



September 2020

VA ACQUISITION MANAGEMENT

Actions Needed to
Improve Management
of Medical-Surgical
Prime Vendor
Program and Inform
Future Decisions

GAO Highlights

Highlights of [GAO-20-487](#), a report to congressional requesters

Why GAO Did This Study

VA is developing the next iteration of its prime vendor program, MSPV 2.0, to meet the healthcare needs of about 9 million veterans. GAO's prior work found that VA medical centers' use of the MSPV formulary fell below targets in VA's prior iteration of the program and that VA lacked an overarching medical supply program strategy. In 2019, GAO elevated VA Acquisition Management to its High Risk List, in part due to its lack of an effective strategy for procuring medical supplies.

GAO was asked to review VA's MSPV program. This report assesses, among other things, VA medical centers' use of MSPV-NG and whether MSPV 2.0 will mitigate current program issues, as well as whether VA has measures for DLA MSPV pilot success and scalability. GAO analyzed VA and DLA documents and data, conducted site visits to 12 VA medical centers with higher medical supply spending, and interviewed VA and DLA officials within various levels at the agencies. GAO completed most of this review prior to March 2020, and, thus, did not address the COVID-19 pandemic.

What GAO Recommends

GAO is making eight recommendations to VA, including that it examine opportunities to automate aspects of the formulary management process, reduce the number of drop-shipped items, and develop a plan to measure the success and scalability of its DLA MSPV pilot. VA agreed with GAO's recommendations.

View [GAO-20-487](#). For more information, contact Shelby S. Oakley at (202) 512-4841 or OakleyS@gao.gov.

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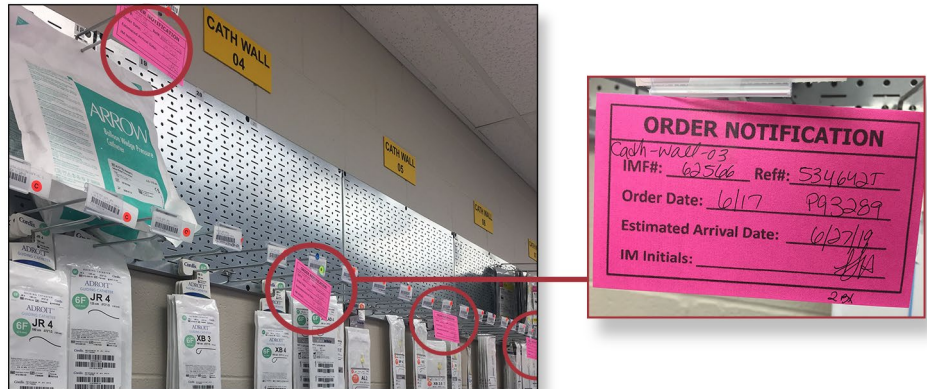
Actions Needed to Improve Management of Medical-Surgical Prime Vendor Program and Inform Future Decisions

What GAO Found

The Department of Veterans Affairs' (VA) Medical-Surgical Prime Vendor-Next Generation (MSPV-NG) program is intended to provide an efficient, cost-effective way for its 170 medical centers to order supplies. But only 11 percent of these centers met VA's target of using the MSPV-NG formulary—the list of supplies offered—for 90 percent of medical supply purchases. GAO met with 12 medical centers and found contributing factors, such as a manual formulary management system, that resulted in ordering errors and delivery delays. VA's planned MSPV 2.0 program is designed to fix some, but not all, issues. The manual formulary management system, among others, will remain unaddressed.

In addition, GAO found that supplies shipped directly from manufacturers instead of local warehouses—known as drop shipments—often result in late deliveries (see figure). About a third of supplies on the MSPV-NG formulary are drop-shipped, and this issue will continue under MSPV 2.0, as reducing drop-shipped items is not part of VA's planned changes under the new program.

Out-of-Stock Notices Observed in VA Medical Center Supply Storage Areas



Source: GAO. | GAO-20-487

VA is also piloting the use of the Defense Logistics Agency's (DLA) MSPV program at three VA medical centers to determine whether it provides a more effective means of obtaining required medical and surgical supplies than MSPV 2.0. VA started the pilot at one location but delayed rollout to the other locations by almost a year, to July and August 2020, because of technology integration challenges. VA has not established comprehensive metrics or criteria from which to determine the pilot's success or whether the pilot could be scalable to medical centers VA-wide. Without these metrics, VA risks not having an effective methodology for evaluating pilot success.

In September 2020, after GAO sent a draft of this report to VA for comment, senior VA officials stated VA has decided to implement DLA MSPV VA-wide in place of MSPV 2.0, and will continue to implement MSPV 2.0 in the interim. This planned approach makes assessing the outcomes of the implementation at the initial sites all the more important, to help VA understand potential challenges.

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Abbreviations

CDSS	Clinician-Driven Strategic Sourcing
DLA	Defense Logistics Agency
DMLSS	Defense Medical Logistics Standard Support
ECAT	Electronic Catalog
IFCAP	Integrated Funds Distribution Control Point Activity, Accounting and Procurement
MSPV	Medical-Surgical Prime Vendor
MSPV-NG	Medical-Surgical Prime Vendor-Next Generation
OSDBU	Office of Small & Disadvantaged Business Utilization
SAC	Strategic Acquisition Center
SD/VOSB	Service Disabled Veteran-Owned and Veteran-Owned Small Businesses
VA	Department of Veterans Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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September 30, 2020

Dear Congressional Requesters:

In December 2016, the Department of Veterans Affairs (VA) launched the Medical-Surgical Prime Vendor-Next Generation (MSPV-NG) program. This program is VA's primary method of purchasing the medical and surgical supplies, such as bandages and scalpels, that 170 VA medical centers use on a daily basis to meet the healthcare needs of about 9 million veterans. The Veterans Health Administration (VHA) places hundreds of millions of dollars in orders for supplies through its MSPV-NG program each fiscal year. In our 2017 review of this program, we found that VA lacked an overarching strategy and clinician involvement and had rushed its approach to MSPV-NG formulary development, which led to low usage of the program by VA medical centers.¹

VA intended to launch the next iteration of its MSPV program—MSPV 2.0—in March 2020 to address challenges faced in the MSPV-NG program, but its implementation is delayed until early 2021.² In addition, as a possible alternative to its MSPV program, VA is piloting the use of the Defense Logistics Agency's (DLA) MSPV program—a Department of Defense program similar to VA's MSPV program. VA is piloting this program to determine if it provides a more economical and efficient means of obtaining required medical and surgical supplies. According to DLA officials, DLA's MSPV program, begun in 1995, currently provides medical centers with access to over 200,000 medical and surgical supplies on its formulary. Underlying any approach VA takes for obtaining medical supplies—through VA's MSPV program or the DLA MSPV pilot—is a unique statutory requirement that VA apply a preference for contracting with Service Disabled Veteran-Owned and Veteran-Owned Small Businesses (SD/VOSB).

You requested that we examine the effectiveness of MSPV-NG, VA's transition to MSPV 2.0, VA's implementation of the DLA MSPV pilot, and

¹The formulary is a list of specific medical and surgical supplies available to VA medical centers to purchase through VA's MSPV program. See GAO, *Veterans Affairs Contracting: Improvements in Buying Medical and Surgical Supplies Could Yield Cost Savings and Efficiency*, [GAO-18-34](#) (Washington, D.C.: Nov. 9, 2017).

²VA Procurement and Logistics senior officials told us they plan to refer to the formulary as the "product list" in MSPV 2.0. However, throughout this report, we will refer to the list as the formulary.

what opportunities VA provides SD/VOSBs to supply medical and surgical supplies to VA medical centers. This report assesses (1) the extent to which MSPV-NG is meeting medical center needs, and whether the planned MSPV 2.0 program will mitigate current program issues we identified; (2) the implementation status of MSPV 2.0; (3) the status of VA's DLA MSPV pilot, and the extent to which VA is measuring pilot success and scalability; and (4) whether SD/VOSB participation in VA's MSPV-NG program has changed over time and what future participation opportunities exist for the MSPV 2.0 program and the DLA MSPV pilot.

The majority of this review was completed prior to March 2020, and thus, the impact of the Coronavirus Disease 2019 (COVID-19) pandemic on the MSPV program is not included in the scope of this review.³

To assess the extent to which MSPV-NG is meeting medical center needs and whether the MSPV 2.0 program will mitigate issues in the MSPV-NG program, we reviewed policy memorandums, MSPV-NG contracts, MSPV 2.0 solicitation documents, agency communications, and other documents. We reviewed prior GAO reports on MSPV-NG issue areas, as well as internal control standards.⁴ We visited a nongeneralizable selection of 12 VA medical centers during 2019, selected based on those with higher medical supply spending, and for representation of all four distribution contractors—known as “prime vendors”—involved in the MSPV-NG program. We interviewed supply chain managers, contracting staff, clinical and logistics staff at the VA medical centers, representatives of the four MSPV-NG prime vendors, and senior VA and VHA officials responsible for implementing MSPV-NG and MSPV 2.0 regarding their perspectives on the programs.⁵ To assess VA's coverage and utilization data, we analyzed data on VA medical center spending through MSPV-NG between October 2019 and March 2020.⁶ We determined that the data were sufficiently reliable for our

³For preliminary observations on VA's supply chain response to COVID-19, see GAO, Veterans Affairs Acquisition Management: COVID-19 Response Strains Supply Chain While Modernization Delays Continue, [GAO-20-716T](#) (Washington, D.C.: Sept. 16, 2020).

⁴[GAO-18-34](#); and GAO, *Standards for Internal Control in the Federal Government*, [GAO-14-704G](#) (Washington, D.C., Sept. 10, 2014).

⁵In MSPV-NG, prime vendors are responsible for working with suppliers within certain geographic areas to deliver medical and surgical supplies to VA medical centers.

⁶Coverage is the percentage of total medical and surgical supply spending for supplies available on the MSPV formulary at an enterprise level. Utilization is—among the supplies available on the MSPV formulary—the percentage of orders VA medical centers place through the MSPV program.

reporting objectives by electronically testing them and speaking with VA officials responsible for maintaining the data, among other steps.

To determine the current implementation status of MSPV 2.0, we reviewed policy memorandums, MSPV 2.0 solicitation documents, agency communications, and other documents. We interviewed supply chain managers, contracting staff, clinical and logistics staff at the 12 VA medical centers, and senior VA and VHA officials responsible for implementing MSPV 2.0 regarding their perspectives on the program.

To assess the extent to which VA is measuring pilot success and scalability for the DLA MSPV pilot, we reviewed policy memorandums, relevant laws that govern VA acquisitions, interagency agreements between VA and DLA, agency communications, and other documents. We reviewed a prior GAO report on leading practices for pilot programs and compared VA's management of its DLA MSPV pilot to these leading practices.⁷ We interviewed supply chain managers, logistics staff at VA medical centers, and senior officials at DLA and VA who are responsible for implementing the DLA MSPV pilot to obtain their perspectives on the pilot. We did not assess DLA's management of its MSPV program.

To assess how SD/VOSB participation in MSPV-NG has changed over time and what future participation opportunities exist, we reviewed policy memorandums, relevant laws that govern VA acquisitions, MSPV-NG contracts and MSPV 2.0 solicitation documents, agency communications, and other documents. We interviewed contracting staff, representatives of an organization representing SD/VOSBs, representatives of the four MSPV-NG distribution contractors, officials from VA's Office of Small & Disadvantaged Business Utilization, and senior VA and VHA officials responsible for implementing MSPV-NG, MSPV 2.0, and the DLA MSPV pilot to obtain their perspectives on SD/VOSB participation in these programs. To determine the amount and percentage of spending on items supplied by SD/VOSBs through MSPV-NG over time, we obtained data from the contractors on VA spending from December 2016 through September 2019. We determined that the data were sufficiently reliable for our reporting objectives by electronically testing them and speaking with prime vendor representatives responsible for maintaining the data,

⁷GAO, *Data Act: Section 5 Pilot Design Issues Need to Be Addressed to Meet Goal of Reducing Recipient Reporting Burden*, [GAO-16-438](#) (Washington, D.C.: Apr. 19, 2016).

among other steps. See appendix I for a more detailed scope and methodology.

We conducted this performance audit from February 2019 to September 2020 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.

Background

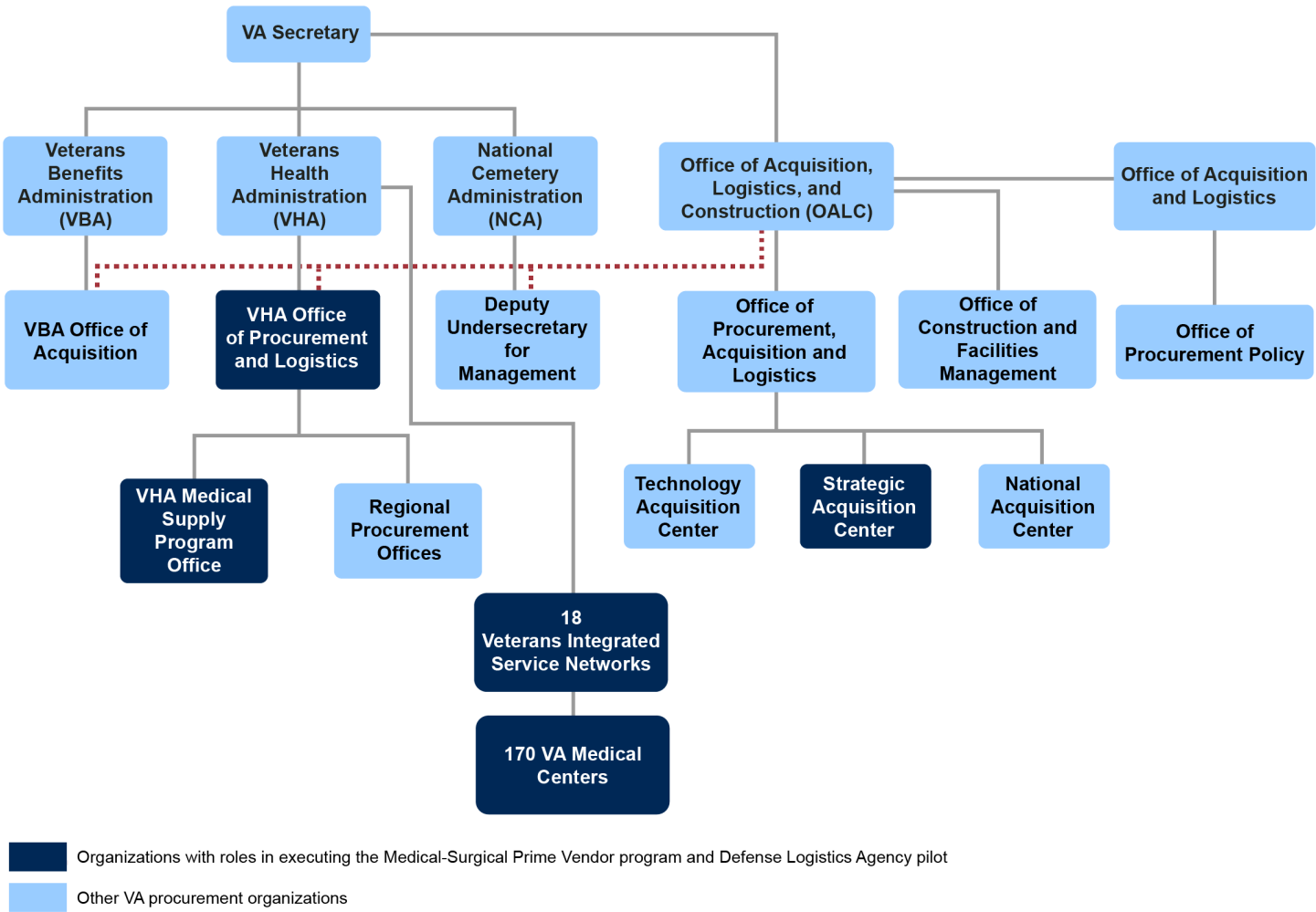
VA serves veterans of the U.S. armed forces and other eligible beneficiaries and provides health, pension, burial, and other benefits. VHA, the largest VA administration, provides medical care to about 9 million veterans at 170 VA medical centers. A variety of VA and VHA offices are responsible for executing the VA MSPV-NG program, which is VA's primary contracting source for purchasing medical and surgical supplies. These same organizations also have roles in executing VA's pilot of the DLA MSPV program:

- Office of Procurement and Logistics: Within VHA, the Office of Procurement and Logistics facilitates the acquisition of medical and surgical supplies by establishing supplier agreements for the VA MSPV 2.0 program.
- Medical Supply Program Office (MSPV program office): Within VHA's Office of Procurement and Logistics, this program office manages the day-to-day activities of VA's current MSPV-NG program and its planned MSPV 2.0 program and manages the DLA MSPV pilot.⁸
- VA medical centers: Under VHA, VA medical centers—through logistics staff such as inventory management specialists—procure medical and surgical supplies for their facilities using VA's MSPV-NG program or the DLA MSPV pilot (if applicable).
- Strategic Acquisition Center (SAC): Under VA, SAC awards and manages the VA MSPV-NG and MSPV 2.0 prime vendor distribution contracts.

