial reasons. Aspects of SEP were merged with the Middle School PEOPLE program, a summer and academic year program for Madison public school students. For example, former SEP participants from Madison who were seventh and eight graders were integrated into the PEOPLE program. Also, additional health science and science program modules were incorporated into the Middle School

PEOPLE program. Former SEP students from middle schools in Milwaukee, Chicago, and the Menominee Indian Nation were referred to pre-college programs in their respective communities.

Informational/Orientation Meeting (Luncheon or Reception)
The orientation meeting is held at the beginning of the semester to welcome first year medical students and to greet second year medical students. Special emphasis is placed on apprising students of academic support services and staff within the Medical School (advising, tutorials, national board review sessions, personal and mental health counseling).

Annual Welcoming Picnic
This activity brings all minority medical students and members of the Medical Students for Minority Concerns (MSMC) together at the beginning of the semester. The activity is usually hosted at the home of a minority physician. The picnic gives medical students, particularly first year students, opportunities to meet and interact with a cross section of Medical School faculty and community physicians. Also, the picnic gives first and second year minority medical students and other MSMC members the opportunity to socialize and network with third and fourth year students whose clinical rotations occur in different clinics and hospitals throughout the state.

Monthly Social
The Minority Affairs Committee in the Health Sciences sponsors a monthly TGIF. This social activity brings together medical students and other students of color pursuing degrees in other health professions. TGIF's give students the opportunities to connect with each other, to share experiences and information, and to interact with faculty and other health professionals on campus and in the community.

Review of Academic Progress
The Student Academic Progress Committee monitors the academic progress of all students on a regular basis. The Committee has been successful in identifying students who may have problems and in developing appropriate plans of action to help them succeed and comply with the School's academic policy. The Committee is chaired by the Associate Dean of Students and includes the Assistant Dean of Multicultural Affairs, the Assistant Dean of Student Services, and the Director and Assistant Director of the Student Academic Development Office.

National Board Exams Review Sessions
National Board Review sessions are available to all medical students who take Step 1 and Step 2 of the United States Medical Licensing Examination. The Student Academic Development Office conducts these review sessions.

Academic Support for Classes
Supplementary instruction for basic science courses is available to all medical students. The Student Academic Development Office provides this support.

Link with Undergraduate Academic Programs at UW-Madison
Pre-med advising of UW-Madison undergraduates is an integral part of the Admissions Office and the Multicultural Affairs Office. Special efforts are made to connect with minority merit-based and minority/disadvantaged academic support programs on campus. These include, but are not limited to, students in the Chancellor's Scholarship and Power-Knapp Scholarship programs, Summer Collegiate Experience program, and the TRIO Program.

Lectures and Roundtable Discussions
The Multicultural Affairs Office in cooperation with the Medical Students for Minority Concerns (MSMC) and other student organizations co-sponsor several lectures and roundtable discussions each academic year.

Minority Graduation Reception
The Minority Graduation Reception is one of the most celebrated activities in the Medical School. It honors the accomplishments that the graduating medical students have made as well as acknowledges those who have supported and made a difference in the students' lives. Parents, spouses, current medical students, community physicians, and medical school faculty and staff are invited to participate in the celebration. The keynote speaker for the event is usually a minority medical school alumnae or a minority physician affiliated with the school. The reception is held on the Thursday before graduation.

Enrollment
In 2000-01, the UW-Madison Medical School enrolled 48 under-represented minority students (the Association of American Medical Colleges guidelines identify these students as African American, Native American, Alaskan Native, Mexican American, and mainland Puerto Rican). In 2001-02, there were 47 students.

b. Number and Percentages of Wisconsin Residents Enrolled

In 2000-01, the Medical School had a total enrollment of 586 students, 521 (88.9 percent) of whom were residents of the State of Wisconsin. In 2000-2, there were 502 Wisconsin residents (86.7 percent) out of a total of 579 enrolled students.

c. Average Faculty Salaries Compared to National Averages

The table below compares UW faculty salaries with 2000-01 faculty salaries reported to the Association of American Medical Colleges (AAMC). The AAMC figures are salary averages for all faculty at US institutions for which complete information was provided.

