

FEMA Did Not Provide Sufficient Oversight of Project Airbridge





OFFICE OF INSPECTOR GENERAL

Department of Homeland Security

Washington, DC 20528 / www.oig.dhs.gov

February 7, 2023

MEMORANDUM FOR: The Honorable Deanne Criswell
Administrator
Federal Emergency Management

FROM: Joseph V. Cuffari, Ph.D.
Inspector General

SUBJECT: *FEMA Did Not Provide Sufficient Oversight of Project Airbridge*

JOSEPH V. CUFFARI
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JOSEPH V CUFFARI
Date: 2023.02.03
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For your action is our final report, *FEMA Did Not Provide Sufficient Oversight of Project Airbridge*. We incorporated the formal comments provided by your office.

The report contains two recommendations aimed at improving the overall effectiveness of future public/private partnerships. Your office concurred with both recommendations. Based on information provided in your response to the draft report, we consider recommendations 1 and 2 open and resolved. Once your office has fully implemented the recommendations, please submit a formal closeout letter to us within 30 days so that we may close the recommendations. The memorandum should be accompanied by evidence of completion of agreed-upon corrective actions and of the disposition of any monetary amounts.

Please send your response or closure request to
OIGAuditsFollowup@oig.dhs.gov.

Consistent with our responsibility under the *Inspector General Act of 1978, as amended*, we will provide copies of our report to congressional committees with oversight and appropriation responsibility over the Department of Homeland Security. We will post the report on our website for public dissemination.

If you have any questions please call me at (202) 981-6000, or your staff may call Bruce Miller, Deputy Inspector General for Audits.



DHS OIG HIGHLIGHTS

FEMA Did Not Provide Sufficient Oversight of Project Airbridge

February 7, 2023

Why We Did This Audit

In response to COVID-19, FEMA initiated Project Airbridge to mitigate shortfalls in medical supply distributors' PPE and facilitate the delivery of critical PPE to locations where it was most needed. The objective of this audit was to determine the extent to which FEMA provided oversight of Project Airbridge and ensured its commercial partners distributed medical supplies to prioritized healthcare facilities in designated locations.

What We Recommend

We made two recommendations to improve FEMA's management and oversight of future public/private partnerships.

For Further Information:

Contact our Office of Public Affairs at (202) 981-6000, or email us at DHS-OIG.OfficePublicAffairs@oig.dhs.gov

What We Found

The Federal Emergency Management Agency (FEMA) did not provide sufficient oversight of Project Airbridge, a COVID-19 initiative. Under unprecedented pressure to mitigate disruptions in global medical supply chains, FEMA established Project Airbridge. The project was intended as a temporary measure to address perceived shortfalls in distributors' personal protective equipment (PPE) inventories of gloves, gowns, and masks. However, the project actually supplemented the distributors' already large domestic inventories. We attribute Project Airbridge's unnecessary air shipment of PPE to the pressure FEMA faced to get medical supplies distributed quickly. With a limited understanding of commercial supply and demand, FEMA did not sufficiently assess whether medical supply distributors needed Project Airbridge to stabilize their supply chains.

In addition, FEMA did not ensure the distributors delivered PPE to healthcare facilities as agreed. We could only confirm distributors delivered 35 percent of Airbridge PPE to designated healthcare facilities in prioritized locations instead of the 50 percent minimum required by FEMA. Because FEMA did not properly define the project's requirements, it did not have sufficient controls to hold the distributors accountable. As a result, FEMA paid to transport PPE that may not have been necessary to meet distributors' needs and was not always delivered to locations most in need. Accordingly, the project's \$238 million may have been better spent on other COVID-19 initiatives. FEMA should leverage lessons learned from this audit when contemplating and undertaking future private-government partnerships.

FEMA Response

FEMA concurred with our two recommendations. We consider both open and resolved.



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Background

The U.S. Department of Health & Human Services (HHS) determined that a nationwide public health emergency existed starting on January 27, 2020, due to COVID-19. In March 2020, the World Health Organization characterized the COVID-19 outbreak as a pandemic¹ and President Trump declared a nationwide emergency.² The Federal Emergency Management Agency (FEMA) initially supported HHS in combating the COVID-19 pandemic, but soon transitioned to leading the Federal response.

In 2020, the FEMA Administrator and HHS Assistant Secretary for Preparedness and Response co-led the Unified Coordination Group³ and assembled task forces to address top priorities for the pandemic response, including supply chain disruption. For example, FEMA and HHS created a Supply Chain Stabilization Task Force (Task Force), one of eight COVID-19-focused task forces under the National Response Coordination Center. The Task Force used a whole-of-America approach to increase the flow of medical supplies and equipment to healthcare workers on the front line. It dealt with personal protective equipment (PPE) supply shortages at different levels, such as:

- (1) supply shortages for healthcare workers on the front line, and
- (2) supply shortages in medical distributors' PPE supply base.

The National Resource Prioritization Cell, led by the Task Force, developed data-driven recommendations to the Unified Coordination Group to ensure distribution of the right resources to the right places at the right time. The cell issued bulletins that identified priority places of care and specific geographic locations that needed PPE the most.

In March 2020, FEMA initiated Project Airbridge to serve as a temporary solution designed to address perceived shortages in medical supply distributors' inventories of PPE. FEMA covered the flight costs of shipping PPE from overseas factories in several countries (such as Malaysia, China, and Vietnam) to U.S. medical supply distributors. By using air freight instead of sea shipments, Project Airbridge reduced shipment times from around 36 days to about 4 days. In exchange for expedited flights at FEMA's expense, the medical supply distributors agreed to distribute at least 50 percent of the transported PPE to distributors' customers at a reasonable price in specific areas prioritized by FEMA and HHS. The distributors would disseminate the

¹ WHO Director-General's opening remarks at the media briefing on COVID-19, March 11, 2020.

² Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak, March 13, 2020.

³ On March 20, 2022, FEMA and HHS established a Unified Coordination Group to make critical prioritization decisions in response to COVID-19. The group provided national-level decision points to the White House Coronavirus Task Force.



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remainder of the shipments into the broader U.S. supply chain as part of their regular course of business.

FEMA signed memorandums of agreement (MOAs) outlining the terms of its public-private partnership with six medical supply distributors⁴ to transport and distribute PPE.

On March 29, 2020, the first Project Airbridge flight landed at New York's John F. Kennedy International Airport; the last flight landed on June 30, 2020, at Ohio's Rickenbacker International Airport. In total, FEMA spent \$237.6 million to transport to the United States approximately 1.1 billion PPE items, primarily consisting of gloves, masks, and gowns. Table 1 identifies the type and amount of PPE transported by Project Airbridge.⁵

Table 1. PPE Transported into the United States by Project Airbridge

PPE Type	Total Airbridge PPE
Gloves	936.9M
Gowns	66.6M
Masks	122.4M
Other	23.2M
Total	1.1B

Source: Department of Homeland Security Office of Inspector General analysis of FEMA Project Airbridge Tracker

The objective of this audit was to determine the extent to which FEMA provided oversight of Project Airbridge and ensured its commercial partners distributed medical supplies to prioritized healthcare facilities in designated locations.

Results of Audit

Although Project Airbridge was a potential solution to address concerns about insufficient PPE during an unprecedented pandemic, FEMA did not provide sufficient oversight of Project Airbridge, which expended approximately \$238 million to transport about 1.1 billion PPE items to the United States. Specifically, FEMA did not assess medical supply distributors' inventories of PPE. This occurred because FEMA went from concept to implementation of Project Airbridge in about 1 week, without assessing the capacity of the distributors' commercial supply chains. According to FEMA, although it gathered demand signals based on PPE resource requests from states, localities, tribes, and territories, as it does in traditional disasters, it operated with a limited understanding of commercial supply and demand. As a result, the project did not address shortfalls in the inventory of PPE. Rather, the project supplemented the distributors' already large domestic inventories of gloves, gowns, and masks, which grew about one-third between March and June 2020. Consequently, FEMA paid to transport PPE that may not have

⁴ The six distributors represented approximately 90 percent of the market share of the domestic medical supply industry before the pandemic.

⁵ The PPE type "Masks" includes surgical and procedure masks but does not include N95 or K95 respirators; the PPE type "Other" includes items such as N95 respirators, face shields, thermometers, and other supplies transported through Airbridge in smaller amounts.



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been necessary to meet the distributors' needs, meaning, the project's \$238 million may have been better spent on other COVID-19 initiatives.

In addition, FEMA did not ensure the distributors delivered PPE to healthcare facilities as agreed. Specifically, we could only confirm distributors delivered 35 percent of the Airbridge PPE to designated healthcare facilities in prioritized locations instead of the 50 percent minimum requirement. This occurred because MOAs with the distributors, which were quickly signed and implemented, contained ambiguous terms that made enforcing them challenging. Because FEMA did not properly define the project's requirements, it did not have the controls necessary to hold the distributors accountable. As a result, PPE was not always delivered to locations most in need. FEMA should leverage lessons learned from this audit when contemplating future private-government partnerships.

Project Airbridge was Not Needed to Stabilize Domestic Supply Chains

In March 2020, one of FEMA's goals was to ensure it met the medical supply and equipment needs of healthcare providers quickly through various initiatives, including Project Airbridge. FEMA was charged with assessing the medical supply chain to identify gaps and shortfalls. In response to anticipated supply chain disruptions and an unprecedented surge in demand for critical PPE in healthcare facilities, Project Airbridge was designed to mitigate medical supply distributors' immediate perceived PPE shortages in domestic medical supply chains. In other words, the project was meant to temporarily stabilize domestic medical supply chains so distributors could satisfy anticipated surges in PPE demands.

Although it was not FEMA's intent, Project Airbridge added to large quantities of existing PPE items in distributors' supply chains and inventories in the United States. As set forth in Table 1, from March through June 2020, FEMA transported into the United States approximately 1.1 billion PPE items for the medical distributors. During that same period, *PPE Monthly Distributor Volume* reports⁶ showed distributors already had 7.5 billion gloves, and imported about 25 billion of the same PPE items from their existing supply chains. This occurred because, despite the pandemic and supply chain issues, the medical distributors continued to use their own commercial supply chains to import PPE throughout the duration of Project Airbridge. For perspective, Project Airbridge PPE shipments represented just under 5 percent of total PPE shipments received by distributors from March through June 2020. Moreover, the distributors already had sufficient domestic inventories to distribute PPE to their customers without Project Airbridge. For example,

⁶ Prepared by the Supply Chain Stabilization Task Force, *PPE Monthly Distributor Volume* reports contained monthly PPE data on distributors' domestic inventories, shipments from manufacturers, and distributions to customers.

