The National Advisory Council on the

National Health Service Corps'

Priorities for Reauthorization

And Legislative Updates

March 2007

ACKNOWLEDGEMENTS

Our *Priorities for Reauthorization and Legislative Updates* is the conclusion of multiple years of shared work by the National Advisory Council on The National Health Service Corps. I would like to thank all of the Council members, both current and former, for their dedication to complete this work. I would also like to mention the hard work of B L Seamon's Diane Fabiyi-King and Karmen Lewis, who managed the logistics for each of the Committee meetings, and Marie Bouvier of WordSculpture, who worked tirelessly during the meetings to gather all our thoughts into the report. Additional thanks goes to Katie Previc, ASPH Public Health Fellow with the NHSC, who supplied early research and support to the Council in drafting and editing the final report.

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The Council is also appreciative for all the believers and clinicians involved with the NHSC who further the mission and maintain enthusiasm in the endless journey to medically serve all of America's underserved.

Sincerely,
Annette Kowal, Chair

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EXECUTIVE SUMMARY

National Health Service Corps

> *The National Health Service Corps (NHSC) is committed to improving the health of the Nation's underserved by uniting communities in need with caring health professionals and supporting those communities' efforts to build better systems of care.*

The **National Health Service Corps (NHSC)** was created in 1970 to improve health care for the underserved in areas of critical need. Designed to **provide comprehensive health care that bridges geographic, financial, cultural and language barriers**, the NHSC works to unite communities in need with caring health professionals, then supports those communities' efforts to build better systems of care.

Underserved areas have been particularly vulnerable to losing access to primary care due to a number of concurrent trends, including an increase in physician specialization, an increase in centralization of health care providers, and a marked decrease in the number of primary care physicians. These issues led to serious fractures in the health care system at the primary care level. The NHSC has become a **critical part of the plan to repair the nation's health care delivery system**.

The NHSC program has had a **clear and demonstrated positive impact in every area of the country.** It has created new health services in areas where Americans had little or no access to primary health care. The crucial importance of this federal program is highlighted by the **millions of Americans who are reliant upon the NHSC for primary care.**

National Advisory Council on the National Health Service Corps

From its inception, the fifteen-member National Advisory Council on NHSC (Council) was created by Congress to advise the administration on the NHSC. The **members are part of the health professional workforce, as well as specialists with knowledge of underserved communities and health care implementation and improvement**. Together, they create an invaluable field of knowledge for the Secretary of the U.S. Department of Health and Human Services (HHS), and the Administrator of the Health Resources and Services Administration (HRSA).

The Council has spent the last year engaged in **extensive review of the NHSC program**, including its legislation, policies and procedures. As a result of this review, the Council finds the need for increased investment in the NHSC to respond to the **growing access gaps in underserved areas to primary health care**. Currently, there are **50 million Americans who lack access to primary health care**. Meeting this immediate need requires **27,000 primary care professionals willing to serve in Health Professional Shortage Areas (HPSA).**[1] This represents a **more than five-fold increase over the current 4,600 clinicians** who diligently serve in the NHSC programs. The Council believes doubling the NHSC in its capacity of

[1] About NHSC: Why we are here. National Health Service Corps: http://nhsc.hrsa.gov/about/

recruiting, matching and retaining primary care clinicians for underserved areas will positively impact the current challenge before the nation.

National Advisory Council Priorities

The Council believes that **primary health care should be within the reach of every American, regardless of income or location.** The NHSC is the key to improved access to **primary care for the underserved**.

The number of Americans who are **underserved and lack access to primary care is 50 million and still growing**. These individuals are often forced to utilize emergency rooms—or go without medical care entirely—because they do not have access to primary care. This creates additional stress on an already overburdened health care system. The NHSC is a crucial part of the solution, placing clinicians where they can effectively address the most critical needs.

The programs of the NHSC do exactly that, and they have proven results. Each primary care physician brings health care access to 2,000 more patients on average[2]. Thus, increasing the NHSC's field strength with 5,000 more clinicians will **provide approximately 10,000,000 additional underserved Americans with needed primary care**. If these underserved Americans do not receive the primary care they need, they will face higher costs and lower quality in America's currently overspecialized system.[3]

Efforts to address this significant challenge are already underway, and increased support of the NHSC will only supplement these efforts. The Presidential Initiative to Strengthen the Health Care Safety Net is already in the process of expanding or creating 1,200 new Community Health Centers (CHCs) in areas with the greatest need. It will require 3,000 new clinicians for those new CHCs to achieve full staff. The NHSC can serve as a **crucial staffing resource for those CHCs, as well as other underserved areas**. Allowing the two programs to grow together creates **economies of scale and dramatic cost savings by leveraging recruiting, placement, and service objectives of each program.**

There is an urgent need for an estimated 27,000 additional clinicians to help close our nation's gap in access to primary care. With a five-year plan to **more than double the NHSC's field strength to 10,000**, the Council sees an opportunity to begin making progress toward the goal of providing primary health care for every American. This strategy will enable the NHSC to contribute to the President's goal of strengthening the Health Care Safety Net.

> ***The Council recommends reauthorization of the NHSC for five years, and protection and enhancement of NHSC funding to at least double its capacity. The Council also recommends legislative changes to increase program flexibility and efficiency.***

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[2] Selecting a Financially Healthy Practice: A Guide for Graduating Residents and Other Job Hunters, American Academy of Family Physicians: http://www.aafp.org

[3] The Impending Collapse of Primary Care Medicine and Its Implications for the State of the Nation's Health Care: *A Report from the American College of Physicians January 30, 2006* Available: http://www.acponline.org/hpp/statehc06_1.pdf

Legislative Recommendations

1. **Reauthorize NHSC for five years** with **increased appropriations sufficient to double its field strength to 10,000 primary care clinicians** in underserved areas.

2. **Allow cancellation of loan repayment contracts** by the Secretary, with or without the clinician's consent, if the clinician's employment with the approved site ends within 90 days of the service start date, and no loan repayment funds were awarded.

   Within the language describing cancellation prior to the start of service**, remove the time statement** of 45 days before the end of the fiscal year (August 17).

