December 31, 2025

The Honorable Governor of the State of Idaho
Members of the Idaho Legislature

Subject: Transmittal of the Idaho Undergraduate Medical Education Report and Multi-Year Plan pursuant to Idaho Code § 33-3732

This report is submitted pursuant to Idaho Code § 33-3732(3), which established a working group for the purpose of developing a "medical education plan" for delivery to the governor and the legislature. It reflects the coordinated work of the Office of the Idaho State Board of Education (OSBE) and the Undergraduate Medical Education Plan Working Group.

Idaho's physician workforce challenge is solvable with a disciplined, Idaho-centered approach that grows undergraduate medical education while coordinating clinical placements and aligning with residency expansion. By executing the *Train Here, Stay Here* plan under the authority of Idaho Code § 33-3732 and leveraging the accountability of Idaho Code § 33-3731, the State can expand access to high-quality training, strengthen rural and frontier care, and retain more Idaho-trained physicians in Idaho practice. The Working Group stands ready to implement this plan in partnership with OSBE, institutions, health systems, and the Legislature.

For the Undergraduate Medical Education Plan Working Group:

Representative Dustin Manwaring
District 29
Co-Chair

Senator Dave Lent
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# IDAHO UNDERGRADUATE MEDICAL EDUCATION PLAN

TRAIN HERE ⬢ STAY HERE ⬢ GROW HERE

## I. EXECUTIVE SUMMARY

Idaho faces a persistent physician shortfall despite meaningful progress in residency and fellowship growth. The state's medical education landscape is anchored by three complementary pathways: the public partnerships between the University of Idaho and University of Washington (Idaho WWAMI) and the University of Utah's Spencer Fox Eccles School of Medicine (UU-SFESOM), and the private program offered by the Idaho College of Osteopathic Medicine (ICOM). These programs collectively support Idaho students through distributed rural learning opportunities, primary care experiences, and clinical rotations across Idaho's communities.

Despite these efforts, Idaho ranks 50th nationally for physicians per capita, and 44th in primary care physicians per capita. Despite a 100% increase in residency programs (9 to 18), 250% increase in fellowship programs (4 to 14), and 119% increase in resident physicians and fellows (134 to 284) since 2017,[1] Idaho still faces a physician shortage. Rapid population growth (+54% since 2000, +22.5% since 2010) and high retirement rates (33% of physicians are over age 60) strain supply. Idaho's aging population – especially those over 55 – is rising and, while Idaho's birth rate is declining, it remains higher than the national average.[2] The state's undergraduate medical education (UME) landscape is further challenged by limited clinical teaching capacity, particularly preceptors in community, rural, and frontier settings.

The central policy conclusion is that Idaho must:

- maintain existing UME capacity with Idaho WWAMI and UU-SFESOM;
- grow new UME capacity in partnerships with UU-SFESOM and ICOM, in compliance with Idaho Code § 33-3732;
- grow GME capacity, especially in rural Idaho to help train UME students and to help prepare future physicians for the state of Idaho;
- prioritize education in Idaho across all UME and GME programs;
- support a dedicated office within or outside of the Office of the State Board of Education to expand, coordinate, and enhance the quality of clinical placements and preceptorships.
- invest in targeted incentives that attract and retain Idaho-trained learners, preceptors, and physicians;
- grow GME capacity, especially in rural Idaho to help train UME students and to help prepare future physicians for the state of Idaho; and
- investigate funding structures to support these efforts – both at start-up and for long-term build-out – and prioritizing emergent opportunities like the Rural Health Transformation Program.

[1] Idaho 2025 Graduate Medical Education Committee Annual Report to the State Board of Education.

[2] University of Idaho McClure Center for Public Policy Research, *Idaho at a Glance: Population Change in Idaho* (May 2025, Vol. 14, No. 1), https://blog.idahoreports.idahoptv.org/wp-content/uploads/2025/06/ MCCLURE0010-IAAG-PopChange2025-DIGITAL.pdf.

In keeping with Idaho Code § 33-3732 (2025), the plan described here is immediately actionable in the near term and scalable as deemed appropriate by the Governor and Legislature. Appendix A contains the Working Group's complete findings, which form the evidentiary and analytical foundation for the recommendations presented here.

## II. TRAIN HERE, STAY HERE, GROW HERE PLAN

To meet growing healthcare demands, the UME Plan Working Group recommends that the state strategically develop its medical education infrastructure, ensure high-quality training, optimize the use of available funds, and expand both undergraduate and graduate clinical opportunities within Idaho. This policy plan outlines a coordinated framework to address these needs, aligning initiatives under the seven key factors crucial to Idaho's healthcare workforce development set forth in Idaho Code § 33-3732(3). The proposal includes short-term and long-term initiatives.

### A. Reducing Idaho's Physician Shortage, in Conjunction with GME: Education Coordination and Pipeline Programs

- **Expand High School and Undergraduate Pre-Med Pathways:** Strengthen and broaden Idaho CTE, AHEC, WWAMI initiatives (RUOP/WRITE/TRUST), and community college bridges, building on successful rural experiences in Clearwater Valley/St. Mary's to attract and prepare students early for medical careers in Idaho.
- **Grow-Our-Own Pipeline (K-16 → MD/DO):** Pursue development and launch an Idaho BA/MD (and BA/DO) track modeled after successful programs like UNM's BA/MD and Nebraska's RHOP/KHOP to recruit, support, and guarantee admission for rural and first-generation Idaho students. This approach fosters a long-term commitment to in-state practice and increases the likelihood of graduates serving rural communities.
- **Co-location of UME and GME:** Place more undergraduate students at sites with active residency programs (e.g., Boise VA, St. Luke's, PMC, Saint Alphonsus) to enhance teaching capacity and increase the likelihood of residents remaining in Idaho post-training.

### B. Ensuring Quality of Medical Education for Idaho Students

- **Retain Existing UME Partnership Programs:** Continue support for existing WWAMI and SFESOM programs. Supporting 50 state-supported seats.
- **Grow Existing UME Partnership Programs in State:** To the extent permitted by law, invest in additional seats at WWAMI and UU-SFESOM programs.
- **Grow Non-WWAMI Medical Programs by 10 seats/year:** As required by Idaho Code § 33-3732, add 10 seats/year until incoming class reaches 30 students.
- **Start New UME Partnerships and Programs in State:** Expand partnerships with other medical programs, prioritizing cost-effective programs with demonstrated availability of clerkship sites.

**C. Maximizing Idaho Medical Education Funds Spent Within the State**

- **Revisit Contracts with Existing Medical Education Institutions:** Work with Idaho State Board of Education to review medical education institution contracts to ensure state investments are maximized in-state and for Idaho students.
- **Support and Monitor Idaho Return-to-Practice Law:** Enhance outreach related to state-supported programs and monitor outcomes associated with Idaho Code §33-3731.
- **Blended Funding Sources:** Combine state appropriations, federal GME funding (DGME/IME), other federal funding mechanisms (e.g., Medicaid), hospital in-kind contributions, and philanthropic partnerships to maximize in-state impact.
- **Direct and Pass-Through Stipends:** Enable direct stipends and hospital pass-throughs for preceptors, offsetting lost clinical time and ensuring financial resources stay within Idaho's healthcare ecosystem.
- **Shared Metrics and Accountability:** Deploy a public dashboard (building on GME's model) to track capacity, fill rates, and outcomes by region and specialty, promoting transparency and trust among all partners.

**D. Maximizing Clinical Medical Education Placements Located in and Managed by Idaho**

- **Statewide Coordination Center:** Establish a Health Education Director position at the Idaho State Board of Education to support an undergraduate medical education, nursing and allied health committees of program officers, stakeholders and agency partners to manage a shared preceptor database, standardized onboarding and collaboration, placement scheduling, and gap analysis.
- **Expand Clerkship Sites:** Leverage Idaho's FQHC network (15 CHCs, 200+ sites) and the Boise VA as anchor teaching sites, maximizing placements near where patients live and expanding rural and underserved access.
- **Housing and Logistics Support:** Address placement barriers by providing stipends or block-leased housing units for rural rotations, as identified in North Idaho and other regions.
- **Standardized Cost Targets:** Set transparent cost targets per rotation ($300–$1,500) to budget state grants, supporting onboarding and coordination without unnecessary overspending.

**E. Maximizing Medical Residency Placements in Idaho**

- **Residency Program Expansion:** Add new residencies in high-need specialties (OB/GYN, General Surgery, Emergency Medicine, Psychiatry, Pediatrics, and selected IM subspecialties), especially in rural and underrepresented locations.
- **Retention Incentives:** Implement state loan-repayment and tax credit programs for physicians who both precept Idaho students and residents and practice in shortage areas, mirroring successful models from West Virginia and Nebraska, thus enhancing retention and service in Idaho communities.

- **Sustained State Support:** Increase per-resident state funding and match federal DGME/IME funds, supporting Idaho's strong return on investment and high physician retention rates.

**F. Minimizing Conflicts with Medical Education Program Partners**

- **Governance Structures:** Establish a Health Education Director position at the Idaho State Board of Education to facilitate collaboration between institutions and with other statewide initiatives and agencies (e.g., CTE, WDC), with clear MOUs, shared metrics, and collaborative oversight, ensuring alignment and minimizing inter-institutional conflicts.
- **Preceptor Development and Recognition:** Offer faculty development modules, annual state awards, and teaching toolkits to address barriers identified by key health systems, supporting high-quality teaching and mentorship.
- **Standardized Onboarding and Access:** Develop a statewide onboarding process and aligned system access for all clerkship sites, ensuring consistent training experiences and reducing administrative burdens.
- **Continuous Quality Improvement (CQI):** Institute regular tracking and evaluation of placements, preceptor engagement, rural service, and multi-year retention outcomes, ensuring that educational quality is measured and improved over time.

**G. Minimizing Conflicts in Delivering Coursework and Clinical Placements Across Programs**

- **Standardized Processes and Scheduling:** Implement standardized onboarding, EMR access, and placement scheduling across all programs to reduce friction and ensure equitable access to clinical experiences for students from different institutions.
- **Support for Rural Student Needs:** Guarantee longitudinal rural rotations and fellowships (WRITE/TRUST-style), along with travel, housing, and tele-education supports, to accommodate students in varied programs and locations.

## III. IMPLEMENTATION AND FISCAL FRAMEWORK

Short-term actions focus on building coordination infrastructure, implementing targeted incentives for teaching, and addressing practical barriers to rural rotations. The Board will establish a statewide coordination function, in partnership with institutions and health systems, to schedule clerkships across regions, maintain a registry of preceptors, and resolve site-specific onboarding hurdles. Incentives for clinical teaching should be designed to be budget-predictable, and Idaho can integrate these elements into a comprehensive strategy that prioritizes Idaho students, rural training, and measurable return on investment through in-state practice.

Long-term actions will scale Idaho's UME access alongside clinical capacity, ensuring that seat expansions occur in step with the number and distribution of clerkship experiences. Annual reporting to the Governor and Legislature will document progress against specific milestones:

increased preceptor participation, expanded rural rotations, and the conversion of Idaho medical graduates into Idaho residents and practicing physicians.

The fiscal approach relies on a combination of one-time startup investments and steady-state commitments, paired with federal, hospital and health center contributions and philanthropic leverage. Federal funds may be uniquely positioned to support one-time investments, including through the Rural Health Transformation Grant,[3] which may be used toward new infrastructure and programs to expand training capacity, strengthen education-to-practice pipelines, and build sustainable community-based workforce solutions.

