United States Government Accountability Office

Report to Congressional Requesters

December 2015

HEALTH CARE WORKFORCE

Comprehensive Planning by HHS Needed to Meet National Needs

GAO-16-17

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GAO Highlights

Highlights of GAO-16-17, a report to congressional requesters

Why GAO Did This Study

An adequate, well-trained, and diverse health care workforce is essential for providing access to quality health care services. The federal government—largely through HHS—funds programs to help ensure a sufficient supply and distribution of health care professionals. Some experts suggest that maintaining access to care could require an increase in the supply of providers, while others suggest access can be maintained by, among other things, greater use of technology.

GAO was asked to review HHS's workforce efforts. In this report, GAO examines (1) HHS's planning efforts for ensuring an adequate supply and distribution of the nation's health care workforce and (2) the extent to which individual HHS health care workforce programs contribute to meeting national needs. GAO reviewed strategic planning documents, workforce projection reports, and other related documents obtained from HHS agencies; interviewed HHS officials; and analyzed performance measures for the largest health care workforce programs operated by HHS.

What GAO Recommends

GAO recommends that HHS develop a comprehensive and coordinated planning approach that includes performance measures, identifies any gaps between its workforce programs and national needs, and identifies actions to close these gaps. HHS concurred with GAO's recommendations and provided technical comments, which GAO incorporated as appropriate.

View GAO-16-17. For more information, contact Kathleen M. King at (202) 512-7114 or kingk@gao.gov.

What GAO Found

The Department of Health and Human Services (HHS) engages in some planning for the 72 health care workforce programs administered by its agencies, but lacks comprehensive planning and oversight to ensure that these efforts meet national health care workforce needs. HHS's current strategic plan includes broad strategies—such as improving access to comprehensive primary and preventive medical services in historically underserved areas and supporting federally funded health centers—to which department officials said the health care workforce programs relate. However, these strategies do not explicitly reference workforce issues or specify how these programs contribute towards HHS's current strategic goals and performance targets. The health care workforce performance measures tracked by HHS and its agencies are specific to individual workforce programs and do not fully assess the overall adequacy of the department's workforce efforts. The Office of the Secretary leads workforce planning efforts, but it does not have an ongoing formal effort to ensure that the workforce programs distributed across its different agencies are aligned with national needs. Multiple external stakeholders, such as the Institute of Medicine and the Council on Graduate Medical Education, have reported that graduate medical education (GME) funding lacks the oversight and infrastructure to track outcomes, reward performance, and respond to emerging workforce challenges and that a more coordinated effort could help to ensure an adequate supply and distribution of the health care workforce. Consistent with leading practices, a coordinated department-wide planning effort is important to ensure that these efforts are aligned and managed effectively to meet workforce needs.

While HHS's workforce programs support education and training for multiple health professions, its largest programs do not specifically target areas of workforce need, such as for primary care and rural providers. For example, its two Medicare GME programs accounted for about three-quarters of HHS's fiscal year 2014 obligations for health care workforce development. However, HHS cannot target existing Medicare GME program funds to projected workforce shortage areas because the programs were established by statute and funds are disbursed based on a statutory formula that is unrelated to projected workforce needs. HHS has limited legal authority to target certain existing programs to areas of emerging needs and has taken steps to do so within its existing authorities, such as the approval of certain demonstration projects to test new payment models for Medicaid GME funds. Further, the President's budget has proposed additional authorities that would allow HHS to implement new education and training programs and payment reforms intended to support primary care providers, but these authorities have not been enacted and officials did not know the extent to which they would be sufficient to address identified needs. External stakeholders have recommended additional reforms that would allow these programs to better targets areas of need. Without a comprehensive and coordinated planning approach, HHS cannot fully identify gaps and actions to address those gaps, including determining whether additional legislative proposals are needed to ensure that its programs fully meet workforce needs.

Contents

Abbreviations

AAMC	Association of American Medical Colleges
ACF	Administration for Children and Families
ASFR	Assistant Secretary for Financial Resources
ASPE	Assistant Secretary for Planning and Evaluation
CMS	Centers for Medicare & Medicaid Services
COGME	Council on Graduate Medical Education
GME	graduate medical education
GPRA	Government Performance and Results Act of 1993
GPRAMA	GPRA Modernization Act of 2010
HCERA	Health Care and Education Reconciliation Act of 2010
HHS	Department of Health and Human Services
HRSA	Health Resources and Services Administration
IHS	Indian Health Service
IOM	Institute of Medicine
MedPAC	Medicare Payment Advisory Commission
NHSC	National Health Service Corps
PPACA	Patient Protection and Affordable Care Act
SAMHSA	Substance Abuse and Mental Health Services Administration

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December 11, 2015

The Honorable Ron Johnson
Chairman
Committee on Homeland Security and Governmental Affairs
United States Senate

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

The Honorable Michael Enzi
Chairman
Subcommittee on Primary Health and Retirement Security
Committee on Health, Education, Labor and Pensions
United States Senate

The Honorable Richard Burr
United States Senate

An adequate, well-trained, and diverse health care workforce is essential for providing Americans with access to quality health care services.[1] According to some studies, a growing demand for services, an aging population, population growth, and increased access to insurance resulting from the implementation of the Patient Protection and Affordable Care Act (PPACA) could result in provider shortages that could limit patient access to care.[2] In addition to current workforce shortages for primary care and in rural areas, according to federal projections, by 2025,

[1]For the purpose of this report, the "health care workforce" includes those professionals who provide direct health care, including, but not limited to, audiologists, chiropractors, dentists, medical assistants, nurses, occupational therapists, optometrists, pharmacists, physical therapists, physicians, physician assistants, podiatrists, psychologists, social workers, and counselors.

[2]See GAO, *Health Care Workforce: Federal Investments in Training and the Availability of Data for Workforce Projections,* GAO-14-510T (Washington, D.C.: Apr. 9, 2014); and U.S. Department of Health and Human Services, *A 21st Century Health Care Workforce for the Nation* (Washington, D.C.: February 2014).

there will be national or regional shortages in a number of health professions, such as dentistry, psychiatry, general surgery, and nursing. Some experts report that maintaining access to care could require an increased supply of providers, while others suggest that access can be improved through policy options.[3] For example, they note that access to care could be increased through greater use of technology, such as telemedicine; changing the mix of providers delivering care; and changing the pattern of practice, such as by providing more team-based care or by eliminating currently provided care that is either unnecessary or of limited value.[4]

The federal government—largely through the Department of Health and Human Services (HHS)—funds a large number of education and training programs to help ensure a sufficient supply and distribution of physicians, nurses, dentists, and other health care professionals who provide care

[3]According to officials of the Department of Health and Human Services (HHS), the HHS models that predict workforce shortages generally assume that health care continues to be provided in the manner that it is currently provided. However, changes in the way that health care services are delivered in the future might alter the demand for health care services and professionals, and the impact of new and existing technology is difficult to predict. See, for example, A. Grover and L. M. Niecko-Najjum, "Building a Health Care Workforce for the Future: More Physicians, Professional Reforms, and Technological Advances," *Health Affairs*, vol. 32, no.11 (2013):1922-1927; and T. S. Bodenheimer and M. Smith, "Primary Care: Proposed Solutions to the Physician Shortage without Training More Physicians," *Health Affairs*, vol. 32, no. 11 (2013): 1881-1886.

[4]T. Bodenheimer and A. Fernandez, "High and Rising Health Care Costs. Part 4: Can Costs be Controlled While Preserving Quality," *Annals of Internal Medicine*, vol. 143, no. 1 (2005); J. P. Weiner, S. Yeh, and D. Blumenthal, "The Impact of Health Information Technology and e-Health on the Future Demand For Physician Services," *Health Affairs*, vol. 32, no.11 (2013): 1998-2004; and D. I. Auerbach, P. G. Chen, M. W. Friedberg, R. O. Reid, C. Lau, and A. Mehrotra, "Nurse-Managed Health Centers and Patient-Centered Medical Homes Could Mitigate Expected Primary Care Physician Shortage," *Health Affairs*, vol. 32, no. 11 (2013): 1933–1941.

directly to patients.[5] These programs are managed by multiple HHS component agencies,[6] but in fiscal year 2014 about 90 percent of funding came through the Centers for Medicare & Medicaid Services (CMS) for graduate medical education (GME) payments to hospitals and other institutions that train physician residents. Most of the remaining HHS workforce funding in 2014 was administered by the Health Resources and Services Administration (HRSA) and generally offers financial assistance to students or institutions to encourage students to train and work in specific needed professions and regions. PPACA expanded many of these programs, in addition to creating new ones to increase training in direct health care professions and care in rural areas.[7] Effective strategic planning and timely workforce projections are important mechanisms for HHS to manage its health care workforce programs, although we have previously found that HHS has faced certain challenges in this area.[8]

Given the increased demands facing the nation's health care workforce and the diversity of HHS's existing programs, you asked us to study

[5]In addition to HHS, other federal agencies—such as the Departments of Defense and Veterans Affairs—also support health care workforce development programs. States have also played a role in health care workforce development. Several states have health care workforce initiatives designed to fill certain gaps in the health care workforce.

For this report, we focused on HHS education, training, and payment programs that supported postsecondary training or education for direct health care professionals by directly providing or funding one or more of the following services—instruction or formal training opportunities; on-the-job clinical training for postgraduate health professionals; financial assistance for health professional students or professionals; or patient care-related continuing education for direct care health professionals if such training was the main program service provided. We excluded workforce programs that assist in the education and training of the public health workforce, individuals pursuing biomedical research careers, or programs that are strictly for information dissemination.

[6]In this report we refer to HHS component agencies as "HHS agency" or "agency".

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

[8]See GAO, *Health Care Workforce: HRSA Action Needed to Publish Timely National Supply and Demand Projections*, GAO-13-806 (Washington, D.C.: Sept. 30, 2013). In this report, we recommended that the department expedite and publish national projections for the primary care workforce and develop tools to monitor report review to ensure timeline goals for publication of the projection reports are met. HHS has implemented these recommendations.

