United States Government Accountability Office

Testimony

Before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

For Release on Delivery
Expected at 2:00 p.m. ET
Wednesday, September 16, 2020

VA ACQUISITION MANAGEMENT

COVID-19 Response Strains Supply Chain While Modernization Delays Continue

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

GAO-20-716T

GAO Highlights

Highlights of GAO-20-716T, a testimony before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

Why GAO Did This Study

VA spends hundreds of millions of dollars annually to meet the health care needs of about 9 million veterans. As of June 30, 2020, VA received about $19.6 billion in supplemental appropriations for COVID-19-related needs. Due to longstanding issues with VA acquisition management, GAO added it to its High Risk List in 2019.

This statement discusses how VA is meeting its needs for medical and surgical supplies during the pandemic and the status of ongoing efforts to modernize its supply chain. This statement is based on information from three reports issued from 2017-2020, a draft report on the MSPV program currently with VA for comment, and preliminary observations from an ongoing review of VA's COVID-19 procurements.

To perform this work, GAO reviewed VA documentation and interviewed VA officials and medical center staff.

What GAO Recommends

GAO has made 40 recommendations since 2015 to improve acquisition management at VA. VA agreed with those recommendations and has implemented 22 of them. VA is currently reviewing recommendations from GAO's draft report on the MSPV program.

View GAO-20-716T. For more information, contact Shelby S. Oakley at (202) 512-4841 or OakleyS@gao.gov.

September 16, 2020

VA ACQUISITION MANAGEMENT

COVID-19 Response Strains Supply Chain While Modernization Delays Continue

What GAO Found

GAO's preliminary observations show that the Department of Veterans Affairs (VA) has leveraged multiple approaches—including a new personal protective equipment tracking tool, additional contracting organizations, emergency flexibilities, and federal partnerships—to meet its critical medical and surgical supply needs during the Coronavirus Disease 2019 (COVID-19) pandemic. These approaches include using regional contracting offices to obtain supplies through new contracts and requesting supplies through the Federal Emergency Management Administration. To aid its response to ongoing and future public health emergencies, VA plans to establish central sources of critical supplies called Regional Readiness Centers.

As GAO reported in June 2020, VA has several supply chain modernization efforts underway. However, in its draft report on the MSPV program, GAO found that each effort faces significant delays.

MSPV modernization. VA's next iteration of its preferred supply source, the Medical-Surgical Prime Vendor (MSPV) 2.0 program, aims to address some shortfalls identified in GAO's past and ongoing reviews, such as supply backorders. However, VA delayed implementation of MSPV 2.0 from April 2020 to early 2021 and, based on its plans, it will not fully address all existing issues.

Inventory management system modernization. VA's inventory management system is antiquated, which has led to supply chain challenges. VA has a program underway to implement a more modern system, but its rollout at initial locations has been delayed over a year by systems integration challenges. Nationwide implementation is not planned until 2027.

Defense Logistics Agency MSPV pilot. VA is piloting the use of the Defense Logistics Agency's MSPV program to provide medical and surgical supplies to several VA medical centers in lieu of MSPV 2.0. In addition to the pilot facing delays of almost a year, VA lacks a comprehensive methodology to measure pilot success.

Infection Control Gowns in Supply Point at a Veterans Affairs Medical Center

Source: GAO. | GAO-20-716T

Chairman Pappas, Ranking Member Bergman, and Members of the Subcommittee:

Thank you for having me here today to discuss our ongoing 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 healthcare needs of about 9 million veterans and has one of the most significant acquisition management functions in the federal government. VA received about $19.6 billion in supplemental appropriations to spend on Coronavirus Disease 2019 (COVID-19)-related needs, as of July 29, 2020. Like most medical institutions worldwide, VA has faced difficulties obtaining sufficient supplies, especially personal protective equipment (PPE), for staff at its 170 VA medical centers during the COVID-19 pandemic. Existing shortcomings in VA's medical supply chain and inventory systems posed additional challenges. VA had several supply chain modernization initiatives underway to address these challenges prior to the pandemic. These include the development of a new iteration of its Medical-Surgical Prime Vendor (MSPV) program—VA's preferred supply source. Under this program, contractors—called prime vendors—deliver a wide range of supplies to VA medical centers on near-daily basis, and it is intended to be the medical centers' primary source for medical supplies.

