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National Health Service Corps: Changes in Funding and Impact on Recruitment

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Summary

The National Health Service Corps (NHSC) recruits and places trained individuals in underserved communities to provide health care services at approved sites. In exchange for a two-year service commitment in federally designated health professional shortage areas (HPSAs), individuals receive scholarships or loan repayments. NHSC clinicians may fulfill their service commitment at approved Federally Qualified Health Centers (FQHCs), FQHC Look-Alikes, Rural Health Clinics, Critical Access Hospitals, and other approved sites.

The primary objective of the NHSC is to increase the availability of primary care services to underserved populations. The NHSC offers scholarships, loan repayments, and loan forgiveness to individuals in selected health professions. In FY2015, an estimated 8,495 NHSC clinicians will provide medical, dental, and other health care services to 8.9 million individuals in underserved communities. Also, in FY2015, the NHSC will award an estimated 2,272 new loan repayment agreements; 1,629 continuing loan repayment agreements; 100 student to service loan repayments; 464 state loan repayments; 163 new scholarships; and 14 continuing scholarships to individuals in various health professions.

The NHSC was established in the Emergency Health Personnel Act of 1970 (P.L. 91-623), and it has been amended and reauthorized several times since its inception. Most recently, Congress revised the NHSC in the Patient Protection and Affordable Care Act of 2010 (ACA; P.L. 111-148) by amending statutory authorities associated with 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 HPSAs or other designated underserved areas. The NHSC is based within the Health Resources and Services Administration (HRSA), an agency in the Department of Health and Human Services (HHS).

The ACA created a new Community Health Center Fund (CHCF) and required that a total of $1.5 billion in mandatory CHCF appropriations be transferred to the NHSC over the course of FY2011 through FY2015. Prior to the ACA, Congress had appropriated funds for the NHSC solely through the discretionary appropriations process for the Departments of Labor, Health and Human Services, and Education, and Related Agencies (Labor-HHS-ED). Since FY2012, in the absence of discretionary funding, the CHCF has been the NHSC's only funding source. On April 16, 2015, the President signed P.L. 114-10, Medicare Access and CHIP Reauthorization Act (MACRA), which amends the ACA to extend mandatory funding for the NHSC from FY2015 through FY2017. Total NHSC funding, regardless of the source, affects the size of the NHSC health workforce that is available to provide health services in underserved areas. This report briefly summarizes the NHSC programs, describes recent trends in clinician service, reviews funding trends for FY2009 through FY2015, and includes data from the President's FY2016 budget.

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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 underserved areas. The NHSC recruits qualified individuals who agree to serve in federally designated health professional shortage areas[1] in exchange for scholarship awards and loan repayment agreements. NHSC scholars must study in a program leading to a degree in medicine (allopathic or osteopathic); a degree in dentistry; or in a program for physician assistants, nurse-midwifery, or nurse practitioners. On the other hand, NHSC loan repayers must be trained and licensed to provide direct patient care as allopathic or osteopathic physicians, physician assistants, nurse practitioners, certified nurse midwives, dentists, dental hygienists, or behavioral/mental health providers. All NHSC scholars and loan repayers must agree to serve at an NHSC-approved facility that is located in a health professional shortage area (HPSA), for a minimum of two years.[2]

The Emergency Health Personnel Act of 1970[3] created the NHSC to eliminate health workforce shortages in federally designated locations. Over the 45 years that the NHSC has existed, Congress has reauthorized and revised the program several times, and most recently permanently authorized and amended the NHSC in the Patient Protection and Affordable Care Act of 2010 (ACA; P.L. 111-148).[4] The ACA also established the Community Health Center Fund (CHCF),[5] which provides mandatory appropriations[6] for the NHSC and the Federal Health Center Program.[7] The ACA modified the law to

- require that a total of $1.5 billion in mandatory CHCF funding be transferred to the NHSC over the course of FY2011 through FY2015;

[1] A health professional shortage area is an urban or rural location, a population group, or a medical facility where there is a critical need for health clinicians, at http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/designationcriteria.html.

[2] 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/.

[3] 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.).

[4] P.L. 111-148 was signed into law on Mar. 23, 2010, and subsequently amended.