3. Give the Secretary the option of **reappointing any member of the Council for one additional three-year term**.

4. Authorize an **additional appropriation of 8% of the total loan repayment funding for states that administer a State Loan Repayment Program (SLRP).** This amount (a total of $500,000 for fiscal year 2008) will **pay for grant-related administrative costs**, including marketing.

   This should not be subject to the matching funds requirement and should not allow for indirect cost reimbursement.

5. Allow states that administer an SLRP to **determine the disposition of clinicians placed in default,** as long as there is a mechanism established to recoup funds already disbursed.

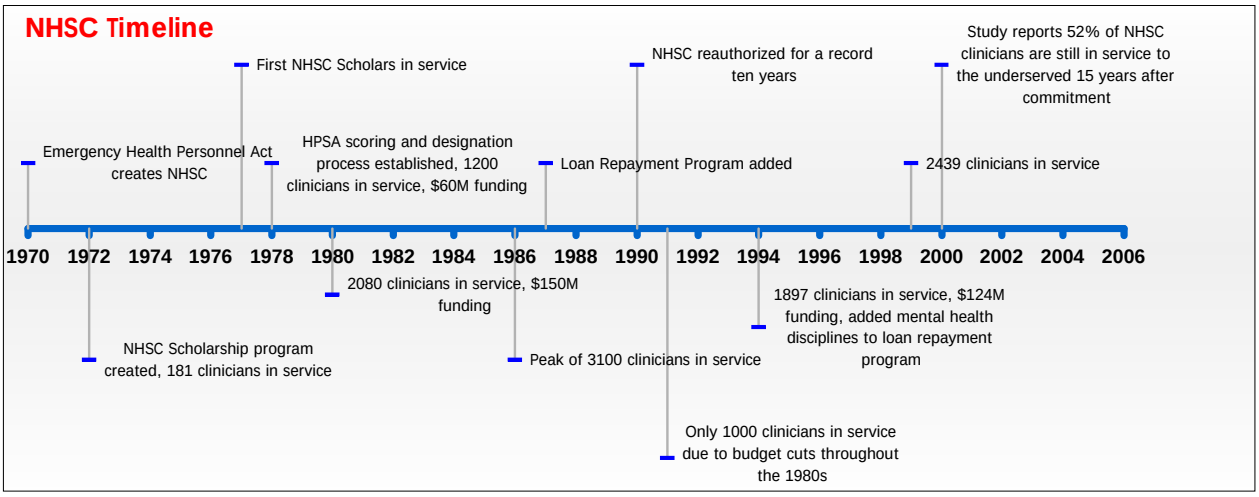
6. **Give authority for NHSC to conduct demonstration projects.** The budget for these expansions shall be determined by the Secretary as deemed appropriate and shall be limited to no more than 2% of the budget in any given year.

Conclusion

Protecting and enhancing NHSC funding will help **support the President's Health Care Safety Net across underserved communities**. The recommended legislative changes will also increase the flexibility and efficiency of the NHSC program, allowing it to better serve those who rely on its programs for primary health care, reduced costs, and improved health status.

HISTORICAL BACKGROUND

National Health Service Corps



The National Health Service Corps (NHSC) is committed to improving the health of the Nation's underserved by uniting communities in need with caring health professionals and supporting those communities' efforts to build better systems of care.

The Emergency Health Personnel Act of 1970 created the **National Health Service Corps (NHSC)**. Designed to **provide comprehensive primary health care that bridges geographic, financial, cultural, and language barriers**, the NHSC works to unite communities in need with caring health professionals, then supports those communities' efforts to build better systems of care.

Underserved areas have been particularly vulnerable to losing access to primary care due to a number of concurrent trends, including an increase in physician specialization, an increase in centralization of health care providers, and a marked decrease in the number of primary care physicians. These issues led to serious fractures in the health care system at the primary care level. In response, the NHSC has become a **critical part of the plan to repair the nation's health care delivery system**.

The NHSC created **two major programs** to serve America's health care needs:

1. **Scholarship Program (SP):** Provides payment of tuition, fees, and stipends for scholars in exchange for a future period of service.
2. **Loan Repayment Program (LRP):** Provides payment toward student loans for primary care clinicians who agree to begin service immediately.

Over the years, the number of clinicians in those programs has grown from just 180 to the **4,600 clinicians currently serving** in primary medical, oral, dental, and mental and behavioral health fields nationwide.

The NHSC continues to place health professionals throughout the country. It has created new health services in areas where Americans had little or no access to primary health care. The importance of this federal program is highlighted by the **millions of Americans who are dependent upon the NHSC for primary care.**

National Advisory Council on the National Health Service Corps

From its inception, the fifteen-member National Advisory Council on NHSC (Council) was created by Congress to advise the administration on the NHSC. The **members are part of the health professional workforce, as well as specialists with knowledge of underserved communities and health care implementation and improvement**. They serve in an advisory capacity to the Secretary of the U.S. Department of Health and Human Services and the Administrator of the Health Resources and Services Administration.

The Council has spent the last year engaged in **extensive review of the NHSC program**, including its legislation, policies and procedures. As a result of this review, the Council finds the need for increased investment in the NHSC to respond to the **growing access gaps to primary health care** in underserved areas. Currently, there are **50 million Americans who lack access to primary health care**. Meeting this immediate need requires **27,000 primary care professionals willing to serve in Health Professional Shortage Areas (HPSA).**[4] This represents a **more than five-fold increase over the current 4,600 clinicians** who diligently serve in the NHSC programs. The Council believes doubling the NHSC in its capacity of **recruiting, matching and retaining primary care clinicians for underserved areas** will positively impact the current challenge before the nation.

National Advisory Council on the National Health Service Corps Priorities

The Council's main goal is to achieve **improved access to primary care for the underserved**. The Council believes that **primary health care should be within the reach of every American, regardless of income or location.**

The number of Americans who are **underserved and lack access to primary care is more than 50 million and still growing**. These individuals are often forced to utilize emergency rooms—or go without medical care entirely—because they do not have access to primary care. This creates additional stress on an already overburdened health care system. The NHSC is a crucial part of the solution: placing clinicians where they can effectively address the most critical needs.