Due to long-standing issues with VA acquisition management, we designated it a high-risk area in 2019. In our priority recommendation letter that we sent to the Secretary of VA earlier this year, we noted that three priority recommendations related to VA acquisition management have yet to be fully implemented. For example, with regard to the MSPV program, we reported that VA had yet to assess potential duplication between MSPV and its Federal Supply Schedule program.

My remarks today will summarize a few key findings on VA's response to COVID-19 and its progress toward modernizing its supply chain based on three issued reports; a draft report on VA's MSPV program, which is

currently with VA for comment; and preliminary observations from our ongoing review of VA's COVID-19-related procurements.[1]

As part of our work for our issued and draft reports, we reviewed VA policies, communications, briefings, prior GAO reports on leading practices for organizational transformation, relevant legislation, and other documents.[2] 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, as well as other VA officials. For our draft report on VA's MSPV program, we also conducted site visits to 12 VA medical centers in 2019, selected based on highest total spending on medical and surgical supplies, among other things. As part of our ongoing work on VA's COVID-19-related procurements, we reviewed the Federal Procurement Data System-Next Generation (FPDS-NG) procurement data through August 31, 2020. We identified contract obligations related to COVID-19 using only the National Interest Action code. We also reviewed VA memorandums, briefings, and we met with key VA personnel responsible for the agency's response to COVID-19. We expect to issue a report on this ongoing review by early 2021. Finally, we met with senior VA officials on September 9, 2020, to obtain agency views on the new observations discussed 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.

[1]See GAO, *High-Risk Series: Substantial Efforts Needed to Achieve Greater Progress on High-Risk Areas*, GAO-19-157SP (Washington, D.C.: Mar. 6, 2019); *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); and *VA Acquisition Management: Supply Chain Management and COVID-19 Response*, GAO-20-638T (Washington, D.C.: June 9, 2020).

[2]See GAO-18-34, GAO-19-157SP, and GAO-20-638T. More detailed information on the scope and methodology is contained within these reports.

VA Leveraged Multiple Approaches to Obtain Supplies during COVID-19

According to senior VA procurement and logistics officials we interviewed during our ongoing review of VA's procurement of COVID-19-related critical medical and surgical supplies, VA experienced difficulty obtaining several types of supplies, such as respirator masks and isolation gowns, needed to protect its frontline workforce during the COVID-19 response. VA uses a "just in time" inventory supply model—a standard practice employed by many hospital networks where only limited stock is maintained on-site. However, for this model to succeed, VA needs consistent deliveries from VA's suppliers. During COVID-19, when there were global supply chain shortages, VA relied on a new PPE tracking tool, additional VA contracting organizations, emergency flexibilities, and federal partnerships to obtain needed supplies for VA medical centers. VA also has begun planning for future public health emergencies by working to stand up Regional Readiness Centers.

Developed new PPE tracking tool. VA supply chain leaders did not have an automated way of tracking the stock of critical supplies at VA medical centers during the COVID-19 pandemic due to VA's antiquated inventory management system, and as a result have relied on manual tracking. According to senior VA acquisition and logistics officials we interviewed during our ongoing review of COVID-19 related procurements, beginning in late February to early March 2020, VA requested that medical centers provide daily updates via spreadsheets in an attempt to obtain near real-time information on the levels of PPE on hand, usage, and supply gaps. These spreadsheets, which VA medical centers updated manually on a daily basis, provided the primary means by which VHA leadership obtained detailed information on the stock of critical supplies at its VA medical centers. VHA leadership did not have insight into supplies in an ongoing or systematic way prior to the pandemic.