[5] The CHCF is established in Section 10503 of the ACA—a Senate amendment defined its purpose. S.Amdt. 3276 (111th Congress), which amended H.R. 3590, the Patient Protection and Affordable Care Act, states that the CHCF is "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." S.Amdt. 3276 was agreed to on December 22, 2009. See CRS Report R43911, *The Community Health Center Fund: In Brief*, by Elayne J. Heisler. For a discussion on the expiring mandatory CHCF, see CRS Report IN10185, *Congress Faces Calls to Address Expiring ACA Funds for Primary Care*, by Elayne J. Heisler and C. Stephen Redhead.

[6] 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 C. Stephen Redhead.

[7] Federal health centers provide care to medically underserved populations regardless of their ability to pay. See CRS Report R42433, *Federal Health Centers*, by Elayne J. Heisler.

- implement a part-time option from which NHSC clinicians may choose to fulfill their service commitments;
- excludes from an individual's gross income any amount that an individual receives under any state loan repayment or loan forgiveness programs that aim to increase health care access in HPSAs or other designated underserved areas;
- permit NHSC clinicians to count time spent teaching toward the fulfillment of their NHSC service commitment; and
- require the Secretary to redefine how HPSAs are designated.

The NHSC is based in the Bureau of Health Workforce (BHW) within the Health Resources and Service Administration (HRSA), an agency in the Department of Health and Human Services (HHS). The NHSC is an integral part of the health safety net, as its clinicians are employed at facilities that provide care to the underserved, such as Federal Health Centers and Rural Health Clinics (RHCs).[8] All NHSC clinicians complete service requirements at NHSC-approved facilities, with most serving at federal health centers or at RHCs.[9]

From FY1972 through FY2011, the NHSC received discretionary funding through the annual Labor-HHS-ED appropriations bills.[10] Beginning in FY2011, the mandatory CHCF began to transfer funds to supplement the NHSC discretionary appropriation. However, in FY2012 and subsequent years, no discretionary funds were appropriated to the NHSC. Instead, the mandatory CHCF has been the sole source of NHSC funding. This funding pattern is a potential concern because legislative authority and appropriations for the CHCF will expire at the end of September 2015. The NHSC's reliance on the CHCF is raising concern among program advocates who represent health professional consortia, institutions, and underserved populations that benefit from, or are associated with, the NHSC's scholarship and loan repayment programs.[11]

On February 2, 2015, the Obama Administration released its FY2016 budget request, which would provide $810 million for the NHSC through a combination of discretionary funds ($287 million) and new mandatory funds ($523 million). This budget request represents an overall increase of $523 million (+182.2%) from the FY2015 operating level of $287 million.[12]

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[8] The National Advisory Committee on Rural Health reported to the Secretary of HHS on these and other health care safety net programs in *A Targeted Look at the Rural Health Care Safety Net*, April 2002, http://www.hrsa.gov/advisorycommittees/rural/healthsafetynet.pdf.

[9] Rural Health Clinics (RHCs) are outpatient facilities located in rural areas. They aim to address an inadequate supply of physicians serving Medicare patients in rural areas and to increase the use of non-physician practitioners such as nurse practitioners and physician assistants in rural areas. See HHS, Centers for Medicare and Medicaid Services (CMS), *Rural Health Clinics (Fact Sheet)*, http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/RuralHlthClinfctsht.pdf. Additional NHSC-eligible sites are FQHC Look-Alikes; School-Based Clinics (SBCs); Critical Access Hospitals (CAH); Community Mental Health Centers (CMHC); American Indian Health Facilities; correctional or detention facilities; state or local health departments; community outpatient facilities; and private practices. See HHS, HRSA, *Justification of Estimations for Appropriations Committees, FY2016*, Rockville, MD, pp. 72-73.

[10] For more information on the HHS budget, see CRS Report R43236, *Labor, Health and Human Services, and Education: FY2014 Appropriations*, coordinated by Karen E. Lynch.

[11] Association of Clinicians for the Underserved, *Save the NHSC*, see hyperlink for "NHSC Stakeholder Letter to Congress," April 7, 2014, http://clinicians.org/save-the-national-health-service-corps/. NHSC Stakeholders consist of more than 50 health-affiliated professional groups and institutions that have a health care-related interest in underserved populations.

[12] HHS, HRSA, *Justification of Estimations for Appropriations Committees, FY2016,* Rockville, MD, p. 72.

