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Report to Congressional Requesters

December 2013

HEALTH RESOURCES AND SERVICES ADMINISTRATION

Review of Internal Communication Mechanisms, Staffing, and Use of Contracts

GAO-14-52

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GAO Highlights

Highlights of GAO-14-52, a report to congressional requesters

Why GAO Did This Study

HRSA is charged with improving access to health care services for people who are uninsured, isolated, or medically vulnerable. HRSA carries out its mission by providing funding and support to a wide variety of programs, which have grown in number and size since the agency was established in 1982. To manage these programs, HRSA has a staff of nearly 1,900 employees, supplemented by contract staff who perform a variety of tasks to support HRSA's programs and operations. HRSA's staff are organized into seven programmatic bureaus that are responsible for overseeing HRSA's programs and nine cross-cutting operational support offices—each of which reports to the Office of the Administrator. In recent years, GAO reported on weaknesses in HRSA's oversight and monitoring of certain programs.

Given GAO's past findings and the expansion of the agency's programs, GAO was asked to review HRSA's management and operations. This report examines (1) HRSA's internal communication mechanisms and how they are used to support the agency's mission; (2) HRSA's staffing and how the agency plans for attrition; and (3) HRSA's use of contracts to support its operations. GAO reviewed and analyzed HRSA's communication methods and organizational structure; analyzed data on HRSA personnel and contracts for fiscal years 2008 through 2012; interviewed HRSA officials knowledgeable about the agency's organization, staffing, and use of contracts; and reviewed relevant documentation.

View GAO-14-52. For more information, contact Debra A.Draper at (202) 512-7114 or draperd@gao.gov.

What GAO Found

The Department of Health and Human Services' (HHS) Health Resources and Services Administration (HRSA) has mechanisms in place to share information important for supporting the agency's mission across its various organizational components and levels of staff—a practice that is consistent with internal control standards for the federal government. These communication methods include an annual operational planning process for allocating agency resources, workgroups that involve staff from across the agency to work on issues of a cross-cutting nature, and regular meetings between the Office of the Administrator and leaders of the agency's various organizational components.

HRSA's staff grew by more than 30 percent from fiscal years 2008 to 2012. The number of HRSA employees grew from 1,418 in fiscal year 2008 to 1,857 in fiscal year 2012. According to agency officials, the most common job function within HRSA is a project officer—an employee responsible for the oversight of grantees funded by the agency's programs; and HRSA has over 400 project officers. From fiscal years 2008 through 2012, HRSA lost an average of 9 percent of its staff annually to attrition. Of those who left HRSA in fiscal year 2012, approximately 59 percent resigned and 35 percent retired. Agency-wide, over 30 percent of HRSA's permanent employees will be eligible to retire by the end of fiscal year 2017. An even larger portion of HRSA's leadership, nearly 50 percent, will be eligible to retire by 2017. If a large portion of the agency's leadership were to actually retire during this time period, HRSA runs the risk of having gaps in leadership and potential loss of important institutional knowledge. HRSA periodically tracks attrition and retirement eligibility. To respond to retirements and other attrition, HRSA has instituted succession planning efforts which generally focus on leadership development for agency staff. For example, HRSA has instituted two leadership development programs, has two other programs under development, and has established mentoring and coaching programs.

In fiscal year 2012, HRSA obligated over $240 million, or about 3 percent of its appropriations, to contracts to acquire goods and services necessary to support its operations, an amount that has generally remained steady over the past few years. Over half of the fiscal year 2012 contract obligations were for two categories of services—information technology and telecommunications services, and professional support services, which includes providing technical assistance to grantees. According to HRSA officials, the agency uses contracts to support its operations for a variety of reasons; these include supplementing HRSA staff or fulfilling short-term needs and performing functions that require specialized skills for which HRSA staff do not have the appropriate expertise, such as clinical or financial expertise.

We provided a draft of this report to HHS for its review. In its written comments, HHS noted that the report recognized the mechanisms HRSA has in place to ensure the coordinated flow of communication and plan for succession.

Contents

Figures

Abbreviations

ARRA	American Recovery and Reinvestment Act of 2009
FPDS-NG	Federal Procurement Data System-Next Generation
GS	General Schedule
HHS	Department of Health and Human Services
HIV/AIDS	human immunodeficiency virus and acquired immunodeficiency syndrome
HPSA	health professional shortage area
HRSA	Health Resources and Services Administration
PPACA	Patient Protection and Affordable Care Act
SES	Senior Executive Service

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December 3, 2013

Congressional Requesters,

The Health Resources and Services Administration (HRSA), an agency within the Department of Health and Human Services (HHS), is charged with improving access to health care services for people who are uninsured, isolated, or medically vulnerable. HRSA's scope of work has evolved since it was established in 1982 and its programs have grown in number and size. According to information provided by HRSA, in the last decade, the agency's appropriation has also increased in nominal dollars from approximately $7.2 billion in fiscal year 2003 to about $8.1 billion in fiscal year 2013. Some of the agency's recent growth is due to additional authority, responsibilities, and funding for HRSA programs provided through the American Recovery and Reinvestment Act of 2009 (ARRA)[1] and the Patient Protection and Affordable Care Act (PPACA).[2] According to HRSA, ARRA provided an additional $2.5 billion from fiscal years 2009 through 2011 and PPACA authorized an additional $8.2 billion for the agency's programs from fiscal years 2010 through 2014.[3] While HRSA's programs and responsibilities have expanded, the agency is also facing new challenges as a result of sequestration,[4] which led the agency to implement a hiring freeze in January 2013.

To carry out its mission "to improve health and achieve health equity through access to quality services, a skilled health workforce, and innovative programs," HRSA provides leadership and financial support to

[1]Pub. L. No.111-5, 123 Stat. 115 (2009).

[2]Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010). In this report, references to PPACA include amendments made by the Health Care and Education Reconciliation Act.

[3]While ARRA and PPACA provided additional funding to HRSA, the annual appropriation made to the agency was reduced during some of these years.

[4]Sequestration refers to mandated budget caps for federal agencies established by the Budget Control Act of 2011, Pub. Law No. 112-25, 125 Stat. 240 (2011), which amended the Balanced Budget and Emergency Deficit Control Act of 1985, Pub. L. No. 99-177, 99 Stat. 1037 (1985), and reinstated caps on discretionary budget authority. These caps subsequently were amended by the American Taxpayer Relief Act of 2012, Pub. L. No. 112-240, 126 Stat. 2313 (2013).

more than 3,000 grantees, including organizations in every state. These grantees serve millions of people each year through a variety of HRSA-sponsored programs. For example, through its Health Center Program, HRSA awards grants to nonprofit community-based or public organizations that provide comprehensive primary care services to millions of people regardless of their ability to pay for care. HRSA also provides funding for poison control centers; programs for organ, bone marrow, and cord blood donation; and scholarships to students and loan repayment to health care providers who agree to work in underserved areas. HRSA also has programs that award grants to organizations that provide health care to people living with human immunodeficiency virus and acquired immunodeficiency syndrome (HIV/AIDS); pregnant women, mothers, and children; and people living in rural communities.

To manage its diverse array of programs, HRSA has a staff of almost 1,900 employees, supplemented by contract staff who perform a variety of tasks to support HRSA's programs and operations. HRSA staff are organized into the Office of the Administrator and 16 other organizational components—7 programmatic bureaus that are responsible for overseeing HRSA's programs, and 9 cross-cutting operational support offices—each of which reports to the Office of the Administrator. Staff must communicate across these bureaus and offices to accomplish certain tasks such as planning for the agency's budget, allocating staff, implementing the HRSA-related provisions in PPACA, and overseeing grantees.

In recent years, we reported on weaknesses in HRSA's oversight and monitoring of certain programs. For example, in 2011, we reported that HRSA's oversight of the 340B Drug Pricing Program—a program through which drug manufacturers give certain covered entities access to discounted prices on outpatient drugs—was inadequate to ensure that covered entities were in compliance with program requirements.[5] In addition, in 2012, we reported that HRSA did not consistently follow HHS regulations and guidance in its oversight of grantees under the Ryan White Comprehensive AIDS Resources Emergency Act of 1990.[6] We

[5]See GAO, *Drug Pricing: Manufacturer Discounts in the 340B Program Offer Benefits, but Federal Oversight Needs Improvement*, GAO-11-836 (Washington, D.C.: Sept. 23, 2011).

[6]See GAO, *Ryan White CARE Act: Improvements Needed in Oversight of Grantees*, GAO-12-610 (Washington, D.C.: June 11, 2012).

also reported in 2012 that HRSA's oversight of its Health Center Program grantees was insufficient to ensure that the agency consistently identified all instances of grantee noncompliance with Health Center Program requirements.[7]

Given our past findings of weaknesses in HRSA's oversight of certain programs, the importance of the agency's programs to low-income and underserved populations, and the expansion of the agency's programs, you asked us to review HRSA's management and operations, including how the agency uses contracts to support its operations. In this report, we examine (1) HRSA's internal communication mechanisms and how they are used to support the agency's mission; (2) HRSA's staffing and how the agency plans for attrition; and (3) how HRSA uses contracts to support its operations.[8]

To examine HRSA's internal communication mechanisms and how they are used to support the agency's mission, we reviewed and analyzed HRSA's methods of communication, organizational structure, and reporting arrangements overall and at the bureau and office level. In addition, we interviewed the leaders of each bureau and selected operational support offices, as well as agency-level officials about a range of management practices related to communication among agency, bureau, and office leaders. We reviewed relevant documents such as organizational charts, meeting minutes, and agency reports and memos. As part of our review, we assessed whether HRSA's communication mechanisms and practices were consistent with internal controls related to communication.[9]

To examine HRSA's staffing and how the agency plans for attrition, we analyzed trends in HRSA personnel data for the most recent five-year period, fiscal years 2008 through 2012, from the Office of Personnel Management's Enterprise Human Resources Integration-Statistical Data Mart (formerly the Central Personnel Data File) for civilian employees and

[7]See GAO, *Health Center Program: Improved Oversight Needed to Ensure Grantee Compliance with Requirements*, GAO-12-546 (Washington, D.C.: May 29, 2012).

[8]We have additional work underway to review HRSA's management of the staff and contractors who have responsibility for overseeing grantees.

[9]See GAO, *Standards for Internal Control in the Federal Government*, GAO/AMID-00-21.3.1 (Washington, D.C.: Nov. 1, 1999).

HHS's Commissioned Corps Personnel and Payroll System for employees in the U.S. Public Health Service Commissioned Corps.[10] For our analysis we combined data from both systems to create a complete picture of HRSA's staff. We analyzed data from these two systems to determine

- the number of staff overall and by location, organizational component, and pay plan;[11]
- attrition rates and the reasons for attrition, which include resignation, retirement, termination, and death;[12] and,
- retirement eligibility for HRSA staff from fiscal years 2012 through 2017, by using birth date and service computation date, as well as retirement eligibility requirements for civilian employees and Commissioned Corps officers.[13]

To determine the reliability of data obtained from the Office of Personnel Management's Enterprise Human Resources Integration-Statistical Data Mart, we reviewed the data system's technical documentation and compared output from our analysis to information provided by HRSA to ensure the information was consistent across sources. To determine the reliability of data obtained from the Commissioned Corps Personnel and

[10]HRSA has employees who are members of the U.S. Public Health Service Commissioned Corps (referred to in this report as Commissioned Corps), which is a part of HHS and fills essential public health leadership and service roles in federal government agencies and programs. Commissioned Corps officers are paid through a different pay plan than employees under the civilian pay plans.

[11]We excluded student interns and staff with intermittent temporary schedules from our analysis due to the transient nature of their employment. Headquarters staff were those in the DC-Metro locality pay area; employees in all other locality pay areas were designated as regional staff. Organizational component codes were used to identify the bureau or office an employee was assigned to within HRSA.

[12]We used the 2-year "onboard" average as the base population of "onboard" staff in a particular year to calculate attrition. These calculations include anyone who left HRSA, including those who left HRSA for jobs with other agencies within HHS. To identify individuals who left HRSA to go to another HHS agency, we tracked HRSA staff over the time period of our review and counted individuals whose agency changed from HRSA to another HHS agency as a departure due to resignation.

[13]Our analysis of retirement eligibility is limited to career permanent employees. To calculate retirement eligibility, we computed the date at which the employee would be eligible for voluntary retirement at an unreduced annuity using age at hire, years of service, birth date, and retirement plan coverage.

