



October 2021

# COVID-19 CONTRACTING

## Indian Health Service Used Flexibilities to Meet Increased Medical Supply Needs

Highlights of [GAO-22-104745](#), a report to congressional addressees.

**Why This Matters**

The Indian Health Service (IHS) serves over 2 million American Indians and Alaska Natives. These groups have been disproportionately vulnerable to negative outcomes from COVID-19. During emergencies, federal contracting staff face pressure to work quickly to meet increased needs. We examined some of IHS's COVID-related contracts to see how the agency's efforts fared.

**Key Takeaways**

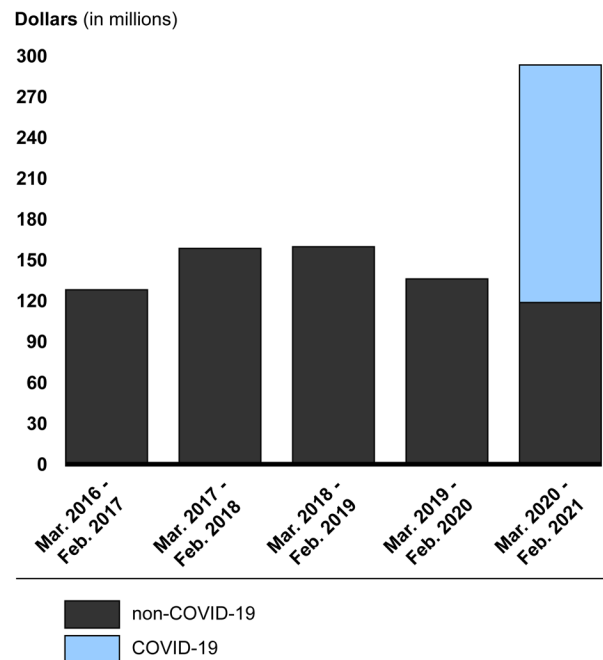
Despite facing challenges, including unprecedented demand for medical supplies, IHS was able to acquire needed products from a variety of vendors. IHS contract obligations for products, excluding prescription drugs, increased substantially during COVID-19 to address emergent needs for additional personal protective equipment, lab supplies, and more. Using emergency contracting flexibilities available under federal regulation, IHS

- bought personal protective equipment and other medical products in bulk
- awarded contracts noncompetitively
- used streamlined procedures for higher dollar contracts to obtain medical supplies faster

However, we found that IHS contracting officers did not notice that some COVID-related supplies were delivered late. Officials attributed this oversight to the spike in volume as well as the urgency of procurements during a pandemic.

Contracting officers are responsible for ensuring the terms of a contract are met—under normal circumstances and in emergency acquisitions. IHS officials told us that they began taking intermediate steps to improve tracking of products during 2020; the agency is currently obtaining new software to improve contractor oversight.

**IHS Contract Obligations Increased Substantially Due to COVID-19**



Source: GAO analysis of Federal Procurement Data System data. | GAO-22-104745

**How GAO Did This Study**

We analyzed relevant federal procurement data through June 30, 2021. We also reviewed four contracts—covering about 1/4 of obligations in IHS's largest product category (medical and surgical instruments, equipment, and supplies). We also interviewed IHS contracting officials.

For more information, contact: Marie A. Mak at (202) 512-4841 or [makm@gao.gov](mailto:makm@gao.gov)

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## Abbreviations

AI/AN	American Indian and Alaska Native
COVID-19	Coronavirus Disease 2019
DHS	Department of Homeland Security
DOD	Department of Defense
FAR	Federal Acquisition Regulation
FPDS	Federal Procurement Data System
GSA	General Services Administration
HHS	Department of Health and Human Services
IHS	Indian Health Service
NSSC	National Supply Service Center
PPV	pharmaceutical prime vendor
U.S.C.	U.S. Code
WHO	World Health Organization

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October 14, 2021

Congressional Addressees

Coronavirus Disease 2019 (COVID-19) has put the U.S. health care system, including the Indian Health Service (IHS), under severe strain, affecting the federal government's ability to buy and maintain critical medical supplies to treat patients and protect health care workers. IHS provides comprehensive health services for American Indians and Alaska Natives (AI/AN)—a population that has long experienced lower life expectancy and health disparities compared to other Americans.

Our prior work found that contracts play a key role in federal emergency response efforts, and that contracting during an emergency can present a unique set of challenges as officials can face significant pressure to provide critical goods and services as expeditiously and efficiently as possible.<sup>1</sup>

You requested that we review IHS's contracting efforts for COVID-19 medical supplies. This report examines (1) the key characteristics of IHS's contract obligations for COVID-19-related products, including medical supplies, and (2) the contracting approaches IHS used to buy medical supplies and any challenges it faced in the award and administration of those contracts.

To conduct this review, we analyzed data available in the Federal Procurement Data System (FPDS) as of June 30, 2021 to identify the IHS area offices with the most contract obligations and obtain detailed information about those contracts.<sup>2</sup> We assessed the reliability of FPDS data by reviewing existing information about the FPDS system and the data it collects, and determined the FPDS data were sufficiently reliable

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<sup>1</sup>GAO, *Disaster Contracting: FEMA Continues to Face Challenges with Its Use of Contracts to Support Response and Recovery*, [GAO-19-518T](#) (Washington, D.C.: May 9, 2019); *2017 Disaster Contracting: Actions Needed to Improve the Use of Post-Disaster Contracts to Support Response and Recovery*, [GAO-19-281](#) (Washington, D.C.: Apr. 24, 2019); *2017 Disaster Contracting: Action Needed to Better Ensure More Effective Use and Management of Advance Contracts*, [GAO-19-93](#) (Washington, D.C.: Dec. 6, 2018).

<sup>2</sup>For the purposes of this report, "contract obligations" means obligations on contracts that are subject to the Federal Acquisition Regulation, and does not include, for example, grants, cooperative agreements, loans, other transactions for research, real property leases, or requisitions from federal stock.

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for the purposes of describing IHS's reported contract obligations in response to COVID-19.