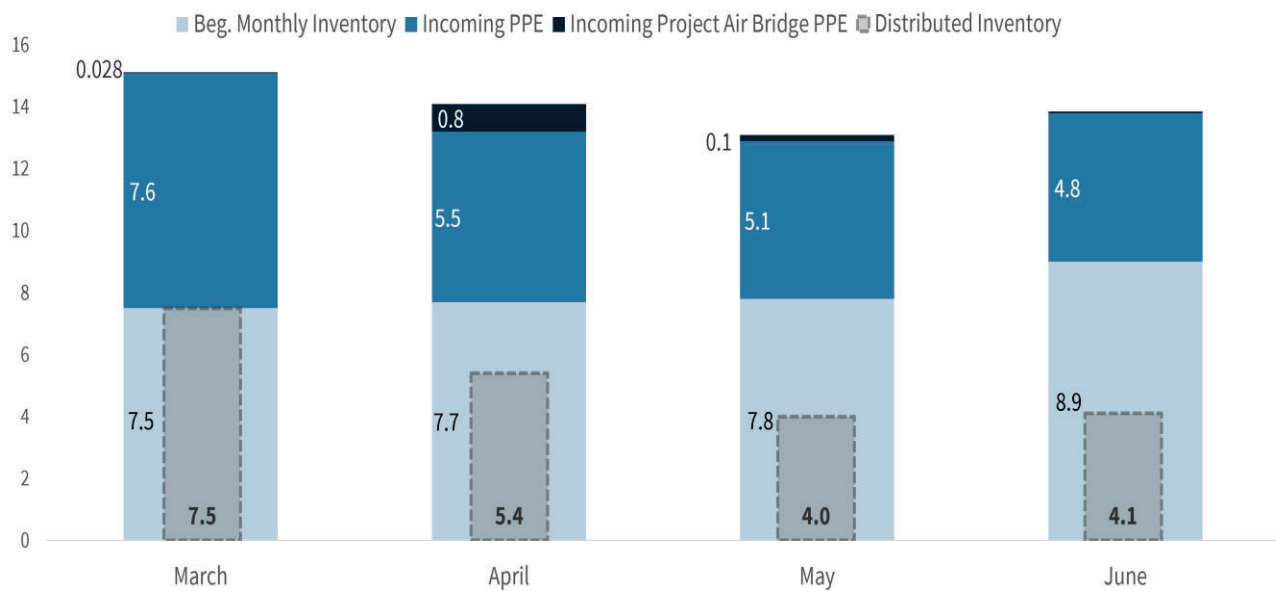


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FEMA transported approximately 937 million gloves during the project. Concurrently, the six distributors imported 23 billion gloves through existing channels and maintained an average PPE ending inventory of 8.5 billion across all distributors. Figure 1 illustrates glove inventories compared to distributions and Airbridge shipments.

Figure 1. Glove Inventory Capacity vs. Distributed Inventory (in billions), March – June 2020



Source: DHS OIG analysis of Supply Chain Stabilization Task Force PPE Monthly Distributor Volume reports

Instead of acting as a temporary measure to address supply chain shortages, Project Airbridge created unnecessary increases to already large domestic inventories of gloves, gowns, and masks. During the project, the PPE inventory increased by about 2.6 billion items (32 percent). Although never intended to augment growing commercial inventories, Project Airbridge contributed to 5 percent of the overall 32 percent inventory growth. The most significant growth occurred in surgical mask inventories, which grew by about 568 million (almost 180 percent). Project Airbridge contributed to 8 percent of the mask inventory growth. Table 2 provides information about PPE imported and present in inventories during Project Airbridge.



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Table 2. PPE in the United States Brought in and Present during Project Airbridge by the Six Distributors, March to June 2020

PPE Type	Beginning Inventory March 2020	Total PPE Brought in by Distributors	Ending Inventory June 2020	Average Inventory	Number of PPE Items Project Airbridge Brought to the United States March 29 - June 30, 2020	Percent Growth in Inventories
Gloves	7.5B	23.0B	9.6B	8.5B	936.9M	27%
Gowns	244.7M	473.7M	248.1M	186.1M	66.6M	1%
Masks	320.9M	1.5B	889.0M	510.8M	122.4M	177%
Total	8.1B	24.9B	10.7B	9.2B	1.1B	32%

Source: DHS OIG analysis of Supply Chain Stabilization Task Force PPE Monthly Distributor Volume reports

FEMA Did Not Assess Medical Supply Distributors' Supply Chains

We attribute Project Airbridge's unnecessary air shipment of PPE items to the pressure FEMA faced to get medical supplies distributed quickly. As a result, FEMA did not sufficiently assess whether medical supply distributors needed Project Airbridge to stabilize their supply chains. FEMA initiated Project Airbridge in about a week without first considering the distributors' existing domestic supply chains, including inventory levels, scheduled sea shipments, and actual customer deliveries. According to FEMA, despite early engagement with private sector partners, neither FEMA nor the partners were able to assess PPE capacity given the uncertainty about supply chains and the urgency of rising demand. FEMA further explained that, given its reliance on Resource Request Forms from states, localities, tribes, and territories to determine demand, it operated with the belief that demand would rapidly deplete available supply because domestic PPE consumption was far greater than usual. Although FEMA eventually obtained some private sector supply data, it still did not have a comprehensive overview of the distributors' inventories during the project. According to FEMA, without a comprehensive understanding of the evolving national supply and demand, it could not fully evaluate the cost and operational effectiveness of the project.

FEMA did not conduct a cost-benefit analysis until mid-April 2020. FEMA justified continuation of the project based on high PPE demand signals and reduced shipping times from an average of 36 to 4 days, emphasizing air



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freight delivery speed over larger sea shipment volumes. Although air freight is quicker, one air shipment can only transport about 1/1,100 of the volume of one container vessel and at a much higher cost. Thus, high demand signals and reduced shipping times are not sufficient justification given that, during Project Airbridge, the distributors continued to import high volumes of PPE at their own expense to increase existing large inventories.

