Case Study: Primary Care Offices and Health Workforce Incentive Programs

Introduction: State Primary Care Offices and Health Workforce Development

State Primary Care Offices (PCOs) operate within all state health departments and are supported with federal funding. They have operated under federal/state cooperative agreements for more than 20 years. PCOs are the state-level focal point for primary care safety net activities, with a focus on the federal National Health Service Corps (NHSC) and Health Center Program.

PCO responsibilities strongly emphasize the assessment and development of the primary care workforce in underserved areas within the state. With funding from the Health Resources and Services Administration (HRSA) Primary Care Office Program, is responsible for several key activities, including:

- **Shortage Designations**: routine updating and expansion of Federal shortage designations, including Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas/Populations (MUAs/ MUPs).
- **National Health Service Corps (NHSC) Coordination**: state level NHSC support efforts, including development and review of site applications and facilitation of individual participant applications.
- **Health Center Expansion**: support of health center expansion and development, including the provision of data and other technical assistance.

Since the inception of the PCO program, the major focus of the PCO cooperative agreement has been workforce assessment and development. In addition to their federal responsibilities, many PCOs are also responsible for implementation of state programs, not in the federal program expectations, including:

- **State Grant Programs**: administration of state-funded grant/contract programs for community health centers and the safety net.
- **State Primary Care Workforce Programs**: administration of state-funded health profession scholarship, stipend and loan repayment programs.
- **NHSC State Loan Repayment Program**: administration of the NHSC State Loan Repayment Program – a grant program for states which does not reimburse administrative costs.
- **J-1 Visa Waiver Program**: administration of the J-1 Visa Waiver Program for Physicians – an unfunded discretionary program under state jurisdiction.

Federal funding of PCOs varies significantly. In some states funding is adequate to support only one or two positions. In other states larger staff sizes are supported. Many states co-locate State Office of Rural Health (SORH) activities with those of the PCO, and coordinate the efforts of staff from these two grant programs on overlapping objectives. There is no state matching requirement for federal support under the PCO Program. Nevertheless, many states have additional state-funded positions assigned to the PCO and provide state funds for support of PCO operations.

Background: Health Workforce Development under ACA
Case Study: Primary Care Offices and Health Workforce Incentive Programs

Title V of the Patient Protection and Affordable Care Act (ACA) authorizes more than thirty different health workforce training, financing and development initiatives. The provisions were included to address the health workforce needs associated with health care reform. The current health workforce capacity is not adequate to serve the millions of newly insured Americans who will get health care coverage under the ACA’s other provisions. While some of these programs are authorized but currently unfunded, several have been initiated, including State Health Workforce Development grants, Primary Care Residency Expansion grants, Physician Assistant and Nurse Practitioner Training grants, and Nurse Managed Health Center grants.

The State Health Workforce Development Grant Program is particularly important. When fully implemented, it will provide funds to states to develop integrated programs designed to improve the supply and distribution of health workforce. States will conduct their locally-initiated activities in coordination with a new National Health Care Workforce Commission, which is charged with workforce development at the national level.

PCOs are well positioned to play a significant role in ACA authorized health workforce programs. They already coordinate and administer multiple workforce programs, and play a lead role in assessing workforce needs. In addition, some of the existing state programs administered by PCOs are innovative and can provide guidance on what is effective to federal government and other states. This case study will explore two such programs which can serve as models for others.

Texas and New Mexico: Different Health Workforce Incentive Approaches

There is a two-fold challenge for health workforce policy and programs:
- How to increase the supply of needed health professionals
- How to improve the distribution of health professionals working with underserved areas and populations.

The distribution of health professionals is a particularly challenging issue in a market economy. Most programs addressing the issue are designed to provide financial incentives that will affect the location decision of a health professional regarding his/her practice. There is a wide variety of possible financial incentives that can be used for the health workforce, but not all of these incentives are equally effective. For example, in the United States an increasing number of professionals are salaried. For these health professionals some financial incentives, such as differential payment for services to the rural underserved, will accrue to the practice and fail to provide any real incentive to an individual.