Based on those data, we then selected and reviewed the five largest completed IHS contracts for COVID-19-related medical supplies as of January 25, 2021, when we began this review. During our review, we excluded one of these contracts because it was potentially the subject of an ongoing Office of Inspector General investigation.<sup>3</sup> We also interviewed the cognizant contracting officers for these contracts as well as officials at IHS headquarters and the IHS National Supply Service Center (NSSC), which manages a large portion of IHS's COVID-19 contracts. Finally, we reviewed IHS's procurement policies and relevant portions of the Federal Acquisition Regulation (FAR). Further details about the scope and methodology for this work can be found in appendix I.

We conducted this performance audit from January 2021 to October 2021 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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## Background

IHS, an agency within the Department of Health and Human Services (HHS), provides health care for over 2 million AI/AN people who are members or descendants of federally recognized tribes.<sup>4</sup> We previously reported that AI/AN people tend to experience health disparities when compared to other Americans.<sup>5</sup> As of October 2019, AI/AN people had a life expectancy that was 5.5 years less than all other races or ethnicities in the U.S. and died at higher rates than other Americans from many preventable causes, including diabetes mellitus and chronic lower

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<sup>3</sup>We refer to the four remaining contracts we reviewed as Contracts A, B, C, and D.

<sup>4</sup>Federally recognized tribes have a government-to-government relationship with the U.S. and are eligible to receive certain protections, services, and benefits by virtue of their status as Indian tribes. The Secretary of the Interior publishes a list of all tribal entities that the Secretary recognizes as Indian tribes annually in the Federal Register. As of January 29, 2021 there were 574 federally recognized tribes. See 86 Fed. Reg. 7554 (Jan. 29, 2021).

<sup>5</sup>GAO, *COVID-19: Opportunities to Improve Federal Response and Recovery Efforts*, [GAO-20-625](#) (Washington, D.C.: June 25, 2020).

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respiratory diseases. AI/AN individuals with these health conditions are at greater risk of developing serious complications from COVID-19.<sup>6</sup>

IHS provides services directly through a network of hospitals, clinics, and health stations it operates, and it funds services provided at tribally operated facilities.<sup>7</sup> IHS also provides funding to nonprofit, urban Indian organizations through the Urban Indian Health program to provide health care services to AI/AN people living in urban areas.

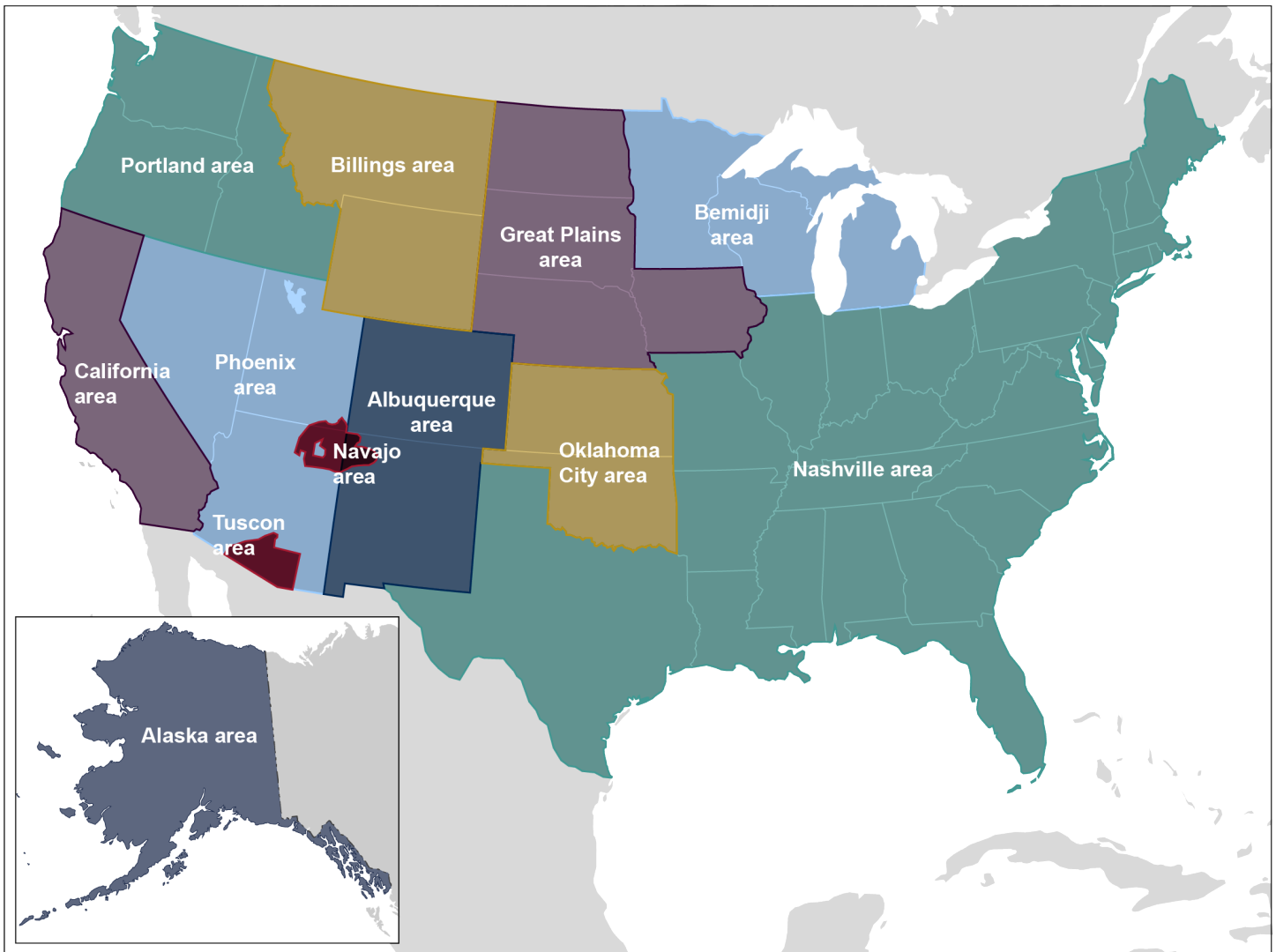
IHS administers services through a system of 12 area offices and 170 IHS and tribally operated service units. IHS's 12 area offices serve different geographic regions within the U.S., as shown in figure 1. Each area has its own contracting office, which is responsible for awarding and administering contracts in that area.

