

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**IHS'S NATIONAL SUPPLY SERVICE
CENTER WAS GENERALLY EFFECTIVE
IN PROVIDING SUPPLIES TO FACILITIES
DURING THE COVID-19 PANDEMIC,
BUT ITS INTERNAL CONTROLS
COULD BE IMPROVED**

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Office of Inspector General

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Report in Brief

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U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Audit

American Indians and Alaska Natives have experienced disproportionately high rates of COVID-19 infection and mortality during the pandemic.

There was a global shortage of basic supplies needed to respond to the COVID-19 pandemic. Tribes and urban Indian organizations have turned to the Indian Health Service (IHS) and its National Supply Service Center (NSSC) for leadership and resources, and IHS has distributed funds appropriated in four supplemental bills to IHS facilities.

Our objective was to determine whether IHS's NSSC effectively distributed medical supplies and equipment in response to the COVID-19 pandemic.

How OIG Did This Audit

Our audit covered almost 21,000 NSSC transactions that occurred between March 1 and December 31, 2020. We selected a judgmental sample of a total of 70 transactions between the NSSC and IHS facilities and reviewed these transactions and associated documentation to determine whether orders were fulfilled completely and to evaluate the NSSC's allocation methodology.

We asked questions of IHS headquarters staff, NSSC staff, Emergency Points of Contact in IHS Areas, and officials from some IHS program health care facilities to help us evaluate IHS's monitoring of the distribution of supplies from the NSSC to facilities.

IHS's National Supply Service Center Was Generally Effective in Providing Supplies to Facilities During the COVID-19 Pandemic, but Its Internal Controls Could Be Improved

What OIG Found

The NSSC was generally effective in facilitating the distribution of medical supplies and equipment during the COVID-19 pandemic. Only two of the sampled transactions had errors. However, we noted that the NSSC's internal controls could be improved. In lieu of written policies and procedures, the NSSC relied on the institutional knowledge of key employees in implementing a new medical supply distribution method as the pandemic developed. The NSSC also did not have sufficient warehouse facilities to accommodate all of the medical supplies and equipment it and its customers needed during the pandemic and thus, had to obtain expensive temporary storage. Finally, the NSSC inventory management system was outdated and could not track the routing of a product that had been shipped or provide necessary information about the shipment to the customer.

Because the NSSC did not have written policies and procedures in place that would provide a framework to guide decision-making for emergency situations, its current process is not optimal or sustainable, particularly when institutional knowledge is subsequently lost or diminished. As a result, there is an increased risk that the NSSC will not be able to respond effectively to future emergencies. The NSSC's outdated inventory management system also poses an increased risk to the effectiveness and efficiency of NSSC operations in the future.

What OIG Recommends and IHS Comments

We recommend that IHS's NSSC strengthen internal controls by developing and implementing written policies and procedures for emergency situations; identify feasibly viable options, including seeking additional funding, to prepare for future emergency situations that address additional storage capacity and inventory distribution; and upgrade its inventory management system software to improve its ability to interface with customers and vendors.

IHS concurred with all of our recommendations and described corrective actions that it had taken or planned to take. Specifically, IHS stated that it was developing a new distribution plan for emergency responses, which was expected to be in place by January 1, 2023. IHS also stated that it was identifying and quantifying needs to expand stockpiling capacity and inventory distribution. Lastly, IHS stated that it had already launched a modernization initiative that includes the procurement and implementation of new inventory management software, and which IHS expects to implement by October 1, 2023. We commend IHS for the actions it has taken and plans to take.

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INTRODUCTION

WHY WE DID THIS AUDIT

The Indian Health Service (IHS) provides comprehensive health services for American Indians and Alaska Natives—a population that has long experienced health disparities (in quality of care, access to care, and outcomes) and a lower life expectancy compared to other Americans. In addition, American Indians and Alaska Natives have experienced disproportionately high rates of COVID-19 infection and mortality during the pandemic. There was a global shortage of basic supplies needed to respond to the COVID-19 pandemic. During the pandemic, Tribes and urban Indian organizations have turned to IHS and its National Supply Service Center (NSSC) for leadership and resources, and IHS has distributed funds appropriated in four supplemental bills to IHS-administered facilities, tribally administered facilities, and urban Indian program clinics.¹

COVID-19 has created extraordinary challenges for the delivery of health care and human services to the American people. As the oversight agency for the Department of Health and Human Services (HHS), the Office of Inspector General (OIG) oversees HHS's COVID-19 response and recovery efforts. This audit is part of OIG's COVID-19 response strategic plan.²

OBJECTIVE

Our objective was to determine whether IHS's NSSC effectively distributed medical supplies and equipment in response to the COVID-19 pandemic.

BACKGROUND

Indian Health Service

Within HHS, IHS delivers clinical and preventative health services to American Indians and Alaska Natives. IHS provides a comprehensive health service delivery system for approximately 2.6 million American Indians and Alaska Natives who belong to 574 federally recognized Tribes in 37 States. IHS receives annual appropriations to fund these services.