FEMA also did not establish procedures for determining when to sunset Project Airbridge and did not define guidelines for assessing the distributors' ability to sustain supplies delivered by sea. Instead, FEMA based decisions on ad hoc discussions with distributors about PPE needs. FEMA expressed concerns that switching to sea shipments too early in the project might result in a lack of PPE importation into the United States for an extended period. To mitigate this risk, the Unified Coordination Group, at FEMA's recommendation, decided to gradually transition from air to sea shipments in May 2020, with only gowns flown through Project Airbridge during June 2020. By that time, 82 percent of the Project Airbridge shipped gloves, masks, and gowns had already arrived in the United States and been delivered to the distributors. Because FEMA did not assess supply needs at the outset of Project Airbridge, FEMA paid to transport PPE that may not have been necessary to meet immediate distributor needs. Accordingly, the project's \$238 million may have been better spent on other COVID-19 initiatives.

FEMA Did Not Ensure Medical Supply Distributors Delivered PPE to Healthcare Facilities in Designated Locations

According to the MOAs signed in March 2020, in exchange for transportation at FEMA's expense, medical supply distributors agreed to distribute at least 50 percent of the transported PPE to FEMA and HHS-designated locations. Designated locations included hospitals, nursing homes, long-term care facilities, and state and local governments in geographic locations with the greatest needs. Distributors also agreed to sell the PPE to existing customers at a reasonable price. On April 8, 2020, at the direction of the FEMA Administrator, the National Resource Prioritization Cell issued *Resource Prioritization Bulletin #2*, which identified recommended priority sites of care, such as hospitals and nursing homes, as well as priority county locations. In accordance with MOA requirements, FEMA provided the distributors with spreadsheets that identified, by county, priority locations with the greatest need for PPE. FEMA updated the spreadsheets weekly or biweekly.

We were only able to confirm that the six medical supply distributors delivered 35 percent (395 million PPE items) of total Project Airbridge shipments to healthcare facilities in designated locations instead of a minimum of 50 percent required by the Project Airbridge MOAs. Although the distributors delivered 35 percent of Project Airbridge PPE to healthcare facilities in prioritized locations, we could not determine the extent to which they prioritized hospitals and



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nursing homes over other medical customers. The MOAs clearly identified targeted recipients, but they did not limit distribution to them. This ambiguity allowed distributors to continue with their normal distribution processes to their customers, including medical professionals who provide non-critical, elective medical services, such as chiropractors, plastic surgeons, dentists, and ophthalmologists — many of whose practices were closed during the project's timeframe — and retail, wholesale, and home improvement stores.

The distributors made non-compliant distributions, meaning PPE was not delivered to healthcare facilities in the designated locations for the minimum 50 percent requirement or the final delivery location of PPE could not be determined from FEMA's records. Specifically, although distributors delivered 696 million gloves, gowns, masks, and N95 respirators, 301 million of these items were non-compliant distributions. Almost 36 percent (107 million) of non-compliant distributions went to customers in non-priority locations. About 61 percent (184 million) of non-compliant distributions went to other distributors instead of healthcare facilities in designated locations. Five of the six distributors had sales to other distributors, ranging from 2 percent to 65 percent of their total distributions. Although the MOAs did not strictly prohibit distributor-to-distributor sales, distributors are not final consumers. Therefore, for distributor-to-distributor sales, we could not determine the geographic location of final recipients for compliance reporting purposes, making these distributions non-compliant. The final 4 percent of non-compliant distributions went to non-medical customers, such as hair salons, veterinarians, or other retail establishments. Figure 2 sets forth information regarding compliant and non-compliant distributions. Appendix B summarizes the distribution locations of the 696 million Project Airbridge PPE.

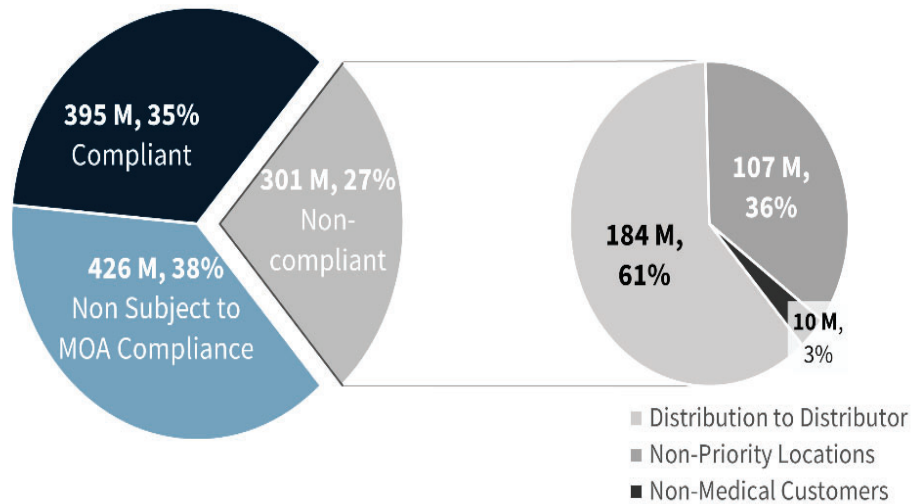


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Figure 2. Airbridge PPE Distribution Compliance with MOA Requirements⁷

Airbridge PPE Distributions and Non-Compliant Distributions, March-June 2020



Source: DHS OIG analysis of medical distributors' Airbridge Compliance Reports

The distributors' compliance rates varied significantly. Individual compliance rates for the six distributors ranged from 6 percent to 58 percent, with only one distributor exceeding the minimum 50 percent requirement. One distributor delivered about 19 million PPE items to its priority customers out of 322 million PPE items shipped to it through Project Airbridge. Another exceeded its overall required distribution to priority locations by more than 3 million PPE items, but it distributed just 13 percent of the 1.2 million N95 respirators it received. Table 3 shows the six distributors' compliance with MOA requirements.

