SUBJECT: Primary care physicians for medically underserved areas

COMMITTEE: Public Health — favorable, with amendment

VOTE: 7 ayes — Berlanga, Hirschi, Coleman, Delisi, Maxey, McDonald, Rodriguez

0 nays

2 absent — Glaze, Janek

SENATE VOTE: On final passage, April 4 — voice vote

WITNESSES: None

DIGEST: SB 979 would establish a state-local matching grant program allowing medically underserved communities to sponsor a physician by contributing start-up money. The bill also would expand the family practice residency training pilot program, amend requirements for physicians authorized to participate in certain student loan repayment plans and expand the Relief Services Program.

The Texas Board of Health would be required to establish and administer a program to increase the number of physicians providing primary care in medically underserved communities (MUCs). A MUC could sponsor a physician who had completed a primary care residency program within seven years of applying to participate in the program and who had agreed to provide primary care in the MUC.

The MUC could contribute start-up money for the physician for up to two years, which could be matched in whole or in part with state funds. The board would be prohibited from paying more than $25,000 to a community in a fiscal year without a specific finding of need by the community. Start-up money could only be used for reasonable costs incurred by a physician to establish a medical office and ancillary facilities for diagnosing and treating patients.

A MUC would be defined as a community located in an area of Texas with a medically underserved population. The U.S. Secretary of Health and Human Services could designate such areas or population groups as having a shortage of personal health services or the communities could instead meet certain criteria adopted by the board. These criteria could include a consideration of relevant demographic, geographic and environmental factors.

The board would be required to adopt rules for the administration of the program including:

• eligibility requirements for the MUC and physician;

• minimum and maximum community contributions to the start-up money for a physician to be matched with state money;

• conditions under which state money must be repaid by the community or physician;

• procedures for disbursement of money by the board, the form and manner of community contributions; and

• the contents of an agreement to be entered into by the parties to include at least a credit check for an eligible physician, community retention of interest in any property, equipment or durable goods for seven years and the requirement of full-time clinical practice for a participating physician.

To be eligible to receive money from the board, a MUC would have to apply and provide satisfactory evidence to the board that it had entered into an agreement with a physician for the physician to provide primary care in the community for at least two years.

The board would be required to prioritize the communities eligible for assistance under this program in order to ensure that the neediest communities could be provided with grants.

Physician training report. The Texas Higher Education Coordinating Board (THECB) would be required to report to the Legislature by December 1, 1996, the allocation of money to the Family Practice Residency Training Pilot Programs, Education Code sec. 61.506, as amended by the bill, for training family practice resident physicians and providing indigent health care.

Family Practice Residency Training Pilot Programs. SB 979 would transfer oversight of the family practice training pilot programs from the Department of Health to THECB and increase the number of family practice residency training pilot programs authorized from three to three to five. Each pilot program would have to provide services to an economically depressed or rural medically undeserved area of the state. One pilot program would be required to be located in an urban area, one pilot program would be required to be located in a rural area, and the others would have to be on the Texas/Mexico border.

Repayment of student loans by physicians. SB 979 would add a provision that would require that not more than 20 percent of the physicians receiving repayment assistance from THECB could be employed by the Texas Department of Health, the Texas Department of Mental Health and Mental Retardation, the Texas Department of Corrections or the Texas Youth Commission.

SB 979 would add clinical faculty and residents in an approved family practice residency training program to the eligibility list for participation in the Physician Education Loan Repayment Program.

A physician who received repayment assistance under the repayment program operated by THECB could not receive assistance under the proposed Medically Undeserved Community-State Matching Incentive Program. The Family Practice Residency Advisory Committee would be authorized to consider, among other criteria, whether the physician is or would be providing service to a MUC. The committee would establish priorities among eligible physicians for repayment assistance.

The bill would expand the use of relief service programs for rural physicians.

SUPPORTERS SAY:

Twenty-five Texas counties have no primary care physician and 229 of the state's 254 counties have been designated by the federal government as medically underserved. Finding close, convenient health care has been a struggle for rural Texans for too long. People in many parts of the state spend hours on the road traveling to see the nearest doctor. The Medically Undeserved Community-State Matching Incentive Program would provide an important tool in enticing more doctors to set up practices in areas of the state where they are truly needed.

The matching program would serve a legitimate public policy goal for a minimal investment. The state and medically underserved communities could provide an incentive in the form of "start-up" funds for physicians who agreed to serve a minimum of two years in the community providing needed medical assistance. This initial investment will pay off in the long run, as good, preventative care for individuals now would save money down the road when more costly medical treatments might be the only alternative.

Rural areas and the indigent would benefit. Medically underserved communities are designated by the U.S. Department of Health and Human Services as having inadequate levels of health services. As of July 1994, 229 of 254 Texas counties were either partially or wholly designed as MUCs; 24 percent of Texas MUCs were in urban areas, while 76 percent were in rural areas. Health care costs are often increased in shortage areas because people lacking access to primary care have little recourse but to use expensive emergency care for primary care or wait until severe and more costly complications set in before seeking needed medical attention.

Family Practice Pilot Programs. The bill would allow the creation of up to two new Family Practice Pilot Programs under the program established last session, with the Texas/Mexican border region targeted. The pilot programs already operate in Waco, Lubbock and Austin, and have been very successful over the past two years in providing a major source of indigent health care and training for family practice resident physicians.

Loan repayment. SB 979 would allow family practice doctors who join the faculty of a family practice residency program after completing their

own residencies to be eligible for tuition loan reimbursement assistance. This eligibility would enhance the ability of residency programs to recruit faculty. The average starting salary in residency programs is approximately $20,000 less than what a starting family doctor could earn in the private sector, but loan-repayment assistance would help even the benefits.

Relief Service Programs. Often doctors in rural communities cannot leave town because there are no other doctors to take their place while they are away. SB 979 would expand the use of relief service programs for rural physicians so they may not only leave their practices to attend continuing medical education programs, but will be supported through these relief service programs if they need to temporarily leave the area for other reasons, such as family emergencies. Expansion of these relief service programs is an important incentive for doctors who are considering setting up practices in rural communities.

OPPONENTS SAY:

Taxpayers should not subsidize health care for particular regions when, if allowed to work, the free market could adjust for any inadequacies existing in the system. The regions of the state that have a lack of doctors should unite their government, community and business leaders to work to develop their own incentive packages to bring doctors to their particular regions of the state.

SB 979 as originally filed would have limited to 10 the number of underserved medical communities that could be served through the community/state matching grant program in each year of the program. The bill now lacks that prudent cap. The potential increase in the state's participation from an open-ended program could place a greater fiscal burden on the state in future years.

NOTES:

The committee amendment would make technical and substantive changes, including a requirement for ranking community needs to ensure that the neediest communities could participate in the MUC incentive program.

The fiscal note determined that SB 979 could provide the legal basis for an appropriation of funds. The probable fiscal impact of implementing the provisions of the legislation would be $250,000 each year during the first five years, the LBB said.

A related bill, SB 1280 also on today's calendar, would create a statewide preceptorship program and expand community-based primary care residency positions.