IHS has a decentralized management structure that consists of two major components: headquarters (IHS HQ) in Rockville, Maryland, and 12 Area Offices. IHS HQ responsibilities include setting health care policy, ensuring the delivery of quality comprehensive health services, and advocating for the health needs and concerns of Tribal members. The Area

¹ The four supplemental appropriations bills were the Coronavirus Preparedness and Response Supplemental Appropriations Act, P.L. No. 116-123 (Mar. 6, 2020); the Families First Coronavirus Response Act, P.L. No. 116-127 (Mar. 18, 2020); the Coronavirus Aid, Relief, and Economic Security Act, P.L. 116-136 (Mar. 27, 2020); and the Paycheck Protection Program and Healthcare Enhancement Act, P.L. 116-139 (Apr. 24, 2020).

² OIG's COVID-19 response strategic plan and oversight activities can be accessed at [HHS-OIG's Oversight of COVID-19 Response and Recovery | HHS-OIG](#).

Offices are responsible for distributing funds to programs within their geographical areas, monitoring operations of IHS Direct programs, and providing guidance and technical assistance to Direct, Tribal, and Urban Programs, which we discuss just below.

A graphic depiction of the IHS Areas, which also marks the locations of the NSSC and the Regional Supply Service Center (RSSC; discussed below), appears as Appendix B.

IHS Programs

Direct Programs

The Indian Health Care Improvement Act (IHCA) authorizes the IHS to provide health services to American Indians and Alaska Natives who are members of federally recognized tribes. The IHS provides these services through IHS Direct programs.³ These programs provide services, such as medical care and dental care, through IHS-operated facilities located within the Area Offices' geographic areas.

Tribal Programs

In 1975, Congress enacted the Indian Self-Determination and Education Assistance Act (ISDEAA). ISDEAA allows Indian Tribes and Tribal organizations to have greater autonomy and to have the opportunity to assume the responsibility for programs and services administered to them on behalf of the Federal Government. ISDEAA ensures that Tribes have paramount involvement in the direction of services provided by the Federal Government in an attempt to target the delivery of such services to the needs and desires of the local communities. Tribal programs authorized under the ISDEAA allow Indian Tribes and Tribal organizations to administer health care programs or services, which the IHS would have otherwise provided, under self-determination contracts with IHS (Title I Tribal programs) or self-governance compacts with IHS (Title V Tribal programs).⁴ Area Offices are responsible for Title I Tribal programs, through which Tribes contract with IHS to provide one or more individual services. IHS's Office of Tribal Self-Governance develops and oversees the implementation of Tribal Self-Governance legislation and authorities within IHS under Title V.

Urban Programs

Urban programs authorized under Title V of the IHCA receive IHS funds through grants and contracts with Area Offices; the contracts are subject to the provisions of the Federal Acquisition Regulation. These programs serve American Indians and Alaska Natives who do not

³ The Indian Health Care Improvement Act, P.L. No. 94-437 (Sep. 30, 1976), as amended; codified under 25 U.S.C. chapter 18.

⁴ The Indian Self-Determination and Education Assistance Act, P.L. No. 93-638 (Jan. 4, 1975), as amended; codified under 25 U.S.C. chapter 46.

have access to the resources offered through IHS or tribally operated health care facilities because they do not live on or near a reservation.

National Supply Service Center

IHS operates the NSSC, which is located in Oklahoma City, Oklahoma.⁵ The NSSC coordinates and manages the purchase and distribution of pharmaceuticals and medical and other health care-related supply items to health care facilities operated by Direct, Tribal, and Urban Programs.

The NSSC also provides advice, consultation, and assistance to IHS HQ, Area Offices, and field programs including Direct, Tribal, and Urban health care facilities. Furthermore, the NSSC serves as the distribution warehouse and supply distribution management center for IHS by providing supply support service and approximately \$93 million in supplies annually to 21 IHS Federal and Tribal Hospitals; 235 other IHS, Tribal, and urban Indian organization health care centers; and Area Offices; which are located across the country representing all 12 IHS Areas. The NSSC Director reports to the Area Director of the Oklahoma City Area.

Within IHS but separate from the NSSC, the Navajo Area operates an RSSC, located in Gallup, New Mexico. The RSSC Director reports to the Area Director of the Navajo Area and has no reporting relationship to the NSSC. The RSSC provides the Navajo, Albuquerque, and Phoenix IHS Areas with the following types of supplies: medical, dental, janitorial, and administrative. Facilities in these three Areas can order from both the NSSC and the RSSC.

National Supply Service Center Operations During the COVID-19 Pandemic

During the early part of the COVID-19 pandemic, the NSSC shipped products to the RSSC and the RSSC then distributed the products to facilities in the Areas it served.⁶ Later in the pandemic, the NSSC shipped products directly to facilities in the Areas that the RSSC served.