## IV. PROPOSED 36-MONTH ROLLOUT: TIMELINE AND MILESTONES

### Phase I – Foundation (FY27)

*Objectives: Build coordination infrastructure, launch new programs, and invest in new state-supported UME seats consistent with Idaho Code § 33-3732*

| Focus Area | Key Actions | Responsible Entities | Milestones | Estimated Cost |
|---|---|---|---|---|
| UME Seat Growth | Increase non-WWAMI medical seats by 10 (per Idaho Code §33-3732). See Appendix Section VI for program options. | OSBE + Partner Institutions. | Seat Funding in FY26 Budget | FY27: $350K-$3.2M<br>*(does not account for possible ICOM purchase)* |
| Residency Expansion Planning | Identify high-need specialties and host sites (OB/GYN, EM, Psychiatry, Pediatrics). | GME + IDHW + OSBE | Funding requests submitted for FY27. | $2.5M for startup cost for OB-GYN residency program |
| Finance & Incentives | Develop statutory language for preceptor tax credit and state loan-repayment expansion. | OSBE + JFAC + DFM | Draft legislation for FY26 session. | Adjustable cap. |

[3] In November 2025, the Idaho Department of Health & Welfare (IDHW) submitted a Rural Health Transformation Program Grant (RHTG) application to CMS which includes funding requests for sustaining rural workforce with training, recruitment, and retention and to "[d]evelop or enhance available training, education, and degree programs for healthcare professions in coordination with educational institutions. This could include new undergraduate medical education pathways explicitly serving rural populations, degree or certificate programs, and space renovations to support learning and training." *See* IDHW, About the Rural Health Transformation Program Grant (Nov. 12, 2025), available at https://healthandwelfare.idaho.gov/providers/rural-health-transformation-program-grant/about-rural-health-transformation-program-grant1.

| Focus Area | Key Actions | Responsible Entities | Milestones | Estimated Cost |
|---|---|---|---|---|
| Governance & Coordination | Establish Health Education Director at OSBE; finalize committee governance structures and MOUs among state agencies and major health systems. | OSBE + Governor's Office | Coordination Center operational by Month 12. | Approx. $350,000 |
| Pre-Med & CTE Pathways | Expand AHEC and WWAMI rural exposure programs; align with CTE and community college bridges. | AHEC, CTE, CCs + SBOE | New rural high-school pipelines launched in 3 regions by Month 12. | TBD |
| Sustainable Funding Mechanism | Explore and develop plan for dedicated funding sources, including federal funds, RHTG, and insurance premium tax | LSO + DFM + OSBE | Options identified by Month 12; pursuit ongoing. | N/A |

**Phase II – Expansion (FY28)**

*Objectives: Scale educational pathways, expand clinical placements, and begin new residencies.*

| Focus Area | Key Actions | Responsible Entities | Milestones | Estimated Cost |
|---|---|---|---|---|
| UME Seat Growth | Increase non-WWAMI medical seats by 10 (per Idaho Code §33-3732). | OSBE + Partner Institutions | Seat funding in FY28 budget. | FY28: $700K-$5.8M<br>*(does not account for possible ICOM purchase)* |
| Residency Program Development | Secure ACGME accreditation for new residencies; initiate recruitment. | Health Systems + GME | At least two new programs accredited by Month 24. | Continued Development of OB-GYN at a class size of 4/4/4/4 at $70K/resident per year will be $1.12M/year when mature. |

| Focus Area | Key Actions | Responsible Entities | Milestones | Estimated Cost |
|---|---|---|---|---|
| | | | | Ongoing development of EM, Surgery and Neurology will be approximately $3M |
| Clinical Placement Expansion | Establish 10 new clerkship sites, including FQHCs and VA placements. | IHEC / OSBE / Health Systems | Placements operational by Month 24. | Approximately $500K/year (10 new clerkship sites for 39/52 wks at $1,000/wk) |
| Statewide Onboarding & Access | Design standardized onboarding, credentialing, and access protocol. | IHEC + Hospitals | System live by Month 24. | Estimate underway |
| Preceptor Recognition | Launch annual awards. | OSBE + Health Systems | First awards by Month 18. | N/A |
| Data & Dashboards | Design unified data system and public dashboard for UME/GME seat tracking, placements, and retention. | UI/ISU + OSBE + GME | | Estimate underway |
| Public Dashboard | Publish baseline metrics for capacity, fill rates, and retention. | OSBE | Basic dashboard public by Month 24. | Estimate underway |
| Pipeline Development | Begin design of Idaho BA/MD & BA/DO framework (admissions standards, partner institutions, scholarships). | CUs + SBOE | Framework completed by Month 24. | Estimate underway |

**Phase III – Consolidation**

*Objectives: Fully operationalize statewide system, demonstrate retention results, and integrate continuous quality improvement (CQI).*

| Focus Area | Key Actions | Responsible Entities | Milestones | Estimated Cost |
|---|---|---|---|---|
| UME Seat Growth | Increase non-WWAMI medical seats by 10 (per Idaho Code §33-3732). | OSBE + Partner Institutions | Seat funding in FY29 budget. | FY29: $1M-$5M<br>*(does not account for possible ICOM purchase)* |
| Residency-UME Co-location | Expand UME placements at GME sites; align rotations with residency growth. | IHEC + WWAMI/SFESOM | Co-located training at 3 sites by Month 30. | |
| Loan Repayment & Tax Credit Implementation | Begin awarding state loan repayment and preceptor tax credits. | IDHW + Tax Commission | Programs operational by Month 28. | Estimate underway |
| Housing & Logistics Support | Launch rural housing stipends or block-lease pilot. | OSBE + IDHW + Health Systems | 25 rural students supported by Month 36. | Estimate underway |
| Statewide Onboarding & Access | Continue design of standardized onboarding, credentialing, and access protocol. | IHEC + Hospitals | System live by Month 24. | Estimate underway |
| Public Dashboard and Accountability | Dashboard fully populated with statewide data; plan for first longitudinal retention analysis at Year-5. | OSBE + Data & Insights | Comprehensive Year-3 report to Legislature and Board. | Estimate underway |
| Pipeline Development | Continue design of Idaho BA/MD & BA/DO framework (admissions standards, partner institutions, scholarships) and pursue accreditation. | CUs + SBOE | Completed by Month 36. | Estimate underway |

### Long-Term Components

| Focus Area | Description / Target Outcome | Target Year |
|---|---|---|
| UME Growth Continuation | Continue adding new Idaho medical seats. | Years 4–7 |
| Residency Maturation | Expand Psychiatry, Pediatrics, and Internal Medicine subspecialties; achieve 300+ residency positions statewide. | Years 4–8 |
| Outcome Evaluation and Legislative Renewal | Report 5-year outcomes on retention, cost efficiency, and rural access to inform next statutory reauthorization under §33-3732. | Year 5 |
| Regional Academic Health Hubs | Develop fully integrated regional academic health partnerships (e.g., Boise, Pocatello, Coeur d'Alene) linking UME, GME, and rural outreach. | Years 5–8 |
| Sustainable Funding Mechanism | Establish permanent state trust or revolving fund leveraging DGME/IME, hospital, and philanthropic dollars. Use one-time federal dollars for strategic infrastructure development. | Year 6 |

## V. CONCLUSION

This report outlines a decisive, Idaho-centered strategy to expand medical education capacity, strengthen clinical training statewide, and ensure that state investments translate into physicians practicing in Idaho communities. The plan is structured to deliver measurable results, protect taxpayer value, and give the Governor and Legislature a clear line of sight into progress over the next several years. With coordinated execution, Idaho can close long-standing workforce gaps while building a resilient, self-sustaining training pipeline that serves every region of the state.

## APPENDIX A:
## FINDINGS OF THE WORKING GROUP

Across its meetings from August through October 2025, the Undergraduate Medical Education Working Group assembled Idaho's public institutions, private partners, hospital and clinic leaders, and front-line clinical educators to identify a pragmatic path forward. Members expressed support for a plan that expands UME access, coordinates clinical placements statewide, and prioritizes rural experiences without compromising training quality.

Deliberations underscored several themes: Idaho should sustain existing and grow new UME pathways; adopt an explicit statewide mechanism to coordinate clinical placements and preceptor engagement across institutions; design incentive structures that recognize uncompensated teaching time and offset onboarding costs; capture the benefit of Idaho Code § 33-3731—return-to-practice for Idaho-funded students—by ensuring high-quality Idaho rotations and practical transition into Idaho residencies; develop a central coordinating position and/or committee to improve collaboration and strategic investments; and publish an accessible implementation roadmap that the Legislature can monitor year over year.

### I. THE UNDERGRADUATE–GRADUATE MEDICAL EDUCATION PIPELINE

#### A. Overview

The development of Idaho's physician workforce depends on the seamless alignment between undergraduate and graduate medical education—the UME–GME continuum. This process begins when students complete a four-year college degree and apply to medical school, either allopathic (MD) or osteopathic (DO). Once accepted, students enter the **Undergraduate Medical Education (UME)** phase, a four-year curriculum that lays the foundation for medical practice.

During the first two years, students build a broad base of biomedical and clinical knowledge through classroom learning, laboratory study, and early exposure to patient care. The third and fourth years emphasize clinical rotations—typically four to twelve weeks each—across major specialties under the supervision of practicing physicians, or preceptors. These rotations not only deepen clinical competence but also expose students to diverse career paths and community health settings.

Upon graduation from medical school, students progress into **Graduate Medical Education (GME)**—residency training that develops expertise within a chosen specialty such as family medicine, internal medicine, pediatrics, psychiatry, or surgery. Completion of residency training is required for medical licensure and board certification in all states. The transition from UME to GME is coordinated through the National Resident Matching Program (NRMP), which uses an

algorithm to pair applicants with programs that rank them highly.[4] While this national process opens doors to programs across the country, Idaho's long-term physician retention depends on strengthening in-state opportunities throughout both stages of training.

### B. Idaho's Pipeline

Each year, approximately 190 Idaho residents apply to allopathic (MD) programs[5] and 213 to osteopathic (DO) programs. [6] Roughly 74 Idaho applicants matriculate to each type of program annually.[7] Of these, **50 students receive state support** through Idaho's long-standing medical education partnerships with the University of Washington (WWAMI) and the University of Utah (Spencer Fox Eccles School of Medicine, UU-SFESOM).

Established in 1972, the Idaho WWAMI program represents Idaho's oldest investment in medical education, providing 40 seats per year for Idaho students in partnership with University of Idaho. The UU-SFESOM partnership, created in 1978, supports 10 Idaho students in Utah, annually. Together, these two programs guarantee 50 publicly supported seats each year, resulting in approximately 200 Idaho-funded students enrolled at any given time. **State support ranges from $50,179 to $61,178 per student per year (FY27)**, allowing Idaho students to pay in-state tuition at partner universities. For WWAMI, state support includes $500/week/student for preceptors. At UU-SFESOM, the state pays an additional $500/week/preceptor. In 2022, the Idaho Legislature reaffirmed its commitment to expanding physician training through Concurrent Resolution 38, endorsing the addition of five new WWAMI seats in 2025 and five more in 2027, contingent on available funding.[8] In 2025, the Idaho Legislature enacted legislation (now, Idaho Code § 33-3732) that provides WWAMI seats "may" be reduced in 2027 to increase non-WWAMI seats by ten annually for a period of three years commencing in 2026.[9]

These expansions complement the growth of Idaho's private medical education sector, represented by the **Idaho College of Osteopathic Medicine (ICOM)**. Founded in 2016 in partnership with Idaho State University, ICOM now trains 220 students per class, including an average of 34 Idaho

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[4] National Resident Matching Program, *Intro to The Match* (2025), https://www.nrmp.org/intro-to-the-match.

[5] AAMC, *Applicants to U.S. Medical Schools by State of Legal Residence, 2015-2016 through 2024-2025* (2024), https://www.aamc.org/media/79801/download?attachment.

[6] AAMC, *Matriculants to U.S. MD-Granting Medical Schools by State of Legal Residence, Academic Years 2015-2016 through 2024-2025* (2024), https://www.aamc.org/media/79811/download?attachment.

