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November 2017

# VETERANS AFFAIRS CONTRACTING

## Improvements in Buying Medical and Surgical Supplies Could Yield Cost Savings and Efficiency

# GAO Highlights

Highlights of [GAO-18-34](#), a report to the Chairman, Committee on Veterans' Affairs, House of Representatives

## Why GAO Did This Study

VA medical centers spend hundreds of millions of dollars annually on medical supplies and services. In December 2016, VA instituted a major change in how it purchases medical supplies—the MSPV-NG program—to gain effectiveness and efficiencies.

GAO was asked to examine VA's transition to the MSPV-NG program and its use of emergency procurements. This report assesses the extent to which (1) VA's implementation of MSPV-NG was effective in meeting program goals, and (2) VA awards contracts on an emergency basis. GAO analyzed VA's MSPV-NG requirements development and contracting processes, and identified key supply chain practices cited by four leading hospital networks. GAO also reviewed a non-generalizable sample of 18 contracts designated in VA's database as emergency procurements with high dollar values; and met with contracting, logistics, and clinical officials at 6 medical centers, selected based on high dollar contract obligations in fiscal years 2014-2016 and geographic representation.

## What GAO Recommends

GAO is making 10 recommendations, including that VA expand clinician input in requirements development, calculate MSPV-NG cost avoidance, establish a plan for awarding future competitive contracts, and identify opportunities to strategically procure supplies and services frequently purchased on an emergency basis. VA agreed with GAO's recommendations.

View [GAO-18-34](#). For more information, contact Shelby S. Oakley at (202) 512-4841 or [oakleys@gao.gov](mailto:oakleys@gao.gov).

November 2017

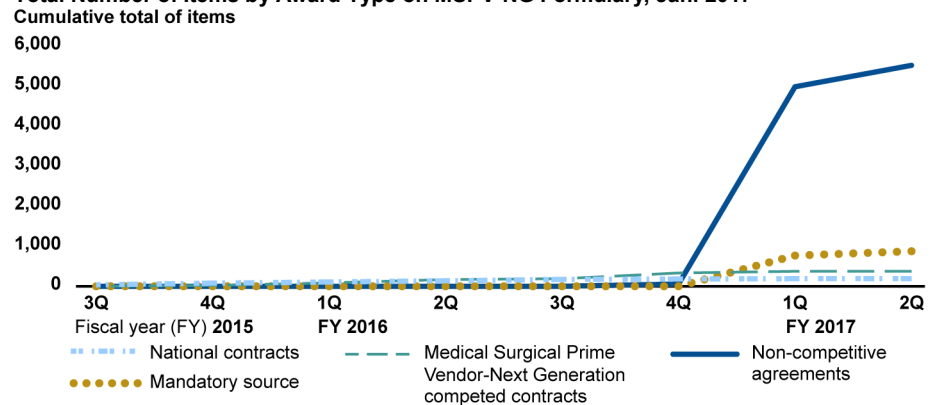
# VETERANS AFFAIRS CONTRACTING

## Improvements in Buying Medical and Surgical Supplies Could Yield Cost Savings and Efficiency

### What GAO Found

The Department of Veterans Affairs (VA) established the Medical Surgical Prime Vendor-Next Generation (MSPV-NG) program to provide an efficient, cost-effective way for its facilities to order supplies, but its initial implementation was flawed, lacked an overarching strategy, stable leadership, and sufficient workforce that could have facilitated medical center buy-in. VA developed requirements for a broad range of MSPV-NG items with limited clinical input. As a result, the program has not met medical centers' needs, and usage remains far below VA's 40 percent target. VA also established cost avoidance as a goal for MSPV-NG, but currently only has a metric in place to measure broader supply chain cost avoidance, not savings specific to MSPV-NG. Also, starting in June 2015, VA planned to award competitive contracts for MSPV-NG items, but instead, 79 percent were added using non-competitive agreements. (See figure.) This was done primarily to meet VA's December 2016 deadline to establish the formulary, the list of items available for purchase through MSPV-NG.

Total Number of Items by Award Type on MSPV-NG Formulary, Jan. 2017



Source: GAO analysis of Veterans Affairs formulary data. | GAO-18-34

The roll-out of MSPV-NG ran counter to practices of leading hospitals that GAO spoke with, which highlighted key steps, such as prioritizing supply categories and obtaining continuing clinician input to guide decision-making. VA has taken steps to address some deficiencies identified in the first phase of implementation and is considering a new approach for this program. However, until VA addresses the existing shortcomings in the MSPV-NG program, such as the lack of medical center buy-in, it will face challenges in meeting its goals.

Medical centers often rely on emergency procurements to obtain routine goods and services—some of which could be made available at lower cost via MSPV-NG. Sixteen of the 18 contracts in GAO's sample were not competed, which puts the government at risk of paying more. For instance, one medical center procured medical gas on an emergency basis through consecutive non-competitive contracts over a 3-year period. VA policy clearly defines non-emergency actions; however, inefficiencies in planning, funding, and communication at the medical centers contributed to emergency procurements, resulting in the contracting officers quickly awarding contracts with no competition.

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## Abbreviations

BPA	Blanket Purchase Agreement
CAO	Chief Acquisition Officer
eCMS	Electronic Contract Management System
FAR	Federal Acquisition Regulation
FY	fiscal year
HCA	Head of Contracting Activity
IPT	Integrated Product Team
MSPV-NG	Medical Surgical Prime Vendor-Next Generation
NCO	Network Contracting Office
OALC	Office of Acquisition, Logistics, and Construction
SAC	Strategic Acquisition Center
VA	Department of Veterans Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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November 9, 2017

The Honorable Phil Roe  
Chairman  
Committee on Veterans' Affairs  
House of Representatives

Dear Mr. Chairman:

In December 2016, the Department of Veterans Affairs (VA) launched the next generation of the Medical Surgical Prime Vendor program as its primary means for purchasing supplies, such as bandages and scalpels, for 170 VA medical centers to meet the health care needs of about 7 million veterans. In fiscal year 2015, VA obligated \$465 million for these types of supplies, and, in 2016, it stated that it planned to achieve \$150 million in cost avoidance through a supply chain transformation effort, which includes the Medical Surgical Prime Vendor-Next Generation (MSPV-NG) program. In addition to leveraging VA's large buying power, the department's other stated goals for this program were to standardize supplies used across VA medical centers and improve supply chain efficiency.

The transition to MSPV-NG has been a major effort, involving stakeholders from the Veterans Health Administration's (VHA) Procurement and Logistics Office and VA's Strategic Acquisition Center (SAC), as well as logistics and clinical personnel at every medical center. The program also includes hundreds of new contracts with individual supply vendors and a new set of prime vendor contracts to distribute the supplies. This transition represents a significant change to how medical and surgical supplies are purchased, which has raised questions about whether MSPV-NG will appropriately balance medical needs with logistical efficiency. Effective supply chain management is an essential part of delivering quality health care to veterans. For instance, in April 2017, the VA Inspector General released an interim report detailing supply management issues at the District of Columbia VA Medical Center that posed risks to patient care.<sup>1</sup> Moreover, VHA's procurement of routine goods on an urgent or emergency basis at medical centers, as our prior

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<sup>1</sup>Department of Veterans Affairs Office of the Inspector General, *Interim Summary Report*, (Washington, D.C.: Apr. 12, 2017).

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work indicated has occurred, has the potential to strain VA's acquisition workforce.<sup>2</sup>

You requested that we examine VA's transition to the MSPV-NG program and the extent to which the department contracts for goods and services on an emergency basis. This report assesses the extent to which (1) VA's implementation of MSPV-NG has been effective in meeting program goals; and (2) VHA awards contracts on an emergency basis for routine supplies and ongoing services and what, if any, impact these awards have on VHA's acquisition function.

To review the extent to which VA's transition to MSPV-NG has been effective, we reviewed policy, communications, briefings, and other documents. We reviewed prior GAO reports on best practices for organizational transformation, as well as internal control standards.<sup>3</sup> We also interviewed supply chain managers from four leading hospital networks regarding their medical supply management practices. We selected the hospital networks because they were identified by an industry study as having leading supply chain practices.<sup>4</sup> During interviews, we asked these supply chain managers a standard set of questions about processes followed to standardize their hospital networks' supply chain. VA had also identified two of these hospital networks as having leading supply chain practices, and used the industry study to identify these hospital networks. We used this information from the leading hospital networks to compare the key steps—identified by each of the four hospital networks—followed in standardizing their medical supply chains to those steps that VA followed when implementing the MSPV-NG program. We also confirmed these key steps with the leading hospital networks. To assess VA's MSPV-NG contracting process, we obtained data on the contents of the formulary (a list of specific items that medical centers are allowed to purchase), and determined that it was sufficiently reliable for our reporting objectives by tracing data to a sample of source documents, among other steps. We analyzed the data to determine what acquisition instrument was used to

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<sup>2</sup>GAO, *Veterans Affairs Contracting: Improvements in Policies and Processes Could Yield Cost Savings and Efficiency*, [GAO-16-810](#) (Washington, D.C.: Sept. 16, 2016).

<sup>3</sup>GAO, *Standards for Internal Control in the Federal Government*, [GAO-14-704G](#), (Washington, D.C., Sept. 10, 2014).

<sup>4</sup>The Healthcare Supply Chain Top 25 for 2015, Gartner, Inc., (a research and advisory firm).

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add items or change the composition of the formulary over time. We conducted site visits to three Veterans Integrated Service Networks (VISNs), selected based on highest total contract obligations in fiscal years 2014 through 2016, geographic diversity, and other factors, and interviewed VISN leadership. We visited two medical centers within each selected VISN and interviewed officials, such as Chief Supply Chain Officers, clinicians, and ordering officers. We also interviewed VHA- and VA-wide procurement leaders, program office managers, and managers and members of three integrated product teams who helped develop requirements for supply items—selected based on those responsible for the largest number of items. Finally, we obtained and analyzed data on VA’s metrics for the program. We determined the data were sufficiently reliable for our purpose of measuring utilization by interviewing officials responsible for maintaining the data and other measures.

To assess the extent to which VHA awards contracts on an emergency basis, we reviewed VA-provided contracting data from fiscal years 2014 through 2016. We determined these data were sufficiently reliable for our reporting objective by reviewing information on system controls, among other things. We used these data to select a non-generalizable sample of 18 contract files, chosen from the three VISNs based on their designated urgency level, among other criteria. We interviewed the contracting officer and medical center customer for each selected contract, as well as leadership of the selected contracting offices. See appendix I for a more detailed scope and methodology.

We conducted this performance audit from November 2016 to November 2017 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.

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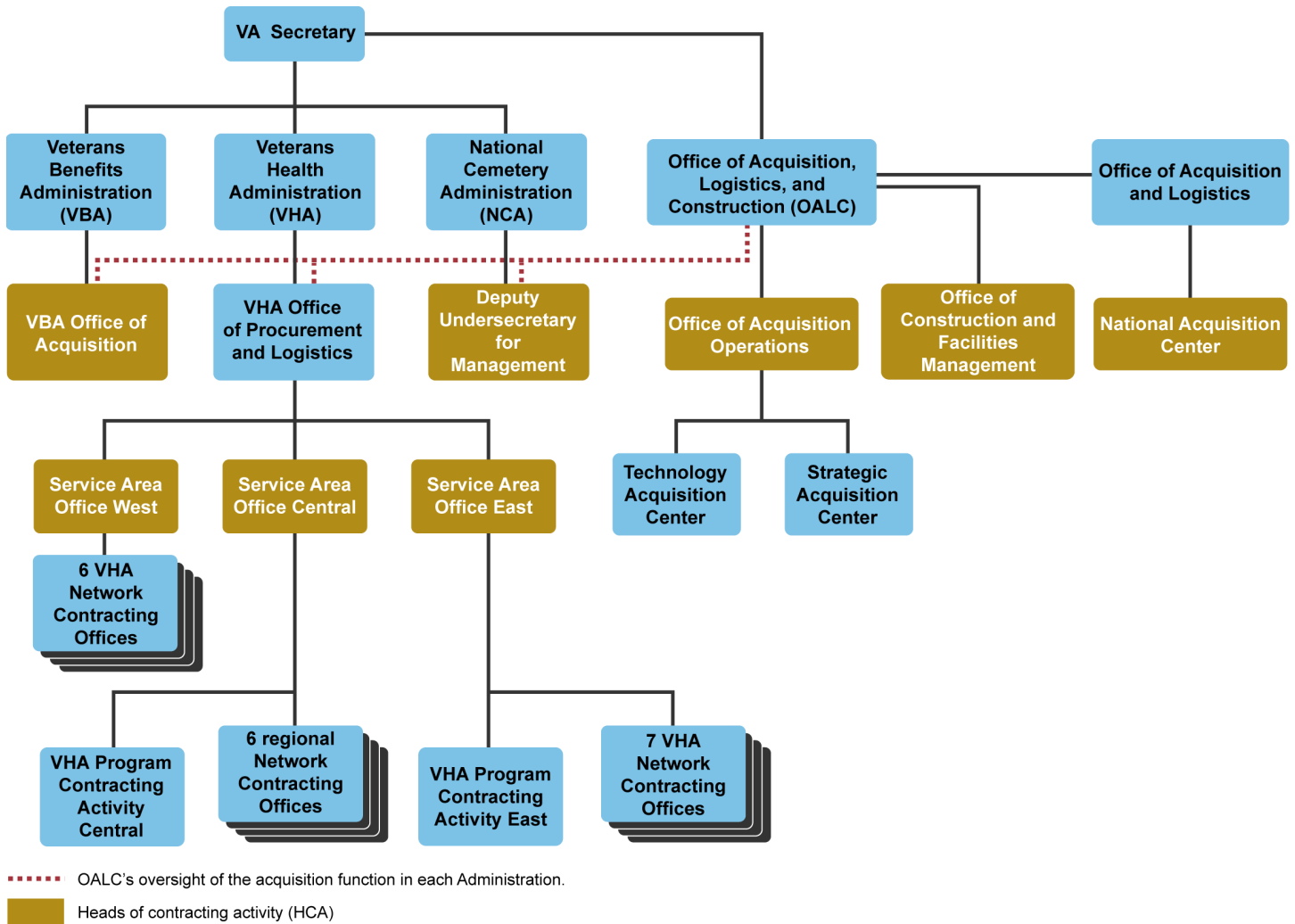
## Background

VA serves veterans of the U.S. armed forces and provides health, pension, burial, and other benefits. The department’s three operational administrations—VHA, Veterans Benefits Administration, and National Cemetery Administration—operate largely independently from one another. Each has its own contracting authority, though all three also work with national contracting organizations under the Office of Acquisition, Logistics, and Construction for certain types of purchases, such as medical equipment and information technology. VHA, which



provides medical care to about 7 million veterans at 170 medical centers, is by far the largest of the three administrations. These medical centers are organized into 18 VISNs, organizations that manage medical centers and associated clinics across a given geographic area. Each VISN is served by a corresponding Network Contracting Office. Figure 1 shows the organizational structure of the procurement function at VA.