Payroll System, we conducted interviews with officials knowledgeable about the system to understand the actions taken to ensure the data's consistency, accuracy, and completeness. We also conducted electronic data testing for data reliability for both systems. We determined that the data obtained from both systems were sufficiently reliable for our purposes. In addition to analyzing data on HRSA staffing, we interviewed HRSA officials including the leaders of each programmatic bureau regarding staffing allocation decisions, practices, and challenges, as well as the agency's tracking and planning for staff attrition and retirements. We also reviewed relevant documentation, such as strategic plans to identify HRSA's approach to staff planning, including for allocation, attrition, and retirements. Finally, we assessed HRSA's practices against best practices for human capital management and planning.[14]

To examine how HRSA uses contracts to support its operations, we analyzed data on HRSA's contracts from the Federal Procurement Data System-Next Generation (FPDS-NG), the primary government-wide contracting database which provides information on government contracting actions and procurement trends. We focused our review on contracts with obligations in fiscal year 2012 to determine dollar amounts of contract obligations agency-wide and by organizational component, as well as key characteristics of contracts used to support the agency's operations. To assess whether HRSA's use of contracts has changed significantly over time, we also reviewed data on the agency's contracts with obligations in fiscal years 2008 through 2011. To assess the reliability of the HRSA data we obtained from FPDS-NG, we reviewed recent audits and certifications of HRSA's contract data, compared the data we obtained with data provided by HRSA, and conducted electronic data testing to look for obvious data errors. Based on this, we determined that the data were sufficiently reliable for our purposes. To supplement the data from FPDS-NG, we obtained information manually compiled by HRSA on the organizational component supported by each contract with obligations in fiscal year 2012. We also interviewed HRSA officials knowledgeable about the agency's contracts, contracting data, and approach to determining when and how to use contractors, and leaders of HRSA's programmatic bureaus about how the bureaus use contracts to support their programs. In addition, we reviewed relevant documentation

[14]See GAO, *A Model of Strategic Human Capital Management*, GAO-02-373SP (Washington, D.C.: Mar. 15, 2002).

about HRSA's process for requesting and approving the need for contract support such as procurement plan, operating plan, and decision memo documentation.

We conducted this performance audit from January 2013 to December 2013 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

HRSA was established in 1982, and its mission is to improve health and achieve health equity through access to quality services, a skilled health workforce, and innovative programs. HRSA's strategic plan contains four main goals: (1) improve access to quality health care and services, (2) strengthen the health workforce, (3) build healthy communities, and (4) improve health equity. HRSA also has a human capital strategic plan meant to ensure that the agency has the workforce it needs to carry out its mission. That plan contains five main goals: (1) plan for and align the workforce to ensure employees have the right experience and skills to fit the job, (2) support continuous learning, (3) build leadership bench strength,[15] (4) strengthen the performance culture, and (5) improve employee satisfaction. As of September 2013, HRSA was in the process of updating its human capital strategic plan for the 2013 through 2015 timeframe.

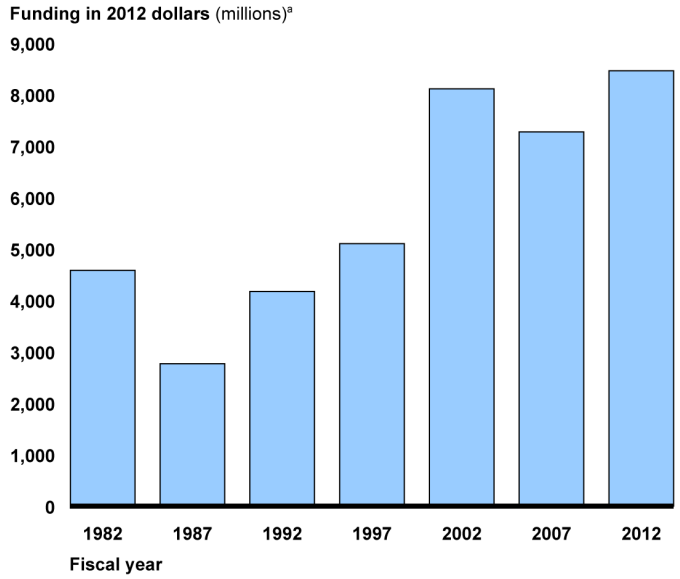
Overview of HRSA Operations

According to information from HRSA, the agency had appropriations of about $8.1 billion in fiscal year 2013. Since its inception in 1982, HRSA's appropriations have generally increased in real terms. (See fig.1.) Increases to HRSA's appropriations since fiscal year 2009 can partially be attributed to ARRA and PPACA. According to HRSA, ARRA provided an additional $2.5 billion to the agency from fiscal years 2009 through 2011. HRSA received approximately $7.8 billion through PPACA from

[15]HRSA defines this goal as ensuring leadership continuity and instilling leadership skills to support the agency's mission.

fiscal years 2010 through 2013, and is expecting another $400 million in fiscal year 2014, for a total of about $8.2 billion over the 5 years.

Figure 1: HRSA's Appropriations, Fiscal Years 1982 through 2012



Source: GAO analysis of HRSA data.

[a]Appropriation amounts are adjusted using the U.S. Department of Commerce, Bureau of Economic Analysis, Gross Domestic Product Price Index.

According to HRSA, in fiscal year 2012 the agency used over 90 percent of its budget on funding for its programs through grants, cooperative agreements, scholarships and loan repayments, and other forms of programmatic funding.[16] In addition to these funding mechanisms, HRSA uses contracts—award mechanisms used to acquire services or property from a non-federal party for the benefit or use of HRSA—to support its operations and programs.

[16]Grants constitute one form of federal assistance consisting of payments in cash or in kind to a state or local government or a nongovernmental recipient for a specified purpose. Cooperative agreements are another form of financial assistance similar to grants, but where the federal agency is more involved with the recipient during the performance of the project. HRSA also has programs that offer scholarships to students and educational loan repayment to health care providers in exchange for a commitment to provide care in underserved areas or for underserved populations.

Through these mechanisms, HRSA provides funding and support for a wide variety of programs. HRSA's programs include a block grant to fund services for maternal and child health across the country, compensation for people injured by vaccines, grants to a national network of health centers to provide primary health care, loan repayment and scholarships for recruiting and training health care providers who practice in underserved communities, and grants to organizations providing services for people living with HIV/AIDS.[17] As a result of ARRA and PPACA, HRSA has expanded some of its programs, and started new programs in recent years. For example, HRSA expanded its Health Center Program and established a Home Visiting Program to improve coordination of services and outcomes for families living in at-risk communities.[18]

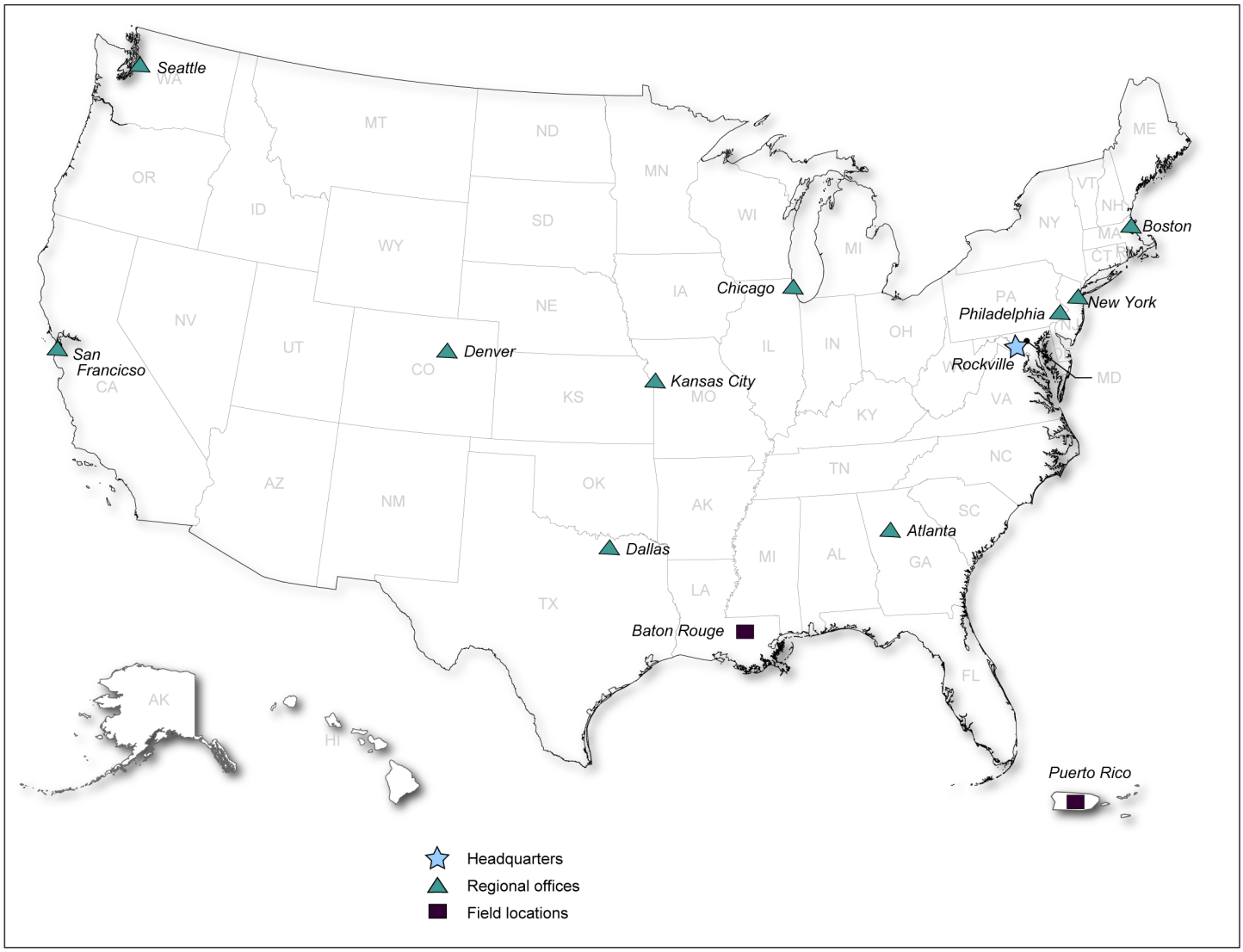
HRSA's staff of nearly 1,900 provides oversight, technical assistance, and operational support for the agency's programs. Its workforce consists of permanent civilian staff, including those within the General Schedule (GS) employment system, the Senior Executive Service (SES), and other government pay plans.[19] HRSA also employs staff from the Commissioned Corps. In addition to permanent civilian and Commissioned Corps staff, HRSA also employs some nonpermanent staff. For example, for its grant review panels, advisory committees, and certain other activities, HRSA may hire individuals for discrete, time-limited activities for which a particular expertise is needed. HRSA has headquarters staff who are assigned to the agency's headquarters in Rockville, Maryland, and "regional staff" who work in 1 of the agency's 10 regional offices or 1 of 2 field locations across the United States and Puerto Rico (see fig. 2).

[17]A block grant is a type of grant where funding recipients have substantial discretion over the type of activities to support, with minimal federal administrative requirements or restrictions.

[18]Under the Home Visiting Program, at-risk communities are communities with concentrations of (1) premature birth, low-birth weight infants, and infant mortality, or other indicators of at-risk prenatal, maternal, newborn or child health; (2) poverty; (3) crime; (4) domestic violence; (5) high-school drop outs; (6) substance abuse; (7) unemployment; or (8) child maltreatment.

[19]The GS system is a classification and pay system for the majority of civilian federal employees. The GS system has 15 grades—GS-1 (lowest) to GS-15 (highest). SES positions are federal employee positions that are classified above GS-15. Other government pay plans for which HRSA has staff include the federal wage system for hourly, blue collar employees and a pay plan for physicians and dentists.

