H.R. 3645, VETERANS HEALTH CARE ITEMS PROCUREMENT REFORM AND IMPROVEMENT ACT OF 2002

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

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WEDNESDAY, JUNE 26, 2002

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC

The subcommittee met, pursuant to call, at 9:30 a.m., in room 334, Cannon House Office Building, Hon. Jerry Moran (chairman of the subcommittee) presiding.

Present: Representatives Moran, Boozman, Filner, Evans, Rodriquez and Carson.

OPENING STATEMENT OF CHAIRMAN MORAN

Mr. MORAN. Good morning. The hearing on our Committee on Veterans' Affairs, Subcommittee on Health, will come to order. Our hearing today deals with procurement and VA's large and diverse healthcare system. It is a system that provides care for millions of veterans, has 185,000 employees, and a budget of more than $22 billion this year. The subject of procurement policy associated with obtaining goods and services to provide that care is a good one for our subcommittee. Today the subcommittee will consider a bill introduced earlier this session by the ranking member of the full committee, the gentleman from Illinois, Mr. Evans, with a number of original co-sponsors. This bill sets new policy in the manner in which the VA procures medical items for its use in the VA healthcare system.

We will hear testimony dealing with the current VA internal strategies in changing and improving its procurement programs and some recommendations from the VA inspector general and the General Accounting Office on ways that the VA may improve its performance in the supply area. Our subcommittee looks forward to accepting that testimony. We welcome our witnesses and others in attendance and I would ask Mr. Evans if he has any opening statement.

Mr. EVANS. I would ask that my statement be made a part of the record.

Mr. MORAN. Those remarks, without objection, will be made part of the record.

[The prepared statement of Congressman Evans appears on p. 28.]

Mr. MORAN. With that, let's take our first panel. Our first panel is Mr. Mark Catlett. He is the Principal Deputy Assistant Secretary for Management at the Department of Veterans Affairs. He is accompanied by Mr. Gary Krump, Deputy Assistant Secretary for Acquisition and Materiel Management, and Ms. Phillipa Anderson, Assistant VA General Counsel. Thank you for attending and, Secretary Catlett, you may proceed.

STATEMENT OF MARK CATLETT, PRINCIPAL DEPUTY ASSISTANT SECRETARY FOR MANAGEMENT, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY GARY KRUMP, DEPUTY ASSISTANT SECRETARY FOR ACQUISITION AND MATERIAL MANAGEMENT, AND PHILLIPA ANDERSON, ASSISTANT GENERAL COUNSEL

Mr. CATLETT. Thank you, Mr. Chairman. Good morning.

Mr. MORAN. Good morning.

Mr. CATLETT. I am pleased to testify today on behalf of the Department of Veterans Affairs regarding H.R. 3645 entitled the Veterans Health Care Items Procurement Reform Act of 2002.

Mr. MORAN. Mr. Secretary, excuse me for interrupting. Would you pull the microphone closer to you. Thank you very much.

Mr. CATLETT. We fully endorse the objective reflected in the H.R. 3645 of leveraging the purchasing power of the VA and other government agencies. Nevertheless, we cannot support the enactment of H.R. 3645. For example, section 2(a) of the bill would amend current section 8125 of title 38 U.S. Code. The new subsection (a) would impose strict mandates that subject to certain narrow exceptions VA would be required to procure all healthcare items through FSS, Federal Supply Schedule contract or national contracts that meet certain requirements. Subsection (b)(1) requires an FSS or national contract to include pre-award audit, post-award audit and price reduction clauses. Subsection (d)(2) limits a distributor contract to distribution services only unless the manufacturer shows that at least 9 percent of the manufacturer's sales through the distributor are made to commercial customers at negotiated prices and that the distributor actually stocks and distributes the items.

These provisions in H.R. 3645 support the objective of leveraging the purchasing power of the VA and other government agencies. On this point we are in complete agreement. We believe that volume leveraging purchasing in the VA is essential. Our vast purchasing power must not be fragmented and the department must employ contracting practices that achieve the best possible terms and prices in our acquisition of healthcare items.

However, after careful consideration of the bill, the VA does not believe that a legislation mandating any particular procurement method in the acquisition of healthcare items is desirable. As acquisitions methods and trends continue to evolve, this legislation may not allow the department the necessary flexibility to take advantage of those improvements and changes. The department should not be compelled to seek legislative changes in order to take advantage of improved procurement practices as they change over time.

In June of 2001, the department convened the VA Procurement Reform Task Force, PRTF, to examine VA's acquisition process and

to develop recommendations for improvement. The PRTF consisted of representatives from the Veterans Health Administration, both from headquarters and field offices, the Office of Management, the Inspector General, the general counsel and various other members. PRTF members were chosen based upon their wide expertise and knowledge of the acquisition process and how it impacts the delivery of care to veterans. The PRTF reviewed documents prepared by the inspector general, former and current VA groups addressing acquisition issues, and other sources. They paid particular attention to the May 15, 2001 Office of Inspector General report on the evaluation of the Department of Veterans Affairs' purchasing practices.

Similar to the mandates that are the basis of the proposed legislation, the PRTF recommended and the Secretary has approved a revised contracting hierarchy that requires the use of FSS and national contracts. The VA's Office of the General Counsel has advised that such a requirement can be implemented administratively. We believe the mandates. We believe that mandates such as this should be made as a department policy decision rather than a statutory requirement, as provided by H.R. 3645. We commend Congressman Evans' efforts in proposing this legislation.

However, we believe that through the work of the PRTF, VA is already on the right track in seeking to maximize savings in its acquisition of healthcare items. The PRTF report, which the Secretary has approved, acknowledged the opportunities to be gained through system discipline while providing maximum flexibility to care of veterans. It is crucial that the department retain flexibility to react quickly to the demands of a dynamic healthcare marketplace in order to most effectively serve veterans.

The PRTF has proposed a comprehensive set of recommendations that address the critical success factor necessary to optimize VA's acquisition system. These recommendations include more than 60 specific reforms for implementation. An ambitious timetable has been established which the department is tracking. VA managers will be held accountable for their attainment. We now need to provide the necessary time and administrative oversight to ensure that these reforms accomplish the department's goal. Although we applaud the objective reflected in H.R. 3645 of leveraging the procurement purchasing power of the VA, we believe that this objective is best achieved through the establishment and implementation of department policy. I am personally optimistic that the task force recommendations also make a real difference for the department and its mission and am compelled to request that statutory requirements not be imposed on us before the efficacy of the task force's work can be proven.

To conclude, the Secretary, who has raised this issue since assuming his job more than a year ago at the VA, as the leader of the organization has made this a major focus for the healthcare system. He personally is very grateful for the attention, recommendations and visibility that Congressman Evans has brought to this important aspect of the VA healthcare system.

That concludes my statement and we are pleased to take any questions the committee has.

[The prepared statement of Mr. Catlett appears at p. 41.]

Mr. MORAN. Mr. Secretary, thank you very much. Is there any statement from Mr. Krump or Ms. Anderson?

Ms. ANDERSON. No.

Mr. KRUMP. Nothing formal, sir.

Mr. MORAN. Thank you. Is it easy for you to summarize the six recommendations by the Procurement Reform Task Force? In general, what do they ask or suggest that the department do?

Mr. CATLETT. Well, if I could, Mr. Chairman, I will cite the five goals of which these six recommendations fall under. And this is general, but hopefully it begins to address your point. And that is to leverage the purchasing power of the VA, as we note, standardizing commodities within the VA, obtaining and approving comprehensive VA procurement information, and improving VA procurement organizational effectiveness, and then finally ensuring a sufficient and talented VA acquisition workforce.

In summarizing, we think that the efforts that have been undertaken for a number of years now in the area of purchasing pharmaceuticals has been effective in terms of getting the VA good pricing with the competition that we have engendered for the pharmaceutical requirements. We are looking to take that example to apply that to the other portions of our healthcare medical and surgical supplies in particular, including prosthetics, which is a fast-growing supply item as well; and apply those principles, both in terms of standardizing and getting to national contracts which lead to competition. Additionally, what we are finding and what we have seen is that the ability for people to have the information in order to make those purchases, we need to make great improvement there. I mean putting at their fingertips the information. Also, many of the things that the IG cited in terms of the problems in the use of the purchase card or other means that go beyond FSS or national contracts is an information issue, as much as anything. We have to improve the information available to many of these people making these decisions daily out there.

So we need to standardize, we need to compete the contracts as we have done in pharmaceutical, and we need to organize more effectively, both the procurement staff in the field and the information available to them, in order to access the information that will lead to purchases through the FSS contracts and the national contracts which we hope to compete.

Mr. MORAN. You indicated, Mr. Secretary, that the Secretary has signed off on the task force's recommendations. Of those 60 items, have any of them been implemented? Is that the way it works, that there are 60 things to do and we are in the process of implementing each of those 60 things?

Mr. CATLETT. Yes, sir. We have a schedule for these items and obviously would be glad to share that with the committee and with the members at any time as we track this. I would ask Mr. Krump to give you a list of the things that currently have been completed or are near completion.

Mr. MORAN. Thank you.

Mr. KRUMP. Mr. Chairman, we have created a database that we have modeled after another database that was available in VA, for tracking the 60 recommendations. We have broken them down into subsets. Each one of the recommendations is on a critical path

management time line. Each is updated by an individual who is responsible for the implementation of their recommendation or subrecommendation. Some of the things that we have done already as of this month is establish a help desk regarding the use and benefits of the national FSS contracts, establish a vendor outreach program through a variety of mechanisms including Fed Mart shows and regional summits, and complemented tiered pricing in all procurement instruments. That is one of the issues that have come up repeatedly with vendors i.e., the capability at the network level to roll up pricing so that we can get better pricing the more we use a national contractor and FSS. Delegation of the authority to appoint the Head of Contracting Activities has been streamlined and replaced with a more corporate format rather than being as decentralized, as had previously been the case.

We have reassigned the function of the Chair of the Supply Fund Board of Directors to the Assistant Secretary for Management, which will report directly to the VA Business Oversight Board, which will be chaired by the Deputy Secretary. We have inaugurated the Business Oversight Board. A charter has been drafted and is proceeding through implementation as we speak. So we have gotten a running start on several of the longer-term processes so that they are up and running at this point in time, in addition to which each of the individual recommendations has been placed into the tracking system, and the first weekly report has been generated on the time lines for those items.

Mr. MORAN. Thank you. Does anything in this legislation impede the implementation of those 60 recommendations?

Mr. KRUMP. It is very congruent.

Mr. MORAN. It seems to me that your main concern is just the statutory nature of legislation directing the department on how to proceed with procurement as compared to your desire to have greater flexibility. Is that an adequate summary?

Mr. CATLETT. Yes, sir, I believe so. I believe there is generally the flexibility that comes with making changes as the dynamics of the marketplace change; as we have seen both with Federal law changing over the years, which has been making acquisition more streamlined and easier for us to do. Most particularly, as the market reacts to both legislation and other changes that they create. We think it is very important that we be flexible in order to react, and that with legislation you sometimes end up with well-intentioned things that work at the moment but a few years later, because market factors have changed, may become a problem. The intention here has been on the efficiency that we are trying to achieve.

First and foremost, the task force recognizes it's about providing access to quality care. So we obviously have to manage those competing interests in terms of getting as efficient as we can, which is generally the responsibility of folks, like Mr. Krump and me and the general counsel's office, but making sure that it is available and in the hands of the clinicians in the field providing the care. They need to have the flexibility to get the supplies and materials that they need to provide health care.

So there will always be a little bit of competition there in terms getting efficient, and the flexibility to provide the health care. It is

always the primary goal of putting the materials and supplies in the hands of the clinicians to get the job done.

So, again, legislatively, we think inevitably that would create some problems when we think administratively we can achieve the same thing. As noted, we agree on the principles and the objectives of the legislation.

Mr. MORAN. Mr. Secretary, thank you.

The gentleman from California, Mr. Filner.

Mr. FILNER. Thank you, Mr. Chairman. I apologize for being late and would ask that my opening statement be made a part of the record.

Mr. MORAN. Without objection, so ordered.

[The prepared statement of Congressman Filner appears on p. 33.]

Mr. FILNER. And again, Mr. Secretary, I am sorry I missed your oral testimony. I read your statement. I was a little surprised by it, given the Secretary's previous support for the outcomes, or at least the intent. You keep talking about flexibility, but the current system is so flexible it has no accountability, and perhaps questionable outcomes. So this legislation does have some oversight mechanisms and reporting requirements.

Now, if you want flexibility, what is your plan to make sure we have accountability?

Mr. CATLETT. Point well taken. I would question the term 'no accountability' in the system. But clearly the need to improve the accountability, particularly in the utilization of FSS and national contracts, is definitely required and is noted in the procurement task force report.

Two things I would suggest that I mentioned, I think, in answering the first question from Chairman Moran—is that we do need to put better information and access to it in the hands of the many hundreds and even thousands of people that need to make the choices out there and make the purchases. That is something that will take some time; we will have to strive to do.