**Figure 1: Organizational Structure of the Department of Veterans Affairs (VA) Procurement**



Source: GAO analysis of Veterans Affairs organizational charts and policies. | GAO-18-34

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## MSPV-NG Program

For over a decade, each of VA's 170 medical centers used VHA's legacy MSPV program to order medical supplies, such as bandages and scalpels. Many of those items were purchased using the Federal Supply Schedules, which provided medical centers with a great deal of flexibility.<sup>5</sup> As we reported in 2016, this legacy program, however, prevented VHA from standardizing items used across its medical centers and affected its ability to leverage its buying power to achieve greater cost avoidance.<sup>6</sup> Standardization is a process of narrowing the range of items purchased to meet a given need in order to improve buying power, simplify supply chain management, and provide clinical consistency. For example, a hospital network might find that it purchases 100 varieties of bandages, but might ultimately determine—with input from clinicians—that it can narrow those choices down to 10 varieties to fill most needs, which would provide greater consistency and allow the hospital to negotiate lower prices. In part because the legacy MSPV program limited standardization, VHA decided to transition to a new iteration, called MSPV-NG.

VHA launched the MSPV-NG program in December 2016 but allowed a 4-month transition period. After April 2017, medical centers could no longer use the legacy program. MSPV-NG now restricts ordering to a narrow “formulary”—a list of specific items that medical centers are allowed to purchase. VA has had a formulary in place for pharmaceuticals since 1997, and many leading hospital networks rely on a similar formulary approach when it comes to purchasing their own medical supplies. VHA policy requires medical centers to use MSPV-NG—as opposed to other means such as open market purchase card transactions—when purchasing items that are available in the formulary.<sup>7</sup> Figure 2 illustrates the program structure and key participants involved in the transition to MSPV-NG.

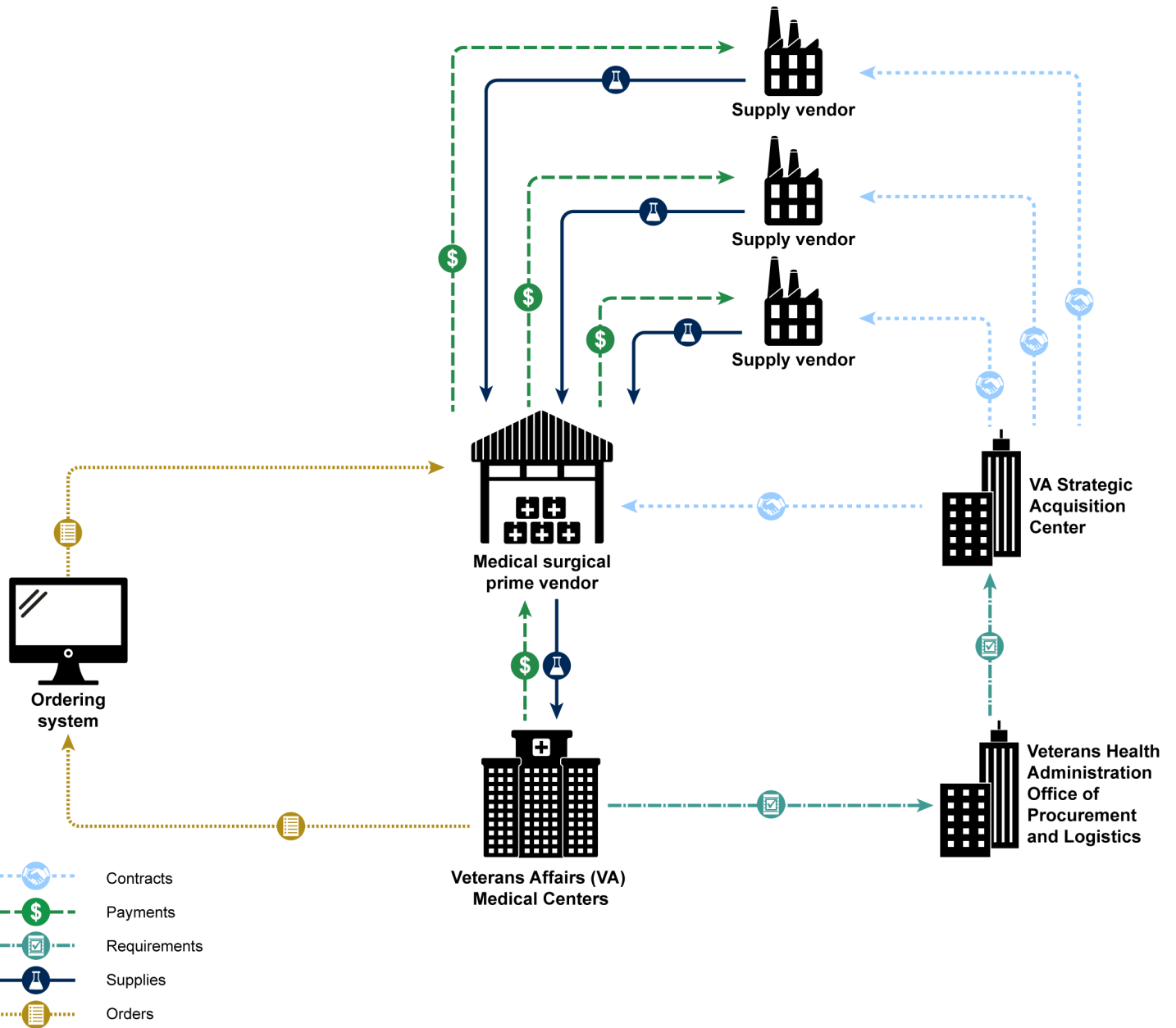
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<sup>5</sup>The Federal Supply Schedules program, managed by the General Services Administration, provides federal agencies a simplified method of purchasing commercial products and services at prices associated with volume buying. A schedule is a set of contracts awarded to multiple vendors that provide similar products and services. The General Services Administration has delegated authority to VA to manage schedules for health-care-related supplies and services. VA is the largest user of these categories of goods and services. For more details on the legacy MSPV program, see [GAO-16-810](#).

<sup>6</sup>See [GAO-16-810](#).

<sup>7</sup>VHA memorandum, “Use of Medical/Surgical Prime Vendor (MSPV) Contracts Is Mandatory,” June 22, 2015.

**Figure 2: Medical Surgical Prime Vendor-Next Generation (MSPV-NG) Program Structure and Key Participants**



Source: GAO analysis of Veterans Affairs contracts and policies. | GAO-18-34

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VA's primary MSPV-NG program goals are to:

- Standardize requirements for supply items for greater clinical consistency.
- Achieve cost avoidance by leveraging VA's substantial buying power when making competitive awards; VA set a goal of achieving \$150 million in cost avoidance in 2016 through a supply chain transformation effort, of which MSPV-NG is a primary part.
- Achieve greater efficiency in ordering and supply chain management, including a metric of ordering 40 percent of medical centers' supplies from the MSPV-NG formulary.
- Involve clinicians in requirements development to ensure uniform clinical review of medical supplies.

VHA gave responsibility for developing and implementing MSPV-NG to its Healthcare Commodity Program Executive Office (program office), an organization within VHA's Procurement and Logistics Office. According to documentation, the program office and SAC, a VA-wide contracting organization, identified several steps to allow for a successful transition to MSPV-NG. These steps included the following:

1. *Identify and develop requirements* – Determine which types of medical supplies should be made available to medical centers via the MSPV-NG formulary and their key characteristics. The program office was responsible for this aspect of the transition.
2. *Award contracts and establish agreements* – SAC was responsible for awarding distribution contracts to a select number of prime vendors within certain geographic areas to deliver supplies to medical centers. SAC was also responsible for awarding contracts and establishing agreements with suppliers that provide the products themselves, which set prices for individual items.
3. *Implement MSPV-NG at medical centers* – MSPV-NG orders are placed by ordering officers—members of the logistics staff at each medical center that are delegated authority by SAC contracting officers to place orders for medical supplies. Each medical center's most frequently purchased items—referred to as their core list—vary based on the type of care provided, local preferences, and other factors.

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## Leading Practices for Organizational Transformation Efforts

We have previously reported that organizational transformations (such as MSPV-NG) require careful planning and implementation to be successful.<sup>8</sup> For instance, one leading practice is for leadership to set clear implementation goals and a timeline to achieve them. Likewise, communicating a strategy and progress to stakeholders—as well as seeking feedback—is a hallmark of successful organizational transformations. We have reported that at the center of any serious change management initiative are the people.<sup>9</sup> Thus, to facilitate success, is to recognize the “people” element and implement strategies to help individuals maximize their full potential in the organization, while simultaneously managing the risk of reduced productivity and effectiveness that often occurs as a result of the changes. Building on the lessons learned from the experiences of large private and public sector organizations, the key practices and implementation steps that we identified in our prior work can help agencies transform their cultures so that they can be more results oriented, customer focused, and collaborative in nature. Standards for Internal Control in the Federal Government also identify related principles, such as the importance of the tone from the top and ensuring that data used in decision-making are reliable.<sup>10</sup>

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## Supply Chain Practices Identified by Selected Leading Hospital Networks

Leading hospital networks we spoke with have similar goals to VA in managing their supply chains, including clinical standardization and reduced costs. In managing their supply chain efforts, the leading hospital networks we identified take consistent approaches to drive change and achieve savings. These hospitals reported they analyze their spending to identify items purchased most frequently, and which ones would be the best candidates to standardize first to yield cost savings. These hospitals also acknowledge that this is an iterative process and do not attempt to standardize all categories of medical supplies at a single time, but instead prioritize categories of supplies based on the potential for standardization. The hospitals’ supply chain managers establish consensus with clinicians through early and frequent collaboration on supply chain standardization.

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<sup>8</sup>GAO, *Organizational Transformation: A Framework for Assessing and Improving Enterprise Architecture Management*, [GAO-10-846G](#) (Washington, D.C.: August 2010); and GAO, *Results-Oriented Cultures: Implementation Steps to Assist Mergers and Organizational Transformations*, [GAO-03-669](#), (Washington, D.C.: July 2, 2003).

<sup>9</sup>See [GAO-03-669](#).

<sup>10</sup>See [GAO-14-704G](#).

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These hospitals also continually involve clinicians in determining key supply characteristics and evaluating potential items, understanding that clinician involvement is critical to the success of any effort to standardize their medical supply chain. For example, a supply chain official from one large hospital we spoke with stated that selecting an item that does not meet clinician needs could damage clinician buy-in for future efforts, so they take great care to be thorough in taking clinician input into account. Supply chain officials from these leading hospitals have reported positive results from these efforts, such as increased cost savings and the potential for improved patient care.

By tackling a few specific categories at a time and communicating with clinicians on an ongoing basis about the outcomes of these processes and the decisions taken, these hospitals are able to achieve efficiencies, including significant cost savings in some cases, while maintaining buy-in from their clinicians. Figure 3 depicts the key steps that selected hospitals' supply chain managers reported following when standardizing their medical supply chains, including the critical role of clinicians throughout the process.

**Figure 3: Key Steps Selected Leading Hospital Networks' Supply Chain Managers Reported Following in Standardizing Their Medical Supply Chains**



Source: GAO analysis of interviews with supply chain officials at leading hospital networks. | GAO-18-34

## Emergency Procurements

The Federal Acquisition Regulation (FAR) generally requires agencies to contract using full and open competition, but permits contracting without full and open competition in specified circumstances, such as when the agency's need for supplies or services is of unusual and compelling

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urgency.<sup>11</sup> The VHA Procurement Manual describes an emergency as a situation—such as response to fires or floods—where delay in award of a contract would result in financial or physical injury to the VA or a veteran. The manual also states that neither a lack of advance planning nor concerns about a need to obligate funds before the end of the fiscal year are valid justifications for an urgent or emergency procurement request.<sup>12</sup>

For needs that cannot be met through MSPV-NG, medical centers submit purchase requests to their local VHA contracting office—the Network Contracting Office. The contracting office provides medical centers with expected lead times for various types of procurements, which can be from days to months, depending on the complexity of the requested item. However, if a medical center has an urgent need that must be met more quickly than the expected lead times, the customer submitting the request can identify it as an emergency. The purchase request is entered into two VA data systems, the Integrated Funds Distribution Control Point Activity, Accounting and Procurement and VA’s Electronic Contract Management System (eCMS). The medical center designates the priority level of the request as:

1. Emergency: life threatening cases, emergency physical plant repair, and requires acquisition action within 24 hours;
2. Special: urgent, non-life threatening, and requires acquisition action within 72 hours; and
3. Standard: all other cases and requires acquisition action within 40 days.

Incoming requests are screened by Network Contracting Office managers and assigned to individual contracting officers, who must prioritize emergency requests over other pending contract actions. Figure 4 illustrates the typical process for submitting and awarding an emergency procurement.

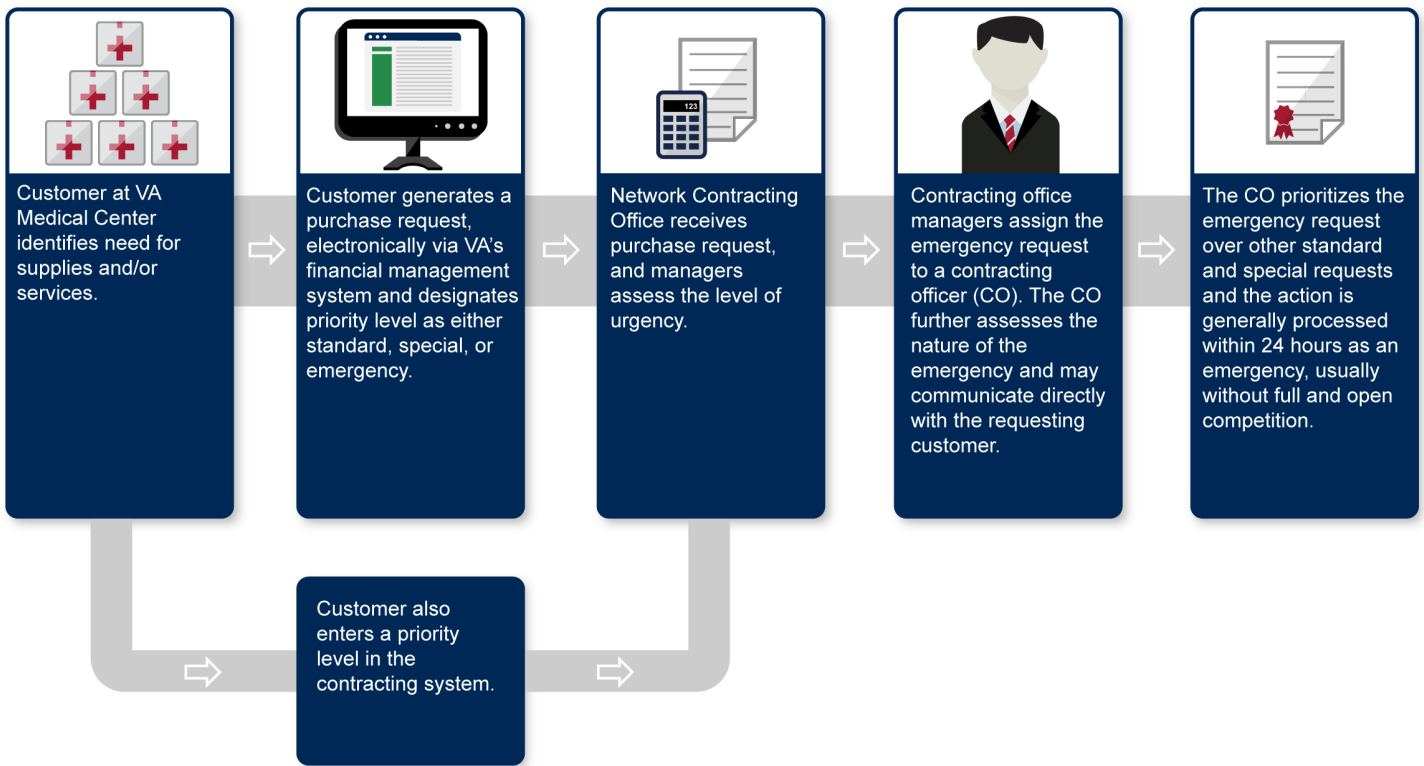
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<sup>11</sup>Even in situations where unusual and compelling urgency exists, the FAR requires that agencies “request offers from as many potential sources as is practicable under the circumstances.” FAR § 6.302-2(c).