The average salaries listed below include all salary components.

	UW	National
Basic Science Departments		
Professor and Chairpersons	$118,400	$123,700
Associate Professors	84,400	80,700
Assistant Professors	78,100	63,900
Clinical Science Departments		
Professors and Chairpersons	218,900	232,800
Associate Professors	193,400	185,400
Assistant Professors	192,900	156,300

d. Development of Cooperative Educational Programs with Other Institutions Throughout the State

Clinical Training Sites

In addition to UW Hospital and Clinics, the Veterans Administration, Meriter and St. Marys Hospital in Madison, the Medical School has cooperative educational programs with the Sinai Samaritan Medical Center and St. Luke's Hospital in Milwaukee, the Gundersen Medical Foundation in LaCrosse, and the Marshfield Clinic, St. Joseph's Hospital and the Marshfield Medical Foundation in Marshfield. These institutions provide educational programs for third and fourth year students in a variety of disciplines. These affiliations serve to (1) enhance and broaden the scope of existing programs in health science education and research, (2) facilitate joint planning and implementation of innovative programs in health sciences education and research, and the delivery of medical care, (3) strengthen the ability of these institutions to serve patients, the community, students, and house staff; and (4) advance scholarship in the biomedical sciences. In addition, the Milwaukee institutions broaden the clinical education of our students by exposing them to the unique social and medical problems found in an urban environment.

Primary Care Initiatives

The *Generalist Partners Program* was initiated in the fall of 1994 as a pilot program with the goal of increasing the numbers of medical students choosing careers in primary care. First and second year medical students are placed with primary care physicians with whom they spend three afternoons per semester. The program is now fully integrated into the curriculum. Each semester, over 100 physicians participate in the clinical curriculum at nearly 60 sites around southern Wisconsin. Approximately one-third of the clinics, about 18 sites, are outside of Dane County.

In 1990, the Medical School instituted an eight-week *primary care clerkship* for all third year students. This clerkship combines clinical experiences with core curriculum. Initially, outpatient sites in Madison and Milwaukee were used. Starting in Fall 1993, students were also placed in Eau Claire, LaCrosse, Minocqua and surrounding communities (see map). Many different institutions served as field sites for the clerkship during 2002 including:

Appleton/Shawano. Family Doctors-North, Kaukauna Clinic, LaSalle Clinic (North Oneida and Richmond Street), Menominee Tribal Clinic, Primary Care Associates, ThedaCare Physicians (Gillett, Neenah, North and Shawano), UW Health Fox Valley Family Practice, Shawano Family Medicine, Shawano Clinic - Gillett Office.

Eau Claire. Augusta Family Medicine, Eau Claire Family Practice, Lakewood Family Clinic, Marshfield Clinic (Eau Claire Center, Chippewa Falls, Oak Leaf Pediatrics, Oakwood Center, Phillips Center and Riverview Center), Midelfort Clinic (Luther Campus and Clairemont Avenue), Red Cedar Clinic – Menomonie.

LaCrosse. Franciscan-Skemp health Care, Gundersen Lutheran (LaCrosse and Onalaska), LaCrosse-Mayo Family Practice.

