House Energy & Commerce Subcommittee on Health

Hearing on Primary Care Workforce Programs

Testimony of

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Chairman Burgess, Ranking Member Green, and Members of the Subcommittee,

Thank you for this opportunity to speak to you today about the National Health Service Corps (NHSC), a program that has had a profound impact upon my life – both personally and professionally. My name is Dr. Adrian Billings, and I am a full spectrum family medicine physician with Presidio County Health Services (PCHS), a federally qualified health center (FQHC), practicing in rural Alpine, Marfa and Presidio, Texas. I am here today as a board member of the Association of Clinicians for the Underserved (ACU), which was founded by NHSC alumni over 20 years ago. The mission of the ACU is to improve the recruitment and retention of primary care providers in underserved communities, and the NHSC is a critical component of that effort. I am also a fellow with the American Academy of Family Physicians, an organization that also strongly supports the NHSC program. The NHSC was created 45 years ago in a bipartisan manner, and since then has proven to be a very effective program placing health care providers in our nation's most medically underserved areas. As an alumnus of the NHSC Scholarship program, I am honored to be here today to give you a firsthand perspective of the significance this program has on medical students, health professionals and underserved communities.

I was born and raised in Del Rio, Texas, a small town on the Texas-Mexico border 3 hours to the east of Alpine, where I currently live and practice. It was in Del Rio, that my passion for primary health care was cultivated. I was delivered by a family physician, Dr. Ramon Garcia, and he was my primary physician throughout my adolescence. Dr. Garcia became my role model and mentor. After my first year of college, I returned to Del Rio for the summer and worked as an anesthesiology technician, which awarded me the opportunity to scrub in on surgeries and deliver babies with Dr. Garcia. By the end of that summer, I knew I wanted to follow in Dr. Garcia's footsteps and care for patients from cradle to grave, just as he had.

My history with the NHSC began as a first year medical student at the University of Texas Medical Branch at Galveston, Texas. Prior to beginning my medical education, I was completing a

postdoctoral fellowship in the Special Pathogens Branch of the Division of Viral and Rickettsial Diseases at the Centers for Disease Control and Prevention (CDC). One of my colleagues, a Commissioned Corps Officer in the Public Health Service, suggested I apply to the NHSC for support with my medical school tuition and expenses. He thought that the NHSC was the perfect program for me because of my desire to return to the Texas-Mexico border to practice family medicine. I enthusiastically submitted an application for the NHSC scholarship knowing that it would allow me to accomplish my dream without the burden of school loans that may have forced me down a different path.

After completing my family medicine residency and surgical obstetrics fellowship, I moved to Alpine, Texas to fulfill my NHSC scholarship commitment. I fulfilled my four year commitment in the private practice option, as an FQHC did not exist in Alpine at the time. When I arrived in Alpine in 2007, I was one of only three family doctors in a 12,000 square mile area serving a total population of 25,000 in the vast Big Bend area of Texas. In those first years of practice, I delivered up to 70 babies each year, rounded on my patients in the hospital, saw patients in the emergency room, performed house calls for those patients who could not easily get to clinic, and rounded on patients in the nursing home. I did this all without a partner, as I was in solo practice. I was on call 24 hours a day, seven days a week. After my first year in practice I started to feel more and more professionally isolated in such a medically underserved area. I missed the academic environment of working with a team, so I began to host medical students and residents in 2008. Over the years I have had more than 250 students and 36 family medicine residents train with me in Alpine. In hindsight, the decision to host trainees turned into one of the best investments I made because after completing their training, four of the trainees chose to return to our small community to practice with me. This is more than all the providers we had in the area when I started. As a result, access to care in our community has increased and my quality of life has vastly improved. I am

now able to spend more time with my family and my partners have restored my energy to sustain my practice in one of the most medically underserved areas along the US-Mexico border.

My work, although rewarding in many ways, was exhausting. For four years my private practice operated in a manner similar to a FQHC – my practice was located in an underserved area, I served all patients regardless of ability to pay, and I delivered comprehensive primary care services. So I made the decision to merge my practice with a FQHC, Presidio County Health Services, in neighboring towns, Marfa and Presidio. Once we were part of PCHS, the practice received both federal funding and malpractice coverage that enabled the practice to recruit a family physician partner to share the load. Again, access was increased and my working schedule became far more manageable.

I am proud of the accomplishments I have made over these past ten years. I am proud that I continue to practice in the underserved area where I completed my NHSC commitment. I am most proud that I have been able to establish an FQHC practice in Alpine where there had not been one previously. The establishment of an FQHC has enabled a significant increase in access to care for the most underserved patients in the Big Bend of Texas. I am also very proud of the almost 300 trainees who have rotated with me, many of whom have decided to pursue primary care in underserved areas, including the four that have joined us in Alpine. In fact, as a result of this long record of hosting trainees, PCHS and our local hospital, Big Bend Regional Medical Center, will begin a rural family medicine residency with Texas Tech University Health Sciences Center in 2018. This collaboration will further improve access to care.