The NSSC also coordinated and managed the purchase and distribution of national supply items (such as gloves and N-95 masks) to Direct, Tribal, and Urban health care facilities and programs nationwide. For this report, we use the term “customer” to denote any IHS, Tribal, or Urban program or facility that requested or received medical supplies or equipment from the NSSC.

During the pandemic, the NSSC used two processes to distribute medical supplies and equipment to its customers.

⁵ The NSSC was originally established (in 1991) as an RSSC for the Oklahoma City Area. The entity transitioned to what is now known as the NSSC in 2001.

⁶ We are conducting a separate audit to determine whether IHS coordinated NSSC and RSSC operations to distribute supplies in an effective manner. OIG’s Work Plan for this review can be accessed at: [Work Plan | Office of Inspector General | U.S. Department of Health and Human Services \(hhs.gov\)](#)

- **Distribution process prior to COVID-19 pandemic.** A customer submitted a request (an order) for an item to the NSSC. Specifically, either a customer requested a needed item from the NSSC’s existing inventory or the NSSC ordered the item at the customer’s request.
- **Distribution process during COVID-19 pandemic.** The NSSC maintained an inventory of certain items (such as masks, thermometers, and COVID-19 test kits) and shipped these—without having received a request to do so—to customers using an allocation methodology that the NSSC developed during the pandemic. Under this methodology, IHS relied on Area Offices’ Emergency Points of Contact (Area EMPOCs), who are assigned to the Area Offices, to help determine the distribution of these allocated supplies. Accordingly, the NSSC developed an informal process by which it sent each Area EMPOC a proposed list of supplies to be distributed to each customer, and the Area EMPOC had the opportunity to provide input and make adjustments to that list before it was executed. The NSSC then distributed the supplies to each customer through a third-party vendor, such as FedEx.

HOW WE CONDUCTED THIS AUDIT

Our audit covered 20,987 NSSC transactions that occurred between March 1 and December 31, 2020.⁷ We selected a judgmental sample of a total of 70 transactions between the NSSC and IHS Direct, Tribal, and Urban facilities and reviewed these transactions and associated documentation to determine whether orders were fulfilled completely and to evaluate the NSSC’s allocation methodology.⁸ We selected transactions that included items that the customers ordered as well as items that the NSSC allocated. In addition, we selected transactions from 11 IHS Areas, as well as transactions that included various types of medical supplies and equipment.

We asked questions of IHS HQ staff, NSSC staff, Area EMPOCs, and officials from some IHS program health care facilities to help us evaluate IHS’s monitoring of the distribution of supplies from the NSSC to IHS Direct, Tribal, and Urban programs.

We conducted this performance audit 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 A contains the details of our audit scope and methodology.

⁷ For this report, we use the term “transactions” to denote both items that a customer ordered from the NSSC and items that the NSSC allocated to a customer.

⁸ For 1 of the 70 transactions that we judgmentally sampled, NSSC staff made a mistake when issuing the supply to the customer and the item was returned to inventory. Therefore, we reviewed 69 transactions.

FINDINGS

The NSSC was generally effective in facilitating the distribution of medical supplies and equipment during the COVID-19 pandemic. Of the 69 sampled transactions that involved the distribution or allocation of items to customers, only 2 had errors. Specifically, one sampled transaction was processed incorrectly and one sampled transaction was unsupported. However, we noted that NSSC's internal controls could be improved to include written policies and procedures for responding to emergency situations like the COVID-19 pandemic.

Specifically, in lieu of written policies and procedures, NSSC relied on the institutional knowledge of key employees in implementing a new medical supply distribution method as the pandemic developed. The NSSC also did not have sufficient warehouse facilities to accommodate all of the necessary medical supplies and equipment it and its customers needed during the pandemic and thus, had to obtain expensive temporary storage. Before the pandemic, the NSSC maintained warehouse facilities that were sufficient only to hold the supplies commonly requested by customers. As a result of the pandemic, the NSSC adjusted its distribution model and had to contract for temporary additional storage space. Finally, the NSSC inventory management system was outdated and could not track the routing of a product that had been shipped or provide necessary information about the shipment to the customer.

Because the NSSC did not have written policies and procedures in place that would provide a framework to guide decision-making for emergency situations, its current process is not optimal or sustainable, particularly when institutional knowledge is subsequently lost or diminished. As a result, there is an increased risk that the NSSC will not be able to respond effectively to future emergencies. Further, due to its outdated inventory management system, the NSSC and its customers could not properly track the shipments of medical supplies and equipment—which also poses an increased risk to the effectiveness and efficiency of NSSC operations in the future.

THE NATIONAL SUPPLY SERVICE CENTER WAS GENERALLY EFFECTIVE IN DISTRIBUTING MEDICAL SUPPLIES AND EQUIPMENT DURING THE COVID-19 PANDEMIC

Responsibilities for Supply Management Operations and Internal Controls

The *Indian Health Manual* states: "Management is responsible for establishing and maintaining internal control to achieve effective and efficient operations" (part 5, chapter 16, section 5-16.2).

