



DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

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BEFORE THE
U.S. HOUSE OF REPRESENTATIVES COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
HEARING ON

*"THE PANDEMIC AND VA'S MEDICAL SUPPLY CHAIN: EVALUATING THE YEAR-LONG
RESPONSE AND MODERNIZATION"*
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Chairman Pappas, Ranking Member Mann, and members of the Subcommittee, thank you for the opportunity to discuss the Office of Inspector General's (OIG's) oversight of the Department of Veterans Affairs' supply chain and logistics program. VA employees working in its medical facilities have reported to the OIG time and again that problems with aspects of supply chain operations, like procurement and inventory management, affect their ability to provide veterans with timely and quality health care. VA has also faced numerous challenges with using and developing the information technology (IT) systems that support these critical functions. The pandemic has stressed those foundations in ways one could not have anticipated even a year ago.

Before I discuss the issues before us today, on behalf of all OIG personnel, I want to express our deep gratitude to the many VA employees who have worked tirelessly during the COVID-19 pandemic to serve veterans, their families and caregivers, and in many cases members of their local communities—often at significant risk and great personal sacrifice. We also appreciate the COVID-19-related funding from Congress supporting our efforts to conduct associated oversight work that can help provide VA with recommendations and information its leaders need for continuous improvement.

Prior to the pandemic, OIG reports identified IT, contracting, and staffing problems contributing to some VA medical centers not consistently having supplies when and where they needed them for patient care. Facilities have long experienced barriers to real-time tracking of inventory, purchasing, distribution, storage, and other supply management functions, leading to operational breakdowns and the need for workarounds that sometimes lack compliance with VA policies and procedures. The COVID-19 pandemic has exacerbated supply chain issues while placing unprecedented demands on healthcare delivery worldwide. Limited supplies affect not only patient care but also the protection of VA personnel working on the front lines. Although VA has significant experience and success in handling regional disasters, the global pandemic has changed how VA competes with all public and private healthcare systems for scarce but critical supplies. VA staff have needed to develop creative strategies,

structures, and workarounds to mitigate the effects of supply shortages. Their efforts have been significantly hampered by the pre-pandemic state of its supply and logistics systems.

My statement focuses on the shaky foundation from which VA needed to build its responses—systems that VA is aware still need to be fixed or replaced going forward. In addition, I will provide examples of the OIG’s oversight of VA’s actions to layer tracking dashboards and processes on top of these flawed foundations. I will also discuss efforts by my office to work with VA, manufacturers, and law enforcement partners to identify and prevent crimes that divert critical healthcare supplies from VA, siphon its funds for counterfeit goods and price-gouging, and other criminal activity.

VA’S SUPPLY CHAIN: FAULTY FOUNDATIONS AND MULTIPLE MISSTEPS

The OIG’s mission is to conduct effective oversight of VA programs and operations to help veterans receive access to quality health care and benefits in a timely manner, as well as ensure VA funds are spent appropriately. The OIG has frequently examined VA’s supply chain because of its tremendous cost, scale, and effect on patient care and employee safety. Concerns reported to the OIG have also focused on the impact of prior modernization efforts and contracting vehicles that faltered or resulted in costly delays. The OIG has identified aspects of improving healthcare access and quality of care as a major management challenge for VA given persistent obstacles in maintaining adequate staffing, quality assurance, and other central functions, such as providing and tracking supplies.¹ High-quality, prompt care is dependent on supplies and equipment being where they are needed in a timely fashion while promoting the strong stewardship of taxpayer funds.

VHA IT Systems and Supply Logistics

Since 2000, the OIG has also identified IT planning and implementation as a major management challenge given VA’s history of failed projects after significant IT investments. OIG audits in recent years have highlighted that IT systems’ development problems have persisted largely because of inadequate planning, fragmented governance, unrealistic timelines, and insufficient monitoring and controls. This has made IT projects, including those associated with supply management, susceptible to cost overruns, schedule slippages, performance problems, and in some cases, complete project failures. VA continues to face challenges in developing the IT systems it needs to support VA’s supply chain challenges. Inventory management is critical to knowing when to purchase, store, and distribute supplies—and then effectively track their use. Logistics processes at each step in the supply chain also must be effective and efficient.

