



Testimony
Before the Committee on Veterans'
Affairs, U.S. Senate

VA ACQUISITION MANAGEMENT

Supply Chain Management and COVID- 19 Response

Accessible Version

Statement of Shelby S. Oakley, Director
Contracting and National Security Acquisitions

For Release on Delivery Expected at 3:00 p.m. EST
Tuesday, June 9, 2020

GAO Highlights

Highlights of [GAO-20-638T](#), a testimony before the Committee on Veterans' Affairs, U.S. Senate

Why GAO Did This Study

VA spends hundreds of millions of dollars annually to meet the health care needs of about 9 million veterans. In March 2019, GAO added VA Acquisition Management to its High Risk list due to longstanding problems such as ineffective purchasing of medical supplies and lack of reliable data systems.

This statement summarizes findings from GAO's 2017 MSPV-NG report and 2019 High Risk report and preliminary observations from two ongoing GAO performance audits to discuss VA's progress in building a more resilient supply chain. For the ongoing work, GAO reviewed VA documentation and interviewed VA officials, and VA medical center staff. Finally, GAO met with senior VA officials on June 5, 2020, to obtain agency views on the new observations GAO discusses in this statement.

What GAO Recommends

GAO has made 40 recommendations since 2015 to improve acquisition management at the VA. VA agreed with those recommendations and has implemented 22 of them. Further actions are needed to implement the remaining recommendations, such as GAO's recommendation that VA implement an overarching MSPV strategy, and demonstrate progress toward removing this area from GAO's High-Risk list.

View [GAO-20-638T](#). For more information, contact Shelby S. Oakley at (202) 512-4841 or oakleys@gao.gov

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What GAO Found

The Department of Veterans Affairs (VA) has taken some steps in recent years to modernize its processes to acquire hundreds of millions of dollars-worth of medical supplies annually. However, implementation delays for key initiatives, including a new, enterprise-wide inventory management system, limit VA's ability to have an agile, responsive supply chain. Prior to the Coronavirus Disease 2019 (COVID-19) pandemic, in November 2017 and in GAO's High-Risk report in March 2019, GAO reported on weaknesses in VA's acquisition management. For example, GAO reported that VA's implementation of its Medical-Surgical Prime Vendor-Next Generation (MSPV-NG) program—VA's primary means for purchasing medical supplies—lacked an effective medical supply procurement strategy, clinician involvement, and reliable data systems. GAO also found that several of VA's medical supply management practices were not in line with those employed by private sector leading hospital networks.

VA is developing another iteration of its MSPV program, called MSPV 2.0, which GAO's preliminary observations show is intended to address some of the shortfalls GAO has identified in its past and ongoing program reviews. In November 2017, GAO recommended that VA develop, document and communicate an overarching MSPV-NG strategy—to include how the program office will prioritize categories of supplies and increase clinician involvement in this process. Preliminary observations from GAO's ongoing work indicate that VA has taken some steps, as it implements MSPV 2.0, to address this priority recommendation. However, GAO's preliminary observations also indicate that the MSPV 2.0 program implementation is delayed and some of these existing program challenges may not be remedied.

Based on preliminary observations from GAO's ongoing work, VA's implementation of a new supply and inventory management system is delayed. As a result, VA had to rely on an antiquated inventory management system, and initial, manual spreadsheets to oversee the stock of critical medical supplies at its medical centers. This limited the ability of VA management to have real-time information on its pandemic response supplies, ranging from N95 face masks to isolation gowns, to make key decisions. As of April 2020, VA has an automated tool to manage its reporting process, but the information must be gathered and manually reported by each of VA's 170 medical centers on a daily basis.

GAO's preliminary observations also show that in response to COVID-19, VA is using various contracting organizations and mechanisms to meet its critical medical supply needs. These include using national and regional contracting offices to obtain supplies from existing contract vehicles, new contracts and agreements, and the Federal Emergency Management Administration's Strategic National Stockpile to respond to the pandemic.

Chairman Moran, Ranking Member Tester, and Members of the Committee:

Thank you for having me here today to discuss our past work and observations on the Department of Veterans Affairs (VA) medical supply chain. VA spends hundreds of millions of dollars annually on medical supplies to meet the health care needs of about 9 million veterans and has one of the most significant acquisition management functions in the federal government.