But to your point on the accountability, again, that is recognized and we are in the process of establishing a business oversight board. Actually in the review of this proposal with the Secretary and the Deputy Secretary, generated the idea was generated of establishing a business oversight board that will be chaired by the deputy secretary and have participation by the deputy under secretaries from each administration and certain critical staff functions, and possibly will consider now outside membership from business to look not just at procurement but other business functions like collections where we do need to improve.

So what I am getting at is to suggest to you that we are going to set in place reporting to the business oversight board, headed by the deputy secretary, objectives and metrics to measure performance particularly in this case tracking the utilization of FSS and national contracts or; maybe on the flip side, the cases where we are not utilizing them. And again, those things will obviously be provided to the committee for your review.

Mr. FILNER. Well, I appreciate your words and what you have done. But I think the organization has had enough time to do this and if they were serious it should have been done long ago. So I

think we need the legislation, and I am going to support the legislation and the mandates that you are so worried about.

I thank the Chairman.

Mr. MORAN. Thank you, Mr. Filner. Mr. Rodriguez.

Mr. RODRIGUEZ. Thank you very much. Thank you, Mr. Chairman. I also would like the opportunity to submit some comments, opening comments for the record.

Mr. MORAN. Without objection, so ordered.

[The prepared statement of Congressman Rodriguez appears on p. 27.]

Mr. RODRIGUEZ. Let me ask you—Has any consideration been paid to, or do you know what the percentage is of the VA procurement contracts that go to small businesses?

Mr. CATLETT. Well, would you repeat the question, sir? I am not sure if——

Mr. RODRIGUEZ. Do you know what percentage of the VA contracts go to small businesses?

Mr. CATLETT. Well, as of now, the goal that we set, the overall department goal is around 40 percent.

Mr. RODRIGUEZ. The goal. What do you accomplish?

Mr. CATLETT. We will have to provide that for the record, we are not quite achieving our goal, but we are very close. The government objective is about 23 percent, so we have set a much higher target traditionally. We are above 23, but we are not quite to 40.

Mr. RODRIGUEZ. You are above 23 percent.

Mr. CATLETT. Yes, sir.

Mr. RODRIGUEZ. Do you know where the SBA ranks VA—they put out a report card on Federal agencies. Do you know where you rank with the SBA?

Mr. KRUMP. In terms of where we rank on the report card, we are very near the top of the report card because most of our activities, the consolidated activities, routinely hit over 30 percent, the activities that are here in the Washington area. In point of fact, we are going to receive an award for exceeding 40 percent. So agency-wide the goals are very well taken care of and are very closely paid attention to.

Mr. RODRIGUEZ. Okay. Do you know how——

Mr. CATLETT. Mr. Rodriguez, we will be glad to provide specific information on that.

(Subsequently, the Department of Veterans Affairs provided the following information:)

Scorecard III (which covered FY 2001) was released by Congresswoman Nydia Velazquez, the Ranking Democrat on the House Small Business Committee, on May 15, 2002:

The Department of Veterans Affairs
Small Business Goal: Letter Grade "B" (29.69%)
Small Disadvantaged Business Goal: Letter Grade "C" (4.72%)
8(a) Program Goal: Letter Grade "C" (3.78%)
Women-Owned Business Goal: Letter Grade "B" (4.63%)
HUBZone Small Business Goal: Letter Grade "A" (1.94%)
VA's "Overall Grade": Letter Grade: "C"

The Scorecard does not score accomplishments for Veteran-Owned or Service-Disabled Veteran-Owned Small Businesses.

The percentages shown above are from Ms. Velazquez's Scorecard III, and are from data obtained from the Small Business Administration (SBA), Federal Procurement Data Center.

The figures VA uses to measure accomplishments for FY 2001 vary slightly from SBA's figures, as we include in our totals purchase card data from those contracting activities that report these transactions, as well as including VBA's Property Management Program expenditures, both of which were not captured in FPDS and thus not reported to FPDC:

Small Business: 32.64% (Secretary's Goal 40%)
Small Disadvantaged Business: 5.12% (Secretary's Goal 5%)
Section 8(a): 3.79% (Secretary's Goal 5%)
Women-Owned Small Business: 5.01% (Secretary's Goal 6%)
Veteran-Owned Small Business: 2.57% (Secretary's Goal 7%)
Service-Disabled Veteran-Owned Small Business: 0.23% (Secretary's Goal 3%)
HUBZone Small Business: 2.29% (Secretary's Goal for FY 01 was 2%)

The information provided above answers all of the questions raised by Congressman Rodriguez during his question and answer session with VA and requiring post-hearing follow-up.

Mr. RODRIGUEZ. Do you know where the VA ranks in terms of minority and women-owned businesses?

Mr. CATLETT. Yes, sir, that is regularly tracked and reported, and we would be glad to provide that.

(See p. 8.)

Mr. RODRIGUEZ. Do you have that data? Do you know?

Mr. CATLETT. We have about seven or eight categories and I don't have that with me, and to be correct I would like to give that to you specifically and quickly for the record. We can get that to you this afternoon.

(See p. 8.)

Mr. RODRIGUEZ. I understand the importance of assuring that we bring down the VA procurement cost—and I agree that we need some degree of flexibility, but I also recognize the importance of ensuring that we look at small businesses and their participation, to give you an example in terms of quality of products, we had in San Antonio where a person who was providing fresh eggs on a regular basis to all the military bases, and then it was contracted out, and now those eggs are now coming out of Kentucky, going into Texas, and there is a delay, so they are not fresh eggs anymore because it was cheaper to import. I know that in a lot of cases, in the area of health, you have a lot of small companies who produce a particular item, and that is what they do and that is what they do best. And when you start lumping it up in terms of large contracts and that kind of thing, those small companies get lost in the shuffle and sometimes, you know, the quality of the product also is reduced tremendously.

Mr. CATLETT. Your point is well taken, and that sometimes conflicting interest of getting as efficient as you can versus meeting the objectives of doing business with small businesses and the various facets there is of concern. It is something that our deputy secretary has highlighted as he reviewed and made his recommendations on this task force report and we are very conscious of that. That will be identified and addressed and, as I said, we regularly track and we have an active small business office. It is not only looking for opportunities but setting the goals and tracking them. So that is something that is visible and important to the department.

Mr. RODRIGUEZ. Do you think the figure is a little bit over 23 percent, about 30 percent for small businesses?

Mr. KRUMP. Overall, yes, sir.

Mr. RODRIGUEZ. Do you know how many 8A programs you might have?

Mr. KRUMP. In a program as vast as this, I would have to agree with Mr. Catlett, we need to get you the specific figures. Offhand, I couldn't tell you.

Mr. RODRIGUEZ. You guys are involved with contracting and procurement, right?

Mr. CATLETT. Yes, sir.

Mr. RODRIGUEZ. And you would think that if you would come to a hearing, those would be some of the things that you would have in hand.

Mr. CATLETT. Well, as I said sir, I apologize for that. We will be glad to get those to you within the hour, if you would like. I don't have those with me, and we will be glad to get those for you.

Mr. RODRIGUEZ. Thank you.

Mr. MORAN. Thank you, Mr. Rodriguez.

We are delighted to have the gentlewoman from Indiana join us. Ms. Carson, welcome to our subcommittee. I know you have a particular interest in this topic, feel free to question our witnesses.

OPENINGS STATEMENT OF HON. JULIA CARSON

Ms. CARSON. I appreciate very much, Mr. Chairman, your allowing me to just insert myself into an area where I truly don't belong. I am on the Subcommittee on Oversight, not this subcommittee. Thank you so very much. And if it is appropriate, I would like to leave a few remarks you can insert in your record.

Mr. MORAN. Without objection.

[The prepared statement of Congresswoman Carson appears on p. 35.]

Ms. CARSON. But I would like to ask Mr. Krump a quick question and I will move on. In Public Law 106–50, sort of what you have been talking about, it establishes goals for small business contracts with specified small business interests. For example, the national goal for contracting with service-connected disabled veterans concerns is 3 percent. Federal procurement data systems data shows the VA is achieving results for disabled veterans-owned business is well below the national goal at only 0.22 percent. What specific mechanisms are in place to help VA achieve performance on this contracting goal? It is a goal that I think that the VA is so far off the mark with service-disabled veteran-owned small businesses.

Mr. KRUMP. Yes, ma'am, it is a very serious area of concern with us as well. What we have done is, as you know, the goal is in the statute. The VA has had a goal of 5 percent of contracting for veteran-owned businesses for several years. What we have done is establish a departmentwide task force that was cochaired or cochartered by myself and Scott Denniston, our director of Small Business. And what we are looking at is putting together a tracking system to increase the capability to reach service-connected disabled veterans in particular.

One of the difficulties that we have had is in finding a comprehensive library or database of businesses that will fit into that area that we can match against our contracts and match against our requirements.

In addition to that, one of the things that we have done at the national acquisition center is we have gotten several service-connected disabled small businesses on our national FSS contracts so that the medical centers can buy from them. Understand that is because the medical centers are decentralized in contracting their contracting activities do not report to us at this time. But by utilization of this particular mechanism they can issue delivery orders against a standing contract and they don't have to go out and search out small businesses or service-connected disabled businesses. That facilitates and provides a contract vehicle for them to do more business with that. We have noticed a significant increase in business done under that schedule, which has been in place for

about 6 months now, and we are looking at getting together a more comprehensive tracking system for small businesses that we can match up with contractual requirements in the department so that all the field stations can issue orders against those contracts.

Ms. CARSON. Thank you, Mr. Krump. Thank you, Mr. Chairman.

Mr. FILNER. Would the lady yield for a moment? I am not sure if you put these into the record. But I thank you for your interest. I have the Federal procurement data system summary in front of me, and it is hard to read, but as I read it, the goal of the department is 3 percent service-connected and you have only achieved 0.2 percent. Is that accurate, and how can you explain that?

Mr. KRUMP. Sir, it is accurate so far as I am aware. It would not be significantly different even including the problems that you have with the FPDS reporting system at this time.

Why—how do I explain that? In large part I explain that initially when we set out to study this matter with our OSDBU office, one of the things that we had was difficulty finding a sufficient number of service-connected veteran owned small businesses to participate. That is why we have been working with SBA and OSDBU on a database to achieve more access to that group.

We have also added five additional people to the VA Office of Small and Disadvantaged Business Utilization to focus specifically on this area. We have also put together, with OSDBU, a Veterans' Enterprise Center with a new director for that Center to be able to develop more contacts with these businesses.

We have created a database within VA so that the field activities will have greater access to that. Right now what we are trying to do is to centralize all of the information and make that information available to all contracting officers throughout the department so that they can issue orders against that. But at this point in time, with the evolving business arrangements in that area—other than that, there is no explanation.

Mr. FILNER. Well, I hope you will read what you just said when it comes out in the record. I think Ms. Carson and Mr. Rodriguez would join me in saying that kind of explanation we have heard for 50 years—the people aren't out there, so don't blame us. And you have hired a whole lot of people now who probably don't fit that classification either to go find some people who you think don't exist. I think that is an incredible admission of incompetence. I don't know if that is the right word. But read your answer. I mean it is incredibly unresponsive and showing that you are not coming really coming to grips with the issue that Ms. Carson brought up.

Mr. MORAN. Mr. Boozman, any questions?

Mr. BOOZMAN. No.

Mr. MORAN. This 3 percent goal that we just talked about, when was it established?

Mr. KRUMP. It was established as part of the statute that went into effect last year.

Mr. MORAN. So it is less than a year in effect?

Mr. KRUMP. Yes, sir.

Mr. MORAN. Thank you. I believe this concludes our panel. We thank the Secretary, Mr. Krump, and Ms. Anderson for joining us. We would call the second panel to the table. This panel consists of Mr. John Bilobran, Deputy Assistant Inspector General for Audit-

ing, Department of Veterans Affairs; Ms. Maureen Regan, Ms. Cynthia Bascetta, Director of the Veterans' Health Benefits Issues, General Accounting Office, accompanied by Mr. Mick Blair of the GAO.

Ms. Bascetta, would you care to begin this panel?

STATEMENTS OF CYNTHIA A. BASCETTA, DIRECTOR, HEALTH CARE, VETERANS' HEALTH AND BENEFITS ISSUES, GENERAL ACCOUNTING OFFICE; AND JOHN S. BILOBRAN, DEPUTY ASSISTANT INSPECTOR GENERAL FOR AUDITING, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY MAUREEN T. REGAN, COUNSELOR TO THE INSPECTOR GENERAL

STATEMENT OF CYNTHIA A. BASCETTA

Ms. BASCETTA. Yes, thank you. Mr. Chairman and members of the subcommittee, I am pleased to participate in this hearing on VA procurement practices. Today I will discuss our work on the purchasing of medical and surgical supplies, including joint procurement with DOD, in the context of H.R. 3645.

