



Testimony
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Affairs, House of Representatives

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VETERANS AFFAIRS CONTRACTING

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

Statement of Shelby S. Oakley
Director, Acquisition and Sourcing Management

GAO Highlights

Highlights of [GAO-18-274T](#), a testimony before the Committee on Veterans' Affairs, House of Representatives

Why GAO Did This Study

VA spends hundreds of millions of dollars annually on medical supplies to meet the health care needs of about 7 million veterans. To provide a more efficient, cost-effective way for its medical centers to order supplies, the VA established the MSPV-NG program.

The program's goals include involving clinicians in requirements development, leveraging buying power when making competitive awards, and consolidating supplies used across medical centers. VA began developing requirements in early 2015 and launched the program in December 2016.

This testimony summarizes key information contained in GAO's November 2017 report, GAO-18-34. Specifically, it addresses the extent to which VA's implementation of MSPV-NG has been effective in meeting program goals. GAO analyzed VA's requirements development and contracting processes, and identified key supply chain practices cited by four leading hospital networks. GAO also met with contracting and clinical officials at six medical centers, selected based on high dollar contract obligations in fiscal years 2014-2016 and geographic representation.

What GAO Recommends

GAO made 10 recommendations in its November 2017 report, including that VA develop an overarching strategy, expand clinician input in requirements development, and establish a plan for awarding future competitive contracts. VA agreed with GAO's recommendations.

View [GAO-18-274T](#). For more information, contact Shelby S. Oakley at (202) 512-4841 or oakleys@gao.gov.

December 7, 2017

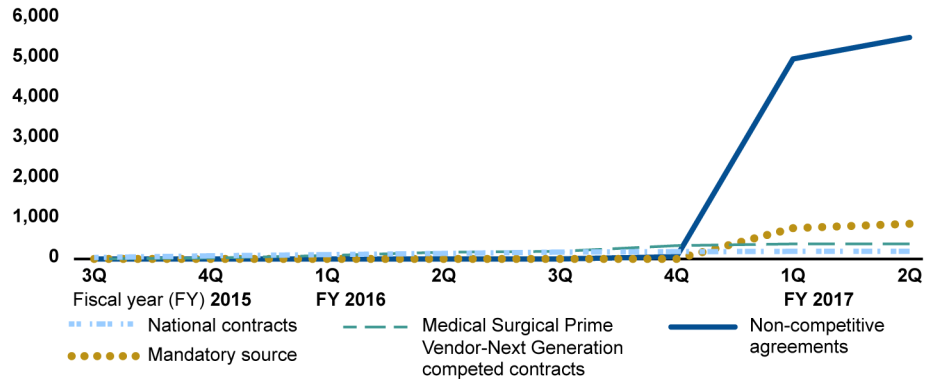
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Improvements in Buying Medical and Surgical Supplies Could Yield Cost Savings and Efficiency

What GAO Found

The Department of Veterans Affairs (VA) established the Medical Surgical Prime Vendor-Next Generation (MSPV-NG) program to provide an efficient, cost-effective way for its facilities to order supplies, but its initial implementation did not have an overarching strategy, stable leadership, and workforce capacity that could have facilitated medical center buy-in for the change. VA also developed requirements for a broad range of MSPV-NG items with limited clinical input. Further, starting in June 2015, VA planned to award competitive contracts, but instead, 79 percent of the items available for purchase under MSPV-NG were added through non-competitive agreements. (See figure.)