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<sup>6</sup>[GAO-20-625](#).

<sup>7</sup>See 25 U.S.C. § 1653.

Figure 1: Map of Indian Health Service Area Offices



Source: Indian Health Service. | GAO-22-104745

Within the Oklahoma City area office, IHS has the NSSC, which coordinates large national contracts. NSSC is a focus of our review because it managed a large portion of IHS's contracting for COVID-19-related products, including medical supplies.



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## COVID-19 Timeline of Events

- December 2019 – A new strain of coronavirus emerged and quickly spread around the globe.
- March 11, 2020 – The World Health Organization declared the outbreak of COVID-19 a pandemic.
- March 13, 2020 – The President of the U.S. declared a national emergency, pursuant to the National Emergencies Act and under section 501(b) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act).
- As of July 24, 2021, IHS reported 204,197 confirmed COVID-19 cases among those receiving care at IHS facilities.

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## Federal Regulations and Agency-specific Acquisition Guidance

The FAR establishes uniform policies and procedures for acquisition by all executive agencies, including requirements for planning and competition for awarding contracts. Although agencies generally must use full and open competition when awarding contracts, the FAR provides exceptions, such as when an agency's need for supplies or services is of such "unusual and compelling urgency" that the government would suffer serious harm unless it is permitted to limit the sources from which it solicits the supplies or services. In addition, the FAR states that it is the policy of the government to provide maximum practicable opportunities in acquisitions to small businesses.

IHS also follows HHS's acquisition regulation that supplements the FAR. In addition, Part 5, Chapter 5 of the Indian Health Manual identifies, explains, and clarifies IHS's policies and procedures for acquisition management.

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## IHS Has Obligated Millions of Dollars on New Contracts for COVID-19-Related Products

IHS obligations for medical supplies increased substantially after the COVID-19 national emergency declaration, primarily through new, noncompetitive contracts used to obtain a variety of critical products.<sup>8</sup> The agency's contract obligations for products in response to the pandemic totaled more than \$206 million as of June 30, 2021. Contract obligations peaked in April 2020 and again in January 2021.

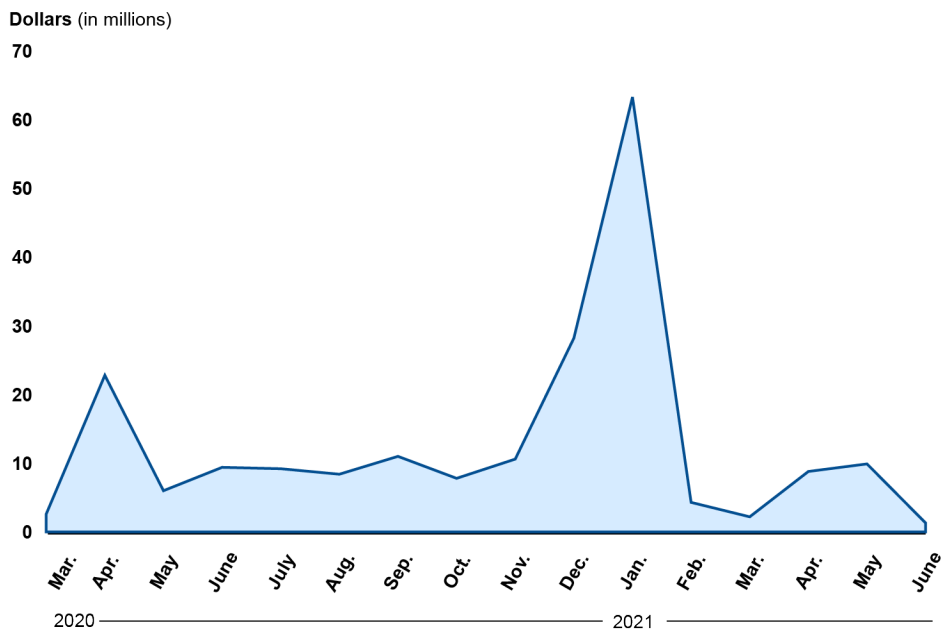
According to FPDS data, the first peak included substantial purchases of masks and gloves, and the second peak was primarily driven by an

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<sup>8</sup>For purposes of this report, "noncompetitive contracts" refers to contracts and orders identified with certain codes in FPDS, as explained in detail in appendix I of this report. Even for contracts and orders identified with these codes, agencies may have solicited more than one source.

agency-wide contract for lab analyzers, test kits, and reagents to test COVID-19 samples. Figure 2 illustrates IHS contract obligations by month for COVID-19-related products since the start of the pandemic.

**Figure 2: Timeline of Indian Health Service Contract Obligations for COVID-19-Related Products by Month, as of June 30, 2021**

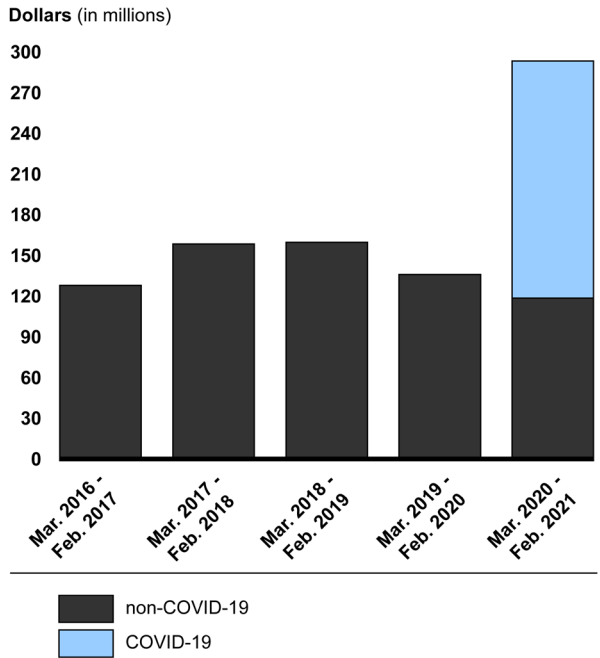


Source: GAO analysis of Federal Procurement Data System data. | GAO-22-104745

Overall IHS obligations for non-pharmaceutical products (such as gloves, masks, and gowns) increased substantially after the COVID-19 national emergency declaration.<sup>9</sup> For example, IHS obligated \$293 million for non-pharmaceutical products in the first 12 months of the national emergency, compared to \$136 million during the 12-month period before the March 2020 declaration (see fig. 3).