HHS's activities to ensure that federal funding is aligned with the nation's health care needs. In this report, we examine the following:

1. HHS's planning efforts for ensuring an adequate supply and distribution of the nation's health care workforce; and
2. The extent to which individual HHS health care workforce programs contribute to meeting national health care workforce needs.

To examine HHS's planning efforts for ensuring an adequate supply and distribution of the nation's health care workforce, we analyzed current and past HHS and component agency documents that contain information on goals, objectives, strategies, and metrics related to health care workforce planning and development. Specifically, we reviewed the four most recent HHS strategic plans (covering the periods 2014-2018, 2010-2015, 2007-2012, and 2004-2009), as well as the President's recent budget proposals for HHS and HHS's annual performance plans and reports—which include performance goals and measures—for fiscal years 2014, 2015, and 2016. We also reviewed the most recent strategic plan for each HHS agency responsible for health care workforce programs,[9] and we interviewed agency officials to determine how its health care workforce strategies are aligned with related strategies in the most recent HHS strategic plan. We also interviewed HHS officials to identify HHS's rationale for its current approach to strategic planning for the health care workforce. We evaluated HHS's strategic planning and other efforts against the GPRA Modernization Act of 2010 (GPRAMA),[10] as well as leading practices for strategic planning and performance measurement identified in prior GAO work.[11] Finally, we reviewed recently published reports by the Institute of Medicine (IOM) and other organizations that have examined HHS's health care workforce programs and made recommendations.

[9]These agencies are the Administration for Children and Families (ACF), CMS, HRSA, the Indian Health Service (IHS), and the Substance Abuse and Mental Health Services Administration (SAMHSA).

[10]Pub. L. No. 111-352, 124 Stat. 3866 (2011). GPRAMA amended the Government Performance and Results Act of 1993 (GPRA), the statutory framework for performance management in the federal government. Pub. L. No. 103-62, 107 Stat. 285 (1993). GPRAMA established new requirements aimed at a more crosscutting and integrated approach to focusing on results and improving government performance.

[11]See, for example, GAO, *Executive Guide: Effectively Implementing the Government Performance and Results Act*, GAO/GGD-96-118 (Washington, D.C.: June 1996).

To examine the extent to which individual HHS health care workforce programs contribute to meeting national health care workforce needs, we identified a list of 72 HHS programs that provided funding for workforce development in fiscal year 2014.[12] For each of these 72 programs, HHS provided basic funding and performance information. From this listing, we selected the 12 programs with the highest obligations—ranging from $42 million to $8 billion—in fiscal year 2014. These 12 programs accounted for 96 percent of the total obligations of the 72 programs. Of these 12 programs, 7 are administered by HRSA, 4 are administered by CMS, and 1 is administered by the Administration for Children and Families (ACF).[13] (See app. I for a list of these 12 programs.) For each of these 12 programs we did the following:

- reviewed performance measures to determine how they contribute toward department and agency goals;
- reviewed documentation and interviewed responsible officials to determine how HHS monitors these programs and how the workforce programs align with HHS strategic planning goals;
- compared agency performance management practices to criteria from GPRAMA as well as leading practices identified in prior GAO work;
- examined the extent to which these programs meet identified areas of health care workforce need; to identify areas of need, we reviewed the literature on the health care workforce, as well as workforce projection reports issued by HRSA that estimate key future areas of shortages in the nation's health care workforce, examining the most recent HRSA

[12]Starting with the list of 69 programs that we identified in our 2013 report (GAO-13-806), in February 2015 we asked each HHS agency to update its list of programs. This process resulted in a list of 72 programs that were funded in fiscal year 2014.

[13]The results of our review of these 12 programs are not generalizable to all of HHS's health care workforce programs.

reports presenting projections for physicians, nurses, dentists, and other clinical specialties;[14]
- reviewed documentation from HHS to identify changes that HHS has made or proposed to the structure or allocation of program funds to meet emerging health care workforce needs; and
- reviewed the statutory requirements relevant to the permissible uses of program funds and confirmed our understanding with agency officials.

We conducted this performance audit from December 2014 to December 2015 in accordance with generally accepted government auditing standards. These 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

HHS Strategic Planning

Strategic planning provides an important mechanism for HHS to establish long-term goals and strategies to improve the performance of its many health care workforce programs. HHS, as with all executive branch agencies, is required by GPRAMA to engage in performance management tasks, such as setting goals, measuring results, and reporting progress toward these goals. As one of its GPRAMA responsibilities, HHS issues a strategic plan at least every 4 years. HHS's most recent plan covers fiscal year 2014 through fiscal year 2018 and describes four broad strategic goals:

[14]These consist of 10 reports by HRSA's National Center for Health Workforce Analysis, Washington, D.C.: *Projecting the Supply and Demand for Primary Care Practitioners Through 2020* (November 2013); *Projecting the Supply of Non-Primary Care Specialty and Subspecialty Clinicians: 2010-2025* (July 2014); *National- and State-Level Projections of Dentists and Dental Hygienists in the U.S., 2012-2025* (February 2015); *Health Workforce Projections: Vision Occupations* (December 2014); *Health Workforce Projections: Occupational Therapy and Physical Therapy* (December 2014*); Health Workforce Projections: Pharmacists* (December 2014); *The Future of the Nursing Workforce: National- and State-Level Projections, 2012-2025* (December 2014); *Health Workforce Projections: Respiratory Therapists* (April 2015); *Health Workforce Projections: Psychologists* (April 2015); and *Health Workforce Projections: Chiropractors and Podiatrists* (April 2015).

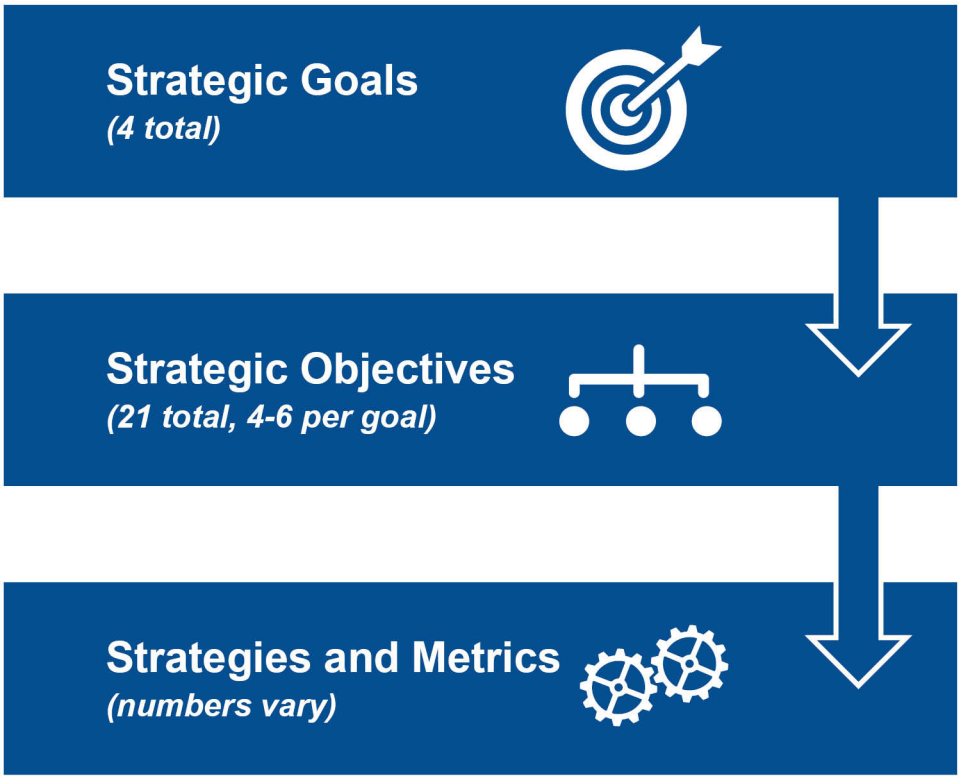
1. Strengthen health care.
2. Advance scientific knowledge and innovation.
3. Advance the health, safety, and well-being of the American people.
4. Ensure efficiency, transparency, accountability, and effectiveness of HHS programs.

Within each strategic goal, the plan presents specific objectives that are linked to a set of strategies for accomplishing that objective, as well as a representative set of performance goals or measures for assessing progress.[15] (See fig. 1.) Annually, HHS releases a performance report that presents progress on the performance measures that contribute to its strategic plan.[16] According to HHS officials, the performance measures included in this performance report are a small but representative subset of HHS's work as a whole and of the performance measures that HHS tracks annually and publishes through other means.

[15]The 2010-2015 HHS strategic plan listed "performance measures" that were used to track performance, while the 2014-2018 HHS strategic plan used "performance goals" for the same purpose. For this engagement we use the term performance measures. See http://www.hhs.gov/about/strategic-plan/message/index.html.

[16]U.S. Department of Health and Human Services, *Fiscal Year 2016 Annual Performance Plan and Report* (Washington, D.C.: February 2015).

