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National Health Service Corps: Background and Trends in Funding and Recruitment

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Summary

The National Health Service Corps (NHSC) is a pipeline for clinician recruitment and training. Its program objective is to increase the availability of primary care services to populations in Health Professional Shortage Areas (HPSAs). It aims to increase clinician availability by making loan repayment and scholarship awards to individuals in exchange for their agreement to serve as clinicians at approved sites. NHSC clinicians are mainly physicians, physician assistants, nurse practitioners, and behavioral/mental health professionals who must serve for a minimum of two years at an approved facility. An approved facility, for example, may be a Federally Qualified Health Center (FQHC) and FQHC Look-Alike, American Indian and Native Alaska Health Clinic, Rural Health Clinic, Critical Access Hospital, School-Based Clinic, Mobile Unit, Free Clinic, or Community Mental Health Center, and must be located in a federally designated health professional shortage area. All NHSC clinicians must fulfill a minimum of two years of NHSC service. The NHSC is administered by the Health Resources and Services Administration (HRSA), within the Department of Health and Human Services (HHS).

Congress established the NHSC in the Emergency Health Personnel Act of 1970 (P.L. 91-623) and has amended and reauthorized the program several times since its inception. In 2010, Congress implemented major revisions in the NHSC in the Patient Protection and Affordable Care Act of 2010 (ACA; P.L. 111-148). Most notably, the ACA permanently authorized the NHSC and created the Community Health Centers Fund (CHCF), a source of mandatory funding for the NHSC from FY2011 through FY2015. Additionally, the ACA amended statutory authorities pertaining to the NHSC's requirements for part-time service, teaching credits toward service obligations, and exclusions from an individual's gross income for those payments from state loan repayment or loan forgiveness programs that seek to increase health care access in designated HPSAs.

In FY2016, an estimated 9,100 NHSC clinicians are providing medical, dental, and other health care services to approximately 9.2 million individuals in rural and urban HPSAs. In addition, in FY2016, the NHSC is planning to award an estimated 2,654 new loan repayment agreements; 1,732 continuing loan repayment agreements; 117 student-to-service loan repayments; 433 state loan repayments; 165 new scholarships; and 16 continuing scholarships. During the five-year period from FY2011 through FY2016, the number of new NHSC awards averaged 5,595. In FY2014, the NHSC issued the largest number of awards, 5,620, in a single year. In FY2016, mental health providers, physicians, and nurse practitioners represent the largest number of NHSC clinicians. In recent years, congressional appropriators have expressed concerns about updating the methodology for designating areas where NHSC providers are placed, and interest in the possibility of authorizing pharmacists as NHSC clinicians.

For FY2016, the CHCF funded 100% of the NHSC budget. Funding for the CHCF was extended in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10). MACRA provided $310 million to support the NHSC in each of FY2015 through FY2017. The President's FY2017 budget request contains a request of $380 million, which includes $20 million in discretionary funds for behavioral/mental health initiatives, and $50 million in new mandatory funding for two treatment initiatives associated with opioid disorders (in addition to the extant $310 million in mandatory funding appropriated through MACRA).

This report summarizes the NHSC's recruitment and retention programs, and the NHSC's funding history from FY2010 through FY2016, and the FY2017 President's budget request.

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Introduction

The National Health Service Corps (NHSC) is a clinician recruitment and retention program that Congress created to reduce health workforce shortages in locations where clinicians historically have not served or have not served in numbers sufficient to address the needs of the local population. The NHSC consists of federal and state programs that recruit qualified individuals who agree to serve at approved facilities[1] located in federally designated health professional shortage areas (HPSAs)[2] for a minimum of two years. The federal NHSC program awards scholarships and loan repayments, and state programs award loan repayments only.

The NHSC awards scholarships to individuals studying in a program leading to a degree in medicine (allopathic or osteopathic)[3] or a degree in dentistry, or in a program that trains physician assistants, nurse-midwives, or nurse practitioners. NHSC makes loan repayment agreements available to clinicians in the professions that the scholarship program permits and expands the list of clinicians to include dental hygienists and behavioral/mental health (BMH) providers.[4] Further, the state loan repayment program includes all the NHSC approved scholarship and loan repayment providers and expands its list to clinicians who are trained in other disciplines (such as pharmacy or optometry). All NHSC scholars and loan repayers (federal and state) must agree to serve for a minimum of two years[5] at an NHSC-approved facility that is located in a HPSA.[6]

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[1] For a list of NHSC-approved facilities and sites, see HHS, HRSA, *National Health Service Corps Site Reference Guide*, http://www.nhsc.hrsa.gov/downloads/sitereference.pdf.