Two health workforce incentive programs are profiled in this case study. Each takes a different approach to the issue; however, when taken together, they demonstrate how incentive programs can complement each other.

The Texas Children’s Medicaid Loan Repayment Program (CMLRP) is an incentive program that provides financial support to early career health professionals with educational debt in exchange for a commitment to provide care to the underserved. It is a program designed to attract health professionals to a different type of practice. In contrast, the New Mexico Rural Health Practitioner Tax Credit Program (RHPTCP) provides tax credits to health professionals at all stages of their careers in exchange...
for their practice in rural underserved areas. Where the first program can be seen as a type of health professional recruitment program, the second program can be perceived as a health professional retention program. They address two sides of the health workforce distribution issue – how to get health professionals to work with the underserved and how to keep them in that type of practice.

Texas: Performance-Based Health Workforce Incentives

Overview:

The Texas Children’s Medicaid Loan Repayment Program (CMLRP) is a state-funded program which provides health professional education loan repayment awards to eligible health care providers in exchange for documented levels of service to Medicaid eligible children. It is a unique form of loan repayment program, as it is linked to desired public program performance levels, not to location of a health care practice.

Background:

The CMLRP developed as one of a series of responses to a lawsuit against the Texas Medicaid Program. That lawsuit alleged that children eligible for Medicaid were not served adequately because of the lack of participating health care providers. The lawsuit led to a consent decree which directed the development of new efforts to increase the participation of Texas health care providers in the Medicaid program.

These efforts are under the guidance of an external consent decree advisory committee, and include improvements in Medicaid reimbursement of physicians and dentists. The advisory committee identified the need to provide other incentives to increase the level of participation of providers. The CMLRP was created to provide this expanded incentive. The expenses associated with the CMLRP, including awards and the administrative costs, are part of the Medicaid budget dedicated to compliance with the consent decree.

Eligibility:

Eligible Health Professionals: Under the CMLRP, eligible applicants are certain physicians and dentists with eligible health professional education loans:

Physicians: Eligible providers for the CMLRP include allopathic or osteopathic physicians at any location in Texas. Physicians can be practicing in any medical specialty or sub-specialty as long as they provide the required level of services to Medicaid enrolled children. Full-time and part-time physicians are eligible, as long as service provision requirements are met.

Dentists: Eligible providers for CMLRP are dentists at any location in Texas that provide the required level of services to Medicaid enrolled children. General and pediatric dentists are eligible for participation. Full-time and part-time dentists are eligible, as long as service provision requirements are met.

Under the general eligibility requirements of the CMLRP, applicants must:
• Have an outstanding eligible education loan.
• Hold an unrestricted license from the Texas Medical Board or the Texas State Board of Dental Examiners.
• If practicing in a specialty or subspecialty, be certified by or be eligible to sit for the applicable specialty or subspecialty board.
• Provide eligible services for four consecutive years and meet the target number of Medicaid visits by children under the age of 21 for each 12-month period.
• Not, at the time of application or at any time during which the recipient is fulfilling his or her obligation under the Program, be fulfilling another service obligation to provide medical or dental services.

**Loans Eligible for Repayment:** To be eligible for repayment under the CMLRP, an education loan must:

• Have been made for undergraduate, graduate, medical or dental education at an accredited institution in the United States.
• Not have been made during residency.
• Not be from a loan made to oneself from one's own insurance policy or pension plan from the insurance policy or pension plan of a spouse or other relative.
• Not have an existing service obligation.
• Not be subject to repayment through another student loan repayment or loan forgiveness program.
• Not be consolidated with non-education loans or with loans obtained by someone other than the provider applying for loan repayment.