<sup>9</sup>For purposes of Figure 3, we removed obligations for the pharmacy prime vendor (PPV) program from our calculations. IHS officials said that prior to August 2019, FPDS data included all obligations for the PPV program. IHS officials added that since August 2019, IHS has not reported PPV obligations for tribally-operated facilities in FPDS to ensure accurate reporting of IHS-specific obligations in FPDS.

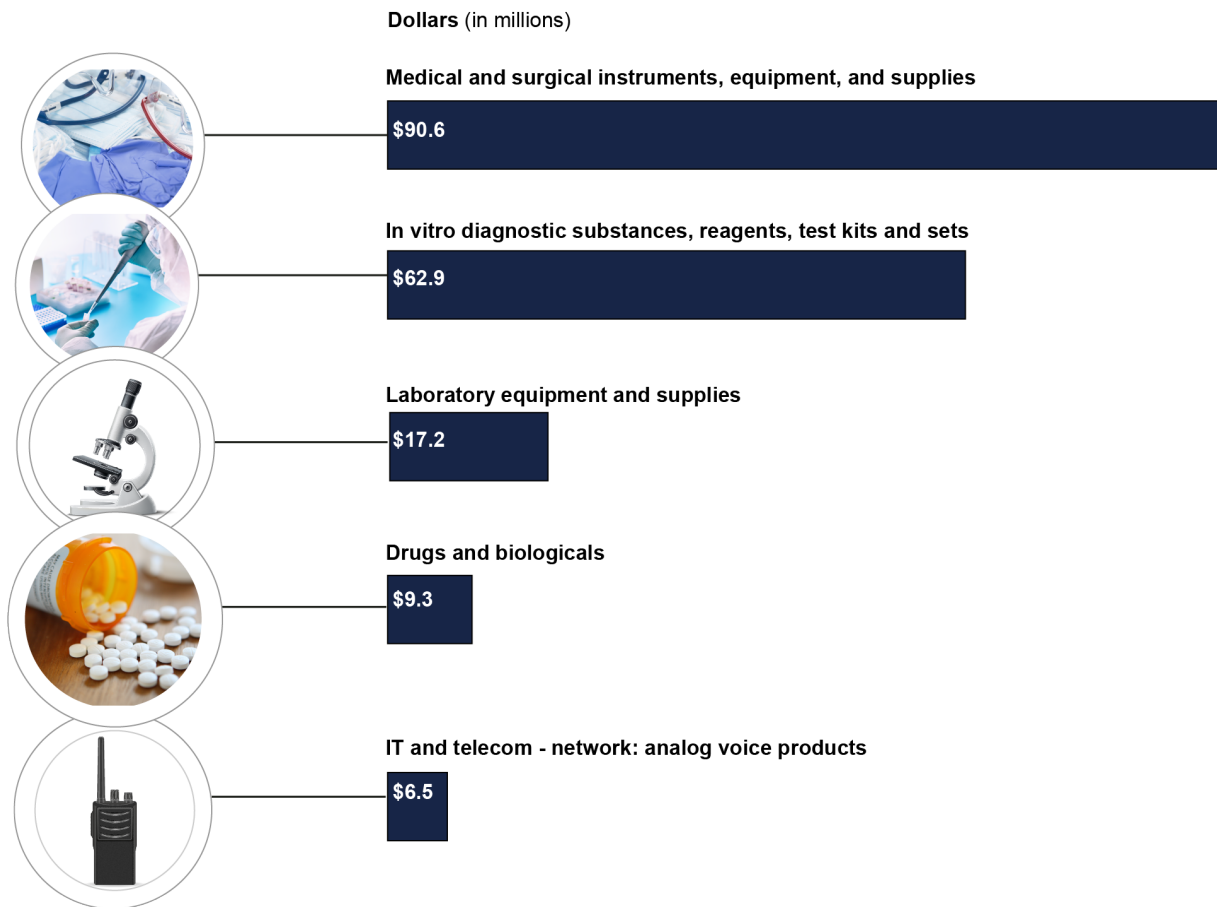
**Figure 3: Indian Health Service Contract Obligations on Non-Pharmaceutical Products, March 2016 through February 2021**



Source: GAO analysis of Federal Procurement Data System data. | GAO-22-104745

IHS procured a variety of critical products in response to the pandemic. The top five product types accounted for 90 percent of total obligations for COVID-19-related products. For example, medical and surgical instruments, equipment, and supplies accounted for nearly \$91 million, or 44 percent, of obligations for COVID-19-related products. Figure 4 shows the top five products by contract obligations.

**Figure 4: Top Five Products Procured in Response to COVID-19 by Indian Health Service, as of June 30, 2021**



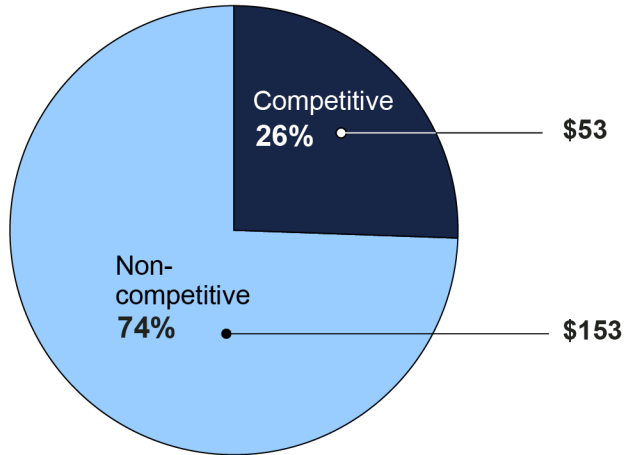
Source: (data) GAO Analysis of Federal Procurement Data System data; (images) Sherry Young, tilialucida, belokrylowa, JJava, Kontur-vid, stock.adobe.com. | GAO-22-104745

Most of IHS’s COVID-19-related contract obligations reported in FPDS, about \$169 million, were for new contracts, compared with about \$37 million in obligations on pre-existing contracts.<sup>10</sup> Almost three-quarters of IHS’s COVID-19 obligations for products were on contracts identified as awarded noncompetitively, as shown in figure 5.