The programs of the NHSC do exactly that, and they have proven results. Each primary care physician brings health care access to 2,000 more patients on average.[5] Thus, increasing the NHSC's field strength with 5,000 more clinicians will **provide another 10,000,000 underserved Americans with needed primary care**. If these underserved Americans do not

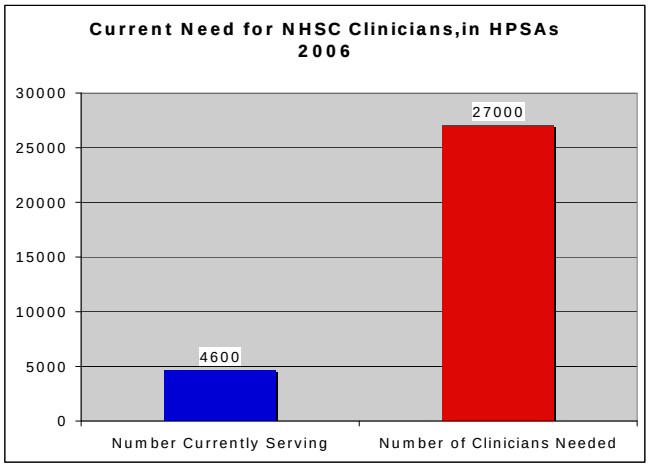
[4] About NHSC: Why we are here. National Health Service Corps: http://nhsc.hrsa.gov/about/
[5] Selecting a Financially Healthy Practice: A Guide for Graduating Residents and Other Job Hunters, American Academy of Family Physicians American Academy of Family Physicians: http://www.aafp.org

receive the primary care they need, they will face higher costs and lower quality in America's currently overspecialized system.[6]

The Presidential Initiative to Strengthen the Health Care Safety Net is already in the process of expanding or creating 1,200 Community Health Centers (CHCs) in areas with the greatest need. It will require 3,000 new clinicians for those new CHCs to achieve full staff. The NHSC can serve as a **crucial staffing resource for those CHCs, as well as other underserved areas**. The NHSC and CHC programs are a valuable partnership of strong, successful programs with a positive impact on health care. Allowing the two programs to grow together creates **economies of scale and dramatic cost savings by leveraging recruiting, placement, and service objectives of each program.**

There is an urgent need for an estimated 27,000 additional clinicians to help close our nation's gap in access to primary care. With a five-year plan to **more than double the number of clinicians in the NHSC to 10,000** and **provide for the infrastructure to support that growth**, the Council sees an opportunity to make progress toward the goal of primary health care for every American by investing in clinicians who will address the lack of access in underserved communities. By also working to **build awareness** of the NHSC's programs and services, the NHSC will reach even more potential clients and clinicians, **improving American health care nationwide**.

While the NHSC works to fill the health care gap for the nation's underserved, the Council is also mindful of future health care needs. Through increased support of the NHSC infrastructure, not only will the Scholarship and Loan Repayment Programs grow, but overall awareness will reach more students, clinicians and communities about the opportunities to serve the underserved. By continuing to analyze needs and determine appropriate strategic solutions, the Council is advocating for funding to build an infrastructure to support steady growth in the number of clinicians over the next five years. This strategy will enable the NHSC to contribute to the President's goal of strengthening the Health Care Safety Net.



[6] The Impending Collapse of Primary Care Medicine and Its Implications for the State of the Nation's Health Care: *A Report from the American College of Physicians January 30, 2006* Available: http://www.acponline.org/hpp/statehc06_1.pdf

The Council recommends reauthorization of the NHSC for five years, and protection and enhancement of NHSC funding to at least double its capacity. The Council also recommends legislative changes to increase program flexibility and efficiency.

LEGISLATIVE RECOMMENDATIONS

1. **Reauthorize NHSC for five years** with **increased appropriations sufficient to double its field strength to 10,000 primary care clinicians** in underserved areas.

2. **Allow cancellation of loan repayment contracts** by the Secretary, with or without the clinician's consent, if the clinician's employment with the approved site ends within 90 days of the service start date, and no loan repayment funds were awarded.

   Within the language describing cancellation prior to the start of service**, remove the time statement** of 45 days before the end of the fiscal year (August 17).

3. Give the Secretary the option of **reappointing any member of the Council for one additional three-year term**.

4. Authorize an **additional appropriation of 8% of the total loan repayment funding for states that administer a State Loan Repayment Program (SLRP).** This amount (a total of $500,000 for fiscal year 2008) will **pay for grant-related administrative costs**, including marketing.

   This should not be subject to the matching funds requirement and should not allow for indirect cost reimbursement.

5. Allow states that administer an SLRP to **determine the disposition of clinicians placed in default,** as long as there is a mechanism established to recoup funds already disbursed.

6. **Give authority for NHSC to conduct demonstration projects.** The budget for these expansions shall be determined by the Secretary as deemed appropriate and shall be limited to no more than 2% of the budget in any given year.

1. NHSC Reauthorization and Appropriations

***Reauthorize NHSC for five years** with **increased appropriations sufficient to double its field strength to 10,000 primary care clinicians** in underserved areas.*

The NHSC has a proven track record of positive impact in underserved communities across America. The need for its services has continued to grow, far outstripping its abilities to serve within the existing budget.

The requested increase in funding is absolutely critical to serving the health care needs of underserved rural areas and inner cities across the country. These areas are already in crisis due to lack of an adequate number of health care providers; inadequate access leads to a spiraling increase in illnesses, hardships and even loss of life. The continued pressure on our already stressed health care system is unacceptable.

Additional funding is needed to increase the number of primary care clinicians immediately and dramatically, investing in the future of our nation's health. Keeping funding at current levels leads to an effective decrease in the number of clinicians in the neediest of communities.

A typical patient panel for a primary care physician averages 2,000 patients.[7] The maps in Appendix A demonstrate national distribution of primary care, mental health and dental health professional shortage areas (HPSA).[8] Maintaining only current funding levels will essentially result in losing one thousand clinicians from the NHSC program, leading to 2,000,000 people losing access to primary care and an increase in the number of HPSAs nationwide. Sequential, year-over-year increases in total funding will enable the NHSC to progress toward its five-year goal of doubling its field strength and placing an additional 10,000 clinicians in underserved areas across the country.