[7] AACOM, U.S. Osteopathic Medical School AACOMAS Applicants and Matriculants by U.S. States and Territories (2024), https://www.aacom.org/docs/default-source/research-reports/applicants-matriculants-by-us-states-2009-2024c1fa982d-628e-4232-a0c5-c8840ca0d898.xlsx?sfvrsn=1d415572_13.

[8] H.C.R. 38, 67th Leg., 2d Sess. (Id. 2022), https://legislature.idaho.gov/wp-content/uploads/sessioninfo/2022/legislation/HCR038.pdf.

[9] Idaho Code § 33-3732, https://legislature.idaho.gov/statutesrules/idstat/Title33/T33CH37/SECT33-3732.

residents each year. ICOM's campus is adjacent to ISU's Meridian campus, facilitating physical proximity and sharing of resources. For example, ICOM has a long-term agreement with ISU's Meridian facility for use of the Treasure Valley Anatomy and Physiology Lab. ISU administrators serve on ICOM's board of trustees. **Idaho does not fund seats at ICOM.**

Average medical school debt among Idaho students is comparable to national norms. In 2024, WWAMI graduates carried $208,418 in average debt, SFESOM graduates $196,875, and ICOM graduates $227,072. Debt loads vary depending on personal and family circumstances but underscore the significance of Idaho's state investment in reducing cost barriers for students who agree to serve in-state.

Idaho's return-to-practice statute (Idaho Code §33-3731) further strengthens this connection. It requires all students receiving state funding for medical education to **return to practice in Idaho for four years** after completing residency or fellowship training.[10] The first class subject to this requirement—those entering in 2023—will begin their service obligations in 2030. This legislative framework reinforces Idaho's intent to invest in students who will, in turn, invest their careers in Idaho communities.

### C. Clinical Training and Capacity

The ability of Idaho's medical students to complete their clinical rotations within the state is central to long-term retention. Of the 40 WWAMI students per cohort, approximately half can currently complete their third- and fourth-year clerkships in Idaho. At the UU-SFESOM, all ten Idaho students rotate for 4-6 weeks in Idaho-based primary care practices, ensuring exposure to in-state practice environments. ICOM, meanwhile, enables its 34 Idaho students to complete all their clinical rotations in Idaho. In 2024, 75 third-year medical students across all programs trained at Idaho clinical sites.

These experiences depend on a finite network of preceptors, hospitals, and clinics. As residency and nursing programs expand, competition for clinical placements and faculty time has intensified. Students seeking certain specialties—particularly surgical subspecialties or emergency medicine—must often leave the state to complete required experiences unavailable in Idaho, such as rotations in Level 1 trauma centers.

Despite these challenges, Idaho-trained students demonstrate high levels of in-state loyalty. Roughly half of Idaho WWAMI graduates ultimately practice in Idaho, exceeding the national average of 39%.ICOM's first class will graduate from residency in 2026 so return-to-state data is not yet available, but early indicators (including strong in-state preceptor participation) suggest strong Idaho retention.

[10] Idaho Code §33-3731, https://legislature.idaho.gov/statutesrules/idstat/title33/t33ch37/sect33-3731.

## II. INSTITUTIONAL PROFILES AND SYSTEM PARTICIPATION

### A. University of Washington School of Medicine (WWAMI), with University of Idaho

Idaho's partnership with the University of Washington School of Medicine, known as WWAMI (an acronym for Washington, Wyoming, Alaska, Montana, and Idaho) was established in 1972, the Idaho WWAMI program was designed to expand medical education opportunities for Idaho residents without requiring the state to build its own medical school.

Through this program, **40 Idaho students** are admitted annually, all of whom are Idaho residents. The first 20 months of training—the pre-clinical phase—take place at the University of Idaho in Moscow, after which students transition to the University of Washington for advanced coursework and clinical rotations. Idaho invests approximately **$ 50,179 per student per year (FY27)**, enabling students to pay in-state tuition and securing guaranteed access to medical education for Idaho residents. Fees for preceptors are included in that investment.

In the pre-clinical phase of the WWAMI program, 28 faculty members and more than 50 volunteer physicians teach foundational sciences and early patient-care skills. A defining feature of the program is its emphasis on rural and underserved training, reflected in several Idaho-based initiatives:

- **Rural Underserved Opportunities Program (RUOP):** A four-week summer immersion in one of over 25 Idaho communities, where students experience rural medicine firsthand.
- **Targeted Rural Underserved Track (TRUST):** A longitudinal track connecting students to specific rural mentors and communities throughout their training.
- **WWAMI Rural Integrated Training Experience (WRITE):** A 21–24-week rotation that integrates family medicine, internal medicine, and psychiatry within a rural practice setting.

During their clinical phase, students rotate through more than **60 clerkship sites statewide**, including Boise, Coeur d'Alene, Idaho Falls, Twin Falls, Lewiston, and Pocatello. These rotations are often shared with Idaho's GME programs, fostering mentorship between medical students and residents and building continuity across the training pipeline.

Since its inception, the Idaho WWAMI program has produced roughly **450 physicians who practice in the state**. This return rate (**72%** with all WWAMI graduates) exceeds the national average of 39% for publicly supported programs. In recent years, Idaho WWAMI graduates have matched into residency programs at Full Circle Health, Idaho State University, St. Luke's Health System, and other in-state sites. From 2021 through 2025, **46 Idaho WWAMI graduates** and **23 other WWAMI graduates** matched into Idaho residencies.

### B. University of Utah – Spencer Fox Eccles School of Medicine, with University of Idaho (UME) and Idaho State University (GME)

Idaho's other publicly-funded medical education partnership is with the Spencer Fox Eccles School of Medicine (UU-SFESOM) at the University of Utah. Since the 1970s, this collaboration has provided Idaho students with access to one of the nation's top academic medical centers while maintaining strong regional and rural ties. Over the decades, more than **320 Idaho students** have completed their medical training through this program. Of note, over 600 graduates of UU-SFESOM (Idaho and non-Idaho-sponsored) currently practice in Idaho.

Each year, **10 Idaho students** are admitted into the SFESOM program under the Idaho contract, which guarantees their placement and provides state support of roughly $**58,700** to offset the cost of in-state tuition and preceptor fees. These students participate in a wide range of clinical experiences and receive targeted mentoring to encourage eventual practice in Idaho. Also, each year, a handful of Idaho students participate in SFESOM's Rural & Underserved Utah Training Experience (RUUTE) Scholars Program, which accepts up to 20 matriculated medical students each academic year to participate in rural research, outreach, clinical engagement, and elective courses throughout medical school.[11] Students who participate in longitudinal rural programs in medical school are twice as likely to match into primary care specialties such as family medicine.[12]

SFESOM complements its classroom and clinical training with robust pipeline development initiatives designed to engage Idaho learners long before they enter medical school. These include:

- **Little RUUTEs (Rural & Underserved Utah Training Experience):** An early exposure program for K–12 students.
- **Undergraduate Ambassadors Program:** Delivered health science outreach to 771 Idaho middle school students in 2024.
- **Summer Undergraduate Research Experience (SURE):** A 10-week paid research program; three Idaho students from ISU and BYU–Idaho participated in 2024.
- **Pre-medical Mentorship and Advising:** Targeted academic and clinical support for Idaho undergraduates preparing for medical school applications.

Since 2020, **60 SFESOM students**—including both Idaho contract students and Utah-based participants—have completed **clerkship rotations across 14 Idaho communities**, including Boise, Twin Falls, Coeur d'Alene, Idaho Falls, and Nampa. These rotations primarily focus on family medicine, internal medicine, and emergency medicine and serve as a bridge between undergraduate and graduate medical education opportunities in the state.

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[11] University of Utah Spencer Fox Eccles School of Medicine, *Rural & Underserved Utah Training Experience (RUUTE) and Regional Affairs* (2025), https://medicine.utah.edu/programs/ruute.

[12] Kathleen Quinn, et al., *Influencing residency choice and practice location through a longitudinal rural pipeline program*, 86 Acad. Med. 11:1397-406 (Nov. 2011), https://pubmed.ncbi.nlm.nih.gov/21952065/.

The UU-SFESOM has also invested in innovative residency models that strengthen Idaho's GME system. Notably, the **Idaho Track Psychiatry Residency Program** allows residents to spend two years in Salt Lake City followed by two years in **Pocatello**, building psychiatric capacity in a region with historically limited access to behavioral health services. A rural child and adolescent psychiatry fellowship was recently established in partnership with ISU, expanding training opportunities and mental health access. Since 2018, **12 SFESOM graduates** have matched into Idaho-based residency programs, including **8 Idaho residents** who trained in family medicine, internal medicine, and psychiatry.

### C. Idaho College of Osteopathic Medicine (ICOM)

The **Idaho College of Osteopathic Medicine (ICOM)** represents Idaho's first homegrown medical school and the only private institution in the state offering a Doctor of Osteopathic Medicine degree. Established in 2016 in partnership with Idaho State University, ICOM enrolled its inaugural class in 2018 and achieved full accreditation in 2022. The college is also pursuing regional accreditation through the Northwest Commission on Colleges and Universities (NWCCU).

In less than a decade, ICOM has grown rapidly to meet regional demand. Its annual class size increased from 162 students in 2018 to **220 in 2025**, reflecting a 35% percent growth in total enrollment. Applications nearly doubled in that period, from 2,137 to **4,821**, with Idaho, Utah, and California serving as top feeder states. Each year, ICOM matriculates roughly **34 Idahoans**, or 20% of its total enrollment. Since the College was established, students have matriculated from 48 states.

ICOM's curriculum mirrors that of other accredited medical schools, divided into three phases:

- Years 1–2: Classroom instruction, laboratories, and simulation-based training on its Meridian campus.
- Year 3: Core clinical rotations conducted through a network of 17 sites in 10 states, including several core sites in Idaho.
- Year 4: Advanced electives, sub-internships, and residency preparation.

Idaho's clinical training sites are a vital part of ICOM's model, with core rotation placements in the **Treasure Valley (41 students)**, **Magic Valley (8)**, and **Eastern Idaho (26)**. This exceeds in-state placements by state-supported programs, particularly at St. Luke's in the Treasure Valley. While placement opportunities continue to grow, competition for clinical sites—particularly in internal medicine, pediatrics, obstetrics and gynecology, and psychiatry—remains a constraint.

ICOM has graduated **588 physicians** to date, including **96** Idahoans. All ICOM graduates have matched or placed into ACGME-accredited residency programs in 20+ specialties. Approximately 53% of graduates have placed into the primary care areas of family medicine, internal medicine, and pediatrics. In 2025, ICOM graduates filled **20 percent of Idaho's first year (PGY1)**

**residency positions**, a notable rise from 8 percent in 2022. The institution maintains a graduation rate between 89 and 94 percent and, as noted, reports strong outcomes for graduates entering primary care fields and rural medicine.

Tuition at ICOM has risen from $62,876 in 2023 to $67,490 in 2025, while total scholarship awards increased modestly from $180,000 to $197,000. Unlike Idaho's public partnerships, ICOM receives **no direct state funding**, yet its graduates increasingly serve Idaho's healthcare system.

### D. Complementary Systemwide Programs

Idaho's medical education pipeline is supported not only by its UME programs, but also by a wide range of high-performing nursing, allied health and health-science pathways offered across the state's K-12 and higher education systems. These complementary programs provide critical support to doctors in training and practice, and form the backbone of Idaho's near-term and long-term workforce capacity.

#### 1. University of Idaho

The University of Idaho, Idaho's only R1 research institution, has a 53-year history of training medical students. The School of Health and Medical Professions (SHAMP), which houses the Idaho WWAMI Medical Education Program, supports a broad portfolio of health and health science programs, including Clinical Psychology (PsyD), Direct Entry Master of Science in Nursing (DEMSN), Master and Doctor of Science in Athletic Training (MSAT, DAT), Doctor of Anatomical Science (DAS), and a Master of Science in Gerontology (MS). Planned programs include Doctor of Health Science (DHSc), a Master of Science in Clinical Research, a Master of Science in Medical Science, a Master of Health Administration (MHA) and Bachelor of Health Administration (BHA), as well as certificates in Healthcare Leadership, Gerontology, and Medical Sciences.

