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National Health Service Corps: Background, Funding, and Programs

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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 repayments and awarding scholarships to individuals in exchange for their agreement to serve as NHSC clinicians (or providers) at approved sites. NHSC providers 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 HPSA. All NHSC providers must fulfill a minimum of two-year service commitment at an NHSC-approved site. The NHSC is administered by the Health Resources and Services Administration (HRSA), within the Department of Health and Human Services (HHS). Congress created the NHSC in the Emergency Health Personnel Act of 1970 (P.L. 91-623), and since then has reauthorized and amended its programs several times. The Patient Protection and Affordable Care Act of 2010 (ACA; P.L. 111-148) permanently reauthorized the NHSC.

Legislation to potentially repeal or replace all or parts of the ACA, depending on its scope, may impact NHSC authorization and funding. In 2010, Congress implemented major revisions in the NHSC through the ACA. Most notably, the ACA permanently authorized the NHSC and created the Community Health Center Fund (CHCF), a source of mandatory funding for the NHSC from FY2011 through FY2015. This funding was subsequently 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 FY2016 and FY2017 through the CHCF. MACRA is the sole source of NHSC funds in FY2017. (Because this fund is subject to the mandatory spending sequester, the FY2017 funding level is \$289 million.) In addition, 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 federally designated HPSAs.

In FY2015, the most recent annual data available, the NHSC awarded 2,934 new loan repayment agreements; 1,841 continuing loan repayment agreements; 96 student-to-service loan repayments; 620 state loan repayments; 196 new scholarships; and 11 continuing scholarships. In FY2014, the NHSC issued the largest number of awards, 5,620, in a single year. Mental health providers, physicians, and nurse practitioners represented the largest number of NHSC clinicians in recent years. Also, 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. The 21st Century Cures Act (P.L. 114-255) expanded the list of NHSC providers to include child and adolescent psychiatrists. This report summarizes the NHSC's recruitment and retention programs, and the NHSC's funding trends from FY2010 through FY2017.

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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 providers 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 facilities¹ located in federally designated health professional shortage areas (HPSAs)² for a minimum of two years. The federal program awards scholarships to, and makes loan repayment agreements with, individuals; the state programs make loan repayment agreements, only, to individuals. All NHSC scholars and loan repayers (federal and state) must agree to serve for a minimum of two years³ at an NHSC-approved facility that is located in a HPSA.⁴

The federal portion of the NHSC program awards scholarships to individuals studying in (1) a qualified academic program that leads to a degree in medicine (allopathic or osteopathic)⁵ or a degree in dentistry, or (2) a qualified program that trains physician assistants, nurse-midwives, or nurse practitioners. Further, NHSC makes loan repayment agreements with eligible providers who may be dental hygienists and mental and behavioral/mental health (BMH) providers, in addition to the aforementioned list of professionals who are scholarship-eligible.⁶ In December

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 (or providers). 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 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/>.

⁴ There are two federal designations for underservice: the Health Professional Shortage Area and the Medically Underserved Area and Population, 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 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 providers (loan repayers and scholars) must serve at an NHSC-approved service site; time spent at an unapproved site does not count towards the clinician’s service commitment, see HHS, HRSA, *National Health Service Corps Loan Repayment Program*, <https://nhsc.hrsa.gov/loanrepayment/lrapplicationguidance.pdf>, p. 30; *National Health Service Corps Scholarship Program, Application and Program Guidance*, pp. 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.

⁵ 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*, March 2016, <https://nhsc.hrsa.gov/downloads/spapplicationguide.pdf>, p. 6.

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

2016 Congress passed legislation to clarify that child and adolescent psychiatrists are eligible providers for the NHSC loan repayment program.⁷

The state portion of the NHSC's loan repayment program may support all providers who are eligible to participate in the federal scholarship and loan repayment programs, and each state may choose to expand the list of eligible providers to include those who are trained in other disciplines (such as pharmacy or optometry).