Last fiscal year VA and DOD spent almost $750 million to purchase approximately 200,000 different types of medical and surgical supplies. Three years ago they signed a memorandum of agreement to use their combined buying power to reduce costs for these supplies. However, VA and DOD have not awarded any joint national contracts for medical and surgical supplies and they are unlikely to do so any time soon. While they have focused on contracting separately, a few DOD and VA facilities have yielded modest savings through local joint contracting agreements. VA and DOD acknowledge that standardizing medical and surgical supplies is a critical step toward achieving greater cost savings individually and through their joint procurements. However, identifying and standardizing like items has been a cumbersome and time-consuming process for both departments because they lack complete data on their medical and surgical supply procurements.

In addition, they lack unique item identifiers such as universal product numbers that would make recognizing similar items easier. Currently VA has standardized and negotiated about 150 national blanket purchase agreements, known as BPAs, covering over 1900 individual medical and surgical supply items on the FSS. VA estimates that it saves about $13 million annually through these national BPAs. DOD has 53 regional incentive agreements through which it expects to save about $6 million annually.

We analyzed about 100 identical medical and surgical items that VA and DOD now contract for separately. In most cases VA had negotiated lower prices with manufacturers, but sometimes DOD negotiated lower prices. Jointly purchasing at the lowest prices would have yielded additional savings for both departments. While these item-by-item savings are relatively small, for example, $52,000 for one item and $200,000 for seven others that we identified, the cumulative effect of jointly purchasing thousands of items can be significant. The potential for savings will likely be reduced to some extent because VA and DOD have chosen different approaches to standardization, national versus regional, which will limit their opportunities for national joint procurements.

In addition, as drafted, H.R. 3645, with certain exceptions, appears to lock VA into purchasing from the FSS or BPA, potentially reducing some of its flexibility in certain situations where they might want to combine and leverage their purchasing power with DOD. Secretary Principi recently approved a procurement reform initiative which is intended to accelerate standardization, minimize local purchases and create greater purchasing power, as well as place VA in a better position to jointly purchase with DOD. H.R. 3645 seems consistent with this initiative and would strengthen it by adding requirements for explicit annual goals as well as a September 2002 effective date.

In addition, VA and DOD are making improvements to their automated information systems. At this point, however, neither department has accurate, reliable and comprehensive procurement information. This is a basic requirement for identifying potential medical and surgical items to standardize, as well as to achieve additional savings. Similar improvements in their data would be needed to assure meaningful compliance with the reporting requirements contained in H.R. 3645.

In conclusion, Mr. Chairman, the current initiatives are positive steps toward improving the efficiency and effectiveness of VA's acquisition system. However, the future of their individual and joint procurement successes will depend on each department improving their automated information systems and holding themselves accountable for achieving savings both individually and through their joint efforts.

This concludes my prepared remarks and we would be happy to respond to any questions you might have.

[The prepared statement of Ms. Bascetta appears on p. 44.]

Mr. MORAN. Thank you, Ms. Bascetta. Mr. Bilobran.

STATEMENT OF JOHN S. BILOBRAN

Mr. BILOBRAN. Thank you, Mr. Chairman, and members of the subcommittee. I am pleased to be here today to report on the work performed by the Office of the Inspector General relating to procurement of pharmaceuticals and medical-surgical items, our recommendations to improve the effectiveness of the Department of Veterans Affairs procurement program, and our views regarding H.R. 3645, the Veterans Health Care Items Procurement Reform and Improvement Act of 2002. I am accompanied by Ms. Maureen Regan, counselor to the inspector general.

Federal Supply Schedule contracts are national contracts that are awarded noncompetitively to multiple vendors for like or similar commercial off-the-shelf products. The government's negotiation objective is to obtain most-favored customer, or MFC prices, that is, prices equal to or better than that offered to commercial customers. To facilitate that goal, FSS vendors are required to disclose specific information relating to the discounts and concessions given to their commercial customers, and these disclosures place the contracting officer in a better position to determine price reasonableness and ensure the government negotiates the best prices. FSS contracts contain a price reduction clause requiring vendors to offer the government the same price reduction it provides to agreed-upon tracking customers. This clause ensures that the government main-

tains commercially favorable pricing throughout the term of the contract.

FSS contracts benefit VA and other government agency customers by affording choice among a variety of pharmaceuticals, medical-surgical supplies, and equipment items. FSS contracts also broaden opportunities for vendors to sell to the government. In many instances these opportunities particularly benefit small businesses that might otherwise lose out in competition with larger suppliers.

Since 1993, the OIG, in conjunction with the Office of Acquisition and Materiel Management, has collected in excess of $161 million for overcharges relating to defective pricing and price reduction violations on Federal Supply Schedule contracts, most of which was returned to VA's supply fund. In addition, since 1994, pre-award reviews of manufacturers' offers have identified potential cost savings of over $373 million.

Pre- and post-award reviews are critical tools needed to negotiate the best possible contract terms and to ensure the government's interests are protected during the term of the contract. We are currently able to conduct pre-award reviews only on medical-surgical contracts greater than $3 million and pharmaceutical contracts greater than $5 million and conduct post-award reviews on overcharges the manufacturers have voluntarily disclosed.

FSS is no longer a mandatory source of supply and some manufacturers have withdrawn high volume items from FSS contracts, refused to negotiate in good faith, cancelled contracts, or decided not to submit proposals for FSS contracts. Vendors have told us that it is not cost-effective to submit a proposal and offer MFC prices on an FSS contract because many VA medical centers want to negotiate separate agreements. Even if a local contract achieves better prices, those terms do not benefit the government as a whole, only the local medical center. We believe that local contracting against an FSS contract should be avoided because it compromises VA's ability to leverage prices nationally and incurs avoidable administrative and overhead costs.

Even without an FSS contract, vendors may continue to sell in large volume to VA medical centers that purchase open market. Vendors recognize that they can sell at any price to medical facilities that purchase open market and do not attempt to negotiate prices with the vendor.

Some medical-surgical vendors that contract directly with commercial customers have decided to sell to the government only through distributors that have FSS contracts. This allows the manufacturers to shield their pricing from the requirements of FSS contracts, shield themselves from audits that may disclose pricing violations, avoid other FSS contract requirements such as the price reduction, clause and avoid requirements of public policy such as the Trade Agreements Act requirements.

Some medical centers have entered into contracts where the distributor establishes the item price. In these cases the VA medical center will not benefit from FSS prices because there is no agreement between the distributor and manufacturer to honor the manufacturer's FSS or other national contract price. We reported our

findings to the Secretary of the Veterans Affairs in a May 2001 report and made four recommendations for improvement:

(1) Make FSS and other national contracts mandatory sources of medical-surgical supplies and equipment, and generic pharmaceuticals, unless otherwise determined by the department's procurement executive; (2) Prohibit the award of local contracts for commercial items unless authorized by the department's procurement executive or designee; (3) Monitor local purchasing; and 4. Limit contracts with distributors to distribution services only unless the distributor can show that it is responsible for negotiating and establishing prices for the majority of items it distributes to each manufacturers' commercial customers.

In June 2002, the Secretary of Veterans Affairs chartered the VA Procurement Reform Task Force. The Task Force recently issued its report and made recommendations that supported our findings and conclusions. However, we believe statutory authority is needed to optimally achieve the purposes described above and ensure that the recommended actions can and will be implemented.

Accordingly, we support H.R. 3645. The proposed legislation complements the recommendations we made in our May 2001 report, the recommendations of the Task Force, and fills in gaps in the authority available to the Secretary to independently implement the recommendations administratively. However, we suggest some technical changes be made to improve administration of the legislative intent.

That concludes my testimony. I will be pleased to answer any questions you may have.

[The prepared statement of Mr. Bilobran appears on p. 59.]

Mr. MORAN. Mr. Bilobran, thank you very much.

Ms. Bascetta, for how long has—have you or the GAO been looking at cooperation on procurement issues between DOD and the VA?

Ms. BASCETTA. Mr. Chairman, I believe it has been at least 2 or 3 years now beginning with the work that we issued last year on joint procurement of pharmaceuticals.

Mr. MORAN. What is your impression or your analysis of progress either being made or not being made? Are we at all moving forward?

Ms. BASCETTA. In the pharmaceutical area I would say yes. Quite a bit. I don't have the statistics off the top of my head, but I know that after we had encouraged the departments to look very closely at specific classes of pharmaceuticals, where they were quite resistant to believing that they were able to do joint procurements, they made many more joint solicitations and are continuing to make quite a bit of progress.

In the medical-surgical area it has been much, much slower.

Mr. MORAN. Part of your testimony that troubles me the most is that you indicate that it is difficult for VA and DOD to identify items that would produce the greatest benefit from standardization within, let alone between, their departments. What is it that we, as policymakers need to do to, in a sense to force DOD and VA to cooperate? It seems to me that one of the things that you also talk about is it is uncertain whether data from the new systems—I assume we are talking about computers—would be compatible. There

is almost always an explanation or the word "excuse", that our computers don't talk to each other. I have heard that in minor settings and major settings. It is just a standard answer to why we can't do something.

What do we need to do to push DOD and VA to be compatible and ultimately save the taxpayers' dollars?

Ms. BASCETTA. That is a difficult question. As you know, it has been a challenge now for, well, since the original sharing legislation was enacted in the early 1980s. I believe that your continued oversight in setting performance goals and expectations that the departments will in fact cooperate and achieve greater savings through those joint procurements is the best action you can take. Being prescriptive about how to do that, you know, could have some impact. But in the final analysis, what we are trying to do is get the result that we want and that the President's task force on VA health care wants as well.

In this particular area, which is really very complex, there are a couple of points that I would also like to make. One is that their own information systems need significant improvement so that, as we said, they can do better procurements individually as well as together. But another common challenge that they face is the lack of UPNs, universal product numbers in a number of cases. And here the VA is actually taking the initiative to prepare a draft regulatory impact statement, a cost-benefit analysis of the effect of UPNs on manufacturers. And if they can issue a regulation that would require UPNs, this would help not only VA but DOD, particularly in this medical and surgical area, compare items both within their systems and across their systems. So that would be a significant help in this particular situation.

Mr. MORAN. Do you have an estimate of the cost savings in procurement alone if the VA and DOD would cooperate?

Ms. BASCETTA. No, we don't.

Mr. MORAN. Is that number not available because of lack of information?

Ms. BASCETTA. That is correct.

Mr. MORAN. Common sense tells me that the savings would be substantial.

Ms. BASCETTA. We would agree with that. On a unit basis they would be relatively small, especially compared to, you know, high ticket items or even compared to many pharmaceuticals. But in the aggregate, the cumulative savings, we would imagine, would be substantial.

Mr. MORAN. Do you have a sense as to whether I should be poking my finger in the chest of the Department of Defense or the Veterans Affairs Department? Is one department dragging their feet more than another?

Ms. BASCETTA. I don't think so. I think there is probably plenty of blame to go around.

Mr. MORAN. I will poke twice. Thank you. Mr. Filner.

Mr. FILNER. Thank you, Mr. Chairman. I am interested in the fact that the inspector general's office differed with the Secretary's Office on its recommendation on the legislation. I would like to ask, if you don't mind, Ms. Regan. Ms. Regan, I am told that you know a lot about this issue and that you have heard the testimony ear-

lier, you heard some of the other questions. I would like to get your reaction to it as an open-ended kind of thing. Do you think that VA can fix this situation internally, or do they need this kind of legislation?

Ms. REGAN. One of the reasons we supported the legislation—the inspector general supported the legislation because it contains a number of components that we have some question as to whether or not the Secretary can independently implement. The distributor issue, in particular.

Mr. FILNER. I am sorry to interrupt. But when you say the Secretary doesn't have the power to independently implement, can you explain that?

Ms. REGAN. As we understand it, the Secretary can independently mandate that VA facilities buy off of Federal Supply Schedule or national contracts, but there is some question as to whether or not the Secretary would be able to independently implement some of the other recommendations in the legislation, such as the pre- and post-award audit clauses, the price reduction clause, and the requirements relating to contracts with distributors. This is why the IG supported the legislation. It is our understanding that concurrence by OMB and possibly with GSA on some of those issues would be necessary before these provisions could be implemented by the Secretary.

Mr. FILNER. Can you address the broader issue somehow? What is going on in the VA that has led to this kind of critique and whether they can fix it on their own?

Ms. REGAN. What led to our report in May? Or——

Mr. FILNER. And this legislation.

Ms. REGAN. We wrote the report at the request of the Secretary. When the Secretary first met with us, he was briefed by our office on a number of issues. One issue was procurement. We had gathered a significant amount of information from various reviews conducted by various parts of the OIG organization and we had some recommendations. And he asked us to put our findings and suggestions into report format. In response, the Secretary put together the Procurement Reform Task Force. While the Task Force was working, the legislation was proposed. The IG feels strongly that the recommendations in our report. The Task Force addressed some of these issues, but we are concerned whether the VA has authority to independently implement all of the recommendations.

Mr. FILNER. Do you share or not my skepticism, as I expressed to the Secretary earlier, about accountability internally?