SHMP also anchors key clinical and research infrastructure, including the Idaho Office of Underserved and Rural Medical Research (IOURMR), the Vandal Health Clinic, the Integrated Sports Medicine and Rehabilitative Therapies (ISMaRT) Clinic, and a recent addition to the Huckabay Medical Education Building in Moscow to expand classroom and clinical training space. Project ECHO is operated within the School, extending specialty expertise to providers statewide through virtual mentoring and case-based learning and other activities that support professional development and licensure.

#### 2. Idaho State University

ISU has over 100 years of experience training professionals in pharmacy, nursing, and allied health. The university offers more than 55 programs across fields such as mental and behavioral health, radiographic science, public health, and nutrition. With over 4,000 affiliation agreements statewide, **ISU places approximately 2,000 students annually in Idaho communities**. Over 40% of ISU graduates enter health professions, making the university the largest producer of healthcare graduates in Idaho.

**ISU operates 22 clinics** that provide 45,000 annual patient visits and 70,000 prescriptions through rural Bengal Pharmacies in Challis, Arco, and McCammon. Recent infrastructure developments include a $2 million simulation center upgrade (with funding from WDC and Portneuf Health Trust), over 100,000 square feet of new facilities at Meridian, and the acquisition of 23 acres for future health science expansion.

Recent expansion includes accelerated BSN programs in Twin Falls, Coeur d'Alene, Meridian, and Pocatello—the only statewide offering in Idaho. ISU has also broadened its health disciplines to include laboratory science, public health, dental hygiene, occupational therapy, physical therapy, and physician assistant programs. New initiatives, such as the Nurse Anesthetist program (beginning Fall 2025), address critical workforce needs. Growth is also evident in mental health counseling and nurse practitioner tracks, particularly in primary care and psychiatry.

Collaboration is a cornerstone of ISU's approach. Partnerships with Lewis-Clark State College (LCSC), community colleges, and industry partners such as St. Luke's Magic Valley and Kootenai Health enhance educational opportunities. ISU is actively involved in Area Health Education Centers (AHEC) across four Idaho regions to support healthcare training in rural and underserved communities. The university also strengthens the medical education pipeline through its Family Medicine Residency (with a 65% in-state retention rate over 32 years) and a psychiatry residency partnership with the UU-SFESOM. ISU shares its Meridian Health Science campus with ICOM and collaborates on interprofessional education, shared faculty, and dual DO–MBA/MHA degrees. A 3+4 medical degree pathway is currently under review.

ISU faces challenges related to faculty retention, limited clinical training capacity, and space constraints. Inflationary pressures and competition for clinical sites—especially from out-of-state institutions and ICOM—pose additional difficulties. There is also an increasing demand for paid preceptorships and structured partnerships to support program expansion.

### 3. Boise State University

Boise State University's College of Health Sciences—which includes the School of Nursing, School of Allied Health Sciences, School of Public and Population Health, and multiple clinical and non-clinical health programs—offers a comprehensive suite of degrees that range from pre-licensure nursing to advanced medical imaging, health studies, kinesiology, and public health.

BSU's pre-licensure Bachelor of Science in Nursing (BSN) program admits **approximately 80 students per semester**, making it the largest single nursing entry point in the state. The institution also operates a large and successful online RN-to-BS completion program, which provides an accelerated pathway for working nurses to advance their credentials and expand Idaho's pool of baccalaureate-prepared practitioners.

BSU's BSN program reports completion rates above 90%, and licensure exam (NCLEX-RN) pass rates in the mid-80s to low-90s, generally exceeding national averages and showing continued

improvement over time. Allied health programs also produce high-performing graduates, with several—such as Diagnostic Radiology and Imaging Sciences—reporting job placement rates at or near 100% within six months of graduation. Alumni outcomes data indicate that nearly two-thirds of career-tracked BSU graduates are employed in their field of study, reflecting both program quality and the absorptive capacity of Idaho's health-care sector.

**4. Lewis Clark State College**

Through its Nursing & Health Sciences Division and the Healthcare Education Center, Lewis-Clark State College (LCSC) offers a focused mix of programs, including pre-licensure BSN, MSN-Leadership, Radiographic Science, Computed Tomography, Medical Assisting, Medical Administrative Assistant pathways, and Health Studies degrees available in both Lewiston and Coeur d'Alene.

Over the past six years, LCSC has posted NCLEX-RN first-time pass rates between 90% and 97%. The program's outcomes are supported by intensive clinical preparation, small cohort sizes, and strong faculty-student engagement, reflected in a 12:1 student-faculty ratio.

LCSC's allied health programs similarly emphasize hands-on training and direct clinical readiness. Radiographic Science and related imaging programs maintain strong completion rates, solid exam pass rates, and high job placement outcomes under national accreditation standards. Across the institution, more than 90% of graduates secure employment—many in Idaho's rural and regional health-care systems—and institutional data show that roughly 95% of graduates are employed or continuing their education within a year.

**5. Idaho Community Colleges**

Idaho's community colleges—North Idaho College (NIC), College of Western Idaho (CWI), College of Eastern Idaho (CEI), and College of Southern Idaho (CSI)—produce the majority of Idaho's entry-level clinicians, technicians, and health-care support professionals, including licensed practical nurses (LPNs), associate-degree registered nurses (ADNs), medical assistants, EMTs and paramedics, surgical technologists, dental hygienists, radiologic technologists, and certified nursing assistants.

***North Idaho College (NIC)***

NIC offers practical nursing, registered nursing (ADN), medical assisting, surgical technology, radiography, dental hygiene, and EMT/paramedic programs. NIC's nursing programs have long maintained strong NCLEX performance, high completion rates, and near-universal job placement in the rapidly growing Coeur d'Alene–Spokane health-care corridor. NIC also provides flexible allied-health pathways and stackable certificates that allow students to move quickly into employment while continuing their education—a key feature supporting workforce mobility and retention in northern Idaho.

***College of Western Idaho (CWI)***
CWI delivers a broad community-college health portfolio in the Treasure Valley. Programs include practical nursing, registered nursing (ADN), medical assisting, dental assisting, dental hygiene, surgical technology, respiratory therapy, medical sonography, pharmacy technology, EMT/paramedic, and an array of health-science certificates. CWI's scale enables deep clinical partnerships across the Treasure Valley, and its ADN program is one of the state's largest contributors to Idaho's annual RN supply. Program outcomes remain strong, with high job placement rates, solid licensure performance, and strong employer demand in a region experiencing some of the fastest health-care workforce growth in the state.

***College of Eastern Idaho (CEI)***
CEI supports eastern Idaho's technical and clinical training pipeline with a set of high-demand health programs, including LPN, ADN, medical assisting, surgical technology, and certified nursing assistant options. CEI's ADN program consistently posts strong NCLEX pass rates, and the college partners extensively with Idaho Falls–area hospitals and clinics for clinical placements. CEI is particularly notable for integrating apprenticeships and employer-sponsored training models, helping students earn wages while progressing through certificates and degrees.

***College of Southern Idaho (CSI)***
CSI supports south-central Idaho's health-care sector through a diverse slate of nursing and allied-health programs, including LPN, ADN, surgical technology, dental hygiene, radiologic technology, EMT/paramedic, medical assisting, and a rapidly expanding suite of health-science certificates. Clinical partnerships span Twin Falls, Jerome, and surrounding rural counties, enabling students to train close to home and fill workforce needs throughout the Magic Valley. CSI's nursing graduates consistently demonstrate high NCLEX pass rates and near-immediate job placement, and its allied-health programs meet critical shortages across imaging, dental, and emergency-medical fields.

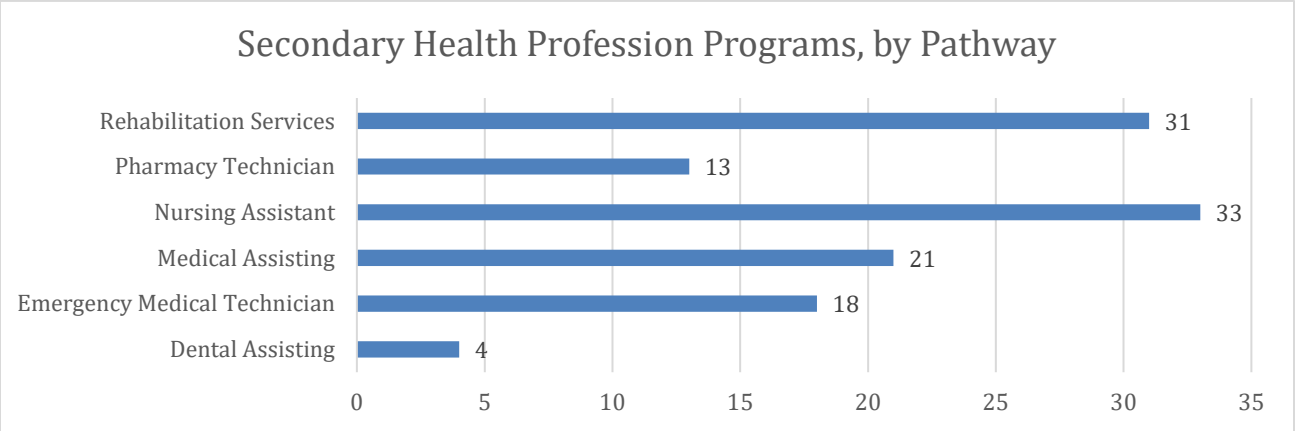
### 6. Idaho Career Technical Education

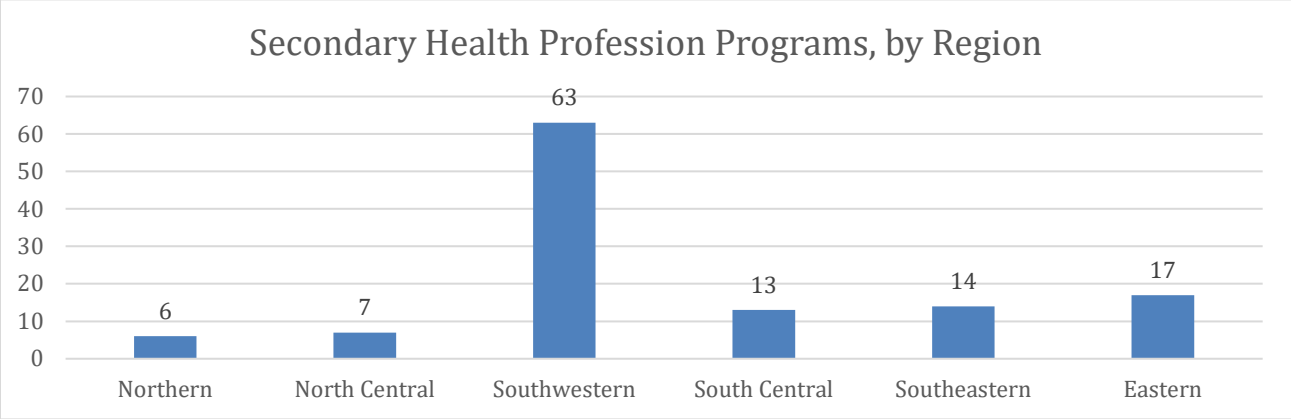
The Career and Technical Education (CTE) Health Professions programs form a broad, statewide training pipeline that contributes to meeting healthcare workforce needs across all six geographical regions. The high school (secondary) pathway includes 120 approved programs, including Dental Assisting**,** Emergency Medical Technician**,** Medical Assisting**,** Nursing Assistant**,** Pharmacy Technician**,** and Rehabilitation Services**.** Programs such as Nursing Assistant, Medical Assisting, and Rehabilitation Services are available in every region, providing a dependable local entry point for students pursuing frontline healthcare roles.

