February 1, 2019

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Department of Veterans Affairs
10300 Spotsylvania Ave, Suite 400
Fredericksburg, VA 22408

Subject: RFI MSPV 2.0 Distribution Draft SOW

Dear Ms. Modlin,

Thank you for the opportunity to provide comments in response to the Department of Veterans Affairs' (VA) Request for Information (RFI) on the Medical/Surgical Prime Vendor (MSPV) 2.0 program, which was published on December 21, 2018.

The Coalition for Government Procurement (the Coalition) is a non-profit association of firms selling commercial services and products to the Federal Government. Our members collectively account for more than $10 billion of dollars of Federal healthcare spending, including more than 40 percent of the spending on the VA Federal Supply Schedules (FSS), and manufacture more than 70 percent of the products on the MSPV formulary. Coalition members include small, medium, and large business concerns. The Coalition is proud to have worked with Government officials for 40 years towards the mutual goal of common-sense acquisition.

The Coalition appreciates the VA's efforts to gather feedback from industry through the RFI and through industry days. As the VA continues to develop the strategy for the MSPV 2.0 program, the Coalition offers the following comments with the goal of contributing to a best-value solution for medical and surgical supplies that meets the needs of our nation's veterans.

MSPV Best Value Attributes

To ensure the delivery of best value healthcare solutions to our nation's veterans, the Coalition recommends that the future MSPV program:

1. Have a *clinically led requirements program* to support a robust Formulary that meets the needs of VA medical facilities.

2. Include a *broad range of products* at fair and reasonable prices to provide best value support for healthcare provider choice and needs.

3. Provide *rapid product availability* so that VA medical centers can access innovative solutions in a timely manner to support veterans' healthcare needs. Product additions should be completed within 2 weeks (consistent with the VA Pharmacy PV, DoD MSPV, and DoD Pharmacy PV), in order to reduce purchase card use and gray market purchases.

4. Ensure *reasonable Administrative costs* for both the VA and industry. Avoid unnecessary, duplicative contracting actions, reduce costly and burdensome processes, and take a balanced approach to oversight issues.

5. Encourage industry participation, as well as competitive pricing, by *making the MSPV Formulary a preferred source for VAMCs (and compliance monitored)*. Use volume commitments as appropriate.

6. Provide *sound business opportunities for industry partners*, including Service-Disabled Veteran-Owned Small Businesses (SDVOSBs) and Veteran-Owned Small Businesses (VOSBs).

7. Establish and maintain *adequate resources for the MSPV program* to ensure that it can execute its mission of delivering best value healthcare to our nation's veterans.

Challenges with MSPV

As the VA is considering the strategy for the MSPV 2.0 program, it is important to review the lessons learned from previous programs.

The VA recognized that the process initially used for the MSPV NG program was not adding enough product to the formulary, and the VA responded by issuing the J&A allowing the prime vendors to both supply and distribute products on the formulary. The MSPV legacy program established a formulary with enough products, however the legacy program was built on the FSS and as a result it could take months to get new products added to the program thereby leaving veterans without access to the latest healthcare technologies.

The MSPV also did not receive adequate clinical input during the creation of the formulary, create sound business opportunities for SDVOSBs, compete individual items for the formulary or have clear processes and points of contact to add new products.

The Coalition recommends that the VA address the unintended consequences from previous iterations of the MSPV program and ensure that they do not resurface in MSPV 2.0.

Adding Products to the MSPV

On page 55 of the draft Statement of Work (SOW), the VA notes that the FSS will be part of the VA's strategy to provide products for the formulary. While the Coalition supports the use of the

FSS program in general, Coalition members are concerned that the FSS is unable to effectively support MSPV 2.0, and that the program will struggle without immediate reforms to the FSS.

The MSPV legacy program relied almost exclusively on the FSS, but the program often faced delays for adding new products. Coalition members report that product addition modifications on the FSS can take months or even years. Once the modifications are approved, the products may be out of date, which means that veterans may not receive access to the highest quality care that the VA seeks to provide.

The delays in adding products to the VA Schedules are unnecessary. In contrast, GSA can award some product addition modifications in as little as 24 hours. Coalition members report that on average a GSA product addition modification can be completed in less than a week. The DoD ECAT program can also process product additions in as little as a week or two.

The Coalition has already submitted a white paper and two sets of streamlining recommendations for the Schedules program to the VA. The VA should implement FSS reforms *before* MSPV 2.0 launches or the VA faces the risk of having a formulary that is not robust enough to support veterans' health.

"Fast Track" for Adding Products

As the VA develops the acquisition strategy for MSPV 2.0, the Coalition recommends that the VA adopt a "fast track" for adding items in order to ensure the viability of the program. Instead of undergoing additional fair and reasonable price determinations, the VA can rely on the determinations already made through other Government programs such as the DoD ECAT, the current MSPV NG formulary, and the VA FSS.

Questions

Coalition members have several questions about the MSPV 2.0 that were not answered in the draft statement of work. We would appreciate any clarification that the VA could provide in future RFIs or other industry communications.