<sup>10</sup>New contract obligations include obligations on new definitive contracts (as reported in FPDS), purchase orders, indefinite delivery vehicles, and blanket purchase agreements awarded or established after March 17, 2020—the date of the first IHS contract obligations in response to COVID-19—and all associated orders, calls, and modifications to these awards. Preexisting contract obligations include obligations on orders, calls, and modifications to definitive contracts, purchase orders, indefinite delivery vehicles, and blanket purchase agreements awarded or established prior to March 17, 2020.

**Figure 5: Competitive Versus Noncompetitive Indian Health Service Contracts for COVID-19-Related Products, as of June 30, 2021**

Dollars (in millions)



Source: GAO analysis of Federal Procurement Data System data. | GAO-22-104745

Note: For purposes of this report, noncompetitive contracts refers to contracts and orders identified with certain codes in the Federal Procurement Data System, as explained in detail in appendix I of this report. Even for contracts and orders identified with these codes, agencies may have solicited more than one source.

Most of the contracts awarded noncompetitively (74 percent) cited the unusual and compelling urgency exception to full and open competition.<sup>11</sup>

As with the federal government overall, competition rates for IHS contracts during the pandemic were much lower than normal due to the national emergency. From fiscal years 2015 through 2019, IHS contracts were awarded noncompetitively, on average, almost 19 percent of the time, compared to 74 percent during the pandemic.

In addition, about 43 percent of IHS's COVID-19 contract obligations were for products provided by small businesses.

<sup>11</sup>Our methodology for identifying noncompetitive contracts is explained in detail in appendix I of this report. Even for contracts identified as noncompetitive, agencies may have solicited more than one source.

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## IHS Adapted Its Contracting Approach to Address COVID-19 Challenges, but Was Unaware of Some Delivery Delays

IHS used available emergency contracting flexibilities and increased bulk purchases to meet its COVID-19 medical supply needs. However, contracting officials experienced challenges due to the increased volume and urgency of procurements and were unaware that vendors delivered some supplies late.

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## IHS Used Contracting Flexibilities and Increased Bulk Purchases to Meet Its COVID-19 Medical Supply Needs

IHS responded to COVID-19-related medical supply challenges by using acquisition flexibilities available in the FAR for emergency acquisitions to streamline its procurement of goods and services, including the following:

- *Unusual and compelling urgency* - Provides an exception to the general requirement for full and open competition when an agency's need for supplies or services is of such "unusual and compelling urgency" that the government would suffer serious harm unless it is permitted to limit the sources from which it solicits the supplies of goods or services.<sup>12</sup>
- *Increased simplified acquisition threshold* – Increases the threshold for using simplified acquisition procedures from \$250,000 to \$800,000 for acquisitions in the U.S. to support a response to an emergency or major disaster declared under the Robert T. Stafford Disaster Relief and Emergency Assistance Act.<sup>13</sup> For purchases at or below the simplified acquisition threshold, agencies may use streamlined procurement procedures, called "simplified acquisition procedures."
- *Increased threshold for simplified procedures for commercial items* – Increases the threshold for using simplified acquisition procedures for commercial items from \$7.5 million to \$15 million for purchases to support a response to an emergency or major disaster declared under

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<sup>12</sup>On March 21, 2020, the HHS senior procurement executive issued a class justification and approval that generally authorized HHS contracting offices to award contracts under the unusual and compelling urgency exception to full and open competition for COVID-19-related procurements.

<sup>13</sup>At the outset of the period covered by our review, the simplified acquisition threshold for acquisitions in the U.S. to support a response to an emergency or major disaster was \$750,000. Effective October 1, 2020, the FAR was amended to increase this threshold to \$800,000. 85 Fed. Reg. 62,485, 62,487 (Oct. 2, 2020).

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the Robert T. Stafford Disaster Relief and Emergency Assistance Act.<sup>14</sup>

Further, on March 21, 2020, HHS's senior procurement executive granted a waiver of the requirement for detailed, formal acquisition plans for all COVID-19-related acquisitions above the simplified acquisition threshold, allowing HHS contracting activities to use HHS's Streamlined Acquisition Plan template instead.<sup>15</sup>

Additionally, on April 2, 2020, the head of contracting activity for the Navajo Area Indian Health Service authorized the acquisition of personal protective equipment for the COVID-19 response without regard to restrictions in the Buy American Act or the Trade Agreements Act, based on exceptions to those restrictions. The Buy American Act establishes a preference that only domestic end products be acquired for public use. The act, however, permits federal agencies to procure foreign products under certain exceptions, such as where domestic products are not reasonably available in sufficient quantities of a satisfactory quality.<sup>16</sup> The Trade Agreements Act, as implemented by the FAR, requires the acquisition of only U.S.-made or designated country end products or U.S. or designated country services, unless offers for such products or services are insufficient for the requirements.<sup>17</sup>

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<sup>14</sup>At the outset of the period covered by our review, these thresholds, as implemented in the FAR, were \$7 million and \$13 million, respectively. Effective October 1, 2020, the FAR was amended to increase these thresholds to \$7.5 million and \$15 million, respectively. 85 Fed. Reg. 62,485, 62,488 (Oct. 2, 2020).