<sup>12</sup>This is consistent with policy contained in the FAR. See FAR § 6.301(c).



**Figure 4: Typical Process for Submission and Award of Emergency Contract Actions**



Source: GAO analysis of Veterans Affairs (VA) policies; VA officials. | GAO-18-34

## VHA's Implementation of MSPV-NG Program Has Not Yet Achieved Its Goals

VHA's implementation of the MSPV-NG program—from its initial work to identify a list of supply requirements in 2015, through its roll-out of the formulary to medical centers in December 2016—was not executed in line with leading practices. Despite changes aimed at improving implementation, the agency continues to face challenges that have precluded achievement of program goals. Specifically, VHA lacked a documented program strategy, leadership stability, and workforce capacity for the transition that—if in place—could have facilitated buy-in for the change throughout the organization. Furthermore, the initial requirements development process and tight time frames contributed to ineffective contracting processes. As a result, VHA developed an initial formulary that did not meet the needs of the medical centers. VA made some changes in the second phase of requirements development to address deficiencies identified in the initial roll out, namely by increasing

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the level of clinical involvement. However, VHA has not yet achieved its goals for utilization and cost avoidance.

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### VA Lacked an Overarching Strategy for Implementing MSPV-NG

VA did not document a clear overall strategy for the MSPV-NG program at the start and has not done so to date. According to program office and SAC officials responsible for developing and executing the program, no document existed at the outset of the MSPV-NG program that outlined the overall strategy. About 6 months after our initial requests for a strategy or plan, an official provided us with an October 2015 plan focusing on the mechanics of establishing the MSPV-NG formulary. However, this plan was used only within the VHA Procurement and Logistics Office and had not been approved by VHA or VA leadership. Leading practices for organizational transformation state that agencies must have well-documented plans and strategies for major initiatives (such as MSPV-NG) and communicate them clearly and consistently to all involved—which included VHA headquarters, the SAC, and all 170 medical centers.<sup>13</sup> Without such a strategy, VA could not ensure that all stakeholders understood VHA’s approach for MSPV-NG and worked together in a coordinated manner to achieve program goals. This is also in contrast to the practices of several leading hospital networks we met with, which placed an emphasis on designing and communicating a strategy and governance structure for their medical supply standardization efforts before making any changes to purchasing. If VA continues to move forward with MSPV-NG without an overarching strategy that it communicates to all stakeholders to ensure they understand VHA’s approach for MSPV-NG, VA will continue to face challenges in meeting program goals.

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### Leadership Instability and Staffing Shortages Were Obstacles to Effective Implementation of MSPV-NG

Leadership instability and workforce challenges also made it difficult for VA to execute its transition to MSPV-NG. Due to a combination of budget and hiring constraints, and lack of prioritization within VA, the program office, which has primary responsibility for implementing MSPV-NG, has never been fully staffed and has experienced instability in leadership. As of January 2017, 24 of the office’s 40 positions were filled, and program office officials stated that this lack of staff affected their ability to implement certain aspects of the program within the planned time frames. Our work has shown that leadership buy-in is necessary to ensure that

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<sup>13</sup>See [GAO-10-846G](#) and [GAO-03-669](#).

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major programs like MSPV-NG have the resources and support they need to execute their missions. We have also previously found that leadership must set a tone at the top and demonstrate strong commitment to improve and address key issues.<sup>14</sup> However, leadership of VHA's Procurement and Logistics Office changed frequently during the implementation of MSPV-NG, and two of its leaders, the Chief Procurement and Logistics Officer and the Deputy Chief Logistics Officer, were serving in an acting capacity. A similar instability in leadership affected the program office itself. Since the inception of MSPV-NG, the program office has had four directors, two of whom were acting and two of whom were fulfilling the director position while performing other collateral duties. For instance, one of the acting MSPV-NG program office directors was on detail from a VISN office to fulfill the position but had to abruptly leave and return to her VISN position due to a federal hiring freeze. Without prioritizing the hiring of the program director position on a permanent basis, this lack of stability could continue to affect execution of MSPV-NG.

Moreover, VA's Chief Acquisition Officer (CAO), whose responsibilities include oversight of VA acquisition programs such as MSPV-NG, is serving in an acting capacity and is not a "non-career employee." By statute, VA is required to appoint or designate a non-career employee as the agency's CAO.<sup>15</sup> VA provided information to show that since 2009, VA has designated career employees as "acting" CAOs rather than appointing or designating non-career employees to the CAO position. As we reported in 2012, clear, strong, and effective leadership, including a CAO, is key to an effective acquisition function that can execute complicated procurements like MSPV-NG.<sup>16</sup> By appointing a CAO in a non-acting capacity, VA could improve the effectiveness of its acquisition function. During our 2012 review, VA indicated that it sought to establish an Assistant Secretary for Acquisition, Logistics, and Construction, who would serve as VA's CAO. In connection with the current review, VA's Office of General Counsel cited a statutory limitation on the number of assistant secretaries that may be established within VA as the reason it has not established that additional assistant secretary position. VA's

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<sup>14</sup>GAO, High-Risk Series: An Update, [GAO-15-290](#) (Washington, D.C.: Feb. 11, 2015).

<sup>15</sup>41 U.S.C. § 1702(a).

<sup>16</sup>GAO, *Chief Acquisition Officers: Appointments Generally Conform to Legislative Requirements, but Agencies Need to Clearly Define Roles and Responsibilities*, [GAO-12-792](#) (Washington, D.C.: July 26, 2012).

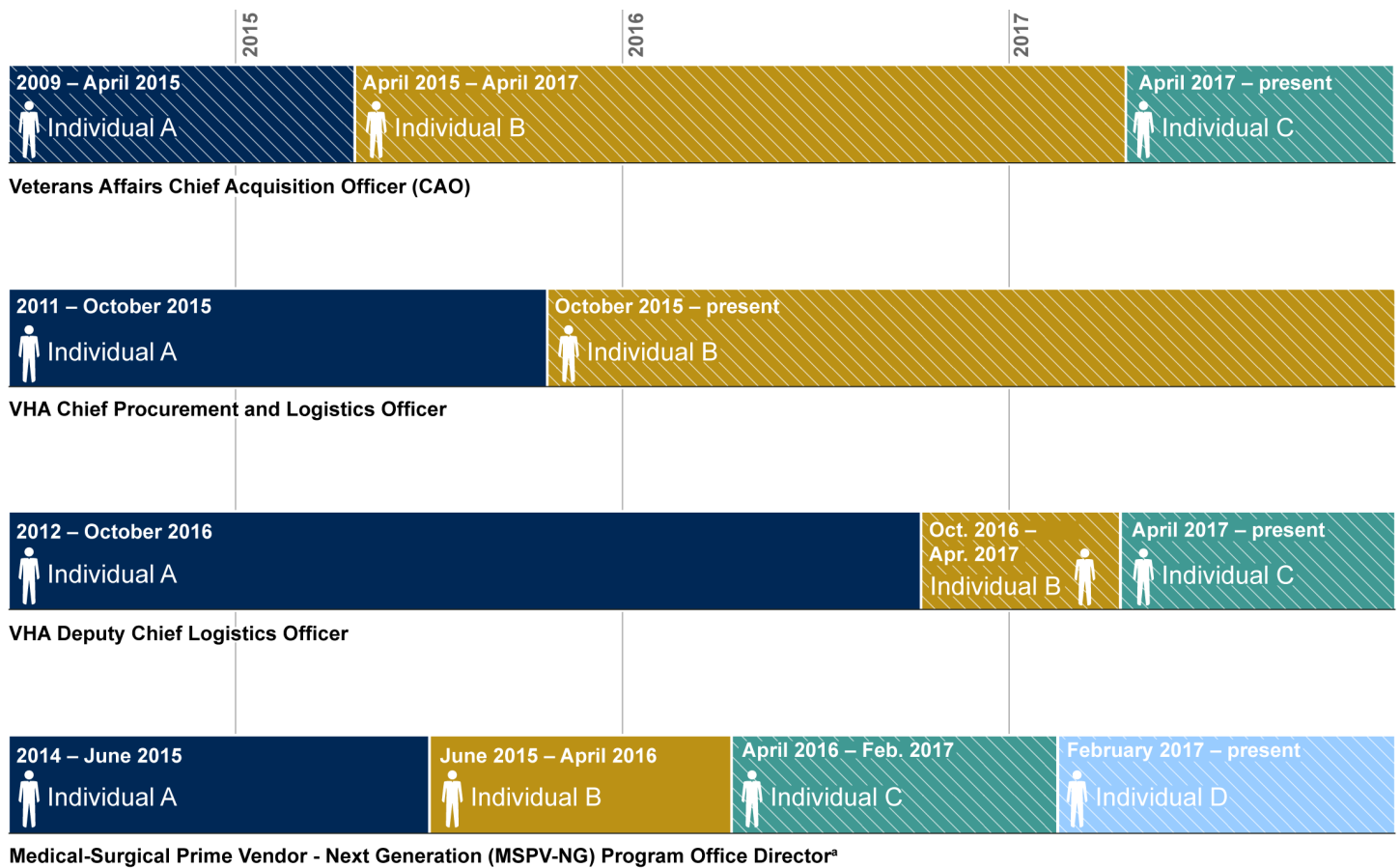
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
Office of General Counsel indicated that the agency was considering requesting, in the reform plan that VA was required to submit to the Office of Management and Budget in September 2017, a change to the statute that limits the number of VA assistant secretaries. However, subsequently, VA's Office of General Counsel indicated that the plan will not include such a request.<sup>17</sup> By not appointing or designating a non-career employee as CAO, VA will continue to be noncompliant with the statute. Figure 5 summarizes the history of leadership changes in these positions, which are all currently filled in an acting capacity.

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<sup>17</sup>The Office of Management and Budget issued memorandum M-17-22 in April 2017, instructing agencies, including VA, to submit Agency Reform Plans by September 2017.

**Figure 5: Changes in Leadership during MSPV-NG Development and Implementation**



 Individual serving in an acting capacity

Source: GAO analysis of Veterans Affairs (VA) data; VA officials. | GAO-18-34

<sup>a</sup>The Healthcare Commodity Program Executive Office was created in October 2016. Prior to that, a predecessor program office and associated integrated project team were responsible for developing strategy for the program.

Further, according to officials, leadership vacancies at medical centers and competing demands on logistics staff time made implementation of MSPV-NG more challenging at the selected VISNs and medical centers we visited. For instance, longstanding vacancies in the Chief Supply Chain Officer positions existed at one of the VISNs and its medical center that we visited. The VISN-level position was vacant for about 4 years, with Chief Supply Chain Officers from individual medical centers filling in for periods of time, according to the current Chief Supply Chain Officer, who took the position in January 2017. In one medical center within that

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VISN, the local position was also vacant for several years, according to the current Chief Supply Chain Officer, who took the position in 2016. He stated that he found that the staffing of the office had suffered in the absence of a leader, leaving it poorly-equipped to execute the transition to MSPV-NG. Medical center logistics staff also had several other major transformation efforts to manage alongside the MSPV-NG transition, such as implementing a new system for managing equipment. Several Chief Supply Chain Officers we interviewed stated that these additional demands made it challenging for their staff to implement the MSPV-NG program.

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**The MSPV-NG Initial Requirements Development Process Had Limited Clinician Involvement and Did Not Prioritize Categories of Supplies**

The MSPV-NG program office initially developed requirements for medical and surgical supply categories—identifying items to include in the formulary—based almost exclusively on prior supply purchases, with limited clinician involvement. The program office concluded in its October 2015 formulary plan that relying on data on previous clinician purchases would be sufficient and that clinician input would not be required for identifying which items to include in the initial formulary.<sup>18</sup> Further, rather than standardizing purchases of specific categories of supplies—such as bandages or scalpels—program officials told us they identified medical and surgical items on which VA had spent \$16,000 or more annually and ordered at least 12 times per year, and made this the basis for the formulary. Officials said this analysis initially yielded a list of about 18,000 items, which the program office further refined to about 6,000 items by removing duplicate items or those that were not considered consumable commodities, such as medical equipment.

In 2015, the program office also took the lead in developing requirements for these 6,000 items. In documentation, and as confirmed by agency officials, we found that the program office did not solicit input from clinicians for most items and did not prioritize categories of supplies. Instead, the program office relied on historical purchase data to set requirements across medical and surgical categories because officials said they thought this would provide a good representation of medical centers' needs. This approach to requirement development stood in sharp contrast to those of the leading hospital networks we met with, which

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<sup>18</sup>The fiscal year 2014 data on historical purchasing by medical centers came from the Medical Product Data Bank database, jointly funded by VA and the Department of Defense, and was the principal source for identifying potential items to include on the initial version of the MSPV-NG formulary.

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relied heavily on clinicians to help drive the standardization process and focused on individual categories of supplies rather than addressing all categories simultaneously.

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### Initial Requirements Development and Tight Time Frames Contributed to Ineffective Contracting Practices for Initial Formulary

Based on the requirements developed by the program office, SAC began to issue solicitations for the 6,000 items on the initial formulary in June 2015. From June 2015 to January 2016, medical supply companies responded to only about 30 percent of the solicitations. As a result, according to SAC officials, they conducted outreach and some of these companies told SAC that VHA's requirements did not appear to be based on clinical input and instead consisted of manufacturer-specific requirements that favored particular products instead of broader descriptions. Furthermore, SAC did not solicit large groups of related items, but rather issued separate solicitations for small groups—consisting of 3 or fewer items—of supply items. This is contrary to industry practices of soliciting large groups of related supplies together. Therefore, according to SAC officials, some medical supply companies told them that submitting responses to SAC's solicitations required more time and resources than they were willing to commit.

By its April 2016 deadline for having 6,000 items on the formulary, SAC had been working on the effort for over a year and had competitively awarded contracts for about 200 items, representing about 3 percent of the items. Without contracts for the items on the formulary in place, VA delayed the launch of the MSPV-NG program until December 2016. To continue the legacy MSPV program through the new launch date, SAC awarded bridge contracts—short-term sole-source contracts—to its legacy prime vendor contractors for a second year.<sup>19</sup> We previously reported that bridge contracts had resulted in higher costs to the government.<sup>20</sup> In part because of these costs, SAC officials stated that VA

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<sup>19</sup>While not defined in the Federal Acquisition Regulation, we have previously defined a bridge contract as an extension beyond an existing contract's period of performance (including 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. See GAO, *Sole Source Contracting: Defining and Tracking Bridge Contracts Would Help Agencies Manage Their Use*, [GAO-16-15](#) (Washington, D.C.: Oct. 14, 2015).