This approach eliminates potential problems, including potential ‘double-dipping’ – where CMLRP participants might also be recipients of loan repayment under other state or federal programs. The PCO, which administers the application process, also coordinates other loan repayment programs, including those of the National Health Service Corps. This makes the PCO uniquely qualified to assure that these programs are appropriately coordinated.

**Priorities:**

While location is not factored into eligibility, during application review, priority is given to providers whose location and discipline increase access to Medicaid services. This includes providers in Lagging Counties, Health Professional Shortage Areas, Federally Qualified Health Centers and Rural Health Centers. In a competitive cycle, high priority applicants are considered for award first.

**Award Levels:**

The CMLRP provides a performance-based loan repayment award to eligible professionals who provide a documented level of service to Medicaid enrolled children. The award level is limited to the total amount of the eligible provider’s health professional loan indebtedness, and can total as much as $140,000 for the four-year CMLRP participation period. In years 1 and 3 of a provider’s participation in CMLRP, a maximum award of $40,000 is possible. In years 2 and 4 of participation, the maximum award
is $30,000. For eligible primary care physicians and dentists, a half-award amount is possible for a lower performance level. For sub-specialists, no half-award is permitted.

CMLRP is not tied to practice in an underserved area, but rather to service for an underserved population. As such, it is not exempt from federal tax liability, as are other state loan repayment programs. Texas has recognized the challenges posed by this issue and is seeking to have federal law modified to incorporate the purposes of the CMLRP.

Application Process:

Eligible providers submit an application for the CMLRP during the open application period for each year. Applications are reviewed by a subgroup of the consent decree advisory committee and forwarded to the full committee for action. In the initial implementation of the CMLRP, the review subgroup included the Director of Medicaid and the Dental Director for the state. Successful applicants agree to participate in the CMLRP for a full four-year period, and receive conditional acceptance for that period. Acceptance is conditional on actual performance each year of participation. If, in any year, a participating provider fails to meet the minimum performance target set out in the agreement, s/he will be dropped from the program and will not be eligible for participation in other key programs. There is an appeal process available for participants proposed for termination. Reviews of each participant’s performance are conducted periodically throughout each year. Reviews are conducted by CMLRP staff in coordination with the Medicaid Program, which provides data on each participant’s services to Medicaid eligible children. There is some difficulty associated with finding individual provider Medicaid data for those clinicians practicing in group settings, such as those providers at FQHCs and RHCs. CMLRP has developed a separate reporting process for these participants.

Administration:

The CMLRP is administered by the Texas Health and Human Services Commission (HHSC), where the state Medicaid Program is located. HHSC contracts with the Texas Higher Education Coordinating Board to handle the financial aspects of the program. The Board manages the payment of awards on behalf of participating providers. Payments are made to loan holders on an annual basis. The Board subcontracts with the Primary Care Office for outreach to potential applicants and for management of the application, performance monitoring and review processes. The subcontract supports 3 FTEs in the PCO. The time of additional PCO staff, including that of the PCO Director, is not included under the contract.

Impact:

In its first year, the CMLRP received more than 440 applications. In its second year CMLRP received more than 460. The total number of awards made was limited by the funding available for the program. In each of the first two application cycles CMLRP made 300 awards. In the first year 140 primary care physicians received awards and 50 subspecialist physicians received awards with the balance of the awards going to dentists. In the second year 300 additional awards were made with 100 awards each going to primary care physicians, subspecialist physicians and dentists. Most awards were for the maximum amount permissible, with some smaller awards going to providers with total indebtedness
less than $140,000. Approximately 30 awards in each year went to providers in rural areas, with the bulk of awards going to urban-based providers in communities with a large number of Medicaid eligible children.

The combination of CMLRP with other incentives developed as a result of the lawsuit has had a significant impact on the provision of services to Medicaid eligible children. During the last four years the average number of Medicaid eligible children seen by primary care physicians has increased from 50 to 150 per month. There has been a three-fold increase in Medicaid eligible children seen by subspecialist physicians from 15 to 45 per month.