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). The NHSC was created in the Emergency Health Personnel Act of 1970⁸ to provide an adequate supply of trained health providers in federally designated HPSAs. Throughout its four decades of existence, legislators have authorized and revised the program several times, with the most recent authorization in the Patient Protection and Affordable Care Act (ACA).⁹ In 2010, Congress permanently authorized the NHSC in the ACA. In addition, the ACA

- established the Community Health Center Fund (CHCF),¹⁰ which authorized mandatory appropriations¹¹ for the NHSC (and the Federal Health Centers Program)¹² from FY2011 through FY2017;¹³

⁷ The 21st Century Cures Act (P.L. 114-255), enacted on December 13, 2016 specified such eligibility in Title IX, Subtitle B, Section 9023, Clarification On Current Eligibility For Loan Repayment Programs. The act requires the Administrator of HRSA to clarify eligibility for individuals who are considering the NHSC Loan Repayment Program, which is established in the PHS Act Section 338B(b)(1)(B).

⁸ P.L. 91-623 was enacted on December 31, 1970. The NHSC is authorized in Sections 331-338 of the PHS Act (42 U.S.C. §254d et. seq.). The federal regulation states the purpose of the loan repayment (42 C.F.R. §62.21) and the scholarship program (42 C.F.R. §62.1).

⁹ The ACA was signed into law on March 3, 2010 (P.L. 111-148, 124 Stat. 119). On March 30, 2010, President Obama 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. Since the law was passed, Congress and President Obama have enacted several other bills that have made more targeted changes to specific ACA provisions.

¹⁰ 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 PHS 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) .

¹¹ 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) .

¹² According to HRSA, "Federally qualified health centers (FQHCs) include all organizations receiving grants under Section 330 of the PHS Act. 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 (organizations that meet PHS Section 330 eligibility requirements, but do 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) (see Appendix B).

¹³ The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10) was signed by President Obama on April 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 of HHS to redefine how HPSAs and Medically Underserved Areas/Populations are designated;¹⁴
- implemented a part-time option from which NHSC clinicians (or providers) 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 centers¹⁵ toward the fulfillment of their NHSC service commitment.

In addition to this background, this report provides funding trends from FY2011 through FY2017, and a summary of the programs for the NHSC.

Funding

Until FY2009, and dating back to its inception in 1972, annual discretionary appropriations were the sole funding source for the NHSC.¹⁶ Now the opposite is true, with mandatory funding accounting for all (through FY2017) funding for NHSC. The ACA created the CHCF and provided mandatory funding for it over a five-year period (FY2011-FY2015). The act also directed the transfer of \$11 billion total from the CHCF over that period to support the NHSC and federal health center programs; the NHSC received various amounts beginning in FY2011. For FY2016 and FY2017, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10)¹⁷ extended the CHCF funding for the NHSC funding transfers, as shown in **Table 1**.¹⁸ The FY2017 NHSC funding level is \$288.6 million for this program, following a mandatory spending sequester for FY2017 of 6.9% (pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985, as amended).¹⁹

¹⁴ 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 federally designated areas where health care resources or professionals may not be adequate. The committee released a report on October 1, 2011, but its recommendations were not unanimous; therefore, the Secretary is not required to implement the recommendations when drafting a 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.

¹⁵ Teaching health centers support residency training in primary care and dentistry in community-based, ambulatory settings. *FY2017 Justification of Estimations for Appropriations Committees*, <http://www.hrsa.gov/about/budget/budgetjustification2017.pdf>.

¹⁶ For more information on the HHS budget, see CRS Report R44691, *Labor, Health and Human Services, and Education: FY2017 Appropriations*.

¹⁷ See CRS Report R43962, *The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10)*, coordinated by (name redacted)

¹⁸ 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.