Ms. REGAN. To some degree, I think there has been a lack of accountability and a lack of oversight in what VA has been purchasing over the years. One of the things we note in our report, and I believe the task force report also noted, is VA does not know what it is are buying. Some of the blame is on changes such as making FSS not mandatory and encouraging the use of the credit cards both of which led to a significant increase in open market purchases. We can't tell you, nobody can tell you, right now what VA is buying or from what vendors. This has caused a problem over time. Frankly, the Department, the National Acquisition Center, also recognized that vendors were going off contracts and starting to complain about why should they have a contract if they have to

go renegotiate at the local level. We began to see in our pre- and post-award audit work that it was a problem. More and more high dollar items were being taken off contract and sold open market.

Something needs to be done to let manufacturers to put items on contract to get good pricing. When you buy open market, you can pay any price quoted. Sometimes above list, sometimes at list, sometimes below list. When somebody comes in and tells the medical center, I am going to give you 50 percent off list, that sounds good. But if you find out that most other commercial customer is getting 90 percent off list, it is not such a great deal.

We support the Federal Supply Schedules because, first, it gives everybody the chance to compete, especially small businesses. It also allows the VA to negotiate most-favored customers pricing and to actually get good prices by leveraging our buying power.

Mr. FILNER. Just internally to the VA operation, I told Secretary Catlett that I was surprised at the testimony because the Secretary earlier had sort of expressed support. Do they ask you or your office about this legislation and what you recommend on it? I mean as part of their process, do they consult with you, given the fact that you had already made some recommendations?

Ms. REGAN. We were consulted. The Department knew our position.

Mr. FILNER. They disagreed with you.

Ms. REGAN. Correct.

Mr. FILNER. All right. Mr. Catlett, as the Principal Deputy Assistant Secretary, is that your title? So there is a Secretary for Management? Is there a Secretary for Management, Assistant Secretary?

Mr. CATLETT. To be nominated.

Mr. FILNER. I'm sorry.

Mr. CATLETT. Yet to be nominated.

Mr. FILNER. And you are the principal deputy. So are there other deputies? I am just looking at the title; it interests me. I was just wondering—how many administrators do we have here that are looking over this information?

Mr. MORAN. Mr. Secretary, if you are going to answer that question, would you come to a microphone.

Mr. FILNER. I guess I was just——

Mr. MORAN. Do you have a question, Mr. Filner?

Mr. FILNER. It just looks like a big administrative structure and then we are not even understanding what we are buying or who we are buying it from. It seems rather strange. And I think it justifies the need for this legislation, Mr. Chairman.

Mr. MORAN. Mr. Boozman.

Mr. BOOZMAN. In regard—you were talking about the purchasing, and I guess there might not be an incentive to get the best purchase price. In your investigation, was that just sloppiness or, like I said, no incentive? Did you find any evidence that—I mean we are talking about large sums of money, you know, potentially. Has anybody ever been found to be doing that for the wrong reason? Do we prosecute people for——

Ms. REGAN. We have prosecuted people for misuse of the credit card, people who use the credit card to buy goods for personal use or to buy goods and resell them. But as far as pricing on medical-

surgical supplies, equipment, and pharmaceuticals, it has just become a problem because the credit cards have been spread out to individual services in the hospitals. The secretaries have the credit cards and they have just gotten used to calling up and ordering an item and not really negotiating a price. And a lot of the items that they buy are under $2,500. They are below the micro threshold purchase limit of which does not require the buyer to do much in the way of negotiation or price comparison. This is the reason why manufacturers have learned just to sell directly to these local people. They wouldn't lose any business. As we cited in our report, they knew they could do that, and some of them have made a lot more money doing it because there is no negotiation and no negotiation is required because of the dollar amount of the purchase.

Mr. BOOZMAN. Thank you.

Mr. MORAN. Mr. Rodriguez.

Mr. RODRIGUEZ. Thank you very much. I think you heard some of the questions I asked earlier in terms of minority. Procurement, ironically enough, the VA has been awarded a C by the Committee on Small Business, minority staff for their operations, although Federal agencies overall get a D because of the fact that as they move forward, a lot of small businesses are cut out from the process. I was wondering if, in your assessment process do you consider small business participation in the process? I wanted to get some feedback from the GAO whether that is looked at at all or, what kind of feedback you might have gotten on this issue.

Ms. BASCETTA. We didn't cover that at all in ours, but I believe the IG has.

Mr. RODRIGUEZ. Did you also consider, the VA set their goal at 3 but the Federal mandate is 5? They are mandated to come up to 5 and they set their goal at 3. I mean automatically they probably look good because on the 8A programs they are at 3.7 percent. But that has been dropping for the last 3 or 4 years since 1998. Have you—do you all look at other studies on how the VA does with small businesses at all?

Mr. BILOBRAN. We have not done any reviews of small business involvement in general VA procurement.

Mr. RODRIGUEZ. The Federal Government has a variety of initiatives—in fact, this administration, President Bush's administration is also pushing HUBZone areas, as well, 8A programs. So as the Federal agencies proceed, do you find them to even be knowledgeable about minority, 8A and HUBZone?

Mr. BILOBRAN. We don't have any information.

Mr. RODRIGUEZ. You don't have that information, they didn't have it either. And if our goal is to try to develop the HUBZone concept based on the administration's proposal, and the people in procurement are not familiar—I mean, that really bothers me that we have this program trying to help certain communities, and we have President Bush trying to push the HUBZone stuff and other initiatives, and yet they are not cognizant of those programs that exist out there or how they even rank in those areas.

I was surprised, the VA has been doing well on women-owned business, and I suppose you had been given a B on women-owned businesses, so the VA has done fairly well in that area. But on the other areas for some reason it has been dropping from a high in

1998 of 7 percent down to a little bit over 3 percent now. But their mandated goal was 5 that is my understanding. Is that your understanding also?

Mr. BILOBRAN. Yes.

Mr. RODRIGUEZ. Are there any other studies that the GAO has done that have taken into consideration small business and minority-owned businesses, women-owned businesses?

Ms. BASCETTA. None that I am aware of in my area, which is health care. It is possible that there have been reports done on small business goals in other parts of GAO. I would be happy to check for you.

Mr. RODRIGUEZ. I understand the importance of quality, flexibility, and bringing down the costs, but also we must remember there are a lot of good small businesses that produce good products, would you like to comment on that?

Mr. BILOBRAN. We have some information related to small business performance on on the Federal Supply Schedule that we have received from the National Acquisition Center. Approximately 66 percent of all of the contractors in fiscal year 2000 were small business enterprises, and in 2001 it was 67 percent.

Mr. RODRIGUEZ. Based on the data I have, they seem to do a little bit better—in all honesty they are not there yet, but they do better than the Department of Defense because they (the DOD) are less than 1 percent on most of the ranking areas.

Mr. REGAN. As we said in our testimony, one of the beauties of the Federal Supply Schedule is that it allows small businesses to get a contract and to sell their products. They don't have to compete on a one-on-one basis with big businesses. This allows more small businesses to go out and sell their products without worrying about the one-on-one price comparison with somebody else. They may not have the buffer zone to out price large manufacturers, but they also may have a product that the VA wants. And that is one of the nice things about the FSS system, and it does work.

Mr. RODRIGUEZ. Thank you very much.

Mr. MORAN. Mr. Rodriguez. Thank you.

For the purposes of today's discussion, what is the definition of a small business?

Ms. REGAN. I believe it is under 400 employees.

Mr. MORAN. Committee, anything further of this panel?

Thank you very much, panel. We appreciate your participation today and the insight you have offered. We are hoping that this bill will receive additional consideration. There is a subcommittee meeting on July 10 to further consider this legislation.

Without objection, written statements of the American Legion, the VFW, the DAV, PVA, VVA, BVA and Allied Health for Veterans Care will be made part of the record. Without objection, so ordered.

(See p. 71.)

Mr. MORAN. The hearing record will remain open for 5 additional days to receive additional statements.

Mr. MORAN. This hearing is adjourned.

[Whereupon, at 10:35 a.m., the subcommittee was adjourned.]

APPENDIX

I

107TH CONGRESS
2D SESSION

H. R. 3645

To amend title 38, United States Code, to provide for improved procurement practices by the Department of Veterans Affairs in procuring health-care items.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 29, 2002

Mr. EVANS (for himself, Mr. FILNER, Mr. GUTIERREZ, Ms. BROWN of Florida, Mr. REYES, Ms. CARSON of Indiana, Mr. LYNCH, Mr. SANDERS, Ms. KAPTUR, Mrs. JONES of Ohio, and Mr. DINGELL) introduced the following bill; which was referred to the Committee on Veterans' Affairs

A BILL

To amend title 38, United States Code, to provide for improved procurement practices by the Department of Veterans Affairs in procuring health-care items.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Veterans Health-Care Items Procurement Reform and Improvement Act of 2002".

SEC. 2. LIMITATION ON USE OF LOCAL CONTRACTS FOR DEPARTMENT OF VETERANS AFFAIRS PROCUREMENT OF HEALTH-CARE ITEMS.

(a) IN GENERAL.—Section 8125 of title 38, United States Code, is amended to read as follows:

"§ 8125. Procurement of health-care items

"(a) Except as provided in subsection (b), any procurement of a health-care item by any element of the Department shall be made through the use of a Federal Supply Schedule contract, or a national contract, that meets the requirements of subsection (d).

"(b)(1) A contract that is not a Federal Supply Schedule contract or national contract meeting the requirements of subsection (d) may be used for the procurement of a health-care item in the case of a procurement—

"(A) that is necessary to meet a current or near-term medical emergency at a medical center;

"(B) that is for a health-care item for which there is a valid clinical need and that is not listed in the Federal Supply Schedule or as part of a national contract;

"(C) that is part of a written and approved sharing agreement between the Department of Defense and the Department of Veterans Affairs with demonstrable cost per item savings for a health-care

item listed on the Federal Supply Schedule or a national contract; or

"(D) that supports prime or subcontracts with small business concerns qualifying for a procurement preference program under section 8 or 15 of the Small Business Act (15 U.S.C. 637, 644), that demonstrates at least cost parity with the health-care item on the Federal Supply Schedule or national contract and meets the requirements of subsections (d)(1)(A) and (d)(2).

"(2) A procurement may be made as authorized under subparagraph (B) of paragraph (1) only if the procurement is specifically authorized in advance in writing by the Secretary. The authority of the Secretary under the preceding sentence may only be delegated to the Under Secretary for Health and the senior procurement executive of the Department acting jointly.

"(c) In the case of an emergency procurement of a health-care item as authorized by subsection (b)(1)(A), the quantity of the item procured may not exceed the quantity of such item that is reasonably necessary to meet the emergency need and the reasonably foreseeable need for that item at the medical center concerned until resupply can be achieved through procurement actions other than emergency procurement.

"(d) A contract meets the requirements of this subsection if—

"(1) the contract includes—

"(A) provisions referred to as preaward and postaward audit clauses; and

"(B) a provision referred to as a price reduction clause; and

"(2) any contract with a vendor that is a distributor will be for distribution services only, unless the manufacturer of the product can clearly demonstrate that at least 90 percent of its sales of the item through distributor is to commercial customers with negotiated product prices and the distributor actually stocks and distributes the product.

"(e) The Secretary shall establish procedures to assure compliance by each Department medical facility with the provisions of this section and with applicable Federal and Department procurement regulations.

"(f) The Secretary shall establish annual goals for Department medical centers for the purchase of healthcare items from Federal Supply Schedule and national contracts meeting the requirements of subsection (d). Such goals shall be designed to maximize the percentage of such purchases that are made from Federal Supply

Schedule and national contracts meeting the requirements of subsection (d).

"(g) The Secretary shall include in the annual report of the Secretary under section 529 of this title information on the procurement of health-care items during the preceding fiscal year. Such information shall be shown by geographical service area and shall include information on procurements made under the authority of subsection (b)(1)(B). Such information shall include the total dollar amount of such procurements, the ratio of the dollar amount of such procurements to the total dollar amount of all procurements of health-care items, and a status report on implementation of this subsection.

"(h) For the purposes of this section:

"(1) The term 'health-care item' includes any item listed in, or (as determined by the Secretary) of the same nature as an item listed in, Federal Supply Classification (FSC) Group 65 or 66.

"(2) The term 'emergency' with respect to a procurement of a health-care item, means a procurement necessary to meet an emergency need affecting the health or safety of a person being furnished health-care services by the Department.

"(3) The term 'Federal Supply Schedule contract' means a contract that is awarded and admin-

istered by the National Acquisition Center of the Department under a delegation of authority from the Administrator of the General Services Administration.".

"(4) The term 'national contract' means a contract for procurement of an item that is entered into by the National Acquisition Center of the Department or another Department procurement activity, as authorized by the Secretary, that is available for use by all Department medical facilities.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on September 30, 2002, and shall apply to procurements by the Secretary of Veterans Affairs after that date.

