DEPARTMENT OF HEALTH AND HUMAN SERVICES

ACQUISITION HUMAN CAPITAL PLAN

April 2011 Update

Executive Summary

In developing the Department of Health and Human Services' (HHS) initial 5-year Acquisition Human Capital Plan (AHCP) in April 2010, we used historical data and statistical projection techniques to estimate our future workload trends and our associated staffing needs. Several things have occurred since the submission of the initial plan—some specific to HHS and others government-wide—that have had an effect on the acquisition workforce itself, as well as on our plans to enhance capacity and capability. These factors include, but are not limited to: the Affordable Care Act; budget reductions; and requirements for greater oversight of service contracts.

The Affordable Care Act (ACA) was enacted on March 23, 2010. While we had anticipated it in our preparation of the AHCP, the ACA's exact magnitude was unknown and there still are uncertainties regarding the timing of full program implementation. Further, budget realities have required us to temper certain of our assumptions as we move into the out-years of the plan—specifically fiscal year (FY) 2011 through FY 2014.

While we have new programs to implement and are working to enhance our oversight of service contracts and make other acquisition improvements, there have been some unforeseen circumstances—we experienced about a 10 percent reduction in the number of GS 1102s from our FY 2009 levels and, given a delayed budget for FY 2011, our hiring numbers may decrease. Therefore, while HHS still plans to increase hiring over the next few years, for both replacement and succession planning, the pace of our hiring may not be as aggressive as originally planned.

For now and the foreseeable future, our emphasis has been (and will continue to be) on the training and certification of our existing workforce, hiring as funding permits, and

continuing our efforts—although at a slower pace—with regard to HHS-wide intern, rotational, and mentoring programs.

Acquisition Workforce Overview

Description of HHS' Acquisition Workforce

The HHS acquisition workforce is comprised of individuals serving the following functions:

- All individuals in General Schedule (GS) 1102, 1105, and 1106 series; and personnel in any other GS series who may be given: (1) warrant authority (e.g., U.S. Public Health Service Commissioned Corps personnel); or (2) Head of Contracting Activity (HCA) designation.

- Contracting Officers' Technical Representatives (COTRs) (typically within a program office) who have been appointed by Contracting Officers to monitor or manage performance under one or more contracts or who are qualified as COTRs even if not currently serving in that capacity, i.e., individuals that can assume COTR duties as needed as a result of attrition or a workload surge (see certification requirements below).

- Project Managers and Program Managers (P/PMs) who currently monitor or manage one or more contract-related projects and programs (respectively), or P/PM candidates who obtain an HHS FAC-P/PM certification (who serve as a cadre of available individuals in the event of creation of new programs or attrition).

Certification requirements apply to the above components of the HHS acquisition workforce as follows:

- Those in the GS 1102 series are required to be FAC-C certified. HHS maintains its own certification program for those individuals with simplified acquisition authorities only (generally individuals in the GS 1105 series).

- COTRs or COTRs "in waiting" must be FAC-COTR certified.

- P/PMs responsible for capital investments and such P/PMs "in waiting" are required to be FAC-P/PM certified.

It should be noted that, at HHS, individuals who serve as COTRs are in varying job series, depending on the type of program or requirement. COTRs, in many cases, perform those responsibilities as an auxiliary duty. Our long-term goal is to develop a professional cadre of COTRs who perform those responsibilities as a primary duty.

Comparison of Current Acquisition Workforce Size to Baseline Numbers

Our Operating Divisions (OPDIVs) are affected differently by budget and program priorities. Because of the differing missions of our OPDIVs, some programs grow in size while others shrink or are discontinued. Also, our OPDIVs vary in how they are organized to carry out the acquisition function. Most plan on hiring GS-1102s, whether to backfill positions or increase capacity (at entry and journeyman levels). Two of our OPDIVs that rely on decentralized purchasing also plan on hiring GS 1105s and 1106s.

Further, different segments of the acquisition workforce are affected somewhat differently by increases or decreases in workload. Because the contracting workforce continues to be understaffed in relation to workload, the elimination of or reduction in a program does not necessarily result in excess resources—those individuals simply spend more time in areas such as contract administration. Therefore, the size of the acquisition workforce generally does not increase or decrease in relation to such changes. For example, even with the American Recovery and Reinvestment Act, we did not see a major increase in acquisition workforce staffing.

We have, however, seen a decrease in the number of GS 1102s from FY 2009 to FY 2010. In the 5-year AHCP, we showed the actual number of individuals in the contracting series (1102, 1105, and 1106) as of September 30, 2009 as 1,453. The number as of September 30, 2010 (the end of FY 2010) is 1,236—a decrease of about 15 percent. This decrease has been across all segments of our contracting workforce. In the 1102 series, we experienced a decrease in the size of the workforce of about 10 percent.

We had estimated the need over the 5-year period FY 2010-2014 for 199 additional positions in the 1102 series and 62 in the 1105 series (beyond the baseline), based on a projected 20 percent increase in obligations against a fairly significant decrease in actions. Our updated projections for FYs 2011-2014 for obligations and actions show a fairly flat level of both obligations and new actions for that period, which then results in a greater contract administration workload in the out-years than originally projected.