Since 2015, we have issued five reports on VA's acquisition management challenges, with 40 recommendations, and we elevated this issue to GAO's High-Risk List in 2019, due to longstanding problems such as ineffective purchasing of medical supplies and lack of reliable data systems.¹ VA has addressed 22 of our prior recommendations. For example, in November 2017, GAO recommended that VA develop, document, and communicate an overarching Medical-Surgical Prime Vendor-Next Generation (MSPV-NG) strategy—to include how the program office will prioritize categories of supplies and increase clinician involvement in this effort. Our preliminary observations from our ongoing work indicate that although VA has taken some steps to address this priority recommendation, it has yet to fully implement it. Further, VA has also begun efforts to modernize its supply chain, but our ongoing work indicates that several key initiatives are delayed, further limiting VA's ability to have an agile, responsive acquisition management system.

Like most medical institutions nationwide, VA has faced difficulties obtaining personal protective equipment (PPE) for its medical workforce during the Coronavirus Disease 2019 (COVID-19) pandemic, and VA's antiquated inventory management system hampered its ability to identify the extent to which each of its 170 medical centers faced these shortages. VA officials reported that they had difficulty obtaining sufficient

¹ GAO, *High-Risk Series: Substantial Efforts Needed to Achieve Greater Progress on High-Risk Areas*, [GAO-19-157SP](#) (Washington, D.C.: Mar. 6, 2019).

supplies from their existing supply chain and associated contracting vehicles; thus, VA used new contracts and agreements to fill some of this void.

My remarks today are based on two issued reports—our 2019 High Risk report segment on VA Acquisition Management and our 2017 report on VA’s MSPV-NG program—as well as our ongoing audits of VA’s COVID-19-related medical expenditures and VA’s MSPV program.² Today, I will summarize a few key findings from these reports and some of our initial observations from this ongoing work related to VA’s progress toward building a more resilient supply chain.

As part of our work for our November 2017 and March 2019 reports and our ongoing MSPV 2.0 work, we reviewed VA policies, communications, briefings, prior GAO reports on best practices for organizational transformation, relevant legislation, and other documents.³ We conducted interviews with VA officials responsible for Veterans Health Administration (VHA) and VA-wide procurement and logistics, program office managers, and supply chain managers, among other VA officials. We also conducted site visits to 12 medical centers, selected based on highest total spending on medical and surgical supplies, among other things. As part of our work on VA’s response to the COVID-19 medical procurements, we reviewed VA memoranda, briefings, Federal Procurement Data System-Next Generation (FPDS-NG) procurement data, and we met with key VA personnel responsible for the agency’s response to COVID-19. Finally, we met with senior VA officials on June 5, 2020, to obtain agency views on the new observations we discuss in this statement.

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

² GAO, *Veterans Affairs Contracting: Improvements in Buying Medical and Surgical Supplies Could Yield Cost Savings and Efficiency*, [GAO-18-34](#) (Washington, D.C.: Nov. 9, 2017).

³ See [GAO-18-34](#) and [GAO-19-157SP](#); more detailed information on the scope and methodology is contained within these reports.

Longstanding Problems in VA Acquisition Management and Medical Supply Management Posed Additional Challenges in VA's COVID-19 Response

The issues VA experienced during the height of the COVID-19 pandemic were a result of global supply chain challenges, but longstanding problems that our work has previously identified posed additional challenges to VA's response.

In November 2017, we reported weaknesses in VA's implementation of its MSPV-NG program—VA's primary means for purchasing medical supplies. These included the lack of an effective medical supply procurement strategy, clinician involvement, and reliable data systems. We also found that several of VA's medical supply management practices were not in line with those employed by private sector leading hospital networks. We recommended, among other things, that VA develop, document, and communicate to stakeholders an overarching strategy for the program.⁴ This strategy, originally planned for completion by December 2017, was delayed to March 2019, and then further delayed due to VA's implementation of its new MSPV 2.0 program, which is also delayed. We also found that VA's initial formulary consisted of around 6,000 items at launch, and, according to senior VA contracting officials, many items on the formulary were not those needed by medical centers. These factors resulted in an initial formulary that did not meet the needs of VA's medical centers (VAMC).

The MSPV-NG program office subsequently took steps to expand the formulary, growing it to over 22,000 items, and is developing the next iteration of the program, called MSPV 2.0. MSPV 2.0 is intended to address some of the shortfalls we previously identified in MSPV-NG, including more than doubling the number of items on the formulary, to a planned 49,000. VA's MSPV 2.0 prime vendor procurement has been subject to multiple bid protests. After three protests challenged the terms of the solicitation, VA responded by voluntarily taking corrective action and revising the solicitation. The terms of the revised solicitation were challenged in a subsequent protest that was sustained, resulting in VA further revising the solicitation to address the matter. Because of these

⁴ See [GAO-18-34](#).

events, agency officials told us that VA has altered its MSPV 2.0 procurement plans several times and there has been significant delay in program implementation from the originally planned March 2020 date to as late as February 2021.

