

VA PROCUREMENT: IDENTIFYING OBSTACLES TO REFORM

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND
INVESTIGATIONS

OF THE

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CONTENTS

Tuesday, September 20, 2016

	Page
VA Procurement: Identifying Obstacles To Reform	1
OPENING STATEMENTS	
Honorable Mike Coffman, Chairman	1
Honorable Ann M. Kuster, Ranking Member	2
WITNESSES	
Mr. Greg Giddens, Executive Director, Acquisition, Logistics and Construction, U.S. Department of Veterans Affairs	4
Prepared Statement	23
Accompanied by:	
Mr. Rick Lemmon, Acting Chief Procurement and Logistics Officer, Veterans Health Administration, U.S. Department of Veterans Affairs	
Mr. Michele Mackin, Director, Acquisition and Sourcing Management, U.S. Government Accountability Office	5
Prepared Statement	25
MATERIALS FOR THE RECORD	
Letter From Chairman Mike Coffman to: The Honorable Robert A. McDonald	32
Letter From Chairman Mike Coffman to: The Honorable Sloan Gibson	35
QUESTIONS FOR THE RECORD	
VA Addresses Letter From Chairman Mike Coffman	37

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Tuesday, September 20, 2016

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON OVERSIGHT
AND INVESTIGATIONS,
Washington, D.C.

The Subcommittee met, pursuant to notice, at 4:01 p.m., in Room 334, Cannon House Office Building, Hon. Mike Coffman [Chairman of the Subcommittee] presiding.

Present: Representatives Coffman, Lamborn, Roe, Benishek, Walorski, Kuster, O'Rourke, and WALZ.

Also Present: Representative WENSTRUP.

OPENING STATEMENT OF MIKE COFFMAN, CHAIRMAN

Mr. COFFMAN. Good afternoon. This hearing will come to order.

I want to welcome everyone to today's hearing on VA procurement. As a preliminary matter, I would like to ask unanimous consent that Dr. Wenstrup, Chairman of the Subcommittee on Economic Opportunity, be permitted to join us today.

Seeing no objection, so ordered.

Over the years, this Subcommittee has discussed countless problems in VA contracts from unauthorized purchase cards, purchase card commitments, and hospital construction overruns in the billions to university affiliate contracts that take years to award, to televisions purchased for hundreds of thousands of dollars but never used, to a material financial statement weakness. These problems run the gamut.

Today, we will examine the root causes. The GAO has just completed an excellent wide-ranging report recommending changes to organization, policy, and process. The VA's procurement and logistics organization is very complex. There is overlap, redundancy, and confusion about who buys what.

The VA has a headquarters run by Mr. Giddens with four organizations awarding contracts. Most of them have multiple locations around the country. The VHA's separate headquarters is the procurement and logistics office run by Mr. Lemmon. Below, there are three regional offices. Two of them have centralized contracting offices attached. Below that are 18 network contracting offices. Then there are the logistics and prosthetics organizations with their own component offices.

The Choice Act independent assessment found widespread concern among VA employees about the proliferation of contracting or-

ganizations and their ability to perform. The procurement rules are just as complex. The VA has its own acquisition regulations supplementing the Federal Acquisition Regulation, the FAR. They are badly out of date. GAO actually discovered there were two different versions simultaneously in force. Then there are many categories of policy different at the VA and VHA levels. Some supersede and contradict each other. Cancelled policies are still being followed. Apparently, VA does not even have a complete list of them. Companies doing business with the VA don't know what the rules are, and even the VA contracting officers get confused.

The Commission on Care recommends simplifying all this into one vertically integrated supply chain organization. The independent assessment recommended the same thing last year. The VA purports to accept the recommendation, but it rejects the quote, "structural solution," end quote, meaning reorganization. The VA says MyVA is already solving these problems. It is not at all clear that that is accurate.

Regarding MyVA, well, what's in it? Some new analysis—some new analytics tools and internal control improvements. Will they be enough to resolve the financial statement/material weakness? We will know in a few months.

But the big item in MyVA is the new version of the Medical/Surgical Prime Vendor contracts, or MSPV. This is an effort to pare down the number of different medical and surgical items that VHA medical centers use and save money by buying them in bulk. It's a good idea.

The concept called standardization is not new, but the implementation is not going well. The reduction of items in the MSPV product catalog is huge, down from almost half a million items to about 8,000. Decisions about which items make the cut and what doctors are allowed to use affect veterans' health care. The VA is badly behind schedule in awarding the supply contracts for these items. The VA has apparently resorted to issuing sole source contracts for thousands of them. This undermines the goal of negotiating the best prices. These are very important contracts. The VA estimates altogether they are worth more than \$4 billion.

I look forward to delving into these issues today.

I now yield to Ranking Member Kuster for her opening remarks.

OPENING STATEMENT OF ANN M. KUSTER, RANKING MEMBER

Ms. KUSTER. Thank you very much, Chairman COFFMAN. And I agree with everything you've said. I look forward to hearing from our witnesses, especially Mr. Giddens, with whom I met shortly after you took office as the principal executive director of the VA's Office of Acquisition, Logistics, and Construction last year. And in our meeting, you promised that you would develop a plan to reform VA logistics and supply chain management. So I'm very interested in hearing about the plan and the steps that you've already taken to reform the system, now that we've received the findings of the recommendations from the independent assessment Commission on Care, and now this GAO report.

It's my understanding that the VA agrees with the recommendations made by GAO, but disagrees with some of the recommendations made by the Commission on Care, specifically the rec-

ommendation that VHA establish a chief supply chain officer position to drive VHA supply chain transformation and reorganize all VHA procurement and logistics under this executive.

Mr. Giddens, I'm interested to hear why you disagree with the recommendation, considering that the GAO, the Commission on Care, and the independent assessment found that the VA's organizational structure for procurement and supply chain management is so confusing to VA contracting personnel and contains duplicative functions. So I'd be interested. I myself had a hard time following the organizational charts, and I know that vendors have brought that same issue to us.

I'm also interested to learn more about VHA's efforts to save taxpayer dollars by transitioning to national contracts for medical supplies under the Medical/Surgical Prime Vendor program. A significant problem with the MSPV is the VA's inability to either determine which supplies should be standardized or incorporate VISN and VAMC administrator and staff feedback for nonstandardized supplies within its national purchasing strategy.

As the GAO identified, VA's move to next generation MSPV without updating obsolete VA acquisition regulations, last updated in 2008, seemingly compounds the problem. Considering this existing—these existing pitfalls and inefficiencies, I'm interested to know how you will quickly ensure VA's national purchasing strategy maintains both clinical excellence and compliance with program standards.

The Commission on Care indicated that over 95 percent of all clinical supplies in the VHA are acquired using purchase cards. This process of procurement is inefficient and costly, yet its apparent preference by VA administrators implies severe shortfalls in VA's national purchasing strategy, such as the lack of clinical flexibility and significant delays in acquiring much needed medical equipment and supplies. And I'm sure my colleagues would all appreciate knowing how the VA intends to resolve this issue, and in particular, the use of old computer software that makes the purchasing of supplies so cumbersome.

I know that last year there was talk of a commercial off-the-shelf system being purchased to help the VA manage its supply chain. So I want to know if this is still a potential solution to address the VA's out-of-date IT systems. And if not, why it is taking so much time for the VA to make a decision on that issue.

Finally, I hope to hear from GAO about how the VA can improve its collection and analysis of contracting data to better plan for the future and develop strategies to lower the cost of supplies. I also want to know what the VA is doing to attract and keep top acquisition talent. These two themes of inaccurate data collection and lack of properly trained VA personnel are reoccurring themes for almost every hearing in this Subcommittee. So I want to know which plans and recommendations can be put in place today to address these two issues.

It's important that the VA establish a medical supply chain that is streamlined and clinically effective. Ultimately, VHA's ability to supply medical supplies and medication to patients affects our veterans' access to high quality health care, and our veterans deserve timely world-class care.

And with that, Mr. Chairman, I yield back.

Mr. COFFMAN. Thank you, Ranking Member Kuster.

I ask that all Members waive their openings remarks as per the Committee's custom.

Hearing no objection, so ordered.

With that, I invite the first and only panel to the witness table. On the panel we have Mr. Greg Giddens, the Principal Executive Director of the Office of Acquisition, Logistics, and Construction. He is accompanied by Mr. Rick Lemmon, the Acting VHA Chief Procurement and Logistics Officer. We also have Ms. Michele Mackin, the Director for Acquisition and Sourcing Management at GAO.

I ask the witnesses to please stand and raise your right hand.

[Witnesses sworn.]

Mr. COFFMAN. Very well. Please be seated.

And let the record reflect that all witnesses have answered in the affirmative.

Mr. Giddens, you are now recognized for 5 minutes.

STATEMENT OF GREG GIDDENS

Mr. GIDDENS. Good afternoon, Chairman Coffman, Ranking Member Kuster, and distinguished Members of the Subcommittee. I appreciate the opportunity to discuss the progress that the Department of Veterans Affairs has made towards transforming procurement and supply chain operations leading to improved business outcomes that benefit our Nation's veterans. I'm joined today by Mr. Rick Lemmon, acting VHA chief procurement and logistics officer.

Under Secretary McDonald's leadership, the VA is transforming the way we do business by embracing a more transparent and collaborative culture where we're putting the needs, expectations, and interests of veterans and their families first. We recognize that persistent challenges exist in delivering business solutions that satisfy veterans' needs, while simultaneously complying with the vast body of laws and regulations that govern Federal acquisition.

The VA is committed to continuous improvement of our procurement practices and procedures, leveraging our buying power to achieve cost avoidances, improving our management information system to support improved decision-making, improving acquisition workforce competencies, and executing our acquisition mission in an integrated manner that establishes clear lines of authority. The VA has taken steps to improve our internal acquisition processes to better communicate with employees and provide the support they need to successfully carry out their responsibilities.

Last December, I issued two VA-wide memos, the first stating my expectations of how we would improve the way we do business by transitioning from a rule base to procurement-based—principle-based procurements, placing greater emphasis on collaboration and rapid sourcing of greater requirements at affordable prices. The second memo encourages having early and frequent dialog with our industry partners throughout the acquisition life cycle. Doing so will improve our ability to articulate our requirements and will result in us receiving better proposals and ultimately in better serving our veterans. The agility of the VA's acquisition and supply

chain communities to adjust to both regulatory requirements and mission challenges continues to improve.

The transformation of the VHA supply chain is one of the MyVA breakthrough initiatives. It's focused on establishing an enterprisewide medical/surgical supply chain that leverages the VA's buying power to achieve best possible pricing and system efficiencies resulting in lower operating costs. This initiative is a comprehensive approach consistent with the Commission on Care's intent to improve the effectiveness and efficiency of the VHA supply chain and is already driving much needed improvements in data visibility and quality, synchronization of technology deployments, standardization, contract compliance, and training. Already in fiscal year 2016, VHA supply chain transformation efforts have yielded in excess of \$75 million in cost avoidance.

The Department has made steady and significant progress over the past 5 years. But admittedly, there is more work to be done, as reflected in the recent GAO report. The VA agrees with the conclusions in the report, and we are pleased that, in most cases, we already have strategies in place that align with GAO's recommendations. For example, the Department's initiative to streamline internal acquisition policy and procedures to clearly delineate what is required by law and statute from what are business process improvements. This deliberate separation of policy from procedure will create a more agile management environment that can respond more quickly to stakeholder and customer needs.

The secretary's senior leaders, managers, and members of the acquisition supply chain communities across the Department are tackling the many challenges that confront us in a transparent manner as mandated by the tenets of MyVA. We made progress, but we still have more work to do. We're committed to being good stewards of taxpayer resources and ensuring veterans and their families receive a seamless unified veteran experience across the entire organization and the country.

Mr. Chairman and Members of the Committee, this concludes my statement. Thank you for the opportunity to testify before the Committee today. We'd be happy to answer your questions.

[THE PREPARED STATEMENT OF GREG GIDDENS APPEARS IN THE APPENDIX]

Mr. COFFMAN. Well, thank you, Mr. GIDDENS.

Ms. Mackin, you are now recognized for 5 minutes.

STATEMENT OF MICHELE MACKIN

Ms. MACKIN. Thank you, Mr. Chairman.

Good afternoon, Ranking Member Kuster and Members of the Subcommittee. Thank you for having me here today to discuss VA contracting.

This is a very important issue. It's essentially about how the money goes out the door at the Department. As the Chairman mentioned, we issued a report last week that covered a number of topics, and we made ten recommendations to the VA. Today, I'll hone in on three key issues. First, the VA's confusing and outdated procurement policy framework; second, its complex procurement organizational structure; and third, opportunities to save money.

You may have seen the graphic in our report of a VA contracting officer walking through a policy forest in a confused manner. The trees represent a number of information letters, acquisition flashes, policy memos, and, most troubling, two active versions of the Department's acquisition regulation, which is the key document contracting officers turn to, one dated from 1997, and the other from 2008. It hadn't been updated in 8 years, and contracting officers were directed to consult each. It's not surprising that we found confusion and problems.

After we raised these issues, the Department rescinded the 1997 regulation, and it also began to cull through over 170 information letters, many dating from the 1990s, to determine which were still relevant. Without clear, consistent policy and guidance, it makes it harder for contracting officers to do their jobs.

Regarding the organizational structure, as we and others have noted, the VA is a complex organization, and that applies to its procurement function as well. Customers in medical centers have to navigate a complex web of national, regional, and local contracting organizations to buy what they need. For example, the National Acquisition Center, or NAC, is responsible for pharmaceuticals and high-tech medical equipment. The Strategic Acquisition Center, or SAC, which is in two different locations, is responsible for prosthetics and patient mobility supplies and services. Adding to the complexity, contracting responsibility for medical and surgical supplies was recently transferred from the NAC to the SAC. While the VA took steps in 2013 to clarify the roles and responsibilities of these organizations, we recommended that the Department consider additional guidance, and it agreed to do so.

Finally, the VA can do more to leverage its substantial buying power. When we looked at medical and surgical supplies, we found that contracting and ordering officers are not making the best use of national contracts that have significant discounts, an average of 30 percent, according to VA officials. In some cases this is understandable. The ordering processes are extremely outdated and cumbersome. I'll admit I'm old enough to remember when we first started using computers, and that's what this ordering screen looks like. You have to enter the exact item number for the type of bandage you need, for example. Because these national contracts are set up to get the best prices, it's important that the VA make it easy to use them. The VA is in the process of developing a new ordering interface.