At present, we plan to hire about 10 percent fewer GS 1102s through FY 2014 than we originally projected due to budget limitations (about 180 rather than 199). Even with that hiring in FY 2011 and beyond, we will be at FY 2010 or lower staffing levels. Thus, we will have fewer resources at both the “corporate” level and within our OPDIVs to focus on workforce-related issues as addressed below.

In the AHCP, we also projected the need for about 1,000 additional certified COTRs and 183 PMs over the period FY 2010-2014. Using our revised projections for new actions and turnover as a result of reassignments, we still project the need for that number of certified COTRs, whether or not they are serving as COTRs at any given time. Because serving as a COTR generally is an auxiliary duty, the number of those actively serving as COTRs may vary based on the extent of new requirements. For P/PMs, we see the potential for a significant increase in the number of individuals that need to be certified

as we move toward implementation of a robust major acquisition program in HHS. However, prior to full implementation of that program, based on current requirements, we project the need for 100 additional certified P/PMs.

Tables 1, 2a, and 2b below were completed accordingly. If there were no budget constraints, we believe the Department would benefit from hiring at least an additional 150 1102's (beyond those needed to address attrition or backfilling) through FY 2014. This would allow for better workload distribution, enhanced guidance and oversight at all organizational levels, and an additional 400 certified COTRs.

Table 1. Acquisition Workforce Size[1]

Segment of AWF	# FY10	% Certified FY10
1102 workforce	958	60 percent[2]
Contracting Officers (outside 1102 series)	*Insignificant	---
P/PMs	54	100 percent
COTRs	6249	100 percent
GS 1105	249	Simplified Acquisition Certification Program
GS 1106	29	--

[1] Labeled Table 2 in the template provided by the Office of Federal Procurement Policy.
[2] Note that this percentage is based on the aggregate number of 1102s. This would increase to 100% if we took into account those certified under legacy programs for whom FAC-C requirements need not be met unless a change in warrant level is requested.

Table 2a - Workforce Projections[3]

	FY11			FY12			FY13			FY14		
	Entry	**Mid**	**Senior**	**Entry**	**Mid**	**Senior**	**Entry**	**Mid**	**Senior**	**Entry**	**Mid**	**Senior**
Hires to manage attrition												
# 1102s	5	55	15	5	15	2	5	10	3	4	8	5
Growth (new positions)												
# 1102s	25	25	--	11	6	1	10	5	---	4	2	---
Growth (through identification of existing agency positions into the acquisition workforce)												
# 1102s	---	---	---	---	---	---	---	---	---	---	---	---
Retention of retirement and transfer eligible employees												
% 1102s	90	95	90	90	95	90	90	95	90	90	95	90
Certification Targets												
# 1102s	Level I= 80%	Level II= 75%	Level III= 90%	Level I= 70%	Level II= 80%	Level III= 95%	Level I= 75%	Level II= 80%	Level III= 95%	Level I= 75%	Level II= 80%	Level III= 95%
Interns (entry level personnel participating in a structured development program that includes training, rotation, mentoring)												
Contracting	10	15	--	4	10	--	2	3	---	2	4	---
P/PM	--	3	2	--	3	2	--	3	2	--	3	2
Other acquisition professions	--	--	--	--	--	--	--	--	--	--	--	--

[3] Labeled Table 4a in the template provided by the Office of Federal Procurement Policy.

Table 2b - Workforce Projections[4]

	FY11	FY12	FY13	FY14
Hires/assignments to manage attrition				
# COTRs	100	200	200	200
# P/PMs	8	10	10	8
Growth (new positions)				
# COTRs	50	50	50	50
# P/PMs	6	6	6	6
Growth (assignment into AWF)				
# COTRs	25	25	25	25
# P/PMs	10	10	10	10
Certification Targets				
# COTRs	100%	100%	100%	100%
# P/PMs	100%	100%	100%	100%

Acquisition Workforce Projection – Building Capacity and Capability

Current budget realities will preclude us from doing more than keeping our GS 1102 workforce at a viable level. A number of areas that we had projected for increased resources -- e.g., allocating an increased number of positions to cost-price analysis, post-award administration, and oversight; developing or obtaining specialized resources that enhance the quality of the acquisition function, such as procurement attorneys; and providing more resources for acquisition workforce training -- will be postponed or funded at reduced levels. This creates a circular effect—greater pressure is placed on existing acquisition staff to do more with less, resulting in burnout and possibly increased attrition.

Therefore, while we still plan to implement the types of programs to build capacity and capability that we had discussed in our initial plan—intern, rotational, and mentoring programs, the schedule for full implementation has been somewhat delayed. We address these efforts in the section on “bold steps.”

[4] Labeled Table 4b in the template provided by the Office of Federal Procurement Policy.