The *Indian Health Manual* also states: "The Area/Program Director has primary responsibility for providing direction and leadership in the supply management program and to assure that the procedures and requirements of this [Supply Management—Central Operations] Chapter are efficiently and effectively carried out" (part 5, chapter 6, section 5-6.3C(1)). Furthermore, "The Supply Management Officer is responsible for the overall direction and guidance of supply management functions" (section 5-6.3C(5)).

In addition, the *Indian Health Manual* states: “The Director, MPICS [Management Policy and Internal Control Staff], has primary responsibility for coordinating all IHS management control functions. This includes developing, maintaining, and providing Agency-wide guidance policies or procedures for FMFIA [Federal Managers Financial Integrity Act] process and related matters” (part 5, chapter 16, section 5-16.2E).⁹ This provision of the manual also states that managers must have records and documents available to properly assess their internal operations and management control systems, including transaction records and internal guidelines.

Distribution of Supplies Was Generally Effective

The NSSC was generally effective in facilitating the distribution of medical supplies and equipment during the COVID-19 pandemic. Of the 70 judgmentally selected transactions that we reviewed, only 2 had errors.

The 70 judgmentally selected transactions consisted of 34 items that had been requested by the customer and 35 items that the NSSC had allocated to IHS Areas for distribution; for the 1 remaining sampled transaction, NSSC staff made a mistake when issuing the supply to the customer and the item was returned to inventory (footnote 8).

Thus, of the 69 sampled transactions that involved either the fulfillment of customer orders or the NSSC’s allocation of items to customers, 1 sampled transaction—a customer request for Remdesivir¹⁰—had a processing error. Specifically, NSSC sent the product to the incorrect customer. The second sampled transaction related to the distribution of exam gloves was unsupported as NSSC did not maintain documentation to support the allocation to a customer. The NSSC employee who worked on this transaction no longer works for the NSSC and the correspondence related to the order was not maintained.

While we found minimal errors in the sampled transactions reviewed, we noted that the NSSC’s internal controls could be improved to include written policies and procedures for responding to emergency situations like the COVID-19 pandemic. During the audit, we found that the NSSC did not have written policies and procedures for distributing medical supplies and equipment in emergency situations such as a pandemic. For the most part, the NSSC allocated supplies to IHS Areas based on user population data in an effort to ensure efficient and equitable distribution, and then each IHS Area used its own methods to allocate the supplies to facilities in its Area.¹¹ In addition, the NSSC sometimes made small adjustments, based largely on the institutional knowledge of its experienced employees, to the number of supplies that were allocated to customers in locations identified as COVID-19 hotspots, but it did not have specific policies to

⁹ The Federal Managers Financial Integrity Act of 1982, P.L. No. 97-255 (Sep. 8, 1982).

¹⁰ Remdesivir is an antiviral medication used to treat COVID-19.

¹¹ User population data are maintained by IHS and are based on registered Indian patients who had at least one inpatient stay, outpatient visit, or direct dental visit during the last 3 years.

tailor the amount of supplies it allocated to Areas that were experiencing higher rates of COVID-19.

In the absence of written policies and procedures, the NSSC relied on the institutional knowledge of key employees in implementing an informal method for distributing medical supplies as the pandemic developed. During our audit, we identified instances in which key NSSC employees' previous experience during other health emergencies benefited the emergency response. For example, the NSSC had maintained in its inventory over 5 million N-95 protective masks that it had acquired during previous infectious disease outbreaks like H1N1 and Ebola. Although these masks had passed their expiration dates, key NSSC employees decided to maintain them in inventory in case they were needed for emergency situations in the future. In the early stages of the COVID-19 pandemic, N-95 masks were in short supply and the NSSC could not obtain them from vendors. The NSSC asked an independent laboratory to test the expired N-95 masks to verify whether they were still safe and effective. The laboratory determined that the masks were safe and the NSSC then distributed them to IHS facilities.

One Area EMPOC whom we contacted stated that the NSSC employees who "had the presence of mind to have those outdated [N-95 masks] sent off to a standards lab to be tested and approved for use—those individuals deserve special recognition." Another stated that the stockpile of expired N-95 masks was "extremely helpful" and that with the N-95 masks provided by the NSSC, the Area was able to support its population until new masks could be acquired.