While VA is engaged in a years-long migration to a new inventory management system called the Defense Medical Logistics Standard Support (DMLSS) system, Veterans Health Administration (VHA) facilities are required to use the Generic Inventory Package (GIP) system. OIG oversight efforts reveal

¹ VA OIG, [Fiscal Year 2020 Inspector General’s Report on VA’s Major Management and Performance Challenges](#). The OIG is required to report annually on VA’s major management challenges.

that because of its limitations, some medical facilities are not using GIP, or not fully, as mandated. Some have created their own inventory workaround tracking systems to better meet their needs. VA failed in a 2013 attempt to replace GIP, which was already considered outdated and underutilized. Currently, the VA Logistics Redesign (VALOR) Program Office's goal is to replace the GIP system and implement the DMLSS system to modernize VA's supply chain, establish an integrated IT system to support business functions and supply chain management, and address the many identified supply chain deficiencies. There are strong indicators that implementing the DMLSS system will face significant hurdles in achieving interoperability with other VA systems and making holistic changes to business processes. The OIG has been conducting oversight on the activation of DMLSS at the Captain James A. Lovell Federal Health Care Center in North Chicago, Illinois, and will publish its findings after VA's review of those findings and report completion.² As with many other VA programs, the OIG is concerned about governance and notes a lack of steady leadership, as VALOR has had at least five different program managers (three who were interim) in the past few years.

Several examples follow of OIG oversight reports highlighting VHA's long-standing challenges in tracking and managing inventory, timing purchases, and distributing supplies to front-line staff. On occasion, the pre-pandemic challenges led to the delay or cancellation of healthcare procedures. The problems identified four years ago at a particular facility, as with the first example, reflect systemic problems that have affected VA medical facilities nationwide.

Critical Deficiencies at the Washington DC VA Medical Center. In March 2017, the OIG received a confidential complaint and additional subsequent allegations that the Washington DC VA Medical Center had equipment and supply issues that could be putting patients at risk for harm. The OIG conducted an inspection, issued an interim report in April 2017, and a final report in March 2018.³ The final report provided findings in four primary areas: (1) risk of harm to patients, (2) hospital service deficiencies affecting patient care, (3) lack of financial controls, and (4) failures in leadership. These deficiencies spanned many years, affecting the core medical center functions that healthcare providers need to effectively provide quality care. In particular, the report detailed problems with ensuring supplies and equipment reached patient care areas when needed, in part due to the facility's failure to use the VA-required GIP system. Veterans' surgical procedures were delayed or canceled due to the unavailability of needed supplies, with clinicians even going to an adjacent hospital to borrow supplies while the patient was under anesthesia. The OIG made 40 recommendations, over a dozen of which related to ensuring the availability of necessary supplies, instruments, and equipment. While the recommendations have now been closed, concerns with the inventory and logistics systems and other VA-wide issues persist. This report was meant to not only improve conditions at the DC VA Medical

² The Captain James A. Lovell Federal Health Care Center (FHCC) is a partnership between VA and the Department of Defense, integrating both agencies' health care operations into a co-located healthcare facility with combined leadership.

³ VA OIG, [Interim Summary Report](#), Report No. 17-02644-202, April 17, 2017; VA OIG, [Critical Deficiencies at the Washington DC VA Medical Center](#), Report No. 17-02644-202, March 7, 2018.

Center, but to serve as a guide for other VA medical facilities' logistical services and to improve reviews and oversight by Veterans Integrated Service Networks (VISNs) and VA central offices.