NHSC Programs

The NHSC supports current and future clinicians who make the choice to serve in areas of critical need in two ways:

1. By offering loan repayments for clinicians who can be placed immediately and remain in service in the underserved area for at least two years, and

2. By providing scholarships to students who commit to serve as clinicians in the future.

These two programs work in tandem to ensure that there is a continual flow of clinicians to areas of critical need. The proposed additional funding will help reinforce the safety net to help meet workforce needs in primary care. Initially this will be accomplished by increasing the number of clinicians in service within areas of greatest need. In addition, the NHSC can concurrently increase the number of candidates willing to fill future vacancies. Fully supporting both

[7] American Academy of Family Physicians: http://www.aafp.org

[8] HRSA Geospatial Data Warehouse: http://datawarehouse.hrsa.gov

programs and planning to invest in strengthening their numbers presents a strategic approach to addressing our nation's growing health care needs.

Need for Additional Clinicians

There remains a strong need for additional clinicians in underserved communities. The NHSC field strength is currently 4,600 clinicians, but each year approximately 4,000 of the 8,000 vacancies identified on the NHSC opportunities list remain unfilled. Given current level funding, the cyclical nature of the loan repayment program, and the projection of 4,200 clinicians for NHSC field strength in 2006, there is a clear ongoing need for many more clinicians, both now and in the future.

The Presidential Initiative to Strengthen the Health Care Safety Net will expand or increase 1,200 new Community Health Centers (CHCs), creating a need for 3,000 clinicians to staff the new and expanded CHCs. Because the new CHCs will serve an additional 6.1 million patients—almost half of them uninsured—there is an opportunity for the two programs to continue to capitalize on common goals.

Nearly half of NHSC clinicians currently serve in CHCs, and they are one of the top sources of quality staff for these clinics. The NHSC provides a pool of skilled workforce for CHCs, as well as for other underserved areas. This is an opportunity to recruit the best and brightest clinicians to serve in the most challenged areas, hopefully retaining them as part of the community for years to come.

Appendix B provides a state-by-state breakdown of community health data, including an estimated number of residents without access to primary care, the annual wasted expenditures on unnecessary emergency room visits (a strong predictor of lack of access to primary care), and the number of clinicians required to eliminate need. Underserved areas can be found in every state of the nation; without substantial funding, each state will have residents whose primary care needs go unmet.[9]

Meeting Health Care Needs

The NHSC should be expanded to help meet the nation's growing need for more clinicians. There are many qualified potential clinicians who remain untapped and unutilized. The NHSC scholarship program already receives seven to fifteen applicants for every award available. With additional, sustainable funding, the NHSC can make a more solid commitment to expanding the number of clinicians, present and future, toward meeting the health care needs of the underserved.

The Council advocates for a doubling of the number of clinicians to 10,000 over the next five years. While this is a portion of the number of clinicians needed to serve every American, building uninterrupted growth will develop the infrastructure needed to support a doubling in

[9] *2006 Access to Community Health Databook Summary of Findings,* National Association of Community Health Centers, http://www.nachc.com/research/files/2006DataSummary.pdf

field numbers. Including the administrative funding to put this program in place will ensure stability, sustainability, and continuous service.

The cost for each funded clinician position is minimal when compared with the potential costs to society. According to a comprehensive report analyzing numerous studies on the costs of primary care, **an increase in primary care physicians is associated with a significant increase in quality of health services as well as a reduction of total costs**. States with more general practitioners use more effective care and have lower spending, while those with more specialists have higher costs and lower quality of care. Improving the quality of care could be accomplished with more effective use of existing dollars.[10]

The U.S. health care system and U.S. physicians are actually moving away from primary care as a specialty, despite the **proven positive effects of primary care**, including:

- Primary care **improves the overall performance** of health care systems.
- **Emergency department use and hospital admissions decrease** when people have primary care.
- Primary care clinicians use **fewer tests and spend less money.**
- Higher levels of primary care are associated with **lower mortality rates**, even controlling for the effects of urban/rural differences, poverty rates, education, and lifestyle factors.[11]

The need for the NHSC is greater than ever.

Over its thirty-seven year history, the NHSC has demonstrated its ability to maximize the return on investment for each funding dollar. In addition to serving the immediate primary care needs of the underserved communities, NHSC clinicians are also helping to build the infrastructure of the communities where they serve. Each placement serves as an effective capital investment, offering the community new resources and creating an economic multiplier effect to the community. A study by the Robert Graham Center on the impact of the NHSC on rural America from 1970 to 1999 concluded that the placement of NHSC clinicians within a community makes substantial contributions to the local economy. In an analysis of 11 rural states with NHSC clinicians, the study found total gains up to $1.5B in economic impact per year, and as many as 14,367 jobs created annually.[12]

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[10] Donaldson, M.S.; Yordy, K.D.; Lohr, K.N.; Vanselow, N.A. 1996. *Primary Care: America's Health in a New Era.* Washington, DC: Institute of Medicine, Division of Health Care Services Committee on the Future of Primary Care, National Academy Press, 52-75.

[11] Ibid.

[12] Fryer, George E., Jr., Ph.D.; McCann, Jessica L.; Dodoo, Martey S., Ph.D.; Green, Larry A., M.D.; Miyoshi, Thomas; Phillips, Robert L., M.D., M.S.P.H. September 2006. *Access, Health and Wealth: The Impact of the National Health Service Corps in Rural America, 1970 – 2000.* Washington, DC: The Robert Graham Center, (http://www.graham-center.org).

In addition, a related study of rural placements of NHSC clinicians found that those placements contributed positively to the long-term growth of the non-NHSC physician workforce in those communities. Rather than providing temporary staffing that competed with and impeded the supply of other local physicians, having NHSC clinicians in a community actually increased primary care physician workforce growth.[13] More than 78% of clinicians continue to practice within the community where they were placed far beyond the term of service; 52% of the program's alumni have remained in their original communities of service for more than fifteen years[14]. **Clearly, the NHSC provides a long-term benefit to the community that goes far beyond the NHSC's initial financial investment.**

For the 50 million Americans who live in underserved areas, the NHSC is the most critical of programs. Increasing the number of clinicians who serve this population is an ongoing commitment and an investment in our nation's future.