Figure 2: Locations of HRSA Employees as of September 2013



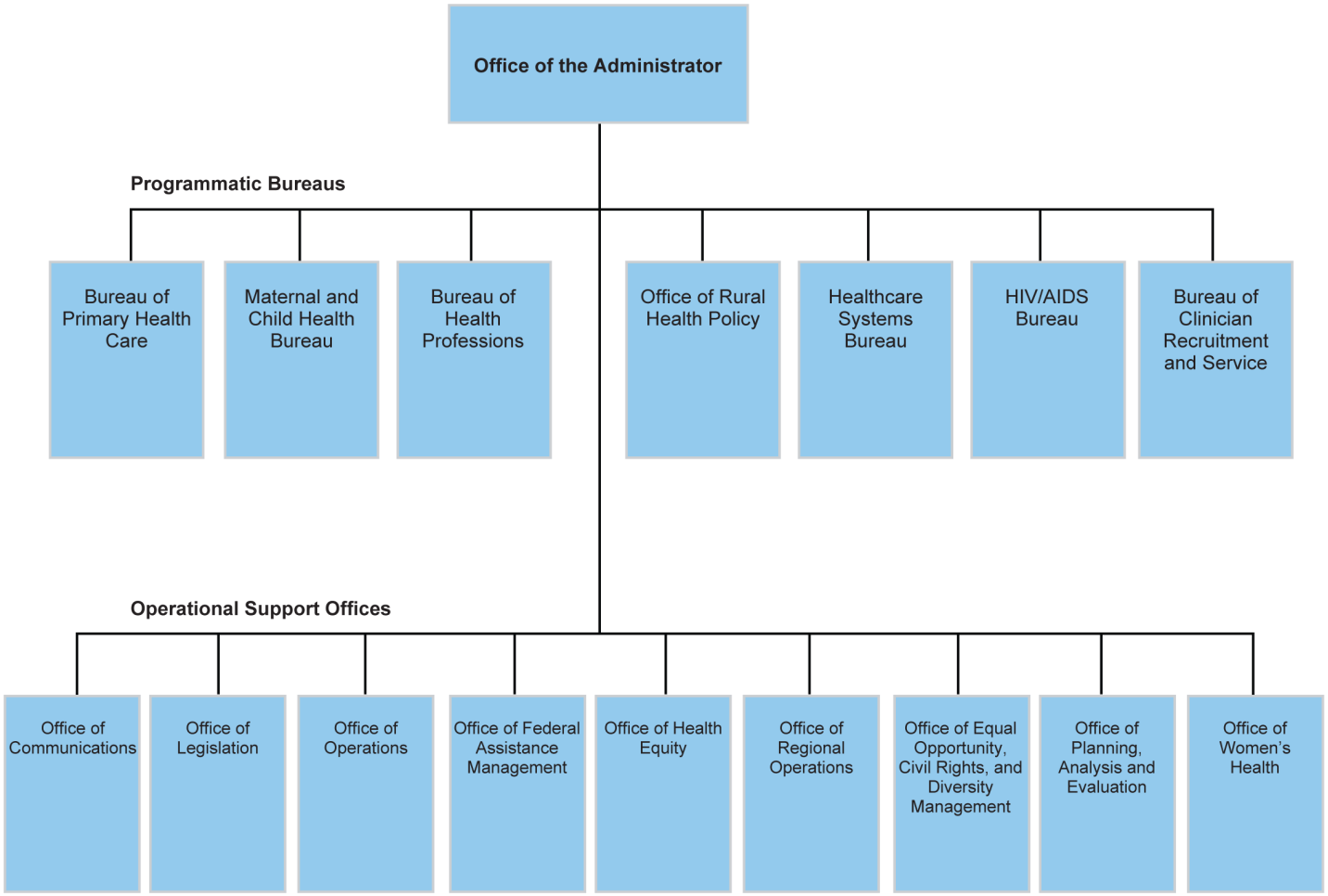
Sources: GAO analysis of HRSA data; Map Resources (map).

HRSA's Organizational Structure

HRSA's organization consists of the Office of the Administrator and 16 other organizational components—7 programmatic bureaus and 9 cross-cutting operational support offices (see fig. 3).[20]

[20]Throughout this report, we use the term "bureaus" to refer to the seven organizational components that carry out the agency's programmatic work: Bureau of Clinician Recruitment and Service, Bureau of Health Professions, Bureau of Primary Health Care, Healthcare Systems Bureau, HIV/AIDS Bureau, Maternal and Child Health Bureau, and the Office of Rural Health Policy. HRSA considers the Office of Rural Health Policy to be similar in function and organizational structure to the six units with "bureau" in their titles.

Figure 3: HRSA's Organizational Chart as of September 2013



Source: HRSA.

Note: HRSA considers the Office of Rural Health Policy to be a programmatic bureau as it is similar in function and organizational structure to the six units with "bureau" in their titles.

HRSA's Office of the Administrator provides broad leadership and direction to HRSA staff and plans, directs, and interprets major policies, programs, and initiatives for the agency. The Office of the Administrator also makes final decisions about HRSA's organization, staff allocation, budget, and contracts. The office includes HRSA's Administrator, Deputy Administrator, and Senior Advisors. HRSA's seven programmatic bureaus each manage a portfolio of activities dealing with a specific area of health care services, systems, or workforce. Each of HRSA's bureaus is led by an Associate Administrator and Deputy Associate Administrator, who are

generally members of the SES. The bureaus are organized into smaller components called divisions or offices that are led by a director, generally a GS-15, who reports to the bureau's Associate Administrator. Some of these divisions and offices are further broken down into subcomponents called branches which are led by chiefs who report to the division or office directors. HRSA's nine operational support offices provide assistance for the agency's programmatic work and coordination for cross-cutting or agency-wide issues, such as human resources, acquisitions management, and grants administration. (See table 1 for an overview of HRSA's bureaus and offices and app. I for a list of HRSA programs by bureau.)

Table 1: Overview of HRSA's Programmatic Bureaus and Operational Support Offices, as of September 2013

Organizational Component	Intended Purpose
Programmatic Bureau	
Bureau of Clinician Recruitment and Service	Helps underserved communities and facilities experiencing critical shortages of health care providers recruit and retain clinicians through scholarship and educational loan repayment programs in exchange for services.
Bureau of Health Professions	Increases access to health care by developing, distributing, and retaining a diverse, culturally competent health workforce.
Bureau of Primary Health Care	Oversees, funds, and supports a national network of health centers that provide access to high quality, family oriented, comprehensive primary and preventive health care for people who are low income, uninsured, or living where health care is scarce.
Healthcare Systems Bureau	Provides infrastructure to protect, improve, and enhance public health including organ, bone marrow, and cord blood donation.
HIV/AIDS Bureau	Administers the Ryan White HIV/AIDS CARE Act Program, which is the largest federal program focused exclusively on HIV/AIDS care, and is for those who do not have sufficient health care coverage or financial resources for coping with HIV/AIDS.
Maternal and Child Health Bureau	Administers the Maternal and Child Health Block Grant to states, as well as discretionary grants to ensure that the nation's women, infants, children, adolescents, and their families, including fathers and children with special health care needs, have access to quality health care.[a]
Office of Rural Health Policy[b]	Promotes better health care services in rural areas. The office works both within government at federal, state, and local levels, and with the private sector—with associations, foundations, providers, and community leaders—to seek solutions to rural health care problems.
Operational Support Office	
Office of Communications	Develops and implements national communication initiatives to inform and educate the public, health care professionals, policy makers, and the media; coordinates, researches, writes, and prepares speeches and audiovisual presentations for the agency; maintains the agency's social media presence; and coordinates with the Department of Health and Human Services' (HHS) Public Affairs staff.
Office of Equal Opportunity, Civil Rights, and Diversity Management	Provides advice, counsel, and recommendations to HRSA personnel, including regional divisions, on equal opportunity and civil rights.

Organizational Component	Intended Purpose
Office of Federal Assistance Management	Serves as a central office for pre-award, award, administration and management, and close-out of the agency's grants and cooperative agreements in partnership with HRSA's programmatic bureaus.
Office of Health Equity	Serves as the principal advisor and coordinator to the agency for the special needs of minority and disadvantaged populations.
Office of Legislation	Provides advice on legislative affairs, including preparing analytic papers and reports on proposed legislation; conducting legislative research, monitoring hearings and congressional activities; and coordinating with HHS legislative staff on information requested by Congress.
Office of Operations	Serves as a central office for managing the agency's operations related to information technology, budgets, financial policy and controls, human resources functions, and acquisitions.
Office of Planning, Analysis and Evaluation	Serves as an agency resource for policy analysis, data synthesis, organizational planning, external liaison activities, research, evaluation, and performance and quality measurement.
Office of Regional Operations	Provides leadership on collaborative efforts between state health care leaders, agency managers, and program resources in each state to improve public health and health care systems.
Office of Women's Health	Provides leadership on women's health and sex/gender-specific issues and policy for the agency and other HHS agencies.

Source: HRSA.

[a]A block grant is a type of grant where funding recipients have substantial discretion over the type of activities to support, with minimal federal administrative requirements or restrictions.

[b]HRSA considers the Office of Rural Health Policy to be a programmatic bureau as it is similar in function and organizational structure to the six units with "bureau" in their titles.

HRSA's underlying organizational structure of bureaus and offices has been in place for some time; however, since 2010, the agency has made several organizational changes. These included creating new organizational components, expanding or otherwise changing the functions of some components, and consolidating functions in order to eliminate a component. In addition, HRSA has made minor organizational changes within bureaus, such as realigning branches or shifting oversight responsibility of certain programs, and the staff responsible for them, between or within bureaus. HRSA officials reported that organizational changes were generally made to improve agency efficiency. For example, in 2010, HRSA established the Office of Operations to consolidate three previously separate offices: (1) the Office of Information Technology; (2) the Office of Management; and (3) the Office of Financial Management, which consisted of procurement, budget, policy, and control functions. These offices had formerly each reported directly to the Office of the Administrator. With this restructuring, the Chief Operating Officer—a position created in 2010—gained responsibility for oversight of these functions. In at least one instance, HRSA made a change as a result of a

legislative requirement, namely, in October 2011 HRSA made its Office of Women's Health, which was previously located within its Maternal and Child Health Bureau, a separate office in response to a requirement in PPACA that the office be established within the Office of the Administrator.[21] Most recently, as a result of fiscal circumstances, including the sequester which went into effect in March 2013, and an ongoing hiring freeze in effect since January 2013, HRSA eliminated its Office of Special Health Affairs and distributed most of its functions to other existing bureaus and offices.[22] According to HRSA, the elimination of the Office of Special Health Affairs was made to reduce overhead costs and better utilize staff.

HRSA Has Mechanisms in Place for Multi-Directional Communication Throughout the Agency

HRSA has mechanisms in place to share information important for supporting the agency's mission across various levels of staff in the agency, including among agency leaders, programmatic bureau and operational support office leaders, and staff. These communication mechanisms include the agency's operational planning process; cross-cutting workgroups and meetings; and regular communications among the Office of the Administrator, leaders in the bureaus and offices, and agency staff. The mechanisms HRSA has in place are consistent with internal control standards for the federal government, which state that effective communications within organizations should occur in a broad sense with a flow of information down, across, and up the organization.[23]

HRSA officials have established an annual operational planning process to facilitate the exchange of information across the agency to plan its budget and allocation of other resources. According to HRSA officials, each bureau and office develops a proposal to request contracts, budget, and other resources for the coming fiscal year. Next, these proposals are shared and discussed among all bureau and office leaders to allow for

[21]Pub. L. No. 111-148, § 3509(a), 124 Stat. 119, 535-536 (codifed at 42 U.S.C. § 914).

[22]As part of this process, the Office of Health Equity, which was previously within the Office of Special Health Affairs, began reporting directly to the Office of the Administrator.

[23]Internal control is a component of an organization's management that provides reasonable assurance that it is, among other things, operating effectively and efficiently. While the standards for internal control provide a general framework, it is up to management in each agency to implement the standards and to create practices to ensure that they are built into and are an integral part of operations. See GAO/AMID-00-21.3.1.

coordination and to reduce the risk of duplication or overlap of resources. Finally, HRSA's Administrator makes a determination about resource allocation—such as budgets and contracts for the coming fiscal year—which is documented in a decision memo for each bureau and office.[24] Agency officials told us that this process improves efficiency and reduces the chance for duplication of effort among the bureaus and offices.

In addition, HRSA has established 20 active workgroups to coordinate across the agency's bureaus and offices on cross-cutting topics. For example, according to agency officials, HRSA established a workgroup in April 2010— following the passage of PPACA—to coordinate communications and activities related to the implementation of provisions in the act pertaining to HRSA. The workgroup includes senior leaders from across the agency or their designees. In November 2012, HRSA established a Standard Operating Procedures Workgroup to monitor the implementation of standard operating procedures related to grantee oversight across bureaus, discuss the status of implementation, and to share successful practices regarding their use. Members include individuals who are tasked with leading the implementation of standard operating procedures within each bureau. Another workgroup—the HRSA Program Integrity Initiative Workgroup, launched in June 2010—is tasked with identifying risks to the agency's management of programs and working to reduce those risks by initiating new or improved oversight efforts. The workgroup is comprised of representatives from all bureaus and offices. Other established workgroups focus on issues such as providing technical assistance to potential grantees who may be new to the application process, analyzing requests for information technology capital projects, and monitoring performance of the agency's ongoing technology investments. In addition to the formal workgroups, officials in all the bureaus told us they regularly work with colleagues from other bureaus and offices as needed to coordinate on program areas where topics and issues overlap.