○

Congressman Ciro D. Rodriguez

HVAC Subcommittee Hearing on H.R. 3645

June 26, 2002

- Thank you Mr. Chairman
- I am anxious to hear the testimony presented this morning regarding "H.R. 3645, the Veterans health Care Items Procurement Reform and Improvement Act of 2002."
- I would like to acknowledge the work of Ranking Member Evans on this legislation which raises crucial questions regarding the procurement process followed by the Department of Veterans Affairs.
- I await the testimony that will be presented today by the Department of Veterans Affairs on our currently employed procurement process and their assessment of the proposed changes.
- Additionally, I am interested in the results of GAO's work in assessing collaborative procurement efforts between the DOV and the Department of Defense.
- Of great importance and guidance also is the voice of our veterans. The perspective of our leading veterans advocacy groups is also of considerable consideration on this critical issue.
- Ultimately, our role here is to serve the needs of our veterans. Providing them with adequate and accessible health care should always be at the top of our list of concerns.
- However, when opportunities arise to save money and cut waste while still meeting the needs of our veterans we need to pay attention.
- Thank you all for being here and I anxiously await your testimony on this urgent issue.

Statement of Honorable Lane Evans
Ranking Democratic Member
Committee on Veterans Affairs
Before the Subcommittee on Health Hearing on H.R. 3645
June 26, 2002

I introduced "The Veterans' Health-Care Items Procurement Reform and Improvement Act of 2002" to resolve an unwelcome drain of taxpayer dollars caused by persistent inefficiencies in Department of Veterans Affairs (VA) procurement and acquisition practices for medical and surgical supplies and a reluctance on the part of VA to aggressively fix that problem. Several generations of "Task Force" reviews have offered suggestions to address procurement problems, but little has been done. Passage of this bill will require long-needed action. Similar legislation to centralize pharmaceutical purchases and leverage the purchasing power of large agencies has already yielded estimated annual savings in the $200 million range.

It is my intent that H.R. 3645 will force a more robust use of the Federal Supply Schedule (FSS) and national contracts for the procurement of medical and surgical items for VA. With H.R. 3645, VA will purchase a greater percentage of items from centrally negotiated contracts which leverage the tremendous purchasing power of a very large organization. Vendors, cognizant of the sales potential in a vast market, will flock to list their wares on the FSS.

The Congressional Budget Office agrees that a cost savings will result from this initiative. This savings translates to greater access and higher quality services for veterans seeking healthcare at VA. It is this overarching goal – to better serve veterans – that is the true underpinning of my bill.

The bill contains several checks and balances to get the job done right. It requires that most contracts for VA healthcare items include a pre- and post-award clause – this allows VA or General Accounting Office auditors to determine if the government is receiving good value for the purchase of health-care items.

The bill includes a price reduction clause to assure that VA receives prices favorably comparable with the best prices offered to a vendor's other customers. It also includes several provisions specific to distributors who are not manufacturers and who engage in business with VA. These distributors would have to demonstrate the value of their wares through costing data valid in the private

sector. The standard set in the bill is high for distributors, perhaps too high regarding the requirement that a manufacturer must demonstrate that at least 90 percent of its sales of the item through the distributor are to commercial customers with negotiated product prices. I recommend we consider lowering the bar regarding demonstrable sales of the item – 50 percent is likely a more appropriate limiting value.

Centralized contracting and procurement is the focus of the bill, but there are four mission-related exceptions. The language in each exception carries with it a specific intent.

First, VA continues to be empowered to meet current or near-term medical emergencies at a medical center. Nothing in this bill should be construed to abrogate that emergency authority. However, I note with dismay that this emergency purchasing authority is often used to cover for a lack of planning. The Secretary should assure that "constructive emergencies," due to a lack of supply channel planning, are identified. VA procurement data should identify egregious offenders and take appropriate corrective action.

Second, is an exception for health-care items not listed on the FSS or a national contract for which there is a valid clinical need. The intent of this exception is to permit identification and local purchase of items that are needed, but are not otherwise available. The need for a specific healthcare item will be identified at the field location and the exemption request forwarded to the appropriate headquarters VA senior-level approval authority. The approval authority is set very high in VA to avoid providing a convenient sanctuary for those vendors wishing to avoid the FSS and maintain [local] business as usual.

This exception strikes a balance between an identified need and the bill's general push to centralized procurement. Nothing in this exception should be construed to prevent VA from providing a veteran with appropriate healthcare. Use of this exception for a specific need, in the purchase of tailored prosthetics for example, if reasonable, should ***NOT*** carry a negative connotation. First look to the FSS or a national contract, and then procure the item locally if it is needed and was approved. With time, eager vendors will engage the FSS more robustly and lessen the need for this exception. After further review, I would be receptive to lowering the level of the approval authority for this exception by one reporting echelon at VA headquarters.

The third exception to the basic centralization philosophy involves the Committee's strong support of DoD and VA joint sharing initiatives. I understand that written and approved sharing initiatives sometimes yield benefits beyond normal costing rationale. This exception allows for non-FSS or non-national contract procurements if the jointly purchased item has a demonstrable cost savings compared to a FSS or national contract.

The final exception is intended to allow small business concerns to compete on a more even footing. It allows for a non-FSS or non-national contract purchase if the vendor is a small business under the definition of the Small Business Act and can demonstrate at least cost parity with the health-care item on the FSS or national contract.

FSS, national contracts, and contracts using the small business concern exception must all include provisions commonly referred to as pre- and post-award audit clauses. FSS and national contracts must include a price reduction clause – if a vendor sells cheaper elsewhere – VA should buy at a reduced price.

The bill also specifies data collecting and reporting requirements – these are needed for analysis and accountability.

In written testimony, VA asserts that legislation is not needed and that improved procurement practice can be accomplished by VA administratively and requests the flexibility to address the problem. Their request is not persuasive – procurement flexibility is currently the status quo and it clearly has failed.

I see three principal reasons VA is not up to the task of cleaning its own procurement house with administrative remedies. Its seeming inability to implement task force recommendations on time, a lack of reliable procurement data, and the insufficient administrative authority currently vested with the Secretary to implement ALL of the changes required by the legislation demonstrate why H.R. 3645 is needed.

The VA has had several task forces address procurement problems. A February 15, 2001, Acquisition and Material Management Task Group Problem Inventory Report identified a number of process-related actions to improve the system, some were implemented, others were not. The net result was that the identified failures of procurement oversight actually became worse over time.

In June 2001, I sent the Secretary two letters regarding the need for procurement reform and he seems to have agreed. In a July 3, 2001, VA News Release, the Secretary announced the appointment of a new task force, charged with reporting back in 120 days with proposals to improve the department's complex procurement system. I publicly lauded his action.

On October 24, 2001, the Secretary notified me that the [new] Procurement Task Force "is on schedule to report to me by mid-November." I introduced H.R. 3645 in January 2002. After numerous prompts, the Task Force finally released its report in May 2002. The numerous delays in its release were troublesome and indicative that consensus was not yet reached by the Task Force.

Accurate procurement data from VA has been elusive at best. In January 2001, I wrote Secretary-designate Principi asking for information about the cumulative additional cost incurred by VA as a result of local procurement vs. Federal Supply Schedule or other centralized procurement. The VA's response on March 5, 2001, to that query was, "Because there are thousands of items on the three Federal supply classes covered by this report, this information would be impossible to collect." That response told me all I needed to know about accountability for data. Knowing where the money goes is a bedrock principle.

Yet VA does periodically report data on local procurement to Congress. While the reporting requirements of Section 8135 of title 38 U.S.C. may now be obsolete, VA reported on March 12, 2002, that only 5.5 percent of its group 65, 66, and 73 purchases were from local procurement. This seemed to contrast strongly with a procurement estimate two months earlier that indicated that 58 percent of medical and surgical purchases were local. These are significant "reporting anomalies" for a billion dollar program! This hinted at the reliability of procurement data.

Finally, VA needs help to engineer procurement reform legislatively because the Secretary is limited in the administrative remedies available to the Department. He may push for centralization to the FSS, but he can not alter national contracting policy alone. This bill is needed to fix the problem.

I extend my thanks to the Office of the Inspector General and especially to Ms. Maureen Regan for her tireless efforts to identify procurement pitfalls and to strengthen VA procurement policy. Her May 15, 2001, *Evaluation of The Department of Veterans Affairs Purchasing Practices*, is a masterwork of analysis – my personnel thanks to her and her team.

Finally, and I am pleased to say a rare occurrence, I am obliged to admonish the Department for their lackluster action on procurement reform and their shoddy analysis on the merits of H.R. 3645. I can only describe the Office of Management and Budget approved statement for this hearing as valueless. Beyond stating that VA does not support the enactment of the bill, it says little else; it is very sparse on the "why." The hearing statement is in near lock-step agreement with the need for H.R. 3645 and it very accurately describes the bill, yet the Department wants "wiggle-room" to do it their way. Past performance of VA on procurement matters does not permit "wiggle-room."

Opening Statement of
Honorable Bob Filner
Ranking Member
Subcommittee on Health
Committee on Veterans Affairs
June 26, 2002

Hearing on H.R. 3645
Veterans Health-Care Items Procurement Reform
And Improvement Act of 2002

Thank you, Mr. Chairman. As you know, I am an original co-sponsor with the Committee's Ranking Member, Mr.Evans, of this important bill. I support the intent and provisions of H.R. 3645 to bring accountability and sound business practices back into government procurement processes.

VA is the largest health care system in the country. Why isn't VA asserting a leadership role worthy of the enormous billion-dollar purchasing power it possesses? Those dollars are my tax dollars and your tax dollars gone amuck in an inefficient, broken down, fragmented process of buying supplies, equipment and services for a national health care organization.

I've read VA's written testimony for this hearing and quite frankly, I'm anxious to hear more from VA. I'm not sure

I understand how the Secretary can offer public support for this legislation a few months ago and then submit testimony before this Subcommittee that opposes the bill.

VA wants to handle the much-needed improvements administratively. I've seen Administrations come and Administrations go during my tenure here in Congress. Administrations change, and we need to change the law!

Flexibility is another cornerstone of VA's opposition to this bill. The current system we have is so flexible, it has no accountability and questionable outcomes. We have flexibility now. Do we really need more?

I welcome the opportunity to learn how VA plans to right its course on a national scope, to maximize its purchasing power, so that scarce resources might be used to provide the quality health care services and benefits veterans deserve. We need to enact H.R. 3645.

Thank you, Mr. Chairman.

Opening Statement of Hon. Julia Carson
Subcommittee on Health, Committee on Veterans Affairs
Hearing on HR 3645, Veterans Health-Care Items Procurement Reform and Improvement Act of 2002.
334 Cannon HOB
June 26, 2002

Mr. Chairman, I want to thank you for allowing me to sit in on this hearing today, as I am not a member of this subcommittee.

I cosponsored HR 3645 because it means more purchasing power for each Federal healthcare dollar spent by the Department of Veterans Affairs. It also will facilitate greater accountability within the overall VA procurement process.

It is important that VA seek the best value for its healthcare item purchases. This is because the healthcare needs of Americas' veterans must always be our prime consideration. The current procurement system strives to meet this need, but it sometimes fails because of funding limitations.

Just imagine what a two or a three percent savings over the billion dollar VA procurement budget would yield in additional services for our veterans.

Waiting times at VA clinics must be reduced and quality services must be provided to meet our veterans' needs. – a more effective procurement system is vital so that our veterans may reap the benefits of those procurement savings. This bill does not limit access to needed medical and surgical equipment – in the long run it will provide greater availability – even for veterans with special and unique healthcare needs.

From what I have read and have heard thus far today, VA does not object to the legislation based on its merit, they are quibbling because, well, they want to do it themselves.

Does this mean another procurement task force and another procurement report? I have read procurement task force reports from previous years yet the system is still broke. This legislation will stop the quibbling and provide for real efficiencies and real savings.

VA would like to fix things administratively, but it is unclear to me if the Secretary currently has the authority to mandate pre- and post-award audit requirements or limitations on distributors?

Mr. Chairman, VA advocates centralized procurement with FSS or national contracts. This legislation accomplishes that task.

VA wants to assure best value and accountability, this bill supports those issues.

VA seeks management efficiencies and this legislation facilitates those efficiencies.

VA seeks to support DoD/VA sharing initiatives and this bill does that while at the same time offering protections to small business owners.

But VA wants – over the course of time – to implement many of the core provisions of this bill, although it is unclear if the Secretary currently has the authority to mandate that some of the provisions of the bill, like pre and post award auditing clauses, be added to all contracts!

Mr. Chairman, the nexus between the VA's roadmap for procurement reform and the mandates of this legislation are crystal clear. At about the time VA went for OMB clearance, the waters were muddied and support waned. Mr. Chairman, why would anyone not support the efficiencies of this bill?

Mr. Chairman, I Yield back the balance of my time.

Statement of Representative Jeff Miller
House Veterans Affairs Committee
Subcommittee on Health Hearing on HR 3645, the Veterans Health Care Items Procurement Reform and Improvement Act of 2002
June 26, 2002

Thank you Mr. Chairman.

I am glad to be here today to hear testimony that is of particular interest to me. I would also like to thank each of the panelists present, for taking the time to speak with us today. Your input is essential to the future of joint VA and DOD procurement initiatives.