Based on preliminary observations of our ongoing work, some of the current MSPV-NG challenges persist and may not be remedied by MSPV 2.0. Specifically, medical center staff we interviewed from May 2019 through October 2019 cited continued problems with consistently receiving the supplies they order through MSPV-NG, such as backorders on frequently ordered items. For example, preceding the COVID-19 pandemic, supply chain problems with one of VA's prime vendors created supply shortages for infection control gowns, and staff at one VAMC we visited in June 2019 had to obtain gowns from its emergency cache as a temporary measure. Further, VA's plans for MSPV 2.0 give no indication that they will update their practice of manually maintaining the formulary using spreadsheets, which, based on our discussions with several VAMC logistics officers, can lead to errors such as inadvertent omission of items from the formulary. We plan to issue a report on our review of the MSPV 2.0 program in fall 2020.

VA's Antiquated Inventory Management System Limited VA Management's Ability to Oversee Real-Time Supply Data at Its 170 Medical Centers

According to senior VA procurement and logistics officials interviewed during our ongoing review of VA's COVID-19 procurement for critical medical supplies, VA experienced difficulty obtaining several types of supplies needed to protect its front-line workforce during the COVID-19 response, ranging from N95 masks to isolation gowns. According to senior VA acquisition and logistics officials, beginning in late February to early March 2020, VA requested that medical centers provide daily updates via spreadsheets to try to obtain the most real time information possible on the levels of PPE on hand, usage, and gaps. These spreadsheets, which were reported manually on a daily basis from each of the VAMCs, were the primary means by which Veterans Health Administration (VHA) leadership obtained detailed information on the stock of critical supplies at its VAMCs in real-time. The insight provided by these spreadsheets was not something that VHA leadership had in any

type of ongoing or systematic way, prior to the COVID-19 pandemic. In April 2020, VA developed an automated tool to manage this reporting process, but, according to officials, the information must still be gathered and manually reported by each of the 170 VAMCs on a daily basis.⁵

In May 2019, the VA Inspector General found that proper inventory monitoring and management was lacking at many VAMCs, noting that inventory management practices ranged from inaccurate to nonexistent.⁶ In 2013, we also reported on weaknesses in VA's inventory management systems and made recommendations to VA to evaluate its efforts to improve in this area.⁷

However, our preliminary observations from our ongoing review of VA's MSPV program indicate that VA will likely rely on its antiquated system for the foreseeable future. Specifically, VA plans to transition to the Defense Logistics Agency's (DLA) inventory management system, called Defense Medical Logistics Standard Support (DMLSS). DMLSS serves as DLA's primary MSPV ordering system and supports DLA's inventory management, among other things. According to DLA officials, DMLSS produces data that VAMCs could use to analyze their order history and find recommendations for future purchases. VA's implementation schedule shows that it will take seven years to roll out DMLSS and its successor at all VAMCs. In the near-term, VA had planned to implement DMLSS at three medical centers in mid-to-late 2019. However, due to technology integration issues between VA's financial system and the DMLSS system, implementation at these three VAMCs is delayed. According to the Chief Supply Chain Officer at one of these VAMCs, the original DMLSS implementation date has changed several times from an

⁵ VHA issued an April 17, 2020 memorandum to VAMCs "to reduce the variation in methods used to report and calculate PPE levels on hand within the VHA." According to VA's Acting Assistant Under Secretary for Health for Support Services, VA developed a Power Business Intelligence Tool in April 2020, in response to the pandemic, which allows VA senior procurement, health, and logistics officials to view PPE supply status at a national and VAMC level.

⁶ Department of Veterans Affairs, Office of Inspector General, *Veterans Health Administration: Expendable Inventory Management System: Oversight of Migration from Catamaran to the Generic Inventory Package* (May 1, 2019).

⁷ GAO, *Veterans Health Care: VHA Has Taken Steps to Address Deficiencies in Its Logistics Program, but Significant Concerns Remain*, [GAO-13-336](#) (Washington, D.C.: Apr. 17, 2013).

initial start date of August 2019, which may be delayed to at least October 2020.

VA uses a “just in time” inventory supply model—a practice employed by many hospital networks where only limited stock is maintained on-site. However, for this model to succeed, VA needs both visibility into current stock and consistent deliveries from the MSPV-NG program. Based on our preliminary observations, VA faces challenges with both visibility and delivery. VA acquisition leadership has recognized the shortcomings in its medical supply chain management, and has identified supply chain modernization as a priority. As part of our ongoing review of VA’s MSPV program, we reviewed VHA’s Modernization Campaign Plan, dated March 2019, and VHA’s Modernization Plan briefing slides, dated February 2020, which describe several modernization initiatives including MSPV 2.0 and DMLSS.⁸ VHA’s February 2020 update on its modernization effort identified both its DMLSS deployment and MSPV 2.0 program at critical risk of not meeting system modernization milestones.