This secondary pipeline connects to postsecondary offerings at Idaho's six technical colleges, which provide advanced certifications and technical degrees in key areas such as Dental Hygiene**,** Physical Therapist Assistant**,** Radiography Technology**,** Surgical Technology**,** and Practical

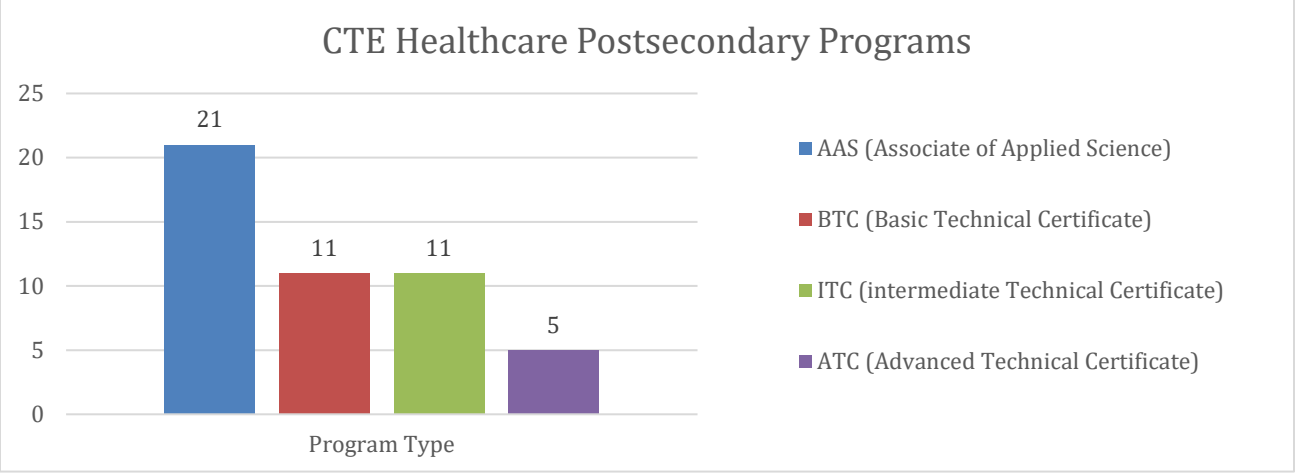
Nursing. Additional programs – including Medical Laboratory Technology**,** Occupational Therapy Assistant**,** Pharmacy Technology**,** and Respiratory Therapy are offered at NIC, CWI, CSI, and ISU. Together, these secondary and postsecondary options prepare students for a wide range of clinical and supportive healthcare roles and strengthens the healthcare workforce.

**Secondary Program Distribution (120 programs)**




**Postsecondary Programs**



## III. IDAHO GRADUATE MEDICAL EDUCATION

Idaho's medical education system depends not only on expanding undergraduate opportunities but also on strengthening **Graduate Medical Education (GME)**—the residency and fellowship programs that provide advanced, hands-on training and serve as the final step before independent medical practice. While Idaho's UME programs have grown substantially in recent years, GME capacity remains the most significant bottleneck in retaining physicians trained in Idaho.

Residency training represents the strongest predictor of long-term practice location. Nationally, **55 to 75 percent** of residents remain within 75 miles of where they complete their final stage of training.[13] Idaho's data align closely with this pattern: once physicians complete a residency in the state, they are more likely than almost anywhere else in the country to stay and practice here. This underscores why GME growth is a central pillar of Idaho's workforce strategy.

Over the past decade, Idaho has made meaningful progress. Since 2017, the state has seen:

- A **100 percent increase** in the number of residency programs (from 9 to 18);
- A **250 percent increase** in fellowship programs (from 4 to 14); and
- A **119 percent increase** in the total number of residents and fellows (from 134 to 284).

Despite this growth, the gap between demand and capacity remains wide. According to the AAMC, Idaho's ratio of residents and fellows to medical students is the **lowest in the nation—approximately 3 to 10**.[14] This ratio presents a structural challenge: residents play a critical teaching role for medical students during clinical rotations, and limited GME capacity constrains both undergraduate training and the overall physician pipeline.

At present, Idaho offers approximately **284 residency positions** (approximately 92/year), including 54 in family medicine, 26 in internal medicine, 8 in psychiatry, and 4 in pediatrics per year. The absence of programs in several high-need specialties—such as surgery, emergency medicine, obstetrics/gynecology, and neurology—forces Idaho-trained students to leave the state for residency. Although many are required to return to Idaho under the return-to-practice law (Idaho Code §33-3731), out-of-state residency often leads to professional and personal ties that make return less certain.

The financial foundation for GME programs in Idaho is diverse. State funding is combined with federal sources such as Medicare's Direct and Indirect Graduate Medical Education (DGME and IME) payments, Health Resources and Services Administration (HRSA) grants, Veterans Affairs (VA), and Teaching Health Center allocations. Local hospitals and health systems also invest

[13] Fagan, E.B., et al., *Family Medicine Graduate Proximity to Their Site of Training*. Family Medicine (February 2015), https://pubmed.ncbi.nlm.nih.gov/25646984.

[14] AAMC, *U.S. Physician Workforce Data: Key Findings* (2024), https://www.aamc.org/data-reports/data/2024-key-findings-and-definitions.

through clinical revenue and staff time. Collectively, these sources allow Idaho to leverage its state appropriations by securing matching federal funds and institutional contributions.

Between **2018 and 2024**, the cost of residency position was approximately **$180,000 per resident**, increasing to **$210,000 starting in 2025**. Idaho currently funds a little less than $60,000 per year of this cost. This enhanced level of support reflects both the rising cost of medical education and the state's commitment to program stability. Nevertheless, as existing programs mature and new specialties are proposed, maintaining adequate funding remains essential to avoid jeopardizing accreditation or long-term sustainability.

For **Fiscal Year 2026**, Idaho's GME Committee submitted a **maintenance budget**, emphasizing program sustainability over rapid expansion. This approach prioritizes stabilizing existing programs—such as the newly created **OB/GYN fellowship** developed during the last legislative session—before adding additional residencies. However, GME leaders acknowledge that this maintenance phase will slow the pace of new specialist training and, by extension, the expansion of clinical capacity for UME students who depend on resident mentorship.

Even with careful growth, the return on investment in GME is substantial. Nationally, each residency position is estimated to yield more than **$11 in economic return** for every dollar invested in the form of clinical services, workforce retention, and local spending. Since 2018, roughly **1,500 residents and fellows** have completed Idaho GME programs, with an impressive **58 percent retention rate**—the **seventh highest** in the nation.[15] These graduates now practice across Idaho's hospitals, clinics, and rural communities, contributing not only to patient care but also to teaching the next generation of medical students.

By investing in both the early and advanced stages of medical training—and ensuring alignment between them—Idaho can maximize the impact of its current programs, attract new faculty and preceptors, and build a sustainable physician workforce that reflects the needs and values of Idaho communities. The goal is a self-reinforcing system in which students begin, train, and stay in Idaho, supported by a medical education pipeline strong enough to serve the state's growing and aging population for decades to come.

## IV. IDAHO MEDICAL SYSTEM PARTICIPATION IN UME AND GME TRAINING

### A. Regional Program Summaries

Regional health systems support UME and GME expansion by leading clinical and resident training. Idaho hospitals remain committed to supporting medical education despite systemic barriers that hinder growth. Despite their leadership role, the hospitals face challenges such as

[15] AAMC, *U.S. Physician Workforce Data: Key Findings* (2024), https://www.aamc.org/data-reports/data/2024-key-findings-and-definitions.

limited physician bandwidth for teaching, extensive mentoring needs for new providers, competition for clinical sites, and a lack of dedicated funding for supervision or infrastructure. Without targeted investment in preceptor incentives, infrastructure, and workforce retention initiatives, the state risks a widening gap in physician supply, especially in rural and primary care specialties. Strategic collaboration between the State of Idaho, medical schools, and health systems is essential to building a sustainable, locally trained healthcare workforce for the next decade.

1. **Saint Alphonsus Health System**

Saint Alphonsus Regional Medical Center in Boise, along with its sister facility in Nampa, forms the largest clinical teaching platform in southwest Idaho. The health system supports hundreds of medical students annually, offering a wide array of required and elective clerkships across family medicine, internal medicine, surgery, OB/GYN, and emergency medicine. Key partner medical schools include ICOM, WWAMI, UU-SFESOM, and regional osteopathic programs. The medical staff comprises 78% MDs and 22% DOs, educated at over 140 institutions nationwide. The average cost per student is $311.87, which covers coordination, EMR access, orientation, and compliance training; however, the institution does not provide preceptor stipends.

Despite its large role in medical education, only 13.7% of physicians at Boise/Nampa serve as preceptors, due to time constraints, productivity demands, lack of compensation, administrative burdens, limited preceptorship training, and growing competition for clerkships. To address these challenges, Saint Alphonsus supports statewide collaborative approaches, including preceptor incentives such as tax credits and paid teaching time, a standardized teaching contract, accessible preceptor training modules, sharing best practices across institutions, and expansion of its Nampa Family Medicine Residency Program.

Saint Alphonsus emphasizes that Idaho's physician shortage requires systemic, collaborative investment in undergraduate and graduate medical education. The organization is committed to working with state and academic partners to expand training opportunities and strengthen the state's healthcare workforce.

2. **St. Luke's Health System**

St. Luke's Health System, the state's largest healthcare provider, serves more than 600,000 patients annually and employs over 1,500 physicians and 726 advanced practice providers. The system is a leader in both undergraduate and graduate medical education, hosting medical students from ICOM, WWAMI, and other institutions. In the 2024–25 academic year, St. Luke's hosted approximately 330 rotations for ICOM students and 159 for WWAMI students.

St. Luke's is a major partner in statewide residency programs in family medicine, internal medicine, psychiatry, pediatrics, and emergency medicine. The average cost per student rotation is around $290, with centralized administrative coordination. Barriers to expanding UME

participation include limited physician preceptor availability, competition for teaching sites, lack of teaching stipends or recognition, and infrastructure constraints.

St. Luke's recommends statewide policy and funding solutions such as tax credits or stipends for preceptors, loan repayment incentives, state-level recognition, and coordinated faculty development programs. Ongoing collaboration among the State Board of Education, medical schools, and health systems, alongside enhanced preceptor incentives and infrastructure support, is vital to educating and retaining Idaho's next generation of healthcare professionals.

### 3. Boise Veterans Affairs Medical Center

The Boise Veterans Affairs Medical Center (VAMC) is one of Idaho's largest clinical training sites for medical students and is nationally recognized as a Center of Excellence for Primary Care and Interprofessional Education. The internal medicine clerkship is the largest in Idaho, with 43 third- and fourth-year medical students participating annually in both inpatient and outpatient rotations, in collaboration with St. Luke's and Saint Alphonsus.

Quality clerkships at the VA depend on ongoing investment in infrastructure, including dedicated workspace, EHR access, and administrative support. Preceptor capacity is limited, and administrative complexity is heightened by partnerships with multiple medical schools. VA physicians do not receive institutional compensation for precepting.

To sustain and expand Idaho's medical training capacity, recommendations include reducing physician workload during teaching rotations, linking incentives to educational engagement, providing funding for faculty development, and expanding graduate medical education programs. Investment in both UME and GME is crucial to maintaining educational quality and meeting the needs of Idaho's veteran and rural populations.

### 4. Kootenai Health

Kootenai Health, based in Coeur d'Alene, is the primary medical education hub for North Idaho and operates a three-hospital system. The region is experiencing rapid population growth and escalating housing costs, which present barriers for trainees and providers. Kootenai Health supports both graduate and undergraduate medical education, with a focus on students from Idaho or those with local ties. The institution partners with WWAMI, UU-SFESOM, WSU, and PNWU, and offers high-demand rotations in OB/GYN, pediatrics, and psychiatry.