As we all know, VA has the largest integrated healthcare system in the United States, and is therefore one of our greatest resources. The Department of Defense also provides health care to millions of beneficiaries. For some twenty years, Congress has urged VA and DOD to work together through improved acquisition processes and increased sharing of medical resources. Already the two are jointly procuring pharmaceuticals, and the savings have been tremendous. This is commendable, and we should now turn our focus to what it will take to lower the costs of supplies and contracts. If VA and DOD can save over $170 million dollars annually by cooperatively procuring pharmaceuticals, imagine the savings of joint purchasing thousands upon thousands of medical and surgical items.

This issue of VA/DOD resource sharing is of particular interest to me and to my veterans' population, the largest in any single district. I represent Florida's First Congressional District, which is home to VA clinics that are so short on resources that many of my veterans are forced to drive two states

away to Biloxi, Mississippi in order to receive the treatment they need. Pensacola Naval Hospital and the hospital at Eglin Air Force base are both DOD facilities where currently, little or no resource sharing exists. Recently, I had the honor of welcoming Secretary Principi to my district for a tour of the facilities. The Secretary and the VA have acknowledged the potential that District 1 holds as a leader in the nationwide movement toward joint resource sharing. Realizing this goal for the many thousands of veterans and retirees in my district is my top priority, and I am committed to doing whatever is necessary to make it happen.

That being said, I am very anxious to hear your recommendations so that we can move to the next step in this process. Again, many thanks for your testimony today and for your continued assistance as we work toward the goals of our nation's veterans.

LUIS V. GUTIERREZ
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
Hearing on H.R. 3645
The Veterans Health-Care Items Procurement Reform & Improvement Act
Wednesday, June 26, 2002, 9:30AM

OPENING STATEMENT

Chairman Moran and Ranking Member Filner, I am glad we are having this Subcommittee hearing today to examine H.R. 3645 and the benefits of centralizing the Department of Veterans' Affairs procurement of health equipment and supplies. I appreciate the leadership of Mr. Evans, my friend and colleague from Illinois and the author of H.R. 3645, on this important issue. I am proud to be a cosponsor of the bill under our consideration today, the Veterans Health-Care Items Procurement Reform and Improvement Act.

Since 1986, the centralization of the VA's purchases of pharmaceuticals has generated a savings of approximately $850 million. I believe this provides us with clear indication that if H.R. 3645 is enacted, it could save the Department of Veterans Affairs tens of millions of dollars annually. I am sure we can all

agree that this money could be better spent on the health care of our nation's deserving veterans. The VA Acquisition System Task Force and the VA Office of Inspector General have both issued recommendations that the Department of Veterans' Affairs establish a national procurement policy. Their recommendations are in close alignment with the intent and purpose of H.R. 3645.

Let us not delay the savings potential of this proposed legislation. The VA, the United States' taxpayers, and most importantly, our nation's veterans stand to benefit tremendously from the passage of H.R. 3645.

I thank the panel of witnesses for their time today and I look forward to their testimony. Thank you.

STATEMENT OF
MARK CATLETT
PRINCIPAL DEPUTY ASSISTANT SECRETARY FOR MANAGEMENT
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
SUBCOMMITTEE ON HEALTH
HOUSE COMMITTEE ON VETERANS' AFFAIRS

June 26, 2002

Good Morning Mr. Chairman and members of the committee. I am pleased to testify today on behalf of the Department of Veterans Affairs (VA) regarding H.R. 3645 entitled the "Veterans Health-Care Items Procurement Reform Act of 2002."

We fully endorse the objective reflected in H.R. 3645 of leveraging the purchasing power of VA and other Government agencies. Nevertheless, we cannot support the enactment of H.R. 3645.

Section 2(a) of the bill would amend current section 8125 of Title 38, United States Code. New Subsection (a) would impose strict mandates that, subject to certain narrow exceptions, VA would be required to procure all health-care items through a Federal Supply Schedule (FSS) contract or national contracts that meet certain requirements. Subsection (b)(1) lists the exceptions whereby contracts for health-care items other than FSS or national contracts may be used. Exceptions would be allowed:

- when necessary to meet a current or near-term medical emergency with a valid clinical need for a health-care item not available through the FSS or a national contract;
- a sharing agreement between VA and the Department of Defense with demonstrable per item cost savings compared to the FSS or national contract; and
- prime or subcontracts with certain qualifying small business concerns with, among other things, prices at least on a parity with the FSS or national contract.

Except in cases of emergency, awards of contracts for health-care items for which there is a valid clinical need and that are not listed in the FSS or as part of a national contract, subsection (b)(2) would require approval of deviations from the general policy in advance, in writing, by the Secretary. This authority could only be delegated to the Under Secretary for Health and the senior procurement executive, acting jointly. This authority could not be re-delegated.

Subsection (d)(1) requires an FSS or national contract to include pre-award audit, post-award audit and price reduction clauses. Subsection (d)(2) limits a distributor contract to distribution services only unless the manufacturer shows that at least 90 percent of the manufacturer's sales through the distributor are made to commercial customers at negotiated prices and that the distributor actually stocks and distributes the item.

Subsection (f) would require annual goals for Department medical centers for the purchase of health-care items from FSS and national contracts and subsection (g) would mandate certain information be included in an annual report on the procurement of heath-care items. Subsection (h) defines "health-care item" as any item listed in Federal Supply Classification Group 65 or 66 or any item determined by the Secretary to be of the same nature as a listed item.

We recognize that H.R. 3645 supports the objective of leveraging the purchasing power of VA and other Government agencies. We believe that volume-leveraged purchasing in VA is essential. Our vast purchasing power must not be fragmented and the Department must employ contracting practices that achieve the best possible terms and prices in our acquisitions of health-care items. However, after careful consideration of the bill, VA does not believe that legislation mandating any particular procurement method in the acquisition of health-care items is desirable. As acquisition methods and trends continue to evolve, this legislation may not allow the Department the necessary flexibility to take advantage of those improvements. The Department should not be compelled to seek legislative changes in order to take advantage of improved procurement practices.

On June 18, 2001, the Department convened the VA Procurement Reform Task Force (PRTF) to examine VA's acquisition process and to develop recommendations for improvement. The PRTF consisted of representatives from the Veterans Health Administration, both from Headquarters and field offices, the Office of Acquisition and Materiel Management, the Inspector General, the General Counsel, and various other members. PRTF members were chosen based upon their wide expertise and knowledge of the acquisition process and how it impacts the delivery of care to veterans. The PRTF reviewed documents prepared by the Inspector General, former and current VA groups addressing acquisition issues, and other sources. They paid particular attention to the May 15, 2001, Office of Inspector General Report, "Evaluation of the Department of Veterans Affairs Purchasing Practices."

Similar to the mandates that are the basis of the proposed legislation, the PRTF recommended and the Secretary has approved a revised contracting hierarchy that requires the use of FSS and national contracts. The VA's Office of

the General Counsel has advised that such a requirement can be implemented administratively. We believe that mandates such as this should be made as a Department policy decision rather than a statutory requirement as provided by H.R. 3645.

We commend Congressman Evans' efforts in proposing this legislation. However, we believe that, through the work of the PRTF, VA is already on the right track in seeking to maximize savings in its acquisition of health-care items. The PRTF report, which the Secretary has endorsed, acknowledged the opportunities to be gained through system discipline while providing maximum flexibility to care for veterans. It is crucial that the Department retain flexibility to react quickly to the demands of a dynamic health-care market place in order to most efficiently serve veterans. The PRTF has proposed a comprehensive set of recommendations that address the critical success factors necessary to optimize VA's acquisition system. These recommendations include more than 60 specific reforms for implementation. An ambitious timetable has been established which the Department is aggressively tracking. VA managers are being held accountable for their attainment. We now need to provide the necessary time and administrative oversight to insure that these reforms accomplish the Department's goals.

In summary, although we applaud the objective reflected in H.R. 3645 of leveraging the procurement purchasing power of VA and other Government agencies, we believe that this objective is best achieved through the establishment and implementation of Department policy. I am personally optimistic that the task force recommendations will make a real difference for the Department and its mission, and am compelled to request that rigid statutory requirements not be imposed on us before the efficacy of the task force's work can be proven.

This concludes my formal testimony.

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Health, Committee on Veterans' Affairs, House of Representatives

For Release on Delivery
Expected at 9:30 a.m.
Wednesday, June 26, 2002

VA AND DEFENSE HEALTH CARE

Potential Exists for Savings through Joint Purchasing of Medical and Surgical Supplies

Statement of Cynthia A. Bascetta
Director, Health Care—Veterans' Health and Benefits Issues

GAO-02-872T

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss an important component of the Department of Veterans Affairs' (VA) business practices—purchasing medical and surgical supplies—and its efforts to jointly procure them with the Department of Defense (DOD). In fiscal year 2001, VA spent about $500 million and DOD spent about $240 million for these supplies. Since the early 1980s, the Congress has urged VA and DOD to achieve greater efficiencies through improved acquisition processes and increased sharing of medical resources. In June 1999, VA and DOD signed a memorandum of agreement to combine their buying power and achieve lower medical supply costs and eliminate contracting redundancies for certain items, including pharmaceuticals and medical and surgical supplies.

Last year we reported that VA and DOD saved over $170 million annually by jointly procuring pharmaceuticals.[1] VA and DOD achieved these savings by agreeing on—or "standardizing"—particular drugs that their facilities would purchase and then contracting with the manufacturers of these drugs for discounts based on their combined larger volume. As a follow-up to that study, you requested that we provide information on VA and DOD's progress in jointly procuring medical and surgical supplies. VA and DOD purchase approximately 200,000 different medical and surgical supplies. Some commonly used supplies include gloves, masks, surgical tape, needles, and syringes. Many medical and surgical supplies are disposable—that is, one-time use items.

My testimony today focuses on (1) the status of VA and DOD's efforts to jointly contract nationally for medical and surgical supplies, including actual and potential savings from collaboration, and (2) factors that impede their efforts for joint contracting. To examine these issues, we conducted site visits at VA and DOD headquarters and at eight of their medical facilities. We also reviewed studies, documents, and current literature relating to standardization, unique identifiers for medical and surgical supplies, and joint contracting. In addition, we compared and analyzed data from current VA and DOD contracts for medical and surgical supplies and conducted numerous interviews with VA and DOD

[1]U.S. General Accounting Office, *DOD and VA Pharmacy: Progress and Remaining Challenges in Jointly Buying and Mailing Out Drugs*, GAO-01-588 (Washington, D.C.: May 25, 2001).

officials. Our work was conducted from January 2002 through June 2002 in accordance with generally accepted government auditing standards.

In summary, VA and DOD have not awarded joint national contracts for medical and surgical supplies as envisioned in their memorandum of agreement, and it is unlikely that the two departments will have joint national contracts for supplies anytime soon. However, a few VA and DOD facilities have yielded modest savings through local joint contracting agreements. VA's and DOD's procurement efforts have focused on contracting separately—VA on a national basis and DOD on a regional basis. VA's and DOD's current separate contracts are expected to save about $19 million annually. Our analysis of about 100 identical medical and surgical items that VA and DOD now contract for separately indicates that jointly purchasing these items will yield additional savings, although we were unable to quantify the full potential. For example, in fiscal year 2001, if VA had collaborated with DOD and obtained a discounted price from one of DOD's regions for needle and syringe disposal containers, VA could have saved tens of thousands of dollars on this one item alone. Similarly, DOD could have realized additional savings if it had obtained VA's lower national contract price on one type of intravenous tubing.

The lack of progress VA and DOD have made in jointly contracting for medical and surgical supplies has, in part, been the result of their different approaches to standardizing medical and surgical supplies. These differing approaches—VA's national approach of selecting specific items for all its facilities to purchase and DOD's regional approach that allows each of nine geographic regions[2] to individually standardize specific items—increase the possibility that VA and DOD regions could select and standardize different items for purchase and thereby minimize the opportunities for national joint procurements. Other impediments to joint purchasing have been incomplete VA and DOD procurement data and the lack of a means for identifying similar high-volume, high-dollar purchases. Because of these shortcomings, it is difficult for VA and DOD to identify items that would produce the greatest benefits from standardization within—let alone between—their departments. The Secretary of Veterans Affairs recently approved a procurement reform initiative to address these impediments. If implemented, this initiative would increase the likelihood that VA could procure medical and surgical supplies more economically

[2]For health care delivery, DOD has 12 regions. However, for standardization, it has combined some regions for a total of nine geographic regions.

and put it in a better position to identify and enter into joint procurements with DOD. In addition, VA and DOD are making improvements to their automated information systems, which should enhance their ability to identify items for standardization. However, neither VA nor DOD could confirm that their enhanced systems will contain compatible data that will allow the two departments to readily exchange procurement information—a key capability for facilitating standardization and joint procurement.