⁸Throughout this report, we refer to VA's Medical Supply Program Office as the MSPV program 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 (VA) organizational charts and policies. | GAO-20-487

Preferences for Veteran-Owned Small Businesses in Awards of VA Contracts

VA has special contracting requirements to engage SD/VOSBs.⁹ The 2006 Veterans Benefits, Health Care, and Information Technology Act requires VA contracting officers to determine whether there is a reasonable expectation that two or more veteran-owned small businesses will submit offers for a particular good or service at a fair and reasonable price that offers best value to the government.¹⁰ If two or more such businesses are found, contracting officers must set aside the procurement for the veteran-owned small businesses. VA refers to this determination as the “VA Rule of Two.”

VA’s Medical-Surgical Prime Vendor Program

VHA manages the MSPV-NG program, which is a strategic sourcing contract vehicle that is intended to streamline VA’s supply chain management for an array of medical, surgical, dental, lab, and environmental medical supplies. For core items—those that a given medical center uses most frequently—MSPV-NG is intended to provide ongoing, just-in-time delivery.¹¹ The program involves four “prime vendors,” who each hold a contract to distribute medical supplies from warehouses or other locations to the VA medical centers in a given geographic area. The program also involves numerous suppliers that provide the items being distributed. Historically, VA has selected these suppliers and negotiated the pricing with them. Logistics staff at VA medical centers order supplies from the formulary—a list of specific supplies available to medical centers to purchase through MSPV.

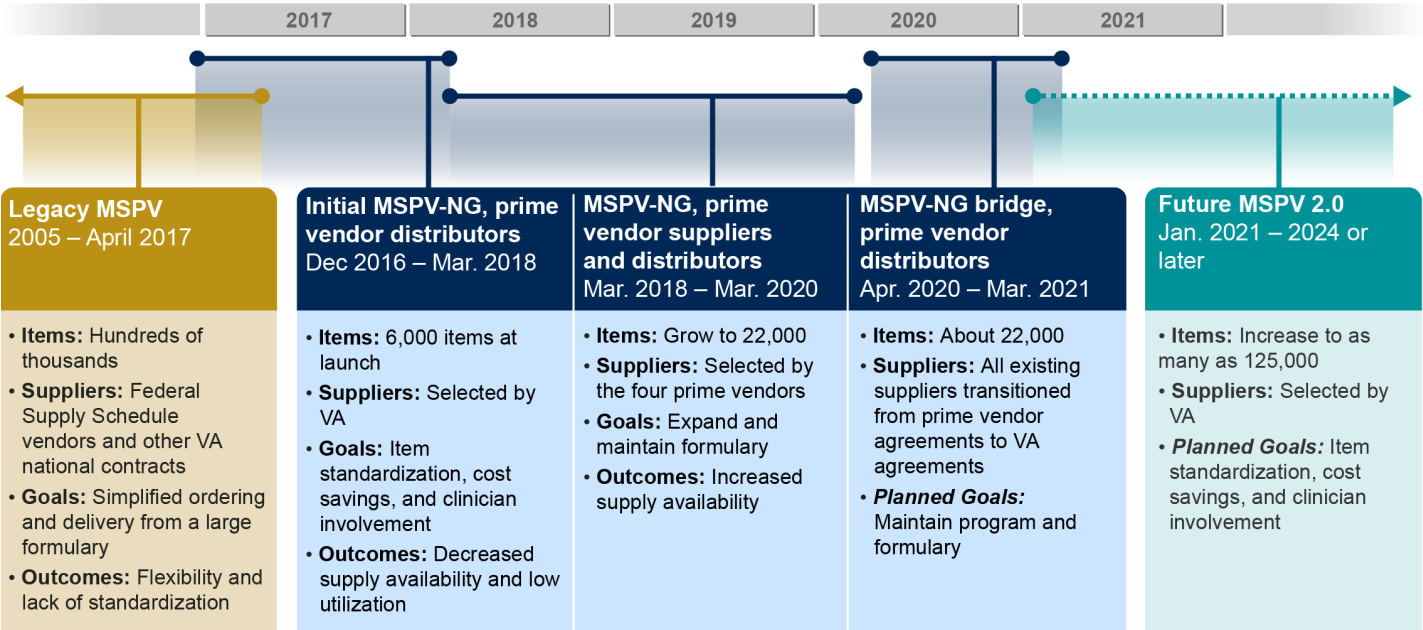
⁹In order for an SD/VOSB to receive such a designation from VA, the business must be unconditionally owned and controlled by one or more eligible veterans, service-disabled veterans, or surviving spouses. Under VA’s SD/VOSB program, a veteran is defined as a person who served in the active military, naval, or air service, and who was discharged or released under conditions other than dishonorable, or a reservist or member of the National Guard called to federal active duty or disabled from a disease or injury incurred or aggravated in line of duty or while in training status. Under VA’s SD/VOSB program, a service-disabled veteran is generally defined as a veteran with either a valid disability rating letter issued by VA or a disability determination from the Department of Defense.

¹⁰The Veterans First program implements The Veterans Benefits, Health Care, and Information Technology Act of 2006, Pub. L. No. 109-461, § 502(a) (2016) (codified as amended at 38 U.S.C. § 8127). For our prior findings on VA’s implementation of the Veterans First program, see GAO, *Veterans First Program: VA Needs to Address Implementation Challenges and Strengthen Oversight of Subcontracting Limitations*, [GAO-18-648](#) (Washington, D.C.: Sept. 24, 2018).

¹¹Under the MSPV-NG contracts, items ordered by a given VA medical center at least once a month are designated as “core” or “recurring” items. The contracts require the prime vendors to maintain inventory levels necessary to provide regular delivery services to the VA facilities.

Since its inception in 2005, VHA has created several iterations of the MSPV program and plans to implement the next version—MSPV 2.0—in early 2021. VHA awarded “bridge” contracts to the MSPV-NG prime vendors to extend the program until MSPV 2.0 is implemented.¹² Figure 2 provides information on how the number of supplies, the method for selecting suppliers, and planned goals for VA’s MSPV program have evolved since its inception.

Figure 2: Department of Veterans Affairs (VA) Medical-Surgical Prime Vendor (MSPV) Programs Since 2005



Source: GAO analysis of VA policy memoranda and program goals documents. | GAO-20-487

Our November 2017 review of MSPV-NG found that VA rushed its approach to developing the formulary.¹³ We also found that VA medical centers were not using the formulary at VA’s target rates due to problems such as a lack of clinician involvement that affected how well the formulary met medical centers’ needs. Additionally, the formulary had a

¹²While there is no government-wide definition for bridge contracts, GAO has defined it as an extension to an existing contract beyond the period of performance (including base and option years) or a new, short-term contract awarded on a sole-source basis to an incumbent contractor to avoid a lapse in service caused by a delay in awarding a follow-on contract.

¹³GAO-18-34.

very limited selection of supplies compared to the supply availability in the legacy MSPV program. We recommended that VA develop a strategy for MSPV-NG, prioritize its requirements development and standardization efforts, and address turnover in leadership of the MSPV-NG program office, among other things. As of June 2020, VA had implemented five of the nine recommendations and had actions in progress to address all of the others, which are at varying stages of implementation and cannot be fully assessed until VA implements MSPV 2.0. Of the outstanding recommendations, GAO identified one as a priority recommendation for the department and all four as recommendations aimed at eliminating duplication and reducing costs.¹⁴ See appendix II for a summary of our past MSPV-NG recommendations and their disposition. These recommendations, along with others, contributed to our decision to add VA acquisition management to our High Risk List in March 2019.¹⁵

The primary purpose of MSPV-NG is to provide just-in-time delivery of medical-surgical supplies to VA medical centers, but VA has shifted its goals for the program over time. From March 2018 through November 2018, VA focused on increasing the number of supplies on the formulary, not on cost savings or standardization, which had been goals in the initial development of MSPV-NG. As part of the effort to increase the formulary size, in March 2018, VA noncompetitively modified the four prime vendor contracts by expanding the scope of work to include both the supply and distribution of items. This action enabled the vendors to quickly increase the number of supply items available through the formulary by selecting their own suppliers, replacing the contracting process that had been administered by VA's SAC. VA and its prime vendors nearly tripled the size of the formulary from about 8,000 supply items in March 2018 to

¹⁴GAO, *Priority Recommendations: Department of Veterans Affairs*, [GAO-20-537PR](#) (Washington, D.C.: Apr. 20, 2020) and GAO, *2020 Annual Report: Additional Opportunities to Reduce Fragmentation, Overlap, and Duplication and Achieve Billions in Financial Benefits*, [GAO-20-440SP](#) (Washington, D.C.: May 19, 2020).

¹⁵ The High Risk List is a list of programs and operations that are "high risk" due to their vulnerabilities to fraud, waste, abuse, and mismanagement, or that need transformation. The list is updated every 2 years at the start of each new session of Congress and has led to more than \$350 billion in financial benefits to the federal government. See GAO, *High-Risk Series: Substantial Efforts Needed to Achieve Greater Progress on High-Risk Areas*, [GAO-19-157SP](#) (Washington, D.C.: Mar. 6, 2019).

about 22,000 supply items in November 2018.¹⁶ As of June 2020, the MSPV-NG formulary had about 21,000 supply items.

However, a group of SDVOSBs that supply medical items challenged VA's decision not to compete the acquisition of the supplies or to apply the VA Rule of Two to the March 2018 modification of the prime vendor contracts in federal court. The court found VA's contract actions violated various statutory requirements but declined to halt the arrangement based on a finding that the public interest favored uninterrupted healthcare to veterans.¹⁷ The SDVOSB suppliers appealed the decision. The appeals court denied the appeal based on the public interest and the limited time period remaining on the prime vendor contracts.¹⁸

VA is planning for a successor program, known as MSPV 2.0, which will include new, competitively-awarded prime vendor contracts. VA's expanded goals for MSPV 2.0 are to:

- provide VHA facilities with just-in-time delivery of medical and surgical supplies, enabling clinicians to provide high-quality veteran care and services;
- provide visibility into enterprise-level spend and usage data, increasing reporting accountability and transparency in VHA purchasing processes;
- leverage leading practices and clinician involvement throughout the acquisition life cycle to align with VHA's integrated supply chain transformation initiative; and
- increase VHA's purchasing power and reduce reliance on less-preferred procurement methods.

¹⁶Each of the prime vendors maintained their own formularies, each of which contained around 22,000 items.

¹⁷See *Electra-Med Corp. v. United States*, 140 Fed. Cl. 94 (2018), *aff'd* and *remanded*, 791 F. App'x 179 (Fed. Cir. 2019).

¹⁸In its decision, the appeals court stated that the prime vendor contracts were to expire in April 2020 but that they appeared to have an option period beyond that. Because of this, the appeals court required that the case could be reopened if VA were to exercise the option. *Electra-Med Corp. v. United States*, 791 Fed. Appx. 179 (Fed. Cir. 2019) (unpublished).

VA MSPV-NG Program Metrics

VA officials established two metrics to assess the extent to which MSPV-NG meets VA medical center needs.

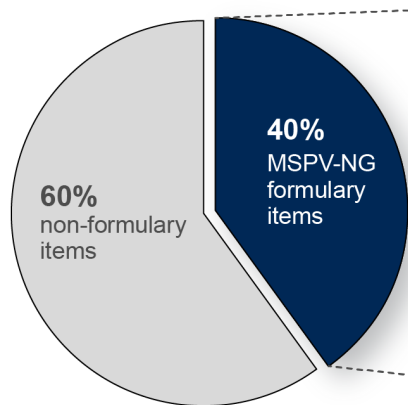
- The first metric is coverage, which is the percentage of total medical and surgical supply spending on supplies available through the MSPV-NG formulary at an enterprise level—that is, across all VA medical centers. VA's current target for the MSPV-NG program is for the formulary to cover 40 percent of total VA supply spending.
- The second metric is utilization, which is the percentage of orders VA medical centers place through the MSPV-NG program—as opposed to another source—among supply items that are on the formulary. Utilization is VA's primary metric for measuring the success of the program, and VA's current target for VA medical center utilization is 90 percent.¹⁹

Figure 3 illustrates each metric.

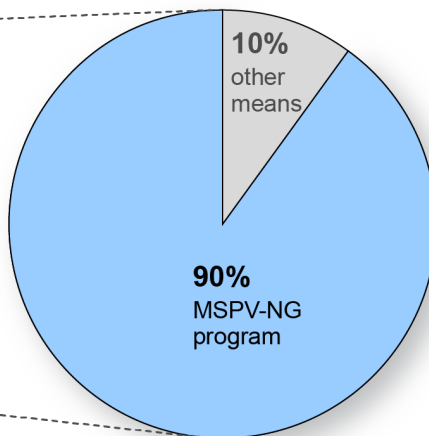
Figure 3: Department of Veterans Affairs (VA) Medical-Surgical Prime Vendor-Next Generation (MSPV-NG) Coverage and Utilization Rate Targets

MSPV-NG coverage target

MSPV-NG utilization target



Total spend on all medical-surgical supplies at an enterprise level



Total spend on items available through MSPV-NG program at the VA medical center level

Source: GAO analysis of interviews with VA officials and contract documentation. | GAO-20-487

¹⁹In March 2018, according to a Supply Chain Data Informatics official, VA revised how it calculates its utilization metric. Results of this metric from before March 2018, including those reported in [GAO-18-34](#), cannot be directly compared to those after this date.

VA's Pilot of the DLA MSPV Program

VA is planning to pilot the use of the DLA MSPV program at three VA medical centers as part of a broader coordination effort between the two agencies. DLA is the nation's combat logistics support agency, and it manages the global supply chain for the Army, Marine Corps, Navy, Air Force, Space Force, Coast Guard, and other federal agencies. Section 8111 of title 38 U.S.C. requires coordination and sharing of healthcare resources between the Department of Defense and VA. VA and DLA entered into an interagency agreement to confirm their commitment to this pilot in January 2019.²⁰ Officials at the North Chicago joint VA–Department of Defense medical center stated the first iteration of the pilot began in March 2019.²¹

VA's MSPV-NG Program Is Not Fully Meeting Medical Center Needs, and Planned MSPV 2.0 Program Will Not Mitigate All Identified Issues

VA's implementation of the MSPV-NG program is not fully meeting the needs of its medical centers. Utilization remains below VA's target rate, in part because of issues such as backorders, limited formulary coverage, and manual formulary management. VA's plans for the MSPV 2.0 program address some of the problems with the current MSPV-NG program, but VA's plans do not address others or only partially address them.

Medical Center Utilization of MSPV-NG Remains below VA's Target Because MSPV-NG Does Not Fully Meet Needs

Most VA medical centers do not meet VA's MSPV-NG 90 percent utilization target. The VA Acquisition Regulation establishes that strategic sourcing contracts—such as MSPV-NG—have priority over other existing contract vehicles and open market purchases.²² According to MSPV program office officials and VA medical center logistics staff we met with, MSPV-NG is intended to be VA's primary source of the supplies and provide an efficient, cost-effective way for its medical centers to order

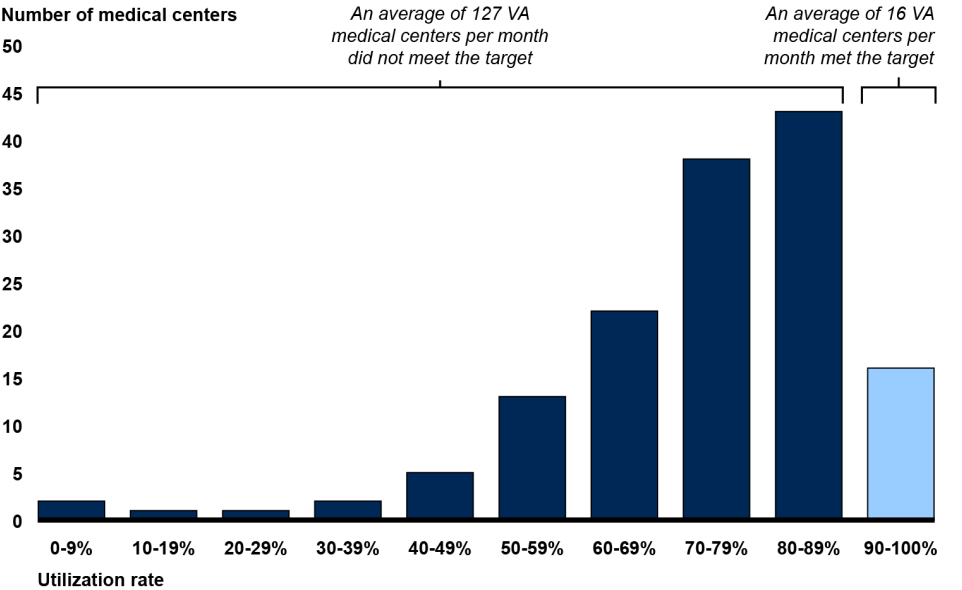
²⁰VA and DLA signed two interagency agreements and one Interface Control Document for the pilot effort. In January 2019, VA and DLA signed the first interagency agreement to begin the pilot effort at the North Chicago joint medical center. The agencies signed a second interagency agreement in August 2019 to include the Veterans Integrated Service Network 20 medical centers in the pilot effort. The Interface Control Document—signed in April 2020—gave DLA access to VA's Vendor Information Pages database, which includes the list of verified SD/VOSBs.