Figure 1: Organization of the HHS Strategic Plan for Fiscal Years 2014-2018

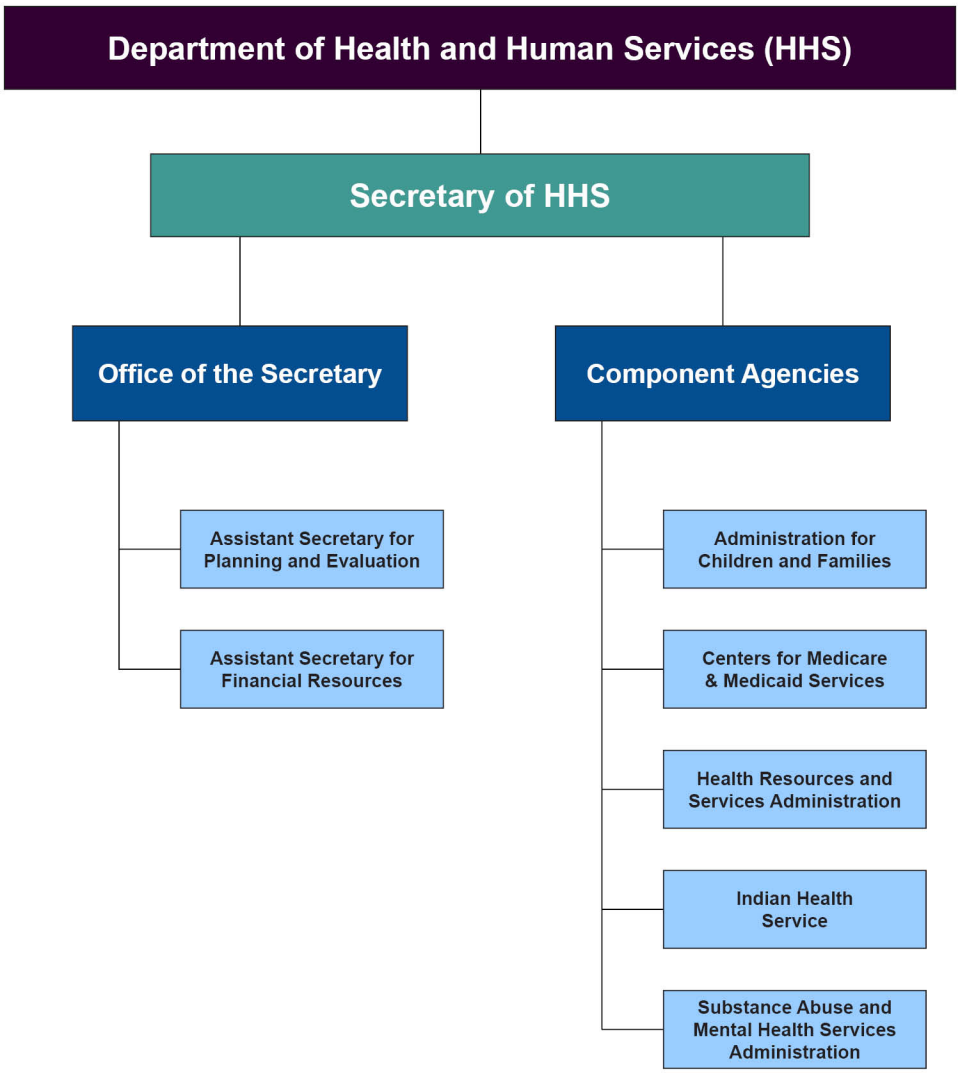


Source: HHS. | GAO-16-17

HHS's strategic planning efforts are led by staff offices that report directly to the Secretary of Health and Human Services. Specifically, the office of the Assistant Secretary for Planning and Evaluation (ASPE) is responsible for the strategic plan, and the office of the Assistant Secretary for Financial Resources (ASFR) is responsible for monitoring performance of HHS's various efforts and programs. ASPE and ASFR are to coordinate with HHS agencies to facilitate department-wide strategic planning and performance measurement efforts looking across all of HHS's programs and initiatives, including health-workforce related efforts. These agencies include HRSA, CMS, ACF, the Indian Health Service (IHS), and the Substance Abuse and Mental Health Services Administration (SAMHSA). (See fig. 2.) In addition, HHS has several advisory bodies that make recommendations to the Secretary about several topics. For example, the Council on Graduate Medical Education (COGME), supported by HRSA, provides an ongoing assessment of physician workforce needs, training issues, and financing policies and

recommends appropriate federal and private sector efforts to address identified needs.

Figure 2: HHS Offices and Agencies with Key Responsibilities for Strategic Planning and Performance Measurement Related to Health Care Workforce Development



Source: HHS. | GAO-16-17

Note: "Health care workforce" includes those professionals who provide direct health care, including, but not limited to, audiologists, chiropractors, dentists, medical assistants, nurses, occupational therapists, optometrists, pharmacists, physical therapists, physicians, physician assistants, podiatrists, psychologists, social workers, and counselors.

HHS Workforce Activities

In fiscal year 2014, HHS obligated about $14 billion to 72 health care workforce education, training, and payment programs administered primarily through five of its agencies. HRSA manages the most programs related to health care workforce development, while CMS, ACF, IHS, and SAMHSA also oversee other such programs.[17]

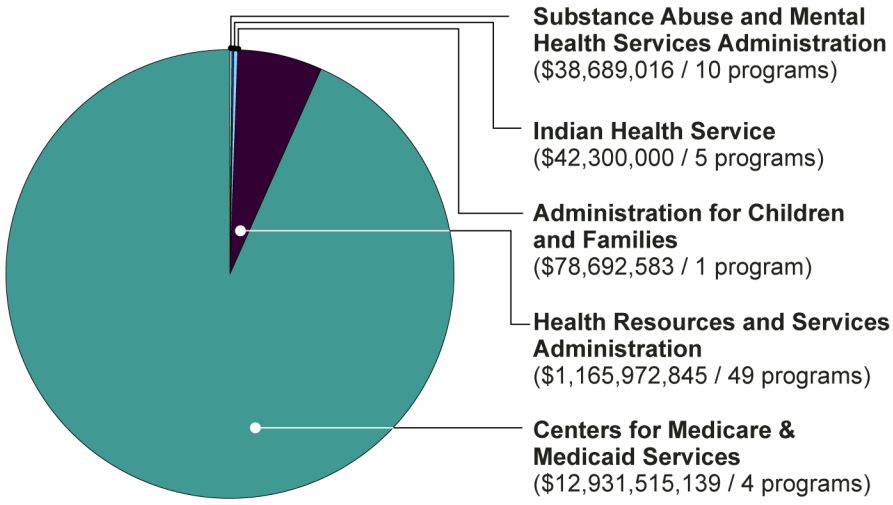
- HRSA managed 49 of the 72 HHS workforce programs in fiscal year 2014. These programs generally provide financial assistance to students and institutions—in the form of scholarships, loan repayments, or grants—to encourage students to train and work in needed professions and regions. These programs accounted for about 8 percent of HHS's $14 billion in obligations for workforce development programs.

- In contrast, CMS managed 3 GME payment programs that together accounted for about 89 percent of this funding. These payments reimburse hospitals for the cost of training medical residents and are calculated, in part, based on the number of residents at the hospital. Some of these payments are included as part of each payment that CMS makes to reimburse hospitals that train residents for care to eligible patients. CMS also manages 1 additional payment program that supports the training of nurses and allied health professionals, which accounts for about 2 percent of total HHS workforce funding.

- The remaining agencies collectively managed 19 programs, accounting for about 1 percent of total HHS workforce funding. (See fig. 3.)

[17]The Office of the Surgeon General and the Office of Population Affairs also fund health care workforce programs, obligating less than $5 million combined in fiscal year 2014.

Figure 3: HHS Obligations for Health Care Workforce Programs, by Agency, Fiscal Year 2014



Source: GAO analysis of HHS data. | GAO-16-17

Note: "Health care workforce" includes those professionals who provide direct health care, including, but not limited to, audiologists, chiropractors, dentists, medical assistants, nurses, occupational therapists, optometrists, pharmacists, physical therapists, physicians, physician assistants, podiatrists, psychologists, social workers, and counselors. The Office of the Surgeon General and the Office of Population Affairs collectively operate three additional health care workforce programs, obligating less than $5 million combined in fiscal year 2014.

In addition to funding health care workforce programs, HHS examines information about the future demand for health care services, as well as the related supply and distribution of health professionals. Specifically, HRSA periodically publishes health care workforce projections regarding the supply and demand of the health care workforce.[18] We previously found that the agency's projections had not been updated and recommended that the agency develop a strategy and time frames to update national health care workforce projections regularly. Following that, HRSA awarded a contract to develop a new model, which according to officials has enabled more accurate estimates of workforce projections as well as workforce projections for a wider array of health professions.

[18]See http://bhpr.hrsa.gov/healthworkforce/supplydemand/usworkforce/projections/index.html.

The agency subsequently issued many of those projections later in 2014 and in 2015.[19]

HHS Planning Efforts to Coordinate and Oversee Its Health Care Workforce Programs Do Not Ensure That National Needs Are Fully Addressed

HHS's current strategic plan lacks specificity regarding how health care workforce programs contribute to its strategic plan goals. Additionally, the performance targets that HHS publicly reports do not comprehensively assess the department's progress towards achieving its broader strategic plan goals regarding the health care workforce. Finally, the department engages in some coordinated planning, but lacks comprehensive planning and oversight to ensure that its many workforce efforts address identified national needs.

HHS's Strategic Plan Lacks Specific Strategies for Its Health Care Workforce Programs Related to Their Effect on Access and Quality

HHS's strategic plan includes broad strategies to which the department's health care workforce efforts relate, but these strategies do not focus specifically on workforce issues. For example, the current 2014-2018 HHS strategic plan does not have a goal or objective specifically dedicated to health care workforce. Instead, HHS officials stated that workforce development efforts are distributed across various broad access and quality objectives within the plan's goal of strengthening health care.[20] Specifically, the plan includes seven strategies that contain a health care workforce component and that are distributed among three broad objectives. These strategies generally do not explicitly reference health care workforce training or education, but instead use broad statements that concurrently encompass numerous different components and methods for improving access to and quality of health care. For

[19]In 2013 and 2014, we reported that publication of these reports had been delayed. See GAO-13-806 and GAO-14-510T. As of April 2015, HRSA had published reports on primary care, clinical specialty professions, dentists, vision occupations, occupational and physical therapists, pharmacists, nurses, respiratory therapists, psychologists, chiropractors, and podiatrists. Workforce projections for behavioral health professionals were due to be released in the fall of 2015.

[20]Workforce development efforts involving HHS's employees are included in the 2014-2018 HHS Strategic Plan within a separate goal—ensuring efficiency, transparency, accountability, and effectiveness of HHS programs. See app. II for more details.

example, as part of one strategy, HHS seeks to improve access to comprehensive primary and preventative medical services in historically underserved areas and to support federally funded health centers. While not explicit in the plan, HHS officials indicated that developing the health care workforce is one element that contributes to these strategies. (See app. II for more details about the strategic plan.)