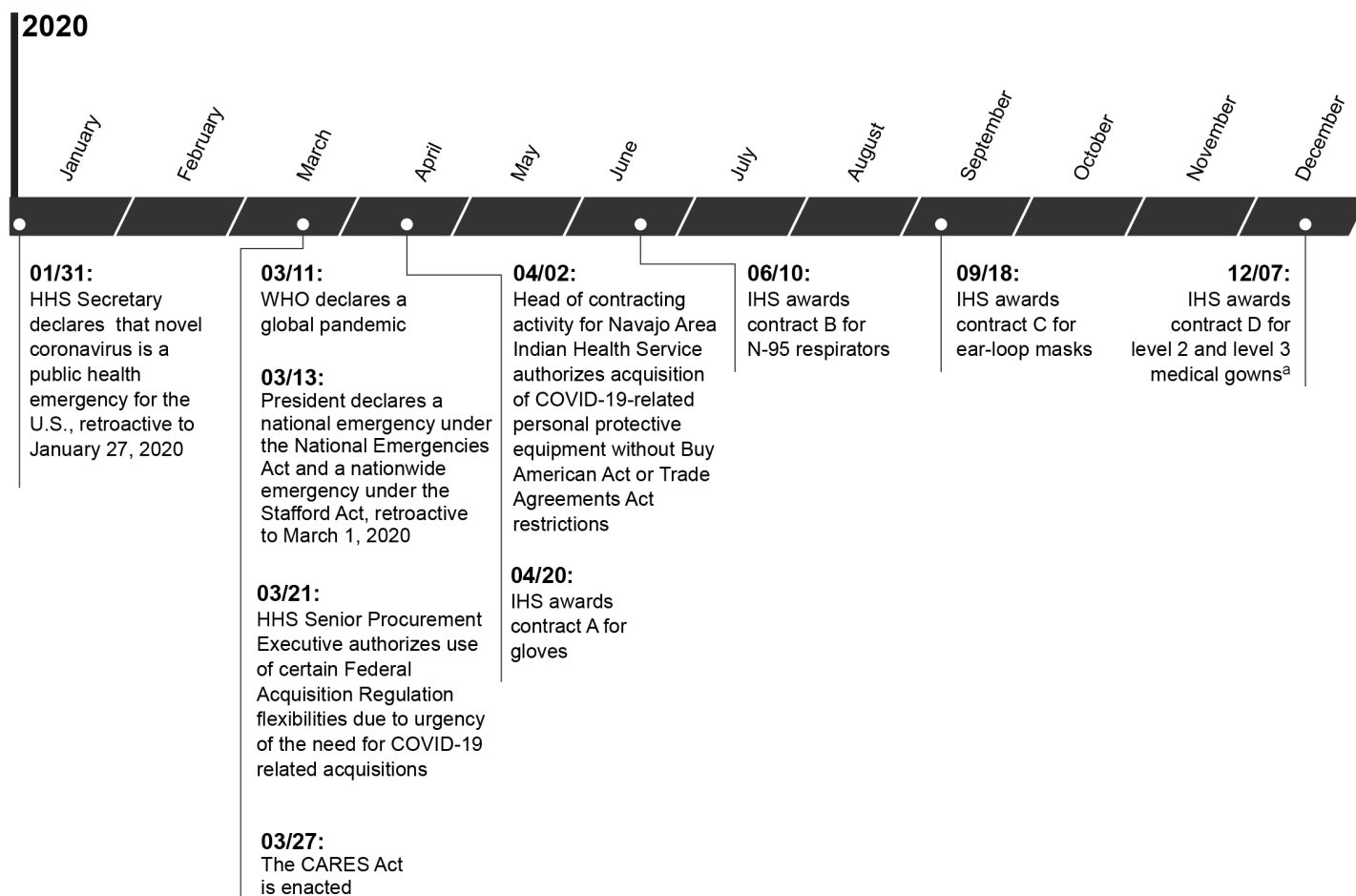
<sup>15</sup>In general, acquisition plans detail milestones at which decisions should be made for an acquisition as well as all the technical, business, management, and other significant considerations that will control the acquisition. See FAR § 7.105. The HHS Acquisition Regulation references the content requirements for a written acquisition plan in the FAR and requires a written acquisition plan for all acquisitions above the simplified acquisition threshold.

<sup>16</sup>41 U.S.C. § 8302; FAR § 25.101, 25.102, 25.103. The head of contracting activity for the Navajo Area Indian Health Service cited this exception in the authorization for the acquisition of COVID-19-related personal protective equipment without Buy American Act restrictions.

<sup>17</sup>19 U.S.C. § 2512(a); FAR § 25.403(c). In the authorization for the acquisition of COVID-19-related personal protective equipment without Trade Agreements Act restrictions, the head of contracting activity for the Navajo Area Indian Health Service cited an exception for acquisitions that do not use full and open competition.

Figure 6 illustrates key events in IHS's procurement response to the COVID-19 pandemic, including the implementation of contracting flexibilities and award dates for the four selected contracts in our review.

**Figure 6: COVID-19-Related Events and Award Dates for Four Selected Indian Health Service (IHS) Contracts**



**IHS** Indian Health Service  
**HHS** Department of Health and Human Services  
**WHO** World Health Organization

Source: GAO Analysis of IHS documentation and GAO-20-625. | GAO-22-104745

Note: We refer to the four selected Indian Health Service contracts as Contracts A, B, C, and D.

<sup>a</sup>According to the Food and Drug Administration, level 2 gowns offer barrier protection for low risk settings, whereas level 3 gowns offer barrier protection for moderate risk settings.



Our review of the four large IHS medical supply contracts found that three of those contracts used at least one of the acquisition flexibilities previously discussed (see table 1). Use of these flexibilities allowed IHS to award these contracts soon after identifying a vendor that could meet its needs.

**Table 1: Acquisition Flexibilities Used for Selected Contracts**

Contract	Class Justification & Approval for noncompetitive award based on urgency	Acquisition Flexibility			
		Increased Simplified Acquisition Threshold	Increased Commercial Items Threshold	Streamlined Acquisition Plan	Waived Buy American Act and Trade Agreement Act Restrictions
Contract A (gloves)	—	—	—	✓	—
Contract B (N-95 respirators)	—	—	—	—	—
Contract C (ear-loop masks)	—	—	—	✓	—
Contract D (level 2 and level 3 medical gowns)	✓	—	✓	✓	—

Source: GAO Analysis of Indian Health Service contract files and Federal Procurement Data System data. | GAO-22-104745

Note: “—” indicates the flexibility was not applicable to the procurement or the contract file did not reflect that IHS used the flexibility

“✓” indicates the contract file reflected that IHS used the acquisition flexibility

IHS officials told us that awarding contracts quickly was important because the medical supply market was volatile, and the availability of items could rapidly change. In addition, some existing vendors were unable to deliver medical supplies at the time.