²¹This medical center's full name is the James A. Lovell Federal Health Care Center. Throughout this report, we refer to it as the North Chicago joint medical center.

²²See VAAR § 808.004-70(b) (class deviation) (July 25, 2016).

supplies. However, from October 2019 through March 2020, a monthly average of only 16 VA medical centers (or roughly 11 percent of all VA medical centers) met or exceeded the 90 percent utilization target, as shown in Figure 4.

Figure 4: Average Medical-Surgical Prime Vendor-Next Generation (MSPV-NG) Utilization Rates by Department of Veterans Affairs (VA) Medical Center, October 2019 – March 2020



Source: GAO analysis of MSPV-NG Utilization Data. | GAO-20-487

Note: The Veterans Health Administration has 170 individual medical centers across its system. Its Veterans Health Information Systems and Technology Architecture system, which is used to gather utilization data, is deployed in clusters that may serve multiple medical centers. There are 145 of these clusters, but the MSPV-NG program does not serve two of these locations (the VA Medical Center in Anchorage, Alaska and Outpatient Clinic in Manila, Philippines), and as a result the total number of separate utilization metrics reported is 143.

VA’s MSPV 2.0 Program Is Unlikely to Mitigate All MSPV-NG Program Issues

Through its planned MSPV 2.0 program, VA seeks to provide VA medical centers with easier and more reliable access to a variety of necessary medical and surgical supplies by addressing some of the issues with MSPV-NG. Specifically, VA plans to introduce contract terms that will increase the amount of regularly ordered supplies prime vendors must maintain in stock to decrease supply backorders, and to increase formulary coverage by significantly increasing the number of supplies available. However, MSPV 2.0 will either partially or not address several issues that we identified. These include lack of clinician involvement, drop shipment delays, manual formulary management, self-reported

performance metrics, and tracking of historical utilization and coverage data. Table 1 provides an overview of these issues, as well as planned mitigation measures in MSPV 2.0.

Table 1: Examples of Department of Veterans Affairs (VA) Medical-Surgical Prime Vendor-Next Generation (MSPV-NG) Issues and Mitigation Measures Planned in VA's MSPV 2.0 Program

MSPV-NG issue	Extent to which planned MSPV 2.0 program will mitigate MSPV-NG issue	Overview
Backorders: Prime vendors do not have supplies available to fill orders	●	The terms of the September 2019 MSPV 2.0 solicitation would explicitly require prime vendors to keep a 30-day supply of stock for regularly ordered supplies. VA also plans to establish new performance metrics for less-frequently-ordered supplies. These measures are intended to reduce problems with supplies being on backorder.
Limited formulary coverage: VA medical centers must purchase many supplies they need outside of MSPV-NG	●	The Veterans Health Administration (VHA) plans to significantly expand the supplies on the current MSPV-NG formulary to initially include up to 125,000 supplies in MSPV 2.0, with a target of 85 percent coverage, as compared to the target of 40 percent coverage under MSPV-NG. ^a
Lack of clinician involvement: Formulary supplies selected through analysis of spend data	◐	VHA developed its initial list of items for MSPV 2.0 based on historical spend data, which mirrored the MSPV-NG formulary development process and lacked clinician involvement. However, integrated project teams, including clinicians, reviewed this list of supplies at several points in the acquisition process. In the future, VA plans to incorporate more extensive clinician involvement in developing requirements for medical supplies through its Clinician-Driven Strategic Sourcing program, but this is still in the pilot phase and will not affect initial MSPV 2.0 offerings.
Drop shipment delays: Supplies shipped directly from manufacturers often take longer to arrive than items warehoused by prime vendors and are difficult to track	◐	The September 2019 MSPV 2.0 solicitation would generally require prime vendors to place an order with the drop shipment supplier within an hour of order acceptance and provide order confirmation to VA medical centers within an hour of when the order is placed; tracking information will be required on drop ship orders. However, VA has not taken steps to reduce the over 30 percent of formulary supplies designated as drop shipments in MSPV 2.0, and does not specify delivery time requirements for drop shipment supplies in terms of the number of days after receipt of an order.
Manual formulary management: The MSPV program manually updates a series of spreadsheets to manage the formulary, creating risk of administrative errors and requiring more effort on the part of VA medical centers	○	There is no mitigation effort planned in MSPV 2.0.
Self-reported performance metrics: The MSPV program office cannot verify prime vendors' self-reported performance	◐	VHA currently plans to require additional transaction reporting from prime vendors that will allow VA to compile its own data on ordering, shipment, and receipt of orders. According to the MSPV program office, these additional system upgrades will allow VHA to independently verify prime vendors' self-reported performance. However, VA has not defined how it will use these data to conduct program oversight.

MSPV-NG issue	Extent to which planned MSPV 2.0 program will mitigate MSPV-NG issue	Overview
No tracking of historical utilization or coverage: The MSPV program office does not track historical performance metrics and lacks accurate historical data, which limit its ability to provide oversight	○	There is no mitigation effort planned in MSPV 2.0.

Legend: ● Substantially Addressed ● Partially Addressed ○ Not Addressed

Source: GAO analysis of VA MSPV 2.0 solicitation and other documentation, and interviews with MSPV program office officials. | GAO-20-487

Note: “Substantially Addressed”: MSPV 2.0, if implemented as planned, will likely address the issue.

“Partially Addressed”: Some additional actions under MSPV 2.0 are necessary to address the issue.

“Not Addressed”: MSPV 2.0 will not address the issue.

^aCoverage involves calculating the percentage of total supply spending across VHA accounted for by supplies available on the MSPV formulary.

Additional details on each element follow.

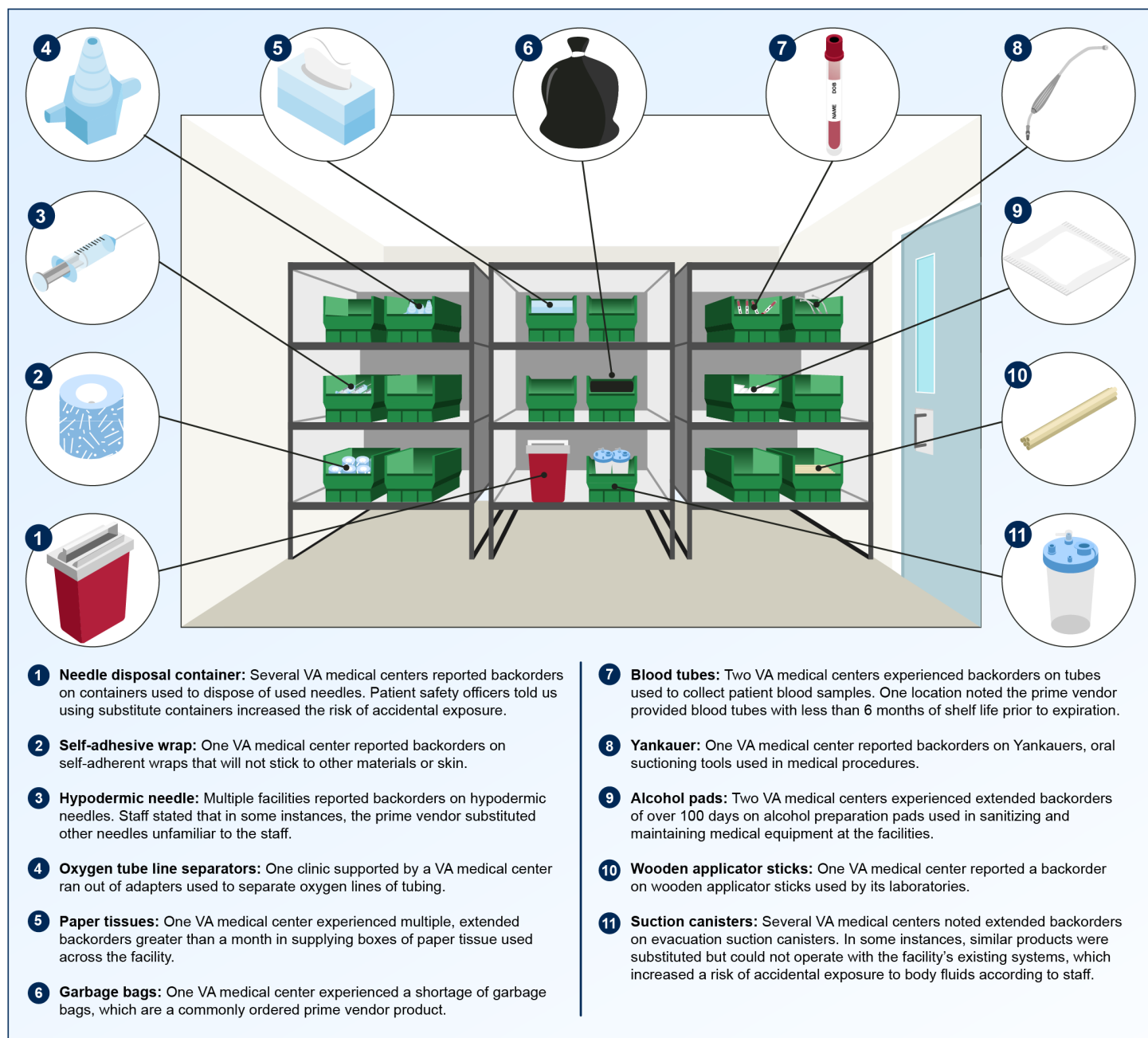
Backorders

According to medical center logistics officials, prime vendors calculated medical center usage in various ways—the MSPV-NG contracts do not expressly describe how contractors are to calculate medical center usage—and some of these approaches contributed to frequent backorders where needed items were out of stock. While backorders were sometimes caused by lack of availability from manufacturers, medical center staff stated that many prime vendor backorders occurred when products were still available elsewhere. Such experiences indicated to the medical center staff that many backorders stemmed from the prime vendors not maintaining sufficient stock, not a shortage in the broader supply chain.

All 12 of the VA medical centers we visited experienced challenges with backorders. For example, inventory managers at one facility estimated that in June 2019, their prime vendor indicated that around 22 percent of supply items they ordered were on backorder. When a prime vendor lacked the available inventory to fulfill an order, some VA medical centers told us they chose to wait for the resolution of the backorder, resulting in delivery delays of several days, weeks, or even months. Other VA medical center staff told us that they pursued alternative sources, such as by using a government purchase card, to meet the facilities’ needs. Several facilities experienced backorders on paper products, for instance, such as toilet paper and tissues. At one medical center, the staff reported

that the prime vendor had recently told them an ongoing backorder of tissues would not be resolved for another month. Further, the staff stated that a previous backorder of tissues had been resolved only a few weeks prior. Figure 5 shows examples of supplies VA medical center staff reported as being on backorder at various times.

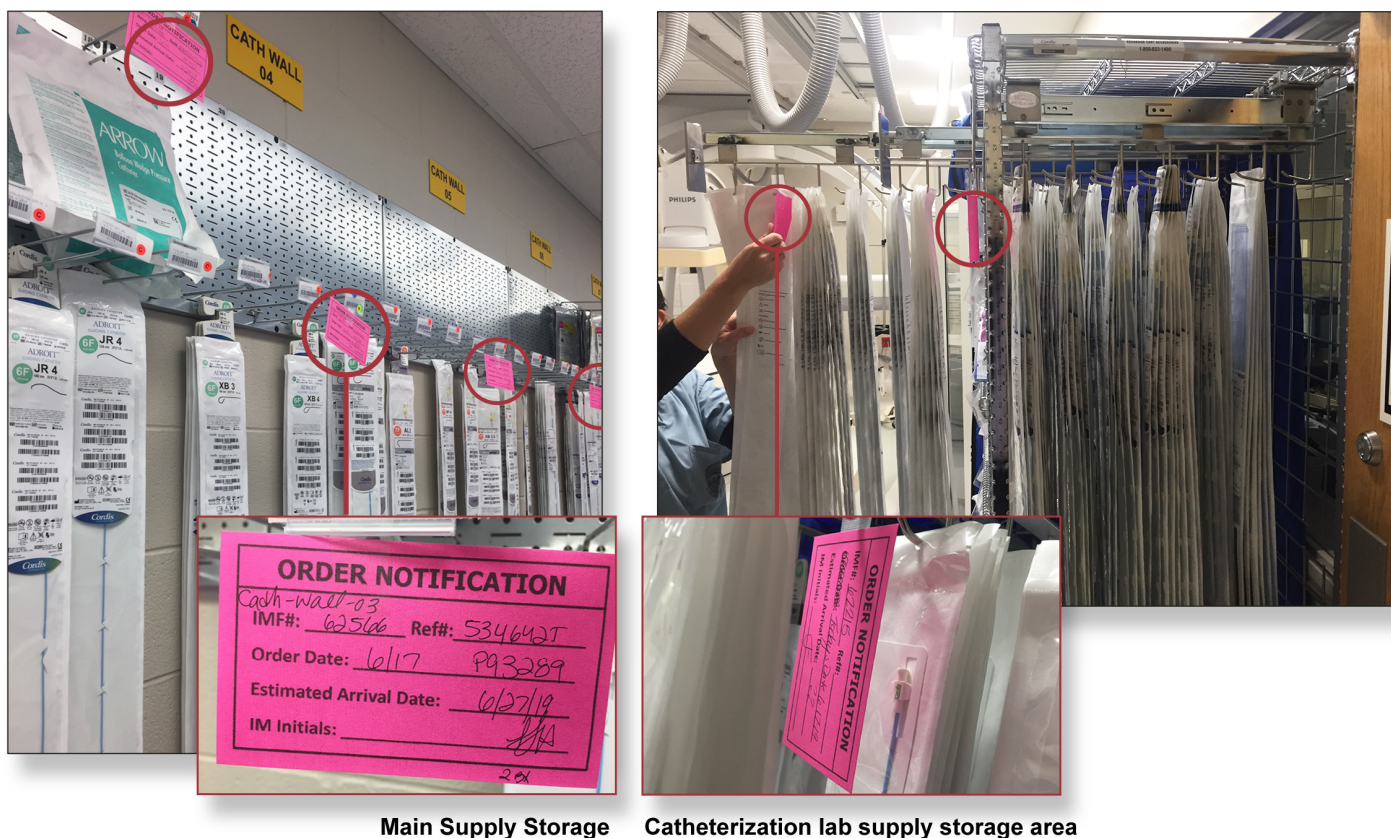
Figure 5: Examples of Supply Items for Which Veterans Affairs Medical Center Staff Reported Backorders



Source: Interviews with Veterans Affairs (VA) medical center staff and GAO analysis of Medical-Surgical Prime Vendor-Next Generation formulary. | GAO-20-487

Backorders also forced workarounds and supply substitutions at some VA medical centers. For example, clinicians at one facility described using workarounds such as bending catheter wires or using multiple smaller stents because the needed sizes were backordered and unavailable. Figure 6 shows examples of backorder notifications for catheters observed in supply storage areas at the Dallas VA Medical Center in June 2019.

Figure 6: Out-of-Stock Notices Observed for Catheters during a Walkthrough of Supply Storage Areas at the Dallas Veterans Affairs Medical Center



Source: GAO. | GAO-20-487

Note: Inventory management specialists identify supply items on backorder with pink notification slips.

MSPV program officials told us that the MSPV-NG contracts do not require prime vendors to maintain specific levels of stock for core supply items and that these contracts provide broad latitude in how the prime vendors are to calculate medical center usage and how they manage their stock. Each prime vendor approached this differently. Some asked for usage data directly from the medical centers every month to calculate how much stock they should keep on hand, while others used data on

prior purchases from internal sales systems to calculate appropriate stock levels to keep on hand for each medical center. As discussed above, these approaches did not ensure that prime vendors had the stock that VA medical centers needed on hand.

VA's September 2019 MSPV 2.0 solicitation requires prime vendors to keep a 30-day supply of regularly ordered core supplies in stock at their distribution centers to minimize backorders. MSPV program office documentation indicates that the terms of the MSPV 2.0 solicitation more clearly define inventory requirements, with the goal of ensuring that prime vendors maintain sufficient stock of core items to meet medical center needs. The solicitation also contains new terms to hold prime vendors accountable for timely delivery of supplies that VA medical centers order less frequently. These changes are intended to reduce problems with backorders.