I was able to go to medical school debt free because of the NHSC, and the program enabled me to help the people of Alpine, Marfa, Presidio, Terlingua, Sanderson, and Ft. Davis, Texas. I have chosen to stay and practice in Alpine and the surrounding region because of the sense of calling I still feel to be practicing out here. The FQHC program's financial and operational support and the ability to teach students and residents have further enhanced and enabled this underserved

practice to not only sustain itself but to grow. I am excited to see what the next 10 years results in for our patients. I am honored to be here today to share my view of the value of the NHSC and to urge the Members of this Subcommittee to extend funding for this vital health care program.

NHSC Background

The National Health Service Corps (NHSC) program, established in 1972, is designed to incentivize primary care professionals – including physicians, nurse practitioners, dentists, mental and behavioral health professionals, physician assistants, certified nurse-midwives, and dental hygienists – to work in underserved areas in urban, rural, and frontier communities. In exchange for their service, the program helps to alleviate the burden of debt accumulated during the course of their education through scholarship and loan repayment programs. The four NHSC programs are:

The Scholarship Program (SP) – Provides a full scholarship for eligible medical, dental, mental and behavioral health students in exchange for service after their training in high need health professional shortage areas (HPSAs). Awards are very competitive, with the program only able to fund 10% of current applications. They look for students who have a real interest in delivering care to underserved communities, and have a high probability of success in their primary care careers. There are about 1,000 scholars now, who will be serving in the field in the years ahead.

The Loan Repayment Program (LRP) – This is by far the largest part of the NHSC program, with over 8,500 of the current field strength receiving loan repayment. The program helps students repay school loans in exchange for service, starting with a two year commitment at $25,000 per year. In order to fund the highest need areas, the program awards loan repayment contracts to applicants serving in the highest scoring HPSAs first. Last year the program was only able to fund applicants down to a HPSA score of 17.

The State Loan Repayment Program (SLRP) – This program provides matching funds for qualifying state loan repayment programs. Not all states take advantage of this program, but there are over 1,300 placements in the field through the state loan repayment programs. This is a very cost-effective program from a federal perspective because of the state matching requirement. In addition, since the state is putting up half the funding, they also have more flexibility on how they structure their program within their state. Some fund lower scoring HPSAs and others fund additional provider types not currently eligible under the federal loan repayment program, such as pharmacists and nurses.

The Students to Service Program (S2S) – The Students to Service program is the most recent addition to the NHSC toolbox, and the smallest in terms of field strength. However, it is a critical link between the scholarship program and the loan repayment program. The S2S program enables those students who are at a key decision point in their education to be able to choose the primary care path with financial support from the NHSC program.

Since its founding, the NHSC has placed more than 50,000 providers in underserved communities, with more than 10,000 placements in the last year alone. The NHSC has proven to be a successful, sustainable solution to the shortage of providers in thousands of communities across the United States. According to HRSA, 82% of NHSC clinicians who complete their service obligation continue to practice in a shortage area up to one year later, and a majority continue to practice in a shortage area for more than 10 years after completing their service obligation. Despite this level of service, it would still take more than 20,000 additional providers to meet the existing need in the more than 15,000 federally-designated HPSAs across the country.

NHSC placements are made at approved sites providing primary medical, dental and/or mental and behavioral health services. All NHSC providers must be open to all, regardless of ability to pay. Eligible facilities include:

- Federally-Qualified Health Centers
- Indian Health Facilities
- Correctional or Detention Facilities
- Certified Rural Health Clinics
- Critical Access Hospitals
- Community Mental Health Centers
- State or Local Health Departments
- School-Based Clinics
- Certain Private Practices
- Mobile Units
- Free Clinics

Current Status of NHSC Funding

Since 1972, funding for the NHSC had been through regular, annual appropriations. This changed under the American Recovery and Reinvestment Act (ARRA) and the Affordable Care Act (ACA). Both of these laws provided new mandatory funding to expand the program to additional communities. However in FY2011, recognizing this new program funding stream, Congress dramatically decreased the regular appropriation. By FY2012, all regular appropriations had been eliminated and the program became 100% reliant on the mandatory trust fund created under the ACA. However, that funding stream expired in FY2016. Fortunately, the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 extended the trust fund for FY2016 and FY2017 at the current rate of $310 million. Unfortunately, no action has been taken to extend funding beyond FY2017, and the NHSC trust fund now faces elimination. Without Congressional action, the funding for the NHSC will expire on September 30, 2017, which will cause an immediate and

severe impact in underserved areas across the country. This potential lapse in funding will result in a dramatically decreased field strength, jeopardizing access to care for millions of people.