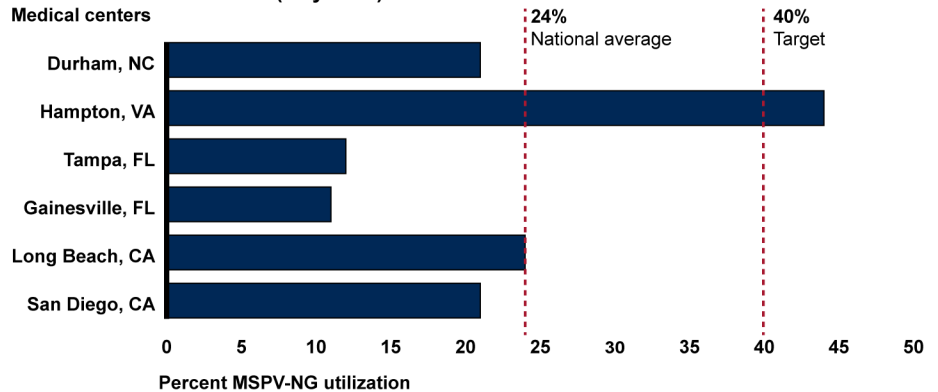
VA's Use of Non-Competitive Agreements Spiked Late in 2016
Cumulative total of items



Source: GAO analysis of Veterans Affairs formulary data. | GAO-18-274T

As a result, the program did not meet the needs of medical centers, and usage remained below VA's 40 percent target. (See figure.)

Utilization of Medical Surgical Prime Vendor-Next Generation (MSPV-NG) Program at Six Selected Medical Centers (May 2017)



Source: Veterans Health Administration Office of Procurement and Logistics. | GAO-18-274T

VA has taken steps to address some deficiencies and is developing a new approach to the program. However, VA will likely continue to face challenges in meeting its goals until it fully addresses these existing shortcomings.

Chairman Roe, Ranking Member Walz, and Members of the Committee:

In December 2016, the Department of Veterans Affairs (VA) launched the Medical Surgical Prime Vendor-Next Generation (MSPV-NG) program as its primary means for purchasing supplies, such as bandages and scalpels, for 170 VA medical centers. These supplies are intended to meet the health care needs of about 7 million veterans. In fiscal year 2015, VA obligated \$465 million for these types of supplies, and, in 2016, it stated that it planned to achieve \$150 million in cost avoidance through a supply chain transformation effort, which includes MSPV-NG. This transition represents a significant change to how medical and surgical supplies are purchased, which has raised questions about whether MSPV-NG will appropriately balance medical needs with logistical efficiency, and whether VA can achieve its planned cost avoidance. Effective supply chain management is an essential part of delivering quality health care to veterans—for instance, an April 2017 interim report issued by the VA Inspector General detailed supply management issues at the District of Columbia VA Medical Center that posed risks to patient care.¹

My remarks today are based on our recently issued report on the MSPV-NG program, and I will summarize a few key findings from that report.² Specifically, I will address the extent to which VA's implementation of MSPV-NG has been effective in meeting program goals.

As part of our work for our November 2017 report, we reviewed VA policy, communications, briefings, and other documents, prior GAO reports on best practices for organizational transformation, and internal control standards.³ We interviewed Veterans Health Administration (VHA)- and VA-wide procurement leaders, program office managers, and members of three integrated product teams who helped develop the product descriptions for supply items (known as requirements). We also interviewed supply chain managers from four leading hospital networks

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

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

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

regarding their medical supply management practices and compared them to those used by VA when implementing the MSPV-NG program.⁴ To assess VA's MSPV-NG contracting process, we analyzed the contents of the formulary (a list of specific items that medical centers are allowed to purchase) to determine what acquisition instrument was used to add the items. We determined that the MSPV-NG formulary data were sufficiently reliable by tracing data to a sample of source documents, among other steps. We selected three VHA regional networks based on those with the highest total contract obligations in fiscal years 2014 through 2016, geographic diversity, and other factors. We conducted site visits to six medical centers within these three regional networks, interviewing contracting and clinical officials. Finally, we obtained and analyzed data on VA's metrics for the program and determined the data were sufficiently reliable for our purpose of measuring utilization by interviewing officials responsible for maintaining the data and other measures.