¹⁹ The Balanced Budget and Emergency Deficit Control Act of 1985 was amended by the Budget Control Act of 2011 (BCA, P.L. 112-25) to provide a budget process mechanism that would reduce mandatory spending and further reduce discretionary spending over an extended period. For mandatory spending, the reductions are to occur through “sequestration” in each of fiscal years between FY2013-FY2025. (As originally enacted in the BCA, mandatory sequestration was scheduled to run through FY2021, but this period has subsequently been incrementally extended to FY2025 by P.L. 113-67, P.L. 113-82, and P.L. 114-74.)

Table 1. National Health Service Corps (NHSC) Funding, FY2011-FY2017
(Dollars in millions)

Funding	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
Discretionary	\$25 ^a	—	—	—	—	—	—
Mandatory	\$290	\$295	\$300 ^b	\$305 ^c	\$310 ^d	\$310 ^e	\$310 ^f
Final	\$315	\$295	\$285	\$283	\$287	\$310	\$289
% Mandatory	92%	100%	100%	100%	100%	100%	100%

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. The FY2017 amount is provided by the Department of Human Services (HHS), Health Resources and Services Administration (HRSA), Office of Legislation (OLA). Data are subject to updates to reflect changes in legislation.

Notes: Abbreviations in the table and table notes are: ARRA—American Recovery and Reinvestment Act of 2009; ACA—Patient Protection and Affordable Care Act; BBEDCA—Balanced Budget and Emergency Deficit Control Act of 1985; CHCF—Community Health Center Fund; NHSC—National Health Service Corps; MACRA—Medicare Access and CHIP Reauthorization Act of 2015; and Office of Management and Budget (OMB).

- a. ARRA represented a source of discretionary funds that were appropriated to the NHSC in FY2009, but those funds are not considered to be a FY2011 appropriation. Still, they were reflected in the FY2011 budget. ARRA contributed \$57 million (not shown in the table) for federal loan repayments. See *Justification of Estimations for Appropriations Committees*, Rockville, MD, vol. FY2013, p. 76.
- b. 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% mandatory spending sequestration, resulting in a total of \$284.7 million for FY2013. The sequestration order was issued pursuant to the BBEDCA, as amended. See footnote 32 for further information.
- c. ACA appropriated \$305 million in mandatory funding for the NHSC to be used in FY2014. However, this amount was subject to the 7.2% mandatory spending sequestration, resulting in \$283 million (see footnote 32).
- d. ACA appropriated \$310 million in mandatory funding for the NHSC to be used in FY2015. However, this amount was subject to the 7.3% mandatory spending sequestration, resulting in \$287 million (see footnote 32).
- e. MACRA (P.L. 114-10) extended mandatory funding for the NHSC, as part of the CHCF, for FY2016 and FY2017, at \$310 million in mandatory funding each fiscal year. However, this funding extension was enacted after the mandatory spending sequester for FY2016 was calculated by OMB. As a consequence, OMB did not include the FY2016 funding in the sequester calculation, and thus no sequester was ordered for the NHSC funding in FY2016. (See *OMB Report to Congress on the Joint Committee Reductions for Fiscal Year 2016*, February 2, 2015, available at https://obamawhitehouse.archives.gov/sites/default/files/omb/assets/legislative_reports/sequestration/2016_jc_sequestration_report_speaker.pdf.)
- f. MACRA appropriated \$310 million in mandatory funding for the NHSC to be used in FY2017. (See table note “e” for an explanation on the MACRA appropriation.) However, this amount is subject to the 6.9% mandatory spending sequestration, resulting in \$289 million (see footnote 32).

From FY2012 through FY2016,²⁰ the CHCF was the sole funding source for the NHSC, as no discretionary funds were appropriated to this program during this period.²¹ In each of FY2013 through FY2015, these mandatory funds were subject to the mandatory spending sequestration

²⁰ The most recent discretionary funding for the NHSC was for FY2011, when the NHSC received \$24.8 million (see **Table 1**).

²¹ 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).

that was required by the Balanced Budget and Emergency Deficit Control Act of 1985, as amended.²²

In FY2015, when authority for NHSC funding through the CHCF expired, this authority was extended through the enactment of MACRA on April 16, 2015. MACRA extended the mandatory funding for the CHCF and authorized a transfer of funds to the NHSC in the amount of \$310 million for each of FY2016 and FY2017. However, because this funding extension was enacted after the mandatory spending sequester for FY2016 was calculated by OMB, the FY2016 funding for the NHSC was not included in OMB's sequester calculation, and thus no sequester was ordered. The final FY2016 funding for the NHSC was \$310 million, whereas the final FY2017 funding level is estimated to be \$288.6 million due to the 6.9% mandatory sequester for FY2017.²³

Recruitment and Retention Programs

Various sections in Title III of the Public Health Service Act (PHS Act) 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.²⁴ 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.²⁵

Federal Scholarship Program

PHSA Section 338A establishes the NHSC Scholarship Program, which recruits students who are enrolled in medical school, physician assistant programs, dental school, or advance practice nursing school. Qualified students may receive financial support through scholarships, which include tuition, reasonable education expenses, and a monthly living stipend. They must be enrolled in a fully accredited training program, and may receive up to four years of benefits in

²² P.L. 99-177. See footnote 32 for further information about the Balanced Budget and Emergency Deficit Control Act of 1985 and sequestration.

²³ OMB calculated that the percentage reduction rate for nonexempt nondefense mandatory spending in FY2017 is 6.9%. All the CHCF funding for the NHSC is subject to this 6.9% reduction. See *OMB Report to Congress on the Joint Committee Reductions for Fiscal Year 2017*, February 9, 2016, available at https://obamawhitehouse.archives.gov/sites/default/files/omb/assets/legislative_reports/sequestration/jc_sequestration_report_2017_house.pdf. For more detail on the OMB calculation, see CRS Report R41301, *Appropriations and Fund Transfers in the Affordable Care Act (ACA)*, by (name redacted) (see Appendix B).

²⁴ The law requires that a state's matching funds for NHSC State Loan Repayment Program consist of nonfederal 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)).

²⁵ See, federal regulations at 42 C.F.R. §62.51 through §62.58 (Subpart C—Grants for State Loan Repayment Programs).

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 full-time service scholar receives three years of scholarship support the scholar would owe three years of full-time service at an approved facility.²⁶ The number of school years of NHSC scholarship support received by the scholar may not exceed four school years.²⁷

Federal Loan Repayment Program

PHSA Sections 338B and 331(i)²⁸ 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.²⁹ 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, a loan repayer 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.³⁰ Also, for full-time service, a loan repayer 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.

Federal Students to Service (S2S) Loan Repayment Program

PHSA Section 338B³¹ 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 residency³² in a HPSA of the greatest need for at least three years (full-time option) or six years (half-time option).³³ Instead of completing a primary care residency, the

²⁶ Each year, the NHSC uses HPSA scores to determine where NHSC scholars will be placed. For example, from October 1, 2016, through September 30, 2017, NHSC scholars must work at NHSC-approved service sites with a HPSA score of 17 or above for their discipline. HHS, HRSA, *NHSC Scholarship Program, School Year 2017-2018 Application & Program Guidance*, <https://nhsc.hrsa.gov/downloads/spapplicationguide.pdf>.

²⁷ *NHSC Scholarship Program, School Year 2017-2018 Application & Program Guidance*, p. 10.

²⁸ 42 U.S.C. §254I-1, as amended; and 42 U.S.C. §254d(i), as amended, respectively.

²⁹ 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, including Child and Adolescent Psychiatrists), 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, FY2017*, January 2017, pp. 10-17, <https://nhsc.hrsa.gov/loanrepayment/lrapplicationguidance.pdf>.

³⁰ 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, FY2017*, January 2017, pp. 16-17.

³¹ 42 U.S.C. §254I1(a)(2) requires the Secretary to establish an NHSC loan repayment program to recruit health professionals as needed.