I understand that our country faces record debt levels and there are nearly continuous negotiations on federal spending levels. However, I truly believe that based on the merits of the program, the NHSC can withstand any kind of debate that focuses on value, impact, and long-term savings. We know that access to primary care saves lives and saves money, and the NHSC is designed to increase access to primary care services where we need it most.

We are grateful to President Trump for including a funding extension for the NHSC for two additional years in his FY2018 budget request. However, the need for primary care services far outstrips the availability, and we are concerned that level funding for the NHSC does not accurately acknowledge this need. As previously mentioned, there are 15,000 HPSAs in the U.S. and they are scored based on need. The primary care and mental/behavioral health HPSAs are scored on a 0-25 scale and dental health HPSAs are scored on a 0-26 scale. Currently funded at $310 million annually, the NHSC is only able to place clinicians at HPSAs with scores between 17-25. In other words, shortage areas with scores of 0-16 cannot even be considered for a NHSC placement despite the obvious need.

Additionally, the current funding level for the program allows for only 40% of Loan Repayment applicants and a mere 10% of scholarship applicants to be granted awards. I mention this to bring attention to the fact that although it is usually difficult to recruit primary care clinicians to these shortage areas, the NHSC is clearly an effective and popular way to overcome this difficulty. As we look for ways to increase access to primary care, we have literally thousands of passionate health professionals applying to the NHSC to serve in our most needed areas of the country. I would urge you to fund as many of these applicants as possible and help our rural and underserved communities get the primary care access they need today.

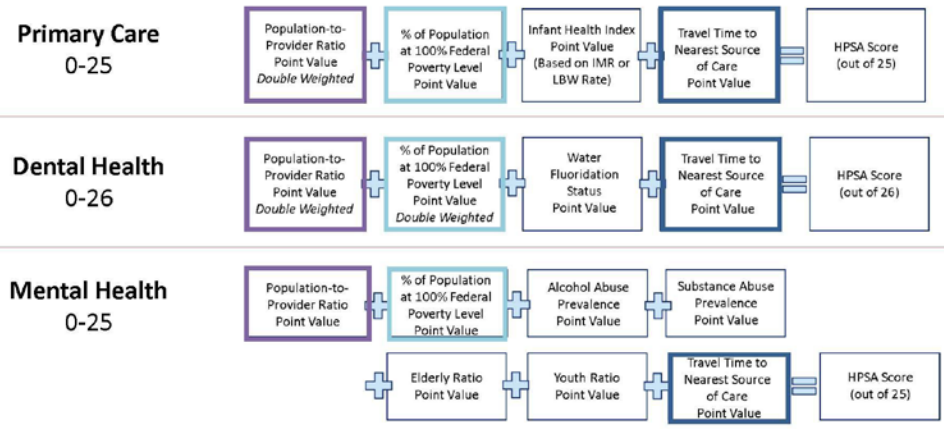
Conclusion

Today, the 10,000 plus NHSC clinicians serve 11 million people. We are hopeful that we can strengthen and grow the program to help address the needs of the additional tens of millions of people in our country in need of primary care services, but I am here today to highlight the importance of preserving this program. Without action from this Subcommittee, funding for the NHSC will expire in two weeks. On October 1, 2017, the NHSC will continue to function, but no new awards can be made, effectively eliminating the next generation of NHSC clinicians. As we face a rapidly aging and growing population, primary and preventative care services will become increasingly needed and the NHSC program has proven to be an effective program to address this need. I can assure you, as an alumnus of this program that the NHSC is one of the most effective programs this country has devised to incentivize primary care providers to choose primary care and to serve in underserved communities. I appreciate the opportunity to testify before you today, and we thank you for making the National Health Service Corps a priority. I would be glad to answer any questions you may have.

APPENDIX 1

HPSA Scoring Criteria

HPSA scores are based on a variety of factors and range from 0 to 25 in the case of Primary Care and Mental Health, and 0 to 26 in the case of Dental Health.



HPSA Scoring Calculations

	Primary Care			Dental Health			Mental Health
Factor	Max Pts Awarded	Multiplier	Total Points Possible	Max Pts Awarded	Multiplier	Total Points Possible	Max Pts Awarded
Population : Provider Ratio	5	x 2	= 10	5	x 2	= 10	7
% of Population below FPL	5	x 1	= 5	5	x 2	= 10	5
Travel distance/time to NSC	5	x 1	= 5	5	x 1	= 5	5
Ratio of children under 18 to adults 18-64	5	x 1	= 5	1	x 1	= 1	3
Ratio of adults 65 and older to adults 18-64							3
Substance prevalence							1
Alcohol abuse prevalence							1
Max Score:			= 25			= 26	= 25