More detailed information on our objectives, scope, and methodology for our work can be found in our November 9, 2017 report.⁵ We conducted the work on which this statement is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

MSPV-NG Program

For over a decade, each of VA's 170 medical centers used VHA's legacy MSPV program to order medical supplies, such as bandages and scalpels. Many of those items were purchased using the Federal Supply

⁴We selected these hospital networks because they were identified by an industry study as having leading supply chain practices. See Gartner, Inc., *The Healthcare Supply Chain Top 25 for 2015* (Nov. 18, 2015).

⁵See [GAO-18-34](#).

Schedules, which provided medical centers with a great deal of flexibility.⁶ However, as we reported in 2016, this legacy program prevented VHA from standardizing items used across its medical centers and affected its ability to leverage its buying power to achieve greater cost avoidance.⁷ Standardization is a process of narrowing the range of items purchased to meet a given need, such as buying 10 varieties of bandages instead of 100, in order to improve buying power, simplify supply chain management, and provide clinical consistency. In part because of the legacy MSPV program's limited standardization, VHA decided to transition to a new iteration, called MSPV-NG.

The transition to MSPV-NG has been a major effort, involving the MSPV-NG program office, stakeholders from the VHA's Procurement and Logistics Office and VA's Strategic Acquisition Center (SAC)—a VA-wide contracting organization—and logistics and clinical personnel at every medical center. The program also includes hundreds of new contracts with individual supply vendors and a new set of prime vendor contracts to distribute the supplies.

VA's goals for the MSPV-NG program include (1) standardizing requirements for supply items for greater clinical consistency; (2) demonstrating cost avoidance by leveraging VA's substantial buying power when making competitive awards; (3) achieving greater efficiency in ordering and supply chain management, including a metric of ordering 40 percent of medical centers' supplies from the MSPV-NG formulary; and (4) involving clinicians in requirements development to ensure uniform clinical review of medical supplies.

VHA launched the MSPV-NG program in December 2016, but allowed a 4-month transition period. After April 2017, medical centers could no longer use the legacy program. MSPV-NG now restricts ordering to a narrow formulary. VHA policy requires medical centers to use MSPV-

⁶The Federal Supply Schedules program, managed by the General Services Administration, provides federal agencies a simplified method of purchasing commercial products and services at prices associated with volume buying. The General Services Administration has delegated authority to VA to manage health-care-related supplies and services. For more details on the legacy MSPV program, see GAO, *Veterans Affairs Contracting: Improvements in Policies and Processes Could Yield Cost Savings and Efficiency*, [GAO-16-810](#) (Washington, D.C.: Sept. 16, 2016).

⁷See [GAO-16-810](#).

NG—as opposed to other means such as open market purchase card transactions—when purchasing items that are available in the formulary.

Supply Chain Practices Identified by Selected Leading Hospital Networks

Leading hospital networks we spoke with have similar goals to VA in managing their supply chains, including clinical standardization and reduced costs. These hospital networks reported they analyze their spending to identify items purchased most frequently, and which ones would be the best candidates to standardize first to yield cost savings. The hospitals' supply chain managers reported establishing consensus with clinicians through early and frequent collaboration, understanding that clinician involvement is critical to the success of any effort to standardize their medical supply chain. By following these practices, these hospital networks have reported they have achieved significant cost savings in some cases, and the potential for improved patient care, while maintaining buy-in from their clinicians.

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

VHA's implementation of the MSPV-NG program—from its initial work to identify a list of supply requirements in early 2015, through its roll-out of the formulary to medical centers in December 2016—was not executed in line with leading practices. Specifically, VHA lacked a documented program strategy, leadership stability, and workforce capacity for the transition that, if in place, could have facilitated buy-in for the change throughout the organization. Further, the initial requirements development process and tight time frames contributed to ineffective contracting processes. As a result, VHA developed an initial formulary that did not meet the needs of the medical centers and has yet to achieve utilization and cost avoidance goals. VA made some changes in the second phase of requirements development to address deficiencies identified in the initial roll out. Key among these was to increase the level of clinical involvement, that is, to obtain input from the doctors and nurses at VA's individual medical facilities. Despite changes aimed at improving implementation, the agency continues to face challenges that prevent the program from fully achieving its goals.