Past HHS strategic plans included more specific strategies and objectives related to the department's workforce programs. However, HHS officials told us that the department decided to remove most of workforce-specific language when developing the current plan. The prior HHS strategic plan (2010-2015) included a dedicated goal related to workforce development, with one objective and six corresponding strategies that were specific to health care workforce planning. Further, while an earlier HHS strategic plan (2007-2012) did not have a workforce-specific strategic goal, it also had one objective and corresponding strategies on health care workforce planning, similar to the detailed strategies in the 2010-2015 plan. However, HHS officials told us that in developing the current strategic plan, the department decided to remove most of the workforce-specific language because it determined that workforce development was an intermediate step in achieving the department's broader strategic goals of improving access to and quality of health care. They also noted that, due to the size of HHS—for fiscal year 2015, HHS spent over $1 trillion through its operating divisions—its strategic plan has to be high level and not too specific about any one topic.

Rather than include specificity in HHS's strategic plan, the department expects that the strategic plans of its agencies will contain additional detail about their health care workforce efforts, as is consistent with their mission, budget, and authorities. However, we found that these agency plans did not always contain this additional detail and were not always updated in a timely manner. For example, while HRSA's 2016-2018 strategic plan contains a dedicated health care workforce goal with three related objectives and eleven strategies, CMS's current 2013-2017 plan did not elaborate on any health care workforce issues presented in the HHS strategic plan, nor did it contain other related strategies. Moreover, IHS's strategic plan was last updated in 2006, and agency officials stated

that the agency was not working to update the plan.[21] (See app. III for more details about agency strategic plans.) Consistent with GPRAMA leading practices, for strategic planning to achieve meaningful results on a crosscutting topic like workforce development, it is important that planning efforts across these agencies be coordinated with those of the department.[22]

In addition to developing its quadrennial strategic plans, HHS has previously developed other planning documents and workforce development efforts. For example, HHS has published a series of strategic initiatives outlining the Secretary's priorities. In 2014, one of these priorities was developing the health care workforce.[23] This document identified specific strategies for developing the health care workforce, such as targeting resources to areas of high need and strengthening the primary care workforce. The paper also discussed the need for reform to payment policy to better support emerging health care delivery models. However, as of November 2015, HHS had not released an update to this series of initiatives since the new Secretary assumed office in June 2014. In addition, previous presidential annual budgets have included proposals for improving HHS's health care workforce programs. Moreover, in conjunction with the President's fiscal year 2015 budget, HHS released a report in February 2014 providing additional information about the fiscal year 2015 proposals.[24] The report described the challenges to ensuring more diversity among and a better distribution

[21]IHS officials said that IHS last updated its strategic plan in 2006, and it is now out of date. Officials stated that IHS programs are aligned with the HHS 2014-2018 strategic plan through Strategic Goal One, Objective E. Moreover, HHS officials told us that in updating the HHS strategic plan to its current version, they received input from various entities, including IHS.

[22]GAO, *Executive Guide: Effectively Implementing the Government Performance and Results Act*, GAO/GGD-96-118 (Washington, D.C.: June 1996). We identified similar coordination challenges with other federal crosscutting programs. See, for example, GAO, *Mental Health: HHS Leadership Needed to Coordinate Federal Efforts Related to Serious Mental Illness*, GAO-15-113 (Washington, D.C.: Dec. 18, 2014).

[23]See U.S. Department of Health and Human Services, *Foster a 21st Century Health Workforce*, accessed 11/12/2014, www.hhs.gov/strategic-plan/health-workforce.html. Document no longer available online.

[24]U.S. Department of Health and Human Services, *A 21st Century Health Care Workforce for the Nation* (Washington, D.C.: February 2014), accessed October 1, 2014, http://aspe.hhs.gov/health/reports/2014/HealthCare_Workforce/rpt_healthcareworkforce.pdf.

of health care professionals and explained the costs and benefits associated with each of the proposals.

HHS Generally Assesses Progress of Individual Health Care Workforce Programs, But Lacks a Comprehensive Assessment of These Efforts Towards Achieving Broader Goals

HHS has identified a subset of performance measures that are intended to represent the effect that all existing health care workforce programs have on the department's broader goal of strengthening health care by improving access and quality. Among other places, HHS reports these workforce performance measures in its annual performance plan and report, which indicate progress towards achieving HHS strategic planning goals.[25] From fiscal year 2014 to 2016, the number of healthcare workforce performance measures tracked by HHS within its annual performance report dropped from five to two, and they are focused on a small percentage of programs.[26] Specifically, for fiscal year 2016, the two measures assess progress related to several HRSA programs— 4 National Health Service Corps (NHSC) programs and 14 Bureau of Health Workforce primary care training programs—that combined represent about 3 percent of the overall funding for all HHS health care workforce programs in fiscal year 2014. According to HHS officials, the department chooses not to include as part of the annual performance report all of the performance measures tracked by HHS agencies.[27] Officials said that these two measures were chosen to be tracked in the strategic plan and annual report because HHS identified them as part of a subset of measures that are representative of the department's overall programming efforts. However, these measures are specific to the 18 programs and do not fully assess the adequacy of the department's broader workforce efforts.

Moreover, HHS has no stated targets to assess the effectiveness of existing health care workforce programs on achieving the department's

[25]The department also reports program specific performance measures through a variety of publications such as the annual budget justification and the Summary of Performance and Financial Information.

[26]These two measures are the 1) field strength of the National Health Service Corps through scholarship and loan repayment agreements and 2) percentage of individuals supported by Bureau of Health Workforce programs that completed a primary care training program and are currently employed in underserved areas.

[27]According to HHS officials, the agency's annual performance plan and report must capture the breadth of the programs implemented by HHS in a format that is consumable by the public.

broader goal of strengthening health care by improving access and quality. As part of a larger measurement project, HHS tracks data on workforce that it indicates are closely related to the supply of trained health care providers. Specifically, HHS tracks (1) the percentage of individuals that have a usual source of medical care and (2) the number of primary care practitioners (such as physicians, nurse practitioners, and physician assistants). However, neither of these broad workforce indicators has a stated target related to necessary provider levels.[28]

GPRAMA leading practices indicate that for performance measures to be effective, agencies need to set specific targets. While it is important to have specific performance measures that assess individual programs, health care workforce is an issue that straddles many different programs and HHS agencies, and therefore it is also important to have broader measures that assess how these individual programs contribute to the department's overall effectiveness in developing the health care workforce to improve access to care. In the absence of these broader measures, HHS lacks information to help it comprehensively determine the extent to which programs are meeting the department's goal of strengthening health care or identify gaps between current health care workforce programs and unmet health care needs.

According to HHS, over three-quarters of the 72 health care workforce programs had performance measures tracked by the relevant HHS agency. HHS indicated that its smaller health care workforce programs generally had performance measures and targets. For example, HRSA's 7 largest health care workforce programs, which accounted for about 5 percent of HHS's health care workforce obligations in fiscal year 2014, each had related performance measures. For most of these 7 programs, HRSA reported meeting or exceeding its performance targets in fiscal year 2014. For example, according to HRSA, the NHSC and Advanced Nurse Education programs exceeded their performance targets for fiscal year 2014, and the Children's Hospital GME program met or exceeded its fiscal year 2014 performance targets. (See app. I for more information about the performance measures of the 12 largest health care workforce programs.)

[28]According to HHS, the department's target for the first measure is that 100 percent of Americans have access to a usual source of care.

However, HHS lacks performance measures related to workforce development for their largest programs.[29] Specifically, HHS's 2 largest health care workforce programs—the Medicare GME programs run by CMS, accounting for 77 percent of obligations in fiscal year 2014—did not have performance measures directly aligned with areas of health care workforce needs identified in HRSA's workforce projection reports.[30] According to HHS officials, the GME programs are not aligned with the workforce objectives in HHS's strategic plan. Leading practices identified in prior GAO work show that for individual programs to address strategic goals and objectives, it is important that the programs be aligned with these goals, and that these goals influence the daily operation of the programs.[31]

HHS Coordinates Some Health Care Workforce Planning, but Lacks Comprehensive and Ongoing Oversight to Ensure Needs Are Fully Addressed

HHS does not have a consistent and ongoing effort to coordinate all of the workforce planning efforts and resources that are distributed across the department's various offices and agencies. According to HHS officials, HHS delegates responsibility for many of its health care workforce planning efforts to its component agencies, based on each agency's mission and expertise.[32] These agencies also collaborate with each other occasionally on various health care workforce development efforts, such as projection reports and workforce programs.[33] Officials

[29]According to HHS officials, those programs without performance measures use a cost reporting system as the mechanism to ensure oversight and accountability. For example, the GME programs are funded activities that are not managed through a grant; therefore, they do not have a "performance management" system. However, HHS officials indicated that CMS uses its cost reports to track data on where the GME funding goes.

[30]Medicare is a federally financed program that provides health insurance coverage to people age 65 and older, certain individuals with disabilities, and those with end-stage renal disease.

[31]GAO, *Executive Guide: Effectively Implementing the Government Performance and Results Act*, GAO/GGD-96-118 (Washington, D.C.: June 1996).

[32]For example, according to agency officials, HRSA is the primary federal agency for improving access to health care and manages 49 of the 72 workforce training and education programs; SAMHSA has several programs related to training mental health and substance use disorder providers; ACF assists in the placement of low-income individuals into the health care field; CMS oversees payments to Medicare providers and therefore handles GME payments; and IHS encourages the placement of physicians into Indian health care facilities.

[33]For example, HRSA and SAMHSA supported a projection report for the behavioral health workforce that is scheduled to be released in the fall of 2015.

said that HHS's coordination of these efforts generally occurs during the department's larger planning and budget process.