⁷ Airbridge Compliance Reports did not include all Project Airbridge distributions, only what was distributed in relationship to the minimum 50 percent compliance requirement of total shipments. The PPE amount labeled as "Non Subject to MOA Compliance" in Figure 2 does not represent distributions but instead the portion of Project Airbridge PPE that distributors could sell through their regular distribution networks into the broader U.S. supply chain.



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Table 3. Airbridge PPE Distribution Compliance with MOA Requirements

Medical Supply Distributors	Project Airbridge Shipments	Distributor-to-Distributor	Non-Priority Locations	Non-Medical Customers	Compliant Distributions	Compliant Distribution as a Percentage of Project Airbridge Shipments
Distributor 1	42M	5M	472K	2M	24M	58%
Distributor 2	11M	2K	76K	97K	5M	43%
Distributor 3	67M	1M	5M	132K	25M	37%
Distributor 4	430M	6M	45M	839K	200M	46%
Distributor 5	250M	21M	583K	3M	122M	49%
Distributor 6	322M	150M	56M	5M	19M	6%
Grand Total	1.1B	184M	107M	10M	395M	35%
PPE Items in: Billions (B); Millions (M); Thousands (K)						

Source: DHS OIG analysis of medical distributors' Airbridge Compliance Reports

FEMA Did Not Implement Controls to Enforce Compliance with MOAs

FEMA did not establish a process to enforce compliance with the MOAs before coordinating flights to deliver PPE. Specifically, FEMA began coordinating Project Airbridge flights prior to finalizing the MOAs, with most signed the day of the first flight. FEMA did not implement sufficient controls because it advanced from concept to implementation of MOAs in less than 1 week. According to one FEMA official, FEMA established processes throughout the project's life. The FEMA official described it as building the plane while it was flying. Because FEMA did not properly define the project's requirements, such as priority facilities and reporting requirements, in the MOAs, it did not have the controls necessary to hold the distributors accountable, which made assessing and enforcing Project Airbridge requirements even more challenging.

FEMA also experienced problems with distributors' reporting because of issues with timeliness, completion, and accuracy. The reports for the six distributors were missing facility types, delivery dates, and pricing information. Five of the six distributors delayed reporting for various reasons described by FEMA including reluctance to share data, internal reporting difficulties, and an inability to determine where they delivered PPE. Due to the omission of basic program metrics, FEMA could not determine if the project helped the distributors accelerate PPE distribution to prioritized healthcare facilities at reasonable prices.



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Conclusion

COVID-19 became the first national pandemic response led by FEMA since its inception. After the President declared a nationwide emergency on March 13, 2020, FEMA needed to develop novel approaches to address potential PPE supply shortages at healthcare facilities throughout the United States.

We understand the need to mitigate supply chain disruptions. However, FEMA still had a responsibility to spend funds on verified needs. Although airlift initiatives move items quickly, they are not justified when inventory growth exceeds distribution rates. During Project Airbridge, the distributors' supply chains were functioning, they had significant PPE inventories, and they imported more PPE than Project Airbridge. FEMA should have implemented better controls to assess and adjust operations based on distributors' inventories and supply lines, but it did not. Additionally, Project Airbridge appears to have had little impact in reducing critical PPE shortages for healthcare workers who needed supplies most. Only one of the six distributors satisfied the MOA minimum 50 percent compliance requirement of total shipments. Thus, the project's \$238 million may have been better spent on other COVID-19 initiatives. FEMA should leverage lessons learned from this audit when contemplating and undertaking future private-government partnerships.

Recommendations

Recommendation 1: We recommend the FEMA Administrator develop and implement assessment criteria for public/private partnerships with distributors in response to life-threatening circumstances or events. At a minimum, assessment criteria should include:

- a justification memorandum explaining why each partnership is necessary, including a clear definition of the problem and why the partnership is an effective solution with consideration of needs, costs, and alternatives;
- an assessment of alternatives;
- a cost/benefit analysis; and
- information regarding the partners' existing supply chain, including existing inventories, supply replenishment shipments and customer orders and deliveries to support public/private partnerships.

Recommendation 2: We recommend the FEMA Administrator develop and implement policies and procedures for the use of memorandums of agreement when establishing public/private partnerships in response to life-threatening circumstances or events. The policies and procedures should ensure FEMA can enforce and assess compliance with the memorandums of agreement requirements and address, at a minimum:

- the review and approval process;



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- statutory authorities;
- roles and responsibilities;
- evaluation and reporting requirements;
- targeted end-use, users, and locations; and
- industry information necessary to monitor compliance.

Management Comments and OIG Analysis

The Acting Associate Administrator Office of Policy and Program Analysis provided written comments on a draft of this report, which are included in their entirety in Appendix A. FEMA concurred with our two recommendations. Prior to drafting our report, FEMA provided technical comments in response to potential findings and recommendations. We made revisions where appropriate to the findings. Following the issuance of our draft report, FEMA did not provide additional technical comments. We consider both recommendations open and resolved.

In its response to our draft report, FEMA stated the OIG concluded there was no shortage of PPE in the early days of COVID-19, and therefore, FEMA did not need to accelerate PPE delivery. FEMA disagreed with that conclusion and cited reports of PPE supply chain disruptions, rising PPE demand signals, and shortages of PPE among hospital staff. However, our findings do not question whether PPE supply chain disruptions existed or whether PPE shortages existed among healthcare workers, but rather whether Project Airbridge was an effective and efficient solution as implemented. We found that Project Airbridge supplemented large and growing PPE inventories of participating medical supply distributors, and FEMA did not ensure those distributors delivered PPE to healthcare facilities as agreed. Therefore, Project Airbridge appeared to have had little impact in reducing critical PPE shortages for healthcare workers who needed supplies most.