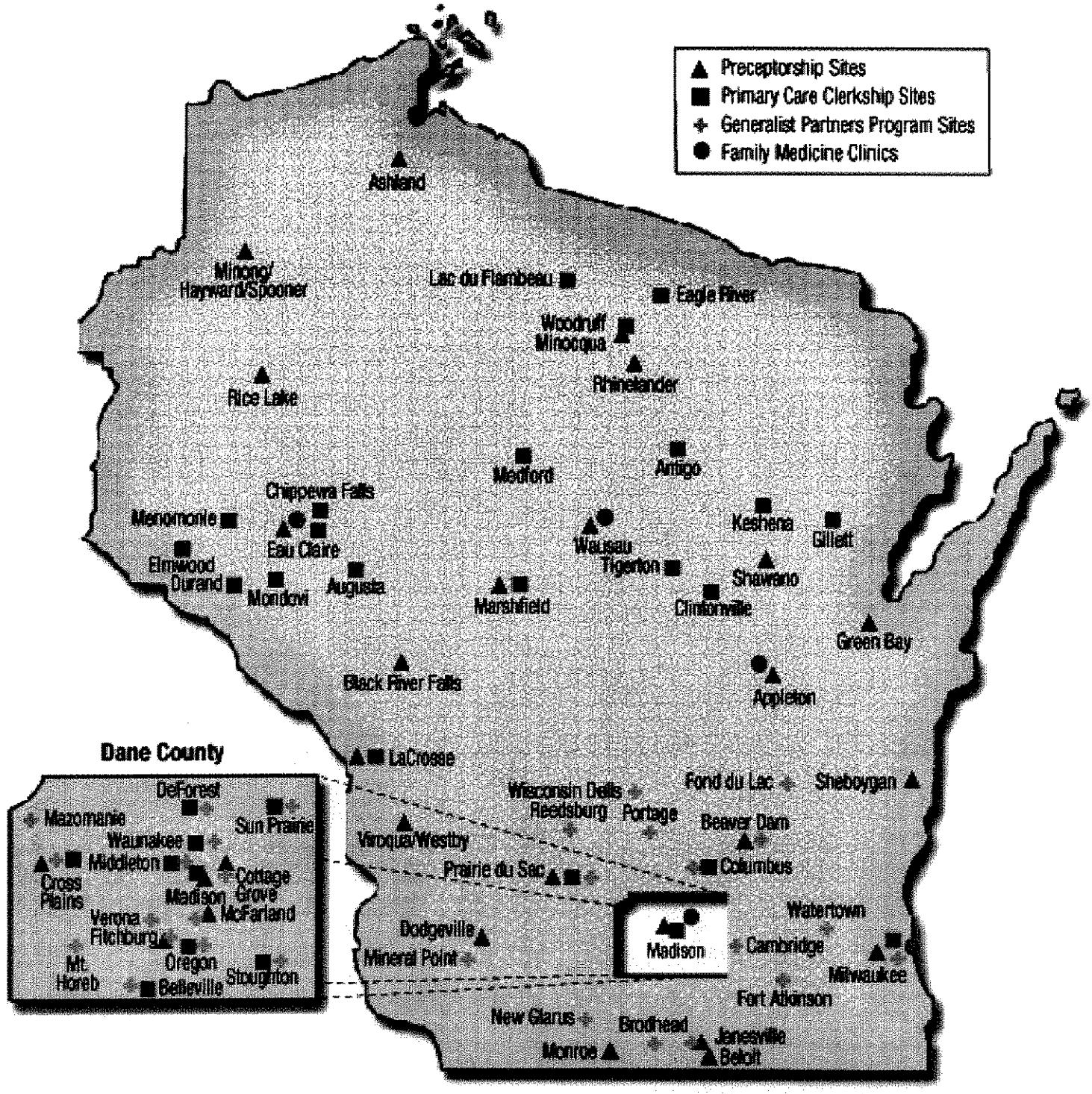
Madison and Vicinity. Associated Physicians, Beloit Area Community Health Center, Beloit Clinic, D.E. Bates Medical Clinic, Dean Clinic (East, Atwood, Sun Prairie and Waunakee), Dells Clinic, GHC - Capitol Health Center, Physicians Plus (Middleton, 1 South Park Street, Portage Clinic, Poser Clinic, Riverview Clinic, River Valley Medical Center and Sun Prairie Clinic), UCC - Crossroad Community Clinic, UW Health (Belleville Family Medical Center, Cottage Grove, Cross Plains, DeForest, Mt. Horeb, Northeast Family Medical Center, Odana Medical Center, Oregon, Stoughton, Verona, and Wingra), UW Pediatrics Clinic, East Clinic and Middleton Pediatrics, UW Health - East Clinic, UW Health/PPlus West Internal Medicine, UW Medical Science Center, UW Women's Health Center, UW Teen Clinic.