[2] HHS, HRSA, *Shortage Designation: Health Professional Shortage Areas & Medically Underserved Areas/Populations*, http://www.hrsa.gov/shortage/. According to federal criteria for designating a HPSA, a shortage area can be an urban or rural location, a population group, or a medical facility where there is a critical need for health clinicians. HPSAs may be designated as having a shortage of primary medical care, dental, or mental health providers. The NHSC uses only HPSA data to determine need for clinicians.

[3] Allopathic (MD) or Osteopathic (DO) Physicians must be Board certified in a primary care specialty from a specialty board approved by the American Board of Medical Specialties or the American Osteopathic Association or have completed a residency program in a primary care specialty, approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association; and have a current, permanent, and unrestricted medical license that meets state licensure requirements. HHS, HRSA, *National Health Service Corps Scholarship Program, Application and Program Guidance, Mar. 2016*, https://nhsc.hrsa.gov/downloads/spapplicationguide.pdf, p. 6.

[4] The NHSC gives scholarships and loan repayments to U.S. citizens only. *National Health Service Corps Scholarship Program, Application and Program Guidance*, p. 6.

[5] Certain exceptions may affect this period-of-service requirement. For example, the period of service may be longer if an individual agrees to serve for more than two years, such as on a part-time basis, or if the scholarship or loan repayment benefit continues beyond the two-year minimum, at http://nhsc.hrsa.gov/.

[6] There are two federal designations for underservice: the Health Professional Shortage Area and the Medically Underserved Area and Population (MUA/P), see *Shortage Designation: Health Professional Shortage Areas & Medically Underserved Areas/Populations.* "Medically Underserved Areas/Populations are areas or populations designated by HRSA as having too few primary care providers, high infant mortality, high poverty or a high elderly population. Health Professional Shortage Areas (HPSAs) are designated by HRSA as having shortages of primary medical care, dental or mental health providers and may be geographic (a county or service area), population (e.g., low income or Medicaid eligible) or facilities (e.g., federally qualified health center or other state or federal prisons)," see HHS, *HRSA Data Warehouse*, http://datawarehouse.hrsa.gov/tools/analyzers/muafind.aspx. NHSC clinicians (loan repayers and scholars) must serve at an NHSC-approved service site; time spent at an unapproved site does not counts towards the clinician's service commitment, see HHS, HRSA, *National Health Service Corps Loan Repayment Program*, https://nhsc.hrsa.gov/loanrepayment/lrpapplicationguidance.pdf, p. 30; *National Health Service Corps Scholarship Program, Application and Program Guidance*, p. 24-25. Regarding NHSC site/location, a state's Primary Care Office (PCO) may coordinate the HPSA or MUA/P designation process, which could affect where an NHSC clinician is placed, *National Health Service Corps Site Reference Guide*, http://www.nhsc.hrsa.gov/downloads/sitereference.pdf, p. 22.

The NHSC's programs are managed within the Bureau of Health Workforce (BHW) in the Health Resources and Service Administration (HRSA), an agency in the Department of Health and Human Services (HHS). Because its clinicians are employed at facilities that provide care to the underserved, such as Federal Health Centers[7] and Rural Health Clinics (RHCs), the NHSC is an integral part of the health safety net.[8]

Brief History

The purpose of the NHSC program, which was created in the Emergency Health Personnel Act of 1970,[9] is to provide an adequate supply of trained health providers in federally designated locations where clinicians are in short supply and access to care is limited. Over the 45 years of the NHSC's existence, Congress has reauthorized and revised the program several times. In 2010, Congress permanently authorized the NHSC in the Patient Protection and Affordable Care Act of 2010 (ACA; P.L. 111-148, as amended).[10] In addition, the ACA

- established the Community Health Center Fund (CHCF),[11] which authorized mandatory appropriations[12] for the NHSC (and the Federal Health Center Program)[13] from FY2011 through FY2017;[14]

[7] CRS Report R43937, *Federal Health Centers: An Overview*, by (name redacted) .

[8] Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), *FY2017 Justification of Estimations for Appropriations Committees*, p. 79. (Hereinafter, *Justification of Estimations for Appropriations Committees.*)

[9] P.L. 91-623 was enacted on Dec. 31, 1970. The NHSC is authorized in Sections 331-338 of the Public Health Service Act (42 U.S.C. §254d et. seq.). The federal regulation states the purpose of the loan repayment (42 CFR § 62.21) and the scholarship program (42 CFR § 62.1).