FEMA's Response to Recommendation 1: FEMA officials concurred and will develop assessment criteria that apply when a public/private partnership is necessary to effectuate the delivery of emergency protective measure assistance under the Stafford Act. FEMA's estimated completion date is December 31, 2024.

OIG Analysis: FEMA's proposed actions are responsive to this recommendation, which we consider open and resolved. It will remain open until we receive evidence of FEMA's implementation of public/private partnership assessment criteria.

FEMA's Response to Recommendation 2: FEMA officials concurred and will develop policies and procedures to establish memoranda of agreement or other



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appropriate agreements that apply when a public/private partnership is necessary to effectuate emergency protective measures assistance under the Stafford Act. FEMA's estimated completion date is December 31, 2024.

OIG Analysis: FEMA's proposed actions are responsive to this recommendation, which we consider open and resolved. It will remain open until we receive evidence of FEMA's implementation of the applicable policies and procedures.

Objective, Scope, and Methodology

The Department of Homeland Security Office of Inspector General was established by the *Homeland Security Act of 2002* (Public Law 107-296) by amendment to the *Inspector General Act of 1978*.

Our audit objective was to determine the extent to which FEMA provided oversight of Project Airbridge and ensured its commercial partners distributed medical supplies to prioritized healthcare facilities in designated locations. Our audit scope covered all Project Airbridge flights from March 2020 through June 2020 and distributions made by medical distributors from March 2020 through August 2020.

We assessed internal controls related to FEMA's oversight of Project Airbridge. Because our review was limited to addressing our audit objective it may not have disclosed all internal control deficiencies that may have existed at the time of the audit. As discussed in the body of this report, we identified weaknesses related to FEMA's establishment and administration of the project.

To gain an understanding of Project Airbridge, we met with Supply Chain Stabilization Task Force leadership, counsel, and staff and with the FEMA Logistics Management Directorate to discuss the intent of the project and the process used to develop its requirements. We reviewed meeting minutes, planning documents, congressional testimony, reports, and MOAs between FEMA and Project Airbridge distributors to understand Project Airbridge requirements and how it was managed and overseen.

To determine the quantity and type of supplies FEMA imported through Project Airbridge, we reviewed FEMA's Project Airbridge Tracker. We assessed the reliability of the tracker by validating the flight numbers, dates, distributor names, quantity, and type of PPE on each flight through reviews of cargo Airway bills, U.S Customs and Border Protection entry forms, distributor inventory controls sheets, packing slips, and transportation provider shipping reports. We also interviewed individuals responsible for maintaining the tracker. We believe the data is sufficiently reliable for our reporting purposes.



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To determine the amount of PPE distributed by the distributors, we reconciled FEMA's Project Airbridge Tracker to the six medical distributors' distribution reports by flight date, flight number, and PPE type. Once reconciled, we compared the distributor reports with FEMA's prioritization bulletins and identified shipments sent to prioritized areas using a combination of state and county codes and/or ZIP Codes. We determined the compliance rate by comparing the amount of PPE distributed to FEMA designated locations to the total amount of Project Airbridge shipments on an individual flight and overall distributor level. We compared our results to FEMA's compliance reports and noted any major discrepancies. Although we did not directly test the accuracy of the distribution reports to supporting documentation, we believe they are sufficiently reliable for reporting purposes because we were able to reconcile them to the Project Airbridge Tracker.

To determine the type of customer that received Project Airbridge supplies, we reviewed and sorted distribution reports by the quantity of PPE distributed and selected the top 50 customers that received the most PPE from each of the distributors. For each of the distributor's top 50 customers, we used customers' names, addresses, and open-source research to identify customer type. We continued customer type testing for all other reported distributions, to identify non-compliant distributions to other distributors and to non-medical customers. We did this by searching known distributor names and non-medical customers, such as non-medical retailers, corporations, salons, spas, veterinary services, and other similar entities.

To determine the extent to which FEMA's Project Airbridge shipments alleviated disruptions in the distributor PPE supply chains, we analyzed Monthly Distributor Volume reports prepared by the Supply Chain Control Tower. These reports included distributor furnished data on their PPE inventory levels, imports, and domestic distributions from March through July 2020. We were able to partially validate Supply Chain Control Tower information. Specifically, we determined the import amounts to be reasonable when compared to corresponding PPE import reporting by the U.S. International Trade Commission. Additionally, we contacted distributors and discussed the reports to ensure information was accurate. Based on our analytical reviews, we determined the data to be sufficiently reliable for our audit. We limited our review to gloves, masks, and gowns supply types because they consisted of 98 percent of supplies imported through Project Airbridge.

We conducted this performance audit between July 2020 and September 2022 pursuant to the *Inspector General Act of 1978, as amended*, and according to 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 upon our



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audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based upon our audit objectives.

The Office of Audits major contributors to this report are Ruth Blevins, Audit Director; Armando Lastra, Audit Manager; Matthew Noll, Auditor-in-Charge; Henry Kim, Auditor; Dennisse Lecaro, Program Analyst; Rolando Chavez, Independent Reference Reviewer.