Milwaukee. Aurora Medical Group Downtown, Clarke Square Family Health Center, Fine-Lando Clinic, Johnston Community Health Center, Lakeshore Medical Clinic, Medical Surgical Clinic - Franklin, Mitchell Point Family Health Center, Lakeshore Family Medicine, Positive Health Clinic, Sinai Samaritan Medical Center, St. Luke's Family Practice and Internal Medicine, Wisconsin Avenue Family Care Center, WiseLives.

Minocqua and Vicinity. Howard Young Medical Center, Marshfield Clinic (Lakeland, Mercer Center and Park Falls).

The required fourth year *Preceptorship Program* has been integral to the Medical School curriculum since the 1920's. All fourth year students participate in a 6-8 week clinical experience in a community setting with community faculty throughout Wisconsin participating. In many cases, the community hospitals provide food and housing for the students. Communities participating in this program include Appleton, Ashland, Beaver Dam, Beloit, Black River Falls, Eau Claire, Fond du Lac, Green Bay (St. Mary's and Family Doctors of Green Bay), Hayward, Janesville, LaCrosse, Madison (UW Meadowood and Capital Health Center), Milwaukee (Sinai Samaritan, Johnston Community Health Clinic and

THE WISCONSIN CLINICAL CAMPUS



Mitchell Point Family Health Clinic), Monroe, New Richmond, Prairie du Sac, Reedsburg, Rhinelander, Rice Lake, Shawano, Sheboygan, Stevens Point, Viroqua, Waterloo and Watertown.

Wisconsin Area Health Education Center (AHEC) System

The Wisconsin AHEC System works to improve the supply, distribution and quality of health care professionals in Wisconsin, thereby improving access to health care in the state's rural and urban underserved areas. AHEC program areas include the following:

- Enhancing the learning experience for all health professions students at community-based sites, with an emphasis on interdisciplinary programs, developing cultural competence, and technology support,
- Supporting health careers recruitment programs in underserved rural and urban areas, to assist high school and college students from underrepresented populations prepare for entry into health professions schools,
- Supporting faculty mentors and preceptors at community-based training sites with continuing education, technology support and other services to enhance the practice environment and maximize the ability of health professionals in underserved communities to provide high quality health care, and
- Partnering with local organizations in a variety of outreach activities to improve the health of the community.

In addition to the UW Medical School, Wisconsin AHEC collaborates with the state's residency training programs (UW, MCW, Marshfield and Mayo-affiliated) in primary care disciplines, the UW School of Pharmacy, the Marquette Dental School, 3 physician assistant programs, 8 advanced practice nursing programs, 21 bachelors degree nursing programs, 3 social work programs and a range of allied health and pre-professional programs at the 13 UW System campuses, 21 private colleges and 2 tribal colleges, as well as the state's 13 UW 2-year Centers and 31 technical college campuses.

Wisconsin AHEC is anchored in four independent not-for-profit regional centers: one single county urban AHEC (Milwaukee AHEC) and three centers with a mix of urban and rural populations in their service areas (38 county Northern AHEC, 20 county Southwest AHEC and 13 county Eastern AHEC). For the most part, these offices function as regional service centers, providing services through AHEC staff and subcontracts to the many training sites in each region. To insure community representation in decision-making on AHEC programs, each center has a community board including health professionals, community representatives, and consumers in the regions served by the community-based AHECs. Board representation and input allows Centers to respond to community identified needs. These four centers cover the entire geographic area of the state and come together in a statewide Board of Directors that, in collaboration with the UW Medical School, oversees statewide AHEC activities.