In April 2020, VA developed a PPE tracking tool to manage this reporting process, and VA medical center staff interviewed during our ongoing COVID-19 review said that the tool is generally effective for tracking inventory levels and usage rates of PPE. However, information must still be gathered and manually reported by each of the 170 VA medical centers on a daily basis because the connection between VA's local inventory system and this tool is not automated. As such, VA medical

center staff must validate the PPE inventory data and perform actions such as manual counting to correct issues.[3]

Leveraged additional VA contracting organizations. According to VA officials, VA leveraged the breadth of its acquisition workforce to respond to COVID-19. Our preliminary observations indicate that during the COVID-19 pandemic, VA is using contracting organizations within VA that normally would not contract for medical supplies to try to meet its PPE needs and find additional supply sources. Our preliminary analysis of contracting reporting in FPDS-NG indicates that VHA's Network Contracting Offices—which provide contracting support to the various regions of VA's hospital network—increased their supply purchases by entering into new contracts.[4] In addition, 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 substantial roles in helping VA obtain necessary supplies.[5]

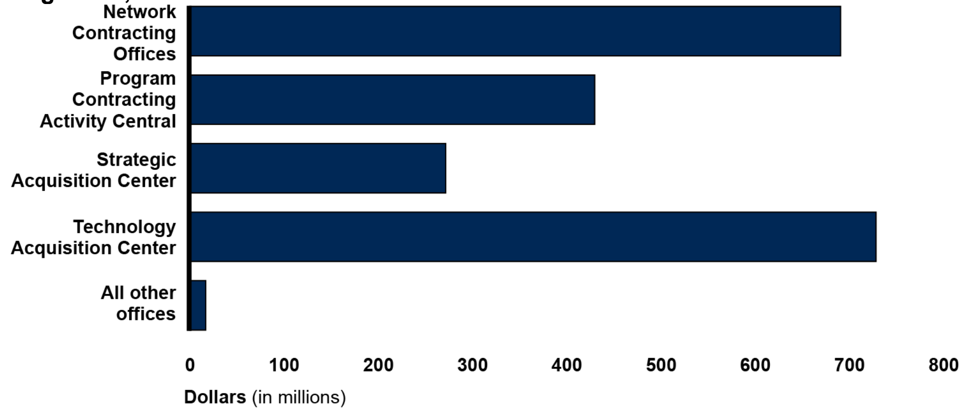
Between March 13, 2020, and August 31, 2020, about 45 percent ($978 million) of the $2.1 billion VA obligated on products and services for the COVID-19 response were through purchases made outside of already existing VA contracting mechanisms. Figure 1 shows the COVID-19-related contract obligations from March 13, 2020, through August 31, 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.

[3]VHA issued an April 17, 2020 memorandum to VA medical centers "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 VA medical center level.

[4]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.

[5]Program Contracting Activity Central typically provides procurement support for VHA-wide programs, such as energy efficiency contracts.

Figure 1: Total Coronavirus Disease 2019-Related Obligations for Selected Department of Veterans Affairs Contracting Offices from March 13, 2020 through August 31, 2020



Source: GAO analysis of Federal Procurement Data System-Next Generation data. | GAO-20-716T

Implemented emergency flexibilities. VA's existing supply contracts and agreements—such as those under the MSPV-NG program—also have not fully met VA medical center needs, leading VA to use emergency flexibilities to obtain critical medical supplies. VA had existing clauses in its MSPV-NG contracts—VA's preferred supply source—that established terms for the suppliers to maintain support to VA in the event of a catastrophe. However, 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. For example, VA's Office of Acquisition and Logistics issued a memorandum on March 15, 2020, to implement emergency flexibilities available under the Federal Acquisition Regulation, such as increasing the micro-purchase threshold from generally $10,000 to $20,000.[6] According to medical center officials we spoke with as part of our ongoing work on VA's COVID-19 related procurements, this flexibility has been helpful in enabling them to meet their medical supply needs. This ongoing work will describe the acquisition flexibilities available to VA to obtain

[6]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).

essential medical supplies and equipment during the COVID-19 pandemic.