[10] The ACA was signed into law on Mar. 3, 2010 (P.L. 111-148, 124 Stat. 119). On Mar. 30, 2010, the President signed the Health Care and Education Reconciliation Act (HCERA; P.L. 111-152, 124 Stat. 1029), which amended numerous health care and revenue provisions in the ACA and added multiple new stand-alone provisions. Congress and the President have since enacted several other bills that have made more targeted changes to specific ACA provisions.

[11] The CHCF is established in Section 10503 of the ACA. The purpose of the CHCF was "to provide for expanded and sustained national investment in community health centers under section 330 of the Public Health Service Act and the National Health Service Corps," according to S.Amdt. 3276 (111th Congress), which amended H.R. 3590, ACA. The ACA provision for the CHCF expired in FY2015. For a discussion on the CHCF, see CRS Report R43911, *The Community Health Center Fund: In Brief*, by (name redacted) .

[12] Mandatory, or direct, spending generally refers to outlays from budget authority (i.e., the authority to incur financial obligations that result in government expenditures such as paying salaries, purchasing services, or awarding grants) that is provided in authorizing laws, as opposed to annual appropriations acts. Mandatory spending includes spending on entitlement programs (such as the Medicare and Social Security programs). See CRS Report R41301, *Appropriations and Fund Transfers in the Affordable Care Act (ACA)*, by (name redacted) .

[13] According to HRSA, "Federally qualified health centers (FQHCs) include all organizations receiving grants under Section 330 of the Public Health Service Act (PHS). FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors. Certain tribal organizations and FQHC Look-Alikes (an organization that meets PHS Section 330 eligibility requirements, but does not receive grant funding) also may receive special Medicare and Medicaid reimbursement," HHS, HRSA, *What are Federally qualified health centers?,"* http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Introduction/qualified.html. See CRS Report R43937, *Federal Health Centers: An Overview*, by (name redacted) .

[14] The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10) was signed by the President on Apr. 16, 2015. MACRA amended Section 10503(b)(2)(E) of the ACA, and extended the CHCF through FY2017. For information on MACRA, see CRS Report R43962, *The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10)*, coordinated by (name redacted)

- required the Secretary to redefine how HPSAs and Medically Underserved Areas/Populations are designated;[15]
- implemented a part-time option from which NHSC clinicians may choose to fulfill their service commitments;
- authorized a policy that excludes from taxed income the money that an individual receives from NHSC and similar loan repayment and scholarship programs that are designed to increase health care access in HPSAs or other designated underserved areas; and
- authorized a policy that permits NHSC clinicians to count time spent teaching at teaching health centers[16] toward the fulfillment of their NHSC service commitment.

This report summarizes the NHSC's recruitment and retention programs, salient trends, and the NHSC's funding history from FY2010 through FY2016, and the President's FY2017 budget request.

Recruitment and Retention Programs

Various sections in Title III of the Public Health Service Act (PHSA) authorize clinician recruitment and retention programs as part of the NHSC. NHSC participants must agree to a period of service in a federally designated HPSA in exchange for scholarships and/or loan repayment. If NHSC scholars and loan repayers are in good standing and eligible for additional awards, they may receive continuation awards, thereby extending the clinician's length of service in a HPSA.

The NHSC supports programs at the federal and state levels. The federal program supports loan repayments and scholarships, with the loan repayment program making the majority of all federal awards. States participating in the NHSC receive federal funding in the form of matching funds.[17] Nearly all NHSC programs offer continuation agreements to qualified individuals, with the objective of increasing the NHSC clinician field strength and length of time served in a HPSA. Each state has the authority to make awards for loan repayments according to its needs, but in a manner that is consistent with federal regulation.[18]

[15] Section 5602 of the ACA mandated the Secretary of HHS to create a "Negotiated Rulemaking Committee on Designation of MUPs and HPSAs" to review criteria for the designation of Medically Underserved Areas and Health Professional Shortage Areas and MUA/Ps. The committee released a report on Oct. 1, 2011, but the Committee's report was not unanimous; therefore, the Secretary is not required to use the report when drafting the new rule. For the Committee's report, see http://www.hrsa.gov/advisorycommittees/shortage/nrmcfinalreport.pdf. As of the publication date of this CRS report, HRSA has not released a final rule.

[16] Teaching health centers support residency training in primary care and dentistry in community-based, ambulatory settings. *FY2015 Justification of Estimations for Appropriations Committees*, http://www.hrsa.gov/about/budget/budgetjustification2015.pdf.

[17] The law requires that a state's matching funds for NHSC State Loan Repayment Program consist of non-federal contributions in cash in an amount equal to a minimum of $1 for each $1 of federal funds provided in the grant (42 U.S.C. § 254q–1 (b).