Limited Formulary Coverage

Because formulary coverage was limited under MSPV-NG, VA plans to increase formulary coverage in MSPV 2.0. We analyzed program data and found that the number of supply items available from MSPV-NG, as a percentage of VA total supply spending for medical-surgical supplies, represented only 47 percent for November 2019 through March 2020. This was above VA's current coverage target of 40 percent, but VA officials stated that private hospital networks typically achieve coverage of around 90 percent for medical and surgical supplies. Logistics and clinical staff at each of the 12 VA medical centers we visited told us that the MSPV-NG formulary lacked some needed supply items—such as certain sizes of catheters, gloves, and gowns—and that some supply items on the formulary were not useful. An on-site representative at a VA medical center stated that there were instances where not all sizes of a given product, such as exam gloves, were available on the formulary. Logistics staff stated that these instances create inefficiencies because they must make two different purchases—one through the prime vendor and a second through another means, such as a purchase directly through the supplier using micro-purchase procedures and a government purchase card—which is a less-preferred method of supply ordering.²³

VA plans to significantly increase the formulary coverage and size in its initial rollout of MSPV 2.0. The MSPV program office's plans envision

²³A micro-purchase is an acquisition of supplies or services using simplified acquisition procedures, the aggregate amount of which does not exceed the micro-purchase threshold. Effective August 31, 2020, the micro-purchase threshold generally is \$10,000.

expanding from the current formulary of about 22,000 supplies in MSPV-NG to up to 125,000 supplies in MSPV 2.0. The program office plans to do this through a combination of items identified through analysis of prior spending, related items proposed by suppliers, and additional items identified by clinicians.²⁴ According to program officials, this expansion of the formulary should meet a wider range of clinician needs. VA aims to cover 85 percent of VHA's medical and surgical supply spend in MSPV 2.0.

Lack of Clinician Involvement

VA involved clinicians in vetting supplies for MSPV 2.0 but still relied on historical spend data in selecting initial formulary supplies. We reported in November 2017 that clinician input in the MSPV-NG formulary was limited and rushed, and we recommended that VA use input from national clinical program offices to prioritize developing its MSPV requirements to focus on supply categories that offer the best opportunity for standardization and cost avoidance.²⁵ However, MSPV 2.0 will only partially address this issue.

VA's February 2019 *MSPV 2.0 Program Acquisition Strategy* stated that VHA would develop the formulary by first reviewing MSPV-NG spend data. After VHA created this initial list, Integrated Product Teams—groups of clinicians, logistics staff, and contracting staff—validated the supplies on the formulary and determined whether to add or remove supplies from the list. These teams also determined appropriate placement of the supplies in categories for the solicitations, and they are reviewing vendor responses for technical acceptability. VA officials stated that about 130 clinicians are currently involved in this effort. While this is an improvement, VA is not in line with the practices we reported leading private hospital networks use to develop their medical supply formularies; these hospitals use clinician-driven sourcing to standardize their medical supply chains.²⁶

While the effort to include additional clinicians in developing MSPV 2.0 is an improvement over MSPV-NG, VA plans to implement more robust clinician involvement in the future through its Clinician-Driven Strategic Sourcing (CDSS) initiative. After MSPV 2.0 is implemented, VA plans to

²⁴These officials stated the formulary will likely decrease in size as the Clinician-Driven Strategic Sourcing initiative is used to review and standardize various categories of supplies over the next few years.

²⁵VA has not yet fully implemented this recommendation. See [GAO-18-34](#).

²⁶See [GAO-18-34](#).

refine the formulary through CDSS. In this initiative, clinicians join small working groups to conduct analyses of supply categories, develop clinical requirements, review each potential supply item's quality and cost, further refine needs, and develop an acquisition strategy. VA is piloting the CDSS process on three supply categories through the end of fiscal year 2020, and VHA Procurement and Logistics officials stated that they view the initial stages of the pilot as successful. According to these officials, they plan to expand CDSS across all supply categories to improve clinician satisfaction and patient outcomes, reduce supply variability, and increase cost avoidance. CDSS will take time to fully implement, but if implemented as intended, CDSS should help support VA's goal of supply standardization. However, because VA is still piloting the initiative, CDSS will not have any input on the items offered in the initial MSPV 2.0 formulary. Further, according to VHA officials responsible for implementing CDSS, it will take years to implement the initiative, limiting the extent of clinician involvement in the MSPV 2.0 formulary in the near term.

Drop Shipment Delays

According to MSPV program officials, about a third (about 7,000 of 22,000) of supplies on the MSPV-NG formulary as of September 2019 were designated for drop shipment. Drop-shipped supplies are shipped directly to VA medical centers from the supply item's manufacturer, not from the prime vendor's local warehouse. As a point of comparison, DLA officials told us that about 10 percent (20,550 of 202,474) of the supplies on their formulary are drop-shipped. According to MSPV program officials, drop-shipped supplies are often specialty clinical items such as catheters or surgical implants. Representatives of two prime vendors stated that some supplies cannot be stored in prime vendor distribution centers due to concerns over safety recalls and spoilage. For example, some products may require specific temperature-controlled storage conditions. Additionally, representatives of one prime vendor stated that some of the companies offering drop shipments lack experience in working through a third-party distributor and are not set up to receive orders, provide invoicing, and ship supplies to multiple parties. The MSPV program officials stated that they added these drop shipment items to the formulary to make it easier for medical centers to order them.

MSPV-NG did not fully achieve its primary purpose—the on-demand delivery of medical-surgical supply items to VA medical centers—due in part to the increased delivery time of drop-shipped supplies. Drop shipments increased delivery time in many cases because the prime vendor had to send the VA medical center's order to the manufacturer, and, according to program officials, the manufacturer's delivery terms

(such as standard or overnight delivery) for drop shipments were not specified in the prime vendor contracts or supplier agreements. Logistics staff at all 12 VA medical centers we visited told us they regularly purchased drop-shipped supplies from the MSPV-NG formulary and identified drop shipments as a top challenge in using this program.

Supplies delivered to VA medical centers via drop shipment were also more difficult to track in MSPV-NG. Unlike purchases made through other sources, drop-shipped supply items lacked easily accessible shipment tracking information because, according to VA officials, the manufacturers were not required to provide it to the prime vendor or the VA medical center that placed the order. VA medical center logistics staff reported that in some critical cases, they had to call drop ship suppliers directly and request shipping information for their orders placed through MSPV-NG to ensure their supplies arrived in time for a scheduled patient procedure. Further, VA medical center staff told us that unlike orders delivered by the prime vendor, drop-shipped supplies often arrived in packages that did not include the VA purchase number on their labels. This increased the time and effort required for VA medical center staff to process the shipment.

One of VA's program goals for MSPV 2.0 is to provide VA medical centers with efficient, just-in-time ordering and delivery of medical and surgical supplies, and VA designed MSPV 2.0 to mitigate some, but not all, of the causes of MSPV-NG drop shipment delivery delays. Specifically, the MSPV 2.0 solicitation includes terms that will generally require prime vendors to place orders with the drop shipment supplier within one hour of accepting an order from the VA customer and require that drop shipment suppliers provide tracking information on drop-shipped supplies, including item and order numbers on shipping labels. However, we found that VA has not taken steps in MSPV 2.0 to reduce the number of formulary supplies designated as drop shipments. Further, the September 2019 MSPV 2.0 solicitation does not specify delivery time requirements for drop shipment supplies after receipt of an order. Examining opportunities to reduce the portion of supplies on the formulary that are drop-shipped and establishing required delivery time frames for drop shipment items would help reduce delivery delays and would make VA medical center staff less likely to purchase using less-preferred methods outside the MSPV 2.0 program.

Manual Formulary Management

Under MSPV-NG, the MSPV program office manages the formulary manually, which has resulted in ordering errors and lags that cause delivery delays at VA medical centers. The MSPV program office is

responsible for creating, updating, and maintaining the formulary. The formulary consists of a series of spreadsheets that contain all 22,000 available supplies for each prime vendor. Every month, responsible MSPV program office staff members review multiple data sources, including information from SAC's contract files and prime vendors' distribution agreements and manually make any changes—such as price, supplier, unit of measure, or other details—in the spreadsheets. However, the spreadsheets lack a structured data format to capture and document changes made to the formulary supplies. This manual process is vulnerable to administrative errors, such as supply items inadvertently omitted or incorrect prices.

Ordering errors stemming from the program office's manual management of the formulary—combined with updates occurring only once per month—pose challenges for the VA medical centers. Staff at all 12 of the facilities we visited described supply items falling off the formulary only to return a month or two later, which they concluded happened inadvertently. Many VA medical center logistics officials told us that they found the real-time, web-based supply catalog information that was previously available under legacy MSPV (the program that preceded MSPV-NG) to be more useful. The manual process VA currently uses to maintain the formulary does not allow real-time updates.

Under MSPV-NG, VA medical center logistics staff must review the formulary spreadsheets each month once they are posted to a website by the MSPV program office to identify any changes and manually update pricing information within the medical center's inventory system. Since SAC and the MSPV program office update and disseminate the MSPV-NG formulary only once a month, representatives of two prime vendors told us that price adjustments are sometimes incorporated into their inventory database before the medical center updates its information, and any orders where the price does not match are rejected. For instance, the prime vendor will reject an order if the price the medical center lists for an item is off by just one cent. According to VA medical center logistics officials, this led to cases where prime vendors rejected an order three or four times before all mismatched information was identified. These officials said that the additional administrative burden caused by reworking orders often resulted in delays of needed supply items at VA medical centers.

VA has begun an initiative that may eventually provide more automation to the distribution of formulary updates. Specifically, in September 2018, VA began developing a tool it calls the Supply Chain Master Catalog,

which is intended to collect information on all available sources of supplies, including MSPV, in one place. However, full implementation of this tool remains several years away. Further, VA's antiquated inventory management system poses an obstacle to automatically providing updates directly to VA medical centers.²⁷

VA currently has no plans to use automatic formulary management in MSPV 2.0, as MSPV program officials consider the current system to be functional and note that the planned Supply Chain Master Catalog will provide some of this capability in the future. According to management representatives of two of the prime vendors, many private hospital networks and other federal agencies such as the Department of Defense have the ability to automatically transmit near real-time price changes directly to both the prime vendors and the facilities. Further, the *Standards for Internal Control in the Federal Government* state that management should design an entity's information system to achieve objectives and respond to risks and that information technology should make information related to operational processes available to the entity on a timely basis.²⁸ If formulary management continues to be a manual monthly process, VA risks continued ordering errors and delivery delays that make the program more difficult for its medical center staff to use. These errors and delays may lead VA medical centers to obtain some supplies from other sources, which defeats the purpose of having the MSPV program serve as VA's preferred supply source.

Self-Reported Performance Metrics

We found that VA did not collect transaction-level performance metric data in MSPV-NG that would allow it to verify the accuracy of the performance metric data and better oversee its prime vendors. The MSPV-NG contracts generally require prime vendors to deliver regularly used items in medical centers' orders at least 95 percent of the time. The prime vendors self-report their performance to VA monthly. However, the MSPV-NG contracts do not require the prime vendors to transmit transaction-level detail that would allow the MSPV program office to independently calculate the unadjusted order completion rate in a systematic or automated manner. According to representatives of the four

²⁷GAO, *VA Acquisition Management: Supply Chain Management and COVID-19 Response*, [GAO-20-638T](#) (Washington, D.C.: June 9, 2020).

²⁸See [GAO-14-704G](#).

prime vendors, they generally report meeting this metric. However, these reports are not always reliable.

In December 2019, the VA Office of Inspector General released an audit report on one prime vendor that found its actual order completion rate was well below what the vendor reported to VA.²⁹ The Inspector General also reviewed all 41 orders placed in June through August 2017 at the Washington, D.C. VA medical center and found that only six were correctly filled, even though the prime vendor reported that all 41 orders were filled. The Inspector General further noted continual challenges with this prime vendor, and identified risks such as lack of product availability, incorrect quantities delivered, and duplicate orders, which we also found during our site visits to three facilities served by this prime vendor. VA took some steps to address issues with this prime vendor, such as issuing cure notices—letters that identify performance problems that must be remedied. VA stated that it terminated this contract for cause on August 1, 2020. According to senior VA officials, medical centers previously served by this prime vendor are now meeting supply needs via the remaining three prime vendors.

Further, in cases where VA medical center staff knew a supply item was on backorder, these staff told us that they avoided ordering that item from the prime vendor; as a result, order completion rates may overstate prime vendor performance. In some cases, VA medical center staff asked the prime vendors' on-site representatives to determine whether stock was available before submitting an order. This approach reduced rework of orders in cases when items were unavailable and allowed medical centers to obtain these items more quickly by purchasing from another source that did have them in stock. However, this type of order avoidance artificially increased the prime vendor's reported order completion rate because orders that prime vendors could not fill were never placed. The order completion rate includes only supply items requested through a submitted order, so the order completion rates were likely higher than they would otherwise be and did not reflect the challenges VA medical centers experienced with persistent backorders of some items.

Under MSPV 2.0, VA plans to collect and validate prime vendor performance data. Specifically, VA plans to require prime vendors to

²⁹Department of Veterans Affairs, Office of Inspector General, *Inadequate Oversight of the Medical/Surgical Prime Vendor Program's Order Fulfillment and Performance Reporting for Eastern Area Medical Centers*, Report #17-03718-240 (Washington, D.C.: Dec. 17, 2019).

electronically submit transaction-level data on each order placed by VA medical centers and data on orders they fill. According to MSPV program officials, this will allow VA to independently compile data on orders and independently calculate prime vendor order completion rates and other metrics—such as the prevalence of backorders—to validate prime vendor-reported metrics. As we reported in March 2019, proper monitoring of contract performance has been an issue VA-wide.³⁰ MSPV program officials stated that the changes they are implementing in prime vendor data reporting in MSPV 2.0 are intended to enable increased accountability and transparency.

However, VA has not defined how and whether it will use this data to conduct program oversight. Specifically, the raw transaction data the MSPV program office collects on prime vendor order completion cannot be used directly to validate the prime vendors' self-reported data. The program office would need to calculate its own metrics on an ongoing basis and coordinate with contracting staff at SAC to conduct regular follow-up with the prime vendors on any differences or performance issues identified. However, according to program officials, they have yet to outline a process for using this transaction-level data to validate prime vendor performance under MSPV 2.0. The *Standards for Internal Control in the Federal Government* state that management should use quality information it collects to make informed decisions and evaluate the entity's performance in achieving key objectives and addressing risks.³¹ Without processes to use order completion data to assess prime vendor contract performance, the MSPV program office will be unable to use this information to ensure prime vendors are meeting the MSPV 2.0 contract terms and to inform actions needed, if any, to improve prime vendor performance.

No Tracking of Historical Utilization or Coverage

The MSPV program office does not capture accurate historical information on formulary coverage and utilization in MSPV-NG nor are its calculations of prior months' results reliable. These shortfalls are due to flaws in the program's methodology for calculating historical metrics. MSPV program officials stated that they focus on the current month's metrics over historical trends and benchmarks because they were concerned that a focus on historical trends might create an adversarial relationship with the prime vendors.

³⁰See [GAO-19-157SP](#).

³¹See [GAO-14-704G](#).

We found that the data that the MSPV program office collects on utilization and coverage are calculated using a methodology that distorts previous months' performance. Specifically, our analysis of utilization and coverage data for MPSV-NG found that the method used to calculate past months' data for both metrics was wholly dependent upon the current month's formulary—reflective of the program office's focus on current data, as opposed to comparisons to past months. As the program office increased the number of supplies on the formulary, it continued to analyze the prior months' purchases through the lens of the current formulary. This made the past coverage look higher than it was at the time because it included items that were not on the formulary at the time of purchase. If the program office were to use these data to compare their current coverage rate to prior months, the flawed historical metrics might overstate their performance over time. While this methodology might lead the MSPV program office to overstate performance in meeting the coverage metric, it conversely generates data that understate VA medical centers' performance on utilization over time. Specifically, this methodological flaw made prior utilization look smaller than it actually was at the time. For instance, using its approach to calculating utilization, if the program office were to compare a medical center's current utilization to prior months, the historical utilization metrics might cause utilization to appear lower in the prior months than it actually was.

Because the MSPV-NG program office does not assess trends in utilization and coverage over time and lacks accurate data if it were to do so, its visibility into how well the MSPV-NG program meets VA medical center needs is limited and will continue to be limited in MSPV 2.0. MSPV program officials told us that they do not plan to capture historical information on formulary coverage and utilization in MSPV 2.0. As a result, the program will not have the ability to routinely review accurate historical data using its current methodology for calculating historical metrics. If VA, for example, archived monthly formulary snapshots, it could correctly analyze past coverage and utilization rates by comparing the metrics against the formulary in place at the time the metrics are collected. The *Standards for Internal Control in the Federal Government* state that management should obtain relevant, timely data from reliable sources that are both accurate and used for effective monitoring.³² Monitoring those trends—and having accurate historical and order

³²See [GAO-14-704G](#).

completion rate data to rely upon—would allow the program office to identify program issues and, if needed, areas for improvement.

Launch of MSPV 2.0 Program Is Delayed

Issues with VA's Acquisition Approach Delayed MSPV 2.0 Launch

VA intended to begin the MSPV 2.0 program in April 2020 to ensure uninterrupted service to VA medical centers when the MSPV-NG contracts ended in March 2020. However, the MSPV 2.0 prime vendor solicitation was subject to multiple protests. In response, VA twice revised the solicitation, resulting in program implementation delays of at least 9 months.