Collaborated with the Federal Emergency Management Agency (FEMA). VA collaborated with FEMA and participated in the Strategic National Stockpile program to obtain supplies.[7] According to VHA senior procurement and logistics officials, although VA's Emergency Management Center had an existing relationship with FEMA, VA support services officials—who had primary responsibility for requesting medical items through FEMA—did not have 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. On April 17, 2020, VA placed its first FEMA supply requests, according to VA senior acquisition and logistics officials. VA's Office of Procurement and Logistics made this request, and the head of this office was on a detail to FEMA from March 20, 2020, to June 12, 2020, to assist in the agency's COVID-19 response efforts. As of September 11, 2020, according to information provided by the VA, it received shipments of several different types of supplies through FEMA, as shown in Table 1. We plan to issue a report on our review of VA's response to COVID-19 by early 2021, which will include information on VA's ability to meet medical center COVID-19 needs.

Table 1: Coronavirus Disease 2019-Related Items Requested by the Department of Veterans Affairs and Received from the Federal Emergency Management Administration, as of September 11, 2020

Item	Total requested	Total received
Respirators	5,000,000	8,233,920
Eye protection (face shield or goggles/glasses)	427,000	427,000
Generic masks	7,500,000	2,479,000
Gloves (single)	22,200,000	5,655,400
Gowns	3,400,000	0
Powered air purifying respirators	6,258	6,258
Swabs	10,000	933,220
Test kits	-	420
Collection and stabilization tubes	10,000	787,248
Viral transport medium	-	94,200

Source: Department of Veterans Affairs. | GAO-20-716T

[7]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.

Establishing Regional Readiness Centers. VHA is also taking steps to better respond to future health emergencies through standing up Regional Readiness Centers to act as a central source for the management and resupply of VA medical center PPE and critical items. According to a July 2020 VHA plan, VHA's intent in establishing these centers is to build resiliency into the supply chain by minimizing disruptions due to the increased global demand for PPE and critical items in COVID-19. Under this plan, each Regional Readiness Center will manage and maintain 120 days of supply, including what each VA medical center within the region was ordering before COVID-19 and the materials required to sustain COVID-19 response efforts. VHA also intends for the centers to perform tasks such as decontaminating respirator masks and providing extra storage to VA medical centers that are unable to store more than 30 days of supply at their facilities.

VHA's plan states that it has completed or is in the process of completing several milestones in its implementation effort. For example, VHA has established interagency agreements with the Department of Health and Human Services and Defense Logistics Agency to acquire warehousing and distribution capabilities and plans to onboard staff to work in the centers by November 2020. VHA anticipates full implementation of the centers will occur by July 2021. In the long term, according to its plan, VHA aims for the Regional Readiness Centers to support VHA preparedness for regional and national public health emergencies, including those secondary to natural disasters. We plan to issue a report on our review of VA's response to COVID-19 by early 2021, which will include information on the status of VHA's Regional Readiness Centers.

Planned Supply Chain Transformations Are Delayed and May Not Fully Address Existing Issues

Our prior work has identified longstanding issues with VA's approach to purchasing medical supplies. The global supply chain disruption caused by COVID-19 created additional challenges for VA's medical supply chain. VA acquisition leadership has recognized the shortcomings in its medical supply chain management and has identified supply chain modernization as a priority. VA has several supply chain transformation initiatives underway, but they are delayed, will take time to implement, and will not fully address existing issues.

MSPV modernization. In November 2017, we reported weaknesses in VA's implementation of its current version of its MSPV program—MSPV-NG.[8] These included the lack of an effective medical supply procurement

[8] See GAO-18-34.