[18] See, federal regulations at 42 CFR § 62.51 through §62.58 (Subpart C—Grants for State Loan Repayment Programs).

Scholarship Program

PHSA Section 338A establishes the NHSC Scholarship Program, which recruits students who are enrolled in medical school, physician assistant school, dental school, or advance practice nursing school. Qualified individuals may receive financial support through scholarships, which include tuition, reasonable education expenses, and a monthly living stipend. Students must be enrolled in a fully accredited training program, and they may receive up to four years of benefits in exchange for a service commitment. With each full year (or partial year) of support after the first year, the student must agree to provide an additional year of service in a HPSA. For example, if a qualified student gets three years of scholarship support they would owe six years of full-time service.[19]

Federal Loan Repayment Program

PHSA Sections 338B and 331(i)[20] establish the Federal Loan Repayment Program, which is designed to recruit licensed professionals, including physicians, physician assistants, dentists, dental hygienists, advanced practice nurses, and behavioral/mental health workers.[21] These professionals must be employed or have accepted an offer to be employed at an NHSC-approved work site. Federal loan repayers have a choice of service options based on full- or part-time service.

For full-time service, an individual may receive amounts up to $50,000 for an initial two-year obligation, when serving at an NHSC-approved site with a HPSA score of 14 or above.[22] Also, for full-time service, an individual who serves at an NHSC service site with a HPSA score of 13 or lower is eligible to receive up to $30,000 for an initial two years of service.

Students to Service (S2S) Loan Repayment Program

PHSA Section 338B[23] establishes authority for the Secretary of HHS to create the Students to Service (S2S) Loan Repayment Program, which began in 2012. The S2S program provides assistance of up to $120,000 to medical students (allopathic and osteopathic) in their final year of medical school. In return for the loan repayment, the S2S loan repayer must complete an approved primary care residency[24] in a HPSA of the greatest need for at least three years (full time) or six years (half time).[25] Alternatively, the S2S loan repayer may complete post-graduate training as an intern or geriatrics fellow in an approved specialty for a period of one year.[26]

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[19] For more information, see HHS, NHSC, *Scholarship Program Overview*, http://www.nhsc.hrsa.gov/scholarships/overview/.

[20] Respectively, 42 U.S.C. § 254*l*-1, as amended; and 42 U.S.C. § 254d(i), as amended.

[21] A behavioral/mental health worker in the NHSC may be a Licensed Clinical Social Worker, Licensed Professional Counselor, Health Service Psychologist, Marriage and Family Therapist, Physician (i.e., a Psychiatrist), Nurse Practitioner (i.e., a Psychiatric Nurse Specialist), or Physician Assistant (i.e., Mental Health & Psychiatry). See HHS, HRSA, *National Health Service Corps Loan Repayment Program, FY2016*, Jan. 2016, p. 7, https://nhsc.hrsa.gov/loanrepayment/lrpapplicationguidance.pdf.

[22] Severity of need is determined by a scoring process that the Secretary applies to each designated area. A high-need HPSA is defined as a HPSA score of 14 or above; the higher the score, the greater the need for an NHSC clinician, *National Health Service Corps Loan Repayment Program, FY2016*, Jan. 2016, p. 4-5.

[23] 42 U.S.C. § 254*l*1(a)(2) requires the Secretary to establish an NHSC loan repayment program to recruit health professionals as needed.

[24] Students must complete a residency in family practice, general internal medicine, general pediatrics, general psychiatry, obstetrics-gynecology, internal medicine/family practice, or internal medicine/pediatrics.

[25] In FY2016, for the S2S Program, sites with HPSAs scores of 14 or above are determined to be of high-need. See (continued...)

State Loan Repayment Program

PHSA Section 338I authorizes the State Loan Repayment Program. The State Loan Repayment Program is similar to the Federal Loan Repayment Program, except that (1) it is a matching grant between the state and the NHSC, and (2) states can choose to expand or contract the number of clinicians in their program. States have the option of addressing their unique workforce needs by choosing from additional types of professionals, such as registered nurses and pharmacists (who are ineligible to participate in the federal loan repayment program). Federal statute, regulation, and a program document provide additional guidance for clinician selection in the State Loan Repayment Program.[27]

Special Loans for Former Corps Members to Enter Private Practice

PHSA Section 338G establishes an additional option for NHSC participants. This provision authorizes the Secretary to make a single loan to an NHSC member on the condition that the member must serve as a full-time private practice provider in a HPSA for a minimum of two years, in exchange for a loan in amounts up to $25,000. This option has never been implemented.[28]

Trends in Recruitment

Within the past five years, from FY2011 through FY2015, the NHSC offered more than 27,000 loan repayment agreements and scholarship awards to individuals who have agreed to serve for a minimum of two years in a HPSA. The following is a summary of those awards:

- 23,854 federal loan repayment agreements (new and continuing);
- 1,084 scholarship awards (new and continuing);
- 322 students to service agreements (new only); and
- 2,206 state loan repayment awards (defined by each state).