<sup>20</sup>In [GAO-16-810](#), we reported that the legacy MSPV prime vendors charged suppliers costly fees to stock items in their warehouses, and these costs were indirectly passed on to the VA. We estimated that these fees could equal between \$120 million to \$169 million for fiscal years 2013 to 2015.

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leadership did not view a third set of bridge contracts for the legacy MSPV program as a viable option. As a result of the pressure not to miss the revised December 2016 deadline, which VA documents we reviewed stated would have been “catastrophic,” SAC abandoned its original goal of using competitive procedures and relied instead on a non-competitive strategy for placing most of the items on the MSPV-NG initial formulary. Starting in August 2016, SAC established 175 limited source blanket purchase agreements with Federal Supply Schedule vendors to complete the initial Phase 1 formulary.<sup>21</sup> While this approach enabled the MSPV-NG program office to establish the formulary more quickly, it did so at the expense of one of the primary goals of the MSPV-NG program—leveraging VA’s buying power to obtain cost avoidance through competition.

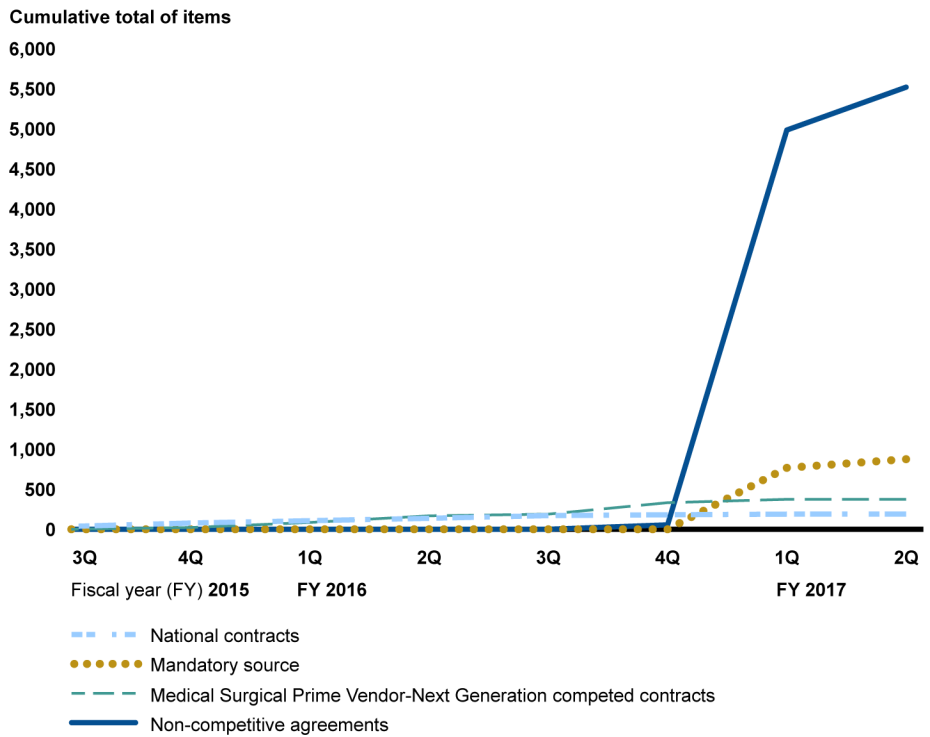
We previously reported that a senior VA procurement official said VA could save 30 percent, on average, on the prices available under the Federal Supply Schedules when awarding competitive contracts that leveraged VA’s buying power under the legacy MSPV program. The discounts VA obtained from these limited source agreements were generally much less. We reviewed a non-generalizable sample of 10 randomly-selected limited source blanket purchase agreements and found that most items (332 of the 376 items covered by these agreements) were discounted 5 percent or less. Competition is the cornerstone of the acquisition system; its benefits are well established, including saving the taxpayer money. As shown in figure 6, the non-competitive agreements awarded in the last few months before the launch of MSPV-NG accounted for approximately 79 percent of the items on the January 2017 version of the formulary.

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<sup>21</sup>A blanket purchase agreement (BPA) is a simplified method of filling anticipated repetitive needs for supplies or services that functions as a charge account, with terms and conditions agreed upon when the BPA is established. FAR §§ 8.405-3, 13.303-1(a). A BPA is not a contract; therefore, the government is not obligated to purchase a minimum quantity or dollar amount and the contractor is not obligated to perform until it accepts an order under the BPA. Depending on the estimated dollar value of the BPA, the FAR requires that agencies follow certain competitive procedures when establishing BPAs under the Federal Supply Schedules. Id. § 8.405-3(b). However, the FAR also provides that under certain circumstances, agencies may “limit sources” when establishing BPAs under the Federal Supply Schedules. Id. § 8.405-6(a). These circumstances include instances where an urgent and compelling need exists and following competitive procedures would result in an unacceptable delay. Id. § 8.405-6(a)(1)(i)(A).



**Figure 6: Total Number of Items by Award Type on MSPV-NG Formulary (as of January 2017)**



Source: GAO analysis of Veterans Affairs formulary data. | GAO-18-34

## Initial Formulary and Unclear Communication Contributed to a Lack of Medical Center Buy-In for MSPV-NG Implementation

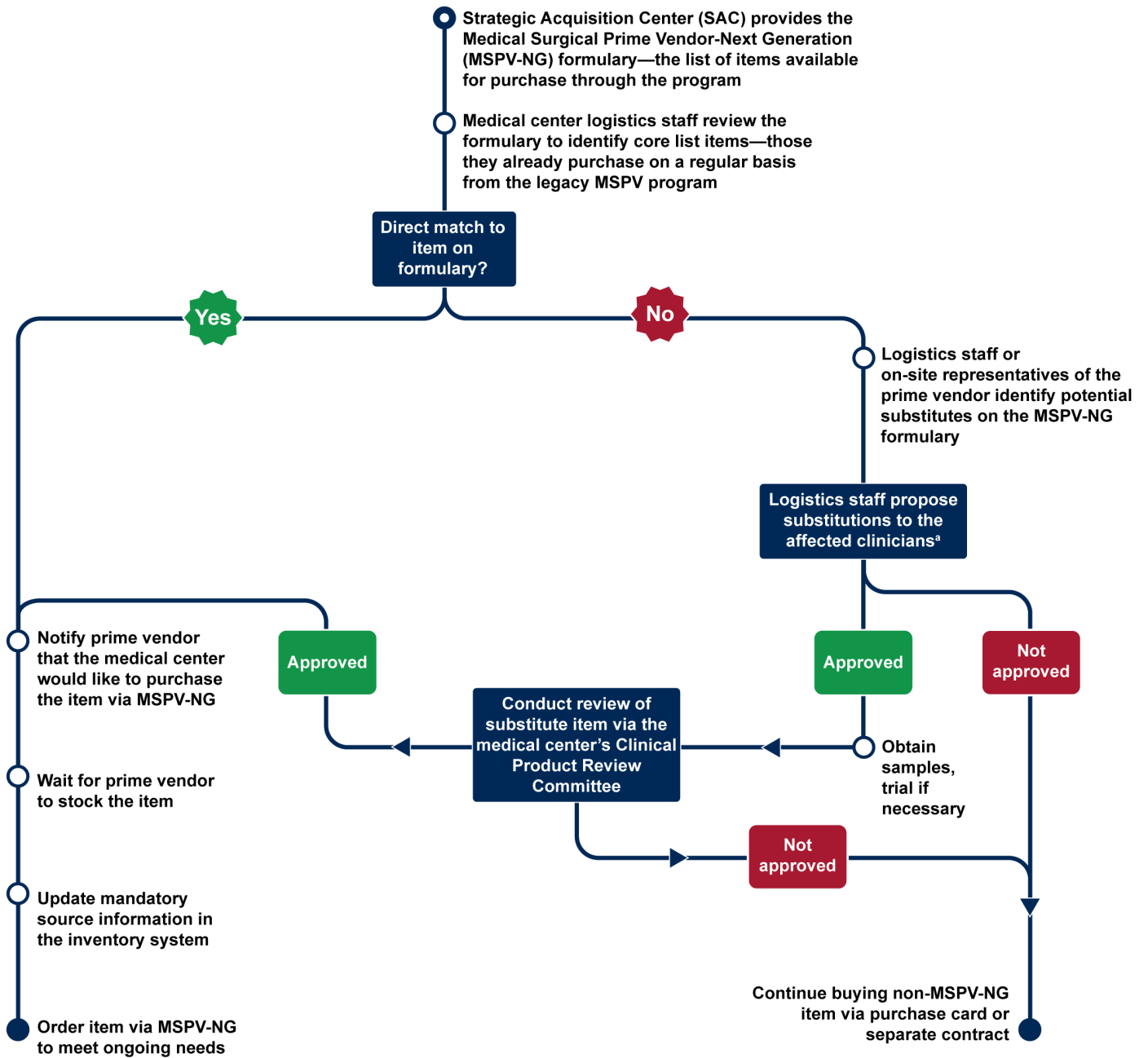
Once VA’s MSPV-NG initial formulary was established in December 2016, each medical center was charged with implementing it. Previously, medical centers had hundreds of thousands of items they could obtain through the legacy MSPV program. In order to transition to the new formulary—consisting of around 6,000 items at launch—the program office directed medical centers to determine if items they had ordered in the past could be fulfilled by the formulary. To do this, each medical center’s Chief Supply Chain Officer—the head of the logistics office—was to review their center’s core list of previously ordered items to try to identify matches on the MSPV-NG formulary in three different categories:

1. *Direct matches* – For some items, the exact same item a medical center had been purchasing was available in the formulary. Identifying these matches may not necessarily be simple, as the names and identification numbers were not typically the same.

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2. *Potential clinical equivalents* – Many items that were no longer available under the MSPV-NG formulary had close matches on the formulary. However, because these were not exactly the same, work was required to ensure that they were clinically equivalent—in nearly all cases, this required clinician input. Clinical Product Review Committees at each medical center, which are comprised of clinicians and others, are responsible for approving new supplies before they are introduced to a medical center.
  3. *Items without matches* – Finally, there were some items that medical centers had been purchasing for which logistics staff were not able to identify a clinical equivalent in the MSPV-NG formulary. In these cases, logistics staff sought non-MSPV methods of obtaining the same items they had previously purchased—usually via purchase card transactions and, in a few cases, via requests to their local contracting office to award new contracts for the items.

Figure 7 shows the typical process for identifying MSPV-NG matches for core list items at individual VA medical centers, as described by logistics officials at the selected medical centers.

Figure 7: Overview of Typical Process for Identifying MSPV-NG Items to Purchase at Each VA Medical Center



Source: GAO analysis of Veterans Affairs (VA) processes; VA officials. | GAO-18-34

<sup>a</sup>Because each medical center approached this process somewhat differently, some steps varied across medical centers, particularly regarding the role of clinicians.

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According to logistics officials we spoke with, the MSPV-NG formulary matching process was challenging for the selected medical centers, and they had varying levels of success, in part, due to incomplete guidance from the program office. The MSPV-NG program office provided some guidance, including a tool for identifying direct matches, but three of the Chief Supply Chain Officers at the selected medical centers stated that they did not find it very helpful, in part, because it only included matches for the highest-volume items. Based on our discussions with the MSPV-NG program office and selected medical centers, as well as our review of communications provided to medical centers, the program office provided various emails and held conference calls, but did not provide complete guidance to summarize the steps medical centers should take to execute the matching process. Without complete guidance, each selected VISN and medical center approached the process somewhat differently. One medical center devoted a great deal of effort to matching items early on, had completed its review, and determined its purchasing strategy for nearly all core list items before the transition period was complete. Others devoted less attention to this and planned instead to rely on purchase cards to continue buying the same items they had purchased under the legacy MSPV program, which works against VA's goal of leveraging buying power through MSPV-NG.

The amount of clinician input on the matching process varied among medical centers in our review, in part, because the various communications from the program office did not provide complete information on how to involve clinicians and Clinical Product Review Committees at medical centers. While the program office asked medical centers to involve clinicians, it did not specify a process for how to do so, and centers were left to develop their own approaches. For example, in one selected VISN, the Deputy Chief Medical Officer became involved with the logistics office coordination effort and obtained active participation from clinicians at each medical center, who formed working groups to review potential clinical equivalent matches. In other VISNs and medical centers, there was little concerted effort to involve clinicians at this stage of the process, and only a few clinical equivalent items were reviewed and matched with clinical input. Without effective matching to the formulary, VA cannot achieve the MSPV-NG utilization rates it needs to meet the program's goals. Without complete guidance, these centers may be unable to effectively match their core lists to the MSPV-NG formulary and, thus, increase their utilization of it.

The MSPV-NG formulary also continued to change while the medical centers were working to match their core list items, which made the

process more challenging. Several clinicians and logistics staff at the medical centers we visited expressed frustration about the frequency by which items were being added and deleted on the formulary and the impact it had on their purchasing strategies. Our analysis found that in April 2017, 690 items were added to the formulary, but, in June, 628 items were deleted. These medical center officials also noted that they had not received any communications from the program office or SAC regarding why items were being added and deleted, and were unsure why the changes were taking place. SAC and MSPV-NG program office officials stated that these continuing changes stemmed from several factors, including elimination of duplicate items from multiple vendors and addition of other items identified as necessary by VHA or medical centers. In some cases, medical center officials told us that they were less willing to expend effort on the matching process because the formulary was a moving target. Without visibility into or an understanding of the criteria used by the program office on its process for adding or removing items on the formulary, medical centers will likely continue to face challenges in matching their items to the formulary. See Table 1 for the number of items added and deleted from the formulary from January to July 2017.

**Table 1: Items Added and Deleted From the Medical Surgical Prime Vendor – Next Generation (MSPV-NG) Formulary (January 2017 to July 2017)**

Month	Additions	Deletions
January	753	45
February	504	23
March	68	40
April	690	64
May	24	117
June	28	628
July	25	24
<b>Total</b>	<b>2,092</b>	<b>941</b>

Source: GAO analysis of monthly changes in the MSPV-NG formulary | GAO-18-34

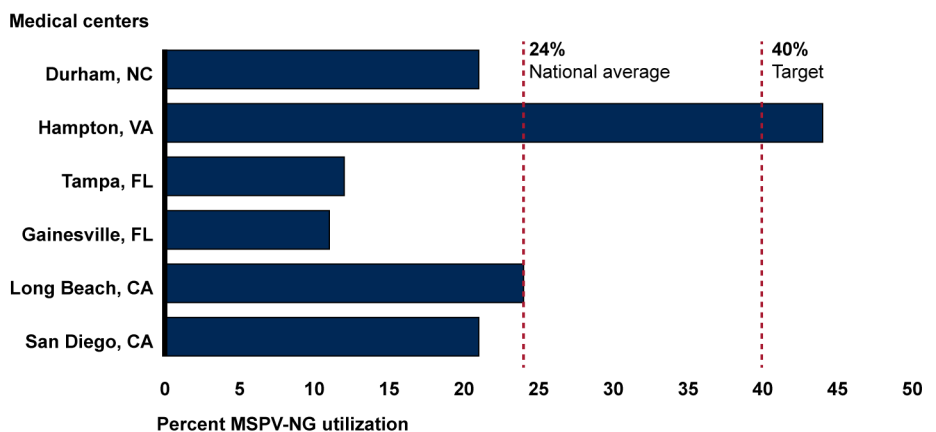
**Initial Formulary Did Not Meet Medical Center Needs, Resulting in Low Utilization of MSPV-NG and a Missed Opportunity to Leverage VA’s Large Buying Power**

Many medical centers were unable to find direct matches or substitutes for a substantial number of items on their core lists, which negatively impacted utilization rates for the initial formulary. In October 2015, the program office estimated that the items on the initial formulary would meet 80 percent or more of the medical centers’ needs. However, according to SAC, as of June 2017, only about a third of the items on the initial version of the formulary were being ordered in any significant

quantity by medical centers, indicating that many items on the formulary may not be those that are needed by medical centers. Senior VHA acquisition officials attributed this mismatch to shortcomings in their initial requirements development process as well as with VA's purchase data.