VA’s COVID-19 Emergency Procurement Included Various VA Contracting Organizations and Mechanisms

Based on our preliminary observations from our ongoing review of VA’s procurement of critical medical supplies, in response to COVID-19, VA is using various existing and new contracting organizations and mechanisms to try to meet its PPE needs. These include using national and regional contracting offices to procure supplies and services, and using existing contract vehicles and new sources. In response to the pandemic, VA’s Office of Acquisition and Logistics also issued a memorandum on March 15, 2020, to implement emergency flexibilities

⁸VHA Modernization Campaign Plan, dated March 2019, and VHA Plan for Modernization, Monthly Co-Leads Meeting (Feb. 28, 2020).

available under the Federal Acquisition Regulation, such as increasing the micro-purchase threshold to \$20,000.⁹

Our analysis of contracting activity in the Federal Procurement Data System-Next Generation (FPDS-NG) indicates that VHA's Network Contracting Offices—which support the various regions of VA's hospital network—increased their supply purchases, mostly by entering into new contracts.¹⁰ Department-wide contracting organizations that would normally not make individual supply purchases—such as VHA's Program Contracting Activity Central and VA's Strategic Acquisition Center—also played a substantial role.¹¹ In addition, logistics staff at VAMCs continued to use the MSPV-NG program to order supplies. VA had existing clauses in MSPV-NG contracts that established terms for the suppliers to maintain support to VA in the event of a catastrophe. But, according to senior VA acquisition officials, because those suppliers faced the same shortages in the broader market, they were not able to provide enough supplies to meet VA's surging demand.

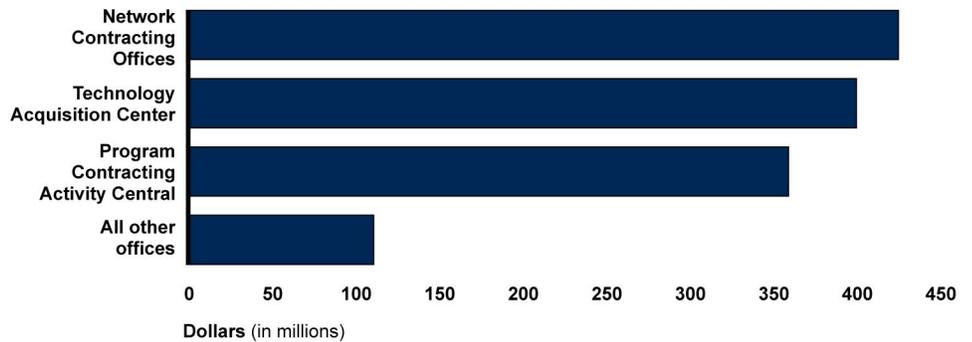
Figure 1 shows the COVID-19-related contract obligations, from March 13, 2020 through June 3, 2020, made by the various VA contracting offices. These obligations include both supplies, such as PPE, and services, such as information technology systems to support telemedicine.

⁹ A micro-purchase is an acquisition of supplies or services using simplified acquisition procedures, the aggregate amount of which does not exceed the micro-purchase threshold. VA's March 15 memorandum delegated authority to specified VA contracting officials to invoke emergency acquisition flexibilities available under Federal Acquisition Regulation part 18. See VA Executive Director, Office of Acquisition and Logistics and Senior Procurement Executive mem. re: Emergency Acquisition Flexibilities—Emergency Assistance Activities in Support of Global Pandemic for Coronavirus Disease 2019 (COVID-19) (Mar. 15, 2020).

¹⁰ FPDS-NG is the central repository for U.S. government procurement data. For contract actions over the micro-purchase threshold, agencies must submit detailed contract information to FPDS-NG. The database includes the product or service, agency and vendor information, contract start and estimated completion dates, and location of performance, among other elements.

¹¹ We have previously found FPDS-NG data sufficiently reliable for summarizing total obligations. FPDS-NG has added a new COVID-19 2020 value for the National Interest Action data element to track the relief contracts.