HRSA also has mechanisms in place to ensure the flow of information up and down the organizational hierarchy, such as from the Office of the Administrator down to individual bureaus and offices. The Office of the Administrator uses a variety of standing meetings and reporting tools to

[24]HRSA also has a process for considering requests for additional resources as needs arise outside of the operational planning process.

communicate and exchange information with bureau and office leadership on a broad range of policy, program, and management matters. For example, HRSA's Administrator holds a weekly senior staff meeting with the leaders of all of HRSA's bureaus and offices. Topics for discussion include HRSA's budget, operations, and implementation of PPACA. During these meetings, bureau and office leaders have the opportunity to share their concerns and discuss issues that they think may be of interest to the other organizational components of the agency. In addition, officials told us that HRSA's Administrator, Deputy Administrator, and a Senior Advisor hold a meeting every other week with each of the bureaus' Associate Administrators to discuss any problems that arise concerning grantees, plans for upcoming grant awards, program integrity issues, and any other bureau news or updates. Officials indicated that HRSA's Administrator meets monthly with the directors from all nine operational support offices; officials from the Office of the Administrator also meet weekly for one-on-one discussions with the directors from most of these offices. In addition, the leaders of each of the bureaus told us they hold regular meetings with their staff such as one-on-one meetings with division directors, weekly senior staff meetings within the bureau where participants can raise issues of concern or topics for discussion, and "all-hands" meetings used to inform all bureau staff.

In addition to participating in these standing meetings, bureau leaders make use of routine reports and other written communication to convey key programmatic information from the bureau to the Office of the Administrator. For example, bureau leaders provide monthly written updates on their programs and activities for inclusion in an agency-level report for the Secretary of HHS. These reports include information about HRSA collaboration with other agencies, programmatic updates, status of efforts related to PPACA, areas of concern, and completed congressional testimonies. HRSA officials also prepare decision papers to outline policy options for the Administrator's consideration. For example, officials sent decision papers to the Administrator to outline proposals for organizational changes, such as the disbanding of the Office of Special Health Affairs. These papers outlined the rationale for the change, budget and staffing implications, and specific recommendations for the Administrator.

HRSA's Staff Has Grown in Recent Years; About Half of Its Leadership Will Be Eligible to Retire by 2017

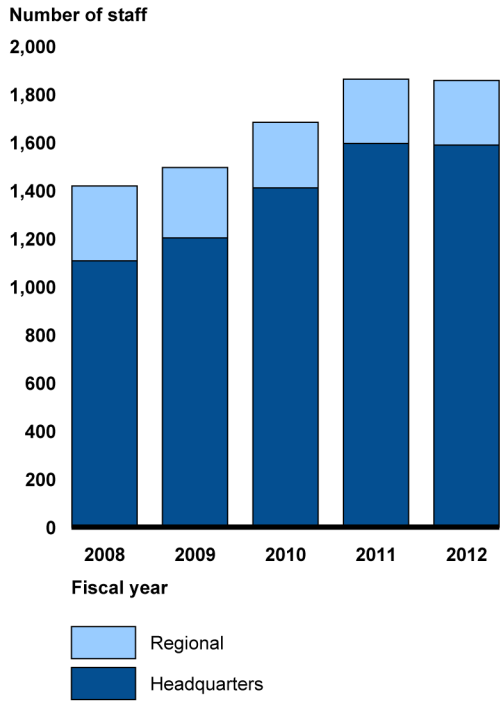
HRSA's staff has grown approximately 30 percent over the last 5 years. While the number of staff has grown, HRSA experienced attrition averaging 9 percent per year over the past five years. Looking forward, almost half of HRSA's leadership will be eligible to retire by fiscal year 2017. HRSA periodically tracks attrition and retirement eligibility and has focused its succession planning efforts on leadership development.

HRSA's Staff Has Grown in Recent Years with the Largest Segment of Staff Concentrated at the GS-13 Level

HRSA's staff grew by more than 30 percent from fiscal years 2008 to 2012; the number of HRSA employees at the end of each fiscal year grew from 1,418 in fiscal year 2008 to 1,857 in fiscal year 2012.[25] (See fig. 4.) HRSA officials indicated that the staffing increases correspond in part with HRSA's increased responsibilities and funding due to ARRA and PPACA. The majority of HRSA's staff, about 86 percent in fiscal year 2012, were stationed in HRSA's Rockville, Maryland headquarters. The remaining employees were regional staff who were located in one of HRSA's 10 regional offices or 2 field locations in the United States and Puerto Rico. While the overall number of staff grew, the total number of regional staff declined by about 14 percent—from 311 in fiscal year 2008 to 269 in fiscal year 2012.

[25]Throughout this report, the data on HRSA staffing represents staff on board as of September 30, which is the end of the federal fiscal year. Our analysis of HRSA staff levels excludes two categories of HRSA employees who serve on a temporary basis—1) students, interns, and similarly classified individuals, and 2) intermittent employees who HRSA officials told us primarily include special government employees who generally serve a few days a year on HRSA advisory committees. At the end of fiscal year 2012, there were 213 such employees (41 students, interns, and similarly classified individuals and 172 intermittent employees).

Figure 4: Number of HRSA Staff by Location, Fiscal Years 2008 through 2012

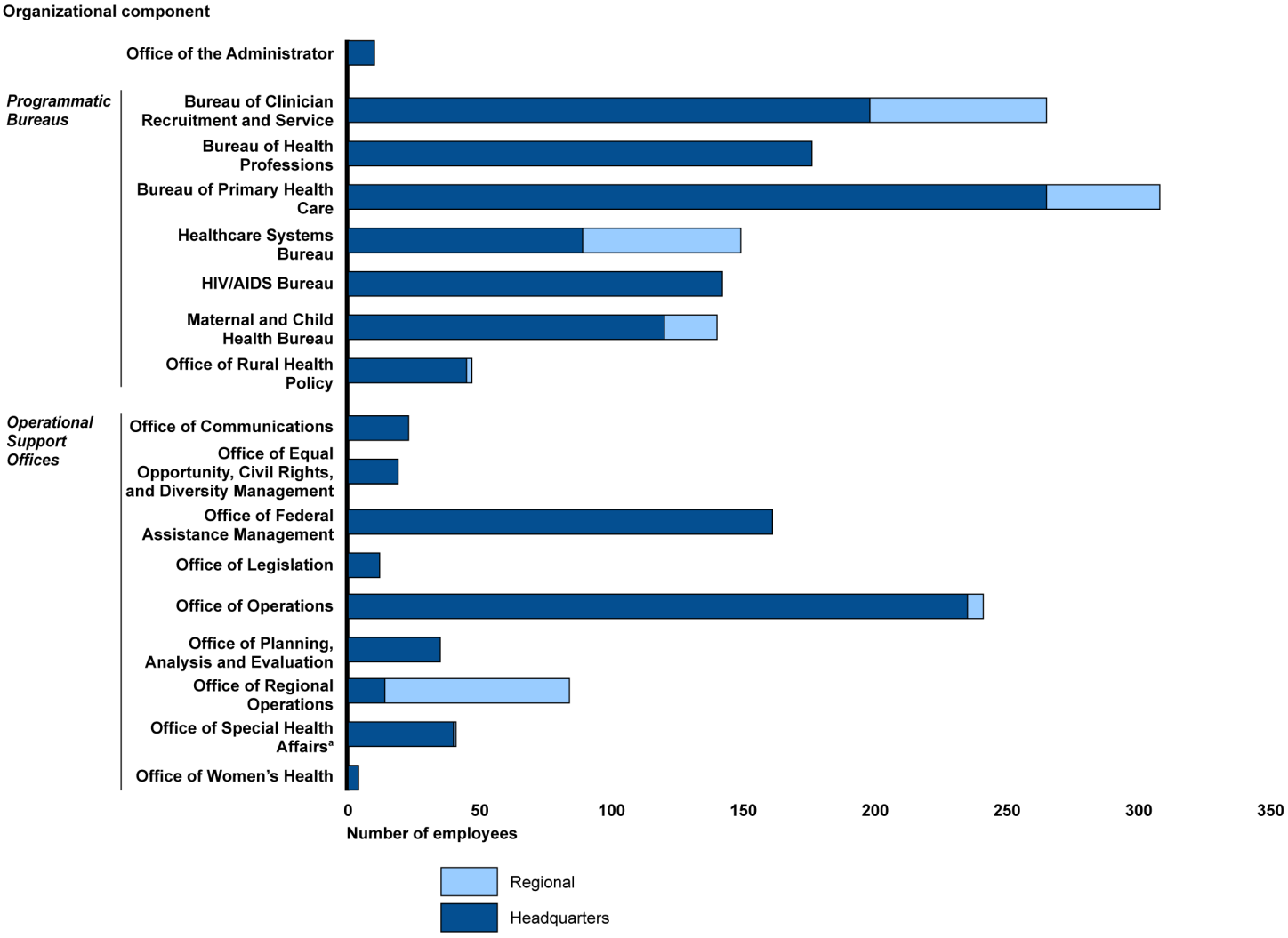


Source: GAO analysis of data from the Enterprise Human Resources Integration-Statistical Data Mart and the Commissioned Corps Personnel and Payroll System.

Note: HRSA's headquarters is located in Rockville, Maryland. HRSA also has "regional staff" who work in 1 of the agency's 10 regional offices or 1 of 2 field locations across the United States and Puerto Rico.

HRSA's organizational components vary in size and how staff are distributed across headquarters and regions. As of the end of fiscal year 2012, the organizational component with the greatest number of staff was the Bureau of Primary Health Care (308 employees) and the one with the fewest staff, with 4 employees, was the Office of Women's Health. Eight of HRSA's organizational components—five programmatic bureaus and three operational support offices—had regional staff. The Office of Regional Operations had the largest number and proportion of regional staff–70 of 84 staff (83 percent), followed by the Healthcare Systems Bureau (40 percent) and the Bureau of Clinician Recruitment and Service (25 percent). (See fig. 5.)

Figure 5: Number of HRSA Employees by Organizational Component and Location, Fiscal Year 2012



Source: GAO analysis of data from the Enterprise Human Resources Integration-Statistical Data Mart and the Commissioned Corps Personnel and Payroll System.

[a]The Office of Special Health Affairs was disbanded in June 2013 and most of its functions and staff were distributed to other Bureaus and Offices. As part of this process, an Office of Health Equity, which was previously within the Office of Special Health Affairs, began reporting directly to the Office of the Administrator.

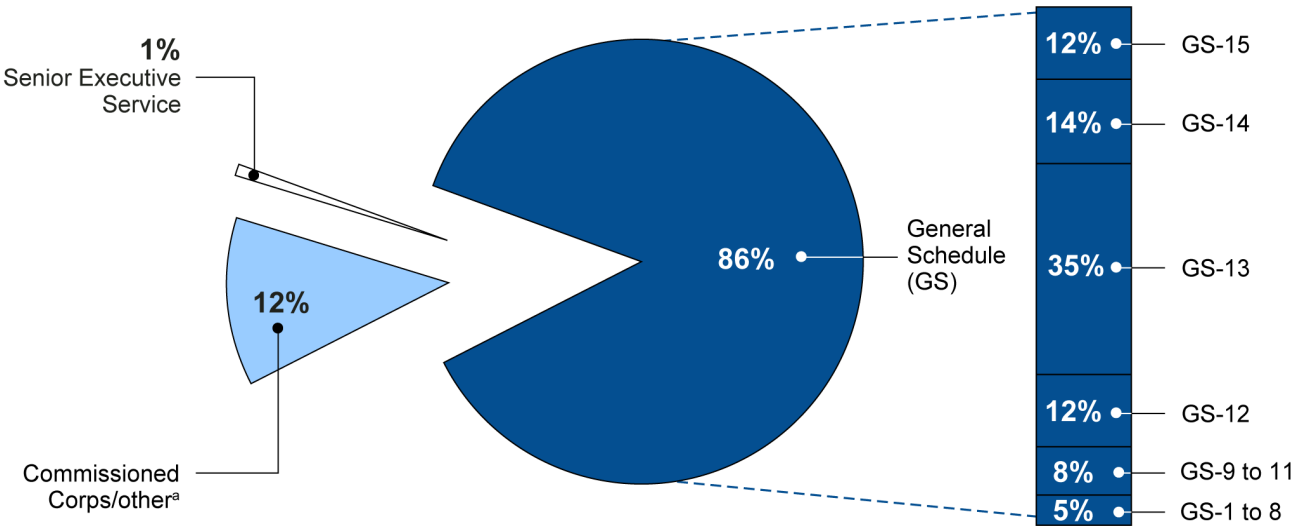
As of the end of fiscal year 2012, HRSA's staff were employed in one of 76 job occupations.[26] The 5 most common occupations were: Public Health Program Specialist (635 employees), Management and Program Analysis (336 employees), General Health Science (165 employees), Grant Management (92 employees), and Miscellaneous Administration and Program (70 employees). Officials indicated that within HRSA, the most common job function is a project officer. HRSA has over 400 project officers who are responsible for the ongoing oversight of an assigned portion of program funding recipients, such as grantees. Individuals from different occupations may serve as project officers, as the project officer function is not a distinct occupation.[27]

The majority of HRSA's staff, 1601 individuals or 86 percent of the staff in fiscal year 2012, were civilians within the GS pay plan, with GS-13s representing the largest number of employees—651 staff members (35 percent of HRSA employees). The remaining HRSA staff were SES, Commissioned Corps officers, or employees paid under one of several additional civilian pay plans. (See fig. 6 for the distribution of HRSA staff by pay plan.) Within HRSA, 510 staff members (27 percent) were GS-14s or above (including individuals in the SES)—individuals who are generally supervisors, according to HRSA officials.