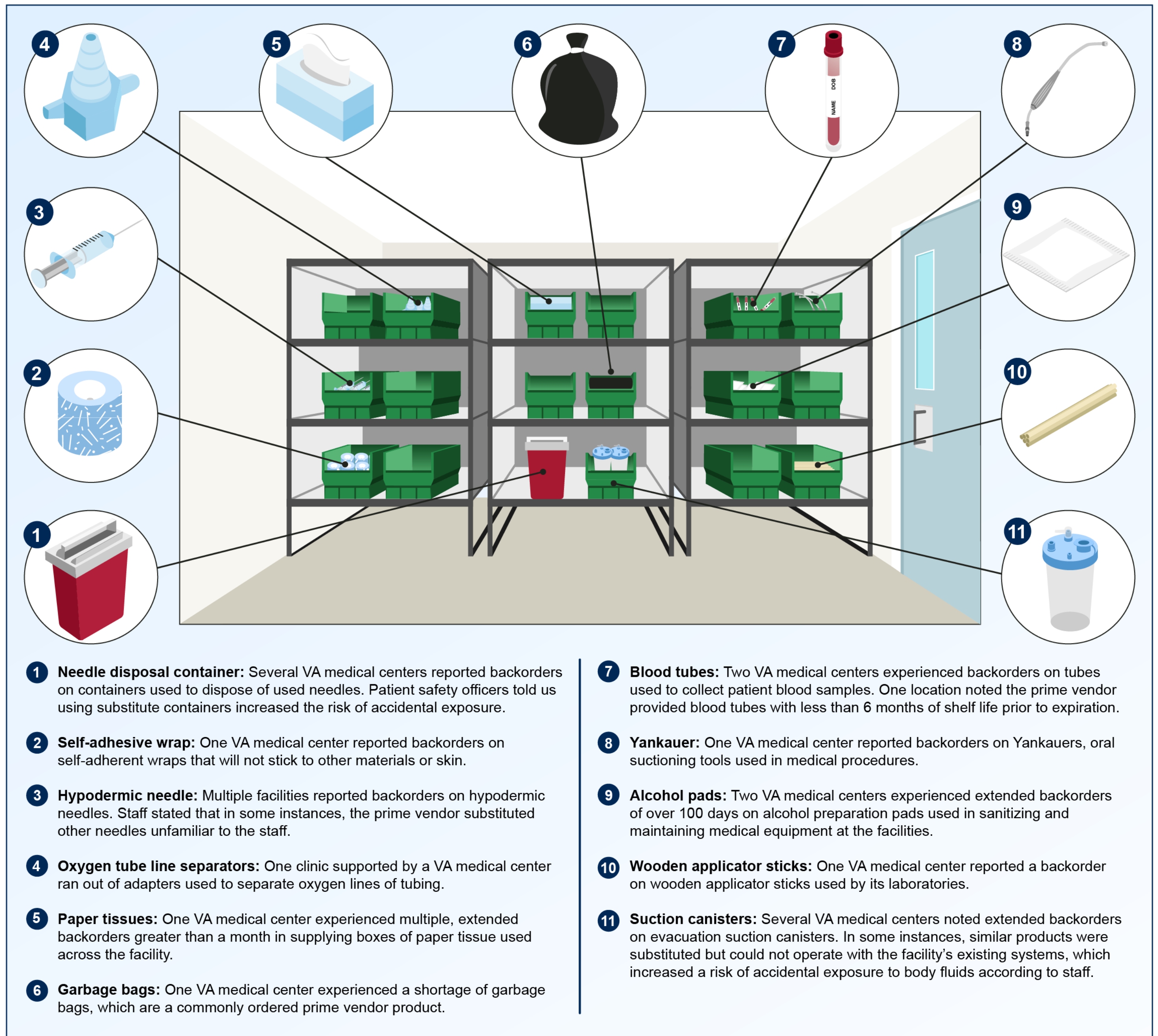
strategy, clinician involvement, and reliable data systems. We found that several of VA's medical supply management practices were not in line with those employed by private sector leading hospital networks. We also found that VA's initial formulary consisted of around 6,000 items at launch, and, according to senior VA contracting officials, many items on the formulary were not those needed by medical centers.[9] These factors resulted in an initial formulary that did not meet the needs of VA medical centers. The MSPV-NG program office subsequently took steps to expand the formulary, growing it to over 25,000 items as of August 2020. We made nine recommendations related to MSPV-NG in our 2017 report. VA has not yet fully implemented four of these recommendations as of August 31, 2020.