VA initially issued the MSPV 2.0 prime vendor solicitation in June 2019, with certain portions set aside for SD/VOSBs under a tiered evaluation approach. Three firms challenged VA's set-aside decision in bid protests filed with GAO.³³ The protests were dismissed after VA elected to take corrective action that would include reassessing its requirements and market research. In September 2019, VA released a new prime vendor solicitation which did not restrict bidding to SD/VOSB firms. In a subsequent protest with GAO, an SDVOSB challenged VA's decision to not set aside any portion of the solicitation for small businesses. GAO sustained the protest based on the finding that VA's set-aside decision was unreasonable and inadequately documented.³⁴ Subsequently, VA issued an amendment to the solicitation in February 2020 that reintroduced set-asides for SD/VOSBs. VHA Procurement and Logistics officials told us in June 2020 that they anticipate launching the MSPV 2.0 program in January 2021.

VA Is Using Bridge Contracts for MSPV-NG to Provide Uninterrupted Service to VA Medical Centers

Because the MSPV-NG contracts ended in March 2020, VA is continuing to provide medical and surgical supply services to VA medical centers through the award of noncompetitive MSPV-NG bridge contracts to the four prime vendors. VA awarded these contracts in April 2020. Unlike the predecessor MSPV-NG contracts, under the bridge contracts, the prime vendors generally no longer serve as both the distributors and suppliers of items on the formulary; rather, the prime vendors generally only serve

³³See *Am. Med. Depot*, B-417745.2, Aug. 7, 2019 (unpublished decision); *Veterans First Healthcare LLC*, B-417745.2, Aug. 7, 2019 (unpublished decision). A third protest was closed without action after it was withdrawn by the protester.

³⁴*Academy Med. LLC*, B-418223, B-418223.2, Jan. 31, 2020, 2020 CPD ¶ 44.

as distributors. Therefore, in conjunction with these contract awards, VA also established new agreements with the suppliers of the medical items, which led to changes in some pricing and part numbers, according to VA medical center staff.

The number of supplies on the formulary under the bridge contracts remained about the same, at around 21,000, but the transition required additional work by VA medical center staff. Officials we interviewed at VA medical centers stated they had to manually review and, in many cases, update pricing and other details for each supply item in their local inventory system, which required extra staff time. Further, VA medical center staff told us the MSPV program office released the formulary one week before the bridge contracts went into effect, and logistics officials at each VA medical center had to make these changes quickly. SAC officials estimated each VA medical center had about 200 to 800 core supplies to update in preparation for the bridge contracts. Further, VA logistics staff at each VA medical center participating in MSPV 2.0 will likely have to repeat this effort when MSPV 2.0 goes into effect, posing an additional burden on VA medical center staff beyond the single transition that would have been necessary if MSPV 2.0 had been rolled out on time. Additionally, the delay in MSPV 2.0—and the use of an MSPV-NG bridge in the interim—means VA medical centers must work with the issues of the MSPV-NG program for longer than anticipated.

VA MSPV Program Office Lacks Consistent Leadership

Leadership instability has posed challenges for VA's transition to MSPV 2.0. We previously reported that leadership instability and workforce challenges made it difficult for VA to execute its transition to the MSPV-NG program. Specifically, in November 2017, we reported that the MSPV program office had repeated leadership vacancies while implementing MSPV-NG and recommended VA prioritize hiring a permanent MSPV program director.³⁵ Six months later, VHA filled this position and we closed the recommendation, but VA officials reported that the position again became vacant in June 2019. VHA officials told us that they temporarily filled this position with an acting official in July 2019; however, the vacancy caused other VHA leaders to assume additional responsibilities to fill this gap, while maintaining their other primary roles and responsibilities. Further, VHA Procurement and Logistics Office officials reported in June 2020 that this position will not be filled permanently for several months. As we reported when adding VA

³⁵[GAO-18-34](#).

VA's Implementation of Its DLA MSPV Pilot Is Delayed and Not in Line with Leading Practices for Pilot Programs

Acquisition Management to GAO's High Risk List in 2019, consistent leadership is necessary to ensure that major programs like MSPV 2.0 have the resources and support they need to execute their missions.³⁶ We will continue to monitor key leadership vacancies as part of the VA Acquisition Management area of GAO's High Risk List.

The implementation of DLA's MSPV program at three VA medical center pilot sites is delayed, and VA has not taken steps to ensure that the pilot is executed in line with leading practices for pilot programs. Through the pilot, these VA medical centers will use DLA's MSPV program formulary in lieu of VA's MSPV 2.0 program.³⁷ To implement the pilot, VA must use DLA's software when placing orders. DLA's Defense Medical Logistics Standard Support (DMLSS) system serves as its primary MSPV ordering system and supports inventory management activities, among other things.³⁸ DLA also has another system available to place orders through its MSPV program—a portal within the DLA's Electronic Catalog (ECAT)—but according to DLA officials, this system provides less capability than DMLSS in areas such as providing real-time data to analyze order history and identifying recommendations for future purchases.³⁹

VA's original plan was to implement the first phase of the pilot at the North Chicago joint medical center using ECAT in March 2019—with a

³⁶[GAO-19-157SP](#).

³⁷DLA officials refer to their list of MSPV medical and surgical supplies as a catalog. However, throughout this report, we will refer to the list as the formulary.

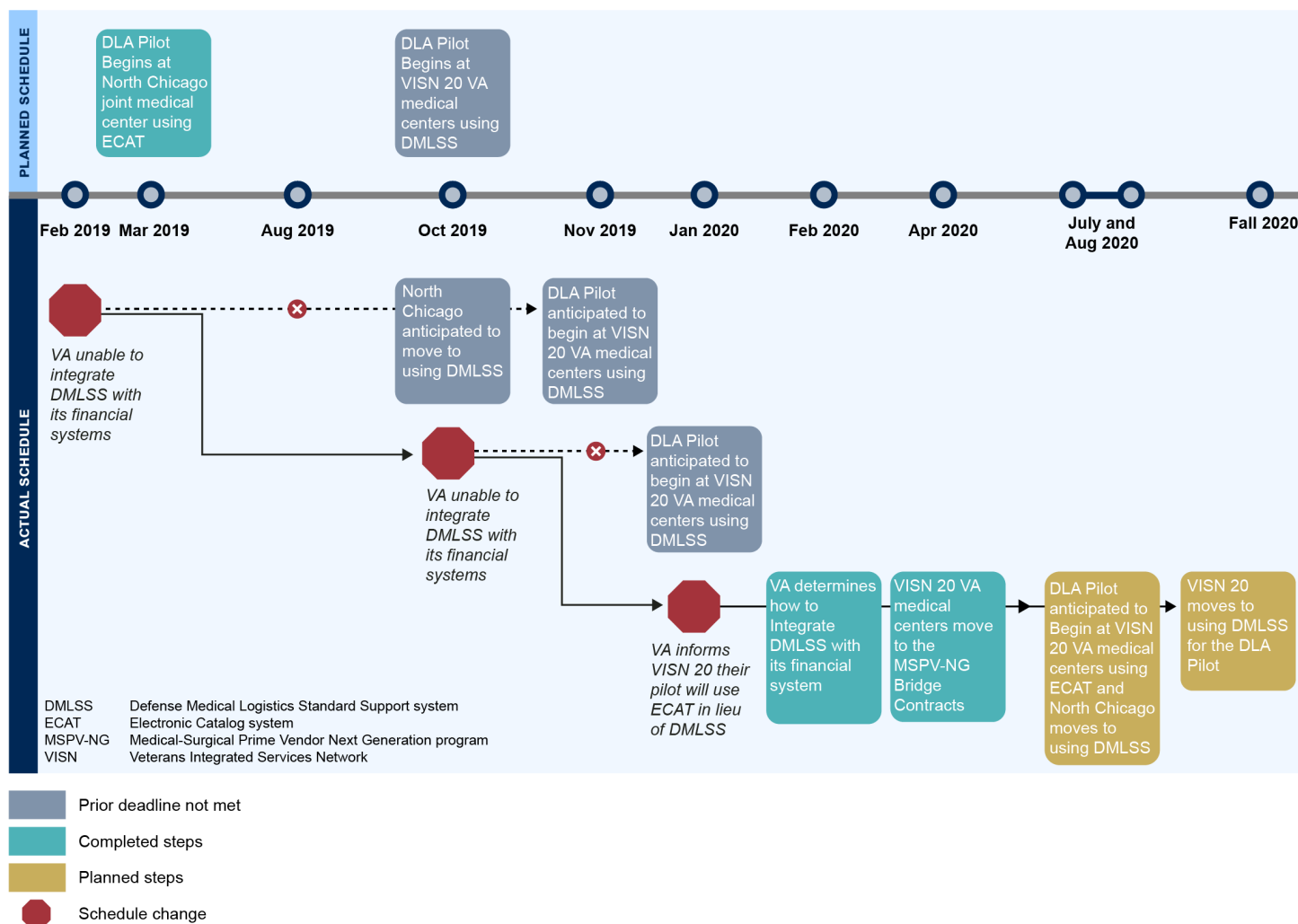
³⁸DMLSS provides other types of capabilities as well, such as facility management. VA is in the process of transitioning to using DMLSS for its medical and surgical supply chain management. In the future, VA will be moving to using LogiCole, a system that provides similar functions to DMLSS, but on a more modern technology platform with some additional features. DLA began its initial rollout of LogiCole to select Department of Defense medical centers in early 2018. By early 2023, LogiCole will completely replace DMLSS. VA plans to begin implementing LogiCole starting in 2023, with implementation wrapping up across all Veterans Integrated Service Networks in 2027. See GAO, *VA Acquisition Management: Supply Chain Management and COVID-19 Response*, [GAO-20-638T](#) (Washington, D.C.: June 9, 2020). In September 2020, VA stated that it plans to expedite this implementation process.

³⁹ECAT is typically used (by both Department of Defense and VA customers) to access ECAT's own catalog of medical equipment and supplies. This is separate from the DLA MSPV catalog; for the pilot, DLA is providing select VA medical centers access to the DLA MSPV catalog through a separate function within the ECAT platform called Prime Vendor Web Ordering.

transition to DMLSS then scheduled to occur in October 2019—but VHA Procurement and Logistics officials confirmed these plans were delayed. VA officials also stated in March 2019 that they planned to enter the pilot’s second phase at two VA medical centers in Veterans Integrated Service Network 20—Spokane and Puget Sound—in October 2019 using DMLSS.⁴⁰ However, VA’s plans for this pilot phase have shifted over time, as illustrated by Figure 7.

⁴⁰Veterans Integrated Service Networks are VHA organizations that manage VA medical centers and associated clinics across a given geographic area. VHA currently has 18 Veterans Integrated Service Networks across the nation.

Figure 7: Department of Veterans Affairs (VA) Defense Logistics Agency (DLA) Pilot Planned and Actual Implementation Timelines



Source: GAO analysis of discussions with VA, DLA, and VA medical center staff. | GAO 20-487

Note: In Veterans Integrated Service Network 20, the two VA medical centers participating in the pilot effort are Spokane and Puget Sound.

VA did not transition to the DMLSS system at the North Chicago joint medical center as planned in October 2019 due to technical integration issues. This joint medical center has continued to order medical supplies from DLA’s MSPV program via ECAT and VA officials stated the center is now planning to transition to DMLSS in August 2020—almost a year later than anticipated. Similarly, VHA Procurement and Logistics officials

stated that they delayed the DLA MSPV pilot at the Puget Sound and Spokane VA medical centers from October 2019 to July and August 2020, respectively. These delays occurred because, according to VHA Procurement and Logistics officials, the initial schedule did not fully consider the time and steps required to integrate DMLSS with VA's existing financial system and address technical implementation issues.⁴¹ Further, VHA's Modernization Plan update, dated February 2020, identified its DMLSS deployment as at critical risk of not meeting system modernization milestones. We have previously reported that schedule slippage in federal information technology investments can stem from not following leading practices in project planning, requirements definition, and program oversight and governance.⁴² The problems VA has encountered in its implementation of DMLSS demonstrate the importance of these leading practices in planning and oversight.

VHA Procurement and Logistics officials stated that VA's transition to DLA's MSPV at the Puget Sound and Spokane medical centers is now anticipated to begin with ECAT in July and August 2020 and transition to DMLSS sometime in the fall of 2020. The ECAT portal cannot perform the same data analysis functions as DMLSS, such as providing spending and usage data to VA medical centers, according to DLA officials and our review of screenshots from the system. VA medical center logistics officials stated that using the ECAT portal to place orders is inefficient and more prone to entry errors, as users must manually document every order in both DLA's system and in VA's financial system. As a result, using the ECAT portal for this initial stage of the pilot at Spokane and Puget Sound will not be entirely representative of outcomes using DLA's MSPV program with DMLSS. The temporary use of ECAT will make it more difficult for VA to accurately assess the results.

VA plans to use the results of the DLA MSPV pilot effort to determine whether the program should be rolled out to all of its VA medical centers. However, while VA continues to move forward with its pilot, it has not developed a comprehensive methodology for evaluating success to

⁴¹VA uses the Veterans Health Information Systems and Technology Architecture system to manage its healthcare information. A program within that system—called the Integrated Funds Distribution Control Point Activity, Accounting and Procurement (IFCAP) platform—passes orders to VA's Financial Management System to be processed. The technology integration issue VA is experiencing with the DLA MSPV pilot is related to the financial reconciliation of received orders.

⁴²GAO, *High-Risk Series: Progress on Many High-Risk Areas, While Substantial Efforts Needed on Others*, [GAO-17-317](#) (Washington, D.C.: Feb. 15, 2017).

determine whether VA should make the transition to DLA's MSPV program in lieu of its own MSPV 2.0 program. VA's February 2019 *MSPV 2.0 Program Acquisition Strategy* states that VA sees the potential for increased efficiencies through the use of DLA's expansive formulary and that VHA will decide by 2025 whether DLA's MSPV program will replace MSPV 2.0. Senior VHA Procurement and Logistics Office officials we spoke with in June 2020 also stated that VA is strongly considering a full transition to DLA's MSPV program in the future. VA acquisition leadership has recognized the shortcomings in its medical supply chain management and has identified supply chain modernization—of which the DLA MSPV pilot is a part—as a priority.⁴³

Leading practices GAO identified for pilot programs state that agencies must clearly articulate an assessment methodology and data gathering strategy that address all components of a pilot program.⁴⁴ Key features of a clearly articulated methodology include a strategy for comparing the pilot implementation and results with other efforts, a plan that clearly details the type and source of the data necessary to evaluate the pilot, and methods for data collection, including the timing and frequency. Further, *Standards for Internal Control in the Federal Government* state that in any program, agencies must clearly define what is to be achieved, who is to achieve it, how it will be achieved, and the time frames for achievement.⁴⁵ The standards further state that agencies must define their objectives in measurable terms so that performance toward achieving those objectives can be assessed.⁴⁶

In March 2020, the MSPV program office identified preliminary metrics to evaluate pilot success, such as cost avoidance, micro-purchase spending using government purchase cards, and VA customer satisfaction. However, program officials characterized these metrics as tentative. We found that VA has not established thresholds for these metrics that would indicate pilot success and has not determined how to best measure and interpret them. For instance, VHA Procurement and Logistics Office officials told us that they collect data on cost avoidance from the North Chicago joint medical center, but VA has not established a level of cost

⁴³[GAO-20-638T](#).

⁴⁴GAO, *Data Act: Section 5 Pilot Design Issues Need to Be Addressed to Meet Goal of Reducing Recipient Reporting Burden*, [GAO-16-438](#) (Washington, D.C.: Apr. 19, 2016).

⁴⁵[GAO-14-704G](#).

⁴⁶*Ibid.*

avoidance that would provide the justification for transitioning away from its own planned MSPV 2.0 program. DLA officials confirmed that VA is solely responsible for evaluating the success of the DLA MSPV pilot. DLA is not collecting any metrics at this time.

In addition, several of the MSPV-NG program challenges that we identified—such as limited formulary coverage, out-of-stock items, and drop shipment delays—are not included in VA’s current evaluation of the pilot. In order to determine whether DLA’s program is more effective than VA’s MSPV 2.0 program, it is important that VA consider all facets of the medical and surgical supply purchasing process. Ensuring that pilot metrics reflect comprehensive outcomes and setting specific goals for those metrics would allow more effective comparisons between DLA’s MSPV and VA’s MSPV 2.0 programs.

Further, VA has not established criteria to determine whether the results of the DLA MSPV pilot can be scalable to other VA medical centers. Leading practices state that to assess scalability, pilot criteria should relate to the similarity or comparability of the pilot to the range of circumstances expected in full implementation.⁴⁷ VHA Procurement and Logistics officials stated that the North Chicago medical center’s unique joint VA–Department of Defense function made it easier to start the pilot at this site because it had an existing relationship with DLA. However, this relationship makes direct VA-to-DLA MSPV program comparisons more difficult to use in predicting pilot success for other VA medical centers that are not joint facilities.