In FY2013 through FY2016, the NHSC gave more than 96% of its awards to federal loan repayers, and the remaining 4% to scholars.[29]

In FY2011, the NHSC awarded more than 4,000 new federal loan repayments, the largest number of new loan repayments in a single year due to a larger program appropriation.[30] **Table 1** shows

(...continued)

HHS, HRSA, *National Health Service Corps, Students to Service Loan Repayment Program, FY2016,* http://nhsc.hrsa.gov/loanrepayment/studentstoserviceprogram/applicationguidance.pdf, p. 5.

[26] *Students to Service Loan Repayment Program, FY2016,* pp. 6-7.

[27] PHSA Section 338I(a)(2) (42 U.S.C. § 254q–1) authorizes the Secretary to make grants to states for the NHSC State Loan Repayment program provided that a state agency agrees to administer the program. Within 42 CFR § 62.54, the state agencies administering the State Loan Repayment Program must comply with regulations to ensure that their health workforce meets requirements for training, placement in medically underserved areas, and comparability to the NHSC Federal Loan Repayment Program, among other things. For program guidance, see HHS, *State Loan Repayment Contacts*, http://nhsc.hrsa.gov/loanrepayment/stateloanrepaymentprogram/contacts.html.

[28] Email communication from HHS, HRSA, Office of Legislation, Dec. 12, 2013.

[29] These percentages exclude state loan repayment awards. *FY2017 Justification of Estimations for Appropriations Committees*, p.82-83; and **Table 1** contains details on the types of loan repayment awards and scholarships.

[30] In FY2011, the NHSC received $315 million in appropriated funds, representing a 121.8% increase over the previous year (from $141 million in FY2010 to $315 million in FY2011) (see, "Trends in Funding" in this report).

NHSC clinician recruitment activity for the NHSC's active programs, by type of award, from FY2011 through FY2016, and the President's budget request for FY2017.

Table 1. NHSC Recruitment, FY2011-FY2016, and the President's FY2017 Budget Request

By Number of Awards or Agreements (Except for States, by Number of Participants)

Program	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017 Pres. Req.
Federal Programs							
Federal Loan Repayment Agreements (New)	4,113	2,342	2,106	2,775	2,943	2,654	2,442
Federal Loan Repayment Agreements (Continuing)	1,305	1,925	2,399	2,105	1,841	1,732	2,006
Total Federal Loan Repayment (New & Continuing)	*5,418*	*4,267*	*4,505*	*4,880*	*4,784*	*4,386*	*4,448*
Scholarship Awards (New)	253	212	180	190	196	165	146
Scholarship Awards (Continuing)	9	10	16	7	11	16	13
Total Scholarship Awards (New & Continuing)	*262*	*222*	*196*	*197*	*207*	*181*	*159*
Students to Service Loan Repayment Agreements	—	69	78	79	96	117	167
President's FY2017 Proposed Mental Health Opioid Initiative Loan Repayment							878
President's FY2017 Proposed Behavioral Health Initiative Loan Repayment							351
State Program							
State Loan Repayment Agreements (Number of Participants)	394	281	447	464	620	433	500

Source: Prepared by CRS, based on data in Department of Health and Human Services, Health Resources and Services Administration, *FY2016 Justification of Estimations for Appropriations Committees,* Rockville, MD, pp. 81-82; in *FY2017 respectively,* pp. 82-83.

Note: SLRP participants are selected by, and contract with, state grantees.

Trends in Funding

As recent as FY2009 annual discretionary appropriations were the sole funding source for the NHSC since its inception in 1972.[31] Now, the opposite is true with mandatory funding accounting for all (through FY2016) funding for NHSC. The ACA created a provision directing the CHCF to transfer $11 billion in mandatory funds over a five-year period (FY2011-FY2015) to support the NHSC and federal health center programs; the NHSC received various amounts beginning in FY2011, as shown in **Table 2**.[32]

Table 2. NHSC Funding, FY2011-FY2016, and the President's FY2017 Budget Request

(Dollars in millions)