2. Defaults and Cancellations

> ***Allow cancellation of loan repayment contracts*** *by the Secretary, with or without the clinician's consent, if the clinician's employment with the approved site ends within 90 days of the service start date, and no loan repayment funds were awarded.*
>
> *Within the language describing cancellation prior to the start of service**, remove the time statement** of 45 days before the end of the fiscal year (August 17).*

Early in the NHSC's history, default penalties were rare, and providers whose commitments changed or were lured by alternatives were able to escape their NHSC commitments relatively easily. Currently, the NSHC cannot cancel an LRP contract without the consent of the clinician, even if the clinician is terminated or leaves the site during the early months of the contract. This is clearly an issue that requires resolution.

Expanding the cancellation authority will also help ensure that the NHSC is not required to find a new site for a clinician when issues arise with the existing site very early in the contract. Though relatively infrequent (less than 10% per year from 2003 to 2005), each occurrence creates a large workload that could be avoided with this cancellation authority. This would reduce NHSC casework, and when appropriate, the clinician could reapply for a new contract upon finding a new service site.

Giving the NHSC the discretion to allow cancellation after the existing deadline of August 17th would also be very beneficial. Each year, after August 17th, unforeseen issues (e.g., family illness, needs of children, unexpected changes in employment status or site management) arise

[13] Pathman, Donald E., M.D., M.P.H.; Fryer, George E., Jr., Ph.D.; Phillips, Robert L., M.D., M.S.P.H.; Smucny, John, M.D.; Miyoshi, Thomas, M.S.W.; and Green, Larry A., M.D. Fall 2006. *National Health Service Corps Staffing and the Growth of the Local Rural Non-NHSC Primary Care Physician Workforce.* The Journal of Rural Health, 22 (4) 285 – 293. Washington, DC: The Robert Graham Center (http://www.graham-center.org).

[14] Mathmatica Inc. "Impact and Effectiveness of the NHSC" Final Report to HRSA, May 2000.

that impact some clinicians' ability to complete their service commitments. If the NHSC could respond by canceling the contract and reutilizing those funds for other contracts, it would benefit the community, the site, the clinician, and another clinician who would then be eligible for the reutilized funds. This also would increase the flexibility for timelines and award times.

Broadening the cancellation authority will allow NHSC funds to be spent where they are most needed and will alleviate the problem of undistributed funds due to cancelled LRP contracts. The NHSC is evaluated in part on its mandate to award every dollar, and this recommendation will help the NHSC effectively meet that goal, as well as the needs of the underserved communities.

3. Terms of National Advisory Council Members

> *Give the Secretary the option of* ***reappointing any member of the Council for one additional three-year term.***

Allowing an additional term for Council members would increase the continuity and strength of the Council's work, especially at times when deliberation of key issues or changes might overlap term expirations. An extra term would serve to increase the value of institutional memory as the Council members began to build on the work of their predecessors, creating a more informed and effective leadership.

Throughout its history, many Council members have noted that the complexity and history of NHSC takes time and first-hand experience to fully understand and advise. Even members who once served as NHSC clinicians notice the time and effort it can take to get up to speed. Members have expressed frustration that they reach the point where they feel fully prepared to advise the NHSC late in their terms. The Council supports the idea of an additional term, though within the constraints of the NHSC's need to obtain fresh perspectives from new members.

4. State Loan Repayment Program: State Use of Funds

> *Authorize an* ***additional appropriation of 8% of the total loan repayment funding for states that administer a State Loan Repayment Program (SLRP).*** *This amount (a total of $500,000 for fiscal year 2008) will* ***pay for grant-related administrative costs****, including marketing.*
>
> *This should not be subject to the matching funds requirement and should not allow for indirect cost reimbursement.*

The current legislation is clear about the restrictions that are placed on SLRP funds. The law is very specific, prohibiting all expenditures except payments to clinicians.

§ 254q_1. Grants to States for loan repayment programs
(d) Restrictions on use of funds

> . . . [T]he State involved agrees that the grant will not be expended-- (1) to conduct activities for which Federal funds are expended-- (A) within the State to provide technical or other non-financial assistance under subsection (f) of section 254c of this title; (B) under a memorandum of agreement entered into with the State under subsection (h) of such section; or (C) under a grant under section 254r of this title; or (2) for any purpose other than making payments on behalf of health professionals under contracts entered into pursuant to subsection (a)(2).

The Council believes that providing states with additional funds to ensure strong administration is a reasonable change that would significantly benefit the SLRP programs. The significant investments that grantees make in program administration currently come from other sources of funding.

State LRP programs are an excellent supplement to NHSC's federal programs. Throughout the U.S., many providers who, for whatever reason, cannot or do not participate in the federal LRP are in an SLRP. However, state versions of federal programs have potential for wide variation in rules and requirements, and they may not have the existing budget for the administrative function of the SLRP. Recent budget problems have even driven some states to withdraw from the SLRP. Allowing additional federal funds for administration would enable grantees to considerably strengthen their programs and enhance their administration.

In the absence of additional funds tied specifically toward administration, then a second option would be to allow a small percentage of the money awarded to be spent for administration and operation. This amount would not be subject to the matching funds requirement and would not allow for indirect cost reimbursement. This second option is inferior to adding a modest administrative allowance, as it could reduce the total amount of SLRP funds in the field in the short term; however, all would have better staffing and be more effectively managed.

Without the choice of one of these options, the SLRP programs will be negatively impacted. The current legislation is too restrictive. It is very rare for programs to be unable to spend some of their grant monies on program support, including marketing. Allowing spending for administrative costs would be consistent with other HRSA grant programs and would provide significant benefits to SLRPs nationwide.

