LFC Requestor: LFC Contractor

2025 LEGISLATIVE SESSION
AGENCY BILL ANALYSIS

Section I: General

Chamber: House
Category: Bill
Number: 395
Type: Introduced

Date (of **THIS** analysis)**:** 02/19/2025
Sponsor(s): Anita Gonzales, Elizabeth "Liz" Thomson, Marianna Anaya, and Patricia A. Lundstrom
Short Title: Health Care Preceptor Tax Credit

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Section II: Fiscal Impact

APPROPRIATION (dollars in thousands)

Appropriation Contained		Recurring or Nonrecurring	Fund Affected
FY 25	FY 26		
$0	$0	N/A	N/A

REVENUE (dollars in thousands)

Estimated Revenue			Recurring or Nonrecurring	Fund Affected
FY 25	FY 26	FY 27		
$0	$0	$0	N/A	N/A

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY 25	FY 26	FY 27	3 Year Total Cost	Recurring or Non-recurring	Fund Affected
Total	$0	$0	$0	$0	N/A	N/A

Section III: Relationship to other legislation

Duplicates: None

Conflicts with: None

Companion to: None

Relates to: None

Duplicates/Relates to an Appropriation in the General Appropriation Act: None

Section IV: Narrative

1. BILL SUMMARY

a) Synopsis

House Bill 395 (HB395) proposes to add a new section of the Income Tax Act to give a tax credit up to one thousand dollars ($1,000) to individuals licensed as a medical doctor, osteopathic physician, advanced practice nurse, physician assistant, dentist, pharmacist, psychologist, or social worker preceptor who is supporting a new medical doctor, osteopathic physician, advanced practice nurse, physician assistant, dentist, pharmacist, psychologist, or social worker in their preceptorship.

The provisions of this act would apply to taxable years beginning on or after January 1, 2025.

Is this an amendment or substitution? ☐ Yes ☒ No
Is there an emergency clause? ☐ Yes ☒ No

b) Significant Issues

New Mexico continues to experience a shortage of medical providers, particularly in rural areas. According to the most recent data from 2021, published in a 2024 study by the University of New Mexico, the state needs an additional 334 primary care providers, 59 OB-GYNs, 10 general surgeons,119 psychiatrists, and 88 dentists to meet national benchmarks for provider-to-population ratios. Additionally, New Mexico faces a nursing shortage. Based on 2023 data, the state requires 5,822 more nurses and clinical nurse specialists to reach national benchmarks. (New Mexico Health Care Workforce Committee 2024 Annual Report).

As with any effort to increase the number of any type of provider, tax incentives are one potential strategy that can be used with an array of options to increase the number of individuals providing clinical services. Increasing incentives for preceptorships can encourage more medical professionals to train students, thereby expanding the pool of available clinicians. A study on nurse practitioners demonstrated the success of incentivization in growing the number of preceptors (https://pmc.ncbi.nlm.nih.gov/articles/PMC9022679/).

Georgia was the first state to establish a Preceptor Tax Incentive Program (PTIP) in 2014. Georgia providers are given tax credits **per rotation** of precepting. Providers earn $500 per rotation for the first

1-3 rotations, and $1,000 per rotation for 4-10 rotations. The maximum credit a provider can receive is $8,500. To qualify for the tax credit, providers must complete rotations at a list of approved institutions, all of which are non-profit organizations. As a result of this initiative, Georgia has become the leading model for Preceptor Tax Credit programs nationwide. (Preceptor Tax Incentive Program (PTIP))

Colorado offers the Rural and Frontier Health Care Preceptor Tax Credit, a program similar to HB395. However, this program operates on a **first-come, first-served basis** and is **limited** to 300 primary healthcare preceptors. Each qualifying preceptor can receive a $1,000 tax credit. (https://tax.colorado.gov/rural-and-frontier-health-care-preceptor-tax-credit)

Arizona's program is similar to HB395 but operates **through a grant system**. Preceptors receive a $1,000 grant per academic fiscal year, regardless of the number of preceptorships they provide during that period. (Preceptor Grant | Arizona Medical Association)

There are at least eight (8) states that enacted legislation addressing preceptor tax incentives. (https://www.healthworkforceta.org/wp-content/uploads/2023/12/Preceptor-Tax-Credits.pdf).

Without these types of incentives, providers are often recruited away from non-profits to for-profit organizations because they pay more for the services. Additionally, with the current reimbursement models for health care, some providers are limiting the number of students they can precept. The time and loss of revenue could be offset by higher incentives. https://mrinetwork.com/hiring-talent-strategy/why-medical-providers-are-leaving-major-hospital-chains-impacts-on-hiring-in-healthcare/.

Lastly, under the Rural Practitioner Tax Credit, these same providers could qualify for an additional tax credit. There is no language that prevents a provider from receiving both tax credits.