VA's Lack of an Overarching Strategy and Leadership Instability Were Obstacles to Effective Implementation of MSPV-NG

VA did not document a clear overall strategy for the MSPV-NG program at the start and has not done so to date. About 6 months after our initial requests for a strategy or plan, a VHA official provided us with an October 2015 plan focusing on the mechanics of establishing the MSPV-NG formulary. However, this plan was used only within the VHA Procurement and Logistics Office and had not been approved by VHA or VA leadership. Leading practices for organizational transformation state that agencies must have well-documented plans and strategies for major initiatives (such as MSPV-NG) and communicate them clearly and consistently to all involved—which included VHA headquarters, the SAC, and all 170 medical centers.⁸ Without such a strategy, VA could not reasonably ensure that all stakeholders understood VHA's approach for MSPV-NG and worked together in a coordinated manner to achieve program goals. In our November 2017 report, we recommended that the Director of the MSPV-NG program office should, with input from SAC, develop, document, and communicate to stakeholders an overarching strategy for the program, including how the program office will prioritize categories of supplies for future phases of requirement development and contracting. VA agreed with this recommendation and reported it would have a strategy in place by December 2017.

Leadership instability and workforce challenges also made it difficult for VA to execute its transition to MSPV-NG. Our work has shown that leadership buy-in is necessary to ensure that major programs like MSPV-NG have the resources and support they need to execute their missions.⁹ Due to a combination of budget and hiring constraints, and lack of prioritization within VA, the MSPV-NG program office has never been fully staffed and has experienced instability in its leadership. As of January 2017, 24 of the office's 40 positions were filled, and program office officials stated that this lack of staff affected their ability to implement certain aspects of the program within the planned time frames. In addition, since the inception of MSPV-NG, the program office has had four directors, two of whom were acting and two of whom were fulfilling the director position while performing other collateral duties. For instance, one of the acting MSPV-NG program office directors was on detail from a regional health network to fulfill the position, but had to abruptly leave and

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

⁹GAO, *High-Risk Series: An Update*, [GAO-15-290](#) (Washington, D.C.: Feb. 11, 2015).

return to her prior position due to a federal hiring freeze. In our November 2017 report, we recommended that VHA prioritize the hiring of a MSPV-NG program director on a permanent basis. VA agreed with this recommendation and indicated a vacancy announcement will be posted by the end of 2017.

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

The MSPV-NG program office initially developed requirements for items to be included in the formulary based almost exclusively on prior supply purchases, with limited clinician involvement. The program office concluded in its October 2015 formulary plan that relying on data from previous clinician purchases would be a good representation of medical centers' needs and that clinician input would not be required for identifying which items to include in the initial formulary.¹⁰ Further, rather than standardizing purchases of specific categories of supplies—such as bandages or scalpels—program officials told us they identified medical and surgical items on which VA had spent \$16,000 or more annually and ordered at least 12 times per year, and made those items the basis for the formulary. Officials said this analysis initially yielded a list of about 18,000 items, which the program office further refined to about 6,000 items by removing duplicate items or those that were not considered consumable commodities, such as medical equipment. This approach to requirements development stood in sharp contrast to those of the leading hospital networks we met with, which rely heavily on clinician input to help drive the standardization process and focus on individual categories of supplies that provide the best opportunities for cost savings.