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Appendix A
FEMA Comments to the Draft Report

U.S. Department of Homeland Security
Washington, DC 20472



FEMA

December 27, 2022

MEMORANDUM FOR: Joseph V. Cuffari, Ph.D.
Inspector General

FROM: Paul Judson
Acting Associate Administrator
Office of Policy and Program Analysis

SUBJECT: Management Response to Draft Report: "FEMA Did Not
Provide Sufficient Oversight of Project Airbridge"
(Project No. 20-041-AUD-FEMA(a))

Thank you for the opportunity to comment on this draft report. The Federal Emergency Management Agency (FEMA) appreciates the work of the Office of Inspector General (OIG) in planning and conducting its review and issuing this report.

FEMA's mission is to help survivors before, during, and after disasters. When the President declared an unprecedented national emergency for COVID-19 and activated FEMA's authorities, FEMA had no choice but to take action to prevent further infection and deaths.

Although FEMA concurs with the OIG's recommendations, FEMA disagrees with OIG's conclusion that there was no shortage of Personal Protective Equipment (PPE) in the early days of COVID-19 and therefore FEMA did not need to accelerate PPE delivery. A number of factors and considerations went into the decision to undertake Project Airbridge, which was made in conjunction with the Department of Health and Human Services (HHS) and the White House, to accelerate PPE delivery using airlift, including:

- On March 3, 2020, the World Health Organization warned of a severe and mounting disruption to the global supply of PPE caused by rising demand, panic buying, hoarding and misuse and called on industry and governments to increase manufacturing.¹

¹ World Health Organization news release, "Shortage of personal protective equipment endangering health workers worldwide" <https://www.who.int/news/item/03-03-2020-shortage-of-personal-protective-equipment-endangering-health-workers-worldwide>



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- On March 11, 2020, the Centers for Disease Control and Prevention (CDC) reported approximately over 1,000 new COVID-19 cases and 14 days later on March 25, 2020 reported approximately 60,000 new cases in the United States (U.S.).²
- On March 13, 2020 the President of the United States declared a nationwide emergency pursuant to Section 501 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (known as the “Stafford Act”, Pub. L. No. 93-288, as amended (42 U.S.C. § 5191(b)), and acknowledged federal efforts to accelerate the acquisition of PPE.³
- The nation was facing both rising cases and a shortage of medical supplies needed to protect citizens that included health care workers, essential industry workers and frontline workers. COVID-19 was a global crisis with many nations competing for the same medical supplies.
- At the time of the pandemic, most PPE was manufactured in Asia, where the virus and related quarantines significantly slowed down private sector production capabilities.
- The pandemic also had adverse effects on the traditional seafair carriers due to fewer delivery drivers and port lockdowns which increased the competition for space on ships and caused delivery uncertainty in the U.S.
- COVID-19 cases were increasing worldwide – reaching an initial reported peak of approximately 1.7 million weekly cases nationally by January 13, 2021,⁴ global demand for personal protection was increasing, and domestic PPE supplies were decreasing.

At the time, all available evidence—including discussions with HHS, rising costs for N- 95 respirators, and the national news—validated that the domestic consumption of an array of supplies far exceeded normal levels. Hospital staff described through media reports and other avenues severe shortages and were forced to use some of the same PPE for days at a time.

Additionally, the International Trade Commission report, “COVID-19 Related Goods: The U.S. Industry, Market, Trade, and Supply Chain Challenges,” dated December 2020, stated - “In the spring of 2020, U.S. demand for PPE substantially increased as a result of the COVID-19 pandemic, outstripping the ability of both domestic and international suppliers to meet demand... and supply shortages led to the use of expired respirators or

² CDC, “Trends in Number of COVID-19 Cases and Deaths in the US Reported to CDC, by State/Territory” https://covid.cdc.gov/covid-data-tracker/#trends_weeklycases_select_00

³ White House, Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak, March 13, 2020 <https://trumpwhitehouse.archives.gov/presidential-actions/proclamation-declaring-national-emergency-concerning-novel-coronavirus-disease-covid-19-outbreak/>

⁴ CDC, “Trends in Number of COVID-19 Cases and Deaths in the US Reported to CDC, by State/Territory” https://covid.cdc.gov/covid-data-tracker/#trends_weeklycases_select_00



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to the re-use of respirators.” This report also stated: “By August 2020, 68 percent of nurses reported using N-95 respirators for five days or more.”⁵

Faced with increasing domestic demand for PPE coupled with the uncertainty of the international PPE supply chains and future infections, FEMA concluded that action was needed to address severe PPE shortages in the U.S. and activated the airbridge to help stabilize and expedite the flow of lifesaving PPE.

The draft report contained two recommendations for FEMA with which the Agency concurs. Attached find our detailed response to each recommendation. FEMA previously submitted technical comments addressing several accuracy, contextual, and other issues under a separate cover for OIG’s consideration.

Again, thank you for the opportunity to review and comment on this draft report. Please feel free to contact me if you have any questions.

Enclosure

⁵ International Trade Commission: “COVID-19 Related Goods,” dated December 2020, [COVID-19 Related Goods: The U.S. Industry, Market, Trade, and Supply Chain Challenges \(usitc.gov\)](https://www.usitc.gov/publications/336/pub336.pdf).



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Enclosure: Management Response to Recommendations Contained in 20-041-AUD-FEMA(a)

OIG recommended that the FEMA Administrator:

Recommendation 1: Develop and implement assessment criteria for public/ private partnerships with distributors in response to life-threatening circumstance events. At a minimum, assessment criteria should include:

- a justification memorandum explaining why each partnership is necessary, including a clear definition of the problem and why the partnership is an effective solution with consideration of needs, costs, and alternatives;
- an assessment of alternatives;
- a cost/benefit analysis; and
- information regarding the partners' existing supply chain, including existing inventories, supply replenishment shipments and customer orders and deliveries to support public/ private partnership.