Funding	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016 Enacted	FY2017 Pres. Req.	FY2017 +/- FY2016
Discretionary	$25	—	—	—	—	—	$20	+20
CHCF Mandatory	$290	$295	$285[a]	$283[b]	$287[c]	$310[d]	$310[d]	0
New B/M/H Mandatory							$50	+50
Total	**$315**	**$295**	**$285**	**$283**	**$287**	**$310**	**$380**	**+$70**
% CHCF Mandatory	92%	100%	100%	100%	100%	100%	82%	0

Sources: Table prepared by CRS based on information from Department of Health and Human Services, Health Resources and Services Administration, *Justification of Estimations for Appropriations Committees,* Rockville, MD, *volumes* FY2013 through FY2017. Numbers may not add up evenly due to rounding. Data are subject to updates to reflect changes in legislation.

Notes: Abbreviations in the table and table notes are: ACA—Patient Protection and Affordable Care Act; BCA—Budget Control Act of 2011; CHCF—Community Health Center Fund; NHSC—National Health Service Corps; MACRA—Medicare Access and CHIP Reauthorization Act of 2015.

a. The ACA (P.L. 111-148, as amended) appropriated $300 million in mandatory funding for the NHSC to be used in FY2013. However, this amount was subject to the 5.1% non-exempt mandatory program spending reduction, resulting in $284.7 million. The sequestration order was issued pursuant to the BCA (P.L. 112-25), as amended, which established new budget enforcement mechanisms for reducing the federal deficit through FY2024.

b. The ACA appropriated $305 million in mandatory funding for the NHSC to be used in FY2014. However, this amount was subject to the 7.2% non-exempt mandatory program spending reduction, resulting in $283 million (see previous note).

c. The ACA appropriated $310 million in mandatory funding for the NHSC to be used in FY2015. However, this amount was subject to the 7.3% non-exempt mandatory program spending reduction, resulting in $287 million (see previous note).

d. The MACRA (P.L. 114-10) amended the ACA (Section 10503(b)(2)(E)) to extend mandatory funding for the NHSC from FY2016 through FY2017, at $310 million. Unlike the prior three years, MACRA did not require a reduction in NHSC funding.

[31] For more information on the HHS budget, see CRS Report R44287, *Labor, Health and Human Services, and Education: FY2016 Appropriations*, coordinated by (name redacted) and (name redacted).

[32] These funds were directly appropriated to the CHCF. The ACA specified an annual amount to be transferred from the CHCF to the NHSC each year.

In FY2015, when authority for NHSC funding through the mandatory CHCF expired, Congress extended this funding through the Medicare Access and CHIP Reauthorization Act (MACRA) (P.L. 114-10).[33] MACRA extended the mandatory CHCF, authorizing a transfer of funds to the NHSC, in the amount of $310 million for each of FY2016 and FY2017.

From FY2012 through FY2016,[34] the CHCF has been the sole funding source for the NHSC, as Congress appropriated no discretionary funds to this program during this period.[35] In each of FY2013 through FY2015, these mandatory funds have been subject to reductions due to sequestration required by the Budget Control Act of 2011 (BCA), as amended (see **Table 2**).[36] On February 9, 2016, the Obama Administration released its FY2017 budget. The President's FY2017 budget request includes a total of $380 million for the NHSC, which would increase the NHSC budget by approximately 22% (+$70 million) over the previous year. The request consists of

- $20 million in discretionary funds,
- $50 million in new mandatory funds, and
- $310 million in funds previously appropriated in MACRA.[37]

The President's FY2017 budget proposes that all new NHSC funding in FY2017 be directed to expand access to behavioral health services. Specifically, the request would expand the use of medication-assisted treatment (MAT) through investments in the NHSC, including loan repayment to clinicians with MAT training. The FY2017 budget also includes $25 million in new mandatory funding for FY2017 and FY2018 as part of an initiative by the Obama Administration to expand access to mental health care.[38]

The President's FY2017 request proposes funding that would support an increase in field strength by 27% over the previous year, thereby proposing to serve 10.7 million individuals (which would be an increase of 1.1 million individuals over the previous year).

Field Strength

NHSC field strength is the number of NHSC clinicians who are fulfilling a service obligation in a HPSA in exchange for a scholarship or loan repayment agreement.[39] As of September 2015, total

[33] See CRS Report R43962, *The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10)*, coordinated by (name redacted)

[34] The most recent discretionary funding for the NHSC was for FY2011, when the NHSC received $24.8 million (see, **Table 2**).

[35] The NHSC and the federal health centers program are administered by HRSA. For more discussion on the NHSC's budget through the ACA, see CRS Report R41301, *Appropriations and Fund Transfers in the Affordable Care Act (ACA)*, by (name redacted) .

[36] The Budget Control Act of 2011 (BCA) amended the Balanced Budget and Emergency Deficit Control Act of 1985 (BBEDCA). "Sequestration" is a process of automatic spending reductions where budgetary resources are permanently canceled to achieve certain budget policy goals. The process was first authorized by the Balanced Budget and Emergency Deficit Control Act of 1985 (BBEDCA, Title II of P.L. 99-177, commonly known as the Gramm-Rudman-Hollings Act).

[37] *FY2017 Justification of Estimations for Appropriations Committees*, p.17.

[38] *FY2017 Justification of Estimations for Appropriations Committees*, p. 11.

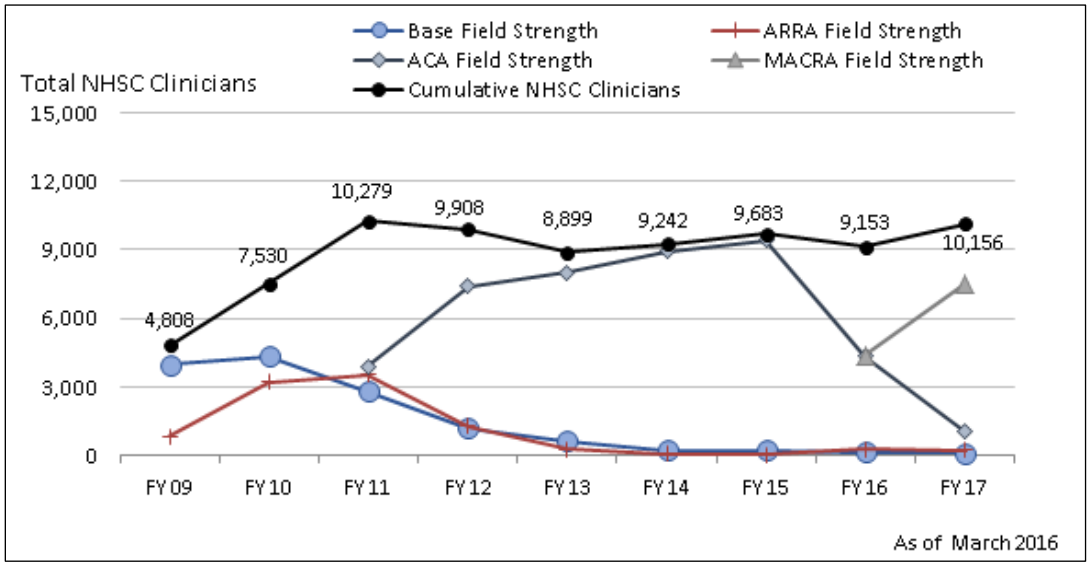
[39] National Advisory Council on the National Health Service Corps, *Meeting Minutes Summary* , HHS, Hilton Washington, DC/Rockville Hotel & Executive Meeting Center, Rockville, MD, Rockville, MD, 2012, p. 2, https://nhsc.hrsa.gov/corpsexperience/aboutus/nationaladvisorycouncil/meetingsummaries/011912minutes.pdf.

NHSC field strength was 9,683, which enabled NHSC clinicians to serve an estimated 10.2 million individuals in HPSAs.[40]

Changes in the size of the NHSC's field strength are, not surprisingly, shaped by appropriation levels.[41] For example, increases in funding from FY2010 to FY2011 resulted in a 36% increase in field strength, from 7,530 to 10,279.

As the NHSC's field strength size has increased or decreased, the number of individuals served by NHSC clinicians has been correspondingly impacted. For example, in FY2011, when the NHSC appropriation peaked at $315 million, NHSC clinicians served 10.5 million individuals, compared to 9.3 million individuals in FY2013 and 10.2 million individuals in FY2015, respectively.[42] The President's FY2017 budget, if enacted, would increase field strength size by as much as 11% above the FY2015 level, resulting in a projected field strength of 10,156 (see **Figure 1**).

Figure 1. Trends in NHSC Field Strength Size by Budget Source, FY2011-FY2017 (Est.)



Source: Prepared by CRS, based on data in Department of Health and Human Services, Health Resources and Services Administration, *Justification of Estimations for Appropriations Committees,* Rockville, MD, volumes FY2013-FY2016.

Notes: *Base Field Strength* represents clinicians who are supported through discretionary funds. *ARRA Field Strength* represents clinicians who are supported through "ARRA funds," which were appropriated in the American Recovery and Reinvestment Act of 2009 (ARRA; P.L. 111-5). *ACA Field Strength* represents clinicians who received appropriations through the mandatory Community Health Center Fund (CHCF), which was authorized in the Affordable Care Act (ACA) (P.L. 111-148). *MACRA Field Strength* represents clinicians supported by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (P.L. 114-10), which extends ACA mandatory funding for the NHSC in FY2016 and FY2017. *Cumulative Field Strength* represents total field strength for the year.