VA set out a target that medical centers would order 40 percent of their supplies from the MSPV-NG formulary, but utilization rates are below this target with a nationwide average utilization rate across medical centers of about 24 percent as of May 2017. Instead of fully using MSPV-NG, the selected medical centers are purchasing many items through other means, such as purchase cards or new contracts awarded by their local contracting office, in part, because they said the formulary does not meet their needs. These approaches run counter to the goals of the MSPV-NG program and result in VA not making the best use of taxpayer dollars. Specifically, Chief Supply Chain Officers—who are responsible for managing the ordering and stocking of medical supplies at the six selected medical centers—told us that many items they needed were not included in the MSPV-NG formulary. As discussed above, the difficult transition process also created a lack of clinician desire to find substitutes on the formulary. As such, we found that these six medical centers generally fell below VA's stated utilization target that medical centers order 40 percent of their items from the MSPV-NG formulary. As shown in figure 8, among the six selected medical centers we reviewed, one met the target, while the remaining five were below 25 percent utilization. The one facility that met the target, Hampton VA Medical Center, is categorized by VA as a smaller, less complex facility, and had fewer items to match, which could contribute to its higher utilization.

**Figure 8: Utilization of MSPV-NG at Six Selected Medical Centers (May 2017)**



Source: Veterans Health Administration Office of Procurement and Logistics. | GAO-18-34

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The utilization rate is VA's primary metric for the success of MSPV-NG—broad usage of the formulary is necessary for VA to meet its goals of more efficient supply purchasing, standardization, and cost avoidance. Utilization is calculated by dividing the purchases made via MSPV-NG by the total purchases under the medical supply budget category. This is the same metric used under the legacy MSPV program, and most medical centers were meeting the 40 percent target prior to the transition to MSPV-NG. Officials stated that the current metric does not provide enough information and, as a result, VHA is in the process of preparing a new metric to more precisely assess MSPV-NG use and effectiveness, and has begun conducting routine surveys of its medical centers to obtain their feedback on MSPV-NG.

Greater utilization of MSPV-NG is essential to VA achieving the cost avoidance goal of \$150 million for its supply chain transformation effort. Under the legacy MSPV program, the National Acquisition Center tracked cost avoidance achieved by comparing prices for competitively-awarded MSPV supply contracts with prices available elsewhere. However, VHA officials stated that they are not currently tracking cost avoidance related specifically to MSPV-NG. VHA officials told us they plan to use a new cost avoidance metric that compares total supply spending for VHA as a whole across fiscal years. This new metric, however, does not measure whether cost savings are being achieved specifically through MSPV-NG. Officials stated the broader metric was more useful than measuring cost avoidance specific to MSPV-NG.

VA's practices are in contrast with those of the leading hospitals we met with, which maintain detailed, item-level data on cost avoidance and use them to inform future supply requirements and contracting. These hospitals we interviewed reported substantial cost savings from their standardization efforts. For example, the director of supply chain management at one leading hospital network stated that it achieved a goal of \$100 million in cost savings on medical supplies in the first 2 years of their standardization effort, and an additional \$35 million annually in the several years since. This hospital achieved these results despite its purchasing power being less than VA's. Without calculating cost avoidance attributable to MSPV-NG, VHA cannot assess whether the program is meeting its goals, nor can it use cost avoidance data to guide future MSPV-NG requirement development and contracting strategy efforts.

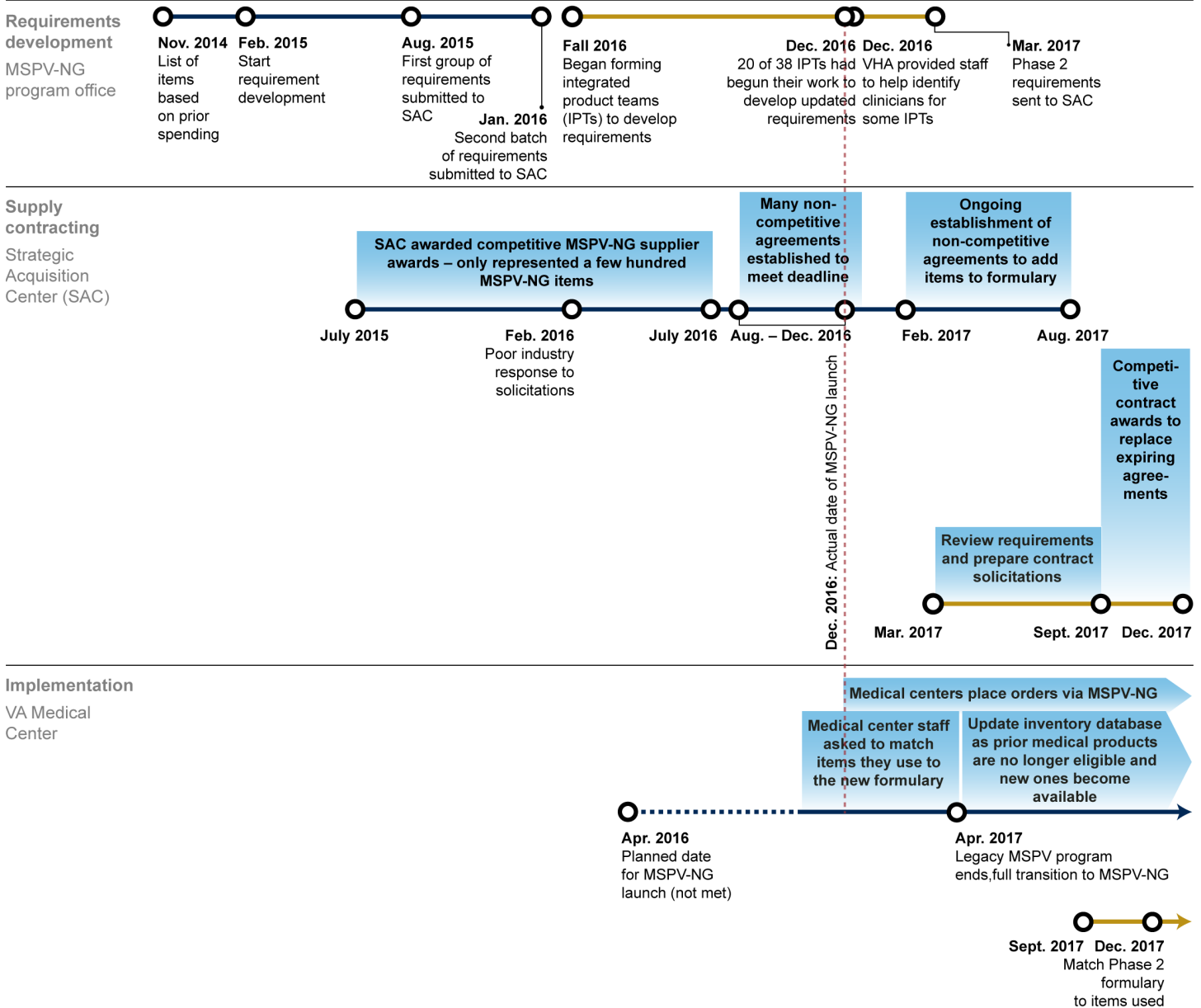
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**VA Encouraged Greater Clinical Involvement in the Second Phase of Requirements Development, but Faced Further Staffing and Schedule Constraints**

In Phase 2 of MSPV-NG, the program office has taken some steps to incorporate greater clinical involvement in subsequent requirement development, but both its requirements development and SAC's contracting efforts have been hampered by staffing and schedule constraints. Work on Phase 2 began while medical centers were implementing Phase 1 and beginning to order from the MSPV-NG formulary. Figure 9 shows key dates in the concurrent requirements development, contracting, and implementation processes for Phases 1 and 2.



**Figure 9: Key Dates in MSPV-NG Phases 1 and 2 Requirements Development, Contracting, and Implementation**



— Phase 1  
— Phase 2  
 FY – Fiscal year  
 MSPV-NG – Medical Surgical Prime Vendor - Next Generation  
 VHA – Veterans Health Administration

Source: GAO analysis of Veterans Affairs (VA) data; VA officials. | GAO-18-34

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In the fall of 2016, the program office began to establish panels of clinicians—including physicians, surgeons, and nurses working in the medical centers—to serve on MSPV-NG integrated product teams (IPT) assigned to the task of developing updated requirements for the second phase of the formulary.<sup>22</sup> The IPTs were to review categories of medical supplies such as operating room surgical supplies and patient exam room instruments and supplies. According to VA officials and our analysis, this revised approach was based on a recognition that more robust mechanisms were needed for incorporating clinician input, in part, because VA had sought information on best practices from leading hospital networks, and because of shortcomings with the Phase 1 requirements that became apparent in the contracting process. Similar to the analysis performed in support of the initial formulary, the MSPV-NG program office analyzed updated data on medical center supply purchases to generate a list that had grown from the 6,000 items established for the initial formulary to a new total of about 9,900 items for these new IPTs to review.

The program office set a March 2017 deadline to complete this second, IPT-based phase of requirements development—VHA ultimately met this compressed timeline, but in a rushed manner that limited the impact of the clinical involvement. Program officials said they had difficulty recruiting clinicians to participate, and the program office's first IPTs were not established until the fall of 2016. In December 2016, slightly more than half (20 of the 38) of the IPTs had begun their work to review items and develop updated requirements. Many of the remaining IPTs were still looking for additional clinicians to participate. Program officials said they received assistance from the Assistant Deputy Under Secretary for Health for Administrative Operations in December 2016. According to program officials, this involvement proved critical in successfully recruiting staff to participate in some of the remaining IPTs, which were then able to make progress in reviewing each item in the formulary.

However, the program office did not provide training for the IPTs on how to carry out their work until late January 2017, about 2 months before the IPTs were scheduled to complete the development of all medical and surgical requirements. Further, staff on the IPTs had to complete their responsibilities while simultaneously managing their regular workload as

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<sup>22</sup>An integrated product team consists of the following participants: (1) an MSPV-NG program office lead; (2) a clinical lead; (3) three clinicians or subject matter experts; (4) a patient safety representative; and (5) a contracting specialist.

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physicians, surgeons, or nurses. By early March 2017, the IPTs still had about 4,200 of the 9,900 items to review. Faced with meeting this unrealistic time frame, the MSPV-NG program office had 9 IPT members travel to one location—with an additional 10 members participating virtually—to meet for 5 days to review the remaining items. Members told us that this time pressure limited the extent to which they were able to pursue the goal of standardizing supplies, and that their review ended up being more of a data validation exercise than a standardization review.

In addition, the program office attempted to pursue standardization across all supply categories rather than those with the greatest potential for standardization and cost avoidance and continues to lack a strategy for doing so going forward. Standards for Internal Control in the Federal Government state that management should define what is to be achieved and who is to achieve it, how it will be achieved, and the time frames for achievement.<sup>23</sup> In addition, this approach runs counter to how leading hospitals standardize their supply chains by tackling individual categories one at a time and obtaining deep clinician involvement. Without a strategy for how best to prioritize these items by category for future phases of the requirement development process, these IPTs will be limited in fully contributing to VHA's goals of more efficient supply purchasing, standardization, and cost avoidance.

### VA Plans to Replace Limited Source Blanket Purchase Agreements, but Faces Challenges Doing So Before They Expire

SAC's ongoing Phase 2 contracting effort also faces an unrealistic schedule. The SAC plans to replace the existing Phase 1 limited source agreements with competitive awards based on the Phase 2 requirements generated by the IPTs, but it may not be able to keep up with expiring agreements.<sup>24</sup> Because they were made on a non-competitive basis, the Phase 1 limited source blanket purchase agreements were established for a period of one year. In order to keep the full formulary available, the SAC director said his staff must award several hundred contracts before the Phase 1 limited source agreements expire later this year. However, the SAC director stated that doing so will be difficult because his staff must award between 200 to 250 contracts in a 3-month period from the end of September 2017 through December 2017. To adhere to this ambitious schedule, each of the 15 contracting staff on the MSPV-NG team would need to award between 13 to 17 contracts within 3 months,

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<sup>23</sup>See [GAO-14-704G](#).

<sup>24</sup>According to VA, the agency plans to use indefinite delivery/indefinite quantity contracts in addition to blanket purchase agreements for Phase 2.

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equaling one contract per staff member every 5 to 6 days, which is significantly faster than SAC's typical pace. SAC officials acknowledged that it is unlikely that they will be able to award the 200 to 250 contracts by the time the existing limited source agreements expire. According to SAC officials, they are in the process of hiring more staff to deal with the increased workload. Further, the SAC division director told us that they cancelled all outstanding Phase 2 solicitations in September 2017 due to low response rates, protests from service-disabled veteran-owned small businesses, and changes in overall MSPV-NG strategy. SAC is still assessing alternative approaches, which poses additional challenges for replacing expiring agreements by December 2017.

For cases where limited source agreements expire without new contracts in place, SAC officials said they intend to use a different type of agreement called a distribution and pricing agreement as a stopgap. They stated that the use of these agreements with suppliers who have existing limited source agreements would prevent items from falling off the formulary. However, like BPAs, the agreements are not contracts—the supplier informally agrees to continue to sell its products to VA at the same price and terms. SAC officials stated that VA has not used these types of agreements previously, and they pose a risk in that the supplier is not required to perform and VA has no remedy if the supplier opts to end the agreement or raise the price. These agreements also do not allow VA to achieve its goal of achieving greater cost avoidance through supply standardization and competitive contracts. Despite the unrealistic time frames and the risks of the stopgap approach, VA has not developed a plan for how to mitigate these risks, established an achievable schedule for making the competitive Phase 2 contract awards, or prioritized the various categories of supplies. Establishing such a plan would help ensure that VA is better positioned to mitigate risks and prioritize supply categories that are most likely to yield cost avoidance.