Finally, VA has not ensured effective stakeholder communication and input into the DLA MSPV pilot. Leading practices for pilot programs state that it is critical that agencies identify who the relevant stakeholders are and communicate early and often to address their concerns and convey the pilot’s overarching benefits.⁴⁸ In our discussions with key VA stakeholders—such as officials from the Office of Acquisition, Logistics, and Construction; Office of Small & Disadvantaged Business Utilization (OSDBU); VA medical center logistics staff; and VA’s general counsel—some stated that they have unanswered questions about the viability of using DLA’s MSPV program. Some of these officials told us they view the MSPV 2.0 program as a more promising approach, and some cited concerns about the feasibility of expanding the pilot of DLA MSPV more

⁴⁷[GAO-16-438](#).

⁴⁸[GAO-16-438](#).

broadly across VA, particularly because of VA's Veterans First requirements. For instance, OSDDBU officials stated that VA has yet to address policy questions regarding how the Veterans First requirements will be implemented under the pilot, such as how VA medical center logistics officials will make purchasing decisions when viewing the list of suppliers on DLA's formulary. Additionally, representatives of the National Veteran Small Business Coalition stated that VA had yet to discuss with SD/VOSBs how logistics officials will apply Veterans First requirements under the pilot, nor explained VA's vision for the relationship between MSPV 2.0 and the DLA MSPV pilot in the long term. Engaging with all relevant stakeholders to understand their views and any concerns would better enable VA to make an informed decision on whether to switch to DLA MSPV VHA-wide—the goal of the pilot program.

In September 2020, after we sent a draft of this report to VA for comment, senior VA officials said they had decided to move ahead with implementing DLA MSPV VHA-wide—a decision they were originally planning to make by 2025. Officials said that they will continue to implement MSPV 2.0 in the interim, as it will take some time to implement DLA MSPV across VHA, but they ultimately plan to move to DLA MSPV in place of MSPV 2.0, and this effort is no longer a pilot. However, this planned approach makes assessing the outcomes of the implementation at the initial sites all the more important, to help VA understand what potential challenges it may face as it rolls out DLA MSPV more broadly. Likewise, effective engagement with all relevant stakeholders is also crucial to ensuring effective implementation.

SD/VOSB Supplier Participation and Sales Increased During MSPV-NG, but the Extent of Future Participation Opportunities in MSPV 2.0 and the DLA MSPV Pilot Is Unknown

While VA has yet to elicit adequate stakeholder input into the DLA MSPV pilot, it has taken some steps to promote SD/VOSB participation in the pilot. Meanwhile, SD/VOSBs have experienced increased participation and sales during the current MSPV-NG, but their prospects are unclear for the future MSPV 2.0.

In April and May 2018, to facilitate an increase in supplies on the formulary, SAC modified its MSPV-NG prime vendor contracts to require these vendors to act as both suppliers and distributors, subcontracting

directly with suppliers for the items in the formulary.⁴⁹ As part of this effort, SAC directed each prime vendor to develop a subcontracting plan to outline their efforts to source medical and surgical supplies from SD/VOSB suppliers. In their subcontracting plans, the four prime vendors included goals for subcontracting with SD/VOSBs of up to 12.5 percent of supplies.⁵⁰ In May 2019, after completing the formulary expansion, each of the prime vendors reported to SAC that they met or nearly met their goals. Table 2 lists the number and the percentage of supplies on the prime vendors' formularies sourced from SD/VOSBs compared to each prime vendor's SD/VOSB subcontracting goal.

Table 2: Supplies Sourced from Service-Disabled and Veteran-Owned Small Businesses (SD/VOSB) in the Medical-Surgical Prime Vendor-Next Generation Program by Prime Vendor, as of May 2019

Prime vendor	Number of supplies on formulary sourced from SD/VOSBs	Total number of supplies added to formulary during formulary expansion	Percentage of supplies available from SD/VOSBs	Prime vendor VOSB subcontracting goal (%) ^a
American Medical Depot ^b	1,762	14,729	12.0	12.0
Cardinal Health	2,537	14,687	17.3	12.0
Kreiser's ^c	1,829	15,429	11.9	12.0
Medline Industries	1,938	15,078	12.9	12.5

Source: GAO analysis of Department of Veterans Affairs data self-reported by prime vendors. | GAO-20-487

^aThe prime vendors' subcontracting plans included goals for veteran-owned small businesses (VOSB) as well as goals for service-disabled veteran-owned small businesses (SDVOSB). Since SDVOSBs are a subset of VOSBs, this table provides the prime vendor goals for VOSBs and information for formulary supplies sourced from SDVOSBs and VOSBs combined. The underlying data shows that nearly all supplies were sourced from SDVOSBs.

^bVA stated that it terminated American Medical Depot's contract for cause on August 1, 2020.

^cKreislers took part in a merger in April 2016 and is now part of Concordance Healthcare Solutions.

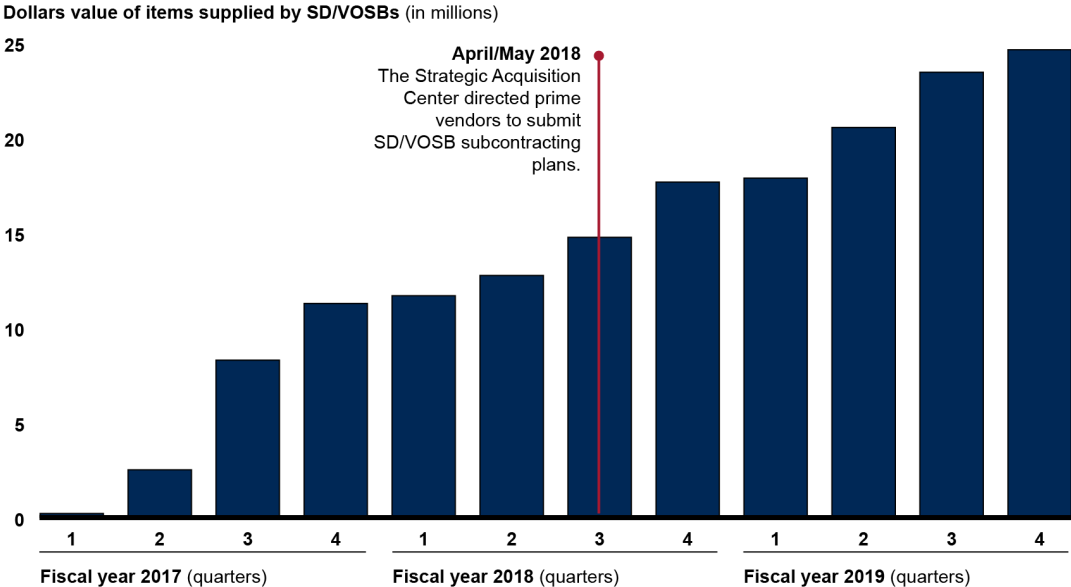
⁴⁹VA issued a class justification and approval to explain its use of noncompetitive procedures for the modification of the prime vendor contracts.

⁵⁰Federal statute and regulations generally require that federal contracts valued over \$700,000 (\$1.5 million for construction) have a small business subcontracting plan, if there are subcontracting opportunities. FAR § 19.702. The plans are to include, among other things, percentage goals for using small businesses, SD/VOSBs, HUBZone small businesses, small disadvantaged businesses, and women-owned small businesses as subcontractors, as well as the total dollars planned to be subcontracted to each type of small business as a percentage of total subcontract dollars. FAR § 19.704. Contracts awarded to small businesses are exempt from the requirement for a small business subcontracting plan. FAR § 19.702. VA's requirement that the prime vendors submit a plan for subcontracting with SD/VOSBs was independent of these requirements, as two of the four prime vendors were small businesses and the other two already had small business subcontracting plans in place.

In May 2019 SAC evaluated the prime vendors' performance against the plans by evaluating the percentage of items available on each prime vendor's formulary that were supplied by SD/VOSBs rather than evaluating the percentage of total planned subcontract dollars that was subcontracted to SD/VOSBs. Under MSPV-NG, VA did not have access to prime vendor data supplier sales data; however, VA plans to require prime vendors to provide quarterly reports of detailed supplier sales data under MSPV 2.0.

Based on sales data we obtained from each of the four prime vendors for December 2016 through September 2019, we found that orders for items supplied by SD/VOSBs continued to increase each quarter since the prime vendors became responsible for both the supply and distribution of items and since VA requested the submission of SD/VOSB subcontracting goals. As shown in figure 8, purchases of items supplied by SD/VOSBs increased from \$15 million to almost \$25 million from the third quarter of fiscal year 2018 to the fourth quarter of fiscal year 2019.

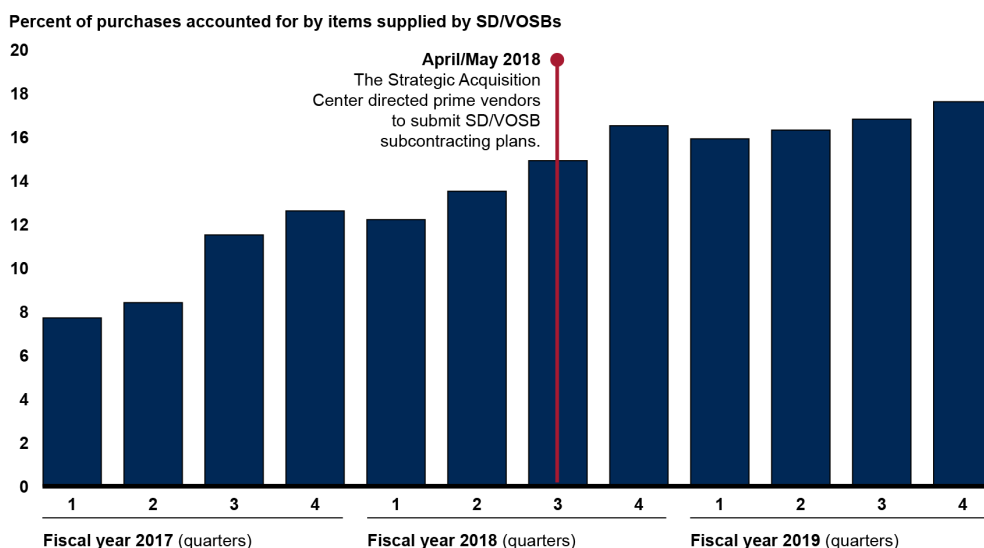
Figure 8: Purchases of Items Supplied by Service-Disabled and Veteran-Owned Small Businesses (SD/VOSB) through the Medical-Surgical Prime Vendor-Next Generation Program, December 2016–September 2019



Source: GAO analysis of prime vendor sales data. | GAO-20-487

In addition, as shown in figure 9, the percentage of dollars spent through the program on items supplied by SD/VOSBs also increased by 3 percentage points from the third quarter of fiscal year 2018 to the fourth quarter of fiscal year 2019.

Figure 9: Percentage of Quarterly Purchases of Items Supplied by Service-Disabled and Veteran-Owned Small Businesses (SD/VOSB) Based on Prime Vendor-Reported Data, December 2016–September 2019



Source: GAO analysis of prime vendor sales data. | GAO 20-487

The number of SD/VOSB firms participating as suppliers in MSPV-NG also increased. According to data from the four prime vendors, 37 SD/VOSB firms supplied items ordered through the MSPV-NG program prior to the expansion of the formulary, out of a total of 258 suppliers. After VA established SD/VOSB goals in April and May 2018, this number rose to approximately 48 SD/VOSBs out of 288 total suppliers by September 2019.⁵¹

SAC officials stated that they expect SD/VOSB participation to remain steady during the interim bridge contract period, as VA entered into agreements with existing MSPV-NG suppliers—including SD/VOSBs—

⁵¹The number of SD/VOSBs counted includes suppliers that were listed as an SD/VOSB by one prime vendor but listed under another socioeconomic category by a different prime vendor.

with the goal of keeping the formulary and suppliers mostly unchanged during the bridge phase.

OSDBU is seeking to maximize the participation of SD/VOSBs in MSPV 2.0. Prior to VA's release of the MSPV 2.0 solicitation, OSDBU officials stated that they—in coordination with SAC—conducted market research to identify SD/VOSB suppliers in connection with the Veterans First Contracting Program. As VA transitions to its MSPV 2.0 program, it will enter into agreements directly with suppliers, which is a change from the prior MSPV-NG process where the prime vendors established these agreements with suppliers. OSDBU officials stated that reestablishing this direct relationship—and the Veterans First preferences for SD/VOSBs that come with it—will provide greater opportunities for SD/VOSB participation in MSPV 2.0. Representatives of the National Veteran Small Business Coalition agreed that the return to a direct business relationship between suppliers and VA would help provide business opportunities to SD/VOSBs.

OSDBU officials also cited two other steps to increase SD/VOSB opportunities in the program: (1) use of nonmanufacturer rule waivers, which allow small businesses to supply products they do not manufacture and still qualify for small business set-asides and (2) use of a “tiered” evaluation process in the competitions for MSPV 2.0 prime vendor contracts and supplier agreements.

- **Nonmanufacturer rule waiver.** VA will expand opportunities for SD/VOSB resellers through nonmanufacturer waivers.⁵² VA contracting officials obtained nonmanufacturer waivers from the Small Business Administration for most MSPV 2.0 supply categories (25 of the 26 categories as of May 2020), such as dental supplies, syringes, and needles. Industry and senior VA acquisition officials said the waivers will likely increase participation by SD/VOSBs in the MSPV 2.0 program by allowing them to act as resellers.
- **Tiered evaluation.** Under this process, offers are solicited from various classes of businesses—for instance, SD/VOSBs, small businesses, and other-than small businesses—but offers from the

⁵²In general, to qualify for award of a small business set-aside for a product, a firm either must be the manufacturer of the product (and cover at least 50 percent of manufacturing costs of the product) or supply a product manufactured by a domestic small business. The latter requirement is called the nonmanufacturer rule. The Small Business Administration may waive this requirement, allowing small businesses to supply the products of large businesses. See 13 C.F.R. § 121.406.

highest tier of business specified in the solicitation—in VA’s case, SD/VOSBs—are considered before offers from those specified as lower tiers in the solicitation. If an award cannot be made at the highest tier, offers from the lower tiers are considered successively, until award is made. VA plans to use a tiered evaluation approach in the MSPV 2.0 supplier solicitations, with tiers in the following order of priority: (1) service-disabled veteran-owned small businesses, (2) veteran-owned small businesses, (3) other small businesses, and (4) large businesses.

VA has yet to establish supplier agreements for most of the 26 MSPV 2.0 supply categories, according to VHA Procurement and Logistics officials, and it is too soon for VA to determine the extent to which SD/VOSBs will participate in the program. However, to increase participation in MSPV 2.0, OSDBU officials hosted two outreach events in February and May 2019, which over 550 representatives of small businesses attended, including SD/VOSBs.

Finally, OSDBU and DLA are collaboratively conducting outreach activities to raise SD/VOSB awareness of and participation in VA’s DLA MSPV pilot. SD/VOSBs must establish supplier agreements with DLA to participate in the pilot effort. Between November 2019 and March 2020, according to DLA officials, they presented and fielded questions at three private sector and VA events. During these events, DLA also provided SD/VOSBs with an instructional guide on obtaining DLA supplier agreements. DLA officials stated that, as of July 2020, 77 SD/VOSBs have entered agreements for a total of 93,248 supplies provided on DLA’s MSPV formulary.

However, according to OSDBU officials, VA does not have a written policy or guidance documenting how VA’s Veterans First requirements will be implemented by VA medical center logistics staff when making supply purchases through the DLA MSPV program. By statute, when VA enters an agreement with another agency to acquire goods or services, the agreement must include a requirement that the non-VA agency meet the Veterans First requirements “to the maximum extent feasible.”⁵³ VA’s August 2019 interagency agreement with DLA reflects that VA notified DLA of this requirement and that DLA made a determination of how it could comply, noting that DLA cannot implement the Veterans First

⁵³See 38 U.S.C. § 8127(i).

preference in the same way that VA does.⁵⁴ Further, the agreement requires VA to provide DLA up to \$300,000 in reimbursement annually for legal costs stemming from the agreement.

In April 2020, VA and DLA agreed to share information and data on verified SD/VOSBs from VA's Vendor Information Pages database.⁵⁵ DLA officials told us that they use this information to note which businesses are SD/VOSBs on their formulary so VA medical center logistics staff can select SD/VOSB suppliers, when appropriate. In May 2020, OSDDBU officials told us that VA medical center logistics staff are responsible for ensuring adherence to VA's Veterans First requirements by selecting items from verified SD/VOSBs on DLA's formulary, when appropriate. However, the OSDDBU officials stated they have yet to provide guidance to these VA logistics staff because the pilot is small in scale. Such guidance would help ensure that logistics staff at VA medical centers participating in the pilot are aware of whether and how to apply the Veterans First preference when selecting supplies.