VA is developing the next iteration of the program, called MSPV 2.0, which is intended to address some of the shortfalls we previously identified in MSPV-NG, including significantly expanding the number of items on the formulary to a planned 125,000. Based on observations from our ongoing work, some of the current MSPV-NG challenges persist and may not be remedied by MSPV 2.0.[10] For example, all 12 of the VA medical centers we visited during 2019 experienced challenges with backorders of needed supplies in MSPV-NG (see figure 2). When a prime vendor lacked the available inventory to fulfill an order, some VA medical centers told us they chose to wait for the resolution of the backorder, resulting in delivery delays of several days, weeks, or even months. Other VA medical center staff told us that they pursued alternative sources, using government purchase cards, to meet the facilities' needs. These challenges obtaining routine supplies through MSPV-NG differ from the nationwide challenges VA and other hospital networks faced obtaining PPE amid the COVID-19 pandemic, but they illustrate how VA faced existing supply chain challenges it was working to address before the pandemic. The terms of the September 2019 MSPV 2.0 solicitation would provide more explicit directions to prime vendors to keep a 30-day supply of stock for regularly ordered supplies. VA also plans to establish new performance metrics for less-frequently-ordered supplies. These changes are intended to reduce problems with supplies being on backorder.

[9]The formulary is a list of specific medical and surgical supplies available to VA medical centers to purchase through VA's MSPV program.

[10]The period of performance for VA's original MSPV-NG contracts has ended. However, VA has put bridge contracts in place with the MSPV-NG prime vendors until it is able to implement MSPV 2.0.

Figure 2: Examples of Supply Items for Which Veterans Affairs Medical Center Staff Reported Backorders During 2019



Source: Interviews with Veterans Affairs (VA) medical center staff and GAO analysis of Medical-Surgical Prime Vendor-Next Generation formulary.. | GAO-20-716T

Note: These examples of supplies on backorder were reported by clinical and logistics staff at 12 VA medical centers we visited during 2019.

Further, under MSPV-NG, the MSPV program office manages the formulary manually by releasing spreadsheets each month with information on supplies available to VA medical centers. Since the formulary is updated only once a month, representatives of two prime vendors told us that price adjustments are sometimes incorporated into their inventory database before the VA medical center updates its information, and any orders where the price does not match are rejected. According to VA medical center logistics officials, this led to cases where prime vendors rejected an order three or four times before all mismatched information was identified. These officials said that the additional administrative burden caused by reworking orders often resulted in delays of needed supply items at VA medical centers. In our draft report on the MSPV program, we made several recommendations for how VA can improve its supply chain. VA is currently reviewing the draft report and is scheduled to provide any comments later this month.

VA intended to begin MSPV 2.0 in April 2020 to ensure uninterrupted service to VA medical centers when the MSPV-NG contracts ended, but it has been delayed. VA's MSPV 2.0 prime vendor procurement has been subject to multiple bid protests and VA officials told us during our ongoing MSPV review that they delayed implementation until at least January 2021 as a result. Because the MSPV-NG contracts ended in March 2020, VA is continuing to provide medical and surgical supply services to VA medical centers through bridge contracts that VA awarded to the four prime vendors without full and open competition.[11] The delay in MSPV 2.0 means VA medical centers will continue to face the issues of the MSPV-NG program for longer than anticipated. Further, on July 29, 2020, VA notified one of the prime vendors of VA's intent to terminate that vendor's contract because of performance problems. According to senior VA officials, medical centers previously served by this prime vendor are now meeting supply needs via the three other existing prime vendors.

