Tripp Umbach
Turning Ideas Into Action

Concept Paper Overview

Establishing a Public MD-Granting School at the University of Rhode Island

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Overview

The University of Rhode Island (URI) is uniquely positioned to address Rhode Island's critical shortage of primary care physicians by developing a public, MD-granting medical education program. With over 300 additional primary care providers needed statewide, and nearly half of the current physicians nearing retirement, the situation has reached a tipping point. Unlike most states, Rhode Island lacks a public MD medical school, and Brown University's medical graduates primarily pursue specialties rather than primary care. URI offers a strong foundation for a new school of medicine through its existing pharmacy, nursing, and health sciences programs, which provide infrastructure, interprofessional education opportunities, and established clinical partnerships. As an R1 research institution, URI has an opportunity to attract high-caliber faculty and students. The proposed program would emphasize primary care and community-based training, with strong integration across health disciplines. This approach, favored over other models such as a public DO school or regional campus, would help retain more graduates in-state, particularly through incentives like loan forgiveness. The school would also generate economic growth, research activity, and healthcare access improvements. With strong stakeholder support and backing from the state government, URI is strategically positioned to lead a transformative effort to expand the physician workforce and improve healthcare equity across Rhode Island.

Demonstrated Need

Rhode Island is experiencing a growing shortage of primary care physicians, a challenge that significantly threatens residents' access to timely and comprehensive healthcare. As of 2024, estimates suggest that between 200,000 and 400,000 adults in the state do not have adequate access to primary care services, indicating a shortage of approximately 133 to 266 clinicians based on standard patient-to-provider ratios.[1]

[1] Rhode Island General Assembly, 2024

On April 29th, 2025, Governor Dan McKee and state health leaders introduced a new initiative to strengthen Rhode Island's weakened primary care system at a news conference. The initiative proposes measures like grant support for clinics and increased payment rates from major commercial insurers. At the conference, it was announced that Rhode Island requires 300 additional primary care providers to meet current demand.[2] This gap is driven by several factors, including an aging physician workforce, increasing rates of burnout due to administrative burdens, and the relatively low financial incentives in primary care compared to specialty fields.[3]

The impact of this shortage is already evident in the healthcare system. Patients frequently encounter long wait times—sometimes several months—for primary care appointments, and many are forced to seek care across state lines.[4] Emergency departments have become overburdened as individuals turn to them for routine care, typically managed in outpatient settings.[5]

This erosion of access has also led to a decline in trust between patients and healthcare providers, especially as maintaining continuity of care becomes increasingly difficult. In response, the state has launched several initiatives, including the Primary Care Training Sites Program, which provides grants to support future workforce development and policy strategies aimed at expanding clinic capacity and improving provider reimbursement rates.[6] Despite these efforts, substantial investment and coordination will be necessary to close the primary care gap and ensure sustainable access to essential services across Rhode Island.

In 2023, Rhode Island had 4,199 physicians (all specialties), of which 327 were family medicine/general practice physicians.[7] Projections suggest that Rhode Island requires approximately 300 additional physicians to meet its healthcare demands effectively.[8] Moreover, the state's physician workforce is aging rapidly, with 44% of active physicians aged 55 and older, suggesting that a substantial number are within a decade of retirement.[9]

Rhode Island is one of only two states without a public MD-granting medical school, making the University of Rhode Island (URI) well-positioned to address this pressing need. Brown University, currently the sole MD-granting institution in the state, predominantly produces specialists rather than primary care providers. Of 106 graduates from primary care residencies in Rhode Island in academic year 2002–2023, only 15 (14%) planned to provide primary care in Rhode Island, demonstrating a critical leakage in the state's healthcare workforce pipeline.[10]

Capability of URI

The University of Rhode Island possesses substantial foundational assets, including established programs in pharmacy, nursing, health sciences, and biomedical research, which ensure a strong foundation for developing a new medical school. These programs offer existing infrastructure such as simulation labs, research facilities, and experienced administrative teams, which can be shared to reduce startup costs and streamline operations. The programs also create valuable

[2] Rhode Island Current, 2025
[3] Office of the Health Insurance Commissioner, 2023
[4] Rhode Island PBS, 2024
[5] Kaiser Family Foundation Health News, 2024
[6] Healthcare Innovation Group, 2024
[7] Association of American Medical Colleges
[8] Rhode Island Current, 2025
[9] Robert Graham Center
[10] Primary Care Access for All: A Roadmap for Addressing the Primary Care Crisis in Rhode Island

opportunities for interprofessional education, allowing medical students to train alongside future nurses, pharmacists, and allied health professionals in team-based care environments that reflect real-world clinical settings, fostering collaboration, patient outcomes, and alignment with accreditation requirements.