Response: Concur. The FEMA Office of Policy and Program Analysis, in coordination with the Office of Chief Counsel, Office of Response and Recovery, Office of the Chief Financial Officer, and the Office of Chief Procurement Officer will develop assessment criteria that are applicable when a public/ private partnership is necessary to effectuate the delivery of emergency protective measure assistance under the Stafford Act. Estimated Completion Date (ECD): December 31, 2024.⁶

Recommendation 2: Develop and implement policies and procedures for the use of memorandums of agreement when establishing public/ private partnerships in response to life-threatening circumstances or events. The policies and procedures should ensure FEMA can enforce and assess compliance with the memorandums of agreement requirements and addresses, at a minimum:

- the review and approval process;
- statutory authorities;
- roles and responsibilities;
- evaluation and reporting requirements;
- targeted end-use, users, and locations; and
- industry information necessary to monitor compliance.

Response: Concur. The FEMA Office of Chief Counsel, in coordination with the Office of Policy and Program Analysis, Office of Response and Recovery, Office of the Chief Financial Officer, and the Office of Chief Procurement Officer will develop policies and

⁶ Interim milestones will be provided in the 90-day letter following up this management response.



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procedures to establish memoranda of agreement or other appropriate agreements that are applicable when a public/private partnership is necessary to effectuate emergency protective measure assistance under the Stafford Act. ECD: December 31, 2024⁷.

⁷ Interim milestones will be provided in the 90-day letter following up this management response.

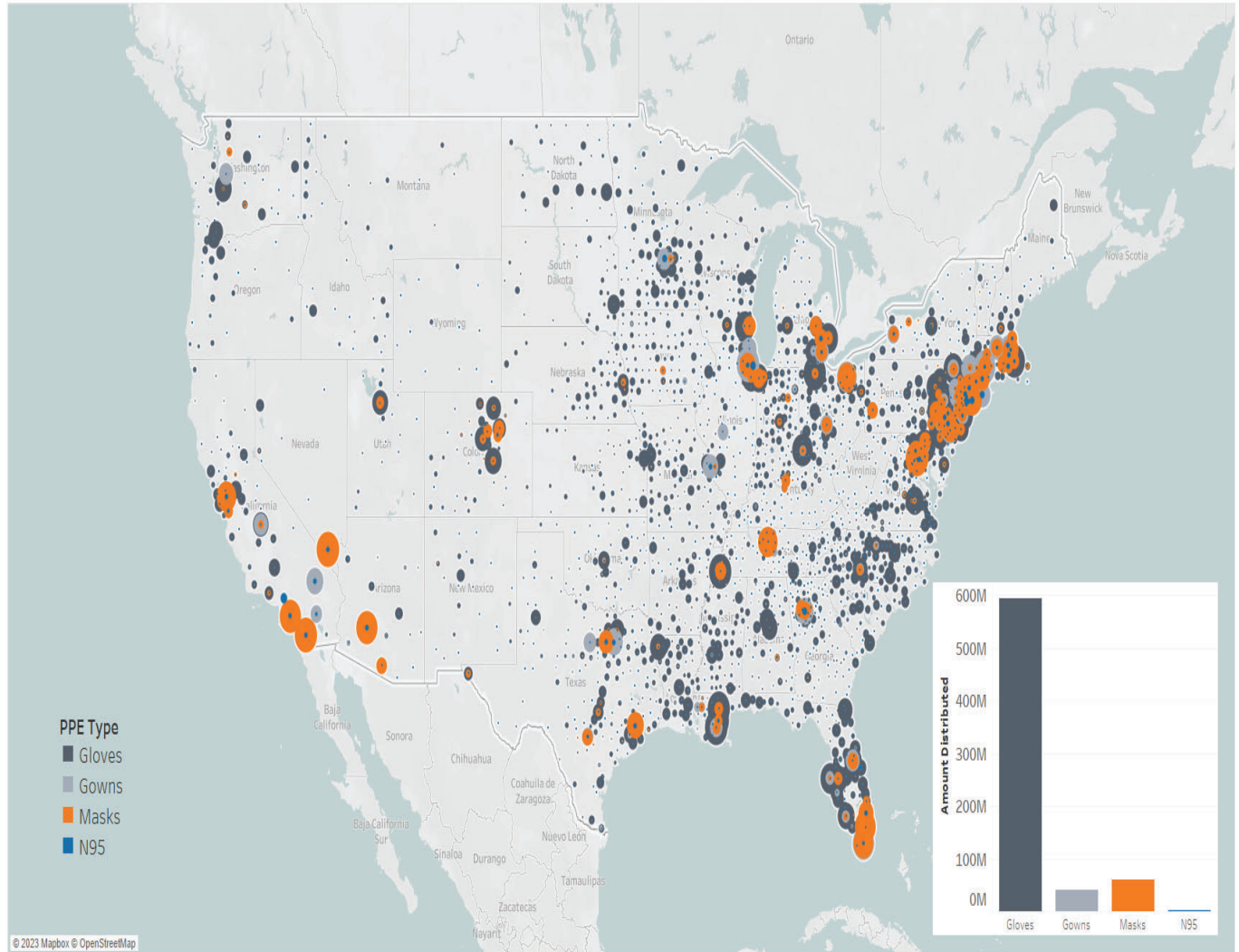


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Appendix B

Map of Airbridge PPE Distributions



Plot points have been capped at one million units and all units are in "eaches". Quantities are mapped to counties. County locations are provided by the U.S. Census and represent the center of a county's geographical area. As the U.S. Census provides the centroid of both land and water area, some county markers may appear as located slightly outside the land area boundary.

Source: DHS OIG Analysis of Medical Distributors' Airbridge Compliance Reports



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Appendix C

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