On April 16, 2015, the President signed the Medicare Access and CHIP Reauthorization Act (MACRA) (P.L. 114-10), which amends Section 10503(b)(2)(E) of the ACA to extend mandatory funding for the NHSC from FY2015 through FY2017.

This report describes the NHSC's recruitment and retention programs, presents trends in field strength, tracks funding history for FY2009 through FY2015, and includes details on the President's FY2016 budget request.

Recruitment and Retention Programs

Various sections of the Public Health Service Act (PHSA) authorize NHSC programs for clinician recruitment and retention. The PHSA also authorizes financial assistance in the form of scholarships and loan repayment. NHSC participants must agree to a period of service in a federally designated health professional shortage (or underserved) area in exchange for scholarships and/or loan repayment. If NHSC participants are scholars in good standing and eligible for additional awards, they may receive scholarship continuations; likewise, eligible loan repayers may receive loan repayment continuations. 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 an underserved area.

The PHSA establishes authority for the following NHSC programs or activities. 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 an underserved area.[13]

Section 338B establishes the Federal Loan Repayment Program, which recruits licensed professionals, including physicians, physician assistants, dentists, dental hygienists, advanced practice nurses, and mental/behavioral health workers. These professionals must be employed or have accepted an offer to be employed at an NHSC-approved work site. Qualified individuals may receive loan repayment agreements in amounts up to $50,000 (for a full-time service commitment) and up to $30,000 (for a part-time service commitment), depending on the severity of need for their selected work site.[14]

Section 338B authorizes the Secretary of HHS to establish the NHSC Students to Service (S2S) Loan Repayment Program, which recruits medical students in their last year of medical school to apply for loan repayment assistance of up to $120,000 in return for completing a primary care residency and working in a HPSA of the greatest need for at least three years.[15]

[13] For more information, see http://www.nhsc.hrsa.gov/scholarships/overview/.

[14] For more information, see http://www.nhsc.hrsa.gov/loanrepayment.

[15] For more information, see http://nhsc.hrsa.gov/loanrepayment/studentstoserviceprogram/index.html. Health Professional Shortage Areas of the greatest need are designated by HRSA.

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 have some flexibility in establishing loan repayment amounts for their clinicians, and for meeting their self-identified health care workforce needs. States may choose to offer continuation agreements to qualified professionals from the various health professions. Registered nurses and pharmacists are the only health professionals who are not included in the Federal Loan Repayment Program but are eligible for the State Loan Repayment Program. If states choose to offer loan repayments to other disciplines not recognized by the Federal Loan Repayment Program, such as optometrists and chiropractors, they may not fund them with NHSC federal or state matching funds.[16] The statute and federal regulation provide guidance to State Loan Repayment Programs on selecting health professionals.[17]

Table 1 shows NHSC clinician recruitment activity for the NHSC's active programs, by type of award, from FY2011 through FY2014, and the FY2015 estimate.

Table 1. NHSC Recruitment, FY2011-FY2015 (Est.)

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

Program	FY2011	FY2012	FY2013	FY2014	FY2015 Estimate
Scholarship Awards (New)	253	212	180	190	163
Scholarship Awards (Continuing)	9	10	16	7	14
Federal Loan Repayment Agreements (New)	4,113	2,342	2,106	2,775	2,272
Federal Loan Repayment Agreements (Continuing)	1,305	1,925	2,399	2,105	1,629
Students to Service Loan Repayment Agreements	—	69	78	79	100
State Loan Repayment Agreements (Number of Participants)	394	281	447	464	464

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, FY2016,* Rockville, MD, pp. 81-82.

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

PHSA Section 338G establishes an additional option for NHSC participants, but it has never been implemented.[18] The provision for Special Loans for Former Corps Members to Enter Private Practice authorizes the Secretary to make one loan to an NHSC member. The NHSC member

[16] For more information, see http://nhsc.hrsa.gov/loanrepayment/stateloanrepaymentprogram/index.html. Email communication from HHS, Office of Legislation, April 6, 2015.

[17] PHSA Section 338I(a)(2) requires that health professionals provide primary health care services. Within 42 C.F.R. §62.54, 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.