5. State Loan Repayment: Default Penalties

> *Allow states that administer an SLRP to **determine the disposition of clinicians placed in default,** as long as there is a mechanism established to recoup funds already disbursed.*

It is important to maintain and enforce strong disincentives to defaults, and this also applies to the SLRP. However, individual states likely face wide variation in circumstances around their LRPs and would benefit from more autonomy and flexibility in default situations.

The current legislation governing SLRP contract inducements, clauses, etc., is quite restrictive regarding state autonomy.

§ 254q_1. Grants to States for loan repayment programs

> (3) Limitation regarding contract inducements
> (A) Except as provided in subparagraph (B), the Secretary may not make a grant under subsection (a) of this section unless the State involved agrees that the contracts provided by the State pursuant to paragraph (2) of such subsection will not be provided on terms that are more favorable to health professionals than the most favorable terms that the Secretary is authorized to provide for contracts under the Loan Repayment Program under section 254l_1 of this title [federal program], including terms regarding—
> (i) the annual amount of payments provided on behalf of the professionals regarding educational loans; and
> (ii) the availability of remedies for any breach of the contracts by the health professionals involved.

SLRPs must adhere to the federal default guidelines, regardless of the salary paid or the cost of living in that particular area. The high federal default penalty has hindered providers' participation; a recent survey of 18 SLRP program administrators found that over 60% felt that the current default penalty hindered both recruitment for and participation in the SLRP.

This recommendation gives states as much autonomy as is practical to maximize the potential of service. It may also stimulate the development of innovative means to resolve the disposition of clinicians placed in default in the NHSC LRP and SP.

6. Demonstration Projects

> ***Give authority for NHSC to conduct demonstration projects.*** *The budget for these expansions shall be determined by the Secretary as deemed appropriate and shall be limited to no more than 2% of the budget in any given year.*

Because of the national scope of this program, the NHSC is faced with a very diverse range of needs. Adequately meeting all of these needs can be a challenge within the NHSC's tightly defined mission. Demonstration projects within the NHSC allow the evaluation of additions or changes with minimal commitment of resources and risk. If the projects are successful and selected for implementation, they can broaden the spectrum of potential strategies that help increase field strength and reduce provider shortages in underserved areas. These new strategies will provide the NHSC with the flexibility to respond to new issues and creative ideas that impact access to care and health disparities.

By instituting and developing partnerships with such entities as academic health centers, health profession organizations, and health-oriented foundations, the NHSC will be able to create additional resources to expand its research development and demonstration capacity. Such flexibility could allow inclusion of other disciplines in the NHSC.

The Council has identified the two issues listed below as potential demonstration projects.

1. Recruiting "seasoned"/retired clinicians and/or private practitioners

2. Allowing scholars first identified for scholarships in their 3rd or 4th years of professional training to receive retroactive payment of only tuition and fees for years one and/or two, in exchange for four years of service

Each demonstration project will be evaluated for its impact on the NHSC mission. Fiscal notes for program expansion can then be attached for each profession added to the list of those eligible for NHSC funding. This will help secure increased appropriations to fund new disciplinary areas, rather than spreading and diluting existing funding. The NHSC will then have the flexibility to increase the budgets as the projects prove themselves.