[26]The occupations are defined by occupational series which consist of positions that are similar in terms of their specialized line of work and qualification requirements.

[27]The most common occupation for a HRSA project officer is the Public Health Program Specialist.

Figure 6: Percent of HRSA Staff by Pay Plan, Fiscal Year 2012



Source: GAO analysis of data from the Enterprise Human Resources Integration-Statistical Data Mart and the Commissioned Corps Personnel and Payroll System.

Notes: Due to rounding, percentages do not add to 100.

[a]Other refers to employees in other federal pay plans, such as the federal wage system for hourly, blue collar employees and a pay plan for physicians and dentists. About 1 percent of HRSA's staff—18 individuals—were in other pay plans, and 11 percent of the agency's employees—211 individuals—were in the U.S. Public Health Service Commissioned Corps, which is part of the United States Uniformed Services.

HRSA's Attrition Averaged About 9 Percent Over the Past 5 Years; Almost Half of Its Leadership Will Be Eligible to Retire by Fiscal Year 2017

From fiscal years 2008 through 2012, HRSA lost an average of about 9 percent of its staff per year to attrition.[28] HRSA's annual attrition rates from fiscal years 2008 through 2012 ranged from a low of 7.6 percent in fiscal year 2009 to a high of 9.9 percent in fiscal year 2008.[29] In fiscal year 2012, HRSA had an attrition rate of 8.8 percent. Of those who left HRSA in that year, approximately 59 percent resigned, 35 percent retired, and 4 percent were terminated or removed.[30]

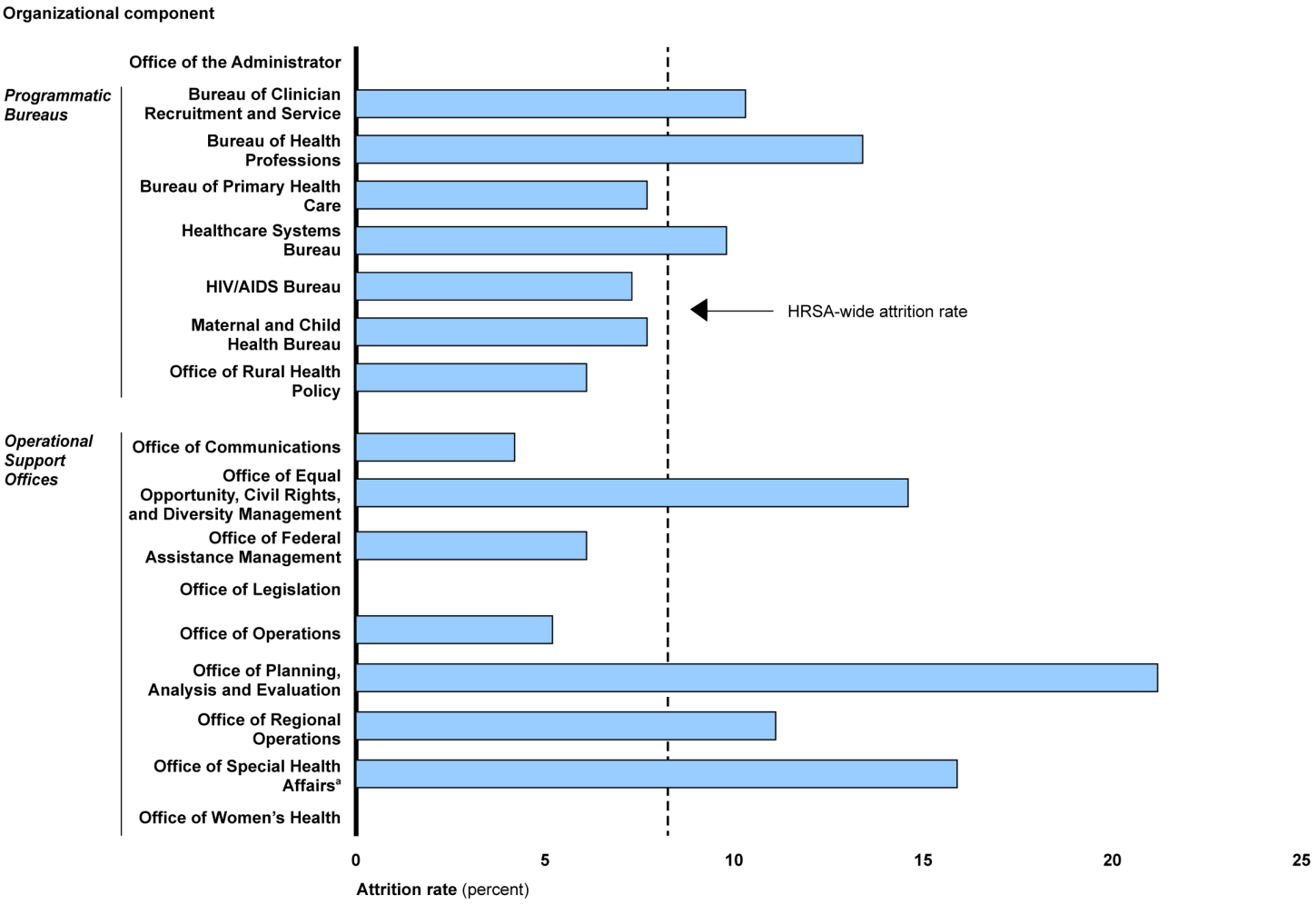
[28]We define attrition as any departure from HRSA, including retirements, resignations, terminations, and deaths. Individuals who left HRSA for jobs with other agencies within HHS are counted as resignations.

[29]HRSA's attrition rates for fiscal years 2008 through 2012 were 9.9 percent (2008), 7.6 percent (2009), 9.3 percent (2010), 8.9 percent (2011), and 8.8 percent (2012).

[30]The remaining two percent of departures were due to death.

Attrition rates varied by pay plan and organizational component. In fiscal year 2012, attrition ranged from a high of 16.1 percent among GS-1s through GS-8s to a low of 3.9 percent for SES employees. While three organizational components, including the Office of the Administrator, had no attrition in fiscal year 2012, the Office of Planning, Analysis, and Evaluation had an attrition rate over 21 percent. Across HRSA's programmatic bureaus, attrition rates ranged from 6.1 percent in the Office of Rural Health Policy to 13.4 percent in the Bureau of Health Professions. (See fig. 7.)

Figure 7: HRSA Attrition Rates by Organizational Component, Fiscal Year 2012



Source: GAO analysis of data from the Enterprise Human Resources Integration-Statistical Data Mart and the Commissioned Corps Personnel and Payroll System.

Notes: In this report, attrition includes anyone who left HRSA, including those who left HRSA for jobs with other agencies within HHS.

[a]The Office of Special Health Affairs was disbanded in June 2013 and most of its functions and staff were distributed to other bureaus and offices. As part of this process, the Office of Health Equity, which was previously within the Office of Special Health Affairs, began reporting directly to the Office of the Administrator.

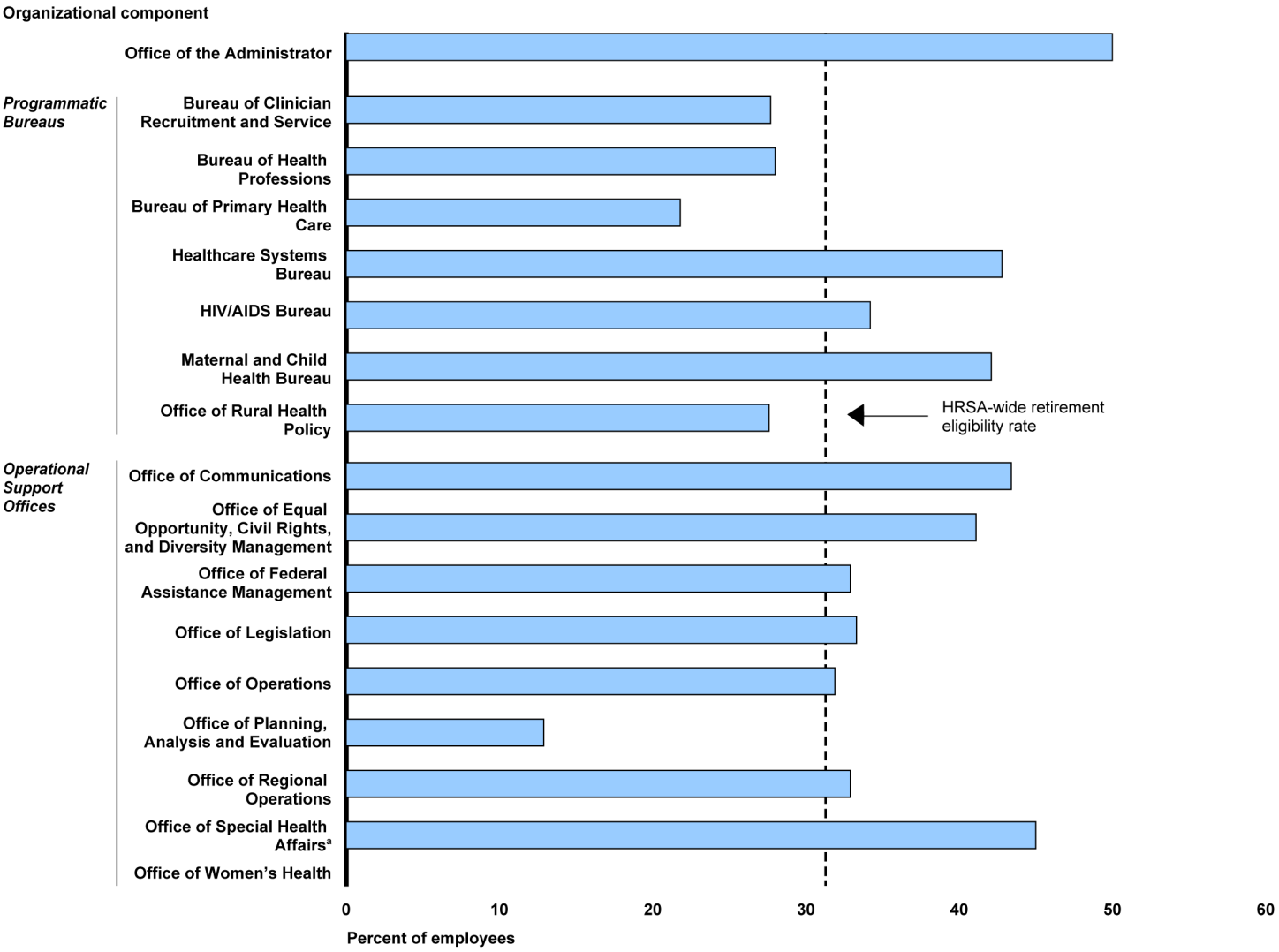
Agency-wide, 31.3 percent of HRSA's permanent employees will be eligible to retire by the end of fiscal year 2017; a rate similar to that for the entire federal government.[31] However, a larger portion of HRSA's leadership, nearly 50 percent, is eligible to retire in the next few years. Specifically, over 55 percent of HRSA's SES employees, who serve as the leaders of HRSA's bureaus and offices, and almost 50 percent of GS-15s, which include Division Directors, will be eligible to retire by the end of fiscal year 2017.[32] Although eligibility to retire does not necessarily mean that employees will do so at the time they become eligible, if there were a large number of retirements among the agency's leadership during this time period, HRSA runs the risk of having gaps in leadership and potential loss of important institutional knowledge.

Within HRSA, retirement eligibility rates also vary by organizational component. By fiscal year 2017, over 40 percent of the employees in HRSA's Office of the Administrator, the Healthcare Systems Bureau, the Maternal and Child Health Bureau, and several of HRSA's operational support offices, will be eligible to retire. (See fig. 8.)

[31]In 2012, we reported that around 30 percent of federal employees onboard at the end of fiscal year 2011 would become eligible to retire by 2016. See GAO, *Human Capital Management: Effectively Implementing Reforms and Closing Critical Skills Gaps Are Key to Addressing Federal Workforce Challenges,* GAO-12-1023T (Washington, D.C.: Sept. 19, 2012).