A related issue is that while these national contracts are supposed to be mandatory, the VA has acknowledged that many purchases are occurring in the open market where these discounts aren't available. The problem is that no one knows the extent of this or where the problems might be because they have not been tracking actuals. The Department's in the process of revamping how it buys medical and surgical supplies, including awarding new contracts, as was mentioned earlier. And in doing so, it'll be very important that the Department make sure the full scope of the items that medical centers need are included on these national contracts. This effort is lagging. The VA identified a goal of 8,000 to 10,000 items to put on these contracts, and as of July 2016, only 1,800 were under contract.

I'll wrap up by noting that the VA's medical centers themselves have opportunities to leverage their buying power at a regional level for items they all buy, like landscaping services, elevator maintenance, and eyeglasses. While we found small pockets of this activity, local autonomy and a preference for using their own contracts have presented obstacles that are difficult to overcome.

Mr. Chairman, Ranking Member Kuster, this concludes my prepared remarks. Thank you.

[THE PREPARED STATEMENT OF MICHELE MACKIN APPEARS IN THE APPENDIX]

Mr. COFFMAN. Thank you, Ms. MACKIN.

The written statements of those who have just provided oral testimony will be entered into the record. We will now proceed with questions.

Mr. COFFMAN. Ms. Mackin, is this just a matter of sorting out what each office is in charge of buying, or is the sheer number of offices with similar responsibilities the problem?

Ms. MACKIN. I think that the latter point is something the Department needs to take a hard look at. As was noted, our report wasn't the first to point out the complexity of these organizations, but time and again, and we ourselves find in going out to the field to the people who are actually buying these things, they're confused. And so guidance helps. But I think the Department needs to take a look at some streamlining activities and what might make sense there.

Mr. COFFMAN. Have you seen, Ms. Mackin, the—you know, obviously there was a concern previously in this Committee about the use of these credit cards or these purchase cards where they would do multiple purchases. You know, I can't remember what the ceiling amount—not to exceed the ceiling whereby they'd have to go through the normal procurement process, it was a way to evade the procurement contracting process, and they would just, you know, do enough transactions to do whatever the price was that they were doing. And it was very problematic.

Are you seeing any evidence that this is still occurring?

Ms. MACKIN. We heard anecdotally. We didn't quantify the use of that for this report. But, you know, the national contracts are there for a reason. If they're not being used, there are other options of using a purchase card or having very small local contracts to buy the needed medical and surgical supplies. Again, not getting the discounts.

Mr. COFFMAN. Well, and I think there were also health safety issues involved. I remember, in terms of the procurement of tissue and things like that, by evading the normal procurement process, that they were actually getting some contaminated tissues from that process.

Why two active sets of regulations that you mentioned, and why not just—why haven't they consolidated into one?

Ms. MACKIN. Quite frankly, that was a troubling finding. I've never seen anything like that in my several decades of working at GAO, and I just have to attribute it to the lack of management attention, the lack of people looking out for what contracting officers need to do their job. I will say that when we raised it, the Depart-

ment acted very swiftly to rectify the situation. But not updating your acquisition regulation for 8 years is problematic.

Mr. COFFMAN. Mr. Giddens, where are we right now with our acquisition regulations?

Mr. GIDDENS. As Ms. Mackin said, we did rescind the one VA acquisition regulation. And we are underway, by December 2017, to have available and ready for public comment the update of the VA acquisition regulation. And as I mentioned, we're separating the process and the procedures that we would use to streamline and make business improvements from those that have a regulatory impact. Those of a regulatory nature need to go through the public comment period. So that's why this effort to update, that will take us as we start that and get everything ready for posting in 2017 and 2018.

In the meantime, we've taken steps to provide more clarity. We've established a Web site where our procurement professionals can go, where the most recent policy guidance is available for them to try to streamline that. We'll also be working to get feedback from contracting officers out in the field, so that we can take additional steps while we work to update that VA acquisition reg.

Mr. COFFMAN. Ms. Mackin, why doesn't the VA simply adopt the FAR, the Federal Acquisitions Regulations? Or, I mean, why have a separate—completely separate set of regulations? Is that necessary?

Ms. MACKIN. It's very common.

Mr. COFFMAN. Okay.

Ms. MACKIN. I think almost every Federal agency has its own supplement to the FAR—

Mr. COFFMAN. Right.

Ms. MACKIN [continued].—where it can tailor the buying to meet its own needs.

Mr. COFFMAN. Okay. Thank you.

Ranking Member Kuster, you're now recognized for 5 minutes.

Ms. KUSTER. Thank you, Mr. Chairman.

I wanted to ask—and this is either Mr. Giddens or Ms. Mackin. I wanted to focus in the GAO, and the Commission on Care, and the independent assessment all found that VHA's pharmaceutical supply chain performs very well, but the medical/surgical supply chain performs poorly in comparison. And my question is: Are there any best practices that we can identify in the pharmaceutical supply chain policies and processes that could be applied to the medical/surgical supply chain to improve the outcomes, both for cost and efficiency?

Mr. GIDDENS. Yes, ma'am. And that is a finding with our pharmacy program. And I'll mention a few things that we've done, and Rick may want to add some from VHA in particular. Because one of the things that VHA did in the procurement logistics office is look at the pharmacy program and adopt some of the things, like the formulary. The pharmacy program has a formulary. Here are the drugs that are approved for use. That's the same approach that they're taking on the med/surg prime vendor. What are the items that are approved for use that are proven to be clinically safe?

They do that by engaging clinicians, just like the pharmacy program did when they established their formulary. And then having

a robust mechanism to make sure that we are meeting our needs through that prime vendor program, and that we minimize the activity, whether it's with purchase cards or other, that are done outside the med/surg prime vendor program.

Rick, did you want to—

Mr. LEMMON. Yeah. The great thing about the pharmacy prime vendor program is that there's clinical involvement and a formulary's developed. It's well published, and we buy off that contract. That's exactly the approach we're wanting to take with med/surg prime vendor.

Right now, we—I believe we have 38 integrated product teams that involve clinicians that's going to help us determine the requirements for those products. And then when we go to the negotiations, will help us make those decisions on what'll best meet their needs.

And so as we develop the formulary and catalog—and I think the Chairman mentioned the sole source contracts that are necessary to get the current contract lifted off the ground. But as we can replace those with these clinically driven source contracts, it will be very similar to what was done with pharmacy. And I think that will also produce a great outcome in terms of quality and price.

Ms. KUSTER. So thank you.

One of the issues we talked about, and referring to page 35 with the page, it looks like—is it DOS? Is this the original computer language that you're having to find the actual acquisition number? And I'm trying to put together, then we learn that 95 percent of the purchases are made outside this system with cards.

What is the status, and how do we bring this system up-to-date so it's searchable and we can have a process that anyone can use anywhere across the country? Because this seems unacceptable.

Mr. LEMMON. Well, certainly what you're referring to, those blue screens, is the MUMPS-based programming that's part of the VistA architecture and, certainly, the integrated financial system that we use as part of that to identify the line items. One of the things we recently did, is we purchased what's called GUI software. But it will overlay that system until we can replace it. And it will provide a very efficient more like a Windows-based environment for our clinicians and—

Ms. KUSTER. Are we on task to replace it, though? I mean, how do you find people in 2016 that even know how to use this?

Mr. LEMMON. There's a vendor that produces that software that will overlay our VistA system and will allow us to—

Ms. KUSTER. So that normal people can use the system?

Mr. LEMMON. Yes.

Ms. KUSTER. All right. And then tell me when this is going to be replaced completely so we don't have to use these patches and overlays.

Mr. GIDDENS. The near-term solution with the graphical user interface that Rick talked about will be deployed in fiscal year 2017, so we will have that capability fully operational in 2017. The larger issue of the Department not having an integrated financial management system is one that we are tackling, that we're moving forward with as part of the Federal Shared Service program. That's an effort that we started in 2016. We'll be making the selection in

2017, and working with the shared service provider, and start to pilot that in fiscal year 2018.

But that will be the system, in fact, that will reconcile a lot of the issues that we're currently seeing with our workforce. While workforce has to do procurement in one system, and then they have to turn to another system and enter that data into another system, anytime you do manual data entry, we're introducing errors in reconciliation. And what this integrated system will do now, will work from end to end, so that information's entered once and used many through the system. It is going to be a very powerful enabler for our workforce.

Ms. KUSTER. Well, I think I can speak for my colleagues on both sides of the aisle that we will be anxiously awaiting the report on that being installed. So thank you.

I yield back.

Mr. COFFMAN. Thank you, Ranking Member Kuster.

Mrs. Walorski, you're now recognized for 5 minutes.

Mrs. WALORSKI. Thank you, Mr. Chairman.

Mr. Giddens, in the past, the VA asked vendors to supply surgical products as needed, and bill the VA after the fact. This month, the VA started requiring contracts to be issued in advance, but there already seems to be a backlog in the issuance of contracts. Companies have raised strong concerns that they are owed money, but don't have a timeframe as to when they'll be paid. The VA apparently owes these companies millions of dollars.

What is the VA doing to remedy the situation, and will these be processed and paid prior to the end of this fiscal year?

Mr. GIDDENS. The effort the VHA started in terms of structuring their process so that we procure an item before we use that, was started many months ago back in late spring, early summer. And they're progressing that implementation. As we do so, we have seen some instances where payments to vendors are starting to lag behind. But I know Rick and his team have been monitoring that, and working with vendors. In particular, with different VISNs.

Mrs. WALORSKI. And do you have a—is there some kind of a timeframe that you look for this to be completed?

Mr. LEMMON. Well, it's not a one event sort of thing, because we're always adding more orders. But—and there's a—I guess a typical type of lag time between when the order's placed, when the product's provided, and when the vendor is paid. There has been some delays due to the new process, but we're working at it very hard as far as using overtime and shifting resources to address it. We're hoping that within the next 30, 60 days, most of it will be worked out.

But the other exciting thing, is our office has been working with prosthetics and with the strategic acquisition center at OALC to put together national contracts with these implant vendors. And with those, we're going to add tremendous efficiency where we can have a much more streamlined process and fix this. So we'll have a more permanent fix instead of always trying to muscle through an inefficient process that we have now. But we had to do it for regulatory compliance, to commit the orders in advance of using the products.

Mrs. WALORSKI. Mr. Giddens, I have another question. I also heard concerns that implementation of a mandatory and additive preauthorization process for medical device implants is overly burdensome. It requires an additional three administrative steps from three different stakeholders. Could you explain the justification for these extra steps, and what's being done to ensure that veterans receive the proper device in a timely manner?

Mr. GIDDENS. Well, as Rick said, needs to make those processes to be in compliance with regulation. And while they're implementing those processes, the end state is the national contracts that we're putting in place so that that process, on an individual basis on order, can be supported by a national contract.

Mrs. WALORSKI. And then, Mr. Lemmon, just quickly, this is just something that's gone on in my district, and so I'm interested. The recently released Commission on Care report took issue with the separation of clinical supplies and prosthetic medical devices that have caused problems in coordinating products needed for procedures. It says that it takes the frontline staff members 1 to 3 months to procure simple items through your contracting and medical staff, complaining the procurement office is not responsive.

I've had surgeries in my district be rescheduled the day of because the medical staff didn't have the devices needed for the procedure. I wish I could say this, like, never happened. It has. And I wish I could say it happened once, but it hasn't. This is happening and continues to happen in my district where some of these veterans get a call day of. Oh, the device didn't come in or, you know, something happened on the way.

Do you think the inclusion of more frontline medical staff in purchasing would improve this?

Mr. LEMMON. Well, I think we have to have process improvement. And that will be driven by the national contracts. Of course, with surgeries, as you know, even in the private sector, a lot of times vendors are called in the day of surgery. Maybe it's expensive items that aren't routinely stocked. And then the surgeon, when they're in the surgery, will decide which particular product would best fit with the anatomy of the patient. So there's some risk of that. But we have to—we're looking at it holistically. We're looking at what products we can potentially bring into inventory so we're not relying on a vendor delivery. We're also going to implement more streamlined processes with ordering officers.

So the idea with prosthetics, as well as other national contracts, we want to get away from transactional contracting at the time of need. We want to have well-leveraged national contracts that can be efficiently executed at the time a clinician or someone needs a product in advance of the need, and then have a delivery that's very timely, and we know they got a quality product at a good price. So the national contracts that Greg's group is working on is going to be just a tremendous help. And then we have to work the processes.

And some of the—when you talk about what we're doing now, we're preauthorization. You're talking about an order in advance to obligate the funds so we're compliant with regulation. But then we have to finalize the order once we know what was actually used. And then we have two different systems we're doing that in. With

the new processes, a lot of those steps can be cut out. And so that's the solution to not only the problem you mentioned, but also the vendor payment issues. We have to unburden our staff and create a very efficient process to get these products, and that we're getting a quality product at the right price.

Mrs. WALORSKI. I appreciate that.

Thank you, Mr. Chairman. I yield back.

Mr. COFFMAN. Retired Sergeant Major Walz, you're now recognized for 5 minutes.

Mr. WALZ. Thank you, Chairman. And thank you all for being here.

I'm going to build on where Mrs. Walorski was going from. And I just—last week when the VA secretary testified over in the Senate, they went down the same line of questioning. And I think the question said only 38 percent of supply orders were made through standing vendor contracts as opposed to 80 or 90 percent in the private sector. Went on to talk about how the VA does it with pharmaceuticals. And it's kind of the gold standard of how you can get cost savings, efficiencies, and the mail order pharmacy gets very high—very high marks, and it's the best.

And then they went on to just ask a very simple question: What's preventing VHA from doing these kind of master contracts across the board? And the answer was: Nothing. I guess the question that's troubling me is, even someone who's not really familiar with this, this just makes great sense. It's the way things are done. It's kind of best practices. Why is the VA secretary waiting until 2016 to say this? I guess I'm asking all of you, have efforts been made over the years to do what seems—and I'm not trying to make light of this. Procurement is difficult. And I've been on the other end of that where I'm running an armory and procuring. And at times, you did want to use that card because I had to go get three cost estimates to sharpen the lawn mower blade. By the time I got done with that, it probably would have been simpler, more efficient, and more cost effective to the taxpayers had I been able to use that. But what's really funny, the standing joke was, is you cannot use that card. That takes an act of Congress. Little did I know, it didn't take an act of Congress. Someone's been using them.

So I guess I'm getting at in asking you: Why did it take this long when this is pretty much standard practice everywhere else?

Mr. GIDDENS. So I don't know in years past why we didn't move to this area. We've been working this collectively now for almost a year to make sure we get an understanding of what the requirements are from VHA, driving in clinicians, looking at our spends, so we put the right contracts in place, so that we put the right prime vendor vehicle in place. That goes live this December. And that'll be the point where I'm sure we will learn some things as we turn that on. And we won't get everything right, but we'll be in a much better position. And we've already seen that leveraging those national contracts provide delivery as well as provide value.