Within the HHS Office of the Secretary, ASFR coordinates the annual budget development process, and ASPE coordinates the quadrennial strategic planning process, and, in doing so, both lead activities to include workforce development in these efforts. In addition, ASPE occasionally collaborates with HHS advisory bodies, such as COGME, supports research on the health care workforce, and periodically creates interagency workgroups to discuss specific priorities that support the development of its budget proposals. However, outside of the context of these strategic planning and budgetary processes, ASPE does not have an ongoing formal effort to coordinate the workforce planning efforts of HHS agencies. Additionally, it does not regularly monitor or facilitate HHS interagency collaborations on workforce efforts or fully communicate identified gaps to stakeholders. A separate entity within the Office of the Secretary, ASFR, coordinates the monitoring of those performance measures for health care workforce programs that the department tracks in its annual performance plan and report. Similar to ASPE, according to officials, ASFR engages in these coordinating and monitoring efforts primarily within the context of developing the annual performance report.

To achieve meaningful results, GPRAMA leading practices emphasize the importance of coordinating planning efforts across agencies and departments.[34] Leading practices state that when multiple federal programs that address a similar issue are spread over many agencies and departments, a coordinated planning approach is important to ensuring that efforts across multiple agencies are aligned.[35] Specifically, a coordinated planning approach is essential to (1) setting targets for these workforce programs and other efforts; (2) identifying and communicating whether there are gaps between existing workforce programs and future needs; and (3) determining whether agencies have the necessary information to assess the reach and effectiveness of their programs. While coordination at the program level is important, it does not take the

[34]GAO, *Managing for Results: Implementation Approaches Used to Enhance Collaboration in Interagency Groups*, GAO-14-220 (Washington, D.C.: Feb. 14, 2014).

[35]GAO, *Mental Health: HHS Leadership Needed to Coordinate Federal Efforts Related to Serious Mental Illness*, GAO-15-113 (Washington, D.C.: Dec. 18, 2014).

place of, or achieve the level of, overall department coordination that we have previously found to be the key to successful coordination.

Recently, multiple stakeholders reported that a more coordinated federal effort—possibly managed at the department level—could help to ensure a more adequate supply and distribution of the health care workforce, especially given changes in the delivery of care. For example, in examining federal GME funding, IOM and COGME each stated that the GME program lacks the oversight and infrastructure to track outcomes, reward performance, and respond to emerging workforce challenges.[36] IOM's recommendations for reforming GME include developing a strategic plan for oversight of GME funding, as well as taking steps to modernize GME payment methods based on performance to ensure program oversight and accountability. Both entities suggested that GME payments are neither sustainable in the long run nor the most effective method to developing the health care workforce to meet future projected health care needs. In each case, the organization recommended the creation of a new entity to provide oversight of national workforce efforts.[37] Moreover, Congress also recognized the need for greater coordinated attention to workforce planning when it authorized the creation of the National Health Care Workforce Commission. Although the Commission has not received an appropriation, it was authorized to provide advice to HHS and Congress about workforce supply and demand and to study various mechanisms to finance education and training. According to HHS officials, to the extent possible, the department has been able to complete work related to a number of the Commission's planned functions, but certain critical functions remain unaddressed. For example, the Commission would have been required to submit an annual report to Congress and the administration that would include, among other things, information on implications of current federal policies affecting the health care workforce and on workforce needs of underserved populations. Without a comprehensive and consistently coordinated approach, it will be difficult for HHS to ensure that workforce

[36]Institute of Medicine, *Graduate Medical Education That Meets the Nation's Health Needs* (Washington, D.C.: 2014); and Council on Graduate Medical Education, *Twenty-Second Report: The Role of Graduate Medical Education in the New Health Paradigm* (Washington, D.C.: November 2014).

[37]Among other things, IOM recommended steps to modernize GME payment methods based on performance, to ensure program oversight and accountability, and to incentivize innovation in the content and financing of GME.

funding and other resources are aligned with future health needs and to provide effective oversight of this funding.

Some of HHS's Largest Health Care Workforce Programs Do Not Target Areas of Need, but HHS Has Made Some Improvements Within Statutory Limitations

Some of HHS's largest health care workforce programs do not target areas of identified workforce needs. While HHS's ability to adjust existing programs to target areas of emerging needs is subject to certain statutory limitations, the department has taken some steps and proposed new authorities that would allow it to better align certain programs to areas of national need. However, the proposed authorities may not fully address the alignment of HHS's largest workforce programs with national needs.

HHS's Largest Health Care Workforce Programs Do Not Target Areas of Identified Need, Although Smaller Programs Do

Our review showed that although HHS's health care workforce programs support education and training for multiple professions, the biggest programs do not specifically target areas of workforce need. The two CMS Medicare GME programs, which accounted for 77 percent of HHS's fiscal year 2014 obligations for health care workforce development, support hospital-based training of the many different types of physician specialties. However, HHS cannot specifically target existing Medicare GME program funds to projected workforce needs—such as primary care and rural areas— because the disbursement of these funds is governed by requirements unrelated to workforce shortages.[38] As a result, the majority of Medicare GME funding is disbursed based on historical patterns. Therefore the Medicare-supported residency slots, supported by this Medicare GME funding, are most highly concentrated in northeastern states.[39] However, the areas of emerging health workforce need identified by HRSA in its health care workforce projection reports include the supply of primary care physicians, as well as various physician and non-physician providers in rural communities as well as ambulatory settings

[38]42 U.S.C. §§ 1395ww(d)(5)(B), 1395ww(h)(2).

[39]According to a 2014 IOM report, Medicare supported residency positions are essentially frozen in place without regard for future changes in local or regional health care workforce priorities or the geography or demography of the U.S. population. IOM also reported that the location of a doctor's medical school is predictive of his practice location, and that the longer a doctor trains in a particular area, the more likely the doctor will practice there.

across the country.[40] According to the Rand Corporation, between 1996 and 2011, the number of primary care residents has increased 8.4 percent, while there has been a 10.3 percent increase in other specialties and a 61.1 percent increase in subspecialty residents, such as cardiology.

In contrast, HHS's smaller health care workforce programs typically target emerging health care workforce needs. For example, HRSA's five largest health care workforce education and training programs, which accounted for about 4 percent of HHS's workforce obligations in fiscal year 2014, targeted the health professions identified as areas of need, such as primary care physicians and nurse professions, including registered nurses.

HHS Has Limited Authority to Target Health Care Workforce Programs to Areas of Need and Has Taken Some Steps To Do So

According to HHS officials, the department generally has limited authority to better target workforce programs to address projected health care workforce needs. Our review showed that funding for many of the largest HHS health care workforce programs—for example, CMS's Medicare GME program—are governed by statutory requirements unrelated to workforce needs. Specifically, the funding formulas for 5 of the 12 largest programs that we reviewed do not provide HHS with authority to realign funding for these specific programs to address projected workforce needs, while the remaining 7 programs provided the department with some flexibility to realign funding.[41] For all of these 7 programs, HRSA officials reported that the agency has been able to exercise some flexibility in reallocating resources within a program or between similar programs, subject to existing law.[42]

[40]Provider shortages are also anticipated in the fields of dentistry, cardiology, behavioral health, and general surgery.

[41]The five formula-based payment programs are Medicare Indirect Medical Education Payments, Medicare Direct Graduate Medical Education, Medicaid Payments for GME, Medicare Payments for Nursing and Allied Health Education, and Children's Hospital GME. HHS officials stated that in the absence of authority to direct GME funds to national needs, HHS is focused on improving access to care for the nation, and in particular the safety net, through its other workforce programs.

[42]For example, in fiscal year 2015, HRSA combined four geriatric programs into one program—the Geriatric Workforce Enhancement Program—to attempt to improve health outcomes for older adults by integrating geriatrics with primary care. In July 2015, $35.7 million was awarded to the program.

HHS officials stated that although they have no authority to realign funding for programs governed by formula, the department has utilized other authorities to better align resources with health care needs. According to these officials, the agency has used demonstration authorities to test new payment models for the Medicaid GME program.[43] HHS officials identified several demonstration projects approved by CMS for states and residency programs using their GME funds. For example, the State Innovation Model demonstration at the Center for Medicare and Medicaid Innovation is providing financial and technical support to states for the development and testing of state-led, multi-payer health care payment and service delivery models that are intended to improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid, and Children's Health Insurance Program beneficiaries–and for residents of participating states.[44] According to HHS, a number of states are using the opportunity of participating in the demonstration to reform GME and make investments in the physician training more accountable. Both Vermont and Connecticut have been awarded funding as "model testing states" based on their state innovation proposals. HHS indicated that these states proposed innovative GME mechanisms, outside of those traditionally supported by CMS, to help better meet their health workforce needs.

HHS officials also reported that the Center for Medicare & Medicaid Innovation conducted demonstrations to test new approaches to paying providers.[45] For example, in 2012, the center initiated the graduate nurse education demonstration to increase the number of graduate nursing students enrolled in advance practice registered nurse training programs.

[43]Medicaid is a joint federal-state program that finances health care coverage for certain low-income individuals.

[44]Section 3021 of PPACA established the Center for Medicare & Medicaid Innovation and authorized the selection of models to test using the funds appropriated to it in that section. Pub. L. No. 111-148, §§ 3021, 10306, 124 Stat. 119, 389, 939 (codified at 42 U.S.C. § 1315a). See also GAO, *CMS Innovation Center: Early Implementation Efforts Suggest Need for Additional Actions to Help Ensure Coordination with Other CMS Offices*, GAO-13-12 (Washington, D.C.: Nov. 15, 2012).

[45]See GAO, *CMS Innovation Center: Early Implementation Efforts Suggest Need for Additional Actions to Help Ensure Coordination with Other CMS Offices*, GAO-13-12 (Washington, D.C.: Nov. 15, 2012).