[32]The HRSA retirement eligibility rates we report for GS-15s and SES employees are similar to the fiscal year 2011 government-wide retirement eligibility rates for the same groups (about 45 percent of GS-15s and 58 percent of SES employees). See GAO-12-1023T.

Figure 8: Percent of HRSA Employees Eligible to Retire by Fiscal Year 2017, by Organizational Component



Source: GAO analysis of data from the Enterprise Human Resources Integration-Statistical Data Mart and the Commissioned Corps Personnel and Payroll System.

Notes: This analysis of retirement eligibility is limited to career permanent employees onboard as of the end of fiscal year 2012.

[a]The Office of Special Health Affairs was disbanded in June 2013 and most of its functions and staff were distributed to other bureaus and offices. As part of this process, an Office of Health Equity, which was previously within the Office of Special Health Affairs, began reporting directly to the Office of the Administrator.

HRSA Periodically Tracks Attrition and Retirement Eligibility; Agency Succession Planning Efforts Focus on Leadership Development

HRSA periodically tracks attrition and retirement eligibility data. Collecting and analyzing data on attrition rates and retirement eligibility are considered a fundamental element for measuring the effectiveness of human capital approaches in support of an agency's mission and goals.[33] HRSA receives a quarterly report from HHS that provides agency-wide attrition data by reason for departure. Additionally, HRSA officials stated that staff in the Office of Operations track employee attrition data as needed for making agency-wide hiring and budget decisions. According to these officials, staff attrition data is shared with leaders of the programmatic bureaus and operational support offices as requested, or when high rates of attrition occur.

In addition to reviewing attrition data, officials from several bureaus reported that they use information from exit interviews to help them understand the reasons for attrition. According to officials, a common reason why staff leave the agency is limited promotion potential, particularly from the GS-12 or GS-13 levels into more senior positions. Another reason officials reported for attrition is that some employees have expertise or skill sets that are easily transferrable and in demand elsewhere, including within other HHS and federal agencies. In particular, officials noted that the skill sets of project officers and those with information technology backgrounds are highly sought elsewhere in the government. While exit interviews provide insight into why staff are leaving the agency, officials also reported that they use information from the Federal Employee Viewpoint Survey to get a sense of the number of staff considering leaving the agency in the next year.[34]

[33]See GAO-02-373SP.

[34]The Federal Employee Viewpoint Survey is a tool that measures employees' perceptions of whether, and to what extent, conditions characterizing successful organizations are present in their agencies. Survey results are intended to provide insight into the challenges agency leaders face in ensuring the federal government has an effective civilian workforce and how well they are responding. The Office of Personnel Management administers this survey and provides reports to participating agencies that include the results of their respondents, including comparisons to results at the agency, department, and government-wide levels. One question asks "are you considering leaving your organization within the next year, and if so, why?" Respondents can indicate: No; Yes, to retire; Yes, to take another federal job; Yes, to take another job outside the federal government; or, Yes, other. Officials also noted that they use results from this survey to gauge employee satisfaction and identify areas for improvement to prevent further attrition.

HRSA also tracks retirement eligibility at the agency, bureau, and office levels. Quarterly, HRSA receives agency-wide data from HHS on the proportion of staff, including supervisory staff, eligible to retire in the next 5 years. Additionally, in early 2013, HRSA officials began providing leaders in each bureau and office with the names and retirement eligibility dates of their staff who are eligible to retire within the next 5 years. HRSA officials indicated they plan to provide these data on an annual basis going forward; however, officials indicated that the retirement eligibility reports are of limited use to them because eligibility to retire does not mean that an employee actually plans to retire.

To respond to retirements and other types of attrition, HRSA has instituted succession planning efforts which generally focus on providing leadership development to agency staff. In 2011, HRSA launched two agency-wide leadership development programs to help prepare staff to take on leadership roles when such opportunities arise. One of these programs, the Mid-Level Leadership Development Program, is for staff at the GS-12 and GS-13 levels and focuses on leadership skills development, interdepartmental project experience, exposure to HRSA leaders, and an understanding of HRSA's mission, challenges, and opportunities. The other program, the Administrative Management Development Program, focuses on individuals who are interested in careers handling the administrative management functions of the agency. HRSA officials indicated that, as of September 2013, 59 staff had completed one of these two programs. According to HRSA officials, as of July 2013, the agency was in the process of developing two additional leadership development programs—one targeted to staff at the GS-11 level and below and another for staff at the GS-14 and GS-15 levels. Officials estimated these additional programs would become operational in fiscal year 2014.

In addition to leadership development programs, HRSA officials said that there are several other opportunities for staff to gain leadership experience and professional development. For example, HRSA has established a mentoring program, which focuses on leadership development for both the participating mentor and mentee, and a coaching program, which provides participating supervisors and managers with opportunities to focus on specific areas for further development. Officials across the agency also promote opportunities for employees to be assigned to acting roles in more senior positions when there is a vacant position or when a supervisor is on leave. For example, if a branch chief were to retire or be out of the office for an extended period, a senior level employee in the branch may be asked to act as the

branch chief until the position can officially be filled or the branch chief returns. HRSA officials indicated that they work to train individuals to enhance their capabilities, which may better position staff to be successful candidates when leadership positions open up in the agency. In addition, opportunities to serve in an acting capacity in a role more senior to their own allows employees to smoothly transition into a position should they be selected for it on a permanent basis. For example, HRSA officials we spoke with told us that when the Associate Administrator of one of the bureaus was recently promoted—leaving a key vacancy—the Deputy Associate Administrator served as Acting Associate Administrator until promoted into the position permanently. Leaders from some bureaus also noted additional bureau-specific succession planning efforts. For example, the HIV/AIDS Bureau created its Organizational Development Unit in fiscal year 2012 to help deal with staff attrition issues within the bureau by providing training, helping staff create individual development plans, and providing mentoring opportunities to encourage staff to stay and continue to grow professionally.

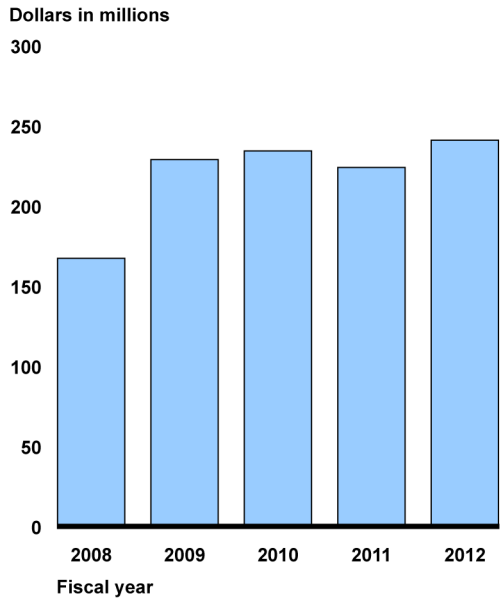
HRSA officials told us they also promote cross-training opportunities among staff, where employees work on multiple programs to assure a broader range of knowledge so that they are able to take over for each other should someone leave the bureau or agency. For example, Office of Rural Health Policy leaders said that they have their staff work on multiple programs to ensure they obtain a broader range of skills than they would acquire by working on just one program. Similarly, they assign their policy staff to a lead and backup role on key regulations so that if one person leaves the organization or is out of the office for an extended period of time, another is also familiar with the topic and able to complete the review. HRSA officials noted that some of these succession planning efforts, such as leadership training, also help with staff retention. In addition, officials noted that they have other efforts in place to promote staff retention, such as employee recognition and morale boosting opportunities.[35]

[35]For example, HRSA officials noted that one bureau has an online recognition system that allows employees at all levels to acknowledge the accomplishments and contributions of one another by generating a recognition email that goes to the recipient, as well as their supervisor.

HRSA Obligated Over $240 Million for Contracts in Fiscal Year 2012, the Majority of Which Were for Information Technology and Program Support

In fiscal year 2012, HRSA obligated over $240 million, or about 3 percent of its appropriations, to contracts to acquire goods or services necessary to support its operations.[36] With the exception of fiscal year 2008, when HRSA had approximately $167 million in contract obligations, the amount of HRSA's contract obligations generally remained steady over the past 5 years. (See fig. 9.)

Figure 9: Amount of HRSA Contract Obligations, Fiscal Years 2008 through 2012



Source: GAO analysis of HRSA data.

The vast majority of HRSA's fiscal year 2012 contract obligations (approximately 97 percent) were used to obtain services, while the remaining 3 percent of obligations went toward goods, such as computer software. Nearly 60 percent of HRSA's fiscal year 2012 contract obligations were for two categories of services:[37] (1) information

[36]When an agency awards a contract, it incurs an obligation, which is a definite legal commitment that will result in payment at some point in the future. The amount of obligations we report accounts for any funds that were deobligated within the fiscal year; funds may be deobligated, for example, due to a reduction in costs or a correction to recorded amounts. In fiscal year 2012, HRSA had just over $2 million in deobligations.

[37]A contract may include more than one product or service, but agencies can only record one product or service per contract in FPDS-NG. Our analysis presents the product or service category that HRSA recorded for the contract.

technology and telecommunications services, which includes HRSA's contract to support the operation and management of the agency's online system for documenting its grantee oversight activities, called the Electronic Handbook; and (2) professional support services, which includes HRSA's contracts for the provision of technical assistance, such as site visits, to grantees. (See table 2.)

Table 2: HRSA Contract Obligations by Category, Fiscal Year 2012

Category	Description	Amount of obligations[a]	Percent of obligations[b]
Information Technology and Telecommunications	Covers contracts for the provision of information technology, including systems development, operations, and maintenance such as for HRSA's Electronic Handbook and the Vaccine Injury Compensation System.	$79,180,379	32.9%
Professional Support	Covers contracts that provide temporary support services, technical assistance for grantees, expert witnesses, evaluations, studies, and accounting assistance.	$62,031,355	25.8%
Medical, Dental, and Surgical Services	Covers contracts that provide critical medical functions such as care for individuals with leprosy through the National Hansen's Disease Program.	$34,170,271	14.2%
Management Support	Covers contracts that provide advertising, data collection, accounting, logistics, public relations, and procurement support.	$25,092,122	10.4%
Special Studies and Analysis	Covers contracts for analysis and studies to all of HRSA's programmatic bureaus for purposes other than research and development.	$12,586,780	5.2%
Education and Training	Covers contracts that provide curriculum development and training for HRSA employees, including grants management and other professional training.	$5,934,606	2.5%
Automatic Data Processing Equipment, Software, Supplies and Support Equipment	Covers the provision of information technology and telecommunication goods and services, such as scanners and records management services.	$5,869,453	2.4%
Other	Covers all other HRSA contract obligations for goods and services.	$16,068,292	6.7%

Source: GAO analysis of information from HRSA and the Federal Procurement Data System-Next Generation.

[a]The amount of obligations we report accounts for any funds that were deobligated within the fiscal year; funds may be deobligated, for example, due to a reduction in costs or a correction to recorded amounts.

[b]Due to rounding, percentages do not add to 100.

In fiscal year 2012, nearly 40 percent, or $95,697,751, of HRSA's contract obligations provided cross-cutting support, meaning that they were utilized by more than one HRSA organizational component. The remaining 60 percent of HRSA's obligations were for programs and activities specific to a single programmatic bureau, though the amount of

obligations varied by bureau. (See table 3 for a summary of the amount of contract obligations by organizational component and app. II for information on the contract with the highest obligation for each component.)

Table 3: Amount of HRSA Contract Obligations by Organizational Component, Fiscal Year 2012

Organizational component	Amount of obligations[a]	Percent of HRSA's obligations
Bureau of Clinician Recruitment and Service	$8,955,736	3.7%
Bureau of Health Professions	$24,974,157	10.4%
Bureau of Primary Health Care	$27,114,951	11.3%
Healthcare Systems Bureau[b]	$63,633,813	26.4%
HIV/AIDS Bureau	$7,770,125	3.2%
Maternal and Child Health Bureau	$7,221,337	3.0%
Office of Rural Health Policy	$5,565,386	2.3%
Cross-cutting[c]	$95,697,751	39.7%
HRSA Total	**$240,933,256**	**100%**

Source: GAO analysis of information from HRSA and the Federal Procurement Data System-Next Generation.

[a]The amount of obligations we report accounts for any funds that were deobligated within the fiscal year; funds may be deobligated, for example, due to a reduction in costs or a correction to recorded amounts.

[b]We have included contract obligations for the National Hansen's Disease Program—a program that provides care and treatment for individuals with leprosy and related conditions—with the data for the Healthcare Systems Bureau, since this bureau took oversight responsibility for this program in August 2012. Prior to that, the program was under the auspices of the Bureau of Primary Health Care.

[c]Cross-cutting refers to contracts that were utilized by more than one HRSA organizational component.