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

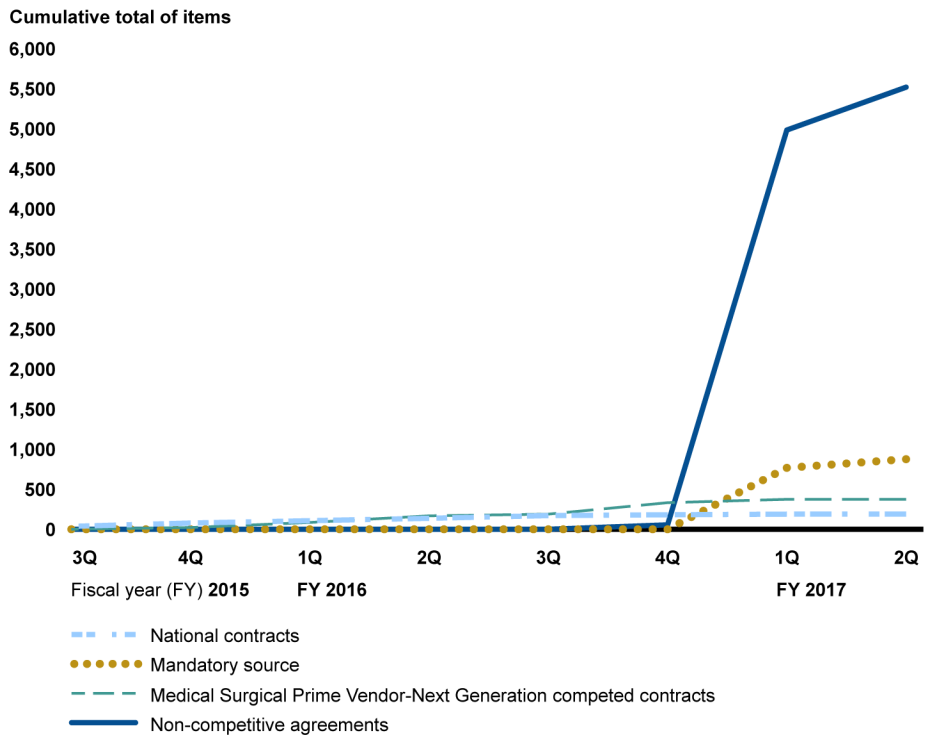
Based on the requirements developed by the program office, SAC began to issue competitive solicitations for the 6,000 items on the initial formulary in June 2015. Medical supply companies had responded to about 30 percent of the solicitations as of January 2016. As a result, according to SAC officials, they conducted outreach and some of these companies responded that VHA's requirements did not appear to be based on clinical input and instead consisted of manufacturer-specific requirements that favored particular products instead of broader descriptions. Furthermore, SAC did not solicit large groups of related

¹⁰The fiscal year 2014 data on historical purchasing by medical centers came from the Medical Product Data Bank database, jointly funded by VA and the Department of Defense, and was the principal source for identifying potential items to include on the initial version of the MSPV-NG formulary.

items, but rather issued separate solicitations for small groups of supply items—consisting of three or fewer items. This is contrary to industry practices of soliciting large groups of related supplies together. Therefore, according to SAC officials, some medical supply companies told them that submitting responses to SAC’s solicitations required more time and resources than they were willing to commit.

By its April 2016 deadline for having 6,000 items on the formulary, SAC had been working on the effort for over a year and had established competitive agreements for about 200 items, representing about 3 percent of the planned items. Without contracts for the items on the formulary in place, VA delayed the launch of the MSPV-NG program until December 2016 and SAC began establishing non-competitive agreements in the last few months before the launch of MSPV-NG. As shown in figure 1, these non-competitive agreements accounted for approximately 79 percent of the items on the January 2017 version of the formulary. While this approach enabled the MSPV-NG program office to establish the formulary more quickly, it did so at the expense of one of the primary goals of the MSPV-NG program—leveraging VA’s buying power to obtain cost avoidance through competition.