Area EMPOCs told us that in their view, communication between the NSSC and the Areas was generally good. The NSSC held weekly meetings to communicate with Area EMPOCs regarding supplies, future shipments, and allocations to Tribes and facilities. One Area EMPOC told us that the NSSC did a "fantastic job" distributing supplies that were available and continuously trying to locate other needed supplies. Area EMPOCs also generally stated that the NSSC employees were very responsive and provided information quickly and accurately. However, according to some Area officials, early in the pandemic, the allocation process was inefficient because of communication issues and because the NSSC did not always have accurate lists of customers and addresses. We also identified some other communication issues. For instance, customers did not always inform the NSSC when they had received supplies from other sources such as State governments or the Federal Emergency Management Agency. The NSSC did not have any written policies and procedures for what customers should do when they received duplicate supplies (i.e., when customers received the same items both through allocation from the NSSC and through their own ordering from other sources). Because the NSSC lacked policies and procedures for such cases, it had no formal way of reallocating supplies from customers that had surpluses to customers that had shortages of the same items.¹²

In addition, we found that different Areas used different methods—none of which had been formalized in writing—to allocate supplies (that had been received from the NSSC) to their

¹² We note that we did not identify, in our review of the 69 judgmentally selected transactions, evidence of widespread or systemic issues involving duplicate shipments.

customers. For example, some Areas allocated supplies to individual facilities based on the populations that those facilities served. Other Areas allocated supplies to facilities based on the rates at which those facilities used those supplies.

NSSC officials told us that they did not believe that the NSSC needed to develop and implement written policies and procedures for emergency situations because these officials regarded emergency planning as an aspect of the NSSC's regular operations and responsibilities. Specifically, NSSC officials said that they did not have specific funding for emergency preparedness and did not have specific planning procedures. As a reflection of this belief, NSSC employees told us that when responding to the COVID-19 pandemic they relied on the institutional knowledge of key employees who had experience in dealing with other emergency situations, such as other infectious disease outbreaks like H1N1 and Ebola.

We believe NSSC officials' rationale to not have established written policies and procedures in place falls short of sound internal control standards that Federal agencies are required to implement.¹³ Further, because NSSC did not have written policies and procedures for emergency situations that would provide a framework to guide decision-making for emergency situations, its current process is not optimal or sustainable, particularly when institutional knowledge is subsequently lost or diminished. As a result, there is an increased risk that when the NSSC confronts an emergency at some point in the future, its employees with the necessary experience will have moved on and the employees on hand will lack the institutional knowledge to be able to respond effectively. Specifically, employees without previous experience of other health emergencies might not have made the decision to store and subsequently test the expired N-95 masks that were distributed to IHS facilities. In addition, the communication issues noted during the beginning of the pandemic could have been lessened if there had been written policies and procedures in place.

Insufficient Warehouse Facilities

The IHCA, 25 U.S.C. §1621(a) (footnote 3), states that the Secretary of HHS is authorized to expend funds to eliminate the deficiencies in health status and health resources of all Indian Tribes, eliminate backlogs in the provision of health care services to Indians, and meet the health needs of Indians in an efficient and equitable manner (25 U.S.C §1621(f)(3)).

The *Indian Health Manual* states: "The Supply Management Officer is responsible for the overall direction and guidance of supply management functions" (part 5, chapter 6, section 5-6.3C(5)).

¹³ *The Standards for Internal Control in the Federal Government* (GAO-14-704G, Sep. 2014), section 12.03, states: "Management documents in policies for each unit its responsibility for an operational process's objectives and related risks, and control activity design, implementation, and operating effectiveness." Section 12.04 states: "Management communicates to personnel the policies and procedures so that personnel can implement the control activities for their assigned responsibilities."

Both the inventory model that the NSSC used, and the relatively small warehouse space (approximately 5,000 square feet) that it maintained, proved to be insufficient to the NSSC's needs during the COVID-19 pandemic. The NSSC modified its normal method of distribution because of the pandemic. The change in distribution methods compelled the NSSC to increase its warehouse space. Previously, the NSSC filled orders for supplies that either the customers directly requested (i.e., ordered from the NSSC's inventory) or that the NSSC ordered at the customer's request; for these operations, the NSSC used a just-in-time inventory model.¹⁴ As the pandemic developed, the NSSC continued to use the just-in-time inventory model, but it also began informally allocating supplies to IHS Areas. Under this modified process, the NSSC sent each Area EMPOC a proposed list of supplies to be distributed to each customer, and the Area EMPOC had the opportunity to provide input and make adjustments to that list before it was executed. The NSSC then distributed the supplies directly to each customer through a third-party vendor, such as FedEx.

As a result of this modification to its distribution method, the NSSC did not have sufficient warehouse facilities to accommodate all of the necessary medical supplies and equipment it and its customers needed during the pandemic. NSSC employees told us that IHS HQ and the NSSC have been involved in discussions to address Executive Orders issued in January and February 2021 that directed immediate actions to secure supplies necessary for responding to the pandemic and to strengthen the resilience of America's supply chains.¹⁵ However, because of the modification in its distribution method, the NSSC did not always have the capacity to store inventory that it was accumulating to fill customer orders and to allocate to IHS Areas. For this reason, the NSSC needed to acquire additional temporary warehouse space during the pandemic (referred to as "turn-key storage"). The cost of the additional turn-key storage that the NSSC had to obtain during the pandemic was approximately \$600,000 for 1 year of storage. This turn-key storage consisted of 12 units, which had a total of approximately 40,000 square feet of usable storage space.