So we're really working through the windshield driving this hard to implement what is a generally accepted best practice and—

Mr. WALZ. No, and I appreciate that. And I don't want—and I know you coming into the job—I guess maybe then I will move to the next place, is as you're implementing and doing this—and I

think Mrs. Walorski was getting at this point on this. The questions we talked about in our office was, are clinical determinations of the primary care providers being taken into consideration? Meaning, are you seeing patterns using data of things that you know you're going to need because that care has shifted in that direction? Are you using that as part of the decision-making on the master contracts?

Mr. GIDDENS. Yes, sir, we are. And actually, that analytics is what informed the work that we're doing to stand this up in December. And we're also then working—and I'll let Rick speak a little more to this—how they're teaming in clinicians to help us understand the way forward.

But also, there's an element in here that Rick talked about with the graphic user interface that's going to allow us to get rid of the blue screen that Ranking Member Kuster showed in the book. That's going to also give us standard data. One of the things that we're suffering from now is, if I may, some medical centers call this a water bottle, and others call it a bottle, comma, water. We don't have a standard nomenclature. And if you don't have that standard nomenclature, it's hard to aggregate your data.

Now, there's some fuzzy logic algorithms that can run and some smart computer folks can try to link those together. But the graphical user interface that we'll be deploying is going to lock those fields down so we all call it the same item. And it's going to make the data analytics even more—

Mr. WALZ. So that's all straight and moving forward. Because, again, I don't want to oversimplify this, but I do think there's somewhat of an analogy here. I go online to shop for a dehumidifier at a Lowe's. They tell me which stores around me have it in, and how long it would take to get to the other one. And they know I, the user, can see that. I would think what Mrs. Walorski's talking about is the primary care physician should be able to tell where that prosthetic is, or where that device is, or where that medical equipment's at.

Is that an oversimplification or is that the direction you're going to? That user interface and that simplicity of tracking inventory and procurement is just so simple.

Mr. GIDDENS. That's absolutely the direction we're going to. And starting with standard data, nomenclature, and inventory systems that link to that so that the field will use that standard nomenclature is how we will get there. I would submit, we really don't even want that physician worried about what's going to be there. They need to set what their requirement is, and then it show up.

Mr. WALZ. Yeah. True enough. And that is happening. And when you say going live in December, what percentage of those medical facilities out there are going to be in this consolidated supply chain, and who's able to use it?

Mr. GIDDENS. I believe we'll be at the 70, 80 percent when we go live in December. And that will be available for VHA to use across their enterprise.

Mr. WALZ. Great. I yield back.

Mr. COFFMAN. Thank you, Sergeant Major Walz.

Dr. Benishek, you're now recognized for 5 minutes.

Mr. BENISHEK. Thank you, Mr. Chairman.

You know, I was reading some of this stuff here about 475,000 line items of medical/surgical supplies being narrowed down to 16,000. Is that quite right there?

Mr. LEMMON. Well, no. If you look at maybe every item that's available on a Federal supply schedule, I think that's where that number came from. The 16,000, in that range, is, based on our data analysis, is what we're buying now under the old contract. So no. And in the private sector, what we've heard from some—like Ascension Health and the Cleveland Clinic, they actually, you know, can get down to even a lower number as they do a better job working with clinicians.

Mr. BENISHEK. Well, I'll tell you what my concern is, and that is this. And I worked at the VA. You know, I'm a surgeon. And all of a sudden, there would be a new IV catheter, okay, that nobody liked. People that were putting in the IV catheters didn't like the new IV catheters. But the VA changed their brand of IV catheters that they purchased, and nobody seemed to know that that was going to happen. All right? And I can imagine—you know, I use certain equipment in the operating room, but I'm not familiar with another equipment. And there's going to be surgeons all over the country that are trained differently, that have different experience, they use different equipment. So you're going to need to have a lot of different equipment.

So to me—I mean, I understand, you know, having a reasonable amount of equipment. But without input from the practitioners, that's very difficult to do. And I don't see why—you know, Amazon sells 470,000 items, I'm sure. And they procure it probably more efficiently than you guys do. So why don't we have, you know, more emphasis on the process of procurement rather than narrowing down the items? Because, to me, that's a critical item.

I mean, when I find out that I'm going to implant, you know, a chemotherapy port, and then all of a sudden they change the type of port because they got a better deal, and they didn't talk to me about it, well, I'm sort of upset because I don't know the details of this port, and I'm going to put it in for the first time on a patient that—you know what I mean? I'm unfamiliar. That happens. Okay? And I'm sure Dr. Wenstrup might have similar experience.

So, I mean, this is kind of worrisome to me when I hear that your primary—or not—maybe not primary, but a significant part of your way of solving this problem is to cut down on the number of things and not improve the overall efficiency. So I just want to make that comment, and that scares me. Okay? So, but what is the—are you going to fix this two headquarter thing that Ms. Mackin was talking about? I can't remember which one it was, the SAC has two separate—what's that about? I mean, how does that—why are there two separate locations for the same thing?

Mr. GIDDENS. That organization has two operating locations. It's not that unusual to have. There's a group that's in Fredericksburg and a group in Frederick. The group in Frederick focuses more on services, and the group in Fredericksburg more on supplies and commodities.

Mr. BENISHEK. Well, you know, I'm just trying to see that there's a lot of thing, to me, about the procurement process that could be made better rather than simply diminishing the amount of possible

supplies. You know what I mean? I understand the formulary, how that works in the pharmacy. But even at the VA where—and at any hospital that I worked in, frankly, has a formulary. And I wasn't very happy with it sometimes because I wanted to use a drug that wasn't on a formulary.

So what—let me ask this other question. So, now, if I'm a surgeon and I want to get a product that's not on your thing, what do I got to do?

Mr. LEMMON. Well, it depends on the value of the product. Certainly, there's purchase card holders in logistics. If it's under the micropurchase threshold, \$3,500. We also have network contracting offices that can do buys larger than that for individual hospitals. But then we're tracking what's being bought on the back end for compliance just to make sure we're buying the right stuff.

Mr. BENISHEK. Right.

Mr. LEMMON. You know, the idea of having a formulary is not that you purchase every product from every vendor. You have to do some narrowing to get the cost-savings and value. But at the same time, it's critical that we have clinical-driven sourcing. The clinicians are involved in making the decisions and then we use that.

Mr. BENISHEK. What is the clinical process now?

Mr. LEMMON. Clinicians participate in the individual teams that determine what the requirements are.

Mr. BENISHEK. What clinicians are those? Now, if I go back to the VA and start working again, am I going to have an opportunity to provide input? Or is it somebody at some university somewhere? I mean, is it a limited number of clinicians or does everybody who does that, use that device, get a chance to provide input?

Mr. LEMMON. Certainly, we don't have every clinician in the VA that would use a particular item participating in the team. But there's—they do have clinical representatives that—

Mr. BENISHEK. Well, that's the part I don't like. Okay? Because why shouldn't every clinician have input? I mean, they're the ones that are actually doing the damn procedure.

Mr. LEMMON. They do in a way. We do have clinical product review Committees in hospitals.

Mr. BENISHEK. Well—okay.

Mr. LEMMON [continued]. And they forward up the items they want us to look at.

Mr. BENISHEK. All right. I'm out of time.

Mr. COFFMAN. Thank you, Dr. Benishek.

Mr. O'Rourke, you're now recognized for 5 minutes.

Mr. O'ROURKE. Thank you, Mr. Chairman.

Ms. Mackin, I wanted to—others have given examples, but I wanted to hear from you. Who does this right? Who's the model? Who should we be emulating?

Ms. MACKIN. That's hard to answer. I think every government agency has its own set of issues. What strikes us about the VA is how decentralized it is. And I think there are some duplicative functions that the Department might want to take a look at, as we've noted, as the Commission on Care noted, as the independent assessment noted. This isn't new. I'm not saying it's easy, but I think over time, it has become a little too convoluted. And I say

that because, again, the contracting officers and the ordering officials at the medical centers are confused.

Mr. O'ROURKE. And, you know, something you said struck home with me, which is that this is not the first time that these challenges and shortcomings have been brought to the attention of Congress. And I recognize that Mr. Giddens is new, relatively, in this position. But it is a familiar theme before this Committee, at least in the 4 years I've been here is: Look. The VA's royally screwed this thing up for a long time. But the people who are—were responsible for screwing it up are gone. We've got new people in place, and we've got these transformational plans that are going to completely, you know, bring the VA into line. You guys got nothing to worry about.

So what cause for optimism do you have, Ms. Mackin, when you look at what the VA's doing right now in response either to your findings or to previous findings? And what causes for concern do you have? And what's your advice to me in my oversight function? What should I be looking at in the years ahead so that we don't find you or your successor here 5 years saying: Look. The VA's now got a graphical user interface, but essentially, it's the same screwed-up system and it's still not working? What—if you could answer those three questions in the 3 minutes that we have remaining, that would be helpful to me.

Ms. MACKIN. I mean, it's a multilayered issue. You have the procurement policy framework, which I think should be pretty easy to streamline. You want one updated acquisition regulation. You want to get rid of these 170 information letters so people know what they're supposed to be doing. The organizational issues we point out will probably be more difficult to deal with. But focusing in on the medical/surgical supply program, I think the VA is on the right track. They have national contracts. That's a good practice. You want to get the best prices you can while having all the items, as I mentioned, that the clinical staff need.

What was troubling to us there, though, is are they being used? Not as much as the VA would hope. How much are they not being used? Nobody knows. There's—you know, they have not been tracking the actuals, and you're not going to get the strategic savings unless you know who's using the national contracts. And just as importantly, who's not using them and why? Is it the ordering interface? Is it the items aren't available? You have to kind of dig down and understand why they're not being used to get the best value.

Mr. O'ROURKE. And to the first question, I mean, any cause for optimism? Is there anything that you're seeing in the VA's response, say, over the last year, to these problems before this report was published, and then the VA's responses report specifically that give you cause for hope or show you that the VA's essentially on the right track—

Ms. MACKIN. I mean, during our—

Mr. O'ROURKE [continued].—or not? Let me know.

Ms. MACKIN [continued]. During our audit, when we raised the procurement policy framework that you have two versions of your acquisition regulation, they took immediate action. I don't know why it took us to point that out. I mean, that's still a concern. But,

you know, once we raised the concerns, they did start taking action. And so I think that's a good thing.

I think in terms of oversight, you know, are they using these national contracts? Are they getting the best value for the taxpayer? They have a lot in the works. MyVA, this initiative is huge and broad. And there's a lot of, we will do this, and we will do that statements.

Mr. O'ROURKE. Right.

Ms. MACKIN. I think for GAO and perhaps Congress, you want to see the documentation and the evidence that the outcomes are happening.

Mr. O'ROURKE. Yeah. And, Mr. Giddens, just—you don't have to answer this if you don't want to, but my constructive criticism would be that—and it's something that I see a lot of folks from the VA do when they testify before us, they use very aspirational language. We're going—we're pursuing supply chain transformation efforts. We're responding to stakeholders and customer needs. What would be very helpful to me is just the numbers. What have you done? What have you not done? When will you do the things that you aspire to do? How can we best hold you to account?

The aspirational we will be the best, we'll deliver for veterans, we all know that, but—we know you're in this for the right reason, that you're going to try your hardest. But it's very helpful to me if you could have a concise by-the-numbers response to, you know, perhaps the questions that were raised today, and perhaps in future testimony, look, here's where we are. That is very helpful, because I get that from GAO, for which I'm very grateful, and I don't always get that from the VA. And, again, you're not unique in that, and I appreciate the aspirations that you, you know, set out to achieve. It's just that the numbers are going to be very helpful, especially in an O&I setting.

Mr. GIDDENS. Sir, I'd welcome the opportunity to do that, to show the plans and the milestones that we have that support those aspirations.

Mr. O'ROURKE. Thank you.

Mr. GIDDENS. It's going to happen.

Mr. COFFMAN. Thank you, Mr. O'Rourke.

Dr. Wenstrup, you're now recognized for 5 minutes.

Mr. WENSTRUP. Thank you, Mr. Chairman.

You know, I appreciate the attempt to bring some order to this process. And, you know, Mr. Walz brought up the example of Lowe's. You know, they've got to do these types of things because customer service is of the utmost importance. And maybe that's something that's missing from time to time in your situation.

But you have tremendous buying power. I mean, what hospital system would not love to have the buying power of the VA health care system and use it to their advantage. It seems to me you're holding a lot of cards. And so that goes to withholding all those cards, sole source type of purchasing doesn't even make sense. Now, you may have something like, hey, a suture removal kit. Yeah, anybody can use the same one. You know, that kind of thing is fine. But it seems to me what we're doing right now is very much related to cost concerns. Now, and doctors get that. You know, we've had to deal with that.

And, you know, when it comes to medical and surgical tools, though, when you're operating on somebody, it's what's best for the patient. And that patient care comes first and foremost over anything else. And so it seems like we're kind of more contract driven right now, and the bean counters are making the decisions of what we have and don't have. And, you know, what happens when doctors don't have a legitimate choice, they leave. This happened in our group.

One of the hospital systems we were heavily entrenched with said: This is the only knee implant you can use. Well, guess what? It's not the right one for every patient. We left. We left that system. Later, they had to come around. They found a way to make it work.

And so, you know, you talk about physician recruitment for the VA. You know, you don't want to tie people's hands when you're trying to get the best in place. And you talked about the vendors delivering that day. You know, sometimes I'd have two opposing vendors and say: You know what? Once I get in there, I'm going to decide which one is going to be best for this patient. That's not a bad thing. That's a good thing.

So the question comes in, is who's always making these calls for the items that are put in the catalog? Maybe something's in the catalog that you got to, say request early, something like that, but don't make it obsolete, and in no way available. And I believe what you were looking for is the integrated procurement team that includes physicians. Well, I hope it includes the right physicians. Because a lot of times, since I've been dealing with health care and the government, they'll have physicians, but not physicians that are familiar with the things they're making decisions on. So we got to be careful on that.

So the question does come in, what happens when a doc says: I need this? And, Mr. Giddens, in August, I think you were on the radio and you were talking about ordering officers that don't have to decide which is the right kind of bandage. Well, I don't consider that a positive because there's a difference between Kling, and Kerlix and Webril, and different bandages. And they're used for different things. So one size doesn't fit all. So sometimes you do have to make a decision on what type of bandage and not just say: Well, this is easy. This is the only one you got.

And so the questions come in, what happens when a doc says: I need this? And is it a fact right now that the VA is selecting one company to supply each type of product? Because that, I think, is dangerous.