A centralized Student Services Department manages affiliation agreements, rotation requests, onboarding, and housing coordination. While preceptor stipends are provided, housing remains a significant barrier for out-of-area trainees. Physicians are motivated to teach to strengthen the workforce and for professional development, but face challenges related to productivity demands, lack of compensation, and limited formal teaching training. Private practice preceptors also experience financial pressures.

Despite strong institutional commitment, program growth is hindered by limited preceptor availability, financial constraints, and housing challenges. Expanded state and institutional support for preceptors, housing, and education infrastructure will be essential to sustain and grow UME capacity in North Idaho.

### 5. Portneuf Medical Center

Portneuf Medical Center (PMC) in Pocatello serves as a regional referral hub and a cornerstone for undergraduate and graduate medical education in southeast Idaho. Its primary and secondary service areas span multiple counties, and the hospital handles high volumes of emergency visits, surgeries, deliveries, and outpatient clinic visits. PMC's medical staff includes 251 physicians and 129 advanced practice providers, representing a diverse range of training backgrounds.

PMC supports medical education across 18 specialties, hosting students from numerous U.S. medical schools and facilitating top rotations in family medicine, OB/GYN, surgery, orthopedics, and pediatrics. The hospital maintains partnerships in residency and fellowship programs and invests $100,000–$125,000 annually to support student rotations.

Medical education at PMC offers institutional benefits, including enhanced quality of care, recruitment pipeline development, academic reputation, and community health engagement. However, challenges include physician time constraints, minimal compensation for teaching, supervision burdens, limited facility space, IT and infrastructure limitations, and a lack of external funding to offset training costs.

PMC's ability to expand training capacity depends on sustained investment in clinical education infrastructure, preceptor support, and state-level funding partnerships to strengthen Idaho's healthcare workforce pipeline.

### 6. Clearwater Valley Health and St. Mary's Health

Clearwater Valley Health (CVH) and St. Mary's Health (SMH) operate two rural critical access hospitals and eight clinics in North Central Idaho, serving a population of 29,000 in a largely underserved region. With 29 providers, including 17 physicians, these hospitals deliver care to a geographically dispersed and high-need population.

For over 30 years, CVH/SMH have partnered with WWAMI to host medical student rotations and have participated in family medicine residency training and rural medicine fellowships. The system also supports the education of physician assistants, nurse practitioners, nurses, and radiology students, in addition to hosting an annual Wilderness Medicine retreat.

Participation in medical education supports physician recruitment, retention, professional engagement, quality of care, and community-focused research. Since 2017, CVH/SMH have

contributed to 11 WWAMI practice-based research studies and have secured over $100,000 for quality improvement initiatives.

### B. Overview of Idaho's Undergraduate Medical Education Landscape

The Idaho Hospital Association (IHA) conducted a comprehensive statewide survey in August 2025 to evaluate the current capacity, barriers, and opportunities related to Undergraduate Medical Education (UME) across Idaho hospitals and provider groups. The survey received responses from 34 facilities, representing all regions of the state. The findings were presented to the UME Plan Working Group, and underscore the critical need for expanded preceptor support, increased financial incentives, and infrastructure investments to sustain and enhance Idaho's pipeline of physician training.

**Hospital and Service Area Participation in UME**

- Most respondent hospitals currently host medical student clerkships or clinical rotations.
- Key partnerships include ICOM, WWAMI, and UU-SFESOM programs.
- Clerkships are available in core specialties such as family medicine, internal medicine, surgery, obstetrics/gynecology, and psychiatry.
- The average cost per student rotation ranges from **$1,000 to $1,500 per week**, which covers onboarding, supervision, and housing assistance.

**Key Barriers to Expansion**

- **Physician Time and Productivity:** Serving as a preceptor reduces patient volume and reimbursement, and physicians receive limited or no compensation for teaching.
- **Infrastructure Constraints:** Many facilities report inadequate workspace, IT support, and electronic medical record (EMR) access for trainees.
- **Preceptor Shortage:** There are few clinicians available or willing to teach due to burnout and increased workload.
- **Financial Gaps:** Hospitals lack sufficient state or federal funding to offset the costs of supervision and training.

**Regional Insights**

- **North Idaho:** Small facilities typically provide only one to two clerkships per year, with time and preceptor availability as main constraints.
- **Southwest Idaho:** Facilities handle a high patient volume (about 50,000 encounters annually) and require incentives to recruit and retain preceptors.
- **Southeast Idaho:** Approximately 30 preceptors are actively engaged in teaching. The lack of Idaho-trained physicians is cited as a significant workforce barrier.
- Each region expects to **need one to two new physicians annually over the next decade**, with the greatest demand in primary care, OB/GYN, and internal medicine subspecialties.

**Recommended State-Level Actions**

- Establish **loan repayment programs or stipends** for physicians who serve as preceptors.
- Offer income **tax credits or direct payments** to hospitals and preceptors for teaching.
- Implement **recognition programs** to honor exemplary preceptors at the state level.
- Provide **funding to offset lost patient revenue** during teaching rotations.
- Expand **residency programs** to align with the growth of medical schools.
- Increase **housing and relocation assistance** for physicians in rural and high-cost regions.

## V. BROADER SYSTEM CONSIDERATIONS

Idaho's healthcare workforce crisis extends well beyond physician shortages; it reflects a deeper structural challenge across the entire clinical education continuum. Statewide, employers report more than **850 open nursing positions**, including approximately 700 RNs and 150 LPNs, with **rural vacancy rates exceeding 15 percent**. High-demand allied health roles – such as surgical technologists, radiologic technologists, and respiratory therapists – carry persistent 10-20 percent vacancy rates, further straining hospitals, clinics, and long-term care facilities. Fundamental barriers to reducing these shortages are similar to those faced within the UME-GME pipeline: limited clinical training capacity, chronic preceptor shortages, highly variable access between urban and rural regions, and a lack of coordinated statewide infrastructure to match students with high-quality clinical experiences.

A recent report of the Idaho Workforce Solutions Collaborative – comprised of Blue Cross of Idaho Foundation for Health, Idaho State Board of Education, and the Workforce Development Council—was presented to the UME Plan Working Group, which helped to frame the UME plan proposed in this document. The report – *The Workforce Rx: Scaling Nursing and Allied Health Talent in Idaho through Preceptorships and Apprenticeships* – recommended several core strategies: expanding preceptorship flexibility, building a centralized statewide clinical placement and preceptor database, improving incentives and recognition for clinical educators, utilizing alternative and rural training sites, and structuring registered apprenticeships to expand hands-on learning in high-need fields. Using these strategies, the Collaborative predicts that, by 2030, **Idaho can generate 200 new healthcare graduates annually**: 100 in nursing pathways (CNA, LPN, RN) and 100 in allied health programs (e.g., surgical and radiologic technology). With a network of over 50 supported preceptors statewide, the plan is projected to reduce workforce shortages by 14% of statewide RN demand, 67% of LPN demand, and 10-20% of allied health demand, depending on the occupation and region.

The Collaborative estimates a **five-year cost of $5.64 million**, with per-learner costs falling from $34,000 in early implementation to under $10,000 by 2030 as the system reaches a steadier state. Conservative ROI projections show a $5-$7 return on every dollar invested, driven by reduced reliance on travel nurses and contract labor, higher retention of Idaho-trained professionals, and greater workforce stability for rural and frontier communities.

## VI. NATIONAL MODELS

### A. Federal and State Loan Repayment Programs

For more than three decades, federal loan repayment initiatives have formed the backbone of national efforts to attract health professionals to rural and underserved areas. Authorized under the Public Health Service Act Amendments of 1987, the **National Health Service Corps (NHSC) Loan Repayment Program** remains the flagship initiative. It offers up to $75,000 in repayment for primary care providers and $50,000 for behavioral or oral health clinicians in exchange for two years of full-time—or four years of part-time—service in a designated Health Professional Shortage Area (HPSA). Participants may renew annually as long as they carry eligible educational debt and continue serving in qualifying sites. In 2024, this program supported **139 Idaho clinicians**.

Complementing this, the **NHSC Students to Service (S2S) Program**, created in 2012, targets medical students in their final year. In exchange for three years of full-time (or six years of part-time) service following an approved primary care residency, participants may receive up to $120,000 in repayment. The S2S initiative supported **eight Idaho medical professionals** in 2024.

Recognizing the growing behavioral health crisis, Congress expanded eligibility through the **Substance Use Disorder (SUD) Loan Repayment Program** in FY 2018, which now includes pharmacists and other behavioral health providers serving in HPSAs. Participants receive $75,000 for three years of full-time service or $37,500 for part-time service; in Idaho, **39 providers** benefited from this program in 2024.

A related offshoot, the **Rural Community Loan Repayment Program**, focuses specifically on expanding opioid and substance use disorder treatment in rural areas. It offers $100,000 for full-time and $50,000 for half-time service over three years and supported **25 Idaho professionals** in 2024.

Finally, the **NHSC State Loan Repayment Program (SLRP)** provides states with federal grants on a 1:1 matching basis, allowing them to administer their own repayment programs. Idaho's SLRP, managed by the Department of Health and Welfare, received $1.3 million in federal funds in 2024 and issues awards through the Idaho Rural Health Care Access Program (RHCAP) and the Rural Physician Incentive Program (RPIP).

Funding stability remains an ongoing concern. These programs depend partly on discretionary appropriations and, more recently, on the Community Health Center Fund (CHCF) created under the Affordable Care Act. The CHCF and related mandatory funding for the NHSC technically expired on September 30, 2025, and have since been extended through January 30, 2026, under a short-term continuing resolution. Without longer-term reauthorization, NHSC programs may revert to annual discretionary funding—creating uncertainty for states, institutions, and participants planning multi-year service commitments.

### B. State-Funded Loan Repayment and Incentive Models

Beyond federally supported programs, many states have designed independent loan repayment or service-based incentive initiatives tailored to their workforce needs. These models differ in eligibility, award size, and service duration, but all share the goal of addressing rural shortages.

Some states allow residents to commit even before entering practice. For example, Kansas's Bridging Plan lets physicians apply during residency, ensuring continuity between training and rural service. Others rely on community-match models, such as those in Utah and Arkansas, where local hospitals, employers, or municipalities contribute funds to supplement state dollars.

Additional variations illustrate the adaptability of state approaches:

- California's CMSP Loan Repayment Program, Ohio's Primary Care Office Workforce Program, and Oklahoma's Physician Loan Repayment Program each target primary care but **define eligibility around local shortage data**.
- Maine's Health Professions Loan Program **ties interest rates to practice location**, lowering costs for graduates who serve in underserved regions.
- North Carolina's High-Needs Service Bonus (HNSB) diverges from the repayment model entirely, offering a **one-time taxable incentive**—up to $100,000 for physicians and dentists and $60,000 for nurse practitioners—for four years of service in high-need areas.

Collectively, these programs demonstrate how states adapt the federal loan repayment framework to local workforce priorities, budget capacities, and regional needs.

### C. Comparative State Approaches: West Virginia and Nebraska

These comparisons are illustrative and based on publicly available information; they are not intended as a financially equivalent or apples-to-apples analysis. A comprehensive comparison would require detailed, program-level data on funding sources and award structures, which are not publicly available and vary year to year. Individual award amounts also depend on recipient-specific factors and governing board discretion, and "up to" amounts do not reflect typical awards.

#### *West Virginia – The Integrated Pipeline Model*

Despite economic challenges and geographic isolation, West Virginia has achieved one of the strongest physician-to-population ratios among rural states by weaving together incentives across every stage of medical education. Students encounter health careers early through high-school clubs, health camps, and shadowing opportunities. Colleges and universities offer early-assurance pathways guaranteeing qualified in-state undergraduates admission to medical school.

At the UME stage, West Virginia keeps tuition low, provides rural housing subsidies, and gives admission preference to in-state residents. Residency programs similarly prioritize West Virginia graduates and offer financial bonuses for those who remain to practice after training. At the practice level, the state layers loan repayment, rural service scholarships, and partial tuition waivers for out-of-state students who commit to serve in West Virginia.

