STATEMENT OF ROGER D. WALDRON

PRESIDENT OF THE COALITON FOR GOVERNMENT PROCUREMENT

BEFORE THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

UNITED STATES HOUSE OF REPRESENTATIVES

SEPTEMBER 16, 2020

Good afternoon Chairman Pappas, Ranking Member Bergman, and Members of the House Committee on Veterans' Affairs Subcommittee on Oversight and Investigations. Thank you for the opportunity to appear before you to the address the procurement challenges the Department of Veterans Affairs (VA) faces as it builds a resilient supply chain to support the healthcare of our nation's veterans.

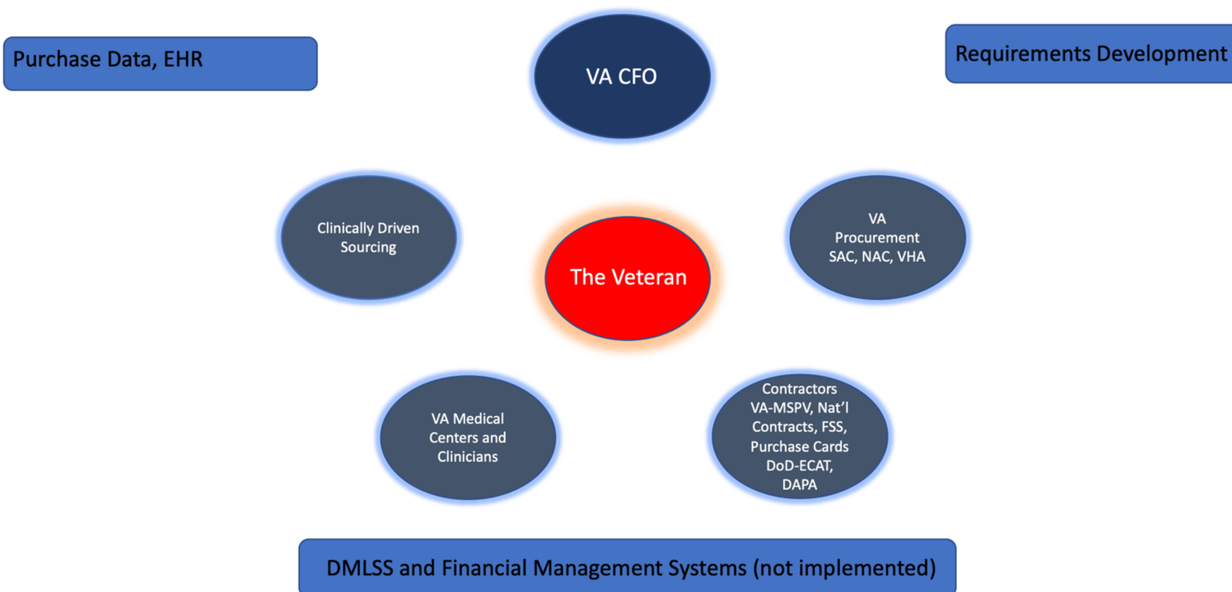
The Coalition for Government Procurement (Coalition) is a non-profit and non-partisan association of firms selling commercial services and products to the Federal Government. Our members collectively account for more than $145 billion dollars of the sales generated annually through government contracts including the GSA Multiple Award Schedules (MAS) program, VA Federal Supply Schedule (FSS), the Government-wide Acquisition Contracts (GWACs), and agency-specific multiple award contracts (MACs). Coalition members include small, medium, and large business concerns. Coalition Healthcare members annually supply the Government with more than $12 billion in medical/surgical products and pharmaceuticals to support the healthcare needs of veterans and active duty service members. The Coalition is proud to have worked with the VA, the Department of Defense (DoD), and other Government officials for more than 40 years towards the mutual goals of common-sense acquisition and best value healthcare for our veterans.

The VA uses several contracting methods to meet its needs for medical/surgical equipment and supplies. These methods include the Medical/Surgical Prime Vendor (MSPV) Program, national contracts, the Federal Supply Schedules (FSS), open market purchases, the Government Purchase Card (GPC), and programs managed by DoD, such as DLA's Medical Surgical Prime Vendor program, which is priced using Distribution and Pricing Agreements (DAPAs), and the Electronic Catalog (ECAT). In March 2019, the Government Accountability Office (GAO) added VA procurement operations to its High-Risk List. GAO indicated that the VA's programs remain fragmented, utilize outdated systems, and rely on emergency acquisitions to purchase common goods and services. A clear indication of the challenges facing the VA is the current high level of Government Purchase Card (GPC) use. The VA uses GPCs to make almost $3.7 billion of *ad hoc* micro-purchases without using an established contracting program. For comparison, DoD, which has more than three times the budget of the VA, makes $3.4 billion of *ad hoc* micro-purchases.[1]

To ensure best value healthcare for veterans, the VA's acquisition policies, programs, and systems need to be modernized to effectively support veterans' healthcare. To this end, the VA has begun addressing its supply chain management programs and e-systems to support its healthcare infrastructure, and, ultimately, the delivery of care to veterans. These management efforts include addressing clinical program leadership for the MSPV, launching the MSPV 2.0 program, engaging with DoD to share resources, such as the Defense Medical Logics Standard Support (DMLSS) system, and modernizing its financial systems and the Electronic Health Record system.

Set forth below is a conceptual representation of the VA's logistics and acquisition process and supply chain infrastructure. The diagram shows the inter-relationship/co-dependency of each part of the chain in delivering medical/surgical products, devices, and technologies to support the VA's mission.

[1] See GSA SmartPay Purchase Card Statistics Report for FPDS 2019, available at https://smartpay.gsa.gov/content/gsa-smartpay-purchase-card-statistics-reports-fpds



Conceptually, **Clinically-Led Sourcing** is executed by a clinically-led and managed program office. Such an office is governed by healthcare professionals with both clinical and medical supply chain expertise, and it is responsible for establishing purchase requirements, including the organization, management, and maintenance of the MSPV formulary. Ideally, MSPV formulary decision-making is based on clinical input made through a transparent process with input from industry and other data from across the VA, including purchase data reported from healthcare treatment centers and the Prime Vendors.

The **VA Procurement** function is responsible for awarding contracts across the VA. Regarding the MSPV program, the VA's Strategic Acquisition Center (SAC) conducts the procurement for the MSPV 2.0 Prime Vendor contracts. At the same time, the Veterans Health Administration (VHA) conducts the open market Blanket Purchase Agreement (BPA) procurements for the products to be distributed by the MSPV 2.0 Prime Vendors. Both the SAC's Prime Vendor procurements and the VHA's supplier BPAs procurements are ongoing. The VA's National Acquisition Center (NAC) manages various national contracts and the Federal Supply Schedules. There is an opportunity to reduce unnecessary duplication and overlap in procurement functions through a reorganization to coordinate clinical needs and purchasing to fulfill those needs.

The **Contractors** support the **VA Medical Centers and Clinicians** delivering medical/surgical products based on clinical needs/requirements. The acquisition of medical/surgical products is accomplished through a myriad of contracts, including the MSPV-NG, national contracts, the Federal Supply Schedules and ECAT. In all this effort, the **VA CFO** accounts for and allocates funding for operations and payments to contractors.

These links in the acquisition process/supply chain are connected by procurement, logistics, and financial systems. The data regarding purchases, usage, outcomes, and clinical assessment of products travels across the VA's systems. Indeed, the systems themselves generate the data used in developing requirements, managing inventory, issuing delivery orders, and executing contracts. The VA's ongoing

implementation of the Financial Management Business Transformation (FMBT) and the Defense Medical Logistics Standard Support (DMLSS) systems is recognition of the vital importance that data plays in delivering best value healthcare for veterans. It often is said that you cannot manage what you cannot measure. Data allows the VA to measure and thus offers a tool to help improve management and process efficiency. In so doing, it addresses a critical concern of the Commission on Care Final Report, namely, that, because needed data is not captured, VHA is limited in its "ability to monitor and drive compliance… ."