The other question I had is, when do we get to see the catalog and take a look at it for ourselves? If you would, Mr. Giddens.

Mr. GIDDENS. Sir, first, to make sure that—to clarify one of the earlier points, this is not bean counting first. We are putting veterans first. We think as we do that, we will be able to realize savings. And talking with health care organizations across the country, that's what they've told us too, that they could serve their patients, and at the same time be more cost effective. They also told us this is not an overnight journey. Now, some of them said it took them 5, 7, 8 years.

So we don't want to rush to this in any way that puts our patient and health care delivery at risk. So we intend to be deliberate, methodical, and to make best be.

You mentioned the radio show. The point I was trying to make on that is, right now, if you're that ordering officer out in the field and you do a search, you may get 5, 7, 10 pages of different kind of bandages. We want to, based on clinically driven sourcing and getting the right input from the health care community, what—if you're looking for a bandage that has bacterial properties of this and an absorption rate of this, we don't want you to have to look through five different pages. We want to provide you the ones for what you need that have already been approved for use in the VA, and that we know give good clinical outcomes.

Mr. WENSTRUP. I appreciate that clarity.

Mr. GIDDENS. And if we can leverage that and now buy at the market instead of buying at the eaches, we think we can also have some cost avoidance.

Mr. WENSTRUP. And the catalog, when do you anticipate that that might be available? Or tentative catalog.

Mr. GIDDENS. In December. We'll be happy to, as we start to go live, to share that with you.

Mr. WENSTRUP. Okay. I appreciate it.

Mr. GIDDENS. And it will be—as Rick stated, it will be evolving. That catalog in December, as we continue to get feedback, as clinicians continue to work on the integrated product teams and procurement teams, that will be adjusted, and we'll look at our spend and our analytics, and we'll—so it will be an evolving catalog. It is not going to be static. It will be dynamic.

Mr. WENSTRUP. And I just—again, I know you've heard it already, but the provider input to what they need is best for their patient has got to be a big component of this. And I understand the need for cost savings as well.

I yield back. Thank you.

Mr. COFFMAN. Yes, sir. Thank you, Dr. Wenstrup.

Doctor Roe, you're now recognized for 5 minutes.

Mr. ROE. Thank you, Mr. Chairman.

A rush in the VA is an oxymoron, Mr. Giddens. And now since I've been here, I haven't seen them get in a rush for anything.

Ms. Mackin, you—

Mr. GIDDENS. Well, sir—

Mr. ROE.—you mentioned confusing, complex, but opportunities. And I'd hope that we're going to take advantage of some opportunities. And I know that this is a huge system. I understand that. And there have to be, when we've seen abuses of the system. And I know you have to have rigid ways to do it.

And I know, Dr. Wenstrup, we all like our toys when we go to the operating room, we like what we do. But obviously, there needs to be some way that you don't have every gadget in the world on there. We understand that.

Dr. Cosgrove mentioned last week when he was here sitting right where you are, about how a different EHR system would benefit the VA, instead of having to lay something over—Ms. Kuster mentioned a minute ago about that, about it would work for an EHR health care system, a supply chain, billing, all the things the VA

is struggling with with this legacy system. Would that be something that would help where you have an off-the-shelf system, that's number one?

And, Ms. Mackin, I guess I've got a question for you. Why did it take an OIG audit to make the changes? Why didn't the VA make those changes before you audited—had to audit the system and point these things out?

Ms. MACKIN. If you're referring to the actions that they took during our audit?

Mr. ROE. Yes.

Ms. MACKIN. I mean, I have to just think it wasn't on anybody's radar screen enough to start moving. They realized that they had two acquisition regulations out there. It just was a very slow moving process. And then when we raised it, they pretty quickly rescinded the old one. So that was good. But, you know, they're still looking at a couple of years before they've updated the 2008 version.

They did agree with all ten of our recommendations. We didn't get the letter in time to publish in our report, but we heard from Mr. Giddens. So we'll be following up on those individual recommendations as well.

Mr. ROE. Well, it's the—in our Veterans Choice Act, when the Committee on care came—the VA seems to always agree, but it's implementation of it that seems to be held up. But what Mr. Walz was saying a minute ago, you know, I can go—I can go—if I want a product in the world now with the technology we have, I can literally go on Amazon and find six, seven different versions of what I want at different price points. I can do that with airline tickets, I can do that with insurance policies. I can do that—and I believe there are health systems that do exactly the same thing, to find the best price for a product in a competitive system.

And I don't know whether the VA's system of looking at it won't allow them to do it. I don't know whether that's the case or whatever. But right now, the technology's out there. You can find the best price for almost anything now.

Mr. ROE. I don't care if it is a pulse oximeter, a blood pressure cuff, stethoscope, whatever you're looking at.

Is that the system, Mr. Giddens, that's going to be in place?

Mr. GIDDENS. Yes, sir. That's the system that we'll begin using this December, where we have looked and put those contracts in place that supports that, so that when somebody is looking to order, it'll start pushing that with the graphical user interface so that they see the right item and how to—

Mr. ROE. It will search out the lowest price for the same product. Is that what you're saying?

Mr. GIDDENS. Well, I've actually already done the analytics, and I can let Rick talk a little about the analytics. We'll have already done the analytics and put the right contracts in place so they are getting the best price, but we'll continue to monitor the market. We may have a contract in place that in 9 months the market has shifted, and now that price is not as good. So we want to be looking at what the market prices are on an ongoing basis and understand maybe our contract price is still good and maybe not, and then we'll start making shifts.

Mr. ROE. Well, that segues into the next question I have, which is, in strategic buying contracts, the VA concentrates its business with a few big companies. A small orthopedic implant startup submitted a statement for the record. They say the VA is paying 68 percent too much with the big manufacturers. The VA seems to shut these small companies out because it's more convenient to get the whole product line from one company. That puts the convenience over competition and savings. How would you respond to that?

Mr. GIDDENS. I don't know any of the details on that particular procurement. It's probably in the VHA's—

Mr. ROE. We can get that for you for the record. You don't have to answer now. We can get that for you.

I notice my time is about out. I yield back.

Mr. COFFMAN. Thank you, Dr. Roe.

We'll do a second round for anybody that has additional questions. I have three additional questions.

Ms. Mackin, GAO's report says the VA is working on an updated version of its acquisition regulations, but it won't be finished until 2019. Is this reasonable?

Ms. MACKIN. It's a slow process. I will say that they began working on it in 2011. I think Mr. Giddens just said they expect to be complete in December of 2018. That is a long time. I know there's public rulemaking, that's part of it. But it seems like a long time.

Mr. COFFMAN. Mr. Giddens, Congress has given the VA numerous special procurement authorities over the years, none of which seem to make the situation any better. Why isn't maintaining these regulations more of a priority?

Mr. GIDDENS. Sir, I think as we've looked at that, it is a priority as we've indicated in working with GAO. We're going to look to accelerate that. But there is a large part of rulemaking in public comment that we must go through as we update the VAAR. That's why we want to separate that and only update in the VAAR what is required for rulemaking, and take the rest and put in a manual that we can more update as business processes are improved.

Mr. COFFMAN. Mr. Giddens, how can you demand businesses, a lot of them being small businesses, live under these regulations if the VA can't even maintain them?

Mr. GIDDENS. Well, the regulations that govern us in the FAR don't govern those businesses, large or small. They govern the interfaces that we have with them, but those interfaces are large and defined by the solicitation and the proposal process, which are clearly articulated.

Mr. COFFMAN. Ms. Mackin, summing this all up, what has MyVA, the program MyVA demonstrably accomplished in the supply chain realm?

Ms. MACKIN. I think the goals of MyVA are all good, but as noted, they're very broad and "we will" kind of statements. I've seen some numbers about cost savings. I haven't seen any backup for those numbers, so that's something I'd be interested in taking a look at.

And I'll just say an organization can't manage what it can't measure. And if the VA can't get a good understanding of, even after these national contracts are up and running, who's not using

them and why, they're not going to get where they want to get with the cost savings.

Mr. COFFMAN. Let me just say, I think Mr. O'Rourke well articulated the need to have metrics instead of these aspirational goals. You know, what we want are a plan with specific metrics that we can measure and that you can measure, Mr. Giddens, to say where you are in terms of improving this process. Can you comment on that?

Mr. GIDDENS. As indicated before, we welcome the opportunity to share those plans.

Mr. COFFMAN. When do you think you can share those with this Subcommittee?

Mr. GIDDENS. We can—next week.

Mr. COFFMAN. Okay. And I'd like Mr. O'Rourke to take a look at those and see if they meet your objectives. I think they were very well expressed.

Any other questions, Mr. O'Rourke, Mr. Walz?

Let's see where we're at here.

Our thanks to the witnesses. The witnesses are excused.

Today, we have had a chance to examine the underlining challenges in VA procurement. I hope the VA will consider streamlining these organizations and cleaning up the rules.

One final note, the VA urges us to pass provider agreement legislation in every single letter we get from the Department. Chairman Miller originally attempted to bring it to the floor in May, and it was derailed by last minute objections to the cost offset proposed by the President that this Committee under both parties has used for years. Chairman Miller again tried to bring it to the floor just last week. The bill had to be pulled over new objections, but at the last minute by the Secretary of Labor that even the VA was not aware of. I reject any implication that the Committee has not been working diligently on this legislation. I would ask the VA to be vocal in its support when it really counts, not just privately.

I ask unanimous consent that all Members have 5 legislative days to revise and extend their remarks, and include extraneous materials.

Without objection, so ordered.

I would like to once again thank all of our witnesses and audience members for joining in today's conversation. With that, this hearing is adjourned.

[Whereupon, at 5:09 p.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Greg Giddens

Good afternoon, Chairman Coffman, Ranking Member Kuster, and distinguished members of the Subcommittee. I appreciate the opportunity to discuss the progress that the Department of Veterans Affairs (VA) is making towards transforming procurement and supply chain operations leading to improved business outcomes that benefit our Nation's Veterans, and taxpayers. I am joined today by Mr. Rick Lemmon, the Acting Chief Procurement and Logistics Officer for the Veterans Health Administration (VHA).

VA recognizes that persistent challenges exist in delivering business solutions that satisfy Veterans needs while simultaneously complying with the vast body of laws and regulations that govern Federal acquisitions. VA is committed to: continuous improvement of our procurement practices and procedures; leveraging our buying power to achieve cost avoidances; improving our management information systems to support improved decision making; improving acquisition workforce competencies; and executing our acquisition mission in an integrated manner that establishes clear lines of authority and holds people accountable for mission outcomes.

To that end, the Department has made steady and significant progress over the past 5 years, but admittedly, there is more work to be done, as reflected in the recent Government Accountability Office (GAO) report titled, "Veterans Affairs Contracting: Improvement in Policies and Processes Could Yield Cost Savings and Efficiency". VA agrees with the conclusions in the report, and we are pleased to report that in most cases, VA already has strategies in place that align with GAO's recommendations. For example, the Department initiative to streamline internal acquisition policy and procedures to clearly delineate what is required by law and regulation from what are business process requirements. This deliberate separation of policy from procedure will create a more agile management environment that can respond more quickly to stakeholder and customer needs.

Other examples of the Department's focus on improving acquisition across the enterprise include enhanced training for members of the acquisition team, including both acquisition professionals and the customers they support; process improvements to improve visibility over acquisition workforce training, certifications, and warrants; and improvements in VA's contract writing system to improve visibility of contract actions across the entire acquisition life cycle from requirements generation to contract closeout. The Department is implementing a 5 year acquisition information technology systems modernization plan that is replacing legacy, proprietary systems technology with world-class, agile, and user-friendly capabilities that will be simpler and cheaper to sustain, and will also support rapid response to changing customer requirements thereby improving customer satisfaction.

Significantly, under the leadership of Secretary McDonald, VA has evolved a new management culture that embraces: industry best practices such as continuous process improvement using LEAN principles; an overarching leadership philosophy, which values employee creativity and diversity and fosters decision making that relies less on bureaucratic rules in deference to "guiding principles" that focus attention and energy squarely on Veteran needs and hold people accountable for individual and enterprise business outcomes.

Apart from improvements that are focused on developing a professional contracting workforce, VA has focused heavily on establishing an acquisition management framework to provide a disciplined, repeatable process for managing programs throughout the acquisition lifecycle. Similar to the approach used by the Department of Defense (DoD), implementation of a Acquisition Program Management Framework (APMF) will complement and support the Department's efforts to integrate business functions more effectively to achieve enterprise outcomes and results. Specifically, the APMF will help drive desired business outcomes and firmly establish accountability for acquisition programs as a component of VA's overarching "Managing for Results" process.

Key tenets of VA's approach to acquisition service delivery include the centralization of policy and workforce development functions, and decentralized execution. Centralization of acquisition policy and workforce development allows the Department to implement a standardized acquisition system and adapt the system to quickly adapt to changes. A recent example of this is the Supreme Court ruling in the case *Kingdomware Technologies, Inc. v. United States*. As a result of the ruling, contracting in the Department has fundamentally changed. Due to continuous efforts to improve integration across VA's acquisition community, the Department was able to rapidly revise numerous internal acquisition policies and procedures to ensure full compliance with the law. In addition, our award winning VA Acquisition Academy was able to quickly develop and deliver targeted training for both contracting professionals and internal customers to ensure rapid implementation of the Court's ruling. Through central management of the enterprise acquisition policy framework, VA adapted to the ruling with minimal impact to critical timely acquisitions.

The agility of VA's acquisition and supply chain communities to adjust to both regulatory requirements and mission challenges continues to improve as VA evolves through the MyVA transformation agenda which is focused on optimizing Veteran outcomes and customer experience, effective stewardship of resources, operational efficiency, and employee satisfaction. Transformation of VHA's supply chain is one of the "MyVA Breakthrough Initiatives". This initiative is focused on establishing an enterprise-wide medical-surgical supply chain that leverages VA's scale to drive both effectiveness of acquisitions (leveraging VA's buying power to achieve best possible pricing) and system efficiencies resulting in lower operating costs.

This initiative is a comprehensive approach consistent with the Commission on Care's intent to improve the effectiveness and efficiency of VHA's supply chain and is already driving much needed improvements in data visibility and quality, synchronization of technology deployments, standardization, contract compliance, and training. Already in fiscal (FY) 2016, VHA supply-chain transformation efforts have yielded in excess of \$75 million in cost avoidance. VHA has also developed a 2 year supply-chain transformation stabilization and standardization plan that will establish a common operational environment to inform investment decisions beyond FY 2018. The Department believes that it is prudent to avoid significant technology investments beyond those currently in the pipeline until such time that a mature supply-chain baseline is established, upon which future incremental IT investment decisions can be based. This is especially important given VA's Financial Management Business Transformation initiative and emerging plans for a new Digital Healthcare Platform (DHP), both of which will impact legacy and contemporary supply-chain systems and interfaces, as well as influence system-improvement alternatives and investment decisions over the next 2 to 5 years. Supply-chain system improvements must be integrated and synchronized with enterprise financial and health care system enhancements to achieve efficiencies in service delivery and support analysis of integrated data to meet VA's current and future needs.