The state supports the AHEC System through a line item ($1.16 million in 2002-03) in the UW System budget. The university contributes direct support of approximately $125,000 annually from school funds plus space and support services. Additional funding for specific projects comes from the federal AHEC and HETC (Health Education Training Centers) programs and a variety of other federal and non-federal sources through competitive grants to the program office in Madison and individual Centers. These grants currently bring in over $940,000 annually. As the "off-ramp to the community," AHEC is an effective partner for communities, academic programs and state agencies as they work together to address emerging healthcare workforce and community health education needs. DHFS and other state agencies subcontract with AHEC Centers for a number of local and regional programs. The state line item and UW Medical School support are critical in providing the organizational infrastructure that makes it possible for the AHEC System to develop these local programs and compete effectively for outside funding.

Accomplishments in each program area include:

Community-based training opportunities. Over 300 community-based training sites are now active that were originally developed, supported or assisted by Wisconsin AHEC. These sites include migrant and community health centers, health care for the homeless projects, rural health clinics, managed care organizations, as well as other public and private community-based clinics, and hospitals that serve rural and urban underserved populations. Of these sites, 28 percent are in small

towns and cities in non-metropolitan counties or small agricultural communities in metropolitan counties. The rest are in larger communities at some distance from the major academic health centers in the state. These training sites provide over 14,000 student-weeks of clinical training, 31 percent of it in medically underserved communities. In all, over 2000 health professions students (including 572 UW medical students) rotate through these community sites annually, with 56 percent of these students having training experiences in medically underserved settings. AHEC programs place special emphasis on developing student's cultural competence and providing opportunities to learn how to function effectively as part of the interdisciplinary healthcare team. They also assist sites in providing access to internet, telehealth, library and distance education resources.

Through these experiences, students gain exposure to diverse populations in varied practice settings, adding immeasurably to the quality of their training. They also gain an appreciation of the rewards and challenges of practice in rural and small town communities as well as urban underserved areas. Of the UW Medical School Class of 2002, 51 percent of graduating students expressed interest in establishing practice in a rural or urban underserved area after residency.

Health careers and healthcare workforce development. AHEC health careers activities include intensive preparation programs for students from minority and underserved communities as well as summer camps and shadowing programs for younger students in order to interest them in the health professions. In 2000-01, AHEC programs reached 585 college students and over 1500 high school and middle school students. In addition, AHEC prepares and distributes a health careers guide to all high schools in the state and maintains a website (www.wihealthcareers.org) providing health careers information with links to training programs and other resources for students. It also facilitates the statewide Health Careers Consortium, a network of health care employers and health careers advisors from the state's high schools and technical colleges. AHEC staff serve on a variety of state and regional taskforces and committees concerned with development of the state's healthcare workforce.

Support for community providers and community health outreach. Equally important to the AHEC System are programs that bring university resources to communities, enhancing the practice environment for providers in underserved areas and providing for health outreach activities to improve the health of the community. In 2000-01, AHEC provided 106 continuing education programs to over 1700 providers, including physicians, nurses, physician assistants, mental health providers, social workers and others health professions. A variety of other continuing education-type programs are offered for a broader audience (over 6700 participants in 2000-01). Topics included cultural issues, women's health, tobacco prevention, urban health, community nutrition needs assessment, working with the underserved, and a variety of consumer health information sessions.

e. Placement of Graduates of Doctor of Medicine into Residency Training Programs

Listed below are the specialty choices of the 280 students who graduated during the period December 2000 through August 2002.