Along these lines, to enhance governance of the VA systems, we believe that VA would be served well by utilizing an electronic dashboard to assess its progress in modernizing systems. In addition to aggregating needed data in a single tool, the resulting transparency of a dashboard will enhance management and thereby facilitate improvement. A dashboard will also assist the VA's industry partners in tracking and responding to the evolution of supply chain management and implementation of new e-systems.

Coalition members very much have appreciated the VA's engagement with industry around these efforts, and we look forward to continuing to work together to deliver best value healthcare for veterans. Our members recognize the significant complexities in the VA supply chain that I have outlined here, and they appreciate the efforts of the department as it works to address the enormous challenges of modernizing its systems. To assist this effort, the Coalition offers the following observations.

Clinically-Led Sourcing

Sound requirements development is foundational to efficient, effective procurements that deliver best value healthcare to veterans. A robust, empowered, clinically-led program office supporting the VA's requirements development via a comprehensive formulary is vital to the success of the MSPV program in the support of veterans' healthcare. Coalition members strongly support the VA's efforts to implement/effectuate a clinically-led sourcing program that is executed by healthcare professionals with both clinical and medical supply chain expertise. It is fundamental, however, that the formulary reflect clinical needs, not contracting needs. In the interests of transparency, and to promote engagement with the VA's industry partners, the VA should provide an update on its efforts to stand up a clinically-led program office.

In addition, the Coalition recommends the creation of a new leadership role, the Medical Supply Chain Leader, responsible for formulary and non-formulary management and engagement with industry. Engagement with industry at a strategic level is vital to ensuring access to information regarding new healthcare technologies in the commercial market, technologies that can be brought to bear in treating our veterans. A single point of contact where industry can engage and share the latest innovations in care is critical to ensuring the information exchange necessary for VA to take advantage of leading healthcare technologies. Medical/surgical technologies develop rapidly, and thus, the VA needs an open, nimble channel for research and engagement with industry on the latest developments and a transparent process by which the VA engages with industry on its product reviews and decision-making. Such an approach that maximizes access to the latest healthcare technologies available in the commercial market is a win-win-win for veterans, the VA, and the VA's industry partners.

Noteworthy, the Commission on Care Report appears to align with this recommendation. In recognizing the challenges with the VA's logistics systems, the report states:

> There is an immediate need to consolidate and streamline procurement and logistics for medical and surgical supplies under one leader in VHA, the VHA chief supply chain officer (CSCO), who would be accountable for transforming VHA supply chain management. As identified under MyVA, medical and surgical supply chain management is the first priority, but the rest of the supply chain needs to be addressed by the CSCO in a staged approach.
>
> Commission on Care Report, page 86, June 30, 2016.

Although it is important to allow for decision making at the local level, from an organization-wide policy and process compliance standpoint, VHA needs a governance structure that enhances the ability to assure organizational alignment while meeting the needs of the clinicals at the local level.

Enhance and Expand the MSPV Formulary

The MSPV formulary should reflect clinical needs. As currently structured, the MSPV program does not include the depth and breadth of products necessary to meet operational needs. The billions of dollars annually spent on medical/surgical devices and products procured through the GPC reflect a program that is out of balance. The following timeline highlights the current state of the MSPV program and the evolving state of the MSPV formulary.