³² 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.

³³ In FY2017, for the S2S Program, sites with HPSAs scores of 14 or above are determined to be of high-need. See HHS, HRSA, *National Health Service Corps, Students to Service Loan Repayment Program, FY2017*, <http://nhsc.hrsa.gov/loanrepayment/studentstoserviceprogram/applicationguidance.pdf>, p. 17.

S2S loan repayer may complete post-graduate training as an intern or geriatrics fellow in an approved specialty for a period of one year.³⁴

State Loan Repayment Program

PHSA Section 338I³⁵ 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 may choose to expand or contract the number of clinicians (or providers) 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.

Special Loans for Former Corps Members to Enter Private Practice

PHSA Section 338G³⁶ 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.³⁷

Trends in Recruitment

From FY2011 through FY2016, the most recent data, the NHSC offered an estimated 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).

The NHSC awarded an estimated 15,303 new federal loan repayments from FY2011 through FY2016, averaging 3,061 new federal loan repayments annually. A significant increase in new federal loan repayments was awarded in FY2011, when the NHSC awarded 4,113 new federal loan repayments, the largest number of new loan repayments issued in a single year during FY2011-FY2015. This increase was made possible by a larger program appropriation in

³⁴ *National Health Service Corps, Students to Service Loan Repayment Program, FY2017*, pp. 6-7.

³⁵ 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 C.F.R. §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>.

³⁶ 42 U.S.C. §254p.

³⁷ Email communication from HHS, HRSA, Office of Legislation, December 12, 2013.

FY2011.³⁸ **Table 2** shows NHSC clinician recruitment activity for the NHSC’s active programs, by type of award, from FY2011 through FY2016 (the FY2017 operating budget is not yet available).

Table 2. National Health Service Corps (NHSC) Recruitment, FY2011- FY2016 (est.)
By Number of Awards or Agreements (Except for States, by Number of Participants)

Program	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016 est.
Federal Loan Repayment Agreements (New)	4,113	2,342	2,106	2,775	2,934	2,654
Federal Loan Repayment Agreements (Continuing)	1,305	1,925	2,399	2,105	1,841	1,732
Total Federal Loan Repayment (New & Continuing)	5,418	4,267	4,505	4,880	4,775	4,386
Scholarship Awards (New)	253	212	180	190	196	165
Scholarship Awards (Continuing)	9	10	16	7	11	16
Total Scholarship Awards (New & Continuing)	262	222	196	197	207	181
Students to Service Loan Repayment Agreements		69	78	79	96	117
State Loan Repayment Agreements (Number of Participants)	394	281	447	464	620	433

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, pp. 81-82; in FY2016, and in FY2017, pp. 82-83.

Notes: Depending on the fiscal year, recruitment awards were funded through multiple budgetary sources. Those sources are discretionary funding through the annual appropriation; funding through the American Recovery and Reinvestment Act of 2009 (ARRA; P.L. 111-5); the Community Health Center Fund (CHCF), which was authorized in the Affordable Care Act (ACA) (P.L. 111-148); and 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. For example, from FY2009 through FY2011, ARRA funded federal loan repayment awards through discretionary funding. State Loan Repayment Program participants are selected by, and contract with, state grantees.

Trends in Field Strength and Composition

NHSC recruits, who remain committed to serve in a HPSA, eventually become the providers that make up its field strength. Field strength is the number of NHSC providers who are fulfilling a service obligation in a HPSA in exchange for a scholarship or loan repayment agreement.³⁹ In FY2015, the most recent data available, total NHSC field strength was 9,683, which enabled