Expendable Inventory Management System: Oversight of Migration from Catamaran to the Generic Inventory Package. As a result of the inventory management issues identified at the DC VA Medical Center, an OIG team conducted a national audit by surveying 21 medical centers and conducting unannounced on-site visits to 11 of those 21.⁴ The migration effort described in this report was an unsuccessful attempt to replace GIP. The team found other medical centers encountered challenges as part of the migration to a new inventory management system and that significant discrepancies existed between actual inventory and the data for tracking expendable medical supplies. Also, they found proper inventory monitoring and management practices were lacking. Some of the issues stemmed from the failure to provide adequate oversight of the migration at the VHA level, while others were from a lack of VISN oversight. The May 1, 2019, report included six recommendations to the executive in charge for the office of the under secretary for health regarding inventory distribution and controls, of which VA has not implemented four.

Not all inventory mismanagement issues result in shortages or delays in patient care. Oversight reports also have focused on how inventory mismanagement can result in stockpiles of supplies being left to expire or incur damage because they have not been properly inventoried, or funds being spent unnecessarily on products already in sufficient supply. For example, the OIG report on ***Equipment and Supply Mismanagement at the Hampton VA Medical Center in Virginia*** was a review of an August 2018 confidential complaint alleging mismanagement of equipment and supplies resulting in wasted funds and canceled operating room procedures at the Hampton VA Medical Center.⁵ The OIG did not substantiate that operating room procedures were canceled. However, about \$1.8 million worth of equipment sat for an undetermined amount of time in an unmarked second-floor storage room and a warehouse basement without being properly inventoried. The OIG partially substantiated the allegation that the facility did not have an effective, reliable inventory system in place to track or order operating room supplies because staff did not consistently and accurately use the software. The OIG team also identified more than 100 equipment items in a storage room that were inaccurately inventoried in the logistics software system, the Automated Engineering Management System/Medical Equipment Reporting System. Facility staff had been unable to track worth about \$750,000 worth of items. The OIG made 12 recommendations, now closed, to the facility director for improving inventory management, including having a plan to ensure adequate staffing and a process to promptly address and correct deficiencies identified during quality control reviews.

⁴VA OIG, [*Expendable Inventory Management System: Oversight of Migration from Catamaran to the Generic Inventory Package*](#), Report No. 17-05246-98, May 1, 2019.

⁵VA OIG, [*Equipment and Supply Mismanagement at the Hampton VA Medical Center, Virginia*](#), Report No. 19-00260-215, September 26, 2019.

VA Contracting Practices

In addition to challenges with supply chain operations at facilities and the attendant IT systems, VA has moved to address supply chain deficiencies by centralizing and standardizing procurement operations. The Medical/Surgical Prime Vendor-Next Generation (MSPV-NG) Program is VA's program for procuring medical and surgical supplies. These contracts allow VA medical centers to obtain medical or surgical supplies from single sources, known as prime vendors, at prices that leverage VA's buying power. From April through November 2020, VA reported spending over \$300 million of all medical or surgical supply dollars through the MSPV-NG contracts. Use of these single-source distributors consolidated and simplified ordering, receiving, invoicing, and payment. VA has now embarked on MSPV 2.0 to replace MSPV-NG. The OIG has identified problems with the existing MSPV-NG contracts and VA medical centers' compliance with using them. When supply items are simultaneously available through an MSPV contract and another procurement vehicle, the MSPV contract must be used. However, the OIG identified pre-pandemic problems with employees using purchase cards and other vendors when inventory system numbers were inaccurate (showing items as available that were not actually on the shelf), the list VA facilities provided prime vendors did not include needed items, or delivery times were too lengthy.

Inadequate Oversight of the Medical/Surgical Prime Vendor Program's Order Fulfillment and Performance Reporting for Eastern Area Medical Centers. This December 2019 audit examined VA's oversight of MSPV-NG order fulfillment and vendor performance.⁶ The audit focused on VA medical centers serviced by American Medical Depot (AMD). The OIG estimated these facilities received incorrect orders from AMD about 60 percent of the time.⁷ Incorrect orders occurred when delivery orders and invoice pricing did not match approved costs, products were obtained from unapproved suppliers, or staff obligated funds without proper authority. The root causes included VA's failure to validate prime vendor performance reporting under the contract or ensure that contracting officer representative positions at four of eight VA medical centers sampled during the audit were filled. Their absence meant VA did not verify AMD's self-reported compliance with performance measures. The audit team estimated that, without correction following the audit, VA would improperly pay AMD about \$84 million over five years. The OIG made 11 recommendations to VA including establishing measures to ensure vendor compliance with contract requirements and developing and implementing processes to validate vendor performance and reporting. As of March 2021, five recommendations focused on controls and performance-tracking by contracting officer representatives were still open.