- April 2015 Initial Bridge Contracts for Legacy MSPV with hundreds of thousands of items available via the legacy contracts
- February 2016 VA awards MSPV-NG contracts
- April 2016 Second Bridge Contract for Legacy MSPV
- October-December 2016 MSPV-NG launched with 1600 items
- April 2017 Legacy bridge contracts expire
- April 2018 VA expands formulary to ***7800 items*** under MSPV-NG and continues working to expand it
- June 2020 currently ***25,000 items*** on the formulary

Currently, the VA is in the midst of the MSPV 2.0 procurement, with the SAC conducting the procurement of the Prime Vendor (distribution) contracts while the VHA is in the process of establishing open market BPAs with suppliers that will be the sources of supply for the prime vendors. The solicitations for the prime vendor contracts and supplier BPAs were issued last summer. The purpose of the BPAs is to compete and award specific products and product categories at fair and reasonable prices. Here again, however, the approach under MSPV 2.0 will establish only a limited formulary.

The current MSPV 2.0 formulary approach relies on limited and incomplete data because it does not capture the GPC purchases and other sources. The VA should develop a strategy to expand the formulary to allow industry partners to provide full portfolios of products. Expansion of the formulary will increase usage and provide the VHA with more holistic data upon which to make clinically-led sourcing decisions around standardization and product mix. An expanded formulary would allow for an incremental approach based on spend data and clinical needs in managing the appropriate product mix on the formulary. The data input, along with clinical input, should provide opportunities to standardize appropriate product categories while maintaining greater flexibility and choice across product categories

based on clinical needs. Further, an expanded formulary will enhance ongoing market competition across suppliers. By executing on this approach, the VA ultimately will be doing less contracting and more buying to support clinical needs.

In addition, the VA should look to enhance and enable VA use of DoD's Electronic Catalog (ECAT) for purchases below micro-purchase threshold ($10,000) involving products that are typically sold direct in the commercial market and not through a prime vendor. The current ECAT system provides access to products via contracts negotiated by the Defense Logistics Agency (DLA). The VA, through its ongoing collaboration with DoD, has access to ECAT as a source of supply. ECAT orders are made through a VA contracting activity in Cleveland. According to feedback from our members, it appears that current paperwork processing requirements limit VA Medical Center (VAMC) use below the micro-purchase threshold, as compared to the GPC. Streamlining the order requirements for purchases below the micro-purchase threshold will promote use of ECAT for products not on the formulary and reduce GPC use for these items. The additional benefit from this action will be the availability of ECAT purchase data to the VA, as compared to the lack of data under GPC purchasing.

Implementation of DMLSS

Coalition members support efforts to improve logistics systems across the VA, including the implementation of DMLSS. As such, the VA's industry partners are interested in hearing more about the VA's progress to date regarding DMLSS. Indeed, the DMLSS implementation would provide an opportunity to beta test an electronic dashboard, such as that mentioned above. Under this effort, the VA should continue to build on its engagement with its industry partners and provide additional detail regarding the DMLSS timeline and implications for VHA operations. Transparency and engagement with industry ensure that the VA's industry partners can prepare for, and respond to, changes in the VA operations and the federal healthcare market, at large. For example, VA industry partners are interested in gaining a clear picture of how the DMLSS implementation impacts ongoing management of current MSPV program DMLSS implementation and rollout will overlap with the current MSPV program, and providing key information regarding the timelines and impacts will ensure the VA's industry partners are better positioned to respond to the VA's needs. Further, as the DMLSS system utilizes the DLA Prime Vendor Program, it is important to understand how VA utilization of the DLA contracts will impact contractors across the federal healthcare market.

Modernizing the VA's logistics systems through implementation of DMLSS should be part of a holistic review/reform of VHA operations. VHA has the opportunity to enhance logistics and acquisition management structure and governance to ensure they are aligned to leverage the improved data management capabilities of DMLSS.

Finally, none of us should lose sight of the important role that small businesses play here. Pandemic or not, the Veterans First program and small businesses are part of the vital economic engine that serves our nation and our veteran's healthcare system. They should not be overlooked as VA seeks to innovate its purchasing systems.

In closing, Mr. Chairman and Members of the committee, again, please accept my appreciation and the appreciation of Coalition members for the opportunity to appear before you today. I hope you found this testimony useful, and I would be happy to address any questions you might have.