This "kitchen-sink" model—integrating financial, academic, and geographic incentives—has created a remarkably stable physician workforce despite limited economic resources, demonstrating the value of continuous, coordinated investment from early education through professional practice.

***Nebraska – Infrastructure and Incentive Alignment***

Nebraska offers a structural comparison particularly relevant to Idaho. Although both states have similar populations, Nebraska employs 30 percent more physicians. Several systemic differences explain this disparity. Nebraska supports 43 percent more public and 71 percent more private postsecondary institutions than Idaho, including two not-for-profit medical schools, both M.D.-granting. Idaho, by contrast, has no public medical school and relies on the WWAMI and ICOM partnerships.

Geography also plays a role: the average distance between Idaho's higher education institutions and the nearest medical school is 184 miles, compared to 66 miles in Nebraska—a factor that influences student exposure and clinical collaboration.

Nebraska's incentive infrastructure is anchored by the Rural Health Systems and Professional Incentive Act**,** administered through a 13-member Rural Health Advisory Commission. This commission oversees the Nebraska Loan Repayment Program and Rural Health Student Loan Program, together providing $2.2 million annually and awarding up to **$**200,000 over three years, renewable for one or two additional terms.

By contrast, Idaho's RHCAP and RPIP programs jointly disburse about $1.8 million annually, offering **$**100,000 over four years ($25,000 per year) to 16 active participants, without renewal options. The result is stark: Nebraska's renewable, higher-value structure supports roughly ten times as many participants.

The Nebraska comparison illustrates that scale, flexibility, and governance integration—not simply funding alone—drive stronger participation and retention outcomes.

### D. Preceptor Incentive and Tax Credit Programs

An emerging complement to loan repayment programs is the use of preceptor incentives, designed to expand clinical training capacity by rewarding practitioners who supervise medical, nursing, and allied health students. These incentives often take the form of state income tax credits, compensating clinicians for otherwise unpaid teaching time.

Program structures vary widely across the country. Hawaii offers one of the most studied examples. **Following the creation of its preceptor tax credit in 2019, the number of active preceptors grew from 204 to 362 by 2023.** Hawaii's success is attributed to its **low threshold**—80 hours of supervision per year—and **flexibility** in counting hours across multiple students or disciplines.

Other states, including Colorado, Georgia, Maryland, Missouri, and South Carolina, have adopted similar programs, typically offering between **$500 and $1,000 per rotation**, with **annual maximums of $3,000 to $10,000**. Despite generous credit limits, several states report underutilization of available funds, often due to limited awareness or administrative complexity.

Eligibility frameworks differ as well. Most programs cover physicians (MD and DO); many include nurse practitioners, physician assistants, and dentists; and a few extend to optometrists, pharmacists, and behavioral health providers.

Administrative processes typically require **third-party certification of hours** by academic institutions or health centers. For instance, Georgia relies on its Area Health Education Centers, while Hawaii administers verification through the Department of Health. A handful of states, such as South Carolina, allow self-certification, though this approach is uncommon.

Evaluations of these programs reveal a consistent trend: flexibility and simplicity drive participation. Hawaii's open eligibility and low hour threshold increased the preceptor pool most effectively, while restrictive or cumbersome systems—such as early iterations in Colorado—showed limited gains, especially in rural areas.

### E. Synthesis and Implications for Idaho

Across federal and state models, one lesson stands out: coordinated, multi-tiered systems outperform isolated incentives. West Virginia's vertically integrated approach and Nebraska's renewal-based loan repayment framework demonstrate that aligning incentives across education, training, and practice can stabilize the physician workforce even in rural or economically constrained states.

Idaho's current incentive landscape—anchored by the RHCAP and RPIP programs and supplemented by participation in NHSC initiatives—has achieved measurable success but remains modest in scale and flexibility. Award amounts are lower, renewal opportunities are limited, and program awareness among eligible clinicians is uneven.

As Idaho considers how to strengthen its medical education pipeline, two strategies emerge from national models:

1. **Expand and modernize loan repayment programs** to allow renewals and higher award levels tied to shortage severity.
2. **Implement or strengthen preceptor tax credits**, ensuring low administrative burden and inclusive eligibility for multiple health professions.

Together, these strategies would align financial incentives, educational infrastructure, and rural service expectations—creating a more resilient, self-sustaining pipeline that ensures Idahoans have access to high-quality care close to home.

## VI. PROGRAM CAPACITY AND PROPOSED MODELS

Multiple partners have the capacity to expand their existing UME programs, as shown in the chart below. However, WWAMI expansion would not meet the requirement of Idaho Code § 33-3732 to grow non-WWAMI seats by 10 students per incoming class per year until the incoming class reaches 30 students.

| | **ICOM** | **UU** | | **WWAMI** |
|---|---|---|---|---|
| | | *In Utah* | *With UofI in Idaho* | |
| Current Idaho supported spots | 0 | 40 total (10 admitted/year) | N/A | *160 total (40 admitted/year)* |
| Additional Idaho-supported student capacity in FY27 | 10+/year | 50 total (20 admitted/year) | N/A | *165 total (45 admitted/year)* |
| Additional Idaho-supported student capacity in FY28 | 10+/year | 60 total (20 admitted/year) | N/A | *175 total (50 admitted/year)* |
| Additional Idaho-supported student capacity in FY29 | 10+/year | 70 total (20 admitted/year) | 30 total (30 admitted/year) | *185 total (50 admitted/year)* |
| Additional Idaho-supported student capacity in FY30 | 10+/year | 80 total (20 admitted/year) | 60 total (30 admitted/year) | *195 total (50 admitted/year)* |
| Additional Idaho-supported student capacity in FY31 | 10+/year | 80 total (20 admitted/year) | 90 total (30 admitted/year) | *200 total (50 admitted/year)* |
| Additional Idaho-supported student capacity in FY32 | 10+/year | 80 total (20 admitted/year) | 120 total (30 admitted/year) | *Growth dependent on clinical preceptor capacity* |
| Estimated base cost to Idaho per student, FY27 | $35,000 | $61,178[3] | N/A | *$50,179[3]* |
| Estimated base cost to Idaho per student, FY28 | $35,000 (plus inflation) | $63,013[3] | N/A | *$51,684* |
| Estimated base cost to Idaho per student, FY29 | $35,000 (plus inflation) | $66,600 | ~$67,000 | *$53,235* |

| | ICOM | UU | | WWAMI |
|---|---|---|---|---|
| | | *In Utah* | *With UofI in Idaho* | |
| Estimated preceptor/institution fee | $250/week/student | $500/week/preceptor | --[4] | *$500/week/student (included in state support)* |
| Projected cost per year to student after Idaho support, FY27 | *$35,000* | $54,168 | N/A | *$58,402*[5] |
| Training time spent in Idaho over all 4 years | 100% | 4-6 wks clinical | *100% classroom >50% clinical (starting FY29)* | *100% classroom >50% clinical*[6] |
| Idaho supported students returning to Idaho to practice | Not Available[1] | Not available | -- | *51% from Idaho WWAMI*[7] |

1- Data not available due to first class graduating from residency in 2026.

2- Under Idaho Code § 33-3732, "[f]or all but twenty (20) of the non-WWAMI students per incoming class, all of the medical education coursework and a majority of the clinical medical education placements shall be physically located in the state of Idaho." With 10 additional seats in FY27, UU would admit 20 students/year, requiring adequate in-state infrastructure to support any future seats to be compliant with the law.

3- For WWAMI: 3% increase from FY26 cost/student of $48,179; for UU: 3% increase from FY26 cost/student of $59,500.

4- UI/UU recommends investing in preceptor build-out immediately to support FY29 program. Estimated investment of $800K-$1M over three-year period. See initial operational start-up costs in table below – "UME Program Recommendations" Section (1).

5- Based on 3% increase from FY26 total cost of tuition including summer terms of $56,701.

6- 90% of the clinical phase can be completed in Idaho with enough clinical training positions.

7- The return on investment is 72% meaning 7 physicians from the at-large WWAMI program return to Idaho for every 10 students supports in Idaho WWAMI.

**UME Program Recommendations**

University of Utah, University of Idaho, ICOM and ISU propose four ways to comply with Idaho Code § 33-3732. Each proposal would be subject to review and approval by the Idaho State Board of Education.

**(1) Develop New UME Program between University of Idaho and University of Utah**

University of Idaho proposes a new MD UME partnership with UU-SFESOM. The collaboration would establish a regional MD campus in the Treasure Valley partnering with ISU for anatomy lab facility use, and targeting a program launch in Fall 2028. The partnership proposes to matriculate 30 students/year starting in 2028, scaling to 120 total students matriculating by 2031–32 to ensure sustainability. University of Idaho estimates that at least 96 students need to be enrolled for the MD program to reach sustainability by 2031.

The proposed program would admit only Idaho students—targeting those from rural backgrounds—and provide clinical exposure in underserved areas. The curriculum intends to emphasize rural practice readiness, teaching skills, and preceptor development.

Initial operational startup costs are estimated to be $11.5 million through 2030 and $8.5 million to remodel needed space, with ongoing operational costs of approximately $8.2 million annually.

| | FY 27 | FY 28 | FY 29 | FY30 | FY 31 | FY 32 |
|---|---|---|---|---|---|---|
| TOTAL Number of Students (30 entering/year beginning in 2028) | | | 30 | 60 | 90 | 120 |
| Water Center Renovation/ISU Space Collaboration - FUNDS FROM DONORS/ POSSIBLY FROM RHT* | $8,500,000 | | | | | |
| Program Operational Start-Up - FUNDS POSSIBLY FROM RHT* | $1,200,000 [a] | $5,800,000 [b] | $2,700,000 [c] | $1,500,000 [d] | $300,000 [d] | $0 [e] |
| Idaho PER STUDENT Appropriation (# Students x ~$67K/year without inflation adjustment) | | | $2,010,000 | $4,020,000 | $6,030,000 | $8,040,000 |
| Combined Program Operational Start-Up and Appropriation TO U OF I | | | $4,710,000 | $5,520,000 | $6,330,000 | $8,040,000 |
| Portion Paid FROM U OF I TO UTAH | | $500,000 | $1,500,000 | $3,000,000 | $4,500,000 | $6,000,000 |

*RHT - Rural Health Transformation Grant

a - Hiring, program design, clerkship development

b - Hiring, capital outlay, equipment purchase, curriculum development

c - Hiring, clerkship development

d - Personnel and operating expenses

e - Program reaches sustainability (no additional costs beyond usual per student appropriation)

These figures represent state investments only; they exclude tuition revenue, institutional contributions, or philanthropic support (e.g., Eccles Foundation intends to commit at least $2M).

**(2) Expand State-Supported Seats at UU-SFESOM**

UU-SFESOM currently admits 10 Idaho-supported medical students per year, who return to Idaho for a primary care clinical elective experience for 3 to 6 weeks. The class size could expand by 10 students to a total of 20 per entering class in AY 26-27. Projections for progressive investment are set forth below and can be adjusted based on Idaho's preferred prioritization and timeline.

| | | PROJECTED ANNUAL COST | | | |
|---|---|---|---|---|---|
| | CURRENT | year 1 | year 2 | year 3 | year 4 |
| **SFESOM - expansion** | 2025-26 | 2026-27 | 2027-28 | 2028-29 | 2029-30 |
| number of Idaho students at Utah campus | 40 | 50 | 60 | 70 | 80 |
| annual base Idaho cost per student | 57,715 | $61,178 | $63,013 | $64,904 | $66,851 |
| total annual Idaho appropriation to UT | 2,348,000 | 3,098,895 | 3,860,794 | 4,663,254 | 5,508,059 |
| **total reflects added ID preceptor fee $5000/3rd yr student* | | | | | |

Enrollment per year with both Utah cohort expansion and combined UU-UI new program in Idaho

| | SFESOM at Utah Salt Lake City | | | | | SFESOM -Univ of Idaho at Treasure Valley | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Academic ye | MS1 | MS2 | MS3 | MS4 | total class | MS1 | MS2 | MS3 | MS4 | total class | combined |
| 2025 | 10 | 10 | 10 | 10 | 40 | | | | | | 40 |
| 2026 | 20 | 10 | 10 | 10 | 50 | | | | | | 50 |
| 2027 | 20 | 20 | 10 | 10 | 60 | | | | | | 60 |
| 2028 | 20 | 20 | 20 | 10 | 70 | 30 | | | | 30 | 100 |
| 2029 | 20 | 20 | 20 | 20 | 80 | 30 | 30 | | | 60 | 140 |
| 2030 | 20 | 20 | 20 | 20 | 80 | 30 | 30 | 30 | | 90 | 170 |
| 2031 | 20 | 20 | 20 | 20 | 80 | 30 | 30 | 30 | 30 | 120 | 200 |

UU-SFESOM expects inflation at a rate of 3%.