Inventory management system modernization. VA also relies on an antiquated inventory management system, which has led to supply chain challenges. In May 2019, the VA Inspector General found that proper inventory monitoring and management was lacking at many VA medical

[11]While there is no government-wide definition for bridge contracts, GAO has defined it as an extension to an existing contract beyond the period of performance (including base and option years) or a new, short-term contract awarded on a sole-source basis to an incumbent contractor to avoid a lapse in service caused by a delay in awarding a follow-on contract.

centers, noting that inventory management practices ranged from inaccurate to nonexistent.[12] 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.[13] VA plans to transition to a Department of Defense inventory management system, called Defense Medical Logistics Standard Support (DMLSS). DMLSS serves as the primary ordering system for the Defense Logistics Agency's (DLA) MSPV program—which is separate from VA's MSPV program—and supports DLA's inventory management, among other things. According to VA, DMLSS is a much-improved inventory management system that provides more powerful analysis and reporting than VA currently has. VA's implementation schedule shows that it will take 7 years to roll out DMLSS and its successor—LogiCole—at all VA medical centers.[14] In the near-term, VA had planned to implement DMLSS at three VA medical centers in mid-to-late 2019. However, due to technology integration issues between VA's financial system and the DMLSS system that VA did not plan for, VA delayed DMLSS implementation by over a year at the initial locations.

DLA MSPV Pilot. VA is also piloting the use of DLA's MSPV program to provide medical and surgical supplies to select VA medical centers in lieu of its own MSPV program, but this effort is also delayed. To implement the pilot, VA must use DLA's inventory management software when placing orders—such as DMLSS or a portal within DLA's Electronic Catalog (ECAT).[15] VA's original plan was to implement the first phase of

[12]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).

[13]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).

[14]In the future, VA will be moving to using LogiCole, a system that provides similar functions to DMLSS, but on a more modern technology platform with some additional features. VA plans to begin implementing LogiCole starting in 2023, with implementation wrapping up across all Veterans Integrated Service Networks in 2027.

[15]According to DLA officials, ECAT provides less capability than DMLSS in areas such as providing real-time data to analyze order history and identifying recommendations for future purchases. ECAT is typically used (by both Department of Defense and VA customers) to access ECAT's own catalog of medical equipment and supplies. This is separate from the DLA MSPV catalog; for the pilot, DLA is providing select VA medical centers access to the DLA MSPV catalog through a separate function within the ECAT platform called Prime Vendor Web Ordering.

the DLA pilot at the Captain James A. Lovell Federal Health Care Center using ECAT in March 2019—with a transition to DMLSS scheduled to occur in October 2019—but VHA Procurement and Logistics officials confirmed this VA medical center's switch to DMLSS did not occur until August 2020. VA officials also stated that they planned to enter the pilot's second phase at two VA medical centers in Veterans Integrated Service Network 20—Spokane and Puget Sound—in October 2019 using DMLSS.[16] This phase of the pilot did not start until July and August 2020 (respectively) using ECAT, with a move to DMLSS not scheduled to occur until fiscal year 2021.

VA plans to use the results of the DLA MSPV pilot to determine if it should implement the program at all VA medical centers, but we found that it lacks the comprehensive methodology to effectively do so. VA's February 2019 *MSPV 2.0 Program Acquisition Strategy* states that VA sees the potential for increased efficiencies through the use of DLA's expansive formulary and that VHA will decide by 2025 whether DLA's MSPV program will replace MSPV 2.0. Senior VHA Procurement and Logistics Office officials told us in June 2020, as part of our ongoing MSPV work, that VA is strongly considering a full transition to DLA's MSPV program in the future.