Background

VA operates one of the world's largest health care systems, spending about $21 billion a year to provide approximately 3.8 million veterans health care through 163 VA hospitals and over 800 outpatient clinics nationwide. DOD spends about $19 billion on health care for over 5.8 million beneficiaries, including active duty personnel and military retirees and their dependents. Most DOD health care is provided at the more than 500 Army, Navy, and Air Force hospitals and other military treatment facilities worldwide.

VA and DOD have separate systems for procuring and distributing medical and surgical supplies. VA purchases supplies through the Federal Supply Schedule (FSS), which is maintained by VA's National Acquisition Center in Hines, Illinois, and is available to all federal purchasers. VA validates a sample of FSS prices to ensure that they are no more than the prices manufacturers charge their most-favored, nonfederal customers.[3] Once FSS prices are established, VA manually analyzes its procurement history to identify like items, such as gauze bandages, for which it could potentially standardize and negotiate blanket purchase agreements (BPA) and national contracts directly with vendors (manufacturers or distributors) for a larger discount based on volume purchasing. After like items are identified, a team of clinicians—including doctors, technicians, and nurses—assesses the products for quality and agrees on a specific item or items that are acceptable for use by all VA hospitals.[4] Acquisition officials then negotiate BPAs with the vendors of the chosen products to obtain lower prices. Once BPAs are established, VA facilities are required to purchase the items from the selected vendors. If medical and surgical

[3]In cases where VA's validation process identifies that the FSS price is more than the price paid by most-favored, nonfederal customers, VA recovers the price differences from the manufacturers.

[4]Not all medical and surgical supplies are viable candidates for standardization for various reasons, such as strong clinician preferences for a specific item.

supplies are not available through BPAs, VA medical facilities have the option of purchasing supplies from FSS, locally, or on the open market directly from manufacturers. Recently, VA began monitoring facility compliance with national BPAs.

DOD purchases medical and surgical supplies through Distribution and Pricing Agreements (DAPA), which are negotiated and maintained by the Defense Supply Center in Philadelphia, Pennsylvania.[5] DOD also allows its regions to individually standardize medical and surgical items and negotiate their own regional incentive agreements (RIA) to obtain larger discounts on certain high-volume, high-dollar medical and surgical items. Teams of military and contractor personnel in each region identify items for standardization. As in VA's process, clinicians then assess and select items to standardize. Finally, the teams negotiate regional price discounts with the vendors. DOD facilities are required to buy from certain vendors to take advantage of DAPA pricing or, if a better price has been negotiated, through RIAs. If items are not available through DAPA or RIAs, facilities can purchase items locally or directly from manufacturers.

Over the past 2 decades, the Congress has urged VA and DOD to maximize efficient use of federal dollars by sharing their health care resources. In May 1982, the Congress passed the VA and DOD Health Resources Sharing and Emergency Operations Act,[6] which encouraged the two departments to enter into health resources sharing agreements. After the Congressional Commission on Servicemembers and Veterans Transition Assistance issued its 1999 report calling for VA and DOD to combine their market power, the Congress passed the Veterans Millennium Health Care and Benefits Act,[7] which required VA and DOD to report on their joint pharmaceutical and medical supplies procurement activities.

[5]Currently, DAPA is being converted to FSS pricing.

[6]Public Law 97-174.

[7]Public Law 106-117.

VA and DOD Have Not Awarded Joint National Contracts; Potential Savings Exist

VA and DOD have not awarded national joint procurement contracts for medical and surgical supplies, and none appear likely in the near future. While a few VA and DOD facilities have obtained modest savings through local joint contracting agreements, we identified some additional joint procurement opportunities that have the potential to increase VA's and DOD's savings. Since their 1999 memorandum of agreement, VA's and DOD's procurement efforts have focused on separately contracting for standardized medical and surgical supplies. Their separate national and regional contracts are expected to save a total of about $19 million annually.

VA and DOD's joint procurement efforts for medical and surgical supplies have been limited to the local level. In May 2000, we reported that six VA and seven DOD facilities had joint purchasing agreements for certain medical supplies, realizing modest savings.[8] Under one local contract, some VA and DOD facilities in Virginia and North Carolina negotiated discounts with a manufacturer for chemistry test slides; these VA and DOD facilities reported savings of $358,000 and $301,000, respectively. Subsequently, VA and DOD facilities in another region joined the contract for additional savings of slightly over $1 million.

Currently, VA has about 150 national BPAs—most of which were awarded in 2000—covering over 1,900 individual medical and surgical items such as examination gloves, surgical face masks, and tongue depressors.[9] VA estimates that it saves about $13 million annually through these national BPAs. DOD has 53 RIAs—most awarded in 2002—for items such as surgical tape, needles, and syringes.[10] The department expects to save about $6 million annually through these agreements. The combined savings of about $19 million are about 22 percent less than the $88 million the two departments would have spent had the RIAs and national BPAs not been negotiated and are indicative of the savings potential that exists.

[8]U.S. General Accounting Office, *VA and Defense Health Care: Evolving Health Care Systems Require Rethinking of Resource Sharing Strategies*, GAO/HEHS-00-52 (Washington, D.C.: May 17, 2000).

[9]VA has 126 national BPAs, 17 basic ordering agreements with industries operated by the disabled, and 6 national contracts covering over 1,900 individual medical and surgical items. For simplicity, we refer to these as national BPAs.

[10]The total number of medical and surgical items for the 53 RIAs in nine geographic regions was not available centrally.

However, additional savings can be achieved through VA and DOD collaboration. By comparing DOD's RIA data from one geographic region to VA's national BPA data, we identified about 100 identical medical and surgical items that are procured by both VA and DOD. For most of these items, the price difference was less than 4 percent. However, for 19 of the items, the cost differentials range from 4 to 43 percent, with DOD generally paying more than VA. For 14 of these items, VA negotiated lower prices with the manufacturer than DOD (see table 1); for 5 others, DOD negotiated lower prices (see table 2). For example, for a large bore intravenous extension set used for quickly delivering fluids or blood, DOD's negotiated unit price per case is $179—43 percent more than VA's negotiated unit price of $102. For borderless dressings, which are used to treat serious wounds, DOD's negotiated case price of $90 is 36 percent lower than VA's negotiated case price of $141. Purchasing the items from the vendors offering the lowest price will yield additional savings for both departments. For example, in fiscal year 2001, VA could have saved over $52,000 on one item alone—8-gallon sharps containers for disposing of used syringes—if it had collaborated with DOD and obtained its regional price. In that same year, DOD could have saved about $200,000 on intravenous pumps and tubing accessories if it had collaborated with VA and obtained VA's lower national BPA prices. While the item-by-item savings may be relatively small, the cumulative effect of joint purchasing thousands of items can be significant.

Table 1: Unit Price Comparison for Select Identical Medical and Surgical Items; VA More Economical Than DOD

Item description	Unit price (dollars)		Difference	
	VA	DOD*	Dollars	Percent
Advanced woundcare – Manufacturer A				
Polyurethane sterile foam dressing, 3" x 3"	$37.39	$51.16	$13.77	27
Polyurethane sterile foam dressing, 12" x 10"	385.47	401.38	15.91	4
Polyurethane sterile foam dressing, 27-5/8" x 15-3/4"	438.57	456.67	18.10	4
Polyurethane sterile foam dressing adhesive, 2" x 2"	44.95	69.81	24.86	36
Polyurethane sterile foam dressing, 4" x 4"	27.25	42.38	15.13	36
Wound dressing alginate, 2 grams	9.93	16.21	6.28	39
Wound dressing alginate, 3" x 4-3/4"	14.91	25.75	10.84	42
Intravenous pumps and tubing accessories				
Luer-Lock Smart-Site needleless valve port	87.00	105.00	18.00	17
Extension set with two injection sites	174.00	273.00	99.00	36
Extension set with 0.2 micron filter	197.00	214.00	17.00	8
Large bore extension set	102.00	179.00	77.00	43
Extension set with 1.2 micron filter	144.00	191.00	47.00	25
Vial adapter/access device	145.00	172.00	27.00	16
Vial dispensing/access device	147.00	209.00	62.00	30

*The DOD unit price is from one DOD geographic region.

Source: GAO analysis of May 2002 VA and DOD prices.

Table 2: Unit Price Comparison for Select Identical Medical and Surgical Items, DOD More Economical Than VA

Item description	Unit price (dollars)		Difference	
	DOD*	VA	Dollars	Percent
Advanced woundcare – Manufacturer B				
Borderless dressing, 8" x 8"	$90.00	$140.63	$50.63	36
Island dressing, 1-3/4" x 2-1/2"	111.00	135.00	24.00	18
Island dressing, 4-1/2" x 9-1/2"	66.00	74.25	8.25	11
Sharps containers				
8-gallon sharps container, red with clear hinged lid	52.08	63.50	11.42	18
2-gallon sharps container, yellow	65.97	77.00	11.03	14

*The DOD unit price is from one DOD geographic region.

Source: GAO analysis of May 2002 VA and DOD prices.

Impediments to Joint Procurement

The lack of progress VA and DOD have made in jointly contracting for medical and surgical supplies has, in part, been the result of their different standardization approaches—national versus regional. Other impediments to joint purchasing have been incomplete procurement data and the lack of a means for each department to identify similar high-volume, high-dollar purchases. Because of these shortcomings, it is not only difficult for VA and DOD to identify items that should be standardized within their departments but between their departments as well. VA is considering improvements to its acquisition policies and is designing an enhanced automated information system. These improvements are intended to minimize local purchases, accelerate identification of items for standardization, and create greater purchasing power, placing it in a better position to jointly purchase with DOD. For its part, DOD is implementing a new automated information system, which is intended to enhance its ability to identify items for standardization. However, according to officials from both departments, it is uncertain whether data from the new systems will be compatible. Such capability would assist both departments in identifying joint procurement opportunities.

Different Approaches to Standardization Limit Potential for Joint National Contracts

While VA and DOD have both begun to independently standardize medical and surgical supplies for their facilities, VA has standardized nationally and DOD has standardized regionally. According to a DOD official, DOD has made several attempts at national standardization but has been unable to do so. The official said that the primary reason was because DOD was unable to gain widespread clinician acceptance across all its medical facilities. DOD officials consider the regional approach more feasible for standardizing medical and surgical supplies because it would be easier to gain acceptance among smaller groups of clinicians. However, this approach limits the prospects for jointly procuring with VA because it increases the possibility that different medical and surgical items will be standardized within DOD regions. For example, while eight of the nine DOD geographic regions individually standardized and contracted for needles and syringes from the same vendor, six of the nine geographic regions standardized on surgical gloves from five different vendors.

Incomplete Procurement Data and Lack of a Means for Identifying Similar Items Complicate Standardization

VA and DOD acknowledge that standardizing medical and surgical supplies is a critical step toward achieving joint procurement. However, identifying and standardizing like items has been a cumbersome and time-consuming process for VA and DOD because they lack complete data on their medical and surgical supply procurements. In addition, they lack unique item identifiers that would make recognizing similar items easier.

Complete data on all medical and surgical supplies purchased by their facilities would enable VA and DOD to more readily identify prospective items for standardization and joint purchasing opportunities. While VA has multiple information systems and databases that provide procurement information, the systems do not have the capability to provide a systemwide list of its top high-volume, high-dollar medical and surgical items purchased by all VA facilities. Instead, VA only has quantity and price information on items purchased from its national BPAs. DOD also does not have information on the top medical and surgical items purchased by its facilities because its systems do not capture information on purchases that individual facilities make locally or directly from manufacturers.

In addition to lacking complete data, VA and DOD face a difficult task in identifying like items because not all medical and surgical supplies have universal product numbers (UPN) or similar coding. Industry estimates

show that from 40 to 80 percent of medical and surgical supplies have UPNs depending on the unit of packaging—individual items, cases, or pallets.[11] A product's UPN and associated bar code identify characteristics such as the manufacturer, product type, size, and unit of packaging (for example, 10 per carton). As such, UPNs not only facilitate standardization but also enable purchasers of medical and surgical supplies to develop standard product groups, track prices, and employ prudent purchasing methods—paying for medical and surgical supplies that meet quality standards at competitive prices.

Without UPNs or another identification system, VA and DOD must pull information from various sources—including ad hoc acquisition reports and multiple databases—to identify like items. For example, to identify the types of surgical gloves used at VA facilities, staff working on the procurement reform initiative had to manually look at item descriptions in various databases. For this one item, VA identified more than 12 different product names, including sterile gloves, surgeon's gloves, and orthopedic gloves. Stock number identifiers were also inconsistent because each facility has the option of using the manufacturers' stock numbers or various distributors' stock numbers. With a dozen product names and a proliferation of stock numbers, this one item—surgical gloves—could appear in VA's acquisition system as numerous separate items.