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## VA Is Revising Its Approach to MSPV-NG

VA is currently revising its approach to MSPV-NG requirement development to adopt a model that focuses on clinician-driven sourcing, a key step that leading hospital networks reported following in standardizing their medical supply chains. The MSPV-NG program office continues to refine its strategy for requirement development and is seeking greater clinician involvement in future requirement development efforts, which it refers to as clinician-driven sourcing. For example, program officials said they plan to involve VHA's national clinical program offices—groups of clinicians at VHA that provide national policy and leadership within their clinical specialty—to obtain greater buy-in from senior clinical leaders and

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to implement a more structured approach for identifying clinicians willing to serve on integrated product teams. This approach, if implemented effectively, could mitigate some of the prior challenges in recruiting clinicians to participate. However, these efforts are in their early stages, and the MSPV-NG program office has not outlined whether or how it will use input from these clinical groups to prioritize its requirements development and standardization efforts. Without input from these national clinical program offices, VA will continue to be challenged to focus on supply categories that offer the best opportunity for standardization and cost avoidance.

Senior VHA and MSPV-NG program officials also told us each VA medical center was expected to use a standing committee, known as the Clinical Product Review Committee, to review new items to include on the formulary and to evaluate opportunities to streamline the formulary through standardization. This approach will likely require additional effort on the part of the MSPV-NG program office to implement, as some centers' clinicians said the Clinical Product Review Committees were not operating as intended.

VA is also exploring major changes in its contracting strategy for MSPV-NG. Specifically, MSPV-NG program office and SAC officials plan to replace the current contract and formulary process with a new contract where the vendor would not only provide distribution services, but also develop the formulary. In October 2017, VA sought information from industry on their capabilities to support such a program. VA stated that its target completion date for this new MSPV-NG contracting strategy is December 2018. To date, VA has provided only limited details on this potential new approach, thus, we cannot assess whether it has the potential to address the shortcomings with the current MSPV-NG approach described in this report.

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## Frequent Use of Emergency Procurements Impacts VHA's Ability to Strategically Manage Its Acquisitions

Some emergencies are to be expected, as VHA operates one of the largest health care systems in the country. However, VHA designated a substantial number of its procurements in fiscal year 2016 as emergencies, and we found that it frequently uses emergency procurements to buy routine supplies and on-going services that do not warrant the emergency designation defined in VHA guidance. Among the 18 contract actions we reviewed from three VISNs, we found instances of emergency procurements caused by shortcomings in planning, funding, and communication. These emergency procurements strain the capacity of VA's acquisition workforce and put the government at risk of paying more than it should for goods and services.

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## Emergency Procurements Account for Almost Two Billion Dollars' Worth of VHA Contract Obligations

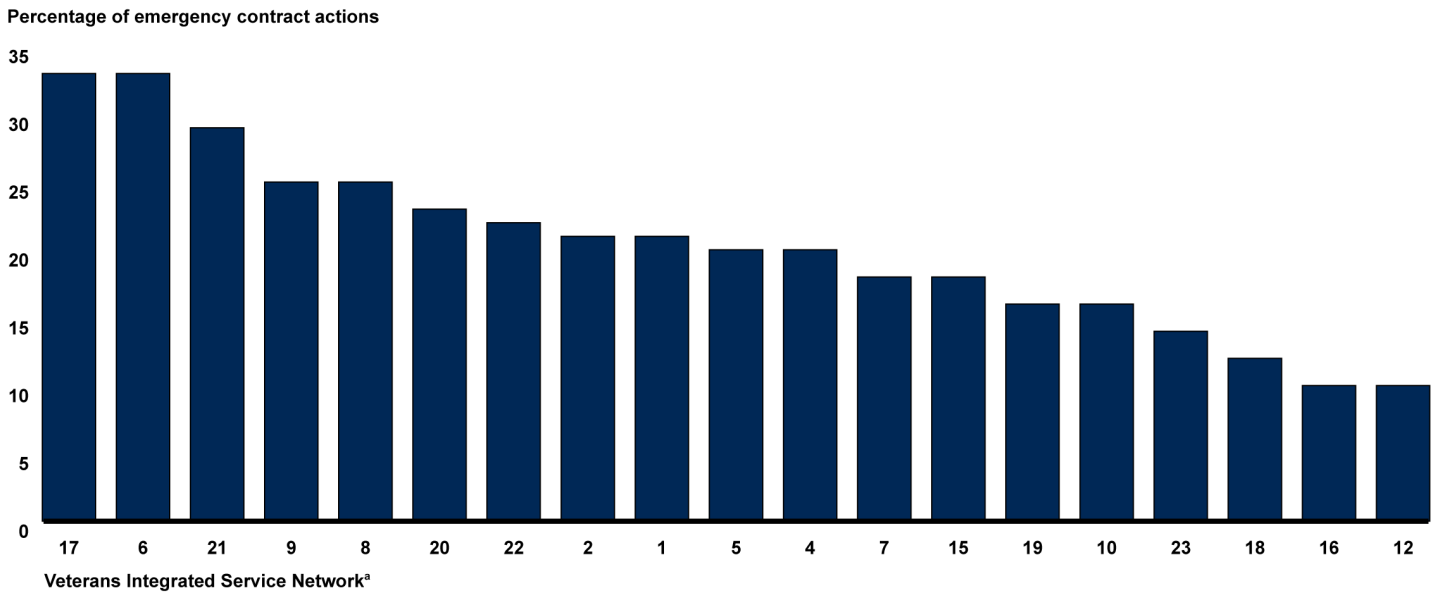
Based on our analysis of VA data, we found that emergency procurements accounted for approximately 20 percent of VHA's overall contract actions in fiscal year 2016, with obligations totaling about \$1.9 billion.<sup>25</sup> As shown in figure 10, we found that the percentage of requests designated as emergencies varied across the 19 VISNs.<sup>26</sup>

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<sup>25</sup>Based on GAO analysis of eCMS data from fiscal year 2016, about a third of contract actions during this period do not have a designated urgency level.

<sup>26</sup>Priority level within eCMS data represents customer designation, not necessarily how the contracting officer processed and prioritized the request.

**Figure 10: Percent of Contract Actions Designated as Emergencies in Fiscal Year 2016**



Source: GAO analysis of Veterans Affairs Electronic Contract Management System data. | GAO-18-34

<sup>a</sup>Some VISNs have been consolidated over time. However, in fiscal year 2016, there were 19 VISNs despite being numbered up to 23. As of fiscal year 2017, there are currently only 18 in total.

**Some Selected Procurements Identified as Emergencies Stemmed from Lack of Planning, Communication Problems, and Other Factors**

We selected a non-generalizable sample of 18 contract actions designated by customers as emergencies. Most of these contracts were not awarded on a competitive basis, and half cited the unusual and compelling urgency exception to full and open competition. Table 2 shows instances in which the 18 contract actions were awarded without competition, those that cited unusual and compelling urgency as the basis for use of non-competitive procedures, and our observations on the main contributing factor to designating these procurements as emergencies.

**Table 2: Overview of Selected Contracts for Routine Supplies and Services Designated as Emergencies**

Requirement description	Non-competitive <sup>a</sup>	Competition limited based on unusual and compelling urgency <sup>b</sup>	Principal Contributing Factor		
			Planning	Funding	Communication
Server license for imaging system	X	-	-	-	X
Payment for surgical supplies used for emergency surgical procedures	X	X	X	-	-
Bulk laundry services	X	-	-	X	-
Home oxygen services	X	X	X	-	-
Custom surgical packs (A)	X	X	X	-	-
Custom surgical packs (B)	X	X	X	-	-
Ablation supplies	X	-	-	-	X
Medical Gas	X	X	X	-	-
Eyeglasses	X	X	X	-	-
Telemetry system	X	X	-	-	X
Histology reagents	X	-	-	-	X
Reagents, antibodies, and prep kit	X	X	-	-	X
Imaging equipment service contract	X	-	-	X	-
Sleep lab furniture	-	-	-	-	X
Postage for metered mail	X	-	-	X	-
Community Based Outpatient Clinic furniture	-	-	X	-	-
Catheters (A)	X	X	-	-	X
Catheters (B)	X	-	-	-	X

Legend:

X - Yes

-- No

Source: GAO analysis of Veterans Affairs contracting data. | GAO-18-34

<sup>a</sup>For the requirements in this column, VA's contract files indicate that VA documented a basis for soliciting only one source.

<sup>b</sup>For the requirements in this column, VA's contract files indicate that VA documented unusual and compelling urgency as a basis for limiting competition.

Additional information on each of the contributing factors follows.

### Planning Challenges

VHA guidance specifies that neither a lack of acquisition advance planning nor concerns about a need to obligate funds before the end of



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the fiscal year are valid justifications for an urgent or emergency procurement request. However, among our selected contract actions, lack of planning by customers was a principal contributing cause, leading to 7 of the 18 contract actions being procured as emergencies, resulting in some non-competitive awards to the incumbent vendor for the same requirement. For instance, one medical center procured medical gas on an emergency basis through consecutive non-competitive contracts. The initial contract was terminated because the company was not licensed by the state where services were being provided, which led to a 3-month emergency contract being awarded to a different vendor. This was followed by a series of non-competitive bridge contracts to that incumbent vendor over a 3-year period. In another case, a medical center routinely procured custom surgical packs through consecutive emergency sole-source purchase orders. The contracting officer's representative told us the medical center may be paying more for custom surgical packs ordered on an emergency basis than it would under a competitive, long-term contract.

## Funding Issues

Funding uncertainty also contributed to three awards being designated as emergencies. For example, one medical center submitted an emergency request to outsource patient laundry due to funding uncertainties for repairs of on-site, VA-owned and operated laundry equipment. The contracting officer's representative stated that the VISN could not provide funds to repair the equipment, leading to a series of last-minute emergency requests, a few months at a time, for contracted patient laundry services to prevent a gap in service.

At another VISN, a large amount of funding became available late in the fiscal year, which led to an emergency request to purchase postage to ensure the funding was spent before it expired at the end of that fiscal year. The contracting office issued an order for \$890,000 worth of metered mail postage, which medical center staff told us would cover 1 to 2 years of usage.<sup>27</sup>

## Lack of Communication

We found that shortcomings in communication between customers and contracting offices also contributed to eight awards made on an emergency basis for routine items. For one of the contracts in our review,

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<sup>27</sup>While outside the scope of this report, the example of the purchase of \$890,000 worth of postage at the end of the fiscal year also raises questions of compliance with the bona fide needs rule. As such, we have referred this matter to the VA Office of the Inspector General for further investigation.

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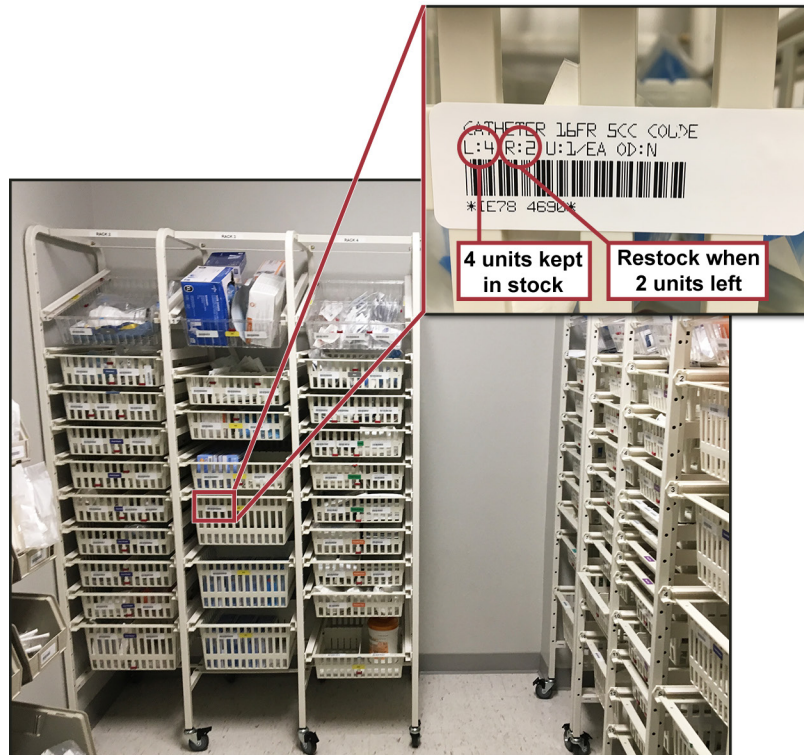
a medical center resubmitted a request in January 2016 to purchase equipment for a new operating room that had previously been submitted as a standard request months earlier. However, the contracting officer's representative at the medical center told us that no action was taken by the contracting office, and he did not receive a response for 6 months. The medical center then upgraded the request to an emergency since the operating room was scheduled to open in June 2016. The contracting officer's representative noted that delays procuring the equipment past the scheduled opening date would delay the opening of the new operating room and possibly result in the rescheduling or cancelling of procedures, affecting patient care. After the order was upgraded to an emergency, the equipment was ultimately delivered before the operating room was opened.<sup>28</sup>

In another case, an inventory manager routinely submitted emergency purchase requests for cardiac catheters as a strategy to manage stock levels. The reason he cited was that he was uncertain how long it would take the contracting office to fulfill standard requests. He stated that the contracting office's time frames for standard orders are unpredictable, and more consistent communication about the expected delivery date of any given order would reduce his need to place emergency orders. He noted that being able to plan around delivery dates was important for maintaining stock at designated levels for the various types of catheters used in the cardiology department. Figure 11 shows a medical center stock room and designated stock levels for one type of catheter. The "L" indicates the standard stock level, and "R" indicates the level of stock at which refill is needed. Ordering officers use these levels to inform when they should place orders.

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<sup>28</sup>The scheduled opening of the new operating room was delayed due to factors unrelated to this emergency procurement.

**Figure 11: Medical Center Supply Closet with Posted Stock Levels**



Source: GAO. | GAO-18-34

## Overreliance on Emergency Procurements Can Drive Up Costs and Overtax the Workforce

### Increased Costs

In addition to being contrary to VHA guidance, overuse of emergency procurement requests has negative effects on the overall operation of VA's procurement system. In reviewing the 18 selected contracts, we identified two primary effects—the potential for increased costs and increased burden on the contracting workforce that could take resources away from other important efforts.

As noted above, half of the contract actions we reviewed (9 out of 18) cited unusual and compelling urgency as the basis for the use of non-competitive procedures. When unusual and compelling urgency exists, an agency may limit competition to the firms it reasonably believes can perform the work in the time available. In all nine cases, however, there was no competition at all, which puts the government at risk of paying more than it should for goods and services.<sup>29</sup> Promoting competition—

<sup>29</sup>See [GAO-16-15](#).

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even in a limited form—increases the potential for quality goods and services at a lower price. We have previously reported that competition in contracting is a critical tool for achieving the best return on investment and that it can improve contractor performance and promote accountability for results.<sup>30</sup>

## Burden on the Contracting Workforce

Emergency procurement requests must be processed quickly, and contracting officers have limited ability to question the validity of an emergency request. Nevertheless, many of the contracting officials we spoke with that had responsibility for our 18 selected contracts told us they generally communicate directly with the requestor to clarify the requirement and assess the nature of the request. As stated in the VHA procurement manual, contracting officers generally must process emergencies within 5 days or less. However, the manual acknowledges that different Network Contracting Offices assign different time frames to priority categories. For instance, officials from all three selected Network Contracting Offices told us they generally process emergencies immediately. Several contracting officials we interviewed stated that, because they do not have clinical expertise, they infrequently question the medical center staff customer about whether their request is truly an emergency. Even if they work with customers to reach a compromise, such as purchasing a smaller quantity to fill just the immediate need, emergencies still require immediate attention and result in deprioritizing other tasks. The impact on the contracting officer workload can be exacerbated by low staffing levels. For example, none of the three Network Contracting Offices we visited were staffed to their authorized levels. Table 3 shows the number of emergency actions processed by each selected Network Contracting Office in fiscal year 2016, along with staff levels.