Bold Steps: Building Capacity and Capability

HHS has three programs that are at the core of its bold steps—intern, rotational, and mentoring (IR&M) programs. Each program will affect all components of the HHS acquisition workforce, albeit not equally. (For example, for the most part, our COTRs are Public Health Analysts, Health Scientist Administrators and others that serve as COTRs as an auxiliary duty; and an intern program would not necessarily be feasible for this group). Also, each program consists of phases: design, development, and implementation. The intern and rotational programs are intended to assist with both capability- and capacity-building by providing: (1) individuals newly entering the profession with training focused on a career path; (2) individuals in the acquisition workforce with a broader perspective or those in other functional areas with knowledge about the roles and responsibilities of the acquisition workforce; and (3) a one-on-one relationship to assist in career planning and direction.

There currently are programs of this nature in use within HHS that vary in size and scope. Our vision is to leverage those programs, including lessons learned, to establish an HHS-wide approach to ensure consistency in objectives and positive outcomes for the entire Department. While we have made progress in the planning and design of these programs, our pace has been slower than expected due to resource constraints and competing priorities.

Initiative Owner, Accountable Representatives, and Contact Information: The initiative owner for our IR&M programs is the Office of Grants and Acquisition Policy and Accountability within the Office of the Assistant Secretary for Financial Resources.

Problem Statement: As we undertake a variety of acquisition process standardization and other improvement efforts, it is imperative that we have training and development programs that are consistent with those objectives. We need to have corporate consistency and continuity for the longer term. Our current approach to training and development, which is largely decentralized, contributes to the diversity that exists within our OPDIVs and sometimes is a disincentive to those seeking to move from one OPDIV to another. With defined programs of this type, we hope not only to be able to attract the best and the brightest for the HHS acquisition workforce, but also to retain them and make them an integral part of achieving the HHS mission, regardless of the employing OPDIV.

Impact on Organization: These bold steps will improve the functioning of our organization by helping to retain individuals in whom we have made a training and development investment. Through the intern program, HHS will be able to attract individuals with the expectation that they will pursue careers in acquisition within HHS. Through the rotational program, we will ensure that, regardless of functional area within HHS, our HHS employees have a full appreciation for various organizational interrelationships—budget, finance, program management, grants, contracts, property management, etc. Through the mentoring program, we will ensure that individuals receive personal attention in developing and pursuing their career goals and objectives.

Resources: In order to be able to move forward with these programs within a challenging budgetary environment, we are leveraging existing programs to the extent possible—while making them "acquisition-centric"— and using internal HHS staff resources (whose limits are described under "Risks and Barriers to Overcome" below). For example, we expect to conduct pilot efforts for an acquisition mentoring program whose design will be based on the HHS human resources mentoring program.

Known Interdependencies: Our IR&M programs need to be closely coordinated with our OPDIVs and with other functional area owners within the HHS Office of the Secretary (OS), such as the Office of Human Resources (OHR). Further, our planned rotation program must be consistent with the Federal Acquisition Institute's proposed interagency job rotation/talent exchange program. This coordination is intended to ensure that we make the most efficient use of our scarce resources in the next few years by supplementing—not supplanting—existing successful efforts. We also want to minimize any potential duplication of effort. Therefore, we will engage in careful transition planning with our OPDIVs and affected OS offices. Once any pilots are completed and the concepts have proven successful, we will have a timely phase-out of any overlapping OPDIV-specific programs.

Risks and Barriers to Overcome: We have several cross-cutting barriers to full implementation of our IR&M programs. The primary barrier is a lack of resources. In general, we do not have sufficient acquisition career management (ACM) full-time equivalents, either in OS or the OPDIVs, who can spend the time needed to define, plan, and develop these programs for rapid implementation and then to manage them. Any milestones that would focus on achieving a particular goal by a certain date are affected by the second barrier—multiple competing priorities. Among these competing priorities are our Service Contract Inventory initiative, and the design and development of a viable major acquisition program for greater oversight and better use of acquisition resources. However, we will continue to pursue our bold step efforts to the best of our abilities and will make sensible tradeoff decisions as part of our management responsibilities.

Possible Stakeholders: Offices and officials that have a direct stake in these efforts are the HHS Secretary and her senior leadership team, OPDIV Heads, OHR, the HHS Heads of Contracting Activity, and all components of the acquisition workforce. However, in a larger sense, all HHS staff members have a stake in the success of these programs because having a top-notch acquisition workforce in place supports mission accomplishment.

Action Plan and Implementation Schedule: We expect to develop a multi-year action plan addressing our IR&M programs, including an implementation schedule, by the end of Calendar Year 2011.

Anticipated and Desired Outputs and Outcomes: The outputs of our efforts will be: (1) a plan, including resource requirements, for bringing these initiatives to fruition; and (2) materials describing each program, eligibility/prerequisites, and other program

facets. Desired outcomes include higher retention rates, greater job satisfaction (as measured by our Acquisition Balanced Scorecard [BSC] surveys), and improved acquisition outcomes (cost-effectiveness, compliance, etc.) as documented by our Procurement Management Reviews (PMRs).

Performance Measures: In addition to PMRs and BSC measures, we will incorporate key aspects of our IR&M programs into HHS' Acquisition Dashboard. As appropriate, we will incorporate program elements into individual performance plans.

/s/ April 15, 2011

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Appendixes:

Appendix A – OGAPA Organization Chart

Appendix B – OPM Human Capital Management Report Acquisition Workforce Resource Chart