Conclusions

For over a decade, VA has tried to design and implement a medical-surgical supply acquisition program that effectively meets its medical centers' needs. While the future MSPV 2.0 aims to solve some of the problems of the current MSPV-NG program, VA's current plans indicate it will fall short in some key respects. MSPV 2.0 is delayed until early 2021, but VA could use the intervening time to improve the program in ways that would better support medical center staff. For example, the 2.0 program will not fully address excessive drop shipments and manual formulary management, both of which cause delayed deliveries and other issues. Additionally, current plans for the MSPV 2.0 program have important shortcomings in two areas of data collection, which will limit the MSPV program office's oversight: prime vendor performance data to ensure they meet performance requirements and accurate historical coverage and utilization trend data to help understand if the program is meeting medical centers' needs.

⁵⁴The agreement states DLA determined it is prohibited from undertaking some actions related to the Veterans First program that conflict with legal authority applicable to the Department of Defense or that apply only to VA.

⁵⁵VA's Vendor Information Page database—maintained by the Center for Verification and Evaluation in OSDDBU—is a list of verified SD/VOSBs. The VA's SD/VOSB verification process is governed by 38 C.F.R. part 74, which includes regulations requiring specific business documents be provided in support of a verification application.

Concurrent with the planned MSPV 2.0 implementation, VA's pilot of DLA's MSPV program is delayed and faces challenges. Specifically, VA has not defined criteria for assessing the pilot's success, has not canvassed widely for internal stakeholder input, and has not generated written guidance on Veterans First opportunities in the pilot. Consequently, VA leadership will lack critical information to assess the pilot's success and to make an informed decision on its scalability to other medical centers. Recent changes to VA's plans, including its decision to move ahead with rolling out DLA MSVP VHA-wide, make assessing the outcomes of the implementation at the initial sites all the more important, so that VA can understand what challenges it will face in making this transition.

Recommendations for Executive Action

We are making eight recommendations to VA.

The Secretary of Veterans Affairs should ensure the Executive Director of the Veterans Health Administration's Office of Procurement and Logistics, as part of the Veterans Health Administration's ongoing efforts to establish and maintain supplier agreements for the Medical-Surgical Prime Vendor 2.0 formulary, examines opportunities to reduce the number of items delivered via drop shipment to minimize less-preferred methods to purchase supplies. (Recommendation 1)

The Secretary of Veterans Affairs should ensure the Executive Director of the Veterans Health Administration's Office of Procurement and Logistics, as part of the Veterans Health Administration's ongoing efforts to establish and maintain supplier agreements for the Medical-Surgical Prime Vendor 2.0 formulary, examines opportunities to establish delivery time frame requirements for drop-shipped items. (Recommendation 2)

The Secretary of Veterans Affairs should ensure the Executive Director of the Veterans Health Administration's Office of Procurement and Logistics automates aspects of the manual Medical-Surgical Prime Vendor formulary management process where feasible, such as electronic transmittal of real-time updates to medical centers and prime vendors, to minimize ordering errors and delivery delays. (Recommendation 3)

The Secretary of Veterans Affairs should ensure the Executive Director of the Veterans Health Administration's Office of Procurement and Logistics and the Strategic Acquisition Center develop processes to routinely use transaction-level data to validate prime vendor performance on key program metrics, such as order completion rate, and identify how this

information will be used to oversee the prime vendors. (Recommendation 4)

The Secretary of Veterans Affairs should ensure the Executive Director of the Veterans Health Administration's Office of Procurement and Logistics develops a process for calculating accurate historical coverage and utilization data for the Medical-Surgical Prime Vendor program, such as archiving monthly formulary snapshots, to increase visibility into medical center needs and issues over time. (Recommendation 5)

The Secretary of Veterans Affairs should ensure the Executive Director of the Veterans Health Administration's Office of Procurement and Logistics develops a plan for assessing the results of the Defense Logistics Agency Medical-Surgical Prime Vendor pilot, including criteria for assessing pilot success and scalability, as well as performance metric targets, and use these criteria and metrics to inform the department's future decision on whether the program should be deployed to all medical centers. (Recommendation 6)

The Secretary of Veterans Affairs should ensure the Executive Director of the Veterans Health Administration's Office of Procurement and Logistics seeks input from stakeholders within the agency, such as the Office of Small and Disadvantaged Business Utilization and medical center staff, on operation of the Defense Logistics Agency Medical-Surgical Prime Vendor pilot to help inform any needed improvements as the pilot progresses. (Recommendation 7)

The Secretary of Veterans Affairs should ensure the Executive Director of the Veterans Health Administration's Office of Procurement and Logistics works with the Office of Small and Disadvantaged Business Utilization to provide written guidance to VA logistics officials at facilities participating in the Defense Logistics Agency Medical-Surgical Prime Vendor pilot program on how to prioritize veteran-owned small businesses when purchases are made through the pilot program, to achieve VA's goal of providing opportunities for these firms to participate in the pilot program. (Recommendation 8)

Agency Comments and Our Evaluation

We provided a draft of this report to the Department of Veterans Affairs and to the Department of Defense for review and comment. In VA's comments, reproduced in appendix III, it concurred with our eight recommendations. VA also requested that GAO consider closure of two of them, based on actions VA has taken.

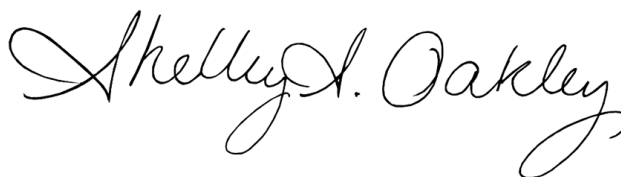
-
- First, in response to our fifth recommendation that VA develop a process for calculating accurate historical coverage and utilization data for its MSPV program, VA stated that it archives prior snapshots of the formulary for historical purposes. However, as detailed in the report, we found that VA's methodology for calculating coverage and utilization data for prior months 1) uses only the current formulary, and 2) can distort historical metrics. To address this issue, VA would need to store not only the prior formularies, but also the coverage and utilization metrics calculated during past months.
 - Second, in response to our eighth recommendation that VA provide written guidance to VA logistics officials on how to prioritize veteran-owned small businesses when purchases are made through the DLA MSPV pilot program, VA cited the interagency agreements it has with DLA. VA asserts that these agreements require DLA to apply the preference for veteran-owned small businesses to the maximum extent feasible. As we noted in the report, the interagency agreements state that DLA determined that it is prohibited from undertaking some actions related to the preferences for veteran-owned small businesses that conflict with legal authority applicable to the Department of Defense or that apply only to VA. As such, logistics officials at VA medical centers would benefit from guidance regarding what steps, if any, they need to take to implement this preference when purchasing through the DLA pilot.

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

The Department of Defense had no comments.

We are providing copies of this report to the appropriate congressional committees, the Secretary of Veterans Affairs, the Secretary of Defense, 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. 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 IV.

A handwritten signature in black ink that reads "Shelby S. Oakley". The signature is written in a cursive, flowing style.

Sincerely yours,
Shelby S. Oakley
Director, Contracting and National Security Acquisitions

List of Requesters

The Honorable Jerry Moran
Chairman
The Honorable Jon Tester
Ranking Member
Committee on Veterans' Affairs
United States Senate

The Honorable Mark Takano
Chairman
The Honorable Phil Roe
Ranking Member
Committee on Veterans' Affairs
House of Representatives

The Honorable Chris Pappas
Chairman
The Honorable Jack Bergman
Ranking Member
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
House of Representatives

The Honorable Ann McLane Kuster
House of Representatives

The Honorable Kathleen M. Rice
House of Representatives

Appendix I: Objectives, Scope, and Methodology

This report assesses (1) the extent to which Medical-Surgical Prime Vendor-Next Generation (MSPV-NG) is meeting medical center needs, and whether the planned Medical-Surgical Prime Vendor (MSPV) 2.0 program will mitigate current program issues we identified; (2) the implementation status of MSPV 2.0; (3) the status of the Department of Veterans Affairs' (VA) Defense Logistics Agency (DLA) MSPV pilot, and the extent to which VA is measuring pilot success and scalability; and (4) whether service disabled-veteran-owned small business (SD/VOSB) participation in VA's MSPV-NG program has changed over time and what future participation opportunities exist for the MSPV 2.0 program and the DLA MSPV pilot.

To assess the extent to which MSPV-NG is meeting VA medical center needs, we obtained monthly data on VA medical center spending on its medical supplies program between October 2019 and March 2020, which also included VA's own calculations of coverage and utilization rates. We determined the data was sufficiently reliable for assessing coverage and utilization rates by electronically testing it and speaking with VA officials responsible for maintaining the data, among other steps.¹ We compared coverage and utilization rates calculated by VA for current months to the coverage and utilization rates calculated by VA for those same months on subsequent monthly reports. We also reviewed policy memorandums, MSPV-NG contracts, agency communications, and other documents. We obtained and analyzed the class justification and approval memorandum that VA prepared to explain its use of noncompetitive procedures to modify the scope of the MSPV-NG prime vendor contracts to include both the distribution and supply of items. 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 reviewed prior GAO reports on MSPV-NG issue areas.²

¹Coverage is the percent of total medical and surgical supply spending for supplies available on the MSPV formulary at an enterprise level. Utilization is—among the supplies available on the MSPV formulary—the percent of orders VA medical centers place through the MSPV program.

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

We conducted site visits to a nongeneralizable selection of four Veterans Integrated Service Networks (VISN) during 2019.³ We visited three VA medical centers within each VISN:

- VISN 8
 - Gainesville, FL – Malcom Randall VA Medical Center
 - Orlando, FL – Orlando VA Medical Center
 - Tampa, FL – James A. Haley Veterans' Hospital
- VISN 12
 - Hines, IL – Edward Hines, Jr. VA Hospital
 - Milwaukee, WI – Clement J. Zablocki VA Medical Center
 - North Chicago, IL – Captain James A. Lovell Federal Health Care Center
- VISN 17
 - Dallas, TX – Dallas VA Medical Center
 - San Antonio, TX – Audie L. Murphy VA Hospital
 - Temple, TX – Olin E. Teague Veterans' Medical Center
- VISN 20
 - Portland, OR – Portland VA Medical Center
 - Seattle, WA – VA Puget Sound Health Care System: Seattle Division
 - Spokane, WA – Mann-Grandstaff VA Medical Center

We selected the VISNs and corresponding medical centers based on those with higher total spend on medical and surgical supplies in fiscal year 2018 and prime vendor diversity. The James A. Lovell Federal Health Care Center in VISN 12 and the Puget Sound and Spokane medical centers in VISN 20 were selected because they are the DLA MSPV pilot sites. At each VISN, we interviewed the Chief Supply Chain Officer and other members of leadership regarding their perspectives on the program. At each medical center, we met with the Facility Chief Supply Chain Officer and other logistics leaders (30 total individuals across the 12 medical centers), ordering officers and other logistics staff

³VISNs are Veterans Health Administration (VHA) organizations that manage VA medical centers and associated clinics across a given geographic area.

(79 individuals), clinicians (101 individuals), and on-site representatives of the prime vendor contractors (25 individuals). We also conducted interviews with senior VA and Veterans Health Administration (VHA) officials responsible for implementing MSPV-NG, and management representatives of the four prime vendors.

We also obtained information on VA's management of the MSPV-NG formulary, including documentation from the MSPV program office and monthly updates of data on the contents of the formulary. We found this data sufficiently reliable for purposes of our audit objectives based on prior reviews of this data, electronic testing of the data, and interviews with program office officials responsible for maintaining it.

To assess the extent to which MSPV 2.0 will mitigate issues with the current MSPV-NG program that we identified in our work, we reviewed policy memorandums, MSPV 2.0 solicitation documents, agency communications, and other documents. We obtained and analyzed the February 2019 *MSPV 2.0 Program Acquisition Strategy*, which is a program planning document that describes the approach to acquiring medical-surgical supplies in MSPV 2.0. We reviewed prior GAO reports related to MSPV-NG to assess how MSPV 2.0 will address our prior recommendations, as well as internal control standards related to designing information systems, using quality information, and evaluating performance.⁴ We also interviewed supply chain managers, contracting staff, clinical staff, and logistics staff at VA medical centers, and senior VA and VHA officials responsible for implementing MSPV 2.0 regarding their perspectives on the program.⁵

To determine MSPV 2.0's implementation status, we reviewed materials related to VA's solicitation for MSPV 2.0 distribution contracts, and GAO decisions resolving protests challenging the terms of the solicitation. We also obtained and reviewed documents related to VA's award of bridge contracts to continue the MSPV-NG program during the delay in MSPV 2.0, including justification and approval documents for the use of other than full and open competition and the four awarded bridge contracts. Furthermore, we interviewed VA officials at the Strategic Acquisition

⁴GAO-18-34 and GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G (Washington, D.C.: Sept. 10, 2014).

⁵In MSPV-NG, prime vendors are responsible for working with suppliers within certain geographic areas to deliver medical and surgical supplies to VA medical centers from suppliers.

Center, VA officials at the MSPV program office, logistics officials at several of the selected medical centers, and others involved in managing the contracting and implementation of MSPV 2.0 and the MSPV-NG bridge contracts.

To assess the extent to which VA is measuring pilot success and scalability for the DLA MSPV pilot and the pilot's implementation status, we reviewed policy memorandums, relevant laws that govern VA acquisitions, interagency agreements between VA and DLA, agency communications, and other documents. We obtained and analyzed the February 2019 *MSPV 2.0 Program Acquisition Strategy*, which includes a description of VA's approach to the DLA MSPV pilot. We reviewed GAO leading practices for pilot implementation, as well as internal control standards for establishing program objectives; and assessed VA's management of its DLA MSPV pilot against these leading practices and standards.⁶ We also interviewed supply chain managers and logistics staff at VA medical centers participating in, or scheduled to participate in, the DLA MSPV pilot regarding their views on the pilot, as well as senior officials at both DLA and VA responsible for implementing the pilot. We did not assess DLA's management of its MSPV program. Finally, we gathered documentation, such as program briefings, related to the implementation of the Defense Medical Logistics Standard Support (DMLSS) system at VA, and interviewed officials at the responsible program office.⁷ We did not assess DMLSS or VA's program to implement it.

To assess how SD/VOSB participation in MSPV-NG has changed over time and what future participation opportunities exist, we reviewed policy memorandums, relevant statutes and regulations that govern VA acquisitions, MSPV-NG contracts and MSPV 2.0 solicitation documents, agency communications, and other documents. We interviewed a number of individuals regarding their perspectives on opportunities for SD/VOSB firms in the MSPV-NG, MSPV 2.0, and DLA MSPV pilot programs, including contracting staff at VA's Strategic Acquisition Center and VHA; representatives from VA's Office of Small & Disadvantaged Business Utilization; representatives of the MSPV-NG prime vendors; senior DLA

⁶GAO, *Data Act: Section 5 Pilot Design Issues Need to Be Addressed to Meet Goal of Reducing Recipient Reporting Burden*, [GAO-16-438](#) (Washington, D.C.: Apr. 19, 2016). [GAO-14-704G](#).

⁷VA's implementation of the Defense Medical Logistics Standard Support system is related to the pilot, because VA plans to use it for VA medical center ordering from DLA MSPV.

and VHA officials responsible for implementing MSPV-NG, MSPV 2.0, and the DLA MSPV pilot; and representatives of an organization representing SD/VOSBs.

To determine the number of SD/VOSBs participating in MSPV-NG, as well as the amount and percentage of VA spending on items purchased through SD/VOSB suppliers over time, we obtained self-reported prime vendor data on SD/VOSB utilization and spend from December 2016 through September 2019 from the four prime vendors. We determined that the data were sufficiently reliable for our reporting objectives by electronically testing them and speaking with prime vendor representatives responsible for maintaining the data, among other steps. We analyzed these data for 17-month periods before and after the March 2018 change under which prime vendors acted as both suppliers and distributors, to determine what changes, if any, had occurred in SD/VOSB participation over that time period. As noted above, we analyzed data on supplies on the four prime vendors' formularies and used them to assess the extent of participation by SD/VOSB firms.

We conducted this performance audit from February 2019 to September 2020 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: Prior GAO Recommendations Related to the VA MSPV-NG Program

In November 2017, we issued a report that included nine recommendations for the Department of Veterans Affairs (VA) to improve its Medical-Surgical Prime Vendor-Next Generation (MSPV-NG) program.¹ Also, in January 2020, we issued a report on VA's Federal Supply Schedules program, which included one recommendation related to VA's MSPV-NG program.² Of these combined 10 recommendations, VA has taken actions to fully implement five of them, while the remaining five have not been fully implemented. Of the outstanding recommendations, GAO has identified two as priority recommendations for the department and all five as recommendations aimed at eliminating duplication and reducing costs.³ Table 3 summarizes the status of each of these prior recommendations.

¹GAO, *Veterans Affairs Contracting: Improvements in Buying Medical and Surgical Supplies Could Yield Cost Savings and Efficiency*, [GAO-18-34](#) (Washington, D.C.: Nov. 9, 2017).

²GAO, *VA Acquisition Management: Steps Needed to Ensure Healthcare Federal Supply Schedules Remain Useful*, [GAO-20-132](#) (Washington, D.C.: Jan. 9, 2020).

³GAO, *Priority Recommendations: Department of Veterans Affairs*, [GAO-20-537PR](#) (Washington, D.C.: Apr. 20, 2020) and GAO, *2020 Annual Report: Additional Opportunities to Reduce Fragmentation, Overlap, and Duplication and Achieve Billions in Financial Benefits*, [GAO-20-440SP](#) (Washington, D.C.: May 19, 2020).

Table 3: Status of GAO Recommendations Made to the Department of Veterans Affairs (VA) for its Medical-Surgical Prime Vendor–Next Generation (MSPV-NG) Program

Recommendation	Status	Action taken/action needed
The Veterans Health Administration (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. Source: GAO-18-34	Implemented	In November 2017, we found that leadership instability and workforce challenges made it difficult for VA to execute its transition to MSPV-NG. Since 2014, 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. We recommended that VHA's 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. In May 2018, VHA hired a Director to serve in a full-time position for its MSPV-NG program office. However, this position again became vacant in June 2019. As of June 2020, this position continues to be filled by an individual serving in an acting capacity. Without a permanent MSPV program office Director, the VHA Chief Procurement and Logistics Officer and VA as a whole are less able to ensure stable leadership of its MSPV programs and formulate and execute long-term strategy to ensure that program goals are met.
The Secretary of Veterans Affairs should assign the role of Chief Acquisition Officer (CAO) to a non-career employee, in line with statute. Source: GAO-18-34	Implemented	In November 2017, we found leadership instability within the MSPV-NG program. Specifically, since 2009, VA has designated career employees as "acting" CAOs rather than appointing or designating non-career employees to the CAO position, as required by statute. We previously reported in 2012 that clear, strong, and effective leadership, including a CAO, is key to an effective acquisition function that can execute complicated procurements like MSPV-NG. We recommended that the Secretary of Veterans Affairs should assign the CAO role to a non-career employee, in line with statute. In August 2018, VA appointed a non-career employee as its CAO.
The Director of the MSPV-NG program office should, with input from the Strategic Acquisitions Center (SAC), communicate to medical centers the criteria and processes for adding or removing items from the formulary. Source: GAO-18-34	Implemented	In November 2017, we found that the MSPV-NG formulary continued to change while medical centers attempted to match the items they regularly ordered with those on the formulary, 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. In addition, medical center officials told us that they had not received any communications from the MSPV-NG program office or the Strategic Acquisition Center regarding why items were being added and deleted and were unsure why the changes were taking place. We recommended that 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 MSPV-NG formulary. In early 2018, the MSPV-NG program office took steps to communicate to clinicians and logistics staff the criteria and processes for adding and removing items from the formulary, such as using the program's newsletters to explain the process for adding items and to notify staff when items were removed.

**Appendix II: Prior GAO Recommendations
Related to the VA MSPV-NG Program**

Recommendation	Status	Action taken/action needed
The VHA Chief Procurement and Logistics Officer, in coordination with SAC, should calculate cost avoidance achieved by MSPV-NG on an ongoing basis. Source: GAO-18-34	Implemented	VA set a goal of achieving \$150 million in cost avoidance in 2016 by transforming its supply chain, which included the MSPV-NG program. VA, however, did not have a metric in place to track cost avoidance attributable to MSPV-NG. We recommended that VA take steps to calculate cost avoidance achieved by MSPV-NG on an ongoing basis. In November 2018, VA officials began using the Medical Product Data Bank tool that calculates the extent to which VA medical centers purchase products via MSPV-NG instead of the open market and the cost avoidance that is achieved when that occurs. VA officials provided documentation on the output of this tool and also reported that they share this cost avoidance data on a biweekly basis with senior supply chain leadership.
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. Source: GAO-18-34	Implemented	We reported that the program primarily relied on noncompetitive, limited source blanket purchase agreements to add medical and surgical items to the initial version of the formulary in December 2016. The Director of the contracting office supporting the program told us that his staff had to award several hundred competitive contracts before the limited source agreements expired in late 2017 in order to maintain the current formulary. Contracting officials acknowledged this was unlikely and they were considering using a different type of agreement (distribution and pricing agreement) as a stopgap. We recommended that the MSPV-NG program office and the contracting office supporting the program should establish a plan for how to mitigate the potential risk of gaps in contract coverage. The MSPV-NG program took actions to keep the formulary viable and to increase the number of items on it. For example, the program used distribution and pricing agreements from September 2017 to April 2018 to maintain the current number of items on the formulary. In March 2018, the program modified the prime vendor contracts so that the prime vendors could serve as distributors and suppliers. This enabled over 13,000 items to be added to the formulary from June 2018 to November 2018.
The Director of the MSPV-NG program office should, with input from the 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. Source: GAO-18-34	Not fully implemented Priority Recommendation Duplication & Cost Savings Action Item	VA concurred with this recommendation. VA planned to implement a new Medical-Surgical Prime Vendor (MSPV) program, called MSPV 2.0, by March 2020; however, this program has been delayed to at least January 2021. MSPV 2.0 includes a process where clinicians review requirements for a set list of products. As of August 2020, VA was beginning the national rollout of this clinician review process, but the results of this process will not be implemented until after MSPV 2.0 begins. VA's strategy for its MSPV program depends on full implementation of this clinician review process.
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. Source: GAO-18-34	Not fully implemented Duplication & Cost Savings Action Item	VA concurred with this recommendation. VA implemented a tool—the Medical Product Data Bank's eZSAVE application—to improve the matching of equivalent supply items. In November 2018, VA reported that it holds monthly meetings with selected clinical and logistics staff to obtain their input on the matching process. However, as of August 2020, VA has not provided documentation showing how it has defined the role of clinical staff, including Clinical Product Review Committees, in this process. Without documentary support, GAO cannot assess the extent of the clinical staff role in the matching process. If the roles of clinicians are not clearly defined, it increases the risk of inconsistent involvement in the matching process.

**Appendix II: Prior GAO Recommendations
Related to the VA MSPV-NG Program**

Recommendation	Status	Action taken/action needed
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. Source: GAO-18-34	Not fully implemented Duplication & Cost Savings Action Item	VA concurred with this recommendation. VA's planned Medical-Surgical Prime Vendor (MSPV) 2.0 program includes engaging selected clinicians in its requirement development for a set list of products, known as Clinician-Driven Strategic Sourcing. In April 2019, VA began a pilot for this clinician review process, including input from national clinical program offices. As of August 2020, VA was beginning the national rollout of this process. VA does not plan to incorporate the results of this clinician review process in the list of available supplies until after MSPV 2.0 is implemented, which has been delayed until at least January 2021. Until VA implements MSPV 2.0 and incorporates the results of the Clinician-Driven Strategic Sourcing process, it will not be able to achieve its goals of cost savings and improved clinical consistency.
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. Source: GAO-18-34	Not fully implemented Duplication & Cost Savings Action Item	VA concurred with this recommendation. VA reported that it added thousands of items to the Medical-Surgical Prime Vendor (MSPV) formulary from June 2018 through December 2018, some of which had previously been purchased on an emergency basis. VA also reported in June 2018 and updated in March of 2020 that it is tracking items purchased on an emergency basis. However, as of August 2020, VA has not provided documentation showing whether and how this analysis has informed its selection of which products to add to the formulary. Without documentary support, GAO cannot assess the extent to which items that VA added to the formulary were previously purchased on an emergency basis. If VA does not use analysis of emergency procurements to help inform which items should be added to the MSPV formulary, it will miss opportunities to avoid emergency procurements and increase efficiency.
The Secretary of Veterans Affairs should take steps to assess duplication between VA's Federal Supply Schedules and MSPV programs, to determine if this duplication is necessary or if efficiencies can be gained. Source: GAO-20-132	Not fully implemented Priority Recommendation Duplication & Cost Savings Action Item	VA concurred with this recommendation. In August 2020, VA stated that it is analyzing duplication of contracting across the department as part of its Category Management efforts, and expects to complete a report to the Office of Management and Budget on this issue by October 2020.

Source: GAO reports and follow-up communications with VA. | GAO-20-487

Appendix III: Comments from the Department of Veterans Affairs



DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

September 17, 2020

Ms. Shelby S. Oakley
Director
Contracting and National Security Acquisitions
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 (GAO) draft report: ***VA ACQUISITION MANAGEMENT: Actions Needed to Improve Management of Medical-Surgical Prime Vendor Program and Inform Future Decisions*** (GAO-20-487).

The enclosure contains technical comments and the actions that will be taken to address the draft report recommendations. VA appreciates the opportunity to comment on the draft report.

Sincerely,

A handwritten signature in blue ink that reads "Brooks D. Tucker".

Brooks D. Tucker
Acting Chief of Staff

Enclosure

Enclosure

Department of Veterans Affairs (VA) Response to
Government Accountability Office (GAO) Draft Report
***VA ACQUISITION MANAGEMENT: Action Needed to Improve Management of
Medical-Surgical Prime Vendor Program
and Inform Future Decisions***
(GAO-20-487)

Recommendation 1: The Secretary of Department of Veterans Affairs should ensure the Executive Director of the Veterans Health Administration's Office of Procurement and Logistics, as part of the Veterans Health Administration's ongoing efforts to establish and maintain supplier agreements for the Medical-Surgical Prime Vendor 2.0 formulary, examines opportunities to reduce the number of items delivered via drop shipment to minimize less-preferred methods to purchase supplies.

VA Response: Concur. As GAO noted, there are several items not suitable for delivery by Veterans Health Administration's (VHA) prime vendors. Drop shipments should be rare occurrences used in the event all normal eCommerce or contracted vendors are not available (such as during a pandemic). This should account for less than 10% of all Medical/Surgical products purchased. When a drop shipment is the only option, it typically means circumstances surrounding the purchase order are unusual (pandemic, national disaster, supply chain disruption) and associated order-ship-time is unpredictable. Although a drop shipment is not preferred, it is substantially better to have drop shipment items available through Medical Surgical Prime Vendor (MSPV) than to move that spend to separate contracts or government purchase cards. VHA's Procurement and Logistics Office will conduct a review to determine if any items that are dropped shipped under VA's MSPV are delivered through the prime vendors for Defense Logistics Agency (DLA). Based on that analysis, VHA will determine the appropriate course of action to reduce the number of drop shipments.

Target Completion Date: November 2020

Recommendation 2: The Secretary of Department of Veterans Affairs should ensure the Executive Director of the Veterans Health Administration's Office of Procurement and Logistics, as part of the Veterans Health Administration's ongoing efforts to establish and maintain supplier agreements for the Medical-Surgical Prime Vendor 2.0 formulary, examines opportunities to establish delivery time frame requirements for drop-shipped items.

VA Response: Concur. Drop shipments should be rare occurrences used in the event all normal eCommerce or contracted vendors are not available (such as during a pandemic). This should account for less than 10% of all Medical/Surgical products purchased. When a drop shipment is the only option, it typically means circumstances surrounding the purchase order are unusual (pandemic, national disaster, supply chain disruption) and associated order-ship-time is unpredictable. Benchmarking or

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establishing delivery timeframe requirements for drop shipped items at the clinic or VA Medical Center is not possible under the existing VA MSPV-bridge contracts, as the vendor is not obligated to meet any shipping standard by VA contract. VA will explore the options available to add established delivery timeframe requirements for drop shipment items for MSPV 2.0.

Target Completion Date: February 2021

Recommendation 3: The Secretary of the Department of Veteran Affairs should ensure the Executive Director of the Veterans Health Administration's Office of Procurement and Logistics automates aspects of the manual Medical-Surgical Prime Vendor formulary management process where feasible, such as electronic transmittal of real-time updates to medical centers and prime vendors, to minimize ordering errors and delivery delays.

VA Response: Concur. With the advent of MSPV 2.0, many of these electronic transmittals and real-time updates will occur via Electronic Data Interchange (EDI) processing and link with the Supply Chain Master Catalog initiative scheduled for October 2020, with implementation in 2021. See Attachment 3 for DLA MSPV Pilot Metrics.

Target Completion Date: February 2021

Recommendation 4: The Secretary of Department of Veterans Affairs should ensure the Executive Director of the Veterans Health Administration's Office of Procurement and Logistics and the Strategic Acquisition Center develop processes to routinely use transaction-level data to validate prime vendor performance on key program metrics, such as order completion rate, and identify how this information will be used to oversee the prime vendors.

VA Response: Concur. A web-based dashboard to provide EDI data across nine transaction sets is under development and is anticipated to be fully deployed under MSPV 2.0. At best, only three EDI transaction sets are currently in use under the MSPV Bridge. The EDI Dashboard will provide data to capture transaction activities from placement of the order through payment of the invoice.

Enhanced capture of EDI data will strengthen visibility and monitoring capabilities of Procurement and Logistics Office and facilitate data driven verification of key performance prime vendor metrics. Therefore, VHA will no longer rely on prime vendor provided performance data. The data and reports available from the EDI Dashboard will also provide Field Supply Chain staff with timely reports that will assist them in managing their orders and inventories. Use of the expanded EDI data transaction sets will begin with award of MSPV 2.0. Implementation of MSPV 2.0 is anticipated early 2021.

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Further, VHA's Medical Supply Program Office and VA's Office of Acquisitions Logistics and Construction's Strategic Acquisition Center are creating a Quality Assurance Surveillance Plan (QASP) that will define the process by which the metrics will be monitored. It will be incorporated into the contract within 30 days of contract award, which is tentatively expected to be completed in October 2020. This QASP will be used to hold contractors accountable to the above stated metrics in accordance with Federal Acquisition Regulation 52.212-4.

Target Completion Date: February 2021

Recommendation 5: The Secretary of Department of Veterans Affairs should ensure the Executive Director of the Veterans Health Administration's Office of Procurement and Logistics develops a process for calculating accurate historical coverage and utilization data for the Medical-Surgical Prime Vendor program, such as archiving monthly formulary snapshots, to increase visibility into medical center needs and issues over time.

VA Response: Concur. VHA's Procurement and Logistics Office maintains formulary snapshots in a VA SharePoint site for historical purposes. Coverage data is calculated on a regular basis by evaluating purchases outside the MSPV program (Government Purchase Cards or one-off contracts). VHA has created a SharePoint site which archives monthly formulary snapshots and increases visibility into medical center needs and issues over time. VHA requests GAO consider closure of this recommendation.

Recommendation 6: The Secretary of Department of Veterans Affairs should ensure the Executive Director of the Veterans Health Administration's Office of Procurement and Logistics develops a plan for assessing the results of the Defense Logistics Agency Medical-Surgical Prime Vendor pilot, including criteria for assessing pilot success and scalability, as well as performance metric targets and use these criteria and metrics to inform the department's future decision on whether the program should be deployed to all medical centers.

VA Response: Concur. The joint VA-DLA MSPV Planning team is currently developing performance metrics to inform future decisions.

Target Completion Date: December 2020

Recommendation 7: The Secretary of Department of Veterans Affairs should ensure the Executive Director of the Veterans Health Administration's Office of Procurement and Logistics seeks input from stakeholder within the agency, such as the Office of Small and Disadvantaged Business Utilization and medical center staff, on operation of the Defense Logistics Agency Medical-Surgical Prime Vendor pilot to help inform any needed improvements as the pilot progresses.

VA Response: Concur. The Executive Director for the Office of Procurement and Logistics is currently crafting a stakeholder communications plan to solicit feedback

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from stakeholders within the agency. Further, VA and DLA MSPV programs are under continuous oversight by the Medical Category Management Team and VA's Office of Small and Disadvantaged Business Utilization.

Target Completion Date: December 2020

Recommendation 8: The Secretary of Department of Veterans Affairs should ensure the Executive Director of the Veterans Health Administration's Office of Procurement and Logistics works with the Office of Small and Disadvantaged Business Utilization to provide written guidance to VA logistics officials at facilities participating in the Defense Logistics Agency Medical-Surgical Prime Vendor pilot program on how to prioritize veteran-owned small businesses when purchases are made through the pilot program, to achieve VA's goal of providing participation opportunities for these firms to participate in the pilot program.

VA Response: Concur. DLA is obligated by the signed Interagency Agreements (Attachment 1) and Memoranda of Agreement (Attachment 2) to adhere and comply with the provisions of 38 U.S.C. § 8127 and the Rule of 2 to the maximum extent feasible when executing VA procurement actions. VHA has provided GAO with the Interagency Agreement as evidence of written guidance to VA logistics officials. VHA requests GAO consider closure of this recommendation.

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Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact

Shelby S. Oakley, 202-512-4841 or oakleys@gao.gov

Staff Acknowledgments

In addition to the individual named above, Lisa Gardner, Assistant Director; Teague Lyons, Assistant Director; Rose Brister; Kelsey M. Carpenter; Jeff Carr; Matthew T. Crosby; Susan Ditto; Lorraine Ettaro; Suellen Foth; Jeff Hartnett; Nicolaus Heun; Jaeyung Kim; Roxanna Sun; and Alyssa Weir made key contributions to this report.

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