The manufacturing and distribution industry has been reluctant to adopt more UPNs for medical and surgical supplies. The industry contends it is too costly and there is a lack of demand from purchasers. To address the cost concerns, VA is in the process of performing an economic analysis to determine the cost and benefits of requiring vendors to include UPNs and associated bar codes for all medical and surgical supplies on FSS. Concerning demand, however, purchasers have presented a different perspective from that held by the manufacturing and distribution industry. For example, the Healthcare EDI Coalition—which represents 20 major health care buying groups, including VA and DOD—endorsed the use of UPNs for medical and surgical items in February 1998. At that time, this group represented over 90 percent of all health care group contract purchases in the nation. In June 2000, a group of four health care purchasing groups, with annual purchases of over $38 billion and whose

[11]Industry standards organizations have created two UPN formats for medical equipment and supplies: (1) an alphanumeric standard that provides detailed product information and (2) an all-numeric standard that is more consistent with international coding standards.

membership includes more than 5,800 health care facilities, teamed with three e-commerce companies to endorse UPNs for medical supplies. According to a VA official, one of the largest group purchasing organizations (GPO)[12] for health care products, which represents over 1,800 nonprofit hospitals and health systems and about $14 billion in annual purchases, recently began an effort to require UPNs for all medical and surgical items purchased through its organization—an initiative we believe is consistent with best business practices. In 1998, we recommended that the Administrator of the Health Care Financing Administration, now the Centers for Medicare and Medicaid Services, require suppliers to identify the specific medical equipment, supplies, and devices they bill to Medicare by including UPNs on their Medicare claims.[13]

Some Impediments Beginning to Be Addressed, but Impact on Joint Procurement Unclear

VA is considering how to implement improvements to its acquisition policies. These improvements are intended to minimize local purchases, accelerate standardization, and create greater purchasing power. If implemented, the improvements will place the department in a better position to jointly purchase with DOD. VA and DOD are also making improvements to their automated information systems. However, it is uncertain whether data from the new systems will be compatible. Such capability would assist both departments in identifying joint procurement opportunities.

In May 2002, VA's Procurement Reform Task Force issued its report on improving the efficiency and effectiveness of VA's acquisition system, which included 65 recommendations. Recognizing that standardizing medical and surgical supplies is critical to achieving cost savings, the task force recommended that VA establish a contract purchasing hierarchy that would require its facilities to purchase supplies first from national BPAs; then multiregional, regional, or local BPAs; and then from FSS. Only when items are not available from these sources can facilities enter into local agreements or purchase them directly from the manufacturers. This recommendation is timely because VA recently estimated that from 30 to 35 percent of facilities' purchases are not from BPA contracts. To further enhance VA national standardization, the task force also recommended

[12]GPOs use volume purchasing of their member facilities to negotiate lower prices from vendors.

[13]U.S. General Accounting Office, *Medicare: Need to Overhaul Costly Payment System for Medical Equipment and Supplies*, GAO/HEHS-98-102 (Washington, D.C.: May 12, 1998).

that VA continue standardizing medical and surgical products to obtain maximum benefits by focusing on high-volume, high-dollar medical and surgical items.

Regarding UPNs, the task force recommended that VA take a leadership position in advocating their use as a way to improve quality, increase safety, and enhance cost-effectiveness of medical and surgical supply purchases. Currently, VA is in the process of preparing a cost-benefit analysis for the Office of Management and Budget (OMB) to support a regulation that would require vendors to include UPNs and associated bar codes on all items sold on FSS.[14] DOD officials stated that DOD has been a long-time supporter of the requirement that vendors include UPNs and plans to participate with VA in discussing the rulemaking initiative with OMB. Until UPNs are established, the task force recommended that VA assign a unique identifier to each medical and surgical product purchased.

Finally, the task force recommended that VA intensify its ongoing initiatives to identify and create opportunities for joint VA and DOD purchasing to achieve lower medical material costs by combining the purchasing power of the two departments and eliminating contracting redundancies. The task force report did not specify how to achieve this, given VA's and DOD's different approaches to standardization. However, joint purchasing could partially be achieved by the task force's recommendation that VA include in its national BPAs a clause allowing DOD facilities or regions to purchase medical and surgical supplies from VA's BPAs and create tiered pricing to provide additional discounts as more items are purchased. A DOD official stated that the department would not require but would support any initiative by its nine geographic regions to take advantage of lower medical and surgical supply item pricing that may be available through VA's national BPAs.

In addition to considering implementation of the task force's recommendations, VA is in the process of designing an enhanced automated information system—the CORE Financial Logistics System. Similarly, DOD is implementing its enhanced automated information system—the Defense Medical Logistics Supply System. VA and DOD officials stated that their improved systems will provide information on all

[14]Under Executive Order 12866, dated September 30, 1993, departments are required to submit assessments of the potential costs and benefits of significant regulatory actions to OMB, along with the draft regulatory actions.

medical and surgical items purchased, including local and high-dollar, high-volume purchases. However, because each department is developing its system independently, neither could assure us that the enhanced systems will contain compatible information that could be compared between the two departments. Without such a capability, it will be more difficult for VA and DOD to routinely exchange information on medical and surgical standardization efforts and identify additional opportunities for joint procurement.

Concluding Observations

While it is difficult to quantify the potential savings joint contracting could yield, these savings could be meaningful given that VA's and DOD's separate approaches to procuring surgical and medical supplies have yielded an estimated $19 million annually in savings. However, much needs to be done to take advantage of additional savings opportunities. At this point, neither department has accurate, reliable, and comprehensive procurement information—a basic requirement for identifying potential medical and surgical items to standardize. Furthermore, because DOD has opted to follow a regional rather than a national approach to standardization, opportunities for national joint procurement will be more difficult to achieve. Within VA, its Procurement Reform Task Force highlighted many department procurement shortcomings and potential solutions. Continued management attention and commitment to implementing the task force's recommendations is a positive step to improving the efficiency and effectiveness of VA's acquisition system. DOD is currently implementing a new procurement system and has been a long time supporter of efforts to establish UPNs for medical and surgical supplies. However, the future of joint VA and DOD procurement initiatives depends on the progress and success each department has in improving its acquisition system and, ultimately, each department's commitment to joint procurement.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you or other members of the subcommittee may have.

Contact and Acknowledgments

For further information, please contact Cynthia A. Bascetta at (202) 512-7101. Individuals making key contributions to this testimony include Michael T. Blair, Jr.; Cherie' M. Starck; John Y. Oh; Allan C. Richardson; and Karen M. Sloan.

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PROCUREMENT PRACTICES OF THE DEPARTMENT OF VETERANS AFFAIRS And H.R. 3645 THE VETERANS' HEALTH-CARE ITEMS PROCUREMENT REFORM AND IMPROVEMENT ACT OF 2002

TESTIMONY OF
JOHN S. BILOBRAN

DEPUTY ASSISTANT INSPECTOR GENERAL
FOR AUDITING
DEPARTMENT OF VETERANS AFFAIRS

HOUSE COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
June 26, 2002

Mr. Chairman and Members of the Subcommittee, I am here today to report on the work performed by the Office of Inspector General (OIG) relating to procurement of pharmaceuticals and medical/surgical items, our recommendations to improve the effectiveness of the Department of Veterans Affairs procurement program, and our views regarding H.R. 3645 – the Veterans' Health-Care Items Procurement Reform and Improvement Act of 2002. Ms. Maureen Regan, Counselor to the Inspector General accompanies me.

In Fiscal Year (FY) 93, the OIG entered into a Memorandum of Understanding (MOU) with the VA's Office of Acquisition and Materiel Management (OA&MM) to conduct pre and post-award reviews of Federal Supply Schedule (FSS) contracts awarded by the National Acquisition Center (NAC). These reviews have provided the OIG and VA contracting officials with in-depth insight into vendor's commercial sales and marketing practices as well as a broad understanding of commercial buying practices. Pre-award reviews provide contracting officers with information needed to strengthen the Government's pricing position during negotiations and post-award reviews identify overcharges for recovery by the Government.

FSS contracts are awarded non-competitively to multiple vendors for like or similar commercial off-the-shelf products. The Government's negotiation strategy is to obtain most favored customer (MFC) pricing. Contract pricing is based on disclosures by vendors identifying the lowest prices and other concessions realized by commercial customers, i.e. the MFC. As the largest healthcare system in the United States, the Government should be able to use its aggregate buying power to compete with most commercial customers and achieve MFC pricing, or better.

Historically, vendors have implemented a variety of marketing strategies to avoid giving the Government MFC pricing. One of the leading arguments is that the commercial customers are not comparable to the Government because of contract terms and conditions not found in the FSS contract. For example, vendors often argue that the commercial customers who receive better pricing have contracts with "volume" or "sole source" commitments. In most cases, VA is able to obtain the more favorable pricing by showing that even without a volume or sole source commitment, the Government buys in comparable or larger volumes than these commercial customers and, therefore, is entitled to comparable prices. In short, the Government's combined purchasing power is usually sufficient to overcome the various non-comparability arguments.

FSS is No Longer a Mandatory Source of Supply

The effectiveness and integrity of the FSS program has deteriorated because FSS is no longer a mandatory procurement source. As a result, vendors have cancelled existing contracts, decided not to submit proposals, removed high-dollar sales items from the contract, or refused to offer MFC pricing. When the latter occurs, NAC contracting officials are left in the difficult position of either:

- Not awarding the contract or not awarding specific line items, thus allowing the vendor to sell open-market to Government customers at higher prices than those offered under the solicitation.
- Accepting the prices offered with the knowledge that the Government is not being offered fair and reasonable prices.

A vendor's ability to sell open market in significant volumes effectively eliminates the Government's ability to leverage prices using its aggregate buying power.

Vendors have cited a number of reasons for not submitting a proposal for an FSS contract, not putting items on contract, pulling items off existing contracts, and/or not offering MFC pricing to the Government. The reasons cited include the following:

- It is not cost-effective to submit a proposal and offer MFC prices on an FSS contract, and then be required to re-negotiate prices with individual VA medical facilities that seek separate agreements with even lower prices.

- Vendors without contracts know that they can sell at any price to medical facilities that simply place orders and make no attempt to negotiate prices with the vendor. With simplified acquisition procedures, micro-threshold purchases, and the extensive use of purchase cards, open-market purchases have become widespread. OIG has identified numerous instances where purchase card holders violate purchasing thresholds, split purchases to circumvent thresholds, and violate procurement warrants, while engaged in these practices.

- The increase in unrestricted, unmonitored open market buying allows vendors to sell items that are manufactured in non-designated countries and cannot be included on FSS contracts because of the provisions of the Trade Agreements Act.

- Vendors can sell their products through distributors holding FSS contracts and thus avoid offering the Government MFC prices and shield themselves from pre- and post-award reviews of their pricing practices, and avoid compliance with price reduction, economic price adjustment, and other FSS requirements.

Local Contracting Practices Make FSS Undesirable to Vendors

In the past few years, individual medical facilities and Veterans Integrated Systems Networks (VISNs) began to negotiate separate contracts or purchasing agreements with vendors of commercial item medical/surgical supplies and equipment. VA procurement officials told us their goal was to obtain better pricing than FSS pricing and thus claim a cost savings. Some contractors have cited this practice as the reason for not seeking an FSS contract or not offering MFC on the FSS contract. Local contracting penalizes VA and Other Government Agencies (OGAs) because VA is no longer buying as an entire system of medical facilities. In these instances, local procurement efforts compromise national objectives and add unnecessary administrative and overhead costs.

As an example, one supplier of wheelchairs, canes, walkers and other related medical supplies advised OIG personnel that it would not seek an FSS contract for one of its product lines because it no longer knew who the customer was, i.e., the NAC, the VISNs or the individual medical centers. It was the contractor's position that it should not have to negotiate multiple contracts with the Government if it had an FSS contract.

In another matter, a large surgical supply vendor submitted a proposal offering its products at a 15 percent discount off list price. Based on past purchases by Government facilities, the anticipated FSS contract was valued at $85 million over a 5-year period. A pre-award review by the OIG revealed that the vendor's most favored customers were getting significantly larger discounts of up to 42 percent off list price. If the Government received comparable MFC pricing, the identified cost savings would be $8.4 million. Because the review did not identify any significant differences in the buying practices of comparable customers receiving MFC pricing, the OIG recommended that the contracting officer seek discounts comparable to the vendor's MFC. In response to the pre-award review, the vendor refused to offer MFC pricing and stated that: "The VA does not operate as a proprietary hospital chain. The VA Central

Office does not enforce/control what individual VA Medical Centers purchase. The Federal Supply Schedule is not a mandatory source of supply." During contract negotiations, the vendor made it clear that it was willing to offer small percentage discounts on the FSS and enter into separate agreements with individual medical centers that "committed" to buying the products. It was determined that this was not cost-effective for the Government because the Department would incur additional administrative costs to negotiate separate agreements with individual facilities. More importantly, overall the Government would pay more for the product because most facilities would not enter into separate agreements; therefore, the vendor would realize a greater profit margin due to the larger volume of FSS sales. Increased profit margins from Government sales help vendors finance deep discounts to lower volume commercial customers.

The advantage of using the FSS is the cost savings to both the vendor and VA. Cost savings are achieved by both parties with the preparation of one solicitation, one offer, and one set of negotiations. It is not cost-effective for each medical center or VISN to subsequently compel vