Utah Department of Health & Human Services

Utah Medical Education Council (UMEC)
Monday, September 29, 2025
Multi-Agency State Office Building (MASOB)
12:00 – 2:00 pm
FY26 Q1 Meeting Minutes

Council Members Present: Kristina Callis Duffin, Karyn Springer, Mark Greenwood, Michael Rhodes, Frank Powers, Collin Lash (virtual), Cami Collette (virtual), and Mark Harris (virtual)

Staff Present: Kendyl Brockman, Julie Olson and Ashley Moretz (virtual)

This meeting was recorded per the Open Public Meetings Act.

Welcome and Approval of Meeting Minutes- Dr. Kristina Callis Duffin
Dr. Callis Duffin opened the meeting with roll call and approval of the 6/12/25 Meeting Minutes.

Motion passed to approve of the 6/12/25 meeting minutes.

Administrative Update- Mollie Mcdonald and UMEC Members
Mollie Mcdonald, Assistant Attorney General who represents the Utah Department of Health and Human Services, administered the Oath of Office to all UMEC members.

Presentation on "Utah GME Development Options"- Charlie Alfero
Charlie Alfero, UMEC consultant, then did a presentation on Graduate Medical Education (GME) development options for Utah. He started his presentation by sharing the benefits of developing GME programs in rural and underserved communities. These benefits include the programs help to combat rural health disparities, bolster rural economies, enhance educational environment and help retain physicians in high need areas.

He then explained that the factors most associated with entering and maintaining rural practice are rural upbringing, positive clinical and education experiences in rural settings in undergraduate medical education, targeting training for rural practice at post- graduate level, and preparedness to be a rural community leader. He shared data that showed physicians who come from an urban background and participate in an urban residency have a 12% likelihood of practicing in a rural area. Physicians from a rural background and participate in an urban residency have a likelihood of 36%, 41% for physicians that have an urban background and participate in rural residency, and 82% if a physician has a rural background and participates in a rural residency program.

Next Charlie shared data that shows graduating residents practicing in primary care, underserved communities, rural areas, and community health centers after either participating in a residency program in a teaching health center vs a traditional hospital training. Graduating residents have a much higher chance of practicing in those areas if they train in a teaching health center.

He then provided an overview of the current GME landscape in Utah. He touched on the number of teaching hospitals, general acute care hospitals, critical access hospitals, community health centers, federally qualified health centers, and rural health clinics in Utah. These different types of facilities

may be eligible for some sort of GME funding.

Following that, Charlie reviewed several Medicaid financing considerations. He shared that states can get changes in their GME process through State Plan Amendments (SPA) or 1115 Waiver to Centers for Medicare & Medicaid Services (CMS). Medicaid GME funding primarily goes to hospitals, although it doesn't have to. Additionally, funding is limited to Medicaid utilization so most places use percentage irrelevant, relative percentage of Medicaid patients of practice to determine the Medicaid share. Federal matching funds are also available to states and most will utilize state general funds to get that match but can also do intergovernmental transfers, provider taxes, etc.

Lastly, Charlie presented on the recommendations he has for Utah on expanding GME funding. These recommendations include:

- Consider facilities outside of the traditional urban hospital setting for residency programs or rotations.
- Develop prioritization of the types of facilities eligible for GME financing
- Provide a Medicaid GME payment differential for specific high needs specialties defined by the state to ensure sufficient incentives to develop and sustainability of smaller programs.
- Prioritize and improve intergovernmental transfers (IGTs) and state general fund appropriations
- Continue to separate GME payments from patient billings in new programs
- Provide Combined IME and DGME or global / fixed payments in community based programs

Break- All

Discussion of GME Development Options and Next Steps- All
Dr. Callis Duffin welcomed everyone back from the break and asked if anyone either in the room or online had any questions for Charlie on what he presented.

Question: Have most of the states Charlie's worked with made significant investments of state money into their GME program? Charlie said yes most states have but there are some that don't. He shared it looks different for each state and many don't understand what's possible with GME funding but most have put in money. Dr. Powers also shared that there are various different funding options that should be considered. The state doesn't have to just settle on one and should explore all options.

Question: What among these opportunities are something we should be capitalizing on with the Rural Health Transformation Program (RHTP)? The Utah Medicaid team shared that they would consider doing an evaluation quickly on what other states are doing that Utah could consider. An evaluation would include a financial and policy analysis. They would then need some legislative direction. With that, GME funding should be included for discussion with the RHTP workgroups for consideration. Dr. Sarah Woolsey shared that we as a state and stakeholder group do not have a strategy to address GME funding so a developing one would be the best next step for planning purposes. One option may be drawing down the GME administrative federal funding to get some infrastructure in place and then an independent group can look at the will of the state and get the legislative support needed to bring funding in. RHTP funding may be used to help strategic planning and use for administrative costs to build infrastructure.

The group then discussed why rural hospitals may not want to participate in GME. They may not be interested in GME for various reasons including cultural aspects, the programs would be small, Medicare GME funding caps, and the amount of time it takes to create a sustainable GME program in rural areas. The group agrees that to set up these program technical assistance, faculty development and a designated group this is specifically focused on GME.

The Utah Medicaid team shared that Utah Medicaid enrollment in Utah is low, especially compared to other states. Utah is the lowest of all states so when you think about the amount of money that you could potentially draw down through Medicaid versus what other states are able to capitalize on, it's just not as much, because we have just a small percentage of enrollment. Utah is able to leverage as much funding through Medicaid as other states because we just don't have the number of individuals in our state who utilize Utah Medicaid.

The group discussed and agreed that there are many specialties, especially those that are considered primary care, needed across the state. Charlie shared that New Mexico created a GME differential for growth in family medicine, internal medicines, pediatrics, general medicine, general psychiatry. Other states have added general surgery and geriatrics. This is determined by the state to meet the states needs. All agree that a GME strategic plan is a crucial first step in expanding GME in Utah.

Another factor in rural training and retaining providers in rural areas is funding. Many times providers are not paid as well in rural areas as they are in urban areas and they have loans to pay off so they aren't willing to take a pay cut. The state needs to find ways to attract new providers to these areas and make it worth their while.

The group agreed that it would take collaboration from all organizations involved in GME to really address the issues and create a strategic plan. The first step is to build infrastructure and create a strategic plan that outlines the goals and defines the scope. Charlie shared that it's important to make sure the state, communities and legislature understand the importance of GME and investing in physician education. There tends to be a disconnect between those and for lasting results it's important to make sure everyone is connected and on the same page.

Wrap Up: Dr. Krstina Callis Duffin, All

Motion passed to adjourn the meeting.

Meeting adjourned by 2:05pm

Respectfully submitted,
Kendyl Brockman