### (3) Purchase of Seats at ICOM

ICOM recommends that the program's participation and repayment terms align with the State's existing medical education contract model under Idaho Code § 33-3731. Specifically:

- *Eligibility:* Participants must be approved for admission through ICOM's standard admissions process and meet Idaho residency criteria as defined in Idaho Code § 33-3717B(1) and (1)(k).
- *Service Commitment:* Students would enter a contract committing to four (4) years of full-time medical practice in Idaho within one year of completing residency or fellowship, consistent with § 33-3731(1).
- *Repayment Obligation:* Graduates who do not fulfill the Idaho practice requirement would reimburse the state under terms like those specified in § 33-3731(3)–(4).
- RPIP Fee: Students would contribute to the Rural Physician Incentive Program per § 33-3723.
- *Selection Process:* ICOM, in consultation with the State Board of Education and other stakeholders, would establish the selection process for tuition-supported seats.

ICOM's anticipated tuition and fees for academic year (AY) 2026-2027 (beginning July 2026) is $69,600. Unlike the WWAMI and UU-SFESOM, which provide Idaho students reduced "in-state" tuition through state support, ICOM is a private institution and does not differentiate between in-state and out-of-state tuition rates. To offer Idaho students a comparable benefit, ICOM proposes that the State fund approximately one-half of the tuition cost, resulting in an estimated per-seat cost to the State of $35,000 for FY 2027. The table below provides estimated annual costs to the

State for varying numbers of State-supported seats for Idaho residents pursuing medical education at ICOM:

| | Annual Cost | Annual Cost x 4 Years* |
|---|---|---|
| Tuition Support for 10 Idahoans | 350,000 | $1,400,000 |
| Tuition Support for 20 Idahoans | $700,000 | $2,800,000 |
| Tuition Support for 30 Idahoans | $1,050,000 | $4,200,000 |
| Tuition Support for 40 Idahoans | $1,400,000 | $5,600,000 |

* The medical school curriculum covers 4 years. Thus, a commitment to provide financial support for a single medical student in exchange for that student's contractual commitment to serve Idaho, must cover 4 years.

ICOM's average annual rate of inflation for tuition and fees over the past three years has been 4%. ICOM's projected rate of inflation for tuition and fees over the next 3 years is 3.15%.

**(4) Purchase of ICOM**

Recent independent analysis by Tripp Umbach recommends that Idaho State University pursue full public ownership and integration of ICOM through a phased 5-year transition. To support scenario modeling, Tripp Umbach utilizes a **placeholder acquisition estimate of $250 million**, noting that this figure is not a valuation but an industry-norm benchmark for comparative purposes. A formal fair-market valuation is currently underway by Huron Consulting. Under the modeled $250 million scenario, the projected 20-year net present value is $11.66 billion, with a return on investment of 45.6:1 and a three-year payback period. The report estimates that ownership of ICOM would allow enrollment of at least 60 Idahoans annually by 2035 and—combined with in-state clinical training and expanded GME—would double Idaho's expected physician retention rate. Increased retention would be driven by three factors: (1) priority admission for Idaho residents, (2) all four years of medical education occurring inside the state, and (3) the ability to align residency expansion with Idaho's community-specific workforce needs.

Legislative action is required to permit a full valuation and analysis of this option for in-state medical education.

**Other Programmatic Recommendations**

In addition, ISU has proposed the creation of an Idaho Health Education Collaborative, to be housed at ISU. The Office of the Idaho State Board of Education (OSBE) proposes, in the alternative, that the collaborative be housed with OSBE and staffed by a Health Education Director who would facilitate broader committees of stakeholders in UME, nursing, and allied health. Estimates below are a valuable bellwether of what may be necessitated immediately or over time to build the infrastructure to support the collaboration necessary to resolve our provider gaps.

| Title | FTE | Cost | Benefits @ 39% | Term Service |
|---|---|---|---|---|
| Program Director | 1.0 | $145,000 | $56,550 | 12-month |

| Title | FTE | Cost | Benefits @ 39% | Term Service |
|---|---|---|---|---|
| Workforce Analyst | 1.0 | $70,000 | $27,300 | 12-month |
| Clinical Integration Coordinator, physician | 0.5 | $110,000 | $42,900 | 12-month |
| Clinical Integration Staff | 2.0 | $130,000 | $50,700 | 12-month |
| Administrative Support Staff | 1.0 | $40,000 | $15,600 | 12-month |
| AHEC Project Director | 0.5 | $95,000 | $37,050 | 12-month |
| Annual Operating/Travel | N/A | $80,000 | N/A | N/A |
| Annual Data Warehouse & Website Development | N/A | $55,000 | N/A | N/A |
| Marketing | N/A | $85,000 | N/A | N/A |
| Recruitment & Events | N/A | $150,000 | N/A | N/A |
| *Subtotals* | | *$960,000* | *$230,100* | |

Total: $1,190,100

## VII. FEEDBACK FROM PUBLIC COMMENT PERIOD

The Working Group received public feedback on the draft plan during the first two weeks of December 2025. Public comment reflected broad agreement that Idaho faces a severe and accelerating physician shortage that threatens access to care across the state, particularly in rural and underserved communities and in certain specialties (e.g., primary care, psychiatry, OB/GYN). Dominant themes included:

**Preserving and expanding UME Programs:** Most submissions emphasized strong support for the Idaho WWAMI program. Many urged that Idaho Code § 33-3732 be revisited to ensure that WWAMI is not precluded from future seat expansion and that growth of the program be considered alongside other UME expansion strategies. Also, several commenters—including faculty, students, and alumni— wrote in support of ICOM. Others encouraged cautious analysis related to acquisition or expansion, citing fiscal risk and cost of acquisition, limited current Idaho enrollment and the lack of long-term retention data.

**Outcomes-focused selection of programs:** Rather than viewing these pathways as competing, public comment reinforced the need for consistent, outcome-based expectations across all programs serving Idaho students. Key considerations included Idaho-resident enrollment, the proportion of training conducted in-state, the rigor and structure of clinical rotations, alignment with rural and primary care needs, and demonstrated return-to-Idaho practice rates.

**Preference for public programs:** A strong preference for public medical education pathways emerged across comments. Commenters frequently emphasized that public and public-affiliated

programs are generally more cost-effective, better aligned with Idaho's workforce needs, and more accountable to taxpayers.

**Prioritizing GME growth:** While there was general support for expanding medical school capacity, commenters consistently emphasized that seat expansion would not meaningfully address Idaho's workforce needs without corresponding growth in residency programs. Public comment strongly reinforced that physicians are most likely to remain in the state where they complete their graduate medical education. As a result, many commenters identified residency capacity as the primary bottleneck in Idaho's physician pipeline and urged that UME growth be deliberately aligned with expansion of in-state GME programs.

**Statewide coordination:** Public comment also reflected broad interest in the proposed Statewide Coordination Center. While many commenters supported improved coordination of clinical rotations and workforce planning, they emphasized that coordination efforts must preserve existing high-quality programs and avoid reducing training to a purely logistical exercise. Commenters stressed the importance of neutral leadership with understanding of medical education; the preservation of established programs such as TRUST, WRITE, and RUOP; and the establishment of clear quality standards for clinical training across participating institutions.

**Value of physician incentives:** Another recurring theme was strong support for physician retention incentives and rural training programs. Commenters widely endorsed loan repayment, tax credits, and preceptor incentives, particularly those funded through the Rural Health Transformation Program. Many shared personal experiences supporting extensive rural training during medical school and residency as a decisive factor in their choice to practice in Idaho, reinforcing the Working Group's emphasis on place-based education as a long-term workforce strategy.

**Attention to Broader Workforce Environment:** Finally, a subset of commenters raised concerns that factors outside the scope of medical education—such as the broader regulatory and legal environment affecting medical practice—may also influence physician recruitment and retention. While these issues were not the primary focus of the draft plan, commenters encouraged acknowledgment that educational investments are most effective when paired with a professional environment that supports physicians in practice.

## GLOSSARY OF MEDICAL EDUCATION TERMS (ALPHABETICAL)

***APPs (Advanced Practice Providers)***
Includes Physician Assistants (PAs) and Nurse Practitioners (NPs)—licensed clinicians with graduate-level training, distinct from physicians.

***Board Certification***
Credential awarded after completing residency and passing specialty-specific exams (e.g., American Board of Family Medicine, American Board of Internal Medicine).

***Clinical / Clerkship***
A 4–12 week clinical experience where a medical student trains under a preceptor in a specific specialty.

***DO (Doctor of Osteopathic Medicine)***
A physician who graduated from a Commission on Osteopathic College Accreditation (COCA)-accredited osteopathic medical school (e.g., ICOM). DOs are known for a holistic, patient-centered approach, emphasizing the body's ability to heal itself. DOs receive similar training as a MD, plus up to 200 additional hours in Osteopathic Manipulative Treatment (OMT)—a hands-on technique used to diagnose and treat. DOs account for roughly 25% of physicians in the US and are rapidly growing.

***Fellows***
Physicians who have completed residency and pursue additional 1–2 years of subspecialty training (fellowship).

***Fellowships***
Advanced training programs (1–2 years) following residency for subspecialty skills (e.g., Cardiology, Gastroenterology, Geriatrics, Infectious Diseases, Sports Medicine, etc.).

***MD (Doctor of Medicine)***
A physician who graduated from a Liaison Committee on Medical Education (LCME)-accredited allopathic medical school (e.g., University of Washington, University of Utah). MDs follow a conventional, science-based approach to diagnosing and treating disease, utilizing medications, surgery, and advanced technologies. They account for roughly 75% of physicians in the US.

***Medical Schools***
Institutions (MD or DO) that educate and train students to become physicians. Graduates earn either an MD or DO degree.

***Medical Students***
Trainees enrolled in MD or DO programs who are working toward becoming licensed physicians.

***NPs (Nurse Practitioners)***
Registered nurses with advanced degrees and clinical training. In Idaho, they may practice independently, but many work collaboratively with and under supervision of physicians.

***PAs (Physician Assistants)***
Healthcare providers who complete a 2-year graduate program and work under physician supervision to provide clinical care.

***Physicians***
Medical doctors who have completed medical school, residency training, and passed licensing exams to practice independently in a state to deliver medical care to citizens of that state.

***Preceptor***
A licensed, board-certified physician who supervises and teaches medical students during clinical rotations in a clinic or hospital based on the medical school's curriculum.

***Residencies***
Post-medical school training programs (3–7 years) where physicians specialize in areas such as Family Medicine, Pediatrics, General Surgery, or Psychiatry.

***Residents***
Physicians in postgraduate training (residency, i.e., GME), specializing in a medical field. Residencies last 3 to 7 years, depending on the specialty.

***Rotation***
A ~4 week period where a resident gains hands-on training in a specialty area under supervision of a preceptor.