One of the Commission on Care report's recommendations that the Department does not believe is prudent at this time is the following. Specifically, the Commission suggested establishment of a Chief Supply Chain Officer (CSCO) and realignment of all procurement and logistics operations under the CSCO executive position. This isolated recommendation would not adequately address underlying management challenges associated with organizational complexity and the need to improve integration processes impacting the supply chain. The Department believes that realignment of VHA's supply-chain structure, including roles and responsibilities of the various VA Central Office staff offices, health networks, and medical facilities, should derive from and be integrated with the transformation of the overall VHA health care organization structure. The intent of the Commission is being met by addressing alignment issues as the supply-chain breakthrough initiative evolves and is synchronized with the Department's overarching strategies to transform VHA through the MyVA initiative.

The Secretary, senior leaders, managers, and members of the acquisition and supply chain communities across the Department are keenly aware of the key business drivers fueling the MyVA Transformation. For members of the acquisition and supply chain communities, these compel us to continuously improve business processes and procedures to overcome long-standing system deficiencies; improve program execution, oversight and accountability; improve business outcomes; provide sound stewardship over resources generously provided by Congress and the American people; and be accountable to our stakeholders. We are tackling the many challenges that confront us in a transparent manner as mandated by the tenets of the MyVA transformation initiative. As stated by the Secretary, VA cannot accomplish the ongoing transformation through MyVA or recommendations from the Commission on

Care without critical legislative changes. VA has aggressively pursued these needed changes with Congress. Many of these proposals are vital to maintaining our ability to purchase community care and best serve our Veterans. One of the Secretary's top legislative priorities concerns Provider Agreements, which enable delivery of necessary care for Veterans through the fullest complement of non-VA providers. VA purchased care authorities must be clarified and modernized. The future of these authorities will have a direct impact on the workload of VA's acquisition workforce. VA and its provider partners who use provider agreements are facing continuing uncertainty, so expeditious action is necessary. VA transmitted the VA Purchased Health Care Streamlining and Modernization Act to Congress on May 1, 2015. We strongly support its passage.

Mr. Chairman and Members of the Committee, this concludes my statement. Thank you for the opportunity to testify before the Committee today. Mr. Lemmon and I would be happy to respond to any questions.

Prepared Statement of Michele Mackin

VETERANS AFFAIRS CONTRACTING

IMPROVEMENTS IN POLICIES AND PROCESSES COULD YIELD COST SAVINGS AND EFFICIENCY

Chairman Coffman, Ranking Member Kuster, and Members of the Subcommittee: The Department of Veterans Affairs (VA) spent about \$20 billion on goods and services in fiscal year 2015.¹ The wide range of goods and services that VA procures—including construction, information technology, medical supplies, and many other categories—is essential to meeting its mission to provide health care, pensions, and other benefits to the nation's military veterans. Prior assessments of VA management, both internal and external, have found shortcomings in VA procurement. In 2015, GAO added VA Health Care to our High Risk list because of issues including ambiguous policies, inconsistent processes, and inadequate oversight and accountability.²

My remarks today are based on our recently issued report on VA contracting, and I will summarize a few key findings from that report.³ I will address 1) the organizational structure of VA's procurement function, 2) VA procurement policies, and 3) the extent to which opportunities exist to improve VA's key procurement functions and to save money.

As part of our work for our September 2016 report, in order to evaluate VA's procurement organizational structure, we reviewed policy documents and interviewed officials in leadership, local contracting office management, and contracting officer roles. To assess VA's procurement policies, we obtained and analyzed policy documents, and interviewed officials responsible for making and implementing procurement policy. To assess opportunities to improve VA's key procurement functions and to save money, we obtained and analyzed information regarding VA's medical-surgical prime vendor program and interviewed officials with roles in management, contracting, and operations for the program. We also reviewed a non-generalizable sample of 37 contracts and 19 associated task orders from fiscal years 2013 through 2015. The selected contracts were chosen from the national contracting offices and local Veterans Health Administration (VHA) contracting offices we visited, and the basis for selection included dollar value and whether these contracts were competed or not. Additionally, we interviewed contracting officers responsible for each of the selected contracts.

More detailed information on our objectives, scope, and methodology for our work can be found in our September 16, 2016 report. 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.

¹ For our purposes, "spent" means obligated, as defined in A Glossary of Terms Used in the Federal Budget Process, GAO-05-734SP; 31 U.S.C. § 1501 (a).

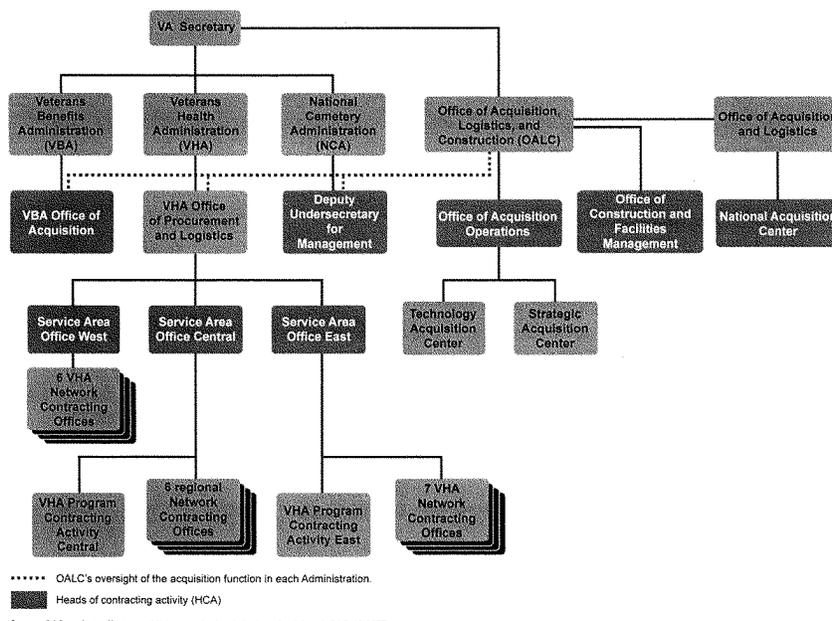
² GAO, High Risk Series: An Update, GAO 15 290 (Washington, D.C.; Feb. 11, 2015).

³ GAO, Veterans Affairs Contracting: Improvements in Policies and Processes Could Yield Cost Savings and Efficiency, GAO 16 810 (Washington, D.C.; September 16, 2016).

Background

VA serves veterans of the U.S. armed forces, and provides health, pension, burial, and other benefits. In fiscal year 2015, VA spent about \$20 billion on goods and services via contracts—more than a quarter of its discretionary budget. As shown in the organizational chart below, these contracts were awarded by VA's eight heads of contracting activity (HCAs). The department's three operational administrations—VHA, the Veterans Benefits Administration, and the National Cemetery Administration—operate largely independently from one another.

Figure 1: Organizational Structure of Veterans Affairs Procurement



In addition to the operating administrations, several VA procurement organizations have department-wide roles:

- The Office of Acquisition, Logistics, and Construction (OALC) is a VA headquarters organization responsible for directing the acquisition, logistics, construction, and leasing functions within VA.
- The Office of Acquisition Operations (OAO), which falls under OALC's purview, conducts procurement activities for customers across the department and has two primary operating divisions—the Technology Acquisition Center (TAC), which focuses on IT purchasing, and the Strategic Acquisition Center (SAC), which is responsible for procurement of certain types of goods and services for the operating administrations, such as VHA.
- The Office of Acquisition and Logistics (OAL) is responsible for oversight of contracting across VA, including setting policy and issuing warrants to contracting officers.
- The National Acquisition Center (NAC) is an OAL contracting organization which serves VHA by providing contracting for certain health care-related goods and services.

VHA provides medical care to veterans and is by far the largest administration in VA, with a budget of \$61.1 billion for fiscal year 2016, representing the majority of VA's \$75 billion discretionary budget. Its 167 medical centers are currently organized into 19 Veterans Integrated Service Networks (VISN), regional networks that manage some aspects of operations. VHA has 19 Network Contracting Offices, each of which serves one of the 19 VISNs.

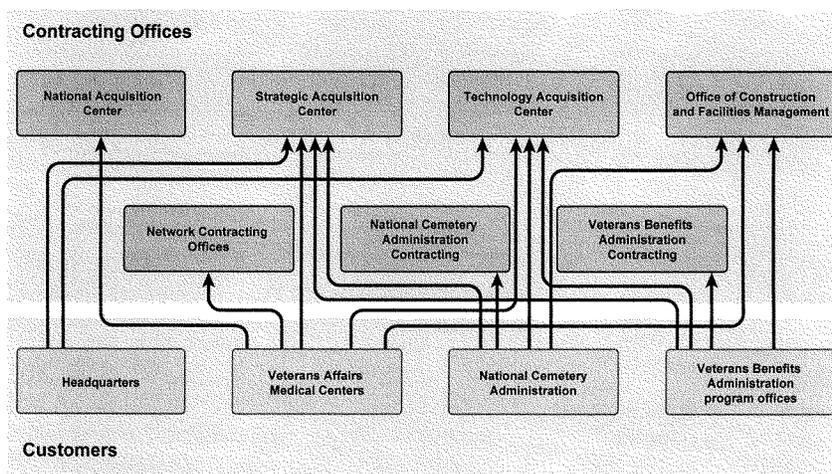
VA has some organizational and programmatic changes in progress that affect procurement. In July 2015, the Secretary of Veterans Affairs announced an organi-

zational transformation for the department called MyVA. In a related effort, responsibility for the medical-surgical prime vendor (MSPV) program—a logistics provider that facilitates ordering and delivery of supplies to medical centers from many different contractors—was recently transferred from NAC to SAC.

VA's Complex Procurement Structure Creates Challenges for Users

Given VA procurement's highly decentralized structure, a given customer—such as a department in a medical center or a program office—may need to work with multiple contracting entities to meet its procurement needs. Figure 2 illustrates the complex working relationship between contracting offices and their customers across VA.

Figure 2: Veterans Affairs Customer Relationships with Contracting Offices



Source: GAO analysis of Veterans Affairs policies. | GAO-16-867T

This can contribute to confusion. Several of the contracting officials we spoke with stated that they were, at times, uncertain about which contracting office handled what requirements. VA issued a memorandum in 2013 to clarify areas of responsibility for the national contracting organizations, but confusion remains. VA's Acting Chief Acquisition Officer stated that he is aware of overlap in the functions of some contracting organizations, especially the NAC and the SAC. At one VISN we visited, an official reported procuring one type of high-tech medical equipment through the SAC even though this area is specifically designated as NAC's responsibility because she expected that the SAC could execute the purchase more quickly.

Without clearly delineated organizational roles and customer relationships—beyond what was provided in the 2013 memorandum—the possibility of duplication in these roles and relationships is increased, and customers lack clear guidance on which organization to approach for certain types of procurements. In our September 2016 report, we recommended that OALC assess whether additional policy or guidance is needed to clarify the roles of VA's national contracting organizations. The Acting Chief Acquisition Officer, OALC said that the department agreed with this recommendation.

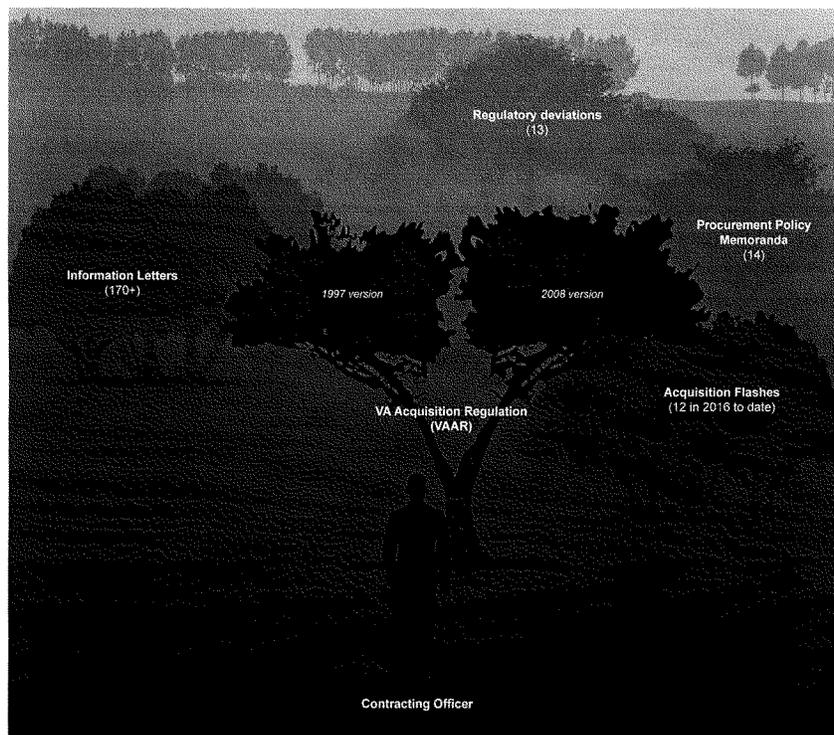
VA Procurement Policies Are Outdated and Not Always Cohesive and Effectively Communicated

Key VA procurement policies are outdated and difficult for contracting officers to use. Standards for Internal Control in the Federal Government state that it is important for an organization's management to update its policies over time to reflect changing statutes or conditions, and that those policies should be communicated to those who need to implement them.⁴ However, many of VA's regulations and policies are outdated, most notably the VA Acquisition Regulation (VAAR), which has

⁴ GAO, Standards for Internal Control in the Federal Government, GAO 14 704G, (Washington, D.C.: Sept. 10, 2014).

not been updated since 2008.⁵ The department has issued a patchwork of policy documents in the interim to fill this gap. VA asks contracting officers to refer to two different versions of the VAAR, one from 1997 and the other from 2008. This causes confusion among contracting officers. In addition, VA communicates interim procurement policies in a number of different forms, some of which can be duplicative. Figure 3 illustrates the numerous sources that contracting officers must turn to for guidance.