Additionally, existing clinical partnerships and rotation sites developed for nursing and pharmacy students can accelerate the development of clinical training placements for medical students. These programs also help establish academic pipelines, encouraging students from related fields to pursue medical education through pre-med tracks and early assurance programs. Complementary health education programs strengthen the institution's credibility, positioning URI for a more successful and sustainable school of medicine (SOM).

The recent classification of URI as an R1 research institution significantly enhances its capacity to attract top-tier faculty, research funding, and high-caliber students. Existing community partnerships and relationships with local hospitals and health systems provide a strong platform for clinical training and community-based healthcare initiatives.

Regional stakeholders strongly support establishing a community-focused allopathic medical school program emphasizing primary care while preparing students for careers in all specialties. Such an approach would integrate interdisciplinary education with existing pharmacy and nursing programs at URI, offering extensive clinical training partnerships with community health centers and hospitals. Longitudinal primary care clerkships and affordability initiatives would further incentivize Rhode Island and regional students to remain in the state after training.

While critical challenges remain, such as securing sustainable funding, expanding clinical training capacities, and managing potential resistance from existing institutions, the long-term benefits of addressing Rhode Island's physician shortage outweigh these hurdles. URI's strong alignment with healthcare partners and support from state government initiatives position the university strategically to overcome these barriers and establish a transformative medical education program that serves the state's future healthcare needs.

Economic Development

Establishing a public medical school at URI would yield substantial economic benefits, including job creation, research funding opportunities, and advancing Rhode Island's biomedical sector. A URI medical school could dramatically increase the proportion of physicians trained and retained within the state by fostering local education and retention incentives, such as loan forgiveness and tuition reimbursement. This strategy would directly improve healthcare access, particularly in underserved regions. Typically, the annual operations of a public medical school in the early years of development have an economic impact of approximately $150 million and supports approximately 1,000 jobs directly and indirectly.[11] Each physician trained at the medical school who completes residency and remains in the community have an annual $2.2 million economic impact and supports 15 jobs directly and indirectly.[12]

[11] Figures subject to change after final analysis. Tripp Umbach data.
[12] Tripp Umbach data.

Stakeholders identified promising opportunities for a diverse financial strategy combining state appropriations, philanthropic contributions, and public-private partnerships. Rhode Island's recent legislative commitment (i.e., HEALTH Initiative) to increasing Medicaid reimbursements and funding for clinical training sites demonstrates the state's readiness and ability to support significant investments in healthcare infrastructure.[13]

Recommended Model

URI should develop a public MD-granting medical education program in partnership with hospitals, health systems, and community clinics throughout Rhode Island. The program will complement Brown University's Alpert School of Medicine, focusing on community education, research, and clinical care. It will also be firmly integrated with the university's nursing, pharmacy, public health, and other health-related programs. Tripp Umbach deemed this model to be superior when compared to a private medical school or a regional campus of an existing institution in neighboring states.

In general, community-based medical schools identified below have multiple health care training partners, which include community health clinics located throughout their service region. These public medical schools are more likely than large medical centers to produce students who enter primary care specialties, participate in community-based research and service initiatives. Most importantly, they are more likely to remain in practice in community settings.

Community-Based Medical Schools:

1. Central Michigan University College of Medicine (COM)
2. Charles E. Schmidt College of Medicine at Florida Atlantic University
3. CUNY SOM
4. East Tennessee State University James H. Quillen COM
5. Eastern Virginia Medical School
6. Florida International University Herbert Wertheim COM
7. Florida State University COM
8. Marshall University Joan C. Edwards SOM
9. Michigan State University College of Human Medicine
10. Northeast Ohio Medical University
11. Southern Illinois University SOM
12. Texas Tech University Health Sciences Center Paul L. Foster SOM
13. Texas Tech University Health Sciences Center SOM
14. University of California, Riverside SOM
15. University of Central Florida COM
16. University of Hawaii, John A. Burns SOM
17. University of Houston Tilman J. Fertitta Family COM
18. University of Nevada, Reno SOM
19. University of North Dakota SOM and Health Sciences
20. University of South Carolina SOM Columbia
21. University of South Dakota, Sanford SOM
22. University of Texas at Austin Dell Medical School
23. University of Texas Rio Grande Valley SOM
24. Virginia Tech Carilion SOM
25. Washington State University Elson S. Floyd COM
26. Wright State University Boonshoft SOM

[13] State of Rhode Island General Assembly, 2024

Vision for the Proposed Medical School

The vision for establishing a new public medical school reflects a strategic and mission-driven response to the state's growing healthcare needs and workforce shortages. This initiative outlines a comprehensive plan to enhance clinical training opportunities, attract Rhode Island students into medicine, and ensure long-term financial sustainability. With a focus on community partnerships, state and cross-border collaborations, and a commitment to improving access to care in underserved areas, the proposed SOM emphasizes both the academic and economic benefits of a public medical school.

Questions Still Remain

The following discussion addresses outstanding questions and considerations for advancing the development of a public medical school, from securing clinical training sites to attracting local students and establishing sustainable financial and legislative support for the proposed SOM.

1. *Where will clinical training take place?*

- URI must secure partnerships with a broad array of health care providers throughout Rhode Island. Organizations interviewed shared an interest in creating a relationship with a public medical institution. These institutions can serve as anchor institutions for clerkships, residencies, and potentially faculty recruitment.
- Leverage community hospitals and Federally Qualified Health Centers (FQHCs) across the state to fulfill rural and primary care training requirements (i.e., Thundermist Health Center)
- Establish Graduate Medical Education (GME) affiliation agreements with hospitals in eastern Connecticut and southeastern Massachusetts to expand access to specialty care training while minimizing the impact on in-state capacity.
- Tripp Umbach believes that there is sufficient training capacity in Rhode Island for a medical school class of 100 students. The following table lists current teaching and non-teaching hospitals as well as their academic affiliations. It is most common for a hospital with an academic affiliation to take medical students from multiple schools.

Teaching Hospitals			Non-Teaching Hospitals		
Hospital	**Bed Size**	**Residency Sponsor**	**Hospital**	**Bed Size**	**Location**
Rhode Island Hospital	719	Brown University	Our Lady of Fatima Hospital	312	North Providence
Kent Hospital	359	Independent	Landmark Medical Center	214	Woonsocket
Meriam Hospital	247	Brown University	Westerly Hospital	129	Westerly
Roger Williams Hospital	220	Boston University	Newport Hospital	125	Newport
Women's & Infants	137	Brown University	South County Hospital	100	South Kingstown
Hasbro Children's	63	Brown University			

2. *How to attract students from Rhode Island?*

To attract and retain Rhode Island students, the proposed medical school should implement a multi-faceted, mission-driven recruitment strategy. A key component is the establishment of guaranteed admission pathways, such as BS/MD programs or early assurance options, designed for high-achieving Rhode Island undergraduates and high school students. These pathways provide clear, structured opportunities for local students to pursue medical education without the uncertainty associated with traditional application routes. Additionally, the school should emphasize a strong commitment to training physicians who will serve within the state, particularly in rural and underserved communities. This mission focus can be woven into admissions criteria, curricular design, and outreach initiatives. Tuition incentives and service-based commitments, such as offering in-state tuition or student loan repayment for graduates who practice in Rhode Island post-residency, can further incentivize students to remain in-state, helping to build a locally rooted physician workforce.

3. *What are the financial realities and estimated capital/start-up costs?*

The development of a new academic and simulation building is a critical component of establishing a medical school at the University of Rhode Island, with estimated capital costs totaling approximately $125 million. This projection is based on recent benchmarks from comparable institutions, such as the University of Central Florida, the University of Nevada, Las Vegas (UNLV), and the University of Texas Rio Grande Valley (UTRGV), all of which have constructed facilities similar to those supporting modern medical education.

To manage costs and maximize efficiency, URI may consider co-locating the new school with existing health science infrastructure or implementing a phased construction plan that aligns facility expansion with projected enrollment growth. This approach would allow for strategic scaling of resources while maintaining financial sustainability during the initial stages of development.

The start-up costs for launching the new medical school, excluding construction, are projected to be approximately $90 million. These funds will support essential early-stage activities, including curriculum development, accreditation preparation, recruitment of founding faculty and administrative leaders, and marketing efforts to build visibility and attract applicants. A private lead donor will be instrumental in generating momentum and credibility for the campaign, catalyzing broader philanthropic support. In addition to private contributions, state appropriations and philanthropic gifts will play a crucial role in funding these foundational efforts, ensuring the school is well-positioned for a successful launch and long-term impact.

<u>Tuition and Revenue</u>

The proposed medical school should anticipate setting tuition at approximately $50,000 annually, based on Tripp Umbach's recommendation, aligning it with rates at other public medical schools and maintaining competitiveness for in-state and regional applicants. Similar to most public medical schools, tuition revenue alone will not suffice to cover the institution's full operating costs. To ensure long-term financial sustainability and quality programs, the proposed medical school will need $20 million in annual state operating revenue. This funding must be supplemented by clinical revenue generated through partnerships with health systems, as well as ongoing philanthropic contributions to support scholarships, faculty development, and programmatic innovation.

To ensure the long-term financial sustainability of the new medical school, URI must secure a recurring state budget line item for operational support, with a recommended annual appropriation of $25 million. This funding stream will be critical for maintaining core academic functions, supporting faculty, and delivering high-quality medical education. Additionally, URI should establish a dedicated medical school foundation to cultivate long-term philanthropic support and build an endowment that provides financial stability and flexibility over time. Additionally, by leveraging clinical faculty from partner health systems, the school can reduce the overhead of full-time salaried faculty; thereby lowering personnel costs while still ensuring students receive high-quality, hands-on clinical instruction.

4. *What is the proposed timetable?*
    - Year 1-2: Planning, community engagement, and accreditation preparation.
    - Year 3: Submit application to LCME, hire a founding dean, and a leadership team.
    - Year 4: Conditional accreditation and student recruitment.
    - Year 5: First class matriculates.
    - Year 9+: Graduate first cohort.
5. *Funding (Over 10-year period)*[14]
    - **$225 million total**
        - Seed funding from the community and university foundations ($20 million)
        - Lead/Private donor ($40 million)
        - State start-up ($30 million)
            - Annual ongoing state support ($25 million*)
        - Seek initial legislative appropriation for feasibility and design ($50 million*)
        - Secure matching private funds or health system commitments ($60 million*)
6. *How do we advocate for a Public Medical School?*

    Advocating for a public medical school in today's environment requires a strategic approach that highlights both the risks of inaction and the wide-ranging benefits of investment. A key argument should focus on the economic consequences of not establishing a public medical school, including lost opportunities

*One-time donation.

[14] Financial figures submit to change after final analysis.

for job creation, research funding, and long-term economic growth. Additionally, proponents must emphasize the role a public medical school can play in advancing health equity and addressing critical physician shortages, particularly in underserved communities. The school should be positioned as an integral component of statewide efforts to strengthen the healthcare workforce, support the retention of local talent, and align with broader economic development goals. To succeed, advocacy efforts must bring together a diverse coalition of stakeholders, including leadership from the University of Rhode Island, state legislators, local hospitals, community health centers, and economic development organizations, all unified around a shared vision for improving health outcomes and economic resilience across the state.

Conclusion

Establishing a public, MD-granting, community-based SOM at URI presents an exceptional opportunity to address Rhode Island's critical shortage of primary care physicians, enhance healthcare access, promote economic development, and increase in-state physician retention. The combination of existing university capabilities, statewide needs, and strategic economic incentives offers a compelling rationale for advancing this pivotal initiative.

Additional Details To Be Included in the Feasibility Study

1. Define a curriculum model emphasizing interdisciplinary training and primary care clerkships.
2. Evaluate the number of potential applicants, including retention rates for URI medical graduates.
3. Examine potential synergies with existing institutions, particularly those at Brown University.
4. Develop a timeline for establishing and accrediting the new medical school, including milestones and key decision points.
5. Identify key indicators to measure the medical school's impact on healthcare outcomes, economic development, and physician workforce retention.

New U.S. Public Medical Schools (Established Post-2000)

The table below lists 15 public medical schools in the U.S. founded (or first class admitted) since 2000, with their inaugural class year and size, current enrollment, and details on state funding for start-up, annual operations, capital, and private donations for facilities:

Public Medical Schools	First Class (Year)	Inaugural Class Size	Current Enrollment	Tuition	State Start-Up Funding	Ongoing State Support	Capital/Private Funding
Recommendation for URI		40	300 total (75 per class)	$50,000	$30 million	$25 million annually	Seed Funding: $20 million State: $50 million Lead Private: $40 million Additional Private: $60 million
Median Data		48	320 total (80 per class)	$41,570	$20 million ($30 million adjusted for inflation)	$22.4 million	State: $56.5 million Lead Private: $27.5 million
Florida International U. Herbert Wertheim COM (Miami, FL)	2009	43	480 total (120 per class)	$34,186	Authorized 2006; received non-recurring start-up appropriations ($5.2M in FY2007- 08, $6.2M in 2008-09) additional $7.1M in FY2009- 2010 for inaugural year.	Annual state operating support $20.3M by year 10 (planned to reach $20M/year when fully enrolled).	$64M for facilities construction including $20M Public Education Capital Layout (PECO) funds for a research building and $20M state-matched to $20M private donations.
U. of Central Florida College of Medicine (Orlando, FL)	2009	41	480 total (120 per class)	$41,570	The state provided $18.6M in start-up funds over 2007–2009. The local community raised $6.5M for full scholarships for charter-class students.	State annual recurring support $20.8M by full enrollment (Year 10)	$82M for new facilities, including $30M in community/private funds matched by $30M state funds, plus $22M from state PECO bonds.
Florida Atlantic U. Charles E. Schmidt COM (Boca Raton, FL)	2011	64	313 total (78 per class)	$33,220	Authorized 2010; Florida provided new funding ($10M in FY2010- 11) to launch the independent FAU medical program.	State annual recurring support $20M by mid-2010 (e.g., $20.7M in FAU's 2014-15 Education and General Budget for the medical school)	$50M state appropriation (2010) for new medical building matched by FAU and donors. $139M new six-story medical school facility opened in 2012
Univ. of Nevada, Las Vegas (UNLV) Kirk Kerkorian SOM (Las Vegas, NV)	2017	60	240 total (60 per class)	$32,903	Nevada's 2015 Legislature appropriated $26.7M for start-up operating costs for hiring faculty and curriculum to launch the SOM in 2017.	State general-fund support $19.6M in FY2016- 17, rising to $30.2M by FY2018- 19 as class size grew. Public funding will ultimately cover 18% of the school's total budget at full size.	$25M state capital appropriation in 2017 for a new medical school building, contingent on a private $25M match. Total project $125M; an anonymous donor provided $25M
Univ. of Arizona College of	2007	24	400 total (100 per class)	$42,590	Established in 2007 in partnership with ASU and the City of Phoenix. State support	Continue as a state-funded UA medical college (now separate from UA Tucson).	The $135M Health Sciences Education Building on the Phoenix Biomedical Campus was

Public Medical Schools	First Class (Year)	Inaugural Class Size	Current Enrollment	Tuition	State Start-Up Funding	Ongoing State Support	Capital/Private Funding
Medicine – Phoenix (Phoenix, AZ)					included operating funds via UA; City donated the downtown Phoenix Union High School site and funded its $30M renovation.	Receives annual state appropriations through UA; class size approved to increase to 100, reflecting ongoing state investment.	funded by state appropriations and city bonds (for UA/ASU). Phoenix provided land and facilities (via city bond projects), enabling a whole 4-year campus.
Washington State Univ. Elson S. Floyd College of Medicine (Spokane, WA)	2017	60	240 total (60 per class)	$43,842	Authorized by WA Legislature in 2015 (ending UW's exclusivity). State provided $2.5M initial planning funds (2015) and $10.0 M in the 2017–19 biennium to support the first 60 students.	Annual state funding $10M–$11M per biennium for each new class added ($10M to support 60 first year students and 60 second year students in 2017–19). By complete 4-year enrollment, ongoing state support is $24M/year.	Utilized existing WSU-Spokane health campus facilities. The state had previously invested $70M in a Biomedical Sciences building in Spokane in anticipation of expanding medical education. In 2019, WSU began planning a new building to double enrollment (seeking state capital funds).
University of Texas at Austin Dell Medical School (Austin, TX)	2016	50	200 total (50 per class)	$24,525	UT System Regents committed $25M/year plus $40M over eight years for start-up (faculty recruitment). In 2012, Travis County voters approved a property tax (Central Health) providing $35M/year to support the new medical school.	Ongoing support includes the $25M annual UT System funding. (Dell Medical also benefits from local tax revenue $35M/yr and external grants.) The Texas Legislature formally authorized the school in 2019 but provides no large direct appropriation (Dell Medical seeks state formula funding parity).	$50M naming gift from the Michael & Susan Dell Foundation for facilities. UT Regents approved the construction of three new medical campus buildings in 2013, which were funded via UT bonds and philanthropy. The main Health Learning Building opened in 2016.
University of Texas Rio Grande Valley School of Medicine (Edinburg/ Harlingen, TX)	2016	55	210 total (55 per class)	$24,970	Founded with UT System support during the creation of UTRGV. UT Regents approved $54M for a new medical school building in Edinburg and $10M for a simulation hospital in Harlingen. Initial operating funds were covered by UT System and reallocated regional campus funds (no separate state line-item at launch).	Now receives state formula funding as part of UTRGV. The Texas Legislature began appropriating support for the medical school in general appropriations by the 2010s. (e.g., $71.4M for UTRGV's health programs in FY2020- 21, including the medical school). Continued UT System backing as needed.	$54M state PUF-funded Medical Education Building in Edinburg. Harlingen's existing Regional Academic Health Center was transferred from UTMB for clinical training. Additional state capital funds provided for expanding research and clinic facilities across the Valley (ongoing).

Public Medical Schools	First Class (Year)	Inaugural Class Size	Current Enrollment	Tuition	State Start-Up Funding	Ongoing State Support	Capital/Private Funding
University of Houston Tilman J. Fertitta College of Medicine (Houston, TX)	2020	30	120 total (30 per class)	$27,726	Authorized by the Texas Legislature in 2019. The start-up funding plan is called for $120M over 10 years (combining state appropriations, philanthropy, and intellectual property revenue). An initial $20M in state funds was secured to launch the college, alongside significant donations (e.g., a $3M anonymous gift to cover inaugural class tuition).	Seeks $10M+ annually in state support as it grows (Texas provided an initial special-item appropriation in 2019, then formula funding as part of UH). The UH System aimed for $40M in state, $40M in donor, and $40M in other funding over the decade. As of 2023, state funding is included in UH's base budget for 120 medical students.	The new medical school building was funded by UH bonds and philanthropy (Tilman Fertitta's $50M naming gift). The college aims to raise capital and endowment funds privately; the state did not directly fund construction. (Local partner HCA will provide clinical training facilities.)
Texas Tech Univ. HSC El Paso – Paul L. Foster SOM (El Paso, TX)	2009	40 (charter class)	400 total (100 per class)	$26,183	Established as a four-year TTUHSC regional campus in 2009. Texas Legislature invested over $60M from 2007–2009 to build and open the El Paso (including new faculty hires and operations). Achieved separate accreditation status in 2013.	Receives recurring state appropriations via TTUHSC El Paso – e.g., $53M/year by 2020. Funded under the Texas formula for medical education and exceptional item support for border health.	$90M in capital funding for the medical campus (state tuition revenue bonds and appropriations in 2006–2008). Included a new Medical Education Building ($40M) and Research building ($50M) adjacent to the University Medical Center of El Paso. Additional $32M state funds 2015 for a new Medical Sciences building.
Central Michigan University College of Medicine (Mt. Pleasant, MI)	2013	64	400 total (100 per class)	$41,788	Michigan provided $12.5M in one-time funds to assist start-up, and CMU raised operational funds internally and via local healthcare partners to admit the first class in 2013.	Receives state support through CMU's base appropriation. CMU's clinical revenues supplement annual medical education funding. (Michigan has no separate line-item for the COM; CMU covers costs via tuition and state university funds.)	The state's $25M in capital outlay helped build CMU's medical education building. CMU bonds and local hospital contributions covered the $30M+ in construction.
Oakland Univ. William Beaumont	2011	50	500 total (125 per class)	$59,096	Launched as a partnership between Oakland University (public) and Beaumont Health	Beaumont's clinical funding and tuition sustain OUWB's operations; it is	$28M joint investment by Beaumont and Oakland U. to renovate and equip a medical

Public Medical Schools	First Class (Year)	Inaugural Class Size	Current Enrollment	Tuition	State Start-Up Funding	Ongoing State Support	Capital/Private Funding
School of Medicine (Rochester, MI)					(private). Beaumont provided substantial start-up funding (>$10 M) and facilities. Michigan's Higher Ed budget did not initially increase for OUWB, so the school operated on Beaumont support and tuition in the early years.	not separately line-funded by the state (state support to Oakland Univ. is general). OUWB matriculates 125 students/annually with stable financing from its health system partnership.	school building and new anatomy labs. Beaumont also invested in a new research and education center on its hospital campus to support the school.
Cooper Medical School of Rowan U. (Camden, NJ)	2012	50	400 total (100 per class)	$49,349	2009 executive order merging Rowan and Cooper Health. New Jersey provided start-up appropriations ($30M over 2010–2012) to hire faculty and attain LCME accreditation. Cooper Health System contributed operating funds before first enrollment.	Receives annual state support through Rowan's appropriation. As of 2015, class size reached four whole cohorts, and state operating support for CMSRU was folded into Rowan's base (Rowan's overall state funding increased after UMDNJ reorganization in 2013 to support its two medical schools).	The $139M new Medical Education Building opened 2012. Funded by a combination of New Jersey state capital bonds and Cooper/Rowan contributions.
Virginia Tech Carilion School of Medicine (Roanoke, VA)	2010	42	168 total (42 per class)	$65,739	Opened in 2010 as a public–private partnership (Virginia Tech & Carilion Clinic). Carilion Clinic invested $100M+ to cover startup and operating costs (the model had no new state funds at launch). VTCSOM became an official college of VT, enabling some state support via VT.	Now part of Virginia Tech, it receives state general funds indirectly, but the medical education program still relies heavily on Carilion's clinical revenue and philanthropy. The relatively small class size helps keep ongoing state funding needs modest.	Carilion financed the original medical school building on its Roanoke campus. Virginia's state government provided $59M for the adjoining Fralin Biomedical Research Institute but no upfront capital for the medical school itself. Expansion plans in 2023 sought state funds for a new education building to double class size.
Carle Illinois College of Medicine (Urbana Champaign, IL)	2018	32	128 total (32 per class)	$53,766	Established in 2018 as a no-state-funds venture: $100M pledge from Carle Health System (over 10 years) covers start-up costs. UIUC is committed to no new state appropriations – additional funding comes from	Continues operating without dedicated state funding. Supported by Carle's ongoing contributions, tuition, and external grants. (The college is part of UIUC but outside the regular state	The college renovated existing UIUC facilities. A donor-funded renovation of Everitt Lab ($10M) created state-of-the-art medical classrooms and labs. Future expansion may seek state capital funds, but no state funds were used.

Public Medical Schools	First Class (Year)	Inaugural Class Size	Current Enrollment	Tuition	State Start-Up Funding	Ongoing State Support	Capital/Private Funding
					donor gifts, research grants, and clinical revenue.	budget for medical education)	

Table 1: Annual In-State Tuition for New Public Medical Schools

Medical School	In-State Tuition (2024–2025)
Carle Illinois College of Medicine (University of Illinois Urbana-Champaign)	$57,525
Central Michigan University (CMU) College of Medicine	$46,325
Cooper Medical School of Rowan University (CMSRU)	$49,349
Florida Atlantic University (FAU) Charles E. Schmidt College of Medicine	$34,186
Florida International University (FIU) Herbert Wertheim College of Medicine	$41,570
Florida State University (FSU) College of Medicine	$32,903
Oakland University William Beaumont (OUWB) School of Medicine	$59,096
Texas Tech University Health Sciences Center El Paso (TTUHSC El Paso)	$26,183
University of Arizona College of Medicine – Phoenix	$42,590
University of Central Florida (UCF) College of Medicine	$33,220
University of Houston Tilman J. Fertitta Family College of Medicine	$27,726
University of Texas at Austin Dell Medical School	$24,525
University of Texas Rio Grande Valley (UTRGV) School of Medicine	$24,970
Virginia Tech Carilion School of Medicine (VTCSOM)	$65,739
Washington State University Elson S. Floyd College of Medicine	$43,842

Source: Shemmassian Academic Consulting