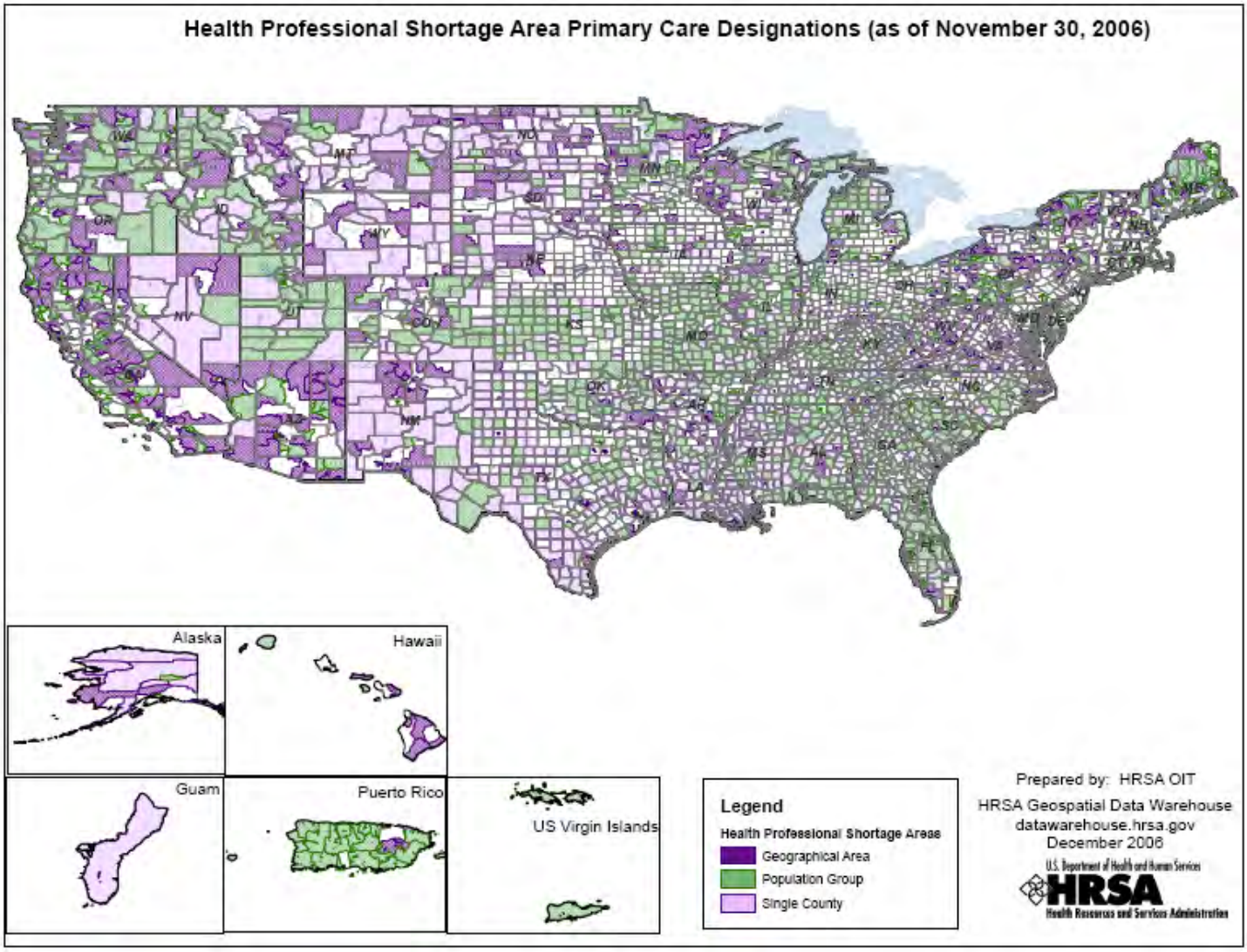
Conclusion

Protecting and enhancing NHSC funding will help **support the President's Health Care Safety Net across underserved communities**. The recommended legislative changes will also increase the flexibility and efficiency of the NHSC program, allowing it to better serve those who rely on its programs for primary health care, reduced costs, and improve health status.

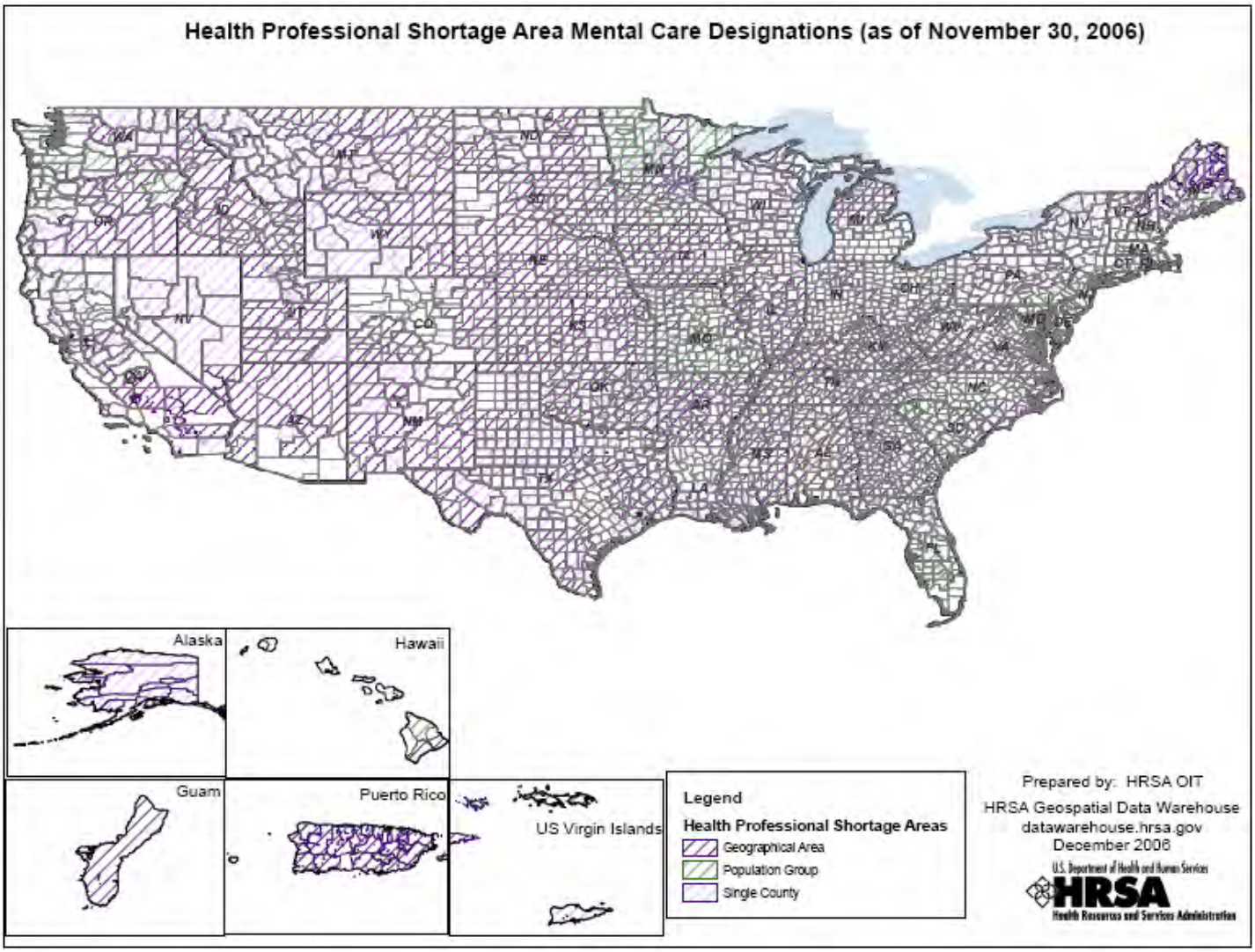
For the 50 million Americans who live in underserved areas, the NHSC is the most critical of programs. Increasing the number of clinicians who serve this population is an ongoing commitment and an investment in our nation's future.