When fully operational, the CMLRP will be providing incentives to 1,200 eligible providers at any given time. Unfortunately, this large impact has a significant cost. Texas is facing serious budgetary problems and has eliminated funding for new CMLRP awards in the next budget period.

New Mexico: Retention Incentives for Health Professionals

Overview:

The New Mexico Rural Health Care Practitioner Tax Credit Program (RHCPTCP) provides an individual state income tax credit to eligible health care practitioners who provide health care services in a designated rural health care underserved area. The tax credit is awarded for each year in which an eligible provider can document the completion of a full year of eligible practice. Tax credits are available for providers in all practice settings, including private practice, community clinic, and hospital-based settings. It is available to both generalists and sub-specialists in eligible provider categories.

Background:

The New Mexico RHCPTCP was developed in 2007 as part of a Governor’s rural health initiative. It was modeled after a successful Oregon program and adapted to the specific needs of New Mexico. The program was created as part of a package of rural health workforce improvement efforts. It was developed as a recruitment and retention incentive for rural health professionals, with recognition that it was primarily a tool for retention of health professionals already in rural practice.

Eligibility:

The tax credits of the RHCPTCP are available to a wide range of licensed health care clinicians, including:

- allopathic and osteopathic physicians;
- dentists;
- clinical psychologists;
- podiatrists;
- optometrists;
- dental hygienists;
- physician assistants;
- nurse practitioners;
- nurse-midwives;
Case Study: Primary Care Offices and Health Workforce Incentive Programs

- nurse anesthetists; and
- clinical nurse specialists.

Tax credits are available for those providers practicing at least half-time (1,040 hours) during a calendar year in a designated rural underserved area. The New Mexico Department of Health has identified eligible practice locations for different categories of providers. Eligible providers must be licensed or certified for practice in the State of New Mexico. Eligible providers in federal employment who are licensed in other states are also eligible for the tax credits.

Practice time is defined as all types of work time related to the provision of clinical services, not just face-to-face time with patients. This includes time spent:

- providing services to patients;
- traveling to eligible practice locations;
- managing/administering health care provision;
- participating in continuing professional education; and
- on routine annual or sick leave.

This broad definition of practice makes it a more useful incentive for a broad range of providers, including those who travel from urban locations to practice in rural areas.

**Award Levels:**

The RHCPTCP provides two levels of awards for full-time (2,080 hours) practice in an eligible underserved rural location. Those providers with doctorate level training (physicians, dentists, clinical psychologists, optometrists and podiatrists) are eligible for an individual state income tax credit of up to $5,000 per year. Other eligible providers can receive a tax credit of up to $3,000 per year. Eligible providers working at least half-time, but less than full-time at an approved location can receive up to half the full-time award – either $2,500 or $1,500. This is not limited to continuous, year-long practice, but can include any combination of eligible practice hours totaling at least 1,080. These tax credit awards are **non-refundable**. This means that the tax credits can only be applied to the actual tax liability of the eligible provider. Any excess amount will not result in a tax refund. Unused tax credits may, however, be rolled over to offset tax liability in subsequent years.

**Application Process:**

Eligible providers submit an annual application to the New Mexico Department of Health (NMDOH) documenting practice in an approved location during the previous calendar year. Applications can be submitted for review at any time after the end of that calendar year. After review and approval by Department of Health staff, a certificate of eligibility is issued to eligible providers. Each participating provider completes an appropriate tax schedule and attaches it with a copy of the certificate of eligibility to his/her state income tax return. The tax return schedule form includes a section which permits applicants to request any carryover tax credit from previous years.
Case Study: Primary Care Offices and Health Workforce Incentive Programs

Administration:

The RHCPCTP is administered cooperatively by NMDOH and the Taxation and Revenue Department (NMTRD). NMDOH manages all activities associated with the application and eligibility certification process, including the identification of eligible practice locations. The NMTRD handles the issuance of appropriate tax credits to eligible providers. All program materials, including application forms and lists of approved practice areas, were developed with the input of an advisory group representing the state’s health professionals.