Figure 3: Sources of Department of Veterans Affairs (VA) Procurement Policy



Source: GAO analysis of Veterans Affairs procurement policies. | GAO-16-867T

Note: A regulatory deviation is a policy, procedure, method, or practice at any stage of the procurement process that is inconsistent with the Federal Acquisition Regulation. Acquisition Flashes disseminate information relevant to day-to-day procurement operations. Information Letters are policy memoranda.

Note: A regulatory deviation is a policy, procedure, method, or practice at any stage of the procurement process that is inconsistent with the Federal Acquisition Regulation. Acquisition Flashes disseminate information relevant to day-to-day procurement operations. Information Letters are policy memoranda.

The sheer volume and number of different forms of communications—many of which are outdated—are confusing and present challenges for contracting officials seeking appropriate guidance. While VA recently fully rescinded the 1997 VAAR after our inquiries, the 2008 version remains out of date. A new revision of the VAAR is also in development, but has faced delays. VA began the process in 2011 but does not plan to finalize the new VAAR until December 2018, including the required rulemaking process. The lengthy delay in updating this fundamental source of policy impedes contracting officers' abilities to effectively carry out their duties. In our September 2016 report, we recommended that VA identify measures to expedite the revision of the VAAR, and take interim steps to clarify its policy framework;

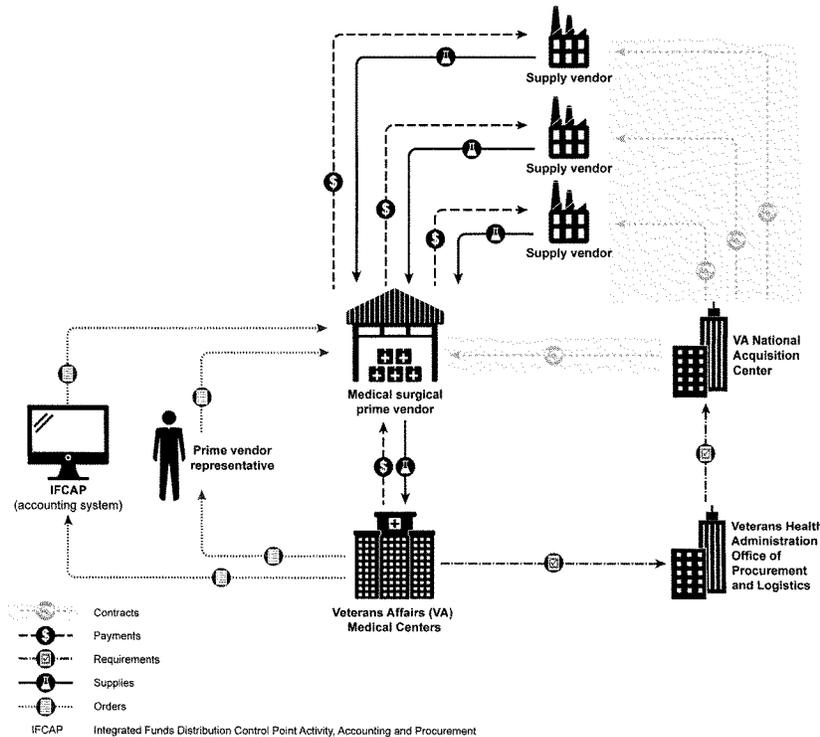
⁵ While we have not reviewed all Federal Register notices since 2008 to determine whether there have been any updates, agency officials confirmed that the VAAR has not been updated since 2008.

the Acting Chief Acquisition Officer, OALC stated that the department agreed with both of these recommendations.

VA Can Improve Its Processes for Medical Supply Purchasing and Identify Other Cost Savings Opportunities

VA medical centers use contractors called medical-surgical prime vendors to obtain many of the supplies they use on a daily basis, such as bandages and surgical sutures. Officials known as ordering officers, who work at the medical centers, regularly place orders. In turn, the prime vendor delivers those orders via a local warehouse. The prices for these medical supplies are established by VA national contracts, which typically provide significant discounts over the Federal Supply Schedule prices—an estimated 30 percent on average, according to a senior NAC official. Use of these national contracts is also required by VA policy and regulation.⁶ Figure 4 provides an overview of the MSPV process.

Figure 4: Structure of Current Medical Surgical Prime Vendor Process



Source: GAO analysis of Veterans Affairs contracts and policies. | GAO-16-867T

However, the current MSPV process is confusing and cumbersome. Most orders are placed through the Integrated Funds Distribution Control Point Activity, Accounting and Procurement (IFCAP) system, a decades-old IT system with a text-based interface, which does not include a tool to look up items that are available on the national contracts. For instance, ordering officers must know the exact item

⁶VA is required to purchase through the MSPV all medical and surgical supplies that are available from an MSPV contract. Department of Veterans Affairs Memorandum, June 22, 2015, Use of Medical/Surgical Prime Vendor (MSPV) Contracts is Mandatory. VA is also required to satisfy supplies and services requirements using the order of priority listed in VAAR 808.002(a)(2), which lists a higher priority of use for national contracts, such as the MSPV contracts, than for Federal Supply Schedule Contracts. See also, Department of Veterans Affairs Memorandum, May 5, 2016, Class Deviation Veterans Affairs Acquisition Regulation (VAAR) Part 808, Required Sources of Supplies and Services, and VAAR Subpart 808.002, Priorities for Use of Government Supply Sources.

number-which is different for each vendor-to enter into IFCAP. The existing tools to look up available national contracts are also cumbersome. Along with discounted items on national contracts, the MSPV system also allows ordering officers to buy thousands of items directly from VA's Federal Supply Schedule contracts, which lack the degree of discounted pricing of the national contracts. Because of the challenges posed by the system, ordering officers in some cases purchase items directly from the Federal Supply Schedules, and might miss opportunities to obtain discounts on the national contracts.

Administration of the MSPV program is being transferred from NAC to SAC, and, along with this transfer, VHA and SAC are making changes to the MSPV program in an effort to address the issues discussed above and streamline the process. To support the next generation MSPV, SAC has already awarded new prime vendor contracts and is in the process of awarding the supporting national contracts for individual types of supplies.

VHA and SAC also plan to implement a new online ordering interface, developed by a contractor for VHA, which will provide ordering officers a more intuitive interface for the outdated and difficult-to-use IFCAP system. Further, unlike the current system, this new interface will only permit ordering officers to purchase items from a specific catalog of items, not the wider range of Federal Supply Schedule items. VA estimates that this catalog will eventually contain 8,000 to 10,000 items to meet the needs of its medical centers. However, there have been some delays in VHA's development of supply requirements and SAC's award of new supply contracts, with only about 1,800 items on national contracts as of July 2016. VA does not anticipate that SAC will be able to award contracts for the full catalog by the time the new MSPV contracts become operational in December 2016. In the interim, SAC and VHA officials stated that they will allow ordering of Federal Supply Schedule items (approximately 4,500) that are not on national contracts, to ease the transition.

Work remains to ensure that the transition to this new approach will be successful. Updating the MSPV process affects how essential supplies are ordered and delivered at 167 medical centers on a daily basis, and facility logistics staff, including ordering officers, must be able to implement the new approach. VHA has an outreach plan in place, but chief logistics officers at medical centers we visited expressed some concerns about the transition-for instance, one reported that his office's analysis found 14 items deemed critical to the function of the medical center were not on a preliminary list of supplies available through the new MSPV, nor were acceptable substitutes. If medical centers instead purchase items through their local contracting offices because the new MSPV does not meet their needs, it will undermine the program's potential to increase efficiency and cost savings.

In our September 2016 report, we recommended that VA take steps to facilitate the transition to the new MSPV process, including ensuring that SAC collects data to monitor the use of national contracts in the new system, that SAC and VHA establish achievable time frames for eliminating Federal Supply Schedule items from the MSPV catalog once national contracts are in place, and that the new ordering interface clearly distinguish between items on national contracts and the 4,500 items on the Federal Supply Schedules. The Acting Chief Acquisition Officer, OALC said that the department agreed with this recommendation.

VA's substantial buying power presents many opportunities for procurement cost savings, but the department has not consistently taken advantage of them. A key aspect of strategic sourcing is consolidating similar requirements to manage them collectively, reaping cost savings and efficiency gains.⁷ VA has done this successfully in some areas, such as pharmaceuticals, and the planned changes to the MSPV program could result in greater use of discounted national contracts for medical supplies if they are successfully implemented.

There are opportunities to better apply strategic sourcing principles at the regional level, as well. Within VHA, each of the 19 VISNs is responsible for a regional network of multiple medical centers and clinics. Individual medical centers within each VISN procure many goods and services separately, despite the fact that their requirements are similar. Consolidating these requirements-such as security services, elevator maintenance, and eyeglasses for patients-can realize both cost savings and greater efficiency in awarding and administering contracts.

We found efforts underway to consolidate requirements at the regional level, but local autonomy and limited planning capacity pose obstacles. For instance, one VISN we visited recently began an initiative to consolidate requirements for purchases made by all of its medical centers, especially services. VISN managers explained that they began with the easiest requirements, such as landscaping services

⁷ GAO, *Strategic Sourcing: Improved and Expanded Use Could Save Billions in Annual Procurement Costs*, GAO 12 919 (Washington, D.C.; Sept. 20, 2012).

and parking administration. They issued a draft memorandum with plans to broaden this approach to most purchases, but medical center staff provided feedback that they preferred their own local contracts and did not want VISN-wide contracts to become the default approach. In our review of 37 selected contracts, we did find several instances of VISN and contracting officials consolidating requirements for greater efficiency and to obtain better pricing. This indicates that consolidating procurement is possible with leadership buy-in, and that there are opportunities to share lessons learned across VISNs. Within VHA, in VISNs where there is not a consistent push by local leadership to pursue consolidation, it is challenging for efforts driven by individual departments or contracting personnel to overcome cultural obstacles.

To provide the necessary leadership commitment to take advantage of these opportunities, we recommended in our September 2016 report that VHA Procurement and Logistics conduct a review of VISN-level strategic sourcing efforts, identify best practices, and, if needed, issue guidance. The Acting Chief Acquisition Officer, OALC said that the department agreed with this recommendation.

Chairman Coffman, Ranking Member Kuster, and Members of the Subcommittee, 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 Acknowledgements

If you or your staff have any questions about this statement, please contact Michele Mackin at (202) 512-4841 or MackinM@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; George Bustamante; Margaret Hettinger; Julia Kennon; Katherine Lenane; Ethan Levy; Teague Lyons; Jean McSween; Sylvia Schatz; Erin Stockdale; and Roxanna Sun.

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Materials for the Record

LETTER FROM CHAIRMAN MIKE COFFMAN TO: THE HONORABLE ROBERT A. MCDONALD

October 14, 2016

The Honorable Robert A. McDonald
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, N W
Washington, DC 20420

Dear Secretary McDonald,

Please provide written responses to the attached questions for the record regarding the oversight hearing of the Committee on Veterans' Affairs Subcommittee on Oversight and Investigations entitled, "VA Procurement: Identifying Obstacles to Reform," that took place on Tuesday, September 20, 2016.

In responding to these questions for the record, please answer each question in order using single-spaced formatting. Please also restate each question in its entirety before each answer. Your submission is expected by the close of business on Thursday, November 10, 2016, and should be sent to Ms. Bernadine Dotson at bemadine.dotson@mail.house.gov.

If you have any questions, please do not hesitate to have your staff contact Jon Hodnette, Majority Staff Director, Subcommittee on Oversight and Investigations, at 202-225-3569.

Sincerely,

MIKE COFFMAN
Chairman
Subcommittee on Oversight and Investigations

MC/wm

Attachment

Cc:Ann McLane Kuster, Ranking Member

QUESTIONS FOR THE RECORD

HOUSE COMMITTEE ON VETERANS' AFFAIRS

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

"VA PROCUREMENT: IDENTIFYING OBSTACLES TO REFORM"

1. Please provide a complete response to Chairman Coffman and Subcommittee on Economic Opportunity Chairman Wenstrup's letter of August 26, 2016 regarding the Next Generation Medical/Surgical Prime Vendor (NG-MSPV) program. A copy is attached for reference.

2. The NG-MSPV contracts, which were awarded in February, require the contractors to provide an electronic product database, consisting of individual product records in standard format data elements, within 90 days after award. The electronic product database is a precursor to the product catalog, which the contract requires within 120 days after award. Please provide the electronic product database.

3. Please provide the NG-MSPV product catalog to the Committee as it currently exists.

4. Will there be only one product catalog which is used in all NG-MSPV regions? Or will product catalogs vary from region to region?

5. Will the final NG-MSPV product catalog be posted online, as the existing MSPV catalog is now?

a. If so, will it be updated dynamically as items are removed and added, or will it be updated periodically?

b. If it will be updated periodically, at what intervals?

6. The NG-MSPV prime vendor contracts, which were awarded in February, stipulate that they shall be implemented within 120 days after award. The contracts define implementation as the contractors "begin[ning] accepting orders and delivering medical/surgical supplies for all facilities." In addition, the contracts' requirements for implementation are to (1) "provide an electronic catalog-like capability to aid Government personnel in finding non-recurring demand or unique medical/surgical supplies;" (2) provide Electronic Data Interchange (EDI) interface capabilities in accordance with ANSI ASC X.12M Supply Chain Standard Transaction sets; and (3) provide an electronic supply chain management interface system, accessible through the Internet for each VHA facility.

Mr. Giddens testified that NG-MSPV "goes live this December."

a. When will the NG-MSPV contractors begin accepting orders and delivering medical/surgical supplies for all VHA facilities? Please also notify the Committee when this begins.

b. When will the NG-MSPV contractors provide the electronic catalog-like capability? Please also notify the Committee when this happens.

c. When will the NG-MSPV contractors provide EDI interface capabilities? Please also notify the Committee when this happens.

d. When will the NG-MSPV contractors provide the electronic supply chain management interface system? Please also notify the Committee when this happens.

7. The NG-MSPV prime vendor contracts, awarded in February, stipulate that, "The MSPV(s) shall be responsible for all contract costs associated with the implementation of the contract." Recognizing that implementation is still ongoing, which implementation costs are the contractors absorbing and which implementation costs are VA paying?

8. VA issued solicitation VA119-16-Q-0644 for sheath introducers, under NG-MSPV. It contemplates the issuance of a single-award Blanket Purchase Agreement. The solicitation requires four categories of sheath introducers, each consisting of multiple individual items. The solicitation attaches a list of the required items, which are described on a "brand name or equal" basis. Multiple brand names are referenced. The solicitation employs a "cascading" set-aside methodology.

a. Based on its market research, has VA determined that it is possible for one contractor to provide all four categories of sheaths? Please provide the market research and acquisition plan.

b. Did the contracting officer execute a "brand name or equal" determination for this solicitation?

c. Please provide a copy of the non-manufacturer rule waiver, pertaining to NAICS 339112, referenced in the solicitation.

d. Under the "cascading" set-aside methodology, if an award cannot be made under the highest priority, Service Disabled Veteran Owned Small Business set-aside and VA proceeds to the next highest priority set-aside, will VA reissue the solicitation or amend the solicitation to change its set-aside and extend the offeror due date?