Figure 1: VA's Use of Non-Competitive Agreements Spiked Late in 2016



Source: GAO analysis of Veterans Affairs formulary data. | GAO-18-274T

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

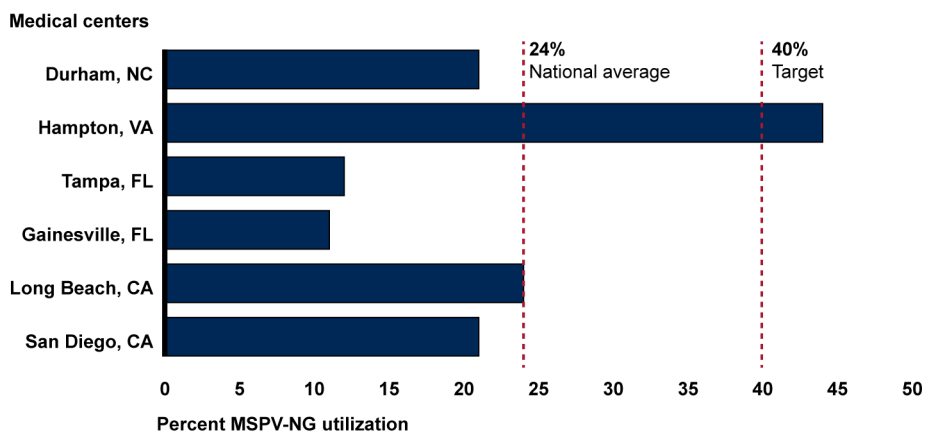
Once VA's MSPV-NG initial formulary was established in December 2016, each medical center was charged with implementing it. According to logistics officials we spoke with at selected medical centers, they had varying levels of success due, in part, to incomplete guidance from the program office. Without clear guidance, many medical centers reported they were unable to find direct matches or substitutes on the MSPV-NG formulary for a substantial number of items they routinely used, which negatively impacted utilization rates for the initial formulary. In our November 2017 report, we recommended that the Director of the MSPV-NG program office provide complete guidance to medical centers for matching equivalent supply items. VA agreed with this recommendation and indicated it would provide this guidance to medical centers by December 2017.

According to SAC, as of June 2017, only about a third of the items on the initial version of the formulary were being ordered in any significant quantity by medical centers, indicating that many items on the formulary

were not those that are needed by medical centers. Senior VHA acquisition officials attributed this mismatch to shortcomings in their initial requirements development process as well as with VA's purchase data.

VA had set a target that medical centers would order 40 percent of their supplies from the MSPV-NG formulary, but utilization rates were below this target with a nationwide average utilization rate across medical centers of about 24 percent as of May 2017. Specifically, Chief Supply Chain Officers—who are responsible for managing the ordering and stocking of medical supplies at six selected medical centers—told us that many items they needed were not included in the MSPV-NG formulary. As such, we found that these six medical centers generally fell below VA's stated utilization target. As shown in figure 2, among the six selected medical centers we reviewed, one met the target, while the remaining five were below 25 percent utilization.¹¹

Figure 2: Utilization of Medical Surgical Prime Vendor-Next Generation (MSPV-NG) Program at Six Selected Medical Centers (May 2017)



Source: Veterans Health Administration Office of Procurement and Logistics. | GAO-18-274T

Instead of fully using MSPV-NG, the selected medical centers are purchasing many items through other means, such as purchase cards or new contracts awarded by their local contracting office, in part, because they said the formulary does not meet their needs. These approaches run

¹¹The one facility that met the target, Hampton VA Medical Center, is categorized by VA as a smaller, less complex facility, and had fewer items to match, which could contribute to its higher utilization.

counter to the goals of the MSPV-NG program and contribute to VA not making the best use of taxpayer dollars.

Greater utilization of MSPV-NG is essential to VA achieving the cost avoidance goal of \$150 million for its supply chain transformation effort. Under the legacy MSPV program, the National Acquisition Center tracked cost avoidance achieved by comparing prices for competitively-awarded MSPV supply contracts with prices available elsewhere. However, VHA officials stated that they are not currently tracking cost avoidance related specifically to MSPV-NG. In our November 2017 report, we recommended that the VHA Chief Procurement and Logistics Officer, in coordination with SAC, should calculate cost avoidance achieved by MSPV-NG on an ongoing basis. VA agreed with this recommendation and reported it would develop a new metric to measure cost avoidance by June 2018.