In March 2020, the MSPV program office identified preliminary metrics to evaluate pilot success, such as cost avoidance, micro-purchase spending using government purchase cards, and VA customer satisfaction. However, we found VA has not established or determined how to measure or interpret the pilot's success metrics. For instance, VHA Procurement and Logistics Office officials told us that they collect data on cost avoidance from the Captain James A. Lovell Federal Health Care Center, but VA has not established a level of cost avoidance justifying a transition away from its own planned MSPV 2.0 program. In addition, VA's current evaluation of the pilot does not include several MSPV-NG program challenges that we identified, such as limited formulary coverage, out-of-stock items, and drop shipment delays. To determine if DLA's program is more effective than VA's MSPV 2.0 program, it is important that VA consider all facets of the medical and surgical supply purchasing process. In our draft report on the MSPV program, we made recommendations for how VA can improve its pilot effort. VA is currently

[16]Veterans Integrated Service Networks are VHA organizations that manage VA medical centers and associated clinics across a given geographic area. VHA currently has 18 Veterans Integrated Service Networks across the nation.

reviewing the draft report and is scheduled to provide any comments later this month.

In summary, VA faces several longstanding medical supply chain challenges. These issues have been further exacerbated by the demands of the COVID-19 pandemic, causing VA to rely on other supply sources and agencies to get needed PPE to its VA medical centers. While VA's supply chain modernization efforts should address some of the issues that have led us to identify VA acquisition management as high risk, these efforts are significantly delayed and will take many years for VA to implement.

Chairman Pappas, Ranking Member Bergman, and Members of the Subcommittee, this completes my prepared statement. I would be pleased to respond to any questions that you may have at this time.

GAO Contact 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 Teague Lyons, Assistant Director; Lisa Gardner, Assistant Director; Kelsey M. Carpenter; Matthew T. Crosby; Lorraine Ettaro; Suellen Foth; Rose Brister; Susan Ditto; and Roxanna Sun.

This is a work of the U.S. government and is not subject to copyright protection in the United States. The published product may be reproduced and distributed in its entirety without further permission from GAO. However, because this work may contain copyrighted images or other material, permission from the copyright holder may be necessary if you wish to reproduce this material separately.

GAO's Mission

The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through our website. Each weekday afternoon, GAO posts on its website newly released reports, testimony, and correspondence. You can also subscribe to GAO's email updates to receive notification of newly posted products.

Order by Phone

The price of each GAO publication reflects GAO's actual cost of production and distribution and depends on the number of pages in the publication and whether the publication is printed in color or black and white. Pricing and ordering information is posted on GAO's website, https://www.gao.gov/ordering.htm.

Place orders by calling (202) 512-6000, toll free (866) 801-7077, or TDD (202) 512-2537.

Orders may be paid for using American Express, Discover Card, MasterCard, Visa, check, or money order. Call for additional information.

Connect with GAO

Connect with GAO on Facebook, Flickr, Twitter, and YouTube.
Subscribe to our RSS Feeds or Email Updates. Listen to our Podcasts.
Visit GAO on the web at https://www.gao.gov.

To Report Fraud, Waste, and Abuse in Federal Programs

Contact FraudNet:

Website: https://www.gao.gov/fraudnet/fraudnet.htm

Automated answering system: (800) 424-5454 or (202) 512-7700

Congressional Relations

Orice Williams Brown, Managing Director, WilliamsO@gao.gov, (202) 512-4400, U.S. Government Accountability Office, 441 G Street NW, Room 7125, Washington, DC 20548

Public Affairs

Chuck Young, Managing Director, youngc1@gao.gov, (202) 512-4800
U.S. Government Accountability Office, 441 G Street NW, Room 7149
Washington, DC 20548

Strategic Planning and External Liaison

James-Christian Blockwood, Managing Director, spel@gao.gov, (202) 512-4707
U.S. Government Accountability Office, 441 G Street NW, Room 7814,
Washington, DC 20548

Please Print on Recycled Paper.