To further the MSPV's goal of helping VA economize, personnel must ensure MSPV contractors are compensated accurately. The OIG reported in March 2021 on the accuracy of distribution fees invoiced

⁶ VA OIG, [*Inadequate Oversight of the Medical/Surgical Prime Vendor Program's Order Fulfillment and Performance Reporting for Eastern Area Medical Centers*](#), Report No. 17-03718-240, December 17, 2019.

⁷ VA subsequently terminated AMD's contract for cause in August 2020.

by the prime vendors.⁸ VA pays the MSPV vendors for the requested products and a distribution fee to cover the costs associated with managing medical facilities' inventories, which totaled approximately \$5 million in fiscal year 2018. The OIG found controls were insufficient to ensure VA medical facility staff accurately reviewed, verified, or certified distribution fee invoices for the MSPV-NG program, making 10 recommendations to improve oversight of verification and certification of the fees.

The combination of flawed IT systems, splintered governance, frequent changes in leadership, and lack of controls and monitoring of prime vendor contracts all have contributed to the unstable foundation on which VA had to rely for supply management when the pandemic hit.

SUPPLY CHAIN MANAGEMENT DURING THE PANDEMIC

Particularly in the early months of the pandemic, supply availability was influenced in part by frequently changing Centers for Disease Control and Prevention (CDC) policies that VHA was following, mainly related to the use and conservation of personal protective equipment (PPE). OIG interviews with medical facility leaders showed rapidly changing and diverse experiences. Facility staff responded to OIG questions about supply levels and shortages. They described situations where they experienced a "shortage" but never completely ran out of supplies, or they defined the "shortage" as a lack of sufficient supplies to conduct operations. In OIG surveys deployed during its routine comprehensive healthcare inspections for two VISNs, medical facility staff reported having varying levels of access to PPE, and facility leaders acknowledged VISN 10 efforts with cross-leveling supplies between facilities. OIG oversight has been primarily conducted virtually during the pandemic, and therefore OIG staff were not able to confirm the reliability or accuracy of VHA-reported inventory data with physical reviews of supplies at facilities.

In July 2020, the OIG published a report that included interviews of VHA leaders and staff to capture a snapshot of their perceptions of the adequacy of equipment and supplies in their facilities.⁹ This review was intended to help VHA leaders share their experiences and perceptions during the highly dynamic first wave of the pandemic. In particular, 67 of the 70 facility leaders reported having sufficient supplies of PPE. The three facility leaders who reported a perceived shortage of PPE specifically mentioned the lack of gowns and properly fitting N95 masks. This was an improvement from the OIG's report issued March 26, 2020, on facility pandemic readiness and visitor screening review. That report highlighted that 33 of 54 facility leaders interviewed stated that they did not have adequate supplies or equipment, or both, including some specific items of PPE such as gowns and N95 masks.¹⁰ The improvements in early

⁸ VA OIG, [*Inadequate Oversight of the Medical/Surgical Prime Vendor Program's Distribution Fee Invoicing*](#), Report No. 19-06147-50, March 4, 2021.

⁹ VA OIG, [*Review of Veterans Health Administration's COVID-19 Response and Continued Pandemic Readiness*](#), Report No. 20-03076-217, July 16, 2020.

¹⁰ VA OIG, [*OIG Inspection of VHA's COVID-19 Screening Processes and Pandemic Readiness*](#), Report No. 20-02221-120, March 26, 2020.

months of the pandemic were the result, in part, of VHA leaders and staff taking quick actions to develop supply management processes and tools.