HRSA's bureaus utilized contracts for different purposes. For example, nearly 78 percent of the Bureau of Health Profession's fiscal year 2012 obligations were for information technology and telecommunications services, primarily for the National Practitioner Data Bank, while the Maternal and Child Health Bureau did not have any obligations for that

purpose.[38] Conversely, 69 percent of the Maternal and Child Health Bureau's obligations in fiscal year 2012 were for professional services such as for a newborn hearing, screening, and intervention programs study, while about 12 percent of the Bureau of Health Professions' obligations were for professional services. See appendix III for information on the top categories of contracted services or goods by organizational component.

According to HRSA officials, the agency uses contracts to support its operations for a variety of reasons, including to supplement HRSA staff because of time constraints, or to fulfill short-term needs. In addition, HRSA uses contracts to perform functions that require specialized skills for which HRSA staff do not have the appropriate expertise, such as clinical or financial expertise. For example, the Office of Rural Health Policy uses contract staff with special expertise in areas such as oral and primary health care to provide technical assistance to its broad range of grantees, while the Bureau of Primary Health Care uses contract staff with financial expertise to conduct site-visits to health center grantees, assist HRSA staff with understanding grantees' financial audits, and help grantees develop plans to improve their financial stability. Furthermore, according to HRSA officials, the agency uses contracts to support its operations when contract staff can perform the functions more efficiently and at a lower cost than HRSA staff. For instance, the Maternal and Child Health Bureau obtains logistical support services, such as supporting large advisory committee meetings, from a contractor because it is more efficient and cost effective than having bureau staff manage these functions. Finally, HRSA uses contracts for other reasons including when the agency is legislatively required to do so. For example, HRSA is required by law to contract with one or more entities to carry out certain aspects of its C.W. Bill Young Cell Transplantation Program, a program overseen by the Healthcare Systems Bureau related to cord blood, bone marrow, and transplantation.[39]

[38]HRSA's Bureau of Health Professions administers the National Practitioner Data Bank, which serves as a flagging system intended to prompt a comprehensive review of health care practitioners' licensure activity, medical malpractice payment history, and record of clinical privileges. Used in conjunction with information from other sources, the National Practitioner Data Bank assists in promoting quality health care, and deterring fraud and abuse in the health care delivery system.

[39]42 U.S.C. § 274k.

Agency Comments

We provided a draft of this report to HHS for its review. In its written comments, HHS noted that the report recognized the mechanisms HRSA has in place to ensure the coordinated flow of communication and plan for succession. (HHS comments are reprinted in app. IV.)

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies of this report to the Secretary of Health and Human Services and the Administrator of HRSA. In addition, the report will be available on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or draperd@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix V.

Debra A. Draper
Director, Health Care

List of Requestors

The Honorable Lamar Alexander
Ranking Member
Committee on Health, Education, Labor, and Pensions
United States Senate

The Honorable Tom Coburn
Ranking Member
Committee on Homeland Security and Governmental Affairs
United States Senate

The Honorable Michael B. Enzi
Ranking Member
Subcommittee on Children and Families
Committee on Health, Education, Labor, and Pensions
United States Senate

The Honorable Richard Burr
Ranking Member
Subcommittee on Primary Health and Aging
Committee on Health, Education, Labor, and Pensions
United States Senate

Appendix I: Health Resources and Services Administration's (HRSA) Programs by Programmatic Bureau, Fiscal Year 2013

Programs	Description
Bureau of Clinician Recruitment and Service	
Faculty Loan Repayment Program	Provides individuals from disadvantaged backgrounds with an eligible health professions degree (e.g., dentistry, physician assistant) opportunities to serve as faculty members in an accredited and eligible health professions school for a minimum of two years. For each year of service, participants are awarded up to $30,000 for their educational loans.
Health Professional Shortage Areas (HPSAs)	Designates federal HPSAs (areas in which there may be a shortage of primary medical care, dental, or mental health providers), Medically Underserved Areas (areas in which residents have a shortage of personal health services), and Medically Underserved Populations (which may include groups of persons who face economic, cultural, or linguistic barriers to health care). Shortage designations are used to prioritize HRSA's health professional scholarship and loan repayment programs and other federal and state programs.
National Health Service Corps	Offers assistance to HPSAs in every U.S. state and territory to recruit and retain qualified primary care providers by providing scholarships or loan repayments to individuals who agree to provide services in shortage areas.
Native Hawaiian Health Scholarship Program	Supports the demand for more health care professionals to deliver primary health services to Native Hawaiians in the State of Hawaii by providing scholarships in return for a commitment to serve in designated areas for a specified time period.
NURSE Corps	Alleviates the shortage of nurses and economic barriers that may be associated with pursuing a career in nursing or teaching as nurse faculty by offering loan repayment assistance to registered nurses in return for a commitment to serve as a nurse in a critical shortage facility (in designated HPSAs) or as nurse faculty at an accredited eligible school of nursing, and offering scholarships to nursing students in return for service in a critical shortage facility.
Primary Care Offices	In partnership with HRSA's Bureau of Primary Health Care, this program supports cooperative agreements with 54 State Primary Care Offices and territorial agencies to facilitate the coordination of activities such as needs assessments and technical assistance within a state that relate to the delivery of primary care services, and the recruitment and retention of critical health providers.
Bureau of Health Professions	
Advanced Nursing Education Program	Provides infrastructure grants to schools to build and enhance advanced nursing education programs, and two traineeships—the Advanced Education in Nursing Traineeship and the Nurse Anesthetist Traineeship. In addition, the Advanced Nursing Education Expansion Program provides grants to schools of nursing to accelerate the production of primary care advanced practice nurses.
Area Health Education Centers	Promotes a national role in addressing health care workforce shortages, particularly in the areas of health career awareness and interdisciplinary and interprofessional community-based primary care training.
Centers of Excellence	Supports activities to enhance the academic performance of underrepresented minority students, support underrepresented minority faculty development, and facilitate research on minority health issues.
Children's Hospitals Graduate Medical Education Payment Program	Supports graduate medical education and training of residents and fellows in freestanding children's teaching hospitals and enhances the supply of primary care and pediatric medical and surgical subspecialties.

Programs	Description
Comprehensive Geriatric Education	Provides support to train and educate individuals who provide geriatric care for the elderly.
Geriatric Programs	Improves access to quality health care to the elderly through a range of programs that focus on increasing the number of geriatric specialists and increasing geriatrics competencies in the generalist workforce through education and training to improve care.
Health Care Workforce Assessment	Collects and analyzes health workforce data and information through the National Center for Health Workforce Analysis (National Center) in order to provide national and state policy makers and the private sector with information on health workforce supply, demand, and needs. The National Center also evaluates workforce policies and programs as to their effectiveness in addressing workforce issues.
Health Careers Opportunity Program	Supports activities for kindergarten through 12th grade, baccalaureate, post-baccalaureate, and graduate students to improve the recruitment and enhance the academic preparation of students from disadvantaged backgrounds into the health professions.
Mental and Behavioral Health Education and Training	Works to close the gap in access to mental and behavioral health care services by increasing the number of adequately prepared mental and behavioral health and substance abuse providers.
National Practitioner Data Bank	Serves as a flagging system intended to prompt a comprehensive review of health care practitioners' licensure activity, medical malpractice payment history and record of clinical privileges. Used in conjunction with information from other sources, the National Practitioner Data Bank assists in promoting quality health care, and deterring fraud and abuse in the health care delivery system.
Nurse Education, Practice, Quality and Retention Program	Supports initiatives to expand the nursing pipeline, promote career mobility, enhance nursing practice, provide continuing education, and support retention.
Nurse Faculty Loan Program	Supports the establishment and operation of a loan fund within participating schools of nursing to assist nurses in completing their graduate education to become qualified nurse faculty.
Nursing Workforce Diversity	Increases nursing education opportunities for individuals from disadvantaged backgrounds, including racial and ethnic minorities underrepresented among registered nurses, by providing student stipends and scholarships.
Oral Health Training Programs	Includes a range of programs designed to increase access to culturally competent, high quality dental health services to rural and other underserved communities by increasing the number of oral health care providers and improving the training programs for oral health care providers.
Primary Care Training and Enhancement	Supports and develops primary care physician and physician assistant training programs.
Public Health and Preventative Medicine Program	Supports activities that train public health and preventive medicine students, residents, and professionals to enhance the supply and expertise of the public health workforce.
Scholarships for Disadvantaged Students	Increases diversity in the health professions and nursing workforce by providing grants to eligible professions and nursing schools for use in awarding scholarships to students from disadvantaged backgrounds with financial need, many of whom are underrepresented minorities.
Teaching Health Centers Graduate Medical Education Payment Program	Provides Graduate Medical Education payments to support community-based training by covering the costs of resident training in community-based ambulatory primary care settings, such as health centers, and bolstering the primary care workforce.

Programs	Description
Bureau of Primary Health Care	
Free Clinics Medical Malpractice	Provides medical malpractice protection at sponsoring health clinics to encourage health care providers to volunteer their time at free clinics, thus expanding the capacity of the health care safety net.
Health Center Capital Development Program	Supports the construction and renovation of health centers.
Health Center Federal Tort Claims Program	The Health Center Program administers the Federal Tort Claims Act program, under which employees of eligible health centers may be deemed to be federal employees qualified for malpractice coverage under the Federal Tort Claims Act.
Health Center Program	Provides grants to eligible health centers to deliver comprehensive, high-quality, cost-effective primary health care to patients regardless of their ability to pay.
School-Based Health Center Facilities	Provides grants for the establishment of school-based health centers; grant funds can be used for expenditures for facilities, equipment, or similar expenditures.
Healthcare Systems Bureau[a]	
340B Drug Pricing Program	Requires drug manufacturers to provide discounts or rebates to a specified set of HHS-assisted programs and hospitals that meet the criteria in the Public Health Service Act and the Social Security Act for serving a disproportionate share of low-income patients.
Countermeasures Injury Compensation Program	Provides compensation to individuals for serious physical injuries or deaths from pandemic, epidemic, or security countermeasures.
C.W. Bill Young Cell Transplantation Program	Attempts to increase the number of transplants for recipients suitably matched to biologically unrelated donors of bone marrow and cord blood.
National Hansen's Disease Program[b]	Provides care and treatment for Hansen's Disease (leprosy) and related conditions to any patient living in the United States or Puerto Rico through direct patient care at its facilities in Louisiana, through grants to an inpatient program in Hawaii, by contracting with 11 regional outpatient clinics, and providing payments to the State of Hawaii for hospital and clinic facilities at Kalaupapa, Molokai, and Honolulu. Also provides for the renovation and modernization of the Louisiana facilities to eliminate structural deficiencies and keep with accepted standards of safety, comfort, human dignity, efficiency, and effectiveness.
National Cord Blood Inventory	Works on building a genetically and ethnically diverse inventory of high-quality umbilical cord blood for transplantation.
National Vaccine Injury Compensation Program	Provides compensation to people found to be injured by certain vaccines given routinely to children and adults, such as seasonal flu vaccine, measles, mumps, rubella, or polio.
Organ Transplantation	Attempts to extend and enhance the lives of individuals with end-stage organ failure for whom an organ transplant is the most appropriate therapeutic treatment by providing a national system to allocate and distribute donor organs to individuals waiting for an organ transplant.
Poison Control Program	Funds poison centers; maintains a single, national toll-free number to ensure universal access to poison center services and connect callers to the poison center serving their area; and implements a nationwide media campaign to educate the public and health care providers about poison prevention, poison center services, and the toll-free number.
HIV/AIDS Bureau	
Ryan White HIV/AIDS CARE Act Program Part A-Emergency Relief	Provides grants to metropolitan areas experiencing the greatest burdens of the country's human immunodeficiency virus and acquired immunodeficiency syndrome (HIV/AIDS) epidemic, and provide those communities with resources they need to confront the highly concentrated epidemic within the jurisdiction.

Programs	Description
Ryan White HIV/AIDS CARE Act Program Part B-Comprehensive Care: HIV Care Grants to States and the AIDS Drug Assistance Program	Provides grants to all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam and 5 U.S. Pacific Territories or Associated Jurisdictions to provide services for people living with HIV/AIDS. The AIDS Drug Assistance Program supports the provision of HIV medications and related services.
Ryan White HIV/AIDS CARE Act Program Part C-Early Intervention Services	Provides grants to 344 community and faith-based primary health clinics and public health providers in 49 states, Puerto Rico, the District of Columbia, and the U.S. Virgin Islands for targeting HIV medical services to underserved and uninsured people living with HIV/AIDS in specific geographic communities, including rural and frontier communities.
Ryan White HIV/AIDS CARE Act Program Part D-Women, Infants, Children, and Youth	Provides grants to public or private nonprofit entities that provide or arrange for primary care and support services for HIV-positive women, infants, children, and youth.
Ryan White HIV/AIDS CARE Act Program Part F-AIDS Education and Training Centers	Funds the AIDS Education and Training Centers—a network of 11 regional centers with more than 130 local performance sites and five national centers—that offers specialized clinical education and consultation on HIV/AIDS transmission, treatment, and prevention to front-line health care providers.
Ryan White HIV/AIDS CARE Act Program Part F-Dental Reimbursement Program	Provides access to oral health care for people living with HIV/AIDS by reimbursing dental education programs for the unreimbursed costs associated with providing care to people with HIV and by working with partners to provide education and clinical training for dental care providers, especially those in community-based settings.
President's Emergency Plan for AIDS Relief	Although overseen by multiple federal agencies, the HIV/AIDS Bureau manages HRSA's contributions to this program whose mission is to deliver HIV/AIDS care and treatment and helps build sustainable health systems so that host countries can confront their epidemics in the future.
Special Projects of National Significance	Supports the development of innovative models of HIV care to quickly respond to the emerging needs of clients served by the Ryan White HIV/AIDS CARE Act Program by evaluating the effectiveness of the models' design, implementation, utilization, cost, and health-related outcomes, and promoting the dissemination and replication of successful models.
Maternal and Child Health Bureau	
Autism and Other Developmental Disorders	Under the auspices of the Combating Autism Act of 2006, this program supports activities to provide information and education to increase public awareness, promote research into the development and validation of screening tools and interventions, promote early learning of individuals at higher risk, increase the number of individuals who are able to confirm or rule out a diagnosis, and increase the number of individuals able to provide evidence-based interventions for autism spectrum disorders or other developmental disabilities.
Emergency Medical Services for Children	Focuses on generating evidence on best practices regarding pediatric emergency care as well as direct outreach to the states, territories, and the District of Columbia to implement these best practices.
Family to Family Health Information Centers	Provides grants funded by the Patient Protection and Affordable Care Act to family-staffed, family-run organizations to ensure families have access to adequate information about health care, community resources, and support in order to make informed decisions around their children's health care.
Healthy Start	Provides grants to communities with exceptionally high rates of infant mortality to reduce disparities in access to and utilization of health services, improve the quality of the local health care system, empower women and their families, and increase consumer and community voices and participation in health care decisions.

Programs	Description
Heritable Disorders	Works to improve the ability of states to provide newborn and child screening for heritable (genetic) disorders.
James T. Walsh Universal Newborn Hearing Screening	Provides grants to support the physiologic testing of newborn infants prior to their hospital discharge; audiologic evaluation by three months of age; and entry into a program of early intervention by six months of age with linkages to a medical home and family-to-family support.
Maternal and Child Health Block Grant	Aims to improve the health of all mothers, children, and their families to reduce health disparities, improve access to health care, and improve the quality of health care. The program has three components: (1) block grant funds to states distributed by formula; (2) Special Projects of Regional and National Significance which supports a variety of projects in research, training, screening, and other services; and (3) Community Integrated Service Systems which supports projects that seek to increase the capacity for service delivery at the local level and to foster formation of comprehensive, integrated, community level service systems for mothers and children.[c]
Maternal, Infant, and Early Childhood Home Visiting Program	Collaborates with the Administration for Children and Families to improve coordination of services for at-risk communities, to identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities, and to strengthen and improve the programs and activities carried out under the Maternal and Child Health Block Grant program.[d]
Sickle Cell Service Demonstrations	Develops systemic mechanisms for the treatment of sickle cell disease and the prevention of morbidity and mortality associated with the condition.
Traumatic Brain Injury	Provides grants to (1) fund the development and implementation of statewide systems that ensure access to comprehensive and coordinated traumatic brain injury services including: transitional service, rehabilitation, education and employment, and long-term community support; and (2) provide services such as referrals, advice, and legal representation to individuals with traumatic brain injury.
Office of Rural Health Policy	
Black Lung	Provides grants to public and private entities, including faith-based and community-based organizations, to establish and operate clinics that provide for the outreach and education, diagnosis, treatment, rehabilitation, and benefits counseling of active and retired coal miners and others with occupation-related respiratory and pulmonary impairments.
Radiation Exposure Screening and Education Program	Provides grants to states, local governments, and appropriate health care organizations to support programs for cancer screening for individuals adversely affected by the mining, transport, and processing of uranium, and the testing of nuclear weapons for the nation's weapons arsenal.
Rural and Community Access to Emergency Devices	Provides funds to community partnerships, which then purchase and distribute automatic external defibrillators to be placed in rural communities and train emergency first responders to use the devices.
Rural Health Care Services, Outreach, Network, and Quality Improvement Grants	Provides grants to improve access to care, coordination of care, integration of services, and focus on quality improvement in rural communities.
Rural Health Policy Development	Supports a range of policy analysis, research, and information dissemination for the Office of Rural Health Policy.
Rural Hospital Flexibility Grants	Supports a range of activities focusing primarily on Critical Access Hospitals through three grant programs: (1) the Medicare Rural Hospital Flexibility (Flex) Grant Program; (2) Small Hospital Improvement Program; and (3) the Flex Rural Veterans Health Access Program.[e]
State Offices of Rural Health	Provides grants to states to establish and maintain State Offices of Rural Health.

Programs	Description
Telehealth[f]	Provides grants that support telehealth technologies through the following three programs: (1) Telehealth Network Grant Program, which provides funding for pilot projects to examine the cost impact and value-added from telehome care and tele-monitoring services and activities such as chronic disease management and distance learning; (2) Telehealth Resource Center Grant Program, which provides technical assistance to communities wishing to establish telehealth services; and (3) Licensure Portability Grant Program, which assists states to improve clinical licensure coordination across state lines.

Source: GAO summary of information from HRSA.

[a]As of April 2013, the Healthcare Systems Bureau managed two programs that no longer receive funding: (1) the Health Care and Other Facilities Program, which provided grants for new construction, renovation, design development and equipment to hospitals, community health centers, universities, and research centers; and (2) the Hill-Burton Loan Guarantee and Project Grant Program which provided loan guarantees and grants to facilities for construction. Although these programs were not funded in fiscal year 2012, HRSA officials told us that they continue to monitor recipients of prior years funding under these programs.

[b]The Healthcare Systems Bureau took oversight responsibility for this program in August 2012. Prior to that, the program was under the auspices of the Bureau of Primary Health Care.

[c]A block grant is a type of grant where funding recipients have substantial discretion over the type of activities to support, with minimal federal administrative requirements or restrictions.

[d]At-risk communities are communities with concentrations of (1) premature birth, low-birth weight infants, and infant mortality, or other indicators of at-risk prenatal, maternal, newborn or child health; (2) poverty; (3) crime; (4) domestic violence; (5) high-school drop outs; (6) substance abuse; (7) unemployment; or (8) child maltreatment.

[e]Critical Access Hospitals are small, rural hospitals. To be certified as a Critical Access Hospital a facility must meet certain criteria, including being located in a rural area, having no more than 25 inpatient beds, and furnishing 24-hour emergency care services 7 days a week.

[f]Telehealth is the use of electronic information and telecommunications technologies to support long distance health care, patient and professional health related education, public health, and health administration.

Appendix II: HRSA Contracts with the Highest Total Amount of Obligations by Organizational Component, Fiscal Year 2012

Organizational component	Purpose of contract with the highest total amount of obligations in fiscal year 2012	Amount of contract obligations[a]	Percent of total HRSA contract obligations
Bureau of Clinician Recruitment and Service	Provides travel, relocation, and logistical support to relocate health care providers for the National Health Service Corps	$4,376,546	1.8%
Bureau of Health Professions	Provides services to maintain, update, and enhance the National Practitioner Data Bank	$9,186,026	3.8%
Bureau of Primary Health Care	Provides supplemental expert assistance and support to health center grantees and federal staff by providing technical and consultative assistance through site visits, documentation reviews, and consultations to new and existing grantees	$13,356,664	5.5%
Healthcare Systems Bureau[b]	Establishes and maintains the National Bone Marrow Coordinating Center	$16,048,000	6.7%
HIV/AIDS Bureau	Provides technical assistance for the Ryan White HIV/AIDS CARE Act Program	$2,480,090	1.0%
Maternal and Child Health Bureau	Operates the Maternal, Infant, and Early Childhood Home Visiting Program Technical Assistance Coordinating Center	$2,580,000	1.1%
Office of Rural Health Policy	Provides technical assistance for grantee programs to expand access to, coordinate, restrain the cost of, and improve the quality of health care through the development of health care networks in rural areas and regions	$1,899,426	0.8%
Cross-Cutting[c]	Supports development, maintenance, and enhancement efforts for HRSA's Electronic Handbook, the agency's online system for documenting its grantee oversight activities, by integrating new business processes into the Electronic Handbook or integrating the Electronic Handbook with other existing systems	$27,791,403	11.5%

Source: GAO analysis of information from HRSA and the Federal Procurement Data System-Next Generation.

[a]The amount of obligations we report accounts for any funds that were deobligated within the fiscal year; funds may be deobligated, for example, due to a reduction in costs or a correction to recorded amounts.

[b]We have included contract data for the National Hansen's Disease Program with the data for the Healthcare Systems Bureau, as this bureau took oversight responsibility for this program in August 2012. Prior to that, the program was under the auspices of the Bureau of Primary Health Care.

[c]Cross-cutting refers to contracts that were utilized by more than one HRSA organizational component.

Appendix III: Top Three Products or Services Obtained through Contracts by Organizational Component, Fiscal Year 2012

Organizational component	Top products or services obtained through contracts	Percent of component's contract obligations
Bureau of Clinician Recruitment and Service	1. Management Support	48.9%
	2. Education and Training	17.6%
	3. Professional Support	17.4%
Bureau of Health Professions	1. Information Technology and Telecommunications	77.5%
	2. Professional Support	12.2%
	3. Special Studies and Analysis	4.5%
Bureau of Primary Health Care	1. Professional Support	72.4%
	2. Special Studies and Analysis	22.4%
	3. Information Technology and Telecommunications	3.4%
Healthcare Systems Bureau[a]	1. Medical, Dental, and Surgical Services	53.7%
	2. Management Support	11.3%
	3. Professional Support	10.7%
HIV/AIDS Bureau	1. Professional Support	48.6%
	2. Information Technology and Telecommunications	28.5%
	3. Management Support	12.7%
Maternal and Child Health Bureau	1. Professional Support	69.0%
	2. Management Support	21.6%
	3. Administrative Support Services	10.4%
Office of Rural Health Policy	1. Professional Support	95.1%
	2. Management Support	4.7%
	3. Administrative Support Services	0.1%
Cross-Cutting[b]	1. Information Technology and Telecommunications	54.1%
	2. Professional Support	17.7%
	3. Management Support	9.9%

Source: GAO Analysis of information from HRSA and the Federal Procurement Data System-Next Generation.

[a]We have included contract data for the National Hansen's Disease Program with the data for the Healthcare Systems Bureau, as this bureau took oversight responsibility for this program in August 2012. Prior to that, the program was under the auspices of the Bureau of Primary Health Care.

[b]Cross-cutting refers to contracts that were utilized by more than one HRSA organizational component.

Appendix IV: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

NOV 8 2013

Debra A. Draper
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Draper,

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "Health Resources and Services Administration: Review of Communication Mechanisms, Staffing, and Use of Contracts" (GAO-14-52).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "HEALTH RESOURCES AND SERVCIES ADMINISTRATION: REVIEW OF COMMUNICATION MECHANISMS, STAFFING, AND USE OF CONTRACTS" (GAO-14-52)

The Department appreciates the opportunity to review and comment on this draft report.

HHS is pleased to note GAO's recognition of the mechanisms HRSA has in place to ensure the coordinated flow of communication both up and down the organizational hierarchy as well as across the agency. HHS is also pleased to note GAO's recognition of HRSA's succession planning efforts, including the leadership development programs, mentoring programs and coaching programs that are in place and that will be continually evaluated and enhanced.

As noted in this draft report, HRSA fulfills an extremely important role in improving access to health care services for people who are uninsured, isolated, or medically vulnerable. HRSA will continue to work to improve its internal processes. HRSA remains committed to their core management philosophy to ensure maximum impact of every dollar the public has entrusted to them. HRSA will also continue to value constructive criticism from outside sources, like GAO, to assist in their continuous cycle of evaluation and improvement.

1

Appendix V: GAO Contact and Staff Acknowledgments

GAO Contact

Debra A. Draper, (202) 512-7114 or draperd@gao.gov

Staff Acknowledgments

In addition to the contact named above, Michelle B. Rosenberg, Assistant Director; Jill K. Center; Kathleen Diamond; Cathleen J. Hamann; Julia Kennon; Emily Loriso; Rebecca Shea; and Jennifer M. Whitworth made key contributions to this report.