1. What will be the entry level requirement for a product to compete for placement on the formulary? For example, will FSS, ECAT, or DAPA be required? Will the products need to be supplied by a Veteran-Owned or Service Disabled Veteran-Owned Small Business?
2. What contract vehicle(s) will be used to build the formulary?
3. What process will be used to compete the products? What categories will be used? What is the timeline for the competition?
4. Does the SAC plan to include FAR 52.208-9 in the final solicitation? According to the RFI, suppliers will provide the VA with products found on the mandatory list of AbilityOne procurement items (e.g., bags, catheters, med kits, surgical kits, gloves, etc.).

5. How will VA facilities be measured on their use of the MSPV program? What outreach is being conducted to the facilities in preparation for the transition to 2.0?
6. On the legacy MSPV, prime vendors provided FSS products without further competition. Will MSPV 2.0 work in the same way? If not, what will the process be for adding products to the formulary?
7. How is the VA improving the FSS to ensure the timeliness of modifications to add products?
8. What are the rules regarding VA facilities access and use of ECATs? Will there be a competitive process that will be required for an ECAT purchase?
9. What is the process to receive a DAPA awarded by the SAC?
10. There did not appear to be any language restricting commercial terms between manufacture/suppliers and the Prime Vendors. Typical commercial terms that leverage industry best practices include the following. Please advise whether any of these will be prohibited under MSPV 2.0:
    a. Cash Discounts for prompt payment
    b. Administrative fees
    c. Reporting/tracing fees
    d. Distribution fees
    e. Inventory management fees
    f. Return fee
    g. Recall Management fee
    h. Penalties around non-compliance of order fulfillment, fill rate, EDI, etc.
    i. Agreements on shipping, ordering, minimums, inventory management and drop ships.
11. Could the fees charged by prime vendors be tied to the level of use of the MSPV contract by each VISN? Higher VISN usage could then support lower fees. This would share the risk between industry and the VA and help the prime vendors recover capital investments.
12. When will the VA reach a decision on the whether MSPV 2.0 is set-aside for small businesses? Will industry be given enough opportunity to respond to the RFP once the VA's decision has been made?
13. Please confirm that MSPV 2.0 orders for supplies from directed suppliers placed under VA approved contracts will be counted as prime contract orders to FSS and other VA contract suppliers as they have been in the past? This approach will continue to earn the VA small business prime contractor credit when awarded to a small business.
14. Since the prime vendor must obtain supplies from directed suppliers, are the prime vendor orders placed with these suppliers under the prime vendor Commercial Agreements considered subcontracts for the purposes of any required small business subcontracting plan goals?
    a. If prime vendor orders to directed suppliers under commercial agreements are not considered subcontracts, does that require large businesses to primarily

meet all small business subcontracting plan goals by subcontracting distribution tasking?

15. The statement of work states that the VA will establish contracts through a competitive process for the supplies.
    a. What is the plan and schedule for these awards?
    b. Who is responsible for making the awards?
    c. Will each item have a potentially unique supplier?
    d. Can existing inventory items be provided by a prime vendor if those items are provided at the not to exceed price?
    e. How does this new plan compare to the previous MSPV NG approach to competitively obtain suppliers for formulary items?
    f. Will these be best value awards?
    g. Will there be a preference for service disabled veteran-owned and veteran-owned small businesses?
    h. How will the VA transition from current MSPV NG formulary suppliers to the MSPV 2.0 catalog directed suppliers?
    i. Will the current MSPV formulary suppliers be extended to support MSPV 2.0 catalog, or will those contracts end prior to the start of MSPV 2.0?
    j. Will the competitions be for brand name items or brand name or equal?
16. There is some confusion over the content of commercial agreements.
    a. Can the VA provide examples of what can and cannot be in a commercial agreement?
    b. Will the directed supplier contracts require each supplier to support a good faith effort to meet the 30-day schedule for establishing a bilateral commercial agreement?
    c. Can these commercial agreements include negotiated discounts for quantity prime vendor buys?
    d. Is there any incentive for either the directed supplier or for the prime vendor to negotiate a discount to the approved not to exceed price for an increase in order quantity?
    e. Will these commercial agreements be allowed to augment the VA contract provisions when necessary to ensure compliance with MSPV 2.0 contract requirements?
    f. Will prime vendors be permitted to acquire supplies from FSS contracts that provide access to over one million medical/surgical items?
    g. Will prime vendors be permitted to place orders on FSS that are under the $10,000 Micro-purchase Threshold without competition?
    h. Will prime vendors be permitted to issue sole source orders on FSS if the required item is only available on FSS from one source?
    i. What FSS orders by the prime vendor will require the prime vendors to seek multiple offers or to compete the order?

j. Does a prime vendor have any responsibility to meet VetsFirst requirements for prime contract awards or directed supplier orders?
k. May a prime vendor use ECAT to provide required products?