[18] Email communication from HHS, Office of Legislation, December 12, 2013.

must agree to serve as a full-time private practice provider in a federally designated health professional shortage area for a minimum of two years, and may apply for loans in amounts up to $25,000.

Field Strength

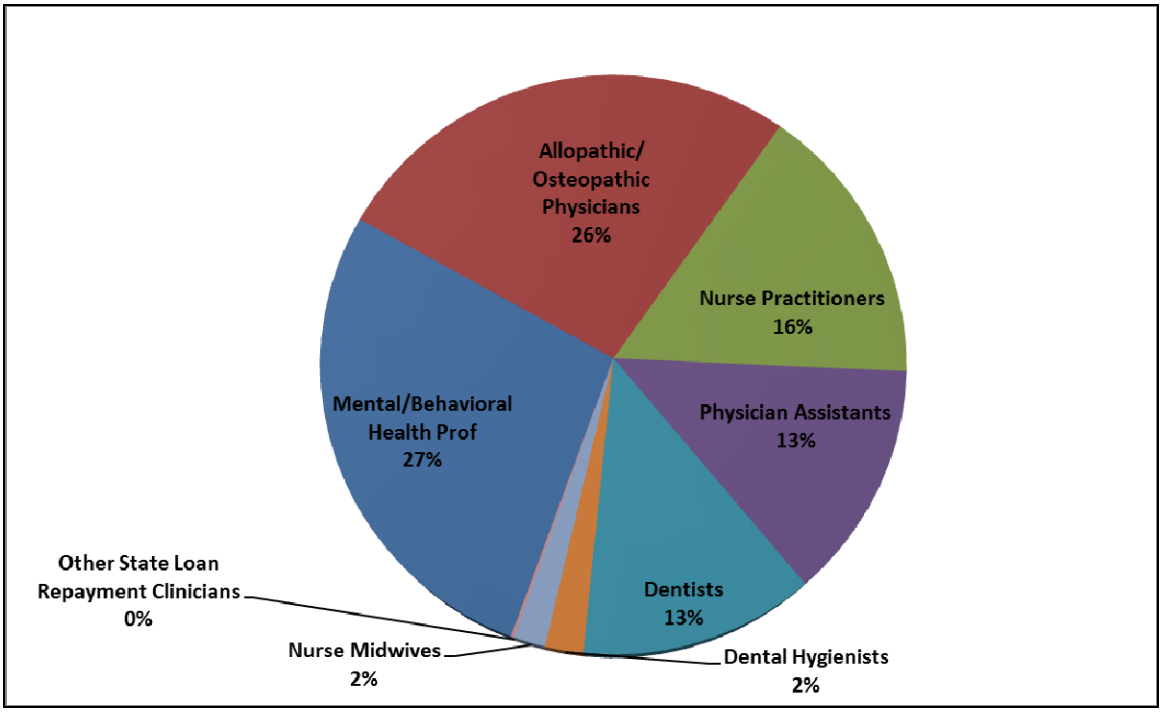
NHSC field strength represents the number of NHSC clinicians that are fulfilling service obligations in return for scholarships and loan repayment agreements. Yesterday's recruits—scholars and loan repayers—comprise today's field strength. As of September 30, 2014, a total of 9,242 NHSC clinicians comprised the NHSC's field strength.[19] From FY2009 through FY2011, NHSC field strength more than doubled, rising from 4,808 clinicians to 10,279. A decrease in field strength, relative to the FY2011 level, occurred in FY2012, with field strength standing at 9,908 clinicians in FY2012 and dropping further to 8,899 in FY2013. FY2015 field strength is an estimated 8,495, or 747 clinicians (-8%) less than the previous year.

Field strength reflects all the different types of disciplines that deliver health care services to underserved populations. Mental/behavioral health professionals and physicians (allopathic and osteopathic) make up more than half of the NHSC's field strength identifies these and other clinicians by discipline. Beginning in 2015, "HRSA is directed to evaluate the establishment of a demonstration project within the NHSC in which optometrists are recognized as primary health services providers for purposes of the Loan Repayment Program."[20]

[19] HHS, HRSA, *Justification of Estimations for Appropriations Committees*, *FY2016*, Rockville, MD, p. 83.

[20] Division G—Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2015, Explanatory Statement of the Consolidated and Further Continuing Appropriations Act, 2015, *Congressional Record*, Daily Edition, vol. 160, no. 151—Book 2, part 1 (December 11, 2014), p. H9828.

Figure 1. NHSC Disciplines as of September 2014



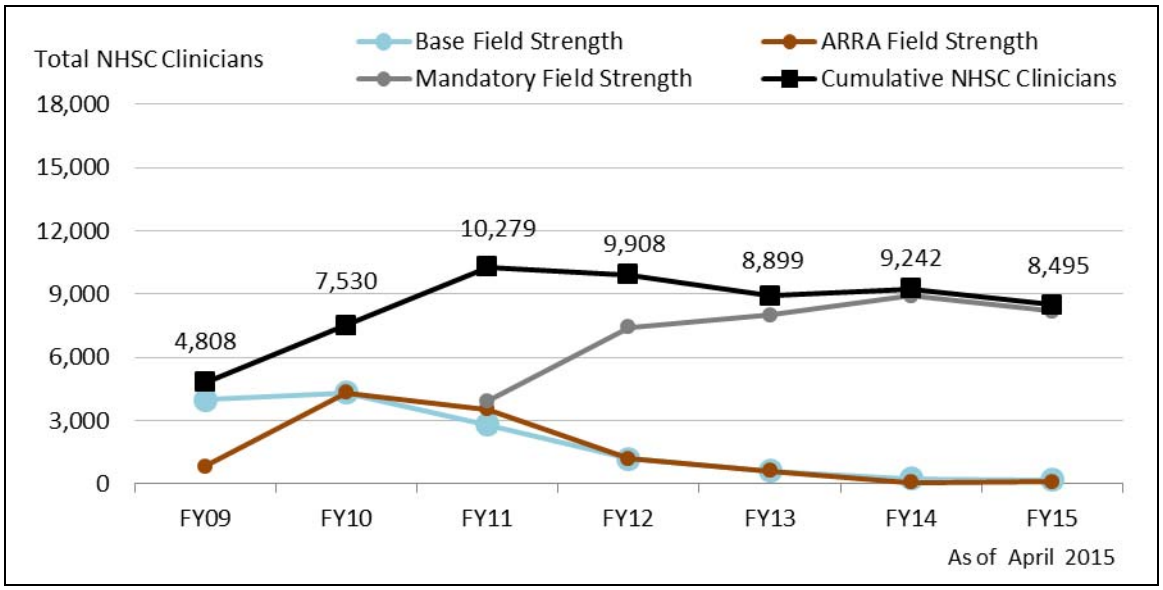
Source: Prepared by CRS, based on data in Department of Health and Human Services, Health Resources and Services Administration, *Justification of Estimations for Appropriations Committees, FY2016,* Rockville, MD, p. 75. Percentages may not sum to 100% due to rounding. "Other State Loan Repayment Clinicians" make up less than half of 1% of NHSC clinicians, and these represent various health professions.

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.

Figure 2 shows trends associated with NHSC funding amounts and funding sources for FY2009 through FY2015. Between FY2009 and FY2012, cumulative NHSC field strength increased as discretionary funding increased. However, cumulative field strength decreased when discretionary funding decreased, even though CHCF funding increased.

Figure 2. Trends in NHSC Field Strength, FY2009-FY2015 (Est.)

By Budget Source: Discretionary, ARRA Supplement, and Mandatory Supplement



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, FY2016,* Rockville, MD, p. 82.

Notes: The NHSC enters into multiyear agreements with its participants, resulting in funding overlaps. *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). *Mandatory 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).

Funding

Before the enactment of the ACA (in March 2010), discretionary funding provided through the appropriations bill for the Departments of Labor, Health and Human Services, and Education, and Related Agencies (L-HHS-ED) was the primary source of NHSC funding. The mandatory CHCF did not exist. In FY2009, the American Recovery and Reinvestment Act of 2009 (ARRA; P.L. 111-5) provided a one-time $300 million supplemental appropriation to the NHSC, and this supplement enabled the NHSC to increase its clinical recruitment and retention efforts over the next five years into FY2014 (of note, a number of NHSC scholars and loan repayers who received ARRA funding in 2009 will complete their period of service in underserved areas during FY2015 and FY2016).

In FY2010, the ACA was enacted. The ACA directly appropriated mandatory funding to the CHCF for each of FY2011-FY2015 and required that specific amounts—totaling $1.5 billion (pre-sequester) over five years—be transferred annually from the CHCF to the NHSC.[21] The

[21] The CHCF received a mandatory appropriation of $11 billion, to be transferred to the NHSC and the federal health centers program over a five-year period from FY2011 through FY2015. 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 C. Stephen Redhead.

ACA funding built on the clinical recruitment and retention efforts established by ARRA, thereby circumventing large reductions in NHSC field strength.[22]

In FY2011, ACA funding from the CHCF combined with annual discretionary appropriations provided a total of $315 million for the NHSC, resulting in a $174 million (+123% increase) over the previous year. In FY2011, the NHSC received a combination of discretionary L-HHS-ED appropriations and directly appropriated (or "pre-appropriated") mandatory funds from the CHCF.[23] However, the NHSC received no discretionary appropriations in FY2012 through FY2015 and has instead been funded solely by mandatory funding transferred from the CHCF. 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.[24] Mandatory ACA funding for the NHSC was scheduled to expire on September 30, 2015, but the Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10) extends ACA mandatory funding for the NHSC from FY2015 through FY2017.[25]

President's FY2016 Budget Request

On February 2, 2015, the Obama Administration released its FY2016 budget. The President's FY2016 budget request includes a total of $810 million for the NHSC, which would increase the total NHSC budget nearly threefold over the previous year. This request consists of $287 million in discretionary funds and $523 million in new mandatory funds in FY2016. In addition, the President's budget proposes new mandatory funding of $523 million annually through FY2020.[26]

Table 2 presents NHSC funding from FY2009 through FY2015 along with the President's FY2016 budget request.

[22] The ACA mandatory appropriation supported increases in field strength, but overall NHSC field strength declined from FY2011 through FY2013 (see **Figure 2**).

[23] 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.

[24] 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). See CRS Report R42050, *Budget "Sequestration "and Selected Program Exemptions and Special Rules*, coordinated by Karen Spar.

[25] The President signed P.L. 114-10 into law on April 16, 2015, amending Section 10503(b)(2)(E) of the ACA. See **Table 2** for funding amounts.

[26] HHS, HRSA, *Justification of Estimations for Appropriations Committees, FY2016,* Rockville, MD, pp. 72 and 78.

Table 2. NHSC Funding, FY2009-FY2015, and the President's FY2016 Budget Request

(Dollars in millions)

Funding	FY2009	FY2009 ARRA	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016 Pres. Req.[a]
Discretionary	$135	$300	$141	$25	—	—	—	—	$287
CHCF Mandatory	—	—	—	$290	$295	$285[b]	$283[c]	$287[d]	$310[e]
New Mandatory									$523
Total	**$135**	**$300**	**$141**	**$315**	**$295**	**$285**	**$283**	**$287**	**$1,120**
% ACA Mandatory	0%	0%	0%	92%	100%	100%	100%	100%	28%[f]

Source: 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, FY2013 through FY2016,* Rockville, MD. Numbers may not add up evenly due to rounding. Data are subject to updates to reflect changes in legislation.

a. Congress may choose to either maintain the current funding amount or authorize a different amount in its FY2016 final budget.

b. The Affordable Care Act (ACA) (P.L. 111-148) 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 Budget Control Act of 2011 (BCA) (P.L. 112-25), as amended, which established new budget enforcement mechanisms for reducing the federal deficit through FY2024.

c. 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).

d. 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).

e. The Medicare Access and CHIP Reauthorization Act (MACRA)(P.L. 114-10) amends the ACA (Section 10503(b)(2)(E)) to extend mandatory funding for the NHSC from FY2015 through FY2017, at the same level as FY2015, $310 million (the amount before the application of the 7.3% non-exempt mandatory program spending reductions).

f. This percentage reflects the portion that MACRA constitutes of the President's FY2016 budget request for NHSC.

In summary, funding provided by the ARRA in FY2009 and by the ACA in FY2011-FY2015 triggered short-term increases in NHSC resources for recruitment, and subsequent increases in field strength. While the CHCF might have been intended to supplement annual discretionary appropriations for the NHSC, it has become the sole source of funding for the NHSC program since FY2012. MACRA extends mandatory funding for the NHSC through FY2017.

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