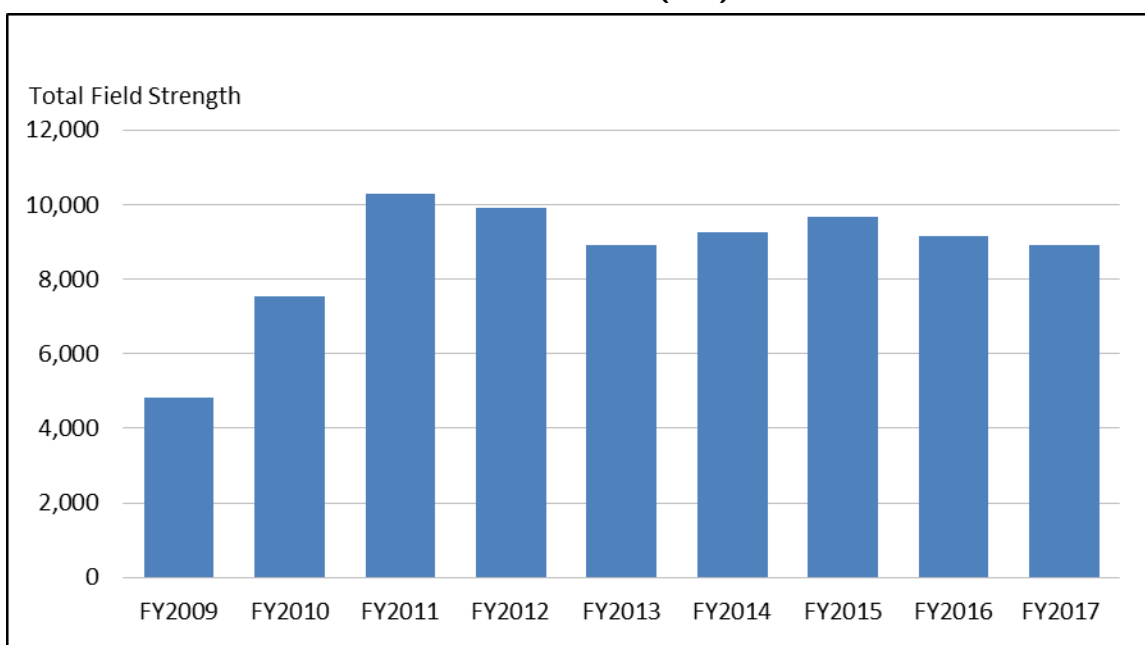
³⁸ In FY2011, the NHSC received a total of \$315 million in appropriated funds, representing a 121.8% increase over the previous year (from \$141 million in FY2010 to \$315 million in FY2011) (see “Funding” in this report).

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/meetingminutes/011912minutes.pdf>.

NHSC providers to serve an estimated 10.2 million individuals in HPSAs.⁴⁰ Changes in the size of the NHSC's field strength are 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 providers has been affected. For example, in FY2011, when the NHSC appropriation peaked at \$315 million, NHSC providers served 10.5 million individuals, compared with 9.3 million individuals in FY2013 and 10.2 million individuals in FY2015 (see **Figure 1**).⁴²

Figure 1. Trends in National Health Service Corps (NHSC) Field Strength, 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-FY2017.

Note: NHSC field strength is the number of NHSC clinicians or providers who are fulfilling a service obligation in a Health Professional Shortage Area (HPSA) in exchange for a scholarship or loan repayment agreement.

The NHSC's workforce composition consists of an increasingly diverse set of health professionals representing mental and behavioral health, medical, nursing, dental and other disciplines. Since FY2010, behavioral/mental health providers are the largest group of providers making up the NHSC's field strength.⁴³ Physicians and nurse practitioners are the next largest group of providers constituting NHSC field strength. Over time, Congress has requested that the

⁴⁰ Total NHSC field strength includes only those providers that are fulfilling a service obligation for a scholarship or loan repayment. This total excludes NHSC alumni that serve in HPSAs alongside NHSC providers but do not have a service obligation. Providers who serve in HPSAs but do not have an NHSC service obligation, such as those who are included in NHSC in retention efforts, are not counted in the NHSC's field strength.

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

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

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

Secretary of HHS 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 as eligible to participate in NHSC loan repayment and scholarship programs. In FY2012, the Secretary of HHS expanded eligibility for the NHSC State Loan Repayment Program (SLRP) to include pharmacists.⁴⁴

In FY2015, the most recent year for which complete data are available, the following three professional groups made up 73% of the NHSC:

- 30% are mental and behavioral health providers,
- 24% are allopathic and osteopathic physicians, and
- 21% are nurse practitioners (including nurse midwives).⁴⁵

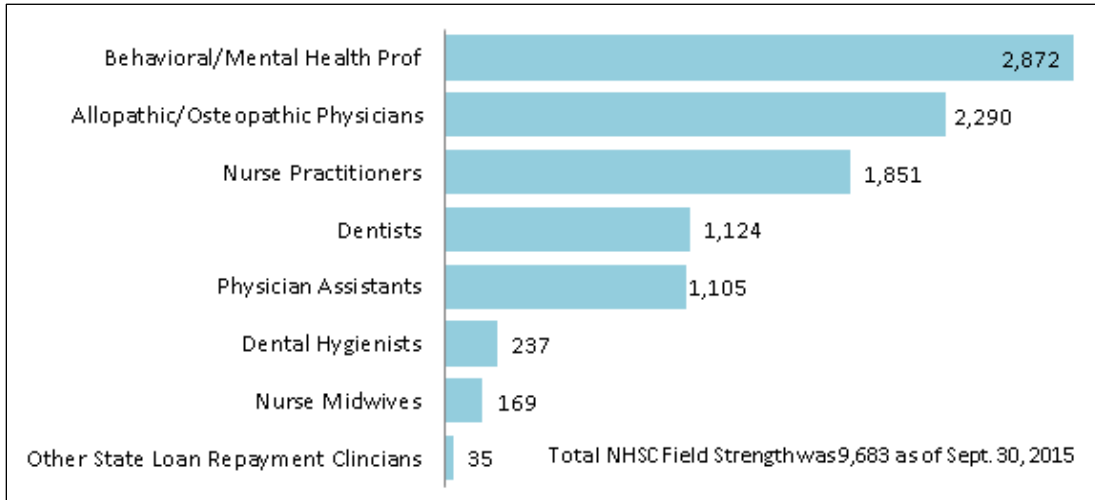
The composition of the NHSC workforce continues to be a subject of debate. In FY2009, physicians accounted for nearly 35% of providers and were the largest group of providers in the NHSC. Some argue for diversification of the NHSC workforce, arguing that many rural populations have little or no access to different types of providers, while opponents argue that the NHSC mission might be spread too thin if too many specialists were added to the program. In December 2016, child and adolescent psychiatrists were the newest group of professionals to be added to the list of NHSC-eligible providers for the loan repayment program.⁴⁶ **Figure 2** shows the NHSC's workforce by provider type in FY2015, the most recent year for which complete data are obtained.

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

⁴⁵ *HRSA FY2017 Justification*, p. 75. Advanced Practice Nurses (APNs) make up 21% of the NHSC's workforce; 2% of these are nurse-midwives. According to the Joint APRN Joint Dialogue Group Report (of the American Nurses Association), July 7, 2008: "APNs include certified registered nurse anesthetists, certified nurse-midwives, clinical nurse specialists and certified nurse practitioners," https://www.ncsbn.org/Consensus_Model_for_APRN_Regulation_July_2008.pdf.

⁴⁶ The 21st Century Cures Act (P.L. 114-255), enacted on December 13, 2016 specified such eligibility in Title IX, Subtitle B, Section 9023, Clarification On Current Eligibility For Loan Repayment Programs. The act requires the Administrator of HRSA to clarify provider eligibility regarding PHSA Section 338B(b)(1)(B), which is the NHSC Loan Repayment Program. Note that although psychiatrists are physicians, they are counted as mental health professionals within the NHSC; they are counted separately from primary care physicians.

Figure 2. National Health Service Corps 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.

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