17. The SOW does not permit the prime vendor to require a directed supplier to comply with any term or condition not required by law or regulation, or generally accepted commercial practices among prime vendors in the medical/surgical industry.
    a. Can the prime vendor require a supplier to comply with MSPV 2.0 requirements for EDI and other information which exceed VA contract requirements?
    b. Can the EDI requirements instead be met and provided by the prime vendor for the directed supplier for a fee negotiated in the commercial agreement?
    c. Can rebates be negotiated in commercial agreements with directed suppliers based on quantity buys?
    d. If the prime vendor negotiates a lower price than the VA approved not to exceed cost, will such cost savings remain with the prime vendor given this is a firm fixed price contract?
    e. Is there any contract incentive for the prime vendor to acquire supplies at lower than the not to exceed cost?
    f. Are there any generally accepted commercial practices that the VA considers counter to any law or regulation?
18. The strategy seems to require both a primary prime vendor and back-up prime vendor for each VISN.
    a. Will the VA consider a simpler alternative supply chain strategy that requires the primary VISN contract winners to also agree to serve as back-up suppliers for adjacent VISN customers if/when required?
    b. Given the high-level of performance required by each prime vendor, the amount of business any backup PV would receive appears to be both random and minimum. Can the VA provide any data on the volume of these backup contracts may have?
    c. What is the business case that might support bidding as a backup prime vendor under the current SOW performance requirements?
19. How many regions is the VA considering for MSPV 2.0?
20. If the MSPV 2.0 awards are based by VISN, what is the purpose for dividing into regions?
21. Will SDVOSBs be provided priority and preference over VOSBs?
22. The small business subcontracting plan requirement in the SOW requires clarification.
    a. What type of small business subcontracting plan will be required for the MSPV 2.0 proposal?
    b. Who will evaluate the subcontracting plans and what are the evaluation criteria?
    c. What will the SDVOSB subcontracting goal be for the plans?

d. If the offeror plans that fail to meet the minimum goal be found unacceptable or will they be evaluated lower than other plans?
e. Since corporate subcontracting plans are based on a single year, how will these plans be evaluated for the life of the MSPV contract term?
f. Will subcontracting plans be updated or revised over the life of the contract?
g. Will failure to meet the plan goals with good faith effort be considered a potential breach of contract?

23. Will the VA seek a waiver to the non-manufacturer rule for MSPV 2.0?
24. Is the VA currently capable of using all EDI transactions requested in the SOW? If not, will they be prior to implementation or is this a restrictive requirement?
25. The RFI provides for the determination of "directed suppliers" that will negotiate NTE pricing for products under contracts established by VHA. See Section I, B. Are those items considered to be the MSPV 2.0 Catalog?
26. Are there other items beyond "directed suppliers" that are considered to be subsumed within the MSPV 2.0 Catalog? For example, the RFI provides that the PVs shall distribute "Core List Supplies," and "Non-Core List Supplies" which supplies may be available through IDIQ contracts "awarded by VA or VHA" or "by authorized contracts/agreements as provided in the government approved Catalog." See Section II, C.1 & D.1. This suggests that the MSPV 2.0 Catalog is not restricted to "directed suppliers" but includes any supplier that provides a "Core List Supply" or "Non-Core List Supply" that is available through any IDIQ contract award by someone in VA. See also Section II, A. 1 which requires PVs to enter into commercial agreements with all suppliers of Core and Non-Core List Supply items.
27. What is the purpose of having VHA conduct separate procurement actions to designate directed suppliers if an individual VAMC may require the PV to distribute a Core List or Non-Core List supply that is available on another VA IDQ contract?
28. Is it an option for a supplier that already has its product on an FSS contract to decline to compete for a "directed supplier" contract award if its products are already available to VAMCs through other contracts such as VA FSS?
29. Section I, B.4 states that the SAC will "ensure that supplies are placed on appropriate catalogs from which the customer may order." This suggests that there is not a single "catalog" but multiple "catalogs" on which suppliers to be distributed by PVs are priced. Please clarify what is meant by "appropriate catalogs from which the customer may order."
30. Regarding the commercial agreements that are required to be established by PVs with suppliers of Core and Non-Core List Supply items, Section II, A. 7 states that the SAC will not intercede in disputes between the PV and direct suppliers that arise in connection with the contract. But Section II, A.6. states that the PVs shall not require a directed supplier to comply with any term or condition that is not "generally accepted commercial practice among PVs in the Medical/Surgical industry." Who is to judge of what is a "generally accepted commercial practice among PVs in the Medical/Surgical

industry? If some PVs do not require certain terms and conditions does that render the term or condition "not generally accepted."

31. The MSPV NG Prime Vendor solicitations and contract prohibited the PVs from charging the Formulary suppliers distribution and other non-value-added service fees. Is it permissible for PVs to require that suppliers or Core and Non-Core List supplies pay them distribution fees and other service fees under the MSPV 2.0 program?

The Coalition appreciates the opportunity to submit comments in response to the MSPV 2.0 Distribution RFI. If there are any questions, please contact me at rwaldron@thecgp.org or (202) 331-0975.

Regards,

Roger Waldron
President