2. PERFORMANCE IMPLICATIONS

- Does this bill impact the current delivery of NMDOH services or operations?

  ☐ Yes ☒ No

  If yes, describe how.

- Is this proposal related to the NMDOH Strategic Plan? ☐ Yes ☒ No

  ☐ **Goal 1**: We expand equitable access to services for all New Mexicans

  ☐ **Goal 2**: We ensure safety in New Mexico healthcare environments

  ☐ **Goal 3**: We improve health status for all New Mexicans

  ☐ **Goal 4**: We support each other by promoting an environment of mutual respect, trust, open communication, and needed resources for staff to serve New Mexicans and to grow and reach their professional goals

3. FISCAL IMPLICATIONS

- If there is an appropriation, is it included in the Executive Budget Request?

☐ Yes ☐ No ☒ N/A

- If there is an appropriation, is it included in the LFC Budget Request?
  ☐ Yes ☐ No ☒ N/A
- Does this bill have a fiscal impact on NMDOH? ☐ Yes ☒ No

4. ADMINISTRATIVE IMPLICATIONS

Will this bill have an administrative impact on NMDOH? ☐ Yes ☒ No

5. DUPLICATION, CONFLICT, COMPANIONSHIP OR RELATIONSHIP

None.

6. TECHNICAL ISSUES

Are there technical issues with the bill? ☒ Yes ☐ No

There needs to be further clarification on what would classify as a "*eligible graduate student*" (page 2 line 25). Is it a newly licensed provider within a year (or other time frame) of obtaining license or only within the first month of receiving license?

There is no proportional tax credit award to recognize time spent as a preceptor. The credit is the same for a clinician who acts as a preceptor for one month as for another who acts as a preceptor for 12 months. A sliding credit schedule based upon months precepting could be more equitable.

This bill defines preceptorship as "*an uncompensated period of supervised clinical training during which a preceptor provides a program of personalized instruction, training and supervision to an eligible graduate student to enable the student to obtain an eligible professional degree*" (page 3, lines 16-20). This would appear to **exclude** preceptors working with post-graduate residency programs, such as medical residency programs, **including rural residencies**. It would also exclude preceptors who receive any monetary incentive for acting as preceptors. Expanding the eligibility to cover residency preceptoring, including compensated preceptoring, could expand the incentive to these efforts.

7. LEGAL/REGULATORY ISSUES (OTHER SUBSTANTIVE ISSUES)

- Will administrative rules need to be updated or new rules written? ☐ Yes ☒ No
- Have there been changes in federal/state/local laws and regulations that make this legislation necessary (or unnecessary)? ☐ Yes ☒ No
- Does this bill conflict with federal grant requirements or associated regulations?
  ☐ Yes ☒ No
- Are there any legal problems or conflicts with existing laws, regulations, policies, or programs? ☐ Yes ☒ No

8. DISPARITIES ISSUES

Rural areas struggle with a shortage of healthcare professionals, including administrative staff. Attracting and retaining healthcare providers in rural communities can be challenging due to factors such as limited career opportunities, lower reimbursement rates, and a lack of infrastructure. Consequently, programs to deal broadly with issues must first assess the abilities at each level – state, county and local – to overcome them. (https://pubmed.ncbi.nlm.nih.gov/37214231/).

9. HEALTH IMPACT(S)

Providing health care and public health services in rural areas poses challenges such as the ability to hire and maintain health care providers. Rural communities throughout the country, but especially in the West, face challenges in health care due to many factors including aging populations, closure and/or downsizing of hospitals (https://pubmed.ncbi.nlm.nih.gov/33011448/), aging out of local health providers (https://pubmed.ncbi.nlm.nih.gov/36205415/) and loss of younger people and changes in local economies away from extractive and agricultural economies. Rural and frontier communities face transportation and isolation. These and other issues create circumstances in which every community is unique in the strength of each of the factors and which ones affect unique health care issues especially health workforce shortages.

1. Health workforce shortages: Rural areas struggle with a shortage of healthcare professionals, including doctors, nurses, and specialists. Attracting and retaining healthcare providers in rural communities can be challenging due to factors such as limited career opportunities, lower reimbursement rates, and a lack of infrastructure. (https://pubmed.ncbi.nlm.nih.gov/35760437/) The labor force participation rate shows a more robust effect on healthcare spending, morbidity, and mortality than the unemployment rate. (https://pubmed.ncbi.nlm.nih.gov/24652416/)

2. Financial constraints: Rural communities have limited financial resources, making it challenging to invest in healthcare infrastructure, recruit healthcare professionals, and offer affordable healthcare services to residents.

10. ALTERNATIVES

None.

11. WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL?

If HB395 is not enacted, providers will not receive a tax credit for training other providers. This could cause providers to leave the state to train in other states that offer this incentive.

12. AMENDMENTS

None.