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<sup>30</sup>GAO, *Federal Contracting: Noncompetitive Contracts Based on Urgency Need Additional Oversight*, [GAO-14-304](#) (Washington, D.C.: Mar. 26, 2014).

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**Table 3: Fiscal Year 2016 Emergency Actions and Staffing Levels at Three Network Contracting Offices (NCO)**

	<b>Number of Emergency Actions</b>	<b>Current Full Time Equivalent Staff<sup>a</sup></b>	<b>Authorized Full Time Equivalent Positions</b>	<b>Emergency Actions Per Year Per Staff Member</b>
NCO 22	2,533	104	124	24.4
NCO 8	3,514	171	181	20.5
NCO 6	4,534	120	133	37.8

Source: GAO analysis of VA office staffing and contracting data. | GAO-18-34

<sup>a</sup>As of July 2017.

We have previously reported that when contracting officers process frequent and emergency small-dollar transactions, it reduces their ability to plan ahead and take a strategic view of procurement needs.<sup>31</sup> Several of the VA contracting officials we spoke with noted that regularly processing emergency contracts and extensions affects their ability to work on bigger-picture efforts, some of which would reduce workload. For instance, one contracting officer stated that awarding emergency contract extensions has prevented him from competitively awarding more than 40 lab contracts. In these cases, the contracting officer stated that he instead extended the period of performance of the non-competitive contracts to the incumbent vendors. In addition, emergency contracts are generally awarded for short periods of time—often 1 year or less—while competitive contracts often have terms of 5 years. According to some contracting officers we spoke with, this can result in contracting officers spending much of their time tending to a large number of short-term contracts, instead of a smaller number of fully-competed contracts with longer periods of performance.

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<sup>31</sup>See [GAO-16-810](#).

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## Better Planning and Management of Contracting Strategies May Help Reduce Emergencies

We found that greater planning and coordination between medical center and contracting staff can help to leverage VA's buying power by employing principles of strategic sourcing—a process that moves away from numerous individual procurements to a broader aggregate approach—and thereby reducing the need for emergencies.<sup>32</sup> For example, inventory managers responsible for two of the selected cardiac catheter contracts in our sample stated that managing catheter inventory was difficult because of the unpredictability of the needs, the high cost of the items, and the long turnaround times from their respective contracting offices. As a result, they had to place frequent emergency orders to keep stock at safe levels. One inventory manager noted, however, that there is no longer a need to place emergency orders for catheters because the SAC has since put in place a purchasing agreement that enabled her to place orders directly, without requiring involvement from the contracting office. In addition to reducing contracting office workload, the supply technician said this agreement greatly reduced the amount of work required to place an order and allowed her to more effectively maintain her inventory with short and predictable turnaround times. She also stated that the agreement protected against the frequent price increases she experienced when purchasing the catheters on the open market through the contracting office. The agreement also reduced workload for the local VISN contracting office. In analyzing eCMS data on awards from fiscal years 2014 through 2016, we identified several types of goods and services that were repeatedly purchased on an emergency basis through stand-alone contract actions. This suggests there may be additional opportunities, at both the VISN and national levels, to reduce emergencies by making supplies and services available through more efficient, competitively-awarded contract vehicles. In addition to reducing burden on logistics and contracting staff, reviewing existing spending to find opportunities to leverage buying power is also in line with strategic sourcing best practices.<sup>33</sup>

MSPV-NG is one such contracting mechanism for procuring routine supplies, and a more strategic approach to developing requirements for the formulary could help avoid some emergency procurements. Our

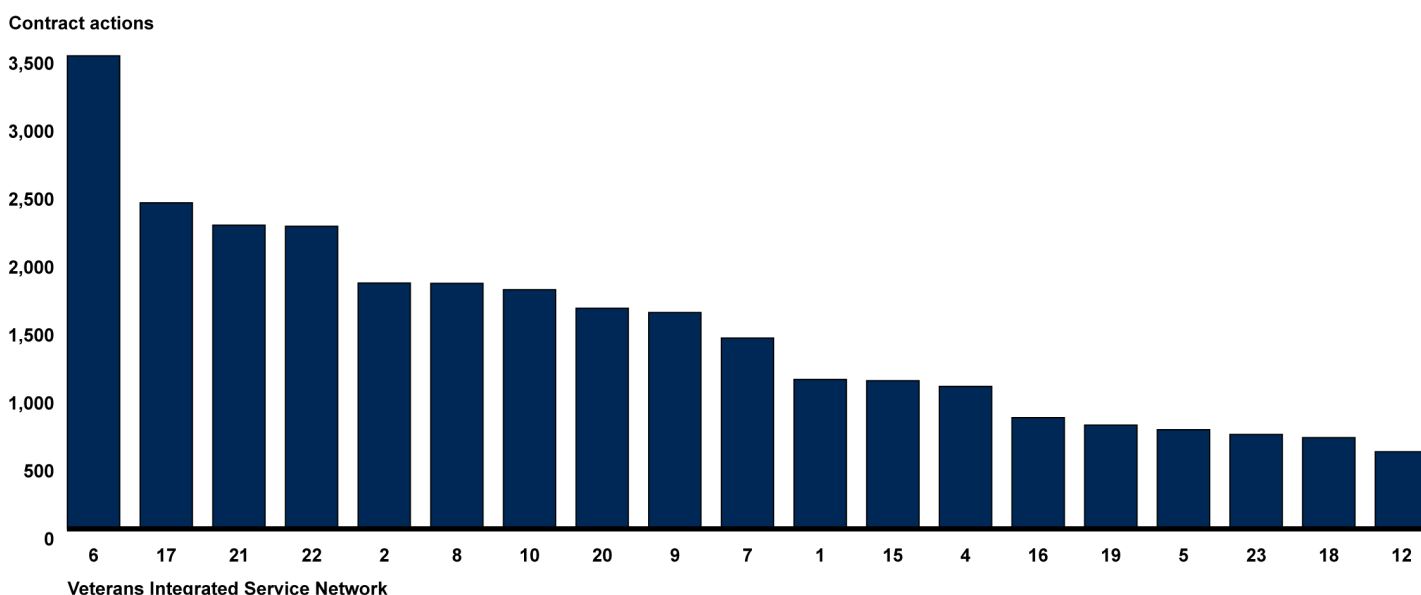
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<sup>32</sup>We have previously reported that strategic sourcing allowed companies to achieve savings of 10 to 20 percent. See GAO, *Strategic Sourcing: Improved and Expanded Use Could Save Billions in Annual Procurement Costs*, [GAO-12-919](#) (Washington, D.C.: Sept. 20, 2012). The supply chain management approaches of the leading private hospitals described in the background section employs key strategic sourcing concepts.

<sup>33</sup>See [GAO-12-919](#).

analysis of VA eCMS data found that many awards designated as emergencies were for medical-surgical items, some of which could likely be purchased through MSPV-NG.<sup>34</sup> Figure 12 shows the number of medical-surgical procurements designated as emergencies within each VISN in fiscal year 2016.

**Figure 12: Number of Contract Actions for Medical-Surgical Items Designated As Emergencies by VISN, Fiscal Year 2016**



Source: GAO analysis of Veterans Affairs Electronic Contract Management System data. | GAO-18-34

Within our sample of 18 contract actions, we found several instances of reoccurring emergency procurements for medical-surgical supplies, such as custom surgical packs and catheters. Procuring routine supplies on an emergency basis defeats the objectives of MSPV-NG to leverage VA’s large buying power and make the process of ordering supplies more efficient and transparent. However, while data on emergency procurements are available, VHA’s Procurement and Logistics Office does not currently analyze this data to identify items frequently purchased on an emergency basis to determine whether such items could be referred to SAC to be added to the MSPV-NG formulary. In addition, local VISN Network Contracting Offices have also not used available data on

<sup>34</sup>Medical-surgical items were identified in eCMS by Product and Service Code 6515 – Medical and Surgical Instruments, Equipment, and Supplies.

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emergency purchases to identify items frequently purchased on an emergency basis. Steps by VHA's Procurement and Logistics Office and individual VISN contracting offices to review such data and identify opportunities for leveraging MSPV-NG or other national contracts could help VA achieve greater efficiency. Purchasing medical supplies through individual emergency contract actions is much less efficient than using MSPV-NG; moreover, by making numerous individual procurements at the local level and not leveraging its aggregate buying power, VA is paying more for items than it needs to.<sup>35</sup>

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## Conclusions

Any major organizational change requires a solid strategic plan that is communicated with stakeholders, stable leadership, and stakeholder involvement and buy-in. VHA was missing all of these elements when it rolled out the MSPV-NG program, which presented obstacles to effective implementation and buy-in and affected the program's ability to meet its goals. Moving forward, without an overall strategy that is communicated to all stakeholders and enhanced leadership stability, VHA will likely continue to face these challenges. In addition, in the initial requirements development process, VHA relied on prior purchase data—rather than clinician input—and did not prioritize categories of medical supplies, both of which veered from practices employed by leading hospital networks. Once the initial formulary was established, medical centers faced challenges matching supply items to the formulary and took varying approaches, in part, due to incomplete guidance on key aspects of the process and frequent changes in the items on the formulary. Providing complete guidance and communicating the criteria and processes for adding or removing items from the formulary would help centers more effectively match items to the formulary, thereby increasing utilization, which as of May 2017 was below VA's established target. Further, because it does not calculate cost avoidance attributable to MSPV-NG, VA cannot accurately measure the extent to which the program is contributing to its overall cost avoidance goal.

VA made changes during the second phase of requirements development, in particular to encourage greater clinician involvement. However, the program faces an unrealistic contracting schedule and has not yet developed a plan for how to manage or mitigate the associated risks. Establishing such a plan is essential for risk mitigation, and supply

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<sup>35</sup>See [GAO-12-919](#).



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category prioritization could help VA target those categories most likely to yield cost avoidance. In addition, while the program is planning to involve national clinical program offices to obtain greater clinician buy-in, it has not outlined whether or how it will use input from these groups to prioritize its requirements development efforts. Without such input, VA will continue to face challenges focusing on those supply categories that offer the best opportunity for standardization and cost avoidance. Further, VA is considering another major change in its MSPV program in which the prime vendor may absorb some of the work currently conducted by SAC. However, VA may face challenges in this new approach until it addresses the existing shortcomings in the MSPV-NG program, such as the absence of a documented overall strategy, insufficient clinician involvement in the requirements development process, and lack of medical center buy-in.

Meanwhile, among the 18 contract actions we reviewed, we found shortcomings in planning and communication that led to medical centers' overreliance on emergency procurements to obtain routine goods and services—some of which could be made available via MSPV-NG—bypassing effective contracting practices like competition. These emergency procurements can be a particular drain on resources, especially those of contracting officers who must respond immediately to fulfill emergency orders. Identifying opportunities to more strategically purchase frequently purchased goods and services—both at the local levels and nationwide through the MSPV-NG program—could help minimize these workforce challenges and minimize costs.

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## Recommendations for Executive Action

We are making 10 recommendations to VA.

The Director of the MSPV-NG program office should, with input from the Strategic Acquisition Center (SAC), develop, document, and communicate to stakeholders an overarching strategy for the program, including how the program office will prioritize categories of supplies for future phases of requirement development and contracting. (Recommendation 1)

The VHA Chief Procurement and Logistics Officer should take steps to prioritize the hiring of the MSPV-NG program office's director position on a permanent basis. (Recommendation 2)

The Secretary of Veterans Affairs should assign the role of Chief Acquisition Officer to a non-career employee, in line with statute. (Recommendation 3)

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The Director of the MSPV-NG program office should provide complete guidance to medical centers for matching equivalent supply items, which could include defining the roles of clinicians and local Clinical Product Review Committees. (Recommendation 4)

The Director of the MSPV-NG program office should, with input from SAC, communicate to medical centers the criteria and processes for adding or removing items from the formulary. (Recommendation 5)

The VHA Chief Procurement and Logistics Officer, in coordination with SAC, should calculate cost avoidance achieved by MSPV-NG on an ongoing basis. (Recommendation 6)

The MSPV-NG program office and SAC should establish a plan for how to mitigate the potential risk of gaps in contract coverage while SAC is still working to make competitive Phase 2 awards, which could include prioritizing supply categories that are most likely to yield cost avoidance. (Recommendation 7)

The VHA Chief Procurement and Logistics Officer should use input from national clinical program offices to prioritize its MSPV-NG requirements development and standardization efforts beyond Phase 2 to focus on supply categories that offer the best opportunity for standardization and cost avoidance. (Recommendation 8)

The VHA Chief Procurement and Logistics Officer should direct VISN Network Contracting Offices to work with medical centers to identify any opportunities to more strategically purchase goods and services frequently purchased on an emergency basis. For example, offices could do this by analyzing existing data. (Recommendation 9)

VHA Chief Procurement and Logistics Officer should analyze data on items that are frequently purchased on an emergency basis, determine whether such items are suitable to be added to the MSPV-NG formulary, and work with SAC to make any suitable items available via MSPV-NG. (Recommendation 10)

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## Agency Comments and Our Evaluation

We provided a draft of this report to the Department of Veterans Affairs for review and comment. VA provided written comments on a draft of this report. In its written comments, reprinted in appendix II, VA concurred with all of our 10 recommendations.

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In its response to our recommendation that VA assign the role of Chief Acquisition Officer to a non-career employee, as required by statute, VA stated that it is unable to implement the recommendation without congressional action and requested closure of the recommendation. We asked VA officials what congressional action they believe is necessary to follow the recommendation. The officials told us they believe the CAO position should be assigned to an assistant secretary, but that the number of assistant secretaries within VA is limited by statute. We decline to close this recommendation. VA should assign the role of CAO to a non-career employee, as required by statute. If VA maintains its view that it cannot meet this requirement without congressional action, then VA should request the specific congressional action that VA believes is necessary.

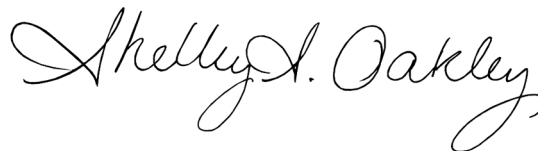
VA provided technical comments on the draft report, which we incorporated as appropriate.

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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 to the appropriate congressional committees, the Secretary of Veterans Affairs, and other interested parties. In addition, the report will be available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff have any questions concerning this report, please contact me at (202) 512-4841 or by email at [oakleys@gao.gov](mailto:oakleys@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix III.

Sincerely yours,



Shelby S. Oakley  
Director, Acquisition and Sourcing Management

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# Appendix I: Objectives, Scope, and Methodology

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You requested that we examine the Department of Veterans Affairs' (VA) transition to the Medical Surgical Prime Vendor-Next Generation (MSPV-NG) program and the extent to which the department contracts for good and services on an emergency basis. This report addresses the extent to which: (1) VA's implementation of MSPV-NG was effective in meeting program goals, and (2) Veterans Health Administration (VHA) awards contracts on an emergency basis for routine supplies and ongoing services, and what impact, if any, these awards have on VHA's acquisition function.