Within the Department of Health, the RHCPCTP is managed by staff of the Primary Care Office. The PCO is a logical choice for this effort, as it can coordinate the activities with its other shortage designation and health workforce development duties. Approximately 2 FTE staff is assigned to the RHCTCP, supported by state funds.

Impact:

More than 1,500 rural health care practitioners annually receive certificates of eligibility for participation in the program. Approximately half the participants – more than 750 - are physicians, including both specialist and primary care physicians. About a quarter of the participants – more than 350 – are non-physician providers of medical services, including nurse practitioners and physician assistants. Another fifth of the participants – more than 300 – are providers of oral health services, including dentists and dental hygienists. The balance of the participants includes psychologists, podiatrists and optometrists.

About 40 participants annually are certified nurse anesthetists. Between 50 and 60 participants annually are clinical psychologists. While these numbers are relatively small, they represent more than half of the entire complement of these providers in rural parts of New Mexico. Nurse anesthetists are particularly important for the state’s rural health system, as they handle the bulk of anesthesiology duties in rural hospitals.

Tax credits with a maximum value exceeding $5 million are issued each year. About 25% of the awards – more than 400 - go to health care providers working part time in approved areas. Part time participants include full-time health care practitioners who split their time between urban and rural locations. Over 80% of the program’s current year participants were also participants in previous years, underscoring the RHCPCTP’s importance as a retention incentive.

The statistics of the program reinforce the anecdotal feedback received from program participants. Program staff have been told by numerous participants that the incentive, while relatively small monetarily, is sufficient to keep them working in rural areas. For health care providers with no education debt and who are salaried or contracted, it is the only rural practice incentive available.
Conclusion: Future Trends and Innovation

The two programs profiled in this case study point out potential future directions for state and federal health workforce development programs. As implementation of the ACA proceeds, and until such time as the supply of health professionals increases substantially, governments will need policy and program tools similar to the ones implemented in Texas and New Mexico. Health workforce incentives will need to become more targeted to address developing trends in the health services market.

One major trend is the increasing number of health professionals who exclude certain patients from their practices. Reports indicate that some physicians are capping the number of Medicare patients they accept while others are refusing to accept any Medicare patients. In some markets physicians are limiting the number of visits per year of their Medicare patients. Some physician and dentist practices place similar limits on Medicaid patients. These practice management approaches severely limit the availability of health services for communities.

Performance-based financial incentives can be used to reverse the limitations that might otherwise be established by health professional practices. The Texas CMLRP is an interesting example of this performance-based approach. Similar programs, potentially using other financial incentives, could be created to increase services to other target populations, including the elderly and chronically ill.

A second major trend is the increasing shortage of key health professionals, likely to become increasingly critical in the next decade. With inadequate numbers of new health professionals entering the workforce, it will be important to retain as many existing health professionals as possible. The bulk of state and federal health workforce incentive programs, including all educational loan repayment programs, are designed to redirect location of recently graduated health professionals. These programs do not impact the large percentage of health professionals who are currently in practice and have no remaining loan indebtedness. Incentives should be considered to help keep them in locations where they can provide care to the underserved and help increase the percentage of their practice that is directed to the underserved.

The New Mexico RHCPTCP demonstrates how an incentive program can be structured to help retain mid-career health professionals and keep their practices focused on the underserved. It benefits a wide range of health professionals, both salaried and proprietors, at all stages of their careers. Its approach can be modified to target any range of underserved populations.

The implementation of the Affordable Care Act will require innovative responses to assure that the health workforce is deployed in the most effective manner. States have independently developed innovative models which can be adapted by others, both at state and national levels, to meet the challenges of health care reform. State PCOs have knowledge and experience in the implementation of workforce incentive programs, and can therefore play an integral role in development of new programs and policy.
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