[40] Total NHSC field strength includes only those providers that are fulfilling a service obligation for a scholarship or loan repayment. Total NHSC field strength excludes providers, who are not obligated to the NHSC. Non-obligated providers and NHSC providers may serve alongside each other in the same HPSA..

[41] See section on "Funding" for a detailed discussion of these NHSC funding sources.

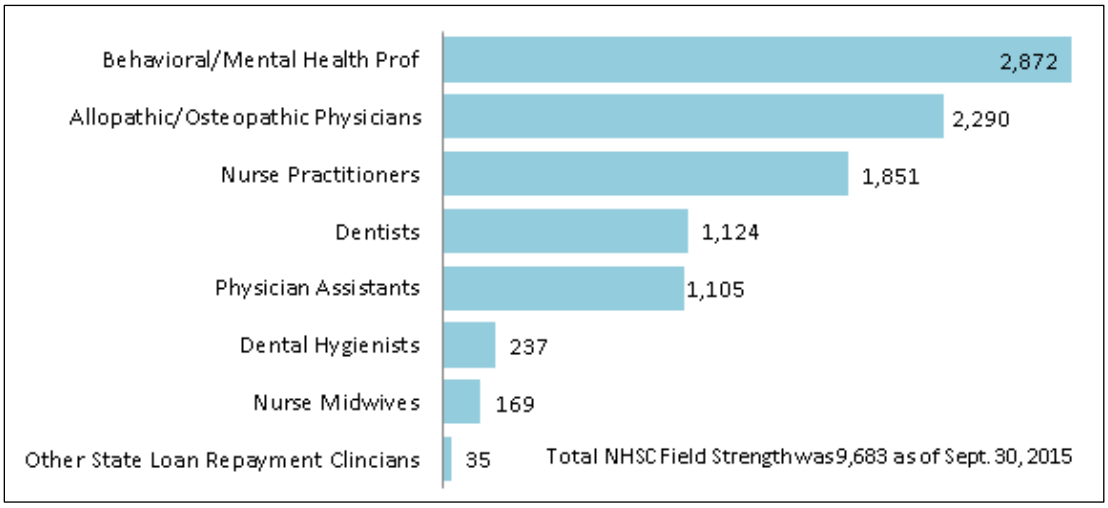
[42] *Justification of Estimations for Appropriations Committees*, for volumes FY2013, FY2015, and FY2017.

Composition

As of FY2015 behavioral/mental health clinicians comprise the majority of the NHSC's field strength, and have done so since FY2010. Physicians and nurse practitioners are the next largest number of disciplines comprising NHSC field strength.[43] Over time, Congress has requested that the Secretary consider adding other disciplines to the NHSC. In FY2015, Congress recognized the Secretary's authority to add other disciplines to the NHSC, and urged the Secretary to include pharmacists in the NHSC loan repayment and scholarship programs. In FY2012, the Secretary expanded eligibility for the NHSC State Loan Repayment Program (SLRP) to pharmacists (see **Figure 2**).[44]

The President's FY2017 budget request contains a first-time proposal that would target an increase in the number of behavioral/mental health providers in the NHSC. If authorized, this measure would add 351 behavioral health providers, and 878 mental health and opioid providers to the NHSC's field strength.[45]

Figure 2. NHSC Field Strength by Discipline as of September 2015



Source: Prepared by CRS, based on data in Department of Health and Human Services, Health Resources and Services Administration, *FY2017 Justification of Estimations for Appropriations Committees,* Rockville, MD, p. 75.

Notes: Allopathic physicians hold a Doctor of Medicine (M.D.) degree; osteopathic physicians hold a Doctor of Osteopathic Medicine (D.O.) degree. "Other State Loan Repayment Clinicians" may include registered nurses and pharmacists.

[43] *FY2011 Justification of Estimations for Appropriations Committees*, p. 69.

[44] *FY2017 Justification of Estimations for Appropriations Committees*, pp. 426-427.

[45] In addition to this FY2017 request for NHSC funding to increase the number of health workers to provide opioid-related health services, the FY2017 budget includes $10 million for the Rural Opioid Overdose Reversal Program, which focuses on prevention, treatment, and intervention of opioid use in rural communities. See, *FY2017 Justification of Estimations for Appropriations Committees*, p. 13.

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