To review the extent to which implementation of MSPV-NG was effective, we reviewed policy and guidance related to the program. We obtained and analyzed the MSPV-NG program's formulary development plan, which explained the program's rationale for pursuing its initial requirements development approach. We also obtained and reviewed additional program documentation, including communications to medical centers and other stakeholders, briefings, and training and tools provided to medical centers. We interviewed leaders in the VHA Procurement and Logistics Office and Healthcare Commodity Program Executive Office (the program office for MSPV-NG), as well as other staff involved in planning and executing aspects of MSPV-NG. We also interviewed VA's Chief Acquisition Officer during the development of MSPV-NG, cognizant Office of General Counsel staff, and others regarding the program. We also interviewed supply chain managers from four leading hospital networks regarding their medical supply management practices. We selected the hospital networks because they were identified by an industry study as having leading supply chain practices. During interviews, we asked each of these supply chain managers a standard set of questions about processes followed to standardize their hospital networks' supply chain. VA had also identified two of these hospital networks as having leading supply chain practices and used the industry study to identify these hospital networks. We used this information from the leading hospital networks to compare the key steps—identified by each of the four hospital networks—followed in standardizing their medical supply chains to those steps that VA followed when implementing the MSPV-NG program. We also confirmed these key steps with the leading hospital networks.

We conducted site visits at a non-generalizable selection of three Veterans Integrated Service Networks (VISNs), and two medical centers within each selected VISN:

- VISN 6: Durham, North Carolina

- Durham, North Carolina VA Medical Center
- Hampton, Virginia VA Medical Center
- VISN 8: St. Petersburg, Florida
  - Tampa, Florida VA Medical Center
  - Gainesville, Florida VA Medical Center
- VISN 22: Long Beach, California
  - Long Beach, California VA Medical Center
  - San Diego, California VA Medical Center

The VISNs were selected primarily based on highest total contract obligations in fiscal years 2014 through 2016 and representation of multiple geographic areas and prime vendor contractors. The first site visit to VISN 22 was also chosen based on the rollout schedule for the graphical user interface, an IT system related to MSPV-NG. The final site visit to VISN 6 was also chosen as the VISN with the highest percentage of contract actions designated as emergencies over the fiscal year 2014 through 2016 period. The selected medical centers in each VISN were chosen based on our review of VA Electronic Contract Management System (eCMS) data on emergency procurements within each VISN (see below) and geographic proximity to the VISN office location. At each selected VISN, we interviewed the Chief Supply Chain Officer and other members of leadership. At medical centers in each selected VISN, we met with the Chief Supply Chain Officer, ordering officers, other logistics staff, clinicians involved in the MSPV-NG transition, and on-site representatives of the prime vendor contractors.

We evaluated MSPV-NG program office status briefings and integrated product team training briefings, which documented the planned role of clinicians in the Phase 2 requirements development process. We interviewed VHA Procurement and Logistics Office leadership, other MSPV-NG program office staff, and integrated product team managers and clinicians about the evolution of the program office's requirements development approach, including the role of clinicians in preparing item descriptions and evaluating items. Three integrated product teams were selected for interviews based on those that covered the greatest number of items, as well as for diversity of types of medical supplies. We also met with members of additional integrated product teams during site visits to the selected medical centers.

We obtained and analyzed the Strategic Acquisition Center's acquisition strategy for MSPV-NG supply contracts and discussed its evolution with the Center's acquisition staff. We analyzed the MSPV-NG formulary as of January 2017 to determine what acquisition instrument was used to add a particular item to the formulary, how the cumulative total of items by award type changed from fiscal year 2014 to fiscal year 2017, and when certain MSPV-NG items would be removed from the formulary because the underlying acquisition instrument had expired. We also analyzed the contents of the formulary monthly from January to July 2017 to determine the number of items added and deleted each month. We determined that the MSPV-NG formulary data were sufficiently reliable for the purposes of our reporting objectives. For the formulary data, we corroborated the supplier's name, award number, award type, and the award's effective and expiration dates with data in the Federal Procurement Data System-Next Generation. We were also able to corroborate the total number of items on the January 2017 MSPV-NG formulary through other documentation, such as program briefings. To determine the level of discounts obtained by the MSPV-NG program office, we randomly selected 10 limited source blanket purchase agreements. We reviewed each agreement and compared the price for each item on the supplier's price list with the item's Federal Supply Schedule price. We obtained and analyzed the current MSPV-NG indefinite delivery, indefinite quantity solicitations and the Defense Logistics Agency's documentation on distribution and pricing agreements. We also reviewed related prior GAO reports and relevant parts of the Federal Acquisition Regulation.

We obtained information on the metrics used by VA to assess the performance of MSPV-NG, primarily the utilization metric, which is calculated by VA based on budget object code spending data from the financial system and MSPV-NG spending data. We obtained data on the performance of the six selected medical centers for May 2017 and July 2017. We also interviewed officials responsible for maintaining this data to gather information on processes, accuracy, and completeness, as well as on planned changes in the metric. We found the utilization metric data to be sufficiently reliable for our purposes.

To assess the extent to which VA has awarded contracts on an emergency basis for routine supplies and ongoing services, and the effect on VA's acquisition function, we obtained and analyzed VA and VHA policy and guidance documents, reviewed relevant parts of the Federal Acquisition Regulation, and reviewed prior GAO reports. We obtained eCMS data for fiscal years 2014 through 2016, and analyzed these data to determine the number of actions designated by customers as

emergencies, the percentage of actions designated as emergencies in each VISN, and the total obligations attributed to these actions. We also calculated the number and value of all actions designated as emergencies in selected Product and Service Codes related to medical supplies and services for fiscal year 2016. We determined that these eCMS data were sufficiently reliable for the purposes of determining the extent of emergency procurements by reviewing information on system controls and conducting validation of data, including tracing selected information to source documents for the contracts that we selected.

We selected a non-generalizable sample of 18 contracts from the three selected VISNs. The selection was based primarily on:

- contracts designated by the customer as emergencies in eCMS data;
- use of the term “emergency” or “urgent” in the description field;
- high dollar value; and
- Product and Service Codes for services and medical supplies.

We obtained and reviewed the contract files for each of the selected contracts, which are also stored in eCMS, including signed awards, limited competition justifications, work statements, and other documents. We compared key information, such as extent of competition, against data reported in eCMS. We interviewed the requesters—in most cases the contracting officer’s representative—for all selected contracts. We also visited Network Contracting Offices for each of the three selected VISNs and interviewed leadership at each location, as well as the contracting officials responsible for each selected contract. Finally, we met with a Strategic Acquisition Center contracting officer to discuss a related contract award.

We conducted this performance audit from November 2016 to November 2017 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.

# Appendix II: Comments from the Department of Veterans Affairs



DEPARTMENT OF VETERANS AFFAIRS  
WASHINGTON DC 20420

October 23, 2017

Ms. Shelby S. Oakley  
Director, Acquisition and Sourcing Management  
U.S. Government Accountability Office  
441 G Street, NW  
Washington, DC 20548

Dear Ms. Oakley:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, "**VETERANS AFFAIRS CONTRACTING: Improvements in Buying Medical and Surgical Supplies Could Yield Cost Savings and Efficiency**" (GAO-18-34). VA agrees with GAO's conclusions and concurs with GAO's recommendations to the Department.

The enclosure provides technical comments and information on actions taken to address the GAO draft report recommendations.

VA appreciates the opportunity to comment on your draft report.

Sincerely,

A handwritten signature in black ink, appearing to read "Gina S. Farrisee".

Gina S. Farrisee  
Deputy Chief of Staff

Enclosure



Enclosure

Department of Veterans Affairs (VA) Comments to  
Government Accountability Office (GAO) Draft Report  
***“VETERANS AFFAIRS CONTRACTING: Improvements in Buying Medical and  
Surgical Supplies Could Yield Cost Savings and Efficiency”***  
(GAO-18-34)

**Recommendation 1:** The Director of the MSPV-NG program office should, with input from the Strategic Acquisition Center (SAC), develop, document, and communicate to stakeholders an overarching strategy for the program, including how the program office will prioritize categories of supplies for future phases of requirement development and contracting.

**VA Comment:** Concur. The Director of the Medical-Surgical Prime Vendor-Next Generation (MSPV-NG) program office, in collaboration with the Strategic Acquisition Center (SAC), shall develop a document that outlines a clear overall strategy for the MSPV-NG program. The document will include a description of how the program office will prioritize categories of supplies for future phases of requirement development and contracting. The document will serve as a communication tool to all stakeholders to increase an understanding of the MSPV-NG program. This process has a target completion date of December 2017.

**Recommendation 2:** The VHA Chief Procurement and Logistics Officer should take steps to prioritize the hiring of the MSPV-NG program office’s director position on permanent basis.

**VA Comment:** Concur. The Veterans Health Administration (VHA) Chief Procurement and Logistics Officer has prioritized hiring of the MSPV-NG program office’s director position on permanent basis. The position description is complete and a vacancy announcement will be posted by the end of the calendar year. This process has a target completion date of December 2017.

**Recommendation 3:** The Secretary of Veterans Affairs should assign the role of Chief Acquisition Officer to a non-career employee, in line with statute.

**VA Comment:** Concur. However, without congressional action, the Department of Veterans Affairs (VA) is unable to appoint a non-career executive to the Chief Acquisition Officer position. VA requests closure of recommendation.

**Recommendation 4:** The Director of the MSPV-NG program office should provide complete guidance to medical centers for matching equivalent supply items, which could include defining the roles of clinicians and local Clinical Product Review committees.

**VA Comment:** Concur. The MSPV-NG program office will redouble its endeavors to provide guidance to medical centers on matching supply items and defining the roles of

Enclosure

Department of Veterans Affairs (VA) Comments to  
Government Accountability Office (GAO) Draft Report  
**“VETERANS AFFAIRS CONTRACTING: Improvements in Buying Medical and  
Surgical Supplies Could Yield Cost Savings and Efficiency”**  
(GAO-18-34)

clinicians and committees in the matching process. To make the matching process easier, the program office has replaced the MSPV Item Conversion Tracker Tool with the Medical Product Data Bank (MedPDB) eZSAVe program, which accesses comprehensive product information collected from over 80 government and private sector sources. This change continues to be communicated to the medical centers via a variety of means through VHA's office of the Deputy Under Secretary for Health for Operations and Management (DUSHOM). This process has a target completion date of December 2017.

**Recommendation 5:** The Director of the MSPV-NG program office should, with input from the Strategic Acquisition Center, communicate to medical centers, the criteria and processes for adding or removing items from the formulary.

**VA Comment:** Concur. The Director of the MSPV-NG program office and the SAC will more frequently and effectively communicate to medical centers the criteria and processes for adding or removing items from the formulary. These communications will include, but not be limited to, briefings, the MSPV newsletter, Change Champion Network teleconferences, and the MSPV VA Pulse page. These communications will be transmitted through the DUSHOM. This process has a target completion date of December 2017.

**Recommendation 6:** The VHA Chief Procurement and Logistics Officer, in coordination with SAC, should calculate cost avoidance achieved by MSPV-NG on an ongoing basis.

**VA Comment:** Concur. VHA is developing a new metric to measure MSPV cost avoidance. The implementation of this metric is contingent upon completion of an Integrated Funds Distribution Control Point Activity, Accounting and Procurement (IFCAP) data standardization project being coordinated with VA's Office of Information and Technology. The project will facilitate standardization of data for enterprise-wide analysis. This process has a target completion date of June 2018.

**Recommendation 7:** The MSPV-NG program office and SAC should establish a plan for how to mitigate the potential risk of gaps in contract coverage while it is still working to make competitive phase 2 awards, which could include prioritizing supply categories that are most likely to yield cost avoidance.

**VA Comment:** Concur. The MSPV-NG program office and SAC plan to replace the current MSPV contract and formulary process with a new contract that will facilitate greater access to a wider variety of medical/surgical products using best commercial

Enclosure

Department of Veterans Affairs (VA) Comments to  
Government Accountability Office (GAO) Draft Report  
***“VETERANS AFFAIRS CONTRACTING: Improvements in Buying Medical and  
Surgical Supplies Could Yield Cost Savings and Efficiency”***  
(GAO-18-34)

and government practices. This current contract replacement plan will include refining and sustaining the current MSPV formulary to provide improved and uninterrupted service until the replacement is fully implemented, to ensure the continuity of supplies. This process has a target completion date of December 2018.

In the interim, the MSPV-NG program office and SAC plan to mitigate the risk of gaps in contract coverage with short and mid-term procurement strategies to ensure continued provision of medical/surgical supplies to VHA facilities. The interim process will be completed by April 2018.

**Recommendation 8: The VHA Chief Procurement and Logistics Officer should use input from national clinical program offices to prioritize its requirements development and standardization efforts beyond Phase 2 to focus on supply categories that offer the best opportunity for standardization and cost avoidance.**

**VA Comment:** Concur. The VHA Procurement and Logistics Office will provide guidance that details the importance of Clinical Program Office (CPO) involvement in MSPV requirements development and standardization efforts. This proposed VHA guidance is being finalized, briefed to the CPOs, and staffed for signature. Emphasis is placed in the guidance on the CPOs to directly manage the selection of items in the portion of the formulary related to their clinical expertise. The CPOs will also prioritize their requirements and be required to emphasize standardization where clinically acceptable. This process has a target completion date of December 2018.

**Recommendation 9: The VHA Chief Procurement and Logistics Officer should direct VISN contracting offices to work with medical centers to identify any opportunities to more strategically purchase goods and services frequently purchased on an emergency basis. For example, offices could do this by analyzing existing data.**

**VA Comment:** Concur. The Procurement and Logistics Office is in the process of formalizing guidance to VHA contracting offices and the Supply Chain Data and Informatics Office (SCDIO) to work with medical centers to seek and identify opportunities to strategically obtain goods and services procured on an emergency basis. This process has a target completion date of June 2018.

Enclosure

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**Recommendation 10:** VHA Chief Procurement and Logistics Officer should analyze data on items that are frequently purchased on an emergency basis, determine whether such items are suitable to be added to the MSPV-NG formulary, and work with SAC to make any suitable items available via MSPV-NG.

**VA Comment:** Concur. The VHA MSPV-NG program office and SCDIO will establish a process to implement this recommendation in parallel with addressing Recommendation 9. This process will result in the identification of commodities or supplies that are frequently purchased using emergency procurement methods. These items will be evaluated and added to the MSPV formulary if appropriate. This process has a target completion date of June 2018.

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# Appendix III: GAO Contact and Staff Acknowledgments

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## GAO Contact

Shelby S. Oakley, 202-512-4841 or [oakleys@gao.gov](mailto:oakleys@gao.gov)

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## Staff Acknowledgments

In addition to the individual named above, Lisa Gardner, Assistant Director; Emily Bond; Matthew T. Crosby; Lorraine Ettaro; Michael Grogan; Jeff Hartnett; Katherine Lenane; Teague Lyons; Roxanna Sun; and Colleen Taylor made key contributions to this report.

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