APPENDIX A

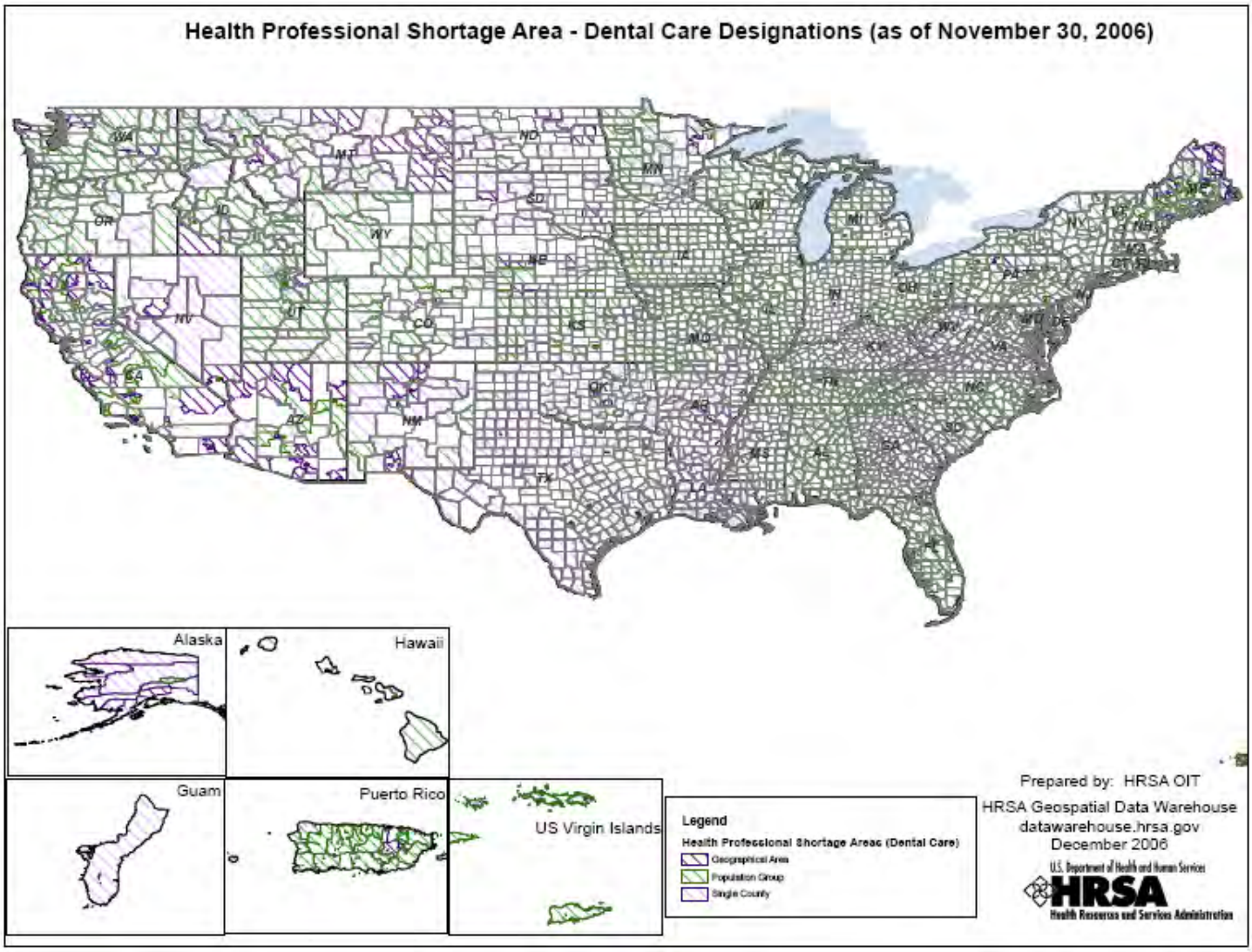
Distribution of Primary Care Health Professional Shortage Areas



Distribution of Mental Health Care Health Professional Shortage Areas



Distribution of Dental Care Health Professional Shortage Areas



APPENDIX B

State-by-State Community Health Data

Source: National Association of Community Health Centers,
2006 Access to Community Health Databook Summary of Findings

STATE	NUMBER OF RESIDENTS WITHOUT ACCESS TO A PRIMARY CARE PHYSICIAN	ANNUAL WASTED EXPENDITURES ON AVOIDABLE EMERGENCY ROOM VISITS	ESTIMATED NUMBER OF CLINICIANS REQUIRED TO ELMINATE NEED (at 1 clinician for every 2000 patients)*
Alabama	1,325,428	$319,400,854	663
Alaska	20,434	$32,732,965	10
Arizona	326,101	$311,438,714	163
Arkansas	636,207	$189,500,122	318
California	2,498,753	$1,829,345,794	1,249
Colorado	272,949	$238,246,230	136
Connecticut	102,615	$207,348,610	51
Delaware	46,820	$47,497,790	23
District of Columbia	80,836	$55,797,643	40
Florida	2,195,915	$1,061,420,739	1,098
Georgia	1,907,670	$537,867,735	954
Hawaii	1,345	$55,098,405	1
Idaho	277,867	$88,713,842	139
Illinois	632,687	$853,731,297	316
Indiana	809,064	$441,019,299	405
Iowa	339,747	$183,880,125	170
Kansas	351,249	$159,038,693	176
Kentucky	821,838	$353,798,163	411
Louisiana	1,630,978	$354,757,738	815
Maine	53,142	$105,902,573	27
Maryland	165,476	$320,407,972	83
Massachusetts	230,772	$401,458,842	115
Michigan	1,124,134	$726,928,960	562
Minnesota	454,920	$256,913,897	227
Mississippi	952,877	$252,769,055	476
Missouri	1,017,673	$429,712,468	509
Montana	150,308	$54,444,985	75
Nebraska	343,218	$94,243,689	172
Nevada	443,131	$112,928,929	222
New Hampshire	31,303	$79,046,610	16
New Jersey	557,531	$438,047,852	279

New Mexico	346,724	$132,027,370	173
New York	2,044,567	$1,126,031,176	1,022
North Carolina	1,664,904	$548,645,880	832
North Dakota	92,533	$41,491,015	46
Ohio	1,110,049	$932,659,694	555
Oklahoma	625,357	$208,230,028	313
Oregon	326,025	$179,035,367	163
Pennsylvania	1,103,118	$790,754,728	552
Rhode Island	23,916	$61,807,552	12
South Carolina	754,321	$265,008,761	377
South Dakota	147,866	$36,418,180	74
Tennessee	1,251,568	$476,285,058	626
Texas	3,956,574	$1,233,549,349	1,978
Utah	458,071	$152,152,368	229
Vermont	34,734	$38,015,757	17
Virginia	963,257	$452,375,606	482
Washington	299,269	$354,817,611	150
West Virginia	239,454	$180,480,840	120
Wisconsin	683,656	$272,179,576	342
Wyoming	119,181	$36,360,931	60
United States	**36,048,131**	**$18,445,991,718**	**18,024**

*** *NOTE:*** The estimated number of clinicians required to eliminate need was calculated from the *2006 Access to Community Health Databook Summary of Findings* but was not included in their original data.