Specialty*	Number of Students in Programs in Wisconsin	Number of Students in Out of State Programs	Total
Anesthesiology	7	12	19
Dermatology	1	1	2
Emergency Medicine	0	13	13
Family Medicine	14	25	39
Internal Medicine	9	46	55
Internal Med/Primary Care	2	2	4

Medicine/Pediatrics	1	3	4
Internal Medicine-Preliminary	3	1	4
Neurology	0	5	5
Obstetrics & Gynecology	3	10	13
Ophthalmology	2	5	7
Orthopedic Surgery	3	1	4
Otolaryngology	1	4	5
Pathology	1	2	3
Pediatrics	8	32	40
Physical Medicine and Rehabilitation	3	6	9
Plastic Surgery	2	1	3
Psychiatry	5	6	11
Radiation Oncology	0	1	1
Radiology-Diagnostic	3	6	9
Surgery-General	4	9	13
Surgery-Preliminary	0	2	2
Transitional	1	2	3
Urology	0	3	
Total	73	198	271
Postponing residency training			9
Total students			280

* To avoid duplication, when the PG-2 placement is known, this specialty is listed and the PG-1 placement is disregarded.

* * * * *

Under the provisions of s. 13.106(2), the UW-Madison Medical School and the Medical College of Wisconsin are required to report on the per student cost of medical education, in a consistent format and methodology to be developed in consultation with the Medical Education Review Committee under s. 39.16.

The results of the Cost of Undergraduate Medical Education Study (Cost Study) for 2000-01 are contained in the attached report entitled "University of Wisconsin Medical School - Cost of Undergraduate Medical Education."

state/bienlrt3.doc

UNIVERSITY OF WISCONSIN MEDICAL SCHOOL

COST OF UNDERGRADUATE MEDICAL EDUCATION

2000-01

Cost of Undergraduate Medical Education
2000-01

February 27, 2003

Direct / Indirect Costs	Row	AFQ Expenditure Category	01 Undergrad Medical Education	02 Graduate Medical Education	03 University Undergrad Education	04 University Graduate Education	05 Research	06 Patient Care and Other	07 Non-Cost Expenses	08 Admin Indirect Costs	09 Plant Indirect Costs	Total
Direct	00	Unrestricted General Instruction	19,765,658		3,868,525	9,840,457						33,474,640
	01	All Other Instruction	1,408,162	13,572,283		3,670,556		273,682,929	89,053			292,422,983
	02	Research	9,400	90,598			136,150,623	20,294,643				156,545,264
	03	Service	187,700	1,809,107				4,100,496				6,097,303
	05	Academic Support	2,782,222	449			2,071,558	79,826		13,919,170		18,853,225
	06	Student Services	1,201,629									1,201,629
	07	Institutional Support								9,941,050		9,941,050
	09	Scholarships	6,788	65,429		2,528,468		12,051	3,888,717			6,501,453
	11	Housestaff	2,400,873	23,140,333								25,541,206
	12	Plant									12,115,088	12,115,088
	90	Transfers							1,785,450			1,785,450
	Total		**27,762,432**	**38,678,199**	**3,868,525**	**16,039,481**	**138,222,181**	**298,169,945**	**5,763,220**	**23,860,220**	**12,115,088**	**564,479,291**
Indirect	05	Academic Support	739,238	1,029,896	103,008	427,088	3,680,482	7,939,458	0	-13,919,170	0	0
	07	Institutional Support	527,963	735,550	73,568	305,026	2,628,595	5,670,349	0	-9,941,050	0	0
	12	Plant	1,809,347	0	252,121	1,045,333	9,008,286	0	0	0	-12,115,088	0
	Total		**3,076,548**	**1,765,446**	**428,698**	**1,777,447**	**15,317,363**	**13,609,806**	**0**	**-23,860,220**	**-12,115,088**	**0**
Total			**30,838,980**	**40,443,645**	**4,297,223**	**17,816,928**	**153,539,544**	**311,779,751**	**5,763,220**	**0**	**0**	**564,479,291**

Number of Medical Students:	610
Direct Cost of Medical Ed:	$45,512
Total Cost of Medical Ed:	$50,556