For example, IHS relied on an existing agreement for purchasing gowns prior to the pandemic, but the vendor was unable to deliver needed quantities once the COVID-19 pandemic began. As a result, IHS had to identify another vendor for gowns, which led to Contract D. Likewise, IHS terminated Contract B for the government’s convenience after the vendor was unable to obtain the N-95 respirators from the manufacturer within the time frame specified in the contract.

IHS also responded to COVID-19 challenges by increasing bulk purchases of medical products by NSSC. While NSSC’s overall mission

has remained unchanged during the COVID-19 emergency, according to IHS officials, the volume of supplies procured by NSSC and the number of customers served have increased, and the urgency of the procurements has escalated.

Responding to these increased demands, IHS provided \$398 million in funding to NSSC to coordinate and manage the purchase and distribution of COVID-19-related medical products nationwide to IHS and tribal medical facilities and urban medical centers.<sup>18</sup> NSSC provided these supplies at no cost to the facilities and centers. Under normal circumstances, NSSC recovers costs by charging reimbursement fees to the medical facilities.

NSSC determined IHS’s COVID-19 medical supply needs by working with IHS’s 12 area offices to calculate cumulative medical supply usage rates. The Oklahoma City Area accounted for \$135.1 million of the \$206 million obligated (see fig. 7).

**Figure 7: Contract Obligations for Products in Response to COVID-19 by Indian Health Service (IHS) Area Office, as of June 30, 2021**

Dollars (in millions)



Source: GAO analysis of Federal Procurement Data System data. | GAO-22-104745

<sup>18</sup>IHS provided \$398 million to NSSC to procure personal protective equipment and other medical supplies for IHS, tribal, and urban medical facilities at no cost to the facilities. Of this, \$10 million was included in an appropriation to IHS under the CARES Act. IHS officials report that the remaining \$388 million came primarily from HHS’s Public Health and Social Services Emergency Fund to prevent, prepare for, and respond to coronavirus. According to IHS officials, some of these funds are available through fiscal year 2024, and some are available until expended.

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## Contracting Officials Experienced COVID-19 Challenges and Were Unaware of Late Deliveries

IHS officials stated that their greatest challenge was dealing with the increased volume of supplies and urgency of procurements during the COVID-19 emergency and that this contributed to the lack of awareness that vendors delivered some products late.<sup>19</sup> IHS officials stated that, as a whole, however, the agency considered these acquisitions successful because they were able to acquire the needed supplies during a national emergency.

We found that deliveries for masks and gowns under contracts C and D were late, according to the terms of the contracts. During initial interviews about the contracts under review, IHS officials told us that the vendors for each of the four contracts we reviewed, except for the vendor whose contract was terminated, delivered all supplies on time. However, we determined that the vendor for contracts C and D delivered some quantities late on both contracts. For example, our analysis found that, under the contract for level 2 and level 3 gowns, the vendor delivered about 20 percent of the level 2 gowns and about 35 percent of the level 3 gowns up to 1 month late. Under the contract for ear-loop masks, the vendor delivered about 6 percent of masks up to 10 days late. For both contracts, the contracting officer acknowledged that they were unaware the supplies were delivered late until we identified the discrepancy.

The Indian Health Manual states that the key to effective contract administration is constantly monitoring contractor performance. The manual also states that, after contract award, a project officer is responsible for tracking contract progress and for advising the contracting officer, in writing, of contractor performance, including monitoring the delivery of acceptable contractor supplies or services according to contract terms and conditions.

IHS officials stated that warehouse staff at NSSC's distribution warehouse generate reports documenting delivery and acceptance once products are successfully delivered. These reports—known as receiving reports—are provided to the contracting officer via intra-office mail. Officials added that these receiving reports should be included in the contract file. Although receiving reports were prepared and, according to

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<sup>19</sup>GAO reviewed four NSSC contract files. No deliveries were made under Contract B, and it was terminated for convenience by the government. Contract A was fulfilled on time. Contracts C and D both involved late deliveries. The FAR provides that contracting officers are responsible for ensuring performance of all necessary actions for effective contracting, ensuring compliance with the terms of the contract, and safeguarding the interests of the U.S. in its contractual relationships. FAR § 1.602-2.

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NSSC officials, a hard copy of each report was delivered to the contracting officer, contracting officials did not realize that supplies ordered under contracts C and D were not delivered according to the schedule terms identified in the contracts.

IHS contracting officials stated that during the COVID-19 emergency, the workload of the contracting and NSSC warehouse staff increased significantly because of the volume of supplies being procured and delivered. IHS officials stated that, under normal circumstances, either the contracting or NSSC warehouse staff would have noticed if products were not yet received or delivered late. In these instances, the contracting officer would have contacted the vendor and discussed possible corrective actions.

NSSC officials stated that they recognized in 2020 the need for improvements in their ability to track supplies during the COVID-19 emergency. As a result, NSSC began implementing procedural changes, including maintaining daily logs of all supplies delivered. These actions are still underway and have not been fully implemented. In addition, NSSC officials stated that they recently procured new software that will enable real-time tracking of deliveries and improved communication between warehouse and contracting staff. NSSC is currently developing internal guidance for the use of this software and plans to have the software fully deployed to track all supply procurements within NSSC by October 2021.

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## Agency Comments

We provided a draft of this report to the Department of Health and Human Services for review and comment. The agency provided technical comments which we incorporated as appropriate.

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We are also sending copies of this report to the appropriate congressional committees and offices. In addition, the report will be made available at no charge on the GAO website at <http://www.gao.gov>.

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If you or your staff have any questions concerning this report, please contact me at (202) 512-4841. Contact points for our offices of Congressional Relations and Public Affairs may be found on the last page of this report. Staff members making key contributions to this report are listed in appendix II.

A handwritten signature in black ink, appearing to read "Marie Mak", with a long horizontal flourish extending to the right.

Marie A. Mak  
Director, Contracting and National Security Acquisitions

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*List of Addressees*

The Honorable Patrick Leahy  
Chairman  
The Honorable Richard Shelby  
Vice Chairman  
Committee on Appropriations  
United States Senate

The Honorable Ron Wyden  
Chairman  
The Honorable Mike Crapo  
Ranking Member  
Committee on Finance  
United States Senate

The Honorable Patty Murray  
Chair  
The Honorable Richard Burr  
Ranking Member  
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The Honorable Carolyn B. Maloney  
Chairwoman  
The Honorable James Comer  
Ranking Member  
Committee on Oversight and Reform  
House of Representatives

The Honorable Richard E. Neal  
Chairman  
The Honorable Kevin Brady  
Republican Leader  
Committee on Ways and Means  
House of Representatives

The Honorable Ruben Gallego  
House of Representatives

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# Appendix I: Objectives, Scope, and Methodology

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To identify the key characteristics of the Indian Health Service's (IHS) contract obligations made in response to the Coronavirus Disease 2019 (COVID-19) pandemic, we analyzed data available in the Federal Procurement Data System (FPDS) as of June 30, 2021.<sup>1</sup> We analyzed the FPDS data to identify the IHS area offices with the most contract obligations, as well as information such as the types of goods procured by these offices, rates of competition on awarded contracts, and characteristics of the vendors that were awarded contracts.<sup>2</sup> We assessed the reliability of FPDS data by reviewing existing information about the FPDS system and the data it collects—specifically, the data dictionary and data validation rules. We determined the FPDS data were sufficiently reliable for the purposes of describing IHS's reported contract obligations in response to COVID-19. We primarily identified these contract actions and associated obligations related to the COVID-19 response by using the National Interest Action code.<sup>3</sup> We supplemented the use of the National Interest Action code by searching for "coronavirus" and "COVID-19" in the contract description field to identify a limited

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<sup>1</sup>For the purposes of this report, "contract obligations" means obligations on contracts that are subject to the Federal Acquisition Regulation, and does not include, for example, grants, cooperative agreements, loans, other transactions for research, real property leases, or requisitions from federal stock.

<sup>2</sup>For purposes of this report, competition rate is the percentage of total obligations associated with contracts awarded competitively. We calculated competition rates as the percentage of obligations on competitive contracts and orders over all obligations on contracts and orders annually. Competitive contracts included contracts and orders coded in FPDS as "full and open competition," "full and open after exclusion of sources," and "competed under simplified acquisition procedures," as well as orders coded as "subject to fair opportunity" and as "fair opportunity given," and "competitive set aside." Noncompetitive contracts included contracts and orders coded in FPDS as "not competed," "not available for competition," and "not competed under simplified acquisition procedures," as well as orders coded as an exception to "subject to fair opportunity," including "urgency," "only one source," "minimum guarantee," "follow-on action following competitive initial action," "other statutory authority," and "sole source." Even for contracts identified as noncompetitive, agencies may have solicited more than one source.

<sup>3</sup>National Interest Action codes were established in 2005 after Hurricane Katrina with the purpose of tracking federal procurements for specific disasters, emergencies, or contingency events. Based on a memorandum of agreement, the Department of Defense (DOD), the Department of Homeland Security (DHS), and the General Services Administration (GSA) are jointly responsible for when a National Interest Action code should be established and closed. DOD requests new or extended National Interest Action codes on behalf of the military departments and defense agencies, DHS requests new or extended codes on behalf of the civilian agencies, and GSA acts as the servicing agency by modifying FPDS.



number of additional contract actions and associated obligations.<sup>4</sup> For the purposes of this report, we are focusing on IHS obligations for COVID-19-related medical products. In order to determine the increased obligations related to procuring COVID-19-related medical products, as presented in figure 3, we removed obligations for the pharmacy prime vendor (PPV) program from our calculations.<sup>5</sup>

To examine the contracting approaches IHS used to buy medical supplies and the challenges it faced in the award and administration of those contracts, we selected and reviewed the contract files for the five largest completed IHS contracts for COVID-19-related medical supplies as of January 25, 2021, when we began this review, based on FPDS data. The selected contract files account for 28 percent of obligations for the top product category—medical and surgical instruments, equipment, and supplies—as of June 30, 2021. During our review, we excluded one of these contracts because it was potentially the subject of an ongoing Office of Inspector General investigation. While the information we obtained from the selected contract files is not generalizable to all IHS contracts, the files provided examples of IHS procurements of COVID-19-related medical products. We also interviewed the cognizant contracting officers for these contracts to obtain their perspective on the contract actions and the circumstances surrounding the contracts. Additionally, we conducted interviews with officials at IHS headquarters, IHS’s National Supply Service Center, located in the Oklahoma City area—which manages a large portion of IHS’s COVID-19 contracts—to determine what challenges the COVID-19 environment presented and what contracting flexibilities IHS utilized to award contracts in response to the COVID-19 pandemic. We also asked officials about their contracting procedures during the interviews we conducted, and reviewed IHS’s procurement policies in Part 5, Chapter 5, of the Indian Health Manual as well as portions of the Federal Acquisition Regulation.

We conducted this performance audit from January 2021 to October 2021 in accordance with generally accepted government auditing standards.

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<sup>4</sup>Our prior work identified some inconsistencies in the information agencies report in the contract description field. See GAO, *DATA Act: Quality of Data Submissions Has Improved but Further Action Is Needed to Disclose Known Data Limitations*, [GAO-20-75](#) (Washington, D.C.: Nov. 8, 2019).

<sup>5</sup>IHS officials said that prior to August 2019, FPDS data included all obligations for the PPV program. IHS officials added that since August 2019, IHS has not reported PPV obligations for tribally-operated facilities in FPDS to ensure accurate reporting of IHS-specific obligations in FPDS.

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Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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# Appendix II: GAO Contact and Staff Acknowledgments

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## GAO Contact:

Marie A. Mak, 202-512-4841 or [MakM@gao.gov](mailto:MakM@gao.gov)

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## Staff Acknowledgments:

In addition to the contact named above, Teague Lyons (Assistant Director), John Warren (Analyst in Charge), Jewel Conrad, Matthew T. Crosby, Suellen Foth, Stephanie Gustafson, Jeff Hartnett, Gina Hoover, and Robin Wilson made contributions to this report.

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