As discussed in the sections that follow, OIG work confirms that VHA developed tracking dashboards and critical processes that they needed to layer on top of the flawed GIP inventory management and other systems to provide the real-time information they needed. Other OIG oversight work examines lessons learned from VHA emergency departments and urgent care centers that faced supply shortages and other challenges. Also previewed below is an upcoming report related to VA's emergency cache program.

Reporting and Monitoring PPE Inventory during the Pandemic

The OIG released a report in February 2021 addressing allegations that VA medical facilities could not acquire and maintain adequate inventories of PPE in line with escalating needs.¹¹ The OIG assessed how VHA reported and monitored its PPE supply levels and solicited information about whether facilities ran out of PPE or experienced significant shortages. The facilities also reported on lessons learned. The OIG concluded that VHA swiftly developed processes and a manual-entry reporting tool to help navigate fluctuating facility demand. In interviews of staff involved in logistics operations, no one reported running out of PPE. However, they described that when they ran low on stock VISNs helped by shifting supplies from other facilities.

However, as past OIG audits and reviews have demonstrated, VHA's facilities have often not shown supply chain discipline, including failing to comply with inventory process requirements or inconsistently using VA's official inventory management system, GIP. In February 2020, VHA began issuing guidance to prepare for shortages and monitor PPE. VHA created new tools and guidance for procuring, tracking, and monitoring PPE supplies that drew on GIP data and processes. VHA developed the Response Monitoring Tool (RMT) to track supply levels at medical facilities and the COVID-19e Power Business Intelligence (or Power BI) Dashboard to monitor national PPE supply levels. This tool built on the existing Supply Chain Common Operating Picture dashboard that was not updated daily, or even weekly, prior to the pandemic. Importantly, Power BI helped identify outliers that could indicate data discrepancies in supply levels. The RMT relied on staff to input PPE levels manually, leaving it more vulnerable to error. The OIG also identified areas of confusion by facility personnel related to how expired supplies should be recorded in the RMT, given it had no capability to identify which items were still usable despite being expired. The OIG team received contradictory responses from VHA officials as to whether expired PPE items should be included in daily reporting. Additionally, there was double counting in the use of some supplies redistributed among facilities, such as when marked as used when transferred to a facility in need and then again when the receiving facility used the supplies. Also, there were complications in leveraging data from GIP and inconsistent methods to verify facilities' self-

¹¹ VA OIG, [*Reporting and Monitoring Personal Protective Equipment Inventory during the Pandemic*](#), Report No. 20-02959-62, February 24, 2021.

reported inventory data into the new tool. For example, in one VISN, by tracking only one size of hand sanitizer, the VISN appeared critically low on hand sanitizer, even though facilities reported being well stocked with other sizes not captured in the dashboard. Here, the issue was with what VHA asked for, not with what the facilities were reporting, as the RMT only asked facilities to report on-hand quantities for one size. The OIG remains concerned about inaccuracies and unreliable data being put into the RMT since VA medical facilities will continue to report PPE using this tool, which directly feeds the Power BI dashboard used to monitor supplies system-wide. The OIG made two recommendations to the under secretary for health related to providing guidance for staff to report on expired PPE as well as creating ways for staff to report on-hand PPE quantities and usage data, and then effectively verify the information.

Review of Emergency Department and Urgent Care Center Operations during the COVID-19 Pandemic

The OIG reviewed the demand and use of VHA's emergency department and urgent care center services when faced with an influx of patients needing evaluation for COVID-19.¹² OIG staff used a survey questionnaire and interviews with emergency department and urgent care center directors to learn what steps they took from March to July 2020, as well as plans they intended to take going forward to respond to the pandemic. The surveys examined physical space, staffing levels, staff well-being, communications from VHA and VISN officials, and equipment and PPE status. Leaders described many ways they altered day-to-day operations to handle the first wave of COVID-19 patients. One emergency department director and one urgent care center director stated that staff "ran out" of PPE. Eighteen emergency department and two urgent care center leaders described a need to ration (use "sparingly") some PPE, such as N95 masks and gowns. Other leaders stated their facilities did not run out of PPE but did not indicate whether rationing occurred. As this report was based on conditions from March to July 2020 at surveyed facilities, the OIG made no recommendations, but rather hoped this report would promote discussion and consideration of lessons learned and best practices.

Inspection of Facilities' Pandemic Readiness and Response in VISNs 10 and 20

The OIG issues the results of unannounced cyclical assessments of operations and quality control programs at VA medical facilities, known as Comprehensive Healthcare Inspection Program reports. Starting in July 2020, pandemic readiness and response was added as an issue.¹³ A March 2021 report

¹² VA OIG, [*Review of Veterans Health Administration's Emergency Department and Urgent Care Center Operations During the COVID-19 Pandemic*](#), Report No. 20-01106-40, December 17, 2020.

¹³ VA OIG, [*Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 10 and 20*](#), Report No. 21-01116-98, March 16, 2021. These reports focus on leadership in a facility and key factors that affect patient care, such as quality, safety, and value; the credentialing and privileging process; environment of care; and medication management. Additionally, the OIG annually rotates high-interest topics in these fields, such as posttraumatic stress disorder care, mammography results and follow-up, and controlled substances inspection programs.

focused on VISNs 10 and 20 medical facilities' responses to COVID-19.¹⁴ The findings are based on healthcare inspections, leadership interviews, and staff survey results compiled during the fourth quarter of fiscal year 2020. At that time, VHA had not yet experienced the full force of the pandemic in November and December but had valuable information to share about its experiences to date. Facility leaders indicated few issues with the adequacy of supplies, equipment, or infrastructure to support treating COVID-19 patients. However, 20 to 40 percent of VISN 10 survey respondents and 10 to 25 percent of VISN 20 survey respondents reported not having access to appropriate PPE to ensure their own safety at work. In follow-up discussions, some facility leaders shared their thoughts on the reasons for their employees' perceptions about PPE unavailability, including administrative staff's denial of masks dedicated to clinical staff and sign-out procedures to ensure staff had access to and used appropriate supplies according to CDC and VHA guidance. Leaders at the John D. Dingell VA Medical Center in Detroit, Michigan, stated that while the facility had sufficient PPE, administrative staff wanted N95 masks, which the facility dedicated to clinical staff. Further, leaders at the Roseburg VA Healthcare System in Oregon reported that staff were required to wear face masks per VHA policy; however, some staff did not want or reported not being able to wear a mask. The report also notes how the Cincinnati VA Medical Center in Ohio worked with VISN 10 to create a PPE tool to help predict supply needs, and that the VISN served as a hub for obtaining supplies and PPE for medical centers. The report was informational and made no recommendations.

Medication Delivery Delays Prior to and During the COVID-19 Pandemic at the VA Manila Outpatient Clinic in Pasay City, Philippines

The OIG assessed allegations of delayed medication delivery at the VA Manila Outpatient Clinic pharmacy in Pasay City, Philippines, prior to and during the pandemic.¹⁵ The OIG substantiated that before the pandemic, a patient experienced medication delivery delays due to a stock shortage, and clinic leaders identified increased prescription processing times in October 2019. Their action plan identified mailing delays and medication stock shortages, beyond just VHA's supply chain, as the primary causes.

During the pandemic, four patients experienced medication delivery delays and clinic pharmacists could not provide an insulin product to one patient due to constraints on shipping perishable medications. None of these delays resulted in adverse clinical outcomes.¹⁶ VISN and clinic leaders tried to mitigate the effects of the Philippine's national quarantine, and leaders communicated with patients on how to

¹⁴ VISN 10 serves Indiana, Michigan, and Ohio; VISN 20 serves Alaska, Idaho, Montana, Oregon, and Washington. The evaluation covers emergency preparedness; supplies, equipment, and infrastructure; staffing; access to care; and community living center patient care and operations.

¹⁵ VA OIG, [*Medication Delivery Delays Prior to and During the COVID-19 Pandemic at the Manila Outpatient Clinic in Pasay City, Philippines*](#), Report No. 20-02779-59, January 28, 2021.

¹⁶ The OIG considered an adverse clinical outcome to be death, a progression of disease, worsening prognosis, suboptimal treatment, or a need for higher level care.

obtain pharmaceuticals through VHA's Foreign Medical Program. VA staff made efforts to get ahead of anticipated quarantine slowdowns in March 2020 and worked with collocated US Department of State personnel to reestablish timely in-person operations at the clinic. The OIG made two recommendations to the clinic manager to evaluate pharmacy ordering to minimize shortages and delays.

UPCOMING OIG OVERSIGHT RELATED TO SUPPLY MANAGEMENT DURING THE PANDEMIC

Among the OIG's many oversight efforts related to the COVID-19 response, there is one report related to supply chain practices currently in draft form and, consistent with our practices, being reviewed by the Department. These reviews allow VA offices to comment on OIG findings and recommendations, as well as to provide responsive action plans to implement the recommendations. After receiving VA's responses, OIG staff will integrate that feedback and publish the final report. While it is not the OIG's practice to testify regarding not-yet-published reports, due to the hearing's timing and VA being in receipt of the report, the findings will be previewed today.

Use and Oversight of the Emergency Caches Were Limited during the First Wave of the COVID-19 Pandemic

The OIG is reviewing how effectively VA managed its emergency caches during the first wave of the COVID-19 pandemic. VA established the emergency cache program in 2002 following the 9/11 attacks to make drugs and medical supplies available for treating veterans, VA employees, and civilians in the immediate aftermath of a local mass casualty event or other public health emergency, including a pandemic. They house a standard supply of drugs and medical supplies, including PPE. Medical facility directors, who were normally authorized to mobilize their caches, were no longer allowed to do so during this time. Instead, requests to mobilize the caches needed to go through the Office of Emergency Management's Emergency Management Coordination Cell because of uncertainty regarding the speed and extent of the virus's spread and how readily VHA could restock depleted caches. While this decision may have been appropriate for the pandemic, key stakeholders—medical facility directors—were not directly notified of this change in procedure. Oversight of the program was also limited, as most of the caches contained at least one type of expired PPE. The negative impact was mitigated because the CDC had issued guidance allowing VHA to use expired PPE that were not degraded. As VHA considers whether emergency caches should be maintained to support medical facilities' pandemic-related needs going forward, attention will need to be refocused on expired inventory that can undercut the cache's mission readiness.¹⁷

PANDEMIC-RELATED SUPPLY CHAIN CRIMINAL MATTERS

¹⁷ The OIG previously uncovered expired, missing or excess inventories of drugs in the caches in 2018. See [*Emergency Cache Program: Ineffective Management Impairs Mission Readiness*](#), Report No. 18-01496-301, October 31, 2018.

The OIG has approximately 250 special agents and other specialized staff at headquarters and in field offices across the nation investigating potential criminal activity involving VA programs and operations. In many instances, VA leaders or personnel work closely with OIG investigators to identify individuals and companies that present a threat to veterans or VA personnel and property. While VA has numerous initiatives to curb fraud, waste, and abuse, the pandemic is creating novel opportunities for bad actors, particularly because of the need to facilitate rapid purchases of essential goods and services. As VA struggled to expand its supply chain fast enough to deal with the spread of COVID-19, many companies—some nefarious and some neophytes—sought contracts for PPE and other medical supplies worth millions of dollars that they cannot fulfill. Some fraudsters have been identified by VA and the matter referred to the OIG, underscoring the need for VA to remain vigilant. For example, in one of the first and largest COVID-19-related fraud cases brought to date, VA staff's suspicion of potential fraud led OIG investigators to collaborate with other law enforcement authorities to arrest a Georgia resident for attempting to sell millions of nonexistent respirator masks and other PPE totaling \$750 million to VA in exchange for large upfront payments.

The OIG has also secured indictments or convictions in other supply chain-related prosecutions:

- The owner of a wholesale pharmaceutical company, Gulf Coast Pharmaceuticals, participated in a scheme to defraud healthcare providers, to include VA, of more than \$1.8 million by acquiring and hoarding PPE. In January 2021, the defendant was indicted in the Southern District Court of Mississippi on multiple charges including those relating to hoarding scarce supplies and fraud. The owner had previously been convicted of similar charges in a Mississippi state court. The owner is accused of directing sales representatives to solicit healthcare providers, including at VA, to purchase PPE and other products at excessively inflated prices through high-pressure sales tactics and by misrepresenting sourcing and actual costs. The owner allegedly sold N95 masks to VA and other healthcare providers for as much as \$25 per mask, despite acquiring such masks at much lower prices. The total amount of designated scarce materials billed to VA by the vendor was approximately \$334,391.
- The chief executive officer (CEO) of a government service provider, Federal Government Experts, LLC, made false statements to VA and FEMA officials to obtain contracts, which were valued at approximately \$38 million, to provide PPE including N95 masks. He also electronically submitted applications containing false information for Paycheck Protection Program and Emergency Injury Disaster Loans, which resulted in his receipt of approximately \$1 million in loans. The investigation also revealed that the CEO submitted fraudulent documentation to VA that falsely reflected that he served in the Marine Corps, resulting in fraudulent receipt of service-connected VA compensation benefits. The loss to the Small Business Administration was approximately \$261,000 and the loss to VA for fraudulent benefits was approximately \$74,000. In February 2021, the CEO pleaded guilty in the Eastern District Court of Virginia to false statements, wire fraud, and theft of government funds.

- A Seattle VA Medical Center employee stole medical equipment, including ventilators and bronchoscopes, and then sold the items on eBay. The stolen items were noticed as missing between December 2019 and April 2020. In January 2021, the employee was sentenced in the Western District Court of Washington to three months' incarceration, nine months' home confinement with electronic monitoring, and three years' supervised release after previously pleading guilty to theft of government property. The employee was ordered to pay restitution to VA in the amount of \$132,291.

The risk of fraud, waste, and abuse has risen due to a trifecta of high-risk conditions: the challenges of monitoring billions of dollars in pandemic-related emergency spending, the need for expedited contracts for medical supplies and other life-saving resources, and the ingenuity and speed exhibited by bad actors. The complex and disjointed architecture of VA's legacy financial management system, which has difficulty meeting increasingly demanding oversight and reporting requirements, also softens the ground for crimes and serious misconduct. Conditions are exacerbated by VA's inconsistent compliance with policies and procedures that strengthen oversight and controls. Moreover, legacy supply chain applications and systems undermine efforts to make swift and significant improvements to reduce waste and inefficiencies. VA is therefore vulnerable to contract and procurement fraud, bribery and kickback schemes, and internal issues such as employee theft or circumvention of controls. Prior to the pandemic, in fiscal years 2019 and 2020, the OIG investigated hundreds of instances of fraud, bribery, theft, and False Claims Act violations related to VA programs and personnel, resulting in judicial actions that involved hundreds of millions of dollars.

OIG staff are working closely with 3M, a manufacturer of PPE, and other law enforcement agencies to ensure that VA's supply chain remains safe from counterfeit products and secure. Such efforts have been successfully employed before, as demonstrated by collaboration with the Department of Homeland Security to remove over 200,000 counterfeit surgical masks from the nation's supply chain.

CONCLUSION

The OIG applauds the work of this Subcommittee and VA in continuing to raise as a priority the need to improve VA's supply and logistics systems. The oversight work detailed in this statement reveals there are still considerable challenges related to VA's administration and oversight, even without the strains the pandemic has placed on supply chains. The OIG is committed to providing practical recommendations that flow from its inspections, audits, reviews, and investigations to help VA support quality health care to veterans and safe working conditions for all VA personnel.

Chairman Pappas, this concludes my statement. I would be happy to answer any questions you or other members of the Subcommittee may have.