The demonstration increased reimbursement for their clinical training by $200 million over 4 years.[46]

HHS's Proposed Authorities May Not Fully Address Alignment of Its Largest Workforce Programs with National Needs

HHS has proposed additional authorities intended to help address changing health care workforce needs, although they may not fully align the department's programs with national needs. In both fiscal years 2015 and 2016, the President's budget proposed to reduce a portion of Medicare's GME payments made to hospitals by 10 percent.[47] It also proposed investing in a new program to provide additional GME funding for primary care and rural communities. The 10-year, $5.3 billion "targeted support" grant to be run by HRSA would build upon the work of HRSA's Teaching Health Centers Graduate Medical Education Payment Program and would train 13,000 physicians in primary care or other high-need specialties in teaching hospitals and other community-based health care facilities, with a focus on ambulatory and preventive care. According to HHS officials, these proposals are intended to serve as a first step to improve the alignment of GME funding with health care needs. The fiscal year 2016 budget also proposed continuation of programs, authorized under PPACA and Health Care and Education Reconciliation Act of 2010 (HCERA), to provide primary care providers with higher Medicare and Medicaid payments as a way to incentivize health care providers to offer primary care services to Medicare and Medicaid beneficiaries.[48] HHS officials indicated that the implementation of these proposals would help

[46]See http://innovation.cms.gov/initiatives/gne/ for more details.

[47]In these budgets, the President proposed reducing indirect GME payments made to hospitals. Moreover, the President also proposed setting standards for teaching hospitals to encourage training of primary care residents and emphasize skills that promote high-quality and high-value health care. According to HHS officials, the legislative authorities sought in these budgets have, to date, not been enacted by Congress. The President made this same proposal in fiscal year 2014 and past budgets have also proposed reforms to GME funding.

[48]PPACA provides for a 10 percent bonus Medicare payment for certain primary care services furnished by eligible primary care providers through 2015. HCERA provides that eligible primary care providers furnishing certain Medicaid primary care services be paid at the Medicare rate through 2014. Pub. L. No. 111-148, § 5501(a), 124 Stat. 119, 652 (2010); Pub. L. No. 111-152, § 1202, 124 Stat. 1029, 1052 (2010). Specifically, the budget proposed $6.3 billion to extend the Medicaid primary care payment increase enacted in PPACA and HCERA through 2016 and to include additional providers. The Medicare Payment Advisory Commission (MedPAC)—an advisory body to Congress on Medicare policy—also endorsed continuation of higher Medicare payments to primary care providers in its 2015 report to Congress to increase access to primary care.

officials recognize any successes and gaps, and, if necessary, they could then develop any additional proposals to supplement the programs.[49] However, while implementing these proposed programs would provide greater funding to some areas of need, HHS officials stated that they do not know the full extent to which these proposals are sufficient to address identified health care workforce needs. While HHS officials indicated that the department planned to determine their sufficiency and identify remaining gaps after these proposals were enacted, the department does not have a comprehensive plan from which to evaluate the impact of the new programs or make a complete assessment of any gaps.

External stakeholders—such as IOM, Medicare Payment Advisory Commission (MedPAC), and COGME—have identified various reforms to HHS's largest health care workforce programs to better target these programs to emerging areas of health care workforce need. HHS officials told us that some of the reforms proposed by these stakeholders were the basis for some of the department's past budget and legislative proposals. For example, IOM convened a panel of experts that recommended restructuring Medicare GME payments to help align the programs to the health needs of the nation.[50] In its 2014 report, IOM proposed, among other things, (a) developing a new center at CMS to administer GME program payment reform and manage demonstrations of new GME payment models and (b) the creation of a transformation fund within the GME programs to finance payment demonstrations. In a report released in 2014, COGME concurred with IOM that there is a need to reform GME payments and, among other things, recommended expanding the GME program's clinical training environment into the ambulatory and community setting.[51] While an advocate for teaching hospitals—Association of American Medical Colleges (AAMC)—has cautioned against reductions in GME funding, it has also proposed reforms to the

[49]HHS officials we interviewed told us that the department is developing additional proposals for fiscal year 2017 to reform workforce programs. These reform proposals are under discussion within HHS and its agencies and, once completed, may be included in the President's fiscal year 2017 budget.

[50]Institute of Medicine, *Graduate Medical Education That Meets the Nation's Health Needs* (Washington, D.C.: 2014). IOM found that the current GME structure and financing lacks the oversight and infrastructure to track outcomes, reward performance, and respond nimbly to emerging workforce challenges.

[51]Council on Graduate Medical Education, *Twenty-Second Report: The Role of Graduate Medical Education in the New Health Care Paradigm* (November 2014).

GME program and Medicare payment policy to bolster primary care training and reduce geographic disparities.[52]

Conclusions

While HHS maintains that developing an adequate supply and distribution of the health care workforce is a priority for the department, it has removed explicit language about goals and objectives related to workforce issues from its current strategic plan, which is the primary planning mechanism to address this issue. HHS's lack of specific planning goals for the health workforce in its current strategic plan makes it challenging for the department to plan and to maintain accountability. Moreover, the department does not currently have a comprehensive set of performance measures and targets to assess whether its workforce efforts and the specific individual workforce programs managed by its agencies are collectively meeting the department's broader strategic goal of strengthening health care by improving access and quality.

Because the responsibilities for HHS's workforce efforts, programs, and resources are dispersed among many agencies, it is important that HHS have a department-wide approach regarding its strategies and the actions needed to ensure an adequate supply and distribution of the nation's workforce. For example, while HRSA manages the largest number of workforce programs and the development of workforce projections, the vast majority of workforce development funds are administered by CMS—for which workforce planning is not a key mission. It is also important for HHS to comprehensively assess the extent to which its many workforce programs, collectively, are adequate to address changing health care workforce needs. Multiple stakeholders have made recommendations to improve these programs. However, because the majority of workforce funds must be dispersed based on statutory requirements unrelated to projected workforce needs, HHS has limited options to retarget them. HHS has proposed additional authorities in the past, but these have not been enacted, and HHS officials acknowledge that these additional authorities may not be sufficient to fully address the existing program limitations identified by stakeholders. Without a comprehensive and

[52]For example, in 2012, AAMC recommended that additional GME training positions be created and that half of these new positions be targeted to primary care and generalist disciplines. AAMC also recommended that payment policy be used to affect the geographic distribution of physicians and make certain clinical specialties more attractive to doctors.

coordinated approach to program planning, HHS cannot fully identify the gaps between existing programs and national needs, identify actions needed to address these gaps, or determine whether additional legislative proposals are needed to ensure that its programs fully meet workforce needs.

Recommendation for Executive Action

To ensure that HHS workforce efforts meet national needs, we recommend that the Secretary of Health and Human Services develop a comprehensive and coordinated planning approach to guide HHS's health care workforce development programs—including education, training, and payment programs—that

- includes performance measures to more clearly determine the extent to which these programs are meeting the department's strategic goal of strengthening health care;
- identifies and communicates to stakeholders any gaps between existing programs and future health care workforce needs identified in HRSA's workforce projection reports;
- identifies actions needed to address identified gaps; and
- identifies and communicates to Congress the legislative authority, if any, the Department needs to implement the identified actions.

Agency Comments and our Evaluation

We provided a draft copy of this report to HHS for its review and HHS provided written comments, which are reprinted in appendix IV. In commenting on this draft, HHS concurred with our recommendation that it is important that the department have a comprehensive and coordinated approach to guide its health care workforce development programs. HHS identified areas where comprehensive and coordinated planning efforts are already underway and where additional efforts are needed.

HHS identified several health care workforce planning efforts related to the elements of our recommendation, many of which we described in the draft report. For example, HHS noted that it coordinates workforce planning efforts through the HHS department-level and agency-specific budget, legislative development, health policy research and innovation work, performance management, and strategic planning. HHS also indicated that the National Health Care Workforce Commission, created under PPACA, has the potential to enhance HHS's ability to implement a more comprehensive and coordinated planning approach, but that the commission has not received federal appropriations. In the absence of appropriations for this commission, HHS stated that it has undertaken

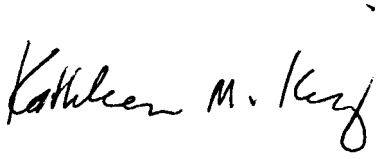
some of the commission's health care workforce planning and coordination activities, to the extent possible. In response to our recommendation, HHS indicated that it could convene an interagency group to assess (a) existing workforce programs, (b) performance measurement, (c) budgetary and other proposals, (d) gaps in workforce programs, and (e) potential requests to the Congress for modified or expanded legislative authority. We agree that a regular and ongoing initiative focused on the coordination of health care workforce programs could provide an important first step toward ensuring a more comprehensive and coordinated planning approach.

HHS also reiterated that its health care workforce programs contribute to its broad goals of access and quality from its strategic plan, as was described in our draft report. However, it indicated that, in response to our recommendation, the department plans to add two new workforce-specific strategies to its strategic plan when it next updates the plan.

HHS also provided technical comments, which we incorporated as appropriate.

As agreed with your office, 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 other interested parties. In addition, the report will be available at no charge on GAO's 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 at kingk@gao.gov. Contact points for our Office of Congressional Relations and Office of Public Affairs can be found on the last page of this report. Other major contributors to this report are listed in appendix V.



Kathleen M. King
Director, Health Care

Appendix I: Performance Measures for Selected HHS Health Care Workforce Programs, 2014

Program	Targeted health professional	# of performance measures	Meets/ exceeds/ has not met performance targets
Centers for Medicare & Medicaid Services			
Medicare Indirect Medical Education Payments	Physicians, dentists, and podiatrists	None	Not applicable
Medicare Direct Graduate Medical Education (GME) Payments	Physicians, dentists, and podiatrists	None	Not applicable
Medicaid Payment for GME	Physicians, dentists, and podiatrists	None	Not applicable
Medicare Payments for Nursing and Allied Health Education	Nurse and allied professionals	None	Not applicable
Health Resources and Services Administration			
Children's Hospital GME	Primary care physicians and pediatric specialists	3 performance measures	Exceeds Meets Meets
National Health Service Corps (NHSC) Loan Repayment Program	Primary care physicians, advanced practice registered nurses, and others	4 performance measures	Exceeds Exceeds Exceeds Exceeds
NHSC Scholarship Program	Primary care physicians, advanced practice registered nurses, and others	Same as NHSC above	Same as NHSC above
Advanced Nursing Education	Advanced practice registered nurses	6 performance measures	Exceeds Exceeds Exceeds Exceeds Exceeds Exceeds
NURSE Corps Loan Repayment Program	Nurses	4 performance measures	Exceeds Not met Exceeds Exceeds
Scholarships for Disadvantaged Students	Multiple health professionals	3 performance measures	Exceeds Exceeds Not Met
Nurse Education Practice, Quality and Retention Grants[a]	Nurses	5 performance measures	Not met Not available Not available Not met Not met
Administration for Children and Families			
Health Profession Opportunity Grants	Multiple health professionals	None	Not applicable

Source: GAO analysis of HHS data. | GAO-16-17

Note:

[a]HHS indicated that this program has two new measures and targets that will be included in its fiscal year 2017 budget.

Appendix II: Goals, Objectives, Strategies, and Metrics from the HHS 2014-2018 Strategic Plan That Are Related to Health Care Workforce Development

Goal	Related Objectives	Related Strategies	Related Metrics
Goal One: Strengthen Health Care (1 of 4 Goals in the plan)	Objective E: Ensure access to quality, culturally competent care, including long-term services and support, for vulnerable populations (1 of 6 Objectives in Goal 1)	• Monitor access to and quality of care across population groups, and work with federal, state, local, tribal, urban Indian, and nongovernmental actors to address observed disparities and to encourage and facilitate consultation and collaboration among them. • Evaluate the impact of the Affordable Care Act provisions on access to and quality of care for vulnerable populations, as well as on disparities in access and quality. • Promote access to primary oral health care services and oral disease preventive services in settings including federally funded health centers, school-based health centers, and Indian Health Services-funded programs that have comprehensive primary oral health care services, and state and community-based programs that improve oral health, especially for children, pregnant women, older adults, and people with disabilities. • Help eliminate disparities in health care by educating and training physicians, nurses, and allied health professionals on disparities and cultural competency, while increasing workforce diversity in medical and allied health care professions. • Improve access to comprehensive primary and preventive medical services to historically underserved areas and support federally funded health centers, the range of services offered by these centers, and increased coordination with partners including the Aging Services Network. (5 of 18 Strategies in Objective E)	• Field strength of the National Health Service Corps through scholarship and loan repayment agreements.[a] • Percentage of individuals supported by Bureau of Health Workforce Programs who completed a primary care training program and are currently employed in underserved areas.[b] (2 of 13 Metrics in Objective E)
	Objective F: Improve health care and population health through meaningful use of health information technology (1 of 6 Objectives in Goal 1)	• Expand the adoption of telemedicine technologies, including more remote patient monitoring, electronic intensive care units, home health, and telemedicine networks, to increase access to health care services for people living in tribal, rural, and other underserved communities, and other vulnerable and hard-to-reach populations. (1 of 18 Strategies in Objective F)	None

Goal	Related Objectives	Related Strategies	Related Metrics
Goal Four: Ensure Efficiency, Transparency, Accountability, and Effectiveness of HHS Programs (1 of 4 Goals in the plan)	Objective C: Invest in the HHS workforce to help meet America's health and human services needs (1 of 4 Objectives in Goal 4)	• Promote the Commissioned Corps as a health resource to provide public health services in hard-to-fill assignments as well as to respond to public health emergencies. (1 of 13 Strategies in Objective C)	None

Source: GAO analysis of HHS's strategic plan. | GAO-16-17

Notes:

[a]According to HHS officials, four programs are included in this metric: National Health Service Corps (NHSC) Loan Repayment Program, NHSC Scholarship Program, NHSC Students to Service Loan Repayment Program, and the State Loan Repayment Program.

[b]According to HHS officials, 14 programs are included in this metric: Academic Administrative Units in Primary Care; Advanced Education Nurse Traineeship; Graduate Psychology Education; Integrative Medicine Program; Nurse Anesthetist Traineeship; Physician Assistant Training in Primary Care; Pre-doctoral Training in General, Pediatric, and Public Health Dentistry and Dental Hygiene; Post-doctoral Training in General, Pediatric, and Public Health Dentistry; Preventive Medicine Residencies; Residency Training in Primary Care; Scholarships for Disadvantaged Students; State Oral Health Workforce; Teaching Health Centers; and Physician Faculty Development in Primary Care.

Appendix III: Goals and Strategies from HHS Agency Strategic Plans That Are Related to Health Care Workforce Development

Agency	Year	Goal	Related Strategies	Related Metrics
Administration for Children and Families	2015	Goal One: Promote Economic, Health, and Social Well-Being for Individuals, Families, and Communities	We will promote efforts to increase family economic security and stability by supporting our state, tribal, and community grantee partners in designing and implementing programs that focus simultaneously on parental employment and child and family well-being, including drawing from promising models in health and career pathways demonstrations.	None
Centers for Medicare & Medicaid Services	2013	None	None	None
Health Resources and Services Administration	2016	Goal Two: Strengthen the Health Workforce	• Support curriculum development and the training of health professionals to ensure the learning, enhancement, and updating of essential knowledge and skills. • Support training and other activities that enhance the health workforce's competency in providing culturally and linguistically appropriate care. • Expand the number and type of training and technical assistance opportunities that educate students and providers to work in interprofessional teams and participate in practice transformations. • Support technical assistance, training, and other opportunities to help safety-net providers expand, coordinate, and effectively use health information technology to support service delivery and quality improvement. • Provide information and technical assistance to ensure that HRSA-supported safety-net providers know and use current treatment guidelines, appropriate promising practices, and evidence-based models of care. • Facilitate and support the recruitment, placement, and retention of primary care and other providers in underserved communities in order to address shortages and improve the distribution of the health workforce. • Support outreach and other activities to increase the recruitment, training, placement, and retention of under-represented groups in the health workforce.	• Field strength of the National Health Service Corps through scholarship and loan repayment agreements. • Percentage of individuals supported by the Bureau of Health Workforce who completed a primary care training program and are currently employed in underserved areas. • Percentage of trainees in Bureau of Health Workforce-supported health professions training programs who receive training in medically underserved communities. • Percentage of trainees in Bureau of Health Workforce programs who are underrepresented minorities and/or from disadvantaged backgrounds.

Agency	Year	Goal	Related Strategies	Related Metrics
Health Resources and Services Administration (cont.)			• Support pre-entry academic advising, mentoring, and enrichment activities for underrepresented groups in order to promote successful health professions training and career development. • Promote training opportunities within community-based settings for health professions students and residents by enhancing partnerships with organizations serving the underserved. • Develop and employ approaches to monitoring, forecasting, and meeting long-term health workforce needs. • Provide policy makers, researchers, and the public with information on health workforce trends, supply, demand, and policy issues.	
Indian Health Service (IHS)	2006[a]	Not applicable[a]	• Not applicable[a]	Not applicable[a]
Substance Abuse and Mental Health Services Administration[b]	2015	Goal Six: Workforce Development	• Develop and disseminate workforce training and education tools and core competencies to address behavioral health issues. • Develop and support deployment of peer providers in all public health and health care delivery settings. • Develop consistent data collection methods to identify and track behavioral health care workforce needs.	• Increase the number of behavioral health providers (professional, paraprofessional, and peers) addressing children, adolescents, and transitional-age youth. • Increase the number of individuals trained as behavioral health peer providers.

Source: GAO analysis of strategic plans for HHS agencies. | GAO-16-17

Notes:

[a]IHS officials said that IHS last updated its strategic plan in 2006, and it is now out of date. Officials stated that IHS programs are aligned with the HHS strategic plan through Strategic Goal One, Objective E. Moreover, HHS officials told us that in updating IHS's strategic plan to its current version, they received input from various entities, including IHS.

[b]HHS officials stated that the department has an additional strategy of influencing and supporting funding for the behavioral health workforce and an additional metric of increasing the percentage of reimbursement rates and potential pay incentives associated with the development of a prospective payment system.

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 1 3 2015

Kathleen King
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. King:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*Health Care Workforce: Comprehensive Planning by HHS Needed to Meet National Needs*" (GAO-16-17).

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 DRAFT REPORT ENTITLED: HEALTH CARE WORKFORCE: COMPREHENSIVE PLANNING BY HHS NEEDED TO MEET NATIONAL NEEDS (GAO-16-17)

The U.S. Department of Health and Human Services (HHS) appreciates the opportunity from the Government Accountability Office (GAO) to review and comment on this draft report.

GAO Recommendation

GAO recommends that the Secretary of HHS develop a comprehensive and coordinated planning approach to guide HHS's health care workforce development program – including education, training, and payment programs – that:

- Include performance measures to more clearly determine the extent to which these programs are meeting the Department's strategic goal of strengthening health care;
- Identifies and communicates to stakeholders any gaps between existing programs and future health care workforce needs identified in Health Resources and Services Administration (HRSA)'s workforce projection reports;
- Identifies actions needed to address identified gaps; and
- Identifies and communicates to Congress the legislative authority, if any, the Department needs to implement the identified actions.

HHS Response

HHS concurs with GAO's recommendation that it is important for the Department to have a comprehensive and coordinated planning approach to guide its health care workforce development programs. In the more detailed response that follows, HHS notes the many areas in which comprehensive and coordinated planning is already underway and what additional authorization or appropriations would enhance such planning activities.

The Department's primary focus, as is evident from its strategic plan, is to improve access to quality health care for all Americans and to enhance the nation's health. The health workforce is an important component of a multi-faceted strategy in achieving this goal. HHS shares with GAO the belief that initiatives must be comprehensive and coordinated in order to best address the nation's needs. With regard to the specific components of the GAO's recommendation:

- GAO Recommendation: *The Government Accountability Office (GAO) recommends that the Secretary of HHS develop a comprehensive and coordinated planning approach to guide HHS's health care workforce development program – including education, training, and payment programs*

HHS Response:

HHS regularly coordinates the workforce planning efforts of its agencies on a number of key national strategies, which include those centered on the health workforce among other areas of Department work. This occurs through the HHS Department-level and agency-specific budget, legislative development, health policy research and innovation work, performance management, and strategic planning roles. These efforts include both recurring, annual and additional cross-Departmental meetings as well as other regular, coordinated planning efforts that engage HHS

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GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: HEALTH CARE WORKFORCE: COMPREHENSIVE PLANNING BY HHS NEEDED TO MEET NATIONAL NEEDS (GAO-16-17)

agency leadership and subject matter experts. The Government Performance and Results Modernization Act of 2010 and OMB Circular A-11 guidance describe the strategic planning, performance measurement, and budget framework that federal agencies must operate within, and HHS workforce planning activities are fully in compliance with this law.

When Congress authorized the National Health Care Workforce Commission under the Affordable Care Act, it was intended to operationalize a federal health workforce strategy that is linked with timely projections of health care workforce supply and demand, is responsive to shifting national needs during a time of massive health system transformation, and is informed by a group of health care experts external to the Federal government (appointed by the Comptroller General of the U.S. and head of the GAO).

In the absence of appropriations for this Commission, HHS has undertaken some of the Commission's health workforce planning and coordinating activities, to the extent possible. Were this Commission to receive federal appropriations, HHS would have an enhanced ability to implement a more comprehensive and coordinated planning approach to guiding its health care workforce development programs as recommended by the GAO in this report. Without the benefit of the Commission, HHS can convene an interagency group for an annual assessment of its workforce budgetary proposals and legislative policies in order to seek a more formal, comprehensive, and coordinated planning approach to these efforts. This group would include cross-Department leadership and health workforce subject matter experts, who would additionally:

1. Provide guidance around potential performance measure modifications so as to better determine the extent to which HHS programs are meeting the Department's strategic goal of strengthening health care;
2. Identify actions needed to address identified health workforce gaps, including those requiring requests to Congress for modified or expanded Departmental legislative authority.

- GAO: *Include performance measures to more clearly determine the extent to which these programs are meeting the Department's strategic goal of strengthening health care;*

HHS Response:

HHS has ensured implementation of performance measures which are reflective of its broader workforce efforts. As discussed above, HHS plans to convene an interagency group which may provide guidance to modify existing performance measures so as to better determine the extent to which HHS programs are meeting the Department's strategic goals. In addition, when HHS next updates the strategic plan, we intend to address GAO's recommendation to "explicitly reference workforce" within the Plan by adding two additional workforce strategies within these objectives. HHS would note that recent updates to the HHS Strategic Plan reflect an evolution in Departmental thinking about how to best address the nation's overall health care needs, and that the Department has not devalued the important contribution of the health workforce to achieving improved access to quality health care for the American people. Strategies listed within the current HHS Strategic Plan relate to health care workforce programs, and align with the strategic objectives focused on

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: HEALTH CARE WORKFORCE: COMPREHENSIVE PLANNING BY HHS NEEDED TO MEET NATIONAL NEEDS (GAO-16-17)

access and quality. These strategies speak to health workforce education and training, serving underserved areas, and health workforce diversity.

- GAO: *Identifies and communicates to stakeholders any gaps between existing programs and future health care workforce needs identified in HRSA's workforce projection reports;*

HHS Response:

The National Center for Health Workforce Analysis (NCHWA), housed at the Health Resources and Services Administration (HRSA) of HHS, has worked to improve the Department's national health workforce projection models – including a microsimulation model – to provide more targeted national and state-level estimates of supply and demand for several health professions. These national projections are used to inform improvements and redesigns of HHS workforce programs as is allowable within the programs' statutory authorities. NCHWA has produced several supply and demand projections for different health professions which are publicly available and can be found on HRSA's website (http://bhpr.hrsa.gov/healthworkforce/index.html).

In addition to the work of NCHWA, many HHS workforce programs have been utilizing retrospective evaluation designs to better understand the benefits from the Department's programs. These evaluations are a strategic approach to better align and revise HHS programs to adequately support national workforce needs. Progress in achieving better access to a usual source of health care for all Americans, reports on the performance of HHS workforce programs, studies of the current and projected national health workforce, and gaps between existing programs and future health care workforce needs are identified and communicated by the Department to key stakeholders through a number of different mechanisms. These include the release of yearly budget justifications, annual performance reports, reports to Congress, other publications and reports, and through venues such as the ASPE Health System Measurement Research Project (https://healthmeasures.aspe.hhs.gov/). GAO identified several of these reporting mechanisms in their report.

Publicly available annual performance reports in particular contain a comprehensive set of measures setting performance targets to track HHS workforce program performance, including measures that aggregate performance metrics that cut across multiple programs. These programmatic outputs, and remaining workforce gaps, are all considered and emphasized by HHS as part of its comprehensive and coordinated efforts around health workforce planning – and inform the recurring, annual budget, legislative development, health policy research and innovation work, performance management, and strategic planning work of the Department.

The proposed HHS interagency group who will annually assess the Department's workforce budgetary proposals, legislative policies, and performance measures, may help HHS achieve a more formal, comprehensive, and coordinated planning approach in its workforce-building efforts. This will be reflected publicly in the Department's yearly budget justification documents, annual performance reports, reports to Congress, and other publications and reports.

- GAO: *Identifies actions needed to address identified gaps; and*

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: HEALTH CARE WORKFORCE: COMPREHENSIVE PLANNING BY HHS NEEDED TO MEET NATIONAL NEEDS (GAO-16-17)

HHS Response:

As progress toward Departmental workforce goals is assessed and gaps are identified, federal workforce programs seek to fill these gaps and further strengthen the workforce to the extent allowed under the Department's statutory authorities. To this end, the Department additionally notes the work of, and collaborates with, a number of external stakeholders – such as the Medicare Payment Advisory Commission (MedPAC), the Council on Graduate Medical Education (COGME), and the Institute of Medicine (IOM; now the National Academy of Medicine). The recommendations from these entities are often incorporated into HHS policy and programs to the extent possible, although certain recommendations are not able to be carried out in the absence of new legislation due to a lack of Departmental statutory authority. For example, the IOM report *Graduate Medical Education That Meets the Nation's Health Needs* made a number of recommendations around how to potentially reform graduate medical education (GME) investments and improve workforce outcomes related to the physician pipeline – but statutorily the Department is not able to implement many of these recommendations unless Congress legislates changes to the GME payment statutory formulas. HHS notes that the Department has a legislative proposal in the President's budget to reform Medicare GME payment as described more fully below.

HHS has long supported state-level innovation around building the health workforce to the extent allowed by statutory law. Many additional examples of GME reform are through innovations supported by Medicaid GME funding, noted in the GAO report (GAO-14-510T) to be around $785 million of the Federal government's annual funding to accredited residency training programs. Medicaid is a Federal-state partnership, and CMS has historically allowed states to include GME payments as part of their inpatient hospital rate structures. CMS has made it easier for states to test certain innovations under their Medicaid managed care programs through the waiver process, allowing certain federally-approved requests by states to have flexibility for activities such as distributing GME payments to nonhospital training programs or to pay for training of non-physicians. In addition, the State Innovation Models (SIM) Initiative at the CMS Center for Medicare and Medicaid Innovation has allowed many states the opportunity to reform GME and make investments in the physician training more accountable, using Medicaid waivers as one mechanism for this.

As discussed above, HHS can convene an interagency group to seek a more formal, comprehensive, and coordinated planning approach to its workforce planning efforts. This group may help better determine the extent to which HHS programs are meeting the Department's strategic goal of strengthening health care and could help identify additional actions needed to address any identified gaps.

- GAO: *Identifies and communicates to Congress the legislative authority, if any, the Department needs to implement the identified actions.*

HHS Response:

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GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: HEALTH CARE WORKFORCE: COMPREHENSIVE PLANNING BY HHS NEEDED TO MEET NATIONAL NEEDS (GAO-16-17)

When HHS seeks to address gaps in the health workforce or to implement the informed recommendations of external stakeholders but is limited by a lack of statutory authority, it will attempt to advance policy through vehicles such as legislative proposals. However, as is recognized in this GAO report, the Department is required to carry out change only to the extent allowable under its authority. The interagency group which HHS has offered to convene may identify actions needed to address any identified health workforce gaps, including those which will require requests to Congress for modified or expanded Departmental legislative authority.

In alignment with the goal of the IOM report for reforming GME investments to improve workforce outcomes related to the physician pipeline, HHS developed a legislative proposal which was included in the President's FY2015 and FY2016 Budgets. The Targeted Support for Graduate Medical Education program would create an updated approach to residency training by targeting $5.25 billion (over 10 years starting in FY 2016) in mandatory funds to an innovative competitive grant program to create new residency slots with a focus on community-based ambulatory care. This program would be administered by the Health Resources and Services Administration (HRSA) and would be expected to produce 13,000 physicians over the next ten years, as well as advance key workforce goals – including the training of more physicians in primary care and other high need specialties, aligning training with more efficient and effective care delivery models, and encouraging physicians to practice in underserved areas, including rural areas. Additionally, HHS has previously sought additional authority, through a legislative proposal, to improve how Indirect Medical Education dollars currently fund building of the physician workforce. However, HHS has been unable to move forward with these strategies without Congress legislating changes in the relevant statutes or providing new programmatic authority and appropriations.

HHS is hopeful that Congress will provide appropriations for the authorized National Health Care Workforce Commission. This Commission would enhance the Department's formal, continuous, comprehensive, and coordinated planning approach to guiding its health care workforce development programs. The Commission would assist HHS in meeting national health workforce needs and to further strengthen the health care system across the nation.

Appendix V: GAO Contact and Staff Acknowledgments

GAO Contact

Kathleen M. King, (202) 512-7114 or kingk@gao.gov

Acknowledgments

In addition to the contact named above, William Hadley, Assistant Director; N. Rotimi Adebonojo; Arushi Kumar; Jennifer Whitworth; and Beth Morrison made key contributions to this report.

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