9. VA issued solicitation VA119-16-Q-0027 for endoscopic snares, under NG-MSPV. It contemplates the issuance of a single-award or multiple-award Blanket Purchase Agreement(s). The solicitation requires four categories of endoscopic snares, each consisting of one item.

a. Formerly, how many individual varieties of endoscopic snares were ordered under the previous Medical/Surgical Prime Vendor program?

b. Please provide the analysis through which VA determined to reduce to four the number of varieties of endoscopic snares that may be ordered.

c. Does a non-manufacturer rule waiver exist for endoscopic snares? If a waiver does not exist, has VA ever requested one? If a waiver does exist, please provide it.

10. Please provide a list of all national contracts awarded by OALC and VHA, including their names, contract numbers, names of contractors, and periods of performance. This includes national contracts related to MSPV and NG-MSPV, as well as other national contracts.

11. Mr. Giddens' stated in his written testimony that, "Already in fiscal (FY) 2016, VHA supply-chain transformation efforts have yielded in excess of \$75 million in cost avoidance." Please explain how this figure was calculated and provide a numerical accounting.

12. How much (in total dollars among all purchase orders and other contracts) does VA currently owe to vendors for surgical implants that have already been implanted in Veterans? Please provide VA's intended timeframe to process the purchase orders and pay the invoices. Please also notify the Committee when all such vendors have been paid.

13. During the hearing, Mr. Lemmon and Mr. Giddens indicated a new contract vehicle or contracting process is being put into place, which will address the issue of delayed payments to surgical implant vendors. Does this refer to NG-MSPV or another contract vehicle/process? Please explain how the new contract vehicle/process will improve this situation. Please indicate when the contract vehicle/process will be in place.

14. Please provide a list of all NG-MSPV Integrated Product Teams (IPTs), including their areas of responsibility and members' names, titles, and locations. If IPTs have members designated as industry liaisons or otherwise tasked to communicate with industry, please indicate them.

15. Will all contracts comprising items on the NG-MSPV product catalog (meaning national contracts or any other categories of contracts) be single-award? If there will be a mix of single-award and multiple-award contracts, how is it decided when each will be used? How is clinician input considered to determine whether VA will rely on one vendor or multiple vendors for a given category of products?

16. Is it correct that the Strategic Acquisition Center charges a 3% user fee on its contract vehicles? Why is this fee much higher than the National Acquisition Center's Industrial Funding Fee?

17. The Strategic Acquisition Center has issued multiple draft versions of its prosthetics catalog and is requiring contractors to submit proposals (not capabilities statements, but proposals) in response to the draft versions. Please explain why VA is asking for proposals during market research.

18. On September 30, 2016, VA provided the below response [excerpted] to an inquiry about national contracts for orthopedic implants. Please determine whether Impact Medical/BZ Medical's offered products are comparable, if the pricing is a result of an overstock, if the products are gray market products, if the market has changed since the national contracts were originally awarded, and whether the national contract pricing should be renegotiated. Please advise the Committee whether VA determines the products to be comparable and whether VA renegotiates the national contract pricing.

When VHA learns of vendors offering pricing that is more favorable than national contract pricing, we must first determine if the products offered are in-fact comparable. Next it is important to determine is [sic] the lower pricing is due to over-stock situations, gray market products, or has the market legitimately changed since the award of the contract. If the market has changed VHA will engage the National Contracting Office responsible for the contract and ask that the contract price be renegotiated. Depending on the outcome of the negotiation the entire requirement could be re-competed. This activity is managed by the VHA Vendor Relations Office and the VHA Program Executive Office.

LETTER FROM CHAIRMAN MIKE COFFMAN TO: THE HONORABLE SLOAN GIBSON

August 26, 2016

The Honorable Sloan Gibson Deputy
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, N W
Washington, DC 20420

Dear Deputy Secretary Gibson,

We are concerned that implementation of the Next Generation Medical/Surgical Prime Vendor (NG-MSPV) program, as it is currently conceived, will result in drastic reductions in medical and surgical product availability within the Veterans Health Administration (VHA). Overly restricting the range of available products could damage the quality of veterans' care as well as lead clinicians to circumvent NG-MSPV, undermining the success of the program.

The process of designing the NG-MSPV product catalog seems to be entirely led by the procurement and standardization offices, not the clinicians who actually use the medical and surgical supplies. We have been informed, variously, that VA intends to reduce the catalog from between 476,000 and 506,000 line items to between 8,000 and 14,000 line items. The catalog will go from being unwieldy large to inadequately small. Furthermore, VA has given itself an unrealistically short timeframe to implement these changes. When the Strategic Acquisition Center (SAC) awarded the NG-MSPV distribution contracts in late February, VA set a 120-day implementation period in which to re-compete and award the underlying supplier contracts before NG-MSPV becomes mandatory for ordering all medical and surgical items. This implementation period has elapsed, and VA does not appear close to finishing the supplier contracts. According to available data, SAC is able to award up to a few dozen supplier contracts¹ per month. At this pace it will take several years to re-compete and award supplier contracts for 14,000 product line items. For this reason, it is our understanding that VA has decided to delay the NG-MSPV implementation deadline until the end of the year and has imminent plans to issue sole-source contracts for as many as 5,000 product line items. Sole sourcing such a large number of contracts is alarming because it locks in higher pricing and indicates VA has run out of time.

We support VA's ongoing standardization efforts where they are appropriate. The supply chain must be manageable and rational. However, the available information about NG-MSPV's implementation seems to indicate that VA created an unrealistic goal motivated by logistical, not medical, considerations and now risks neither saving money nor ensuring clinicians have adequate access to the medical and surgical products they need.

The key question is how VA determined the appropriate size of the NG-MSPV product catalog, and how meaningfully clinicians were involved in making this decision. NG-MSPV program officials have explained several times that development of the catalog is an ongoing process and items will be continually added and removed as needed. Nonetheless, it is crucial that the product catalog meets the needs of providers on the day NG-MSPV becomes mandatory. For NG-MSPV to be successful, clinician buy-in is imperative. The NG-MSPV program office, SAC, and VHA must support a clinically-led process to develop the requirements and make the standardization decisions.

¹Typically these are Blanket Purchase Agreements (BPAs) created by the SAC against Federal Supply Schedules (FSS), which are created and administered by the National Acquisition Center (NAC).

Please provide answers to the following questions:

- 1) How were clinical end-users and experts involved in designing the NG-MSPV program strategy and product catalog? Please identify these personnel by name and title.
- 2) How many product lines does VA intend to include in the NG-MSPV catalog? Please provide the list of product lines intended for the catalog.
- 3) How many individual contracts, roughly, will these product lines comprise?
- 4) How did VA decide which product lines in the old MSPV catalog are unnecessary and should be removed?
- 5) Please detail the process by which NG-MSPV program personnel and the SAC consulted VISNs and VAMCs while designing the NG-MSPV program strategy and catalog.
- 6) When will NG-MSPV become mandatory for use?
- 7) Which product lines will the sole-source supplier contracts include? Please provide complete copies, including attachments, of all sole-source supplier contracts as they are awarded.
- 8) How did VA determine this reduction in the range of available medical and surgical items will not degrade the standard of care for veterans?
- 9) VHA has gone to great lengths to hire and retain medical professionals. What steps has VHA taken to ensure that frustration with perceived limited choice of products under NG-MSPV does not deter clinicians from practicing in VHA?
- 10) In designing the NG-MSPV product catalog, how did VA consider the variations of VAMCs' needs across different geographic regions, patient mixes, and academic affiliations?
- 11) Has VA determined whether the removal of familiar items or the addition of unfamiliar items will necessitate retraining medical or surgical staff? If so, what is VA's plan to provide the training?
- 12) Please detail the process by which physician and surgeon input into the product catalog was collected. Please provide copies of any surveys, desired product lists, or reports that were generated.
- 13) Please detail the process by which, after NG-MSPV becomes mandatory for use, physicians and surgeons will be consulted as to which items should be added to the catalog. Who will make the final decision about adding items?
- 14) Please detail, step-by-step, the procedure for approving and adding items to the catalog after NG-MSPV becomes mandatory for use. How long will an addition take?
- 15) Will any other avenues be allowed, besides NG-MSPV, to procure categories of medical and surgical items included in NG-MSPV? For instance, if an uncommon surgical instrument is suddenly needed that is not specifically included in the product catalog but whose category is included. Please detail these avenues and their procurement procedures.
- 16) Will anyone in VA be allowed to procure any of the over 450,000 items that are being removed from the product catalog, or will these items cease to be available? If these items will remain available in some way, please detail the procurement procedures.
- 17) How have VAMCs been instructed to respond to clinicians who express objections or reservations about the reduced NG-MSPV product catalog? How will these objections or reservations be cataloged?
- 18) In July 2015, VA requested and obtained from the Small Business Administration (SBA) a Non-manufacturer Rule waiver for MSPV. At the time, VA conducted incomplete market research and identified 16 items in the product catalog available from small business manufacturers. SBA instructed VA to submit revised market research by May 31, 2016, at which time SBA would reissue a modified waiver. Please provide VA's revised market research that was submitted to SBA, and the modified Non-manufacturer Rule waiver that SBA issued.

Please provide this information in electronic, soft-copy format by the close of business Friday, September 16, 2016. Do not alter the documents in any way, including but not limited to application of redactions or a water mark or by disabling printing.

The Committee will continue to consider these deliverables to remain open until it is satisfied by the responses provided. If you have any questions, please do not hesitate to have your staff contact Dr. Eric Hannel, Majority Staff Director of the Subcommittee on Oversight & Investigations, at (202) 225-3569.

Thank you for your time and attention. We know that we share the same desire to ensure that our veterans' health care providers have access to the proper implements and equipment. We look forward to continuing to work on this issue together.

Sincerely,

MIKE COFFMAN
Chairman
Subcommittee on Oversight and Investigations

BRAD WENSTRUP, D.P.M.
Chairman
Subcommittee on Economic Opportunity

Cc: Mark Takano, Acting Ranking Member

MC/wm

Questions for the Record

HOUSE COMMITTEE ON VETERANS' AFFAIRS

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

"VA PROCUREMENT: IDENTIFYING OBSTACLES TO REFORM"

1. Please provide a complete response to Chairman Coffman and Subcommittee on Economic Opportunity Chairman Wenstrup's letter of August 26, 2016 regarding the Next Generation Medical/Surgical Prime Vendor (NG-MSPV) program. A copy is attached for reference.

VA Response: Enclsoure 1 is VA's responded jointly signed letter, signed December 16, 2016.

2. The NG-MSPV contracts, which were awarded in February, require the contractors to provide an electronic product database, consisting of individual product records in standard format data elements, within 90 days after award. The electronic product database is a precursor to the product catalog, which the contract requires within 120 days after award. Please provide the electronic product database.

VA Response: The required electronic product database is required within the 120 day implementation period. VA issued the notice to proceed starting the implementation period on July 29, 2016; therefore the prime vendors are currently in the process of creating their databases. Veterans Health Administration (VHA) is currently in the process of compiling the electronic product database .

3. Please provide the NG-MSPV product catalog to the Committee as it currently exists.

VA Response: The most current product catalog is available at: <http://www.va.gov/officeofacquisitionoperations/sac/mspvng.asp>.

4. Will there be only one product catalog which is used in all NG-MSPV regions? Or will product catalogs vary from region to region?

VA Response: VA is developing and will maintain one product catalog to be used across VHA. The product catalog will include items that are available to all facilities, with few exceptions if there are facilities, VISN, or region specific contracts in place for items that do not conflict with the catalog, requests to add those contracted items may be submitted directly to the MSPV-NG Program Management Office in VHA.

5. Will the final NG-MSPV product catalog be posted online, as the existing MSPV catalog is now?

a. If so, will it be updated dynamically as items are removed and added, or will it be updated periodically?

b. If it will be updated periodically, at what intervals?

VA Response: The MSPV-NG product catalog is a dynamic document and will be continuously updated and maintained through the duration of the MSPV-NG program. Updates to the product catalog are scheduled to be posted on the 1st and 15th of each month at: <http://www.va.gov/officeofacquisitionoperations/sac/mspvng.asp>.

6. The NG-MSPV prime vendor contracts, which were awarded in February, stipulate that they shall be implemented within 120 days after award. The contracts define implementation as the contractors "begin[ning] accepting orders and delivering medical/surgical supplies for all facilities." In addition, the contracts' requirements for implementation are to: (1) "provide an electronic catalog-like capability to aid Government personnel in finding non-recurring demand or unique medical/surgical supplies;" (2) provide Electronic Data Interchange (EDI) interface capabilities in accordance with ANSI ASC X.12M Supply Chain Standard Transaction sets; and (3) provide an electronic supply chain management interface system, accessible through the Internet for each VHA facility.

Mr. Giddens testified that NG-MSPV "goes live this December."

a. When will the NG-MSPV contractors begin accepting orders and delivering medical/surgical supplies for all VHA facilities? Please also notify the Committee when this begins.

b. When will the NG-MSPV contractors provide the electronic catalog-like capability? Please also notify the Committee when this happens.

c. When will the NG-MSPV contractors provide EDI interface capabilities? Please also notify the Committee when this happens. When will the NG-MSPV contractors provide the electronic supply chain

d. management interface system? Please also notify the Committee when this happens.

VA Response: The contractors will provide their electronic catalog submissions, EDI interface capabilities, and electronic supply chain management interface systems no later than November 28, 2016. Contractors began accepting orders on December 1, 2016, with deliveries starting the following day.

7. The NG-MSPV prime vendor contracts, awarded in February, stipulate that, "The MSPV(s) shall be responsible for all contract costs associated with the implementation of the contract." Recognizing that implementation is still ongoing, which implementation costs are the contractors absorbing and which implementation costs are VA paying?

VA Response: As stipulated in the contract, contractors are responsible for the following activities and associated costs:

34.1.1. Assist facilities with the identification of facility recurring and non-recurring medical/surgical supplies and gather product usage data from each individual facility covered by the contract.

34.1.2. Negotiate distribution agreements, as necessary, with Federal Government product contractors for 100% of the medical/surgical supplies identified in the Government provided master listing of approved medical/surgical supplies and their associated pricing for inclusion in the electronic catalog, by the contract effective date. The MSPV shall provide immediate notification to the Contracting Officer concerning problems with the execution of distribution agreements.

34.1.3. Load all facility medical/surgical supplies into the MSPV data base using Federal Government contract pricing as provided at www.va.gov/vastorenac, located under the topic?Med/Surg MSPV Program and Standardization. Maintain accuracy by utilizing this source in resolving pricing discrepancies. Update the MSPV data base when change notices are received from the VA by the effective contract date.

34.1.4. Ensure full capability to deliver 100% of the medical/surgical supplies required by the contract customers timely at the appropriate inventory levels within the phase-in period.

34.1.5. Set-up facilities with any value added services requested by facilities (reference Section 5.5).

34.1.6. Mutually establish delivery days, times and delivery points.

34.1.7. Coordinate and provide necessary training to using facilities.."

VA has taken on the cost for creating the product catalog (formulary), creation of an ordering officer tracking tool, creation of other tracking tools to monitor compliance and usage of the contract.

8. VA issued solicitation VA119-16-Q-0644 for sheath introducers, under NG-MSPV. It contemplates the issuance of a single-award Blanket Purchase Agreement (BPA). The solicitation requires four categories of sheath

introducers, each consisting of multiple individual items. The solicitation attaches a list of the required items, which are described on a “brand name or equal” basis. Multiple brand names are referenced. The solicitation employs a “cascading” set-aside methodology.

a. Based on its market research, has VA determined that it is possible for one contractor to provide all four categories of sheaths? Please provide the market research and acquisition plan.

VA Response: VA intends to issue a single BPA to one contractor that will serve as the single source of supply to provide all four types of sheath introducers enterprise-wide. The intention is that no more than one contractor will be selected to provide products for a particular type of forceps, considering standardization is a top priority of this acquisition. Successful award of this acquisition will allow VHA to maintain uniformity amongst the four types of sheath introducers being utilized by its field activities. Our market research and acquisition plan are included as enclosures 2 and 3, respectively.

b. Did the contracting officer execute a “brand name or equal” determination for this solicitation?

VA Response: VA did not execute a brand name of equal determination, because it is not required under Federal Acquisition Regulation (FAR) 6.302–2.

c. Please provide a copy of the non-manufacturer rule waiver, pertaining to NAICS 339112, referenced in the solicitation.

VA Response: Enclosure 4 provides the responsive document.

d. Under the “cascading” set-aside methodology, if an award cannot be made under the highest priority, Service Disabled Veteran Owned Small Business set-aside and VA proceeds to the next highest priority set-aside, will VA reissue the solicitation or amend the solicitation to change its set-aside and extend the offeror due date?

VA Response: As indicated in the solicitation, the procurement opportunity is a single event welcoming all interested offerors, precluding VA from having to reissue or amend the solicitation as a set-aside:

“1. Any award(s) resulting from the items listed on Tab 1 of this solicitation will be made using the following the tiered set-aside order of precedence:

a. Any award under this solicitation will be made on a competitive basis first to an eligible Service Disabled Veteran Owned Small Business [SDVOSB] in accordance with VAAR 819.7005, provided that there is adequate competition among such firms.

b. If there is inadequate competition for award to a SDVOSB concern, award will be made competitively to a Veteran Owned Small Business (VOSB) concern in accordance with VAAR 819.7006, provided that there is adequate competition among such firms.

c. If there is inadequate competition for award to a SDVOSB or VOSB concern, award will be made competitively to a Small Business (SB) concern in accordance with FAR Subpart 19.5.

d. If there is inadequate competition for award to any of the small business concerns provided in paragraphs (a) through (c), award will be made on the basis of full and open competition considering all offers submitted by responsible business concerns.

2. Adequate competition shall be deemed to exist if-

a. At least one acceptable offer is received from a SDVOSB concern; or

b. At least two competitive offers are received from qualified, responsible business concerns at the tier under consideration; and

c. Award will be made at fair market prices as determined in accordance with FAR 13.106–3(a).”

9. VA issued solicitation VA119-16-Q-0027 for endoscopic snares, under NG-MSPV. It contemplates the issuance of a single-award or multiple-award Blanket Purchase Agreement(s). The solicitation requires four categories of endoscopic snares, each consisting of one item.

a. Formerly, how many individual varieties of endoscopic snares were ordered under the previous Medical/Surgical Prime Vendor program?

VA Response: The previous Medical/Surgical Prime Vendor included all varieties of endoscopic snares including specialized items that had a low volume.

b. Please provide the analysis through which VA determined to reduce to four the number of varieties of endoscopic snares that may be ordered.

VA Response:

- Based upon our historical procurement spend and market research (enclosure 4), VA, with clinical expertise from the Integrated Product Team (IPT), determined that the national BPA would focus on the 80% endoscopic snares solution for this national BPA. Consequently, low volume specialized snares were excluded.
 - After SMEs analyzed the historical spend endoscopic snares; it was determined there were four logical groupings; micro, mini, medium (standard), and jumbo. After additional analysis of historical spend the SMEs combined the Micro/mini into one contract line-item number within the solicitation.
 - A formal technical evaluation was conducted by the clinician SMEs which included physical testing, inspection, and literature review.
 - An award was made as a national BPA with a procurement value estimated at \$1.35 million over 5 years (base and 4 option years) for micro/mini, medium, and jumbo endoscopic snares.
- c. Does a non-manufacturer rule waiver exist for endoscopic snares? If a waiver does not exist, has VA ever requested one? If a waiver does exist, please provide it.

VA awarded a national BPA with a procurement value estimated at \$1.35 million over 5 years (base and 4 option years) for micro, mini, medium, and jumbo endoscopic snares. Market research (Enclosure 5) along with the technical evaluation process, which included physical testing, inspection, and literature review supported the solicitation for four contract line-item numbers. As the solicitation sought only “manufacturers” for endoscopic snares, a non-manufacturer rule waiver is not applicable.

10. Please provide a list of all national contracts awarded by OALC (Office of Acquisition, Logistics, and Construction) and VHA, including their names, contract numbers, names of contractors, and periods of performance. This includes national contracts related to MSPV and NG-MSPV, as well as other national contracts.

VA Response: Enclosure 6 lists OALC and VHA national contracts.

11. Mr. Giddens’ stated in his written testimony that, “Already in fiscal (FY) 2016, VHA supply chain transformation efforts have yielded in excess of \$75 million in cost avoidance.” Please explain how this figure was calculated and provide a numerical accounting.

VA Response: By September 20, 2016, VA recorded \$91.8 million in cost avoidance across the following categories. By the end of September 2016, VHA supply chain transformation efforts recorded \$101 million in cost avoidance/savings.

- “Inventory Management” (Reduce/Reutilize) realized \$14.9 million in cost avoidance and savings combined. Facilities are better managing stocks on hand to ensure that stockage levels are right-sized and that consumables no longer required in one location are reutilized within the VHA supply chain.
- “Redistribution of Equipment” realized \$9 million in cost avoidance. Facilities report excess equipment that is available to other facilities in need, preventing the purchase of new equipment for those receiving the reported excess.
- “Medical Product Databank” (MedPDB) realized \$5.9 million in savings. Facilities utilize this tool to find better pricing opportunities through contracts that are in place and available for the same item they may be purchasing locally at a higher price.
- “National Contracts” realized \$44.8 million in savings. Through strategic sourcing efforts, products that are purchased by multiple facilities are competed for better pricing and placed on national contracts available to all facilities.
- “Regional Contracts” realized \$8.9 million in savings. Where appropriate, regional contacts have been and continue to be awarded for better pricing when combining the demands of all facilities within the specific region.
- “De-Obligation of Equipment Funds” realized \$8.2 million in cost avoidance. Prior to purchase, funds that were previously obligated for equipment that is no longer required is returned for redistribution for other purchases as the orders for unneeded equipment are cancelled.

12. How much (in total dollars among all purchase orders and other contracts) does VA currently owe to vendors for surgical implants that have already been implanted in Veterans? Please provide VA’s intended time-

frame to process the purchase orders and pay the invoices. Please also notify the Committee when all such vendors have been paid.

VA Response: VHA will routinely have a balance owed to implant vendors because the ordering and payment processes are continuous. As of October, the open obligations were approximately \$30.8 million. As discussed at the hearing, calculating a total dollar amount for vendor payments owed is a constantly moving target as the “open obligations” include orders awaiting cancellation, not yet delivered orders, delivered orders pending payment, and paid orders.

The intended payment date is within 30 days of receipt, which complies with the Prompt Payment Act. Payments to implant vendors are high priority until late payments are reconciled. VHA is focused on making payments older than 60 days from delivery and continuous improvement of our payment process by working with the vendor community to identify overdue payments and reduce payment backlog. As we pursue these holistic efforts to improve efficiencies, unburden our staff, and reconcile vendor payments within 30 days, we anticipate more accurate and verifiable calculations at each stage of the ordering process will result.

13. During the hearing, Mr. Lemmon and Mr. Giddens indicated a new contract vehicle or contracting process is being put into place, which will address the issue of delayed payments to surgical implant vendors. Does this refer to NG-MSPV or another contract vehicle/process? Please explain how the new contract vehicle/process will improve this situation. Please indicate when the contract vehicle/process will be in place.

VA Response: There are three initiatives to increase efficiency in our implant supply chain management. First is the award of contracts to our top 20 implant vendors which is in effect as of November 2016. The second initiative is to put implants into the NG-MSPV catalog during fiscal year 2017 for stock-level ordering to support just-in-time ordering. Finally, VHA is investigating the clinical and economic feasibility of maintaining many more implants as stock items within each hospital to accelerate delivery of care and reduce just-in-time ordering within the next few years.

14. Please provide a list of all NG-MSPV Integrated Product Teams (IPTs), including their areas of responsibility and members’ names, titles, and locations. If IPTs have members designated as industry liaisons or otherwise tasked to communicate with industry, please indicate them. (Jodi Cokl/Jaime Friedel)

VA Response: Enclosure 7 lists MSPV-NG IPT members by focus.

15. Will all contracts comprising items on the NG-MSPV product catalog (meaning national contracts or any other categories of contracts) be single-award? If there will be a mix of single-award and multiple-award contracts, how is it decided when each will be used? How is clinician input considered to determine whether VA will rely on one vendor or multiple vendors for a given category of products?

VA Response: The MSPV-NG Formulary development employed Clinical Product Review Committees (CPRC) and the IPTs to help to identify new items while the MSPV-NG program management office regularly reviews proposed items with IPTs. All clinicians on the Clinical Product Review Committees (CPRCs) and the IPTs are practicing in the VISNs and VAMCs across VHA. This broad spectrum engagement ensures that the program will simultaneously meet clinicians’ needs by improving product safety and ensuring the right supplies are available without regard to the product supplier. VA conducts extensive market research using the identified minimum technical requirements, which is then validated for inclusion into MSPV-NG. Also, national BPA and blanket operational agreements (BOA) are examined for MSPV-NG inclusion, and solicitations will include the MSPV-NG language to obtain vendor buy-in once awarded. If clinicians and vendor agree to participate, then these commodity items will also be added into the MSPV-NG Formulary. There will be a mix of single and multiple-award contracts issued, with the majority being single. The decision is ultimately guided by the work of the CPRCs and IPTs, however, the Contracting Officer retains the authority to determine which approach will be the most advantageous to the Government.

16. Is it correct that the Strategic Acquisition Center charges a 3% user fee on its contract vehicles? Why is this fee much higher than the National Acquisition Center’s Industrial Funding Fee?

VA Response: The Strategic Acquisition Center rate for assisted contracting services (open market procurements) was 3 percent for fiscal year (FY) 2016. The industrial funding fee rate pertains to schedule-based procurements (Federal Supply Schedule) and was 0.5 percent for both the National and Strategic Acquisition Centers

17. The Strategic Acquisition Center has issued multiple draft versions of its prosthetics catalog and is requiring contractors to submit proposals (not capabilities statements, but proposals) in response to the draft versions. Please explain why VA is asking for proposals during market research.

VA Response: The Strategic Acquisition Center rate for assisted contracting services (open market procurements) was 3 percent for fiscal year (FY) 2016. The industrial funding fee rate pertains to schedule-based procurements (Federal Supply Schedule) and was 0.5 percent for both the National and Strategic Acquisition Centers. Enclosure 8 provides the FY 2016 VA Supply Fund Fee Structure. The Strategic Acquisition Center has issued multiple draft versions of its prosthetics catalog and is requiring contractors to submit proposals (not capabilities statements, but proposals) in response to the draft versions. VA actively engaged Industry in the design and development of prosthetic implant and accessories catalogs. To ensure availability of implants for nationwide usage, VA reviewed clinical procurement histories and identified the specific items, by manufacturer, that were the most requested by VA physicians, to meet patient-specific requirements. Based on the clinical demand history and anticipated demands over a 5-year period, VA pursued efforts to ensure the availability of the vendor's product line with clinical demands for product(s). In accordance with 38 U.S. Code § 8123 - Procurement of Prosthetic Appliances, VA may procure prosthetic appliances and necessary services required in the fitting, supplying, and training and use of prosthetic appliances by purchase, manufacture, contract, or in such other manner as determined to be proper, without regard to any other provision of law. Under this authority, VA issued draft requests for proposal (RFP) for prosthetics implantable devices and required that sole source offerors submit proposals. VA completed the market research prior to the release of the draft RFPs. VA issued solicitation amendments to the draft RFPs, when change was necessary. VA issued the final RFP on September 13, 2016, which resulted in seven sole source awards on September 30, 2016.

18. On September 30, 2016, VA provided the below response [excerpted] to an inquiry about national contracts for orthopedic implants. Please determine whether Impact Medical/BZ Medical's offered products are comparable, if the pricing is a result of an overstock, if the products are gray market products, if the market has changed since the national contracts were originally awarded, and whether the national contract pricing should be renegotiated. Please advise the Committee whether VA determines the products to be comparable and whether VA renegotiates the national contract pricing.

When VHA learns of vendors offering pricing that is more favorable than national contract pricing, we must first determine if the products offered are in-fact comparable. Next it is important to determine is [sic] the lower pricing is due to overstock situations, gray market products, or has the market legitimately changed since the award of the contract. If the market has changed VHA will engage the National Contracting Office responsible for the contract and ask that the contract price be renegotiated. Depending on the outcome of the negotiation the entire requirement could be re-competed. This activity is managed by the VHA Vendor Relations Office and the VHA Program Executive Office.

VA Response: A determination has not yet been made whether the products are comparable. Our next course of action will be determined after an assessment of Impact Medical/BZ Medical's products is made. The VHA Vendor Relations Office will coordinate this effort with the Healthcare Commodity Program Executive Office. It is anticipated that the assessment will be completed by January 2017.