NSSC officials told us that they would like to transition to a permanent model that includes both just-in-time inventory distribution and the storage of larger quantities of certain supplies that may be needed in an emergency, which would include health-related emergencies as well as natural disasters. NSSC officials added that to facilitate this transition, the NSSC would need to increase its warehouse space. Officials in several IHS Areas were also sensitive to the challenges of insufficient warehouse facilities. One Area EMPOC told us that it would be helpful if all Areas had a storage center that could be used to stock supplies and to receive shipments. Another Area EMPOC suggested that the NSSC consider implementing distribution centers that could serve as regional personal protective equipment stockpiles.

¹⁴ In general, the just-in-time inventory model calls for a supply facility—in this case the NSSC—to order from its wholesale retailers only the amount of items necessary to fulfill current and ongoing requirements for these items from its customers. Because it used this just-in-time inventory model, the NSSC did not generally have large quantities of items in its on-hand inventory and maintained a small warehouse space.

¹⁵ Executive Order No. 14001, On a Sustainable Public Health Supply Chain, Jan. 21, 2021; and Executive Order No. 14017, On America's Supply Chains, Feb. 24, 2021.

NSSC officials also told us that the cost of permanent warehouse space needed for the new inventory model that the NSSC would like to implement would be approximately \$450,000 per year (\$7.50 per square foot for 60,000 square feet of permanent warehouse space). This cost would represent a 25 percent cost savings from the cost of the turn-key storage units that the NSSC has been using. In addition, the permanent warehouse would allow the NSSC to store supplies in a permanent space instead of using storage units.

The NSSC did not have sufficient storage because it used a just-in-time inventory system and because of that maintained a small warehouse space for its normal (i.e., pre-pandemic) operations. Consequently, the NSSC did not have sufficient warehouse facilities for the medical supplies and equipment that it distributed to its customers during the pandemic. The NSSC had to obtain more expensive turn-key storage instead of obtaining permanent warehouse space to store necessary supplies.

Inventory Management System Lacked Tracking Functionality

The *Indian Health Manual* states: “The Area/Program Director has primary responsibility for providing direction and leadership in the supply management program and to assure that the procedures and requirements of this [Supply Management—Central Operations] Chapter are efficiently and effectively carried out”(part 5, chapter 6, section 5-6.3C(1)).

The NSSC’s inventory management system lacked tracking functionality, which limited effective operations. Specifically, the inventory management system did not allow the NSSC to track the shipment of supplies. During the pandemic, the NSSC was not always able to locate an item after it had left its warehouse. The insufficient warehouse facilities, coupled with the inability to track the shipment of supplies in the inventory management system, made it difficult to identify where an item was at a specific time, particularly if a third-party vendor had been involved in the shipping process. For example, an official at a facility told us that the facility was unable to determine when it would receive supplies that it had ordered or that had been allocated to it.

The lack of tracking functionality in the NSSC’s inventory management system was exacerbated by the pandemic, during which the NSSC had communication issues with some Area EMPOCs regarding both the shipment and tracking of supplies. For example, one Area EMPOC stated that more detailed notification and tracking information would have helped its staff to know what resources, such as pallet jacks or forklifts, would be needed to accept and store the distributed supplies. Another Area EMPOC stated that there was initially some confusion about the requisition process for supplies.

The communication issues and inability to track the shipment of supplies occurred because the NSSC’s inventory management system was outdated and unable to interface with either customers’ supply inventory systems or third-party vendors’ systems. Specifically, the NSSC’s system had limits in the numbers of allowable characters in data fields, which affected users’ ability to enter complete and accurate information about a product or transaction. As a result,

the NSSC lacked the ability to: (1) track the routing of a product that had been shipped and (2) provide necessary information to the customer about the status of the shipment. Thus, the NSSC could not properly track the shipment of medical supplies and equipment to know whether customers had already obtained supplies that they had requested or been allocated. Nor could the NSSC accurately and comprehensively track the order fulfillment or shipments of allocated supplies. The shortcomings in the NSSC's inventory management system thus prevented its officials from being able to systemically identify problems and test solutions involving the timeliness of supply delivery.

CONCLUSION

The NSSC was generally effective in facilitating the distribution of medical supplies and equipment during the COVID-19 pandemic. However, the NSSC's internal controls could be improved to include written policies and procedures for responding to emergency situations like the COVID-19 pandemic. Established written policies and procedures would provide a framework to guide decision-making for emergency situations, as the NSSC's current process is not optimal or sustainable, particularly when institutional knowledge is subsequently lost or diminished. As a result of the absence of written policies and procedures for emergency situations, there is an increased risk that the NSSC will not be able to respond effectively to an emergency in the future. In addition, the use of expensive temporary storage space and the reliance on an outdated inventory management system point to the need for additional resources to enable the NSSC to provide more effective and efficient support to its many customers.

RECOMMENDATIONS

We recommend that IHS's National Supply Service Center:

- strengthen internal controls by developing and implementing written policies and procedures for emergency situations when normal NSSC supply distribution processes are not possible or must be augmented;
- identify feasibly viable options—including seeking additional funding—to prepare for future emergency situations that address additional storage capacity and inventory distribution needs when transitioning to a permanent inventory model; and
- upgrade its inventory management system software to improve its ability to interface with IHS Areas, other customers, and third-party vendors.

IHS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, IHS concurred with all of our recommendations and described corrective actions that it had taken or planned to take. For our first recommendation, IHS stated that a "new NSSC Emergency Distribution Plan is under

development and is expected to be in place by January 1, 2023.” NSSC also stated that it had implemented new software to improve internal and external communication. For our second recommendation, IHS stated that it is “exploring opportunities to identify and quantify needs to expand stockpiling capacity and inventory distribution.” In addition, IHS stated that the NSSC would develop longer-term plans for supporting the expanded storage capacity.

For our third recommendation, IHS concurred that new inventory management software is needed to perform at “industry standards for product management and distribution.” IHS stated that prior to the COVID-19 pandemic, it had launched a modernization initiative that included the procurement and implementation of new inventory management software. Because of the onset of COVID-19, this initiative had to be delayed. IHS added that it expects new inventory management software to be implemented by October 1, 2023, and said that it is “working to ensure proper alignment and information transfer capabilities within the government.”

IHS’s comments appear in their entirety as Appendix C.

We commend IHS for the actions it has taken and plans to take to address our recommendations.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 20,987 NSSC transactions that occurred between March 1, 2020, and December 31, 2020. We selected a judgmental sample of a total of 69 transactions (footnote 8) between the NSSC and IHS Direct, Tribal, and Urban facilities and reviewed these transactions and associated documentation to determine whether orders were fulfilled completely and to evaluate the NSSC's allocation methodology. We selected transactions that included items that the customers ordered as well as items that the NSSC allocated. In addition, we selected transactions from 11 IHS Areas, as well as transactions that included various types of medical supplies and equipment.

We asked questions of IHS HQ staff, NSSC staff, Area EMPOCs, and officials from some IHS program health care facilities to help us evaluate IHS's monitoring of the distribution of supplies from the NSSC to IHS Direct, Tribal, and Urban programs.

We determined that the NSSC's control environment, risk assessment, and information and communication were significant to our audit objective. We assessed the design and implementation of the NSSC's internal controls related to the distribution of supplies during our audit period. We met with NSSC staff to gain an understanding of the NSSC's organizational structure, responsibilities, and emergency response. In addition, we interviewed Area EMPOCs to assess the effectiveness of the distribution of supplies as well as the communication between the NSSC and the IHS Areas.

We performed audit work from August 2020 through August 2022.

METHODOLOGY

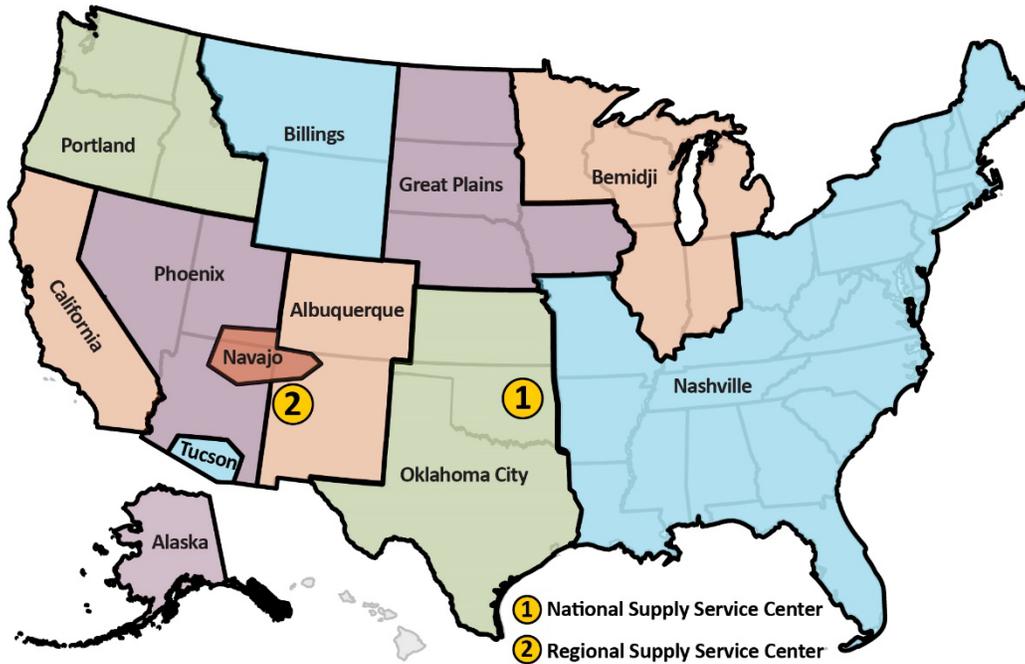
To accomplish our objective, we performed the following steps:

- We reviewed applicable Federal laws, regulations, and guidance.
- We discussed with IHS program officials the operations of the NSSC.
- We interviewed NSSC staff to gain an understanding of how the NSSC operated both before and during the COVID-19 pandemic.
- We assessed the design and implementation of internal controls applicable to our objective.
- We obtained and evaluated the NSSC's policies and procedures (which are under revision) for normal operations.

- We obtained a list of transactions between the NSSC and its customers from March 1, 2020, through December 31, 2020.
- We judgmentally selected 70 transactions (footnote 8) to review. We selected transactions that included items that the customers ordered as well as items that the NSSC allocated. In addition, we selected transactions from 11 IHS Areas, as well as transactions that included various types of medical supplies and equipment.
- For each of the 69 transactions, we reviewed documentation such as customer orders, allocation lists, and delivery lists and determined whether the transaction was ordered or allocated and whether the transaction was fulfilled.
- We asked questions of IHS Area EMPOCs to gain an understanding of their operating procedures during the pandemic and to evaluate relevant aspects of their working relationships with the NSSC.
- We asked questions of staff at four IHS facilities to determine how supplies were ordered by and distributed to them.
- We discussed the results of our audit with IHS officials on February 3, 2022.

We conducted this performance audit 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 B: IHS AREAS AND NATIONAL AND REGIONAL SUPPLY SERVICE CENTERS



NOTE—Texas is within the Oklahoma City Area but also includes programs that report to the Albuquerque and Nashville Areas. In addition, IHS does not have any direct service, tribal, or urban Indian organization sites in Hawai'i, but the California Area does have a contract to provide limited services at one facility in Hawai'i.



DATE: September 7, 2022

TO: Inspector General

FROM: Acting Director

SUBJECT: IHS Response to Draft OIG Report: *IHS's National Supply Service Center Was Generally Effective in Providing Supplies to Facilities During the COVID-19 Pandemic, but Its Internal Controls Could Be Improve* (A-07-20-04124), dated August 8, 2022

We appreciate the opportunity to provide our official comments on the Draft Office of Inspector General (OIG) Report entitled, *IHS's National Supply Service Center Was Generally Effective in Providing Supplies to Facilities During the COVID-19 Pandemic, but Its Internal Controls Could Be Improve* (A-07-20-04124), dated August 8, 2022. The Indian Health Service (IHS) concurs with the three OIG recommendations discussed below.

Recommendation Number 1: IHS concurs with the recommendation.

OIG recommends that IHS's National Supply Service Center strengthen internal controls by developing and implementing written policies and procedures for emergency situations when normal NSSC supply distribution processes are not possible or must be augmented.

Planned and completed actions:

The IHS agrees that strengthened internal controls at the National Supply Service Center (NSSC) will better prepare the agency to effectively distribute products during unique and extraordinary emergency responses like COVID-19. A new NSSC Emergency Distribution Plan is under development and is expected to be in place by January 1, 2023. NSSC has implemented project management software to track workflow and improve internal and external communication.

Recommendation Number 2: IHS concurs with the recommendation.

OIG recommends that IHS's National Supply Service Center identify feasibly viable options—including seeking additional funding—to prepare for future emergency situations that address additional storage capacity and inventory distribution needs when transitioning to a permanent inventory model.

Planned and completed actions:

The IHS is exploring opportunities to identify and quantify needs to expand stockpiling capacity and inventory distribution. NSSC will develop longer-term plans for supporting the expanded capacity once one-time funds are exhausted.

Recommendation Number 3: IHS concurs with the recommendation.

OIG recommends that IHS’s National Supply Service Center upgrade its inventory management system software to improve its ability to interface with IHS Areas, other customers, and third-party vendors.

Planned and completed actions:

The IHS concurs that a new inventory management software is needed to perform at industry standards for product management and distribution. Prior to COVID-19, NSSC launched a modernization initiative to improve overall efficiency, accountability, and support to customers. The procurement and implementation of a new inventory management software was included in the modernization plan. The onset of COVID-19 required NSSC to redirect its priorities toward preparedness and response activities. The IHS has since received supplemental funding and NSSC will begin strategic planning for the modernization beginning October 1, 2022. Award and implementation of a new Enterprise Resource Planning (ERP) solution, which includes inventory management software, is expected to be completed by October 1, 2023. NSSC has performed market analysis on existing ERPs being used within the government and is working with other agencies to ensure alignment and interface. NSSC is also included in numerous workgroups trusted with building a more resilient supply chain and is working to ensure proper alignment and information transfer capabilities within the government.

Thank you for the opportunity to review and comment on this draft report. Please refer any follow up questions you have regarding our comments to Ms. Athena Elliott, IHS Chief Compliance Officer by email at athena.elliott@ihs.gov.

Elizabeth A. Fowler -S
Digitally signed by Elizabeth A. Fowler -S
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Elizabeth A. Fowler