Figure 1: Total COVID-19-Related Obligations for Selected Department of Veterans Affairs Contracting Offices from March 13, 2020 through June 3, 2020



Source: GAO analysis of Federal Procurement Data System-Next Generation data. | GAO-20-638T

Accessible Data for Figure 1: Total COVID-19-Related Obligations for Selected Department of Veterans Affairs Contracting Offices from March 13, 2020 through June 3, 2020

Category	Dollars (in millions)
Network Contracting Offices	424.5
Technology Acquisition Center	399.4
Program Contracting Activity Central	358.7
All other offices	110.4

Our analysis of preliminary data on orders placed directly by VAMC staff for COVID-19-related items found that, in April 2020, the value of VA's reported COVID-19-related purchases through the MSPV-NG program began to decrease relative to the values reported in prior months.

According to senior VA acquisition and logistics officials, in part, because MSPV-NG and other existing VA supply contracts and agreements did not meet VA's needs, its acquisition workforce had to make purchases through other contracting mechanisms, such as micro-purchases using government purchase cards, to fill the gap. Between March 13, 2020 and June 3, 2020 VA obligated more than 51 percent (\$687 million) of the \$1.3 billion it spent on products and services for the COVID-19 response through purchases made outside the MSPV-NG program and other established VA contracting mechanisms. About 27 percent of this \$1.3

billion (\$364 million) was for veteran-owned small business set-aside purchases, under VA's Veterans First program.¹²

VA Collaborated with the Federal Emergency Management Agency (FEMA) in Response to COVID-19

On April 17, 2020, VA placed its first supply requests through the Federal Emergency Management Administration's (FEMA) Strategic National Stockpile program, according to VA senior acquisition and logistics officials.¹³ As of June 5, 2020, according to information provided by the VA, it had received shipments of several different types of supplies through FEMA from these requests, as shown in Table 1.

¹² In 2006, in order to increase opportunities for veterans to do business with VA, Congress directed the department to apply a preference for contracting with Veteran-Owned Small Businesses (VOSB) and Service-Disabled Veteran-Owned Small Businesses (SDVOSB). VA created what it calls its Veterans First Contracting Program to implement the statute. The Veterans Benefits, Health Care, and Information Technology Act of 2006, Pub. L. No. 109-461, § 502(a), 120 Stat. 3403, 3431 (2016) (codified as amended at 38 U.S.C. § 8127).

¹³ The Strategic National Stockpile's role is to supplement state and local supplies during public health emergencies. The supplies, medicines, and devices for life-saving care contained in the stockpile can be used as a short-term stopgap buffer when the immediate supply of adequate amounts of these materials may not be immediately available.

Table 1: COVID-19-Related Items Requested by the Department of Veterans Affairs and Received from the Federal Emergency Management Administration, as of June 5, 2020

Item	Total Requested	Received as of June 5, 2020
N95 Masks	5,000,000	7,042,320
Eye Protection (Face Shield or Goggles/Glasses)	660,000	427,000
Generic Masks	7,500,000	0
Gloves (in pairs)	7,200,000	4,992,000
Gowns (Isolation gowns – Level 2)	3,400,000	0
Powered Air Purifying Respirator	11,500	3,258

Source: Department of Veterans Affairs. | GAO-20-638T

According to VA senior procurement and logistics officials, VA’s Emergency Management Center has an existing relationship with FEMA. However, these senior procurement and logistics officials noted that VA support services officials—who had primary responsibility for requesting medical items through FEMA—did not have an existing relationship with FEMA or a process in place prior to the COVID-19 pandemic for placing medical supply requests through FEMA. Officials said that this led to a brief, initial delay in processing VA’s first request.

In summary, VA experienced many of the same challenges obtaining medical supplies as most private sector hospitals and other entities in responding to this devastating pandemic. This situation put stress on an already overburdened acquisition and logistics workforce—resulting in staff initially scrambling to address supply chain shortfalls while simultaneously working with VA’s antiquated inventory system, through manual, daily reports on PPE levels to VA leadership. While VA has made progress in addressing some of the issues that have led us to identify VA acquisition management as high risk, it will take many years for VA to put in place a modern supply chain management system that would position it to provide the most efficient and effective service to our nations veterans.

Chairman Moran, Ranking Member Tester, and Members of the Committee, this concludes my prepared statement. I would be pleased to respond to any questions that you may have at this time.

GAO Contacts and Staff Acknowledgments

If you or your staff have any questions about this testimony, please contact Shelby S. Oakley at 202-512-4841 or OakleyS@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made key contributions to this testimony are Lisa Gardner, Assistant Director; Teague Lyons, Assistant Director; Daniel Singleton, Analyst-in-Charge; Jeff Hartnett, Nicolaus Heun, Kelsey M. Carpenter, Sara Younes, Matthew T. Crosby; Suellen Foth, Lorraine Ettaro, Rose Brister, Susan Ditto, Roxanna Sun, Carrie Rogers, and Helena Johnson.

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