VA Continues to Encounter Requirements Development and Contracting Challenges as It Works to Address MSPV-NG Shortcomings

In Phase 2 of MSPV-NG, the program office has taken some steps to incorporate greater clinical involvement in subsequent requirements development, but both its requirements development and SAC's contracting efforts have been hampered by staffing and schedule constraints.¹² In the fall of 2016, the program office began to establish panels of clinicians to serve on MSPV-NG integrated product teams (IPT) assigned to the task of developing updated requirements for the second phase of the formulary. Program officials said they had difficulty recruiting clinicians to participate. We found that slightly more than half (20 of the 38) of the IPTs had begun their work to review items and develop updated requirements by the time the MSPV-NG program launched in December 2016. Staff on the IPTs had to complete their responsibilities by the end of March 2017 while simultaneously managing their regular workload as physicians, surgeons, or nurses.

By early March 2017, the IPTs still had about 4,200 items to review. Faced with meeting this unrealistic time frame, the MSPV-NG program office had 9 IPT members travel to one location—with an additional 10 members participating virtually—to meet for 5 days to review the remaining items. Members told us that this time pressure limited the extent to which they were able to pursue the goal of standardizing

¹²Work on Phase 2 began while medical centers were implementing Phase 1 and beginning to order from the MSPV-NG formulary.

supplies, and that their review ended up being more of a data validation exercise than a standardization review. VHA ultimately met this compressed timeline, but in a rushed manner that limited the impact of clinician involvement.

In our November 2017 report, we recommended that the VHA Chief Procurement and Logistics Officer use input from national clinical program offices to prioritize its requirements development and standardization efforts beyond Phase 2 to focus on supply categories that offer the best opportunity for standardization and cost avoidance. VA agreed with this recommendation and stated it is in the process of finalizing guidance that will detail the importance of involving the national clinical program offices in MSPV-NG requirements development and standardization efforts.

The SAC plans to replace the existing Phase 1 non-competitive agreements with competitive awards based on the Phase 2 requirements generated by the IPTs, but it may not be able to keep up with expiring agreements due to an unrealistic schedule.¹³ Because they were made on a non-competitive basis, the Phase 1 agreements were established for a period of 1 year. In order to keep the full formulary available, the SAC director said the staff must award 200 to 250 contracts before the Phase 1 agreements expire later this year. SAC officials acknowledged that it is unlikely that they will be able to award the contracts by the time the existing agreements expire. According to SAC officials, they are in the process of hiring more staff to deal with the increased workload. Further, the SAC division director told us that they canceled all outstanding Phase 2 solicitations in September 2017 due to low response rates, protests from service-disabled veteran-owned small businesses, and changes in overall MSPV-NG strategy.

In our November 2017 report, we recommended that the MSPV-NG program office and SAC should establish a plan for how to mitigate the potential risk of gaps in contract coverage while SAC is still working to make competitive Phase 2 awards, which could include prioritizing supply categories that are most likely to yield cost avoidance. VA agreed with this recommendation and indicated it has developed a plan to mitigate the risk of gaps in contract coverage with short- and mid-term procurement

¹³According to VA, the agency plans to use indefinite delivery/indefinite quantity contracts in addition to blanket purchase agreements for Phase 2.

strategies to ensure continued provision of medical and surgical supplies to VHA facilities. The department also stated that it plans to replace the current MSPV-NG contract and formulary process with a new approach where the prime vendor would develop the formulary. However, VA will likely face challenges in this new approach until it fully addresses the existing shortcomings in the MSPV-NG program.

Chairman Roe, Ranking Member Walz, and Members of the Committee, this concludes my prepared statement. I would be pleased to respond to any questions that you may have at this time.

GAO Contacts and Staff Acknowledgments

If you or your staff have any questions about this statement, please contact Shelby S. Oakley at 202-512-4841 or OakleyS@gao.gov. In addition, contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Individuals who made key contributions to the report on which this testimony is based are Lisa Gardner, Assistant Director; Emily Bond; Matthew T. Crosby; Lorraine Ettaro; Michael Grogan; Jeff Hartnett; Katherine Lenane; Teague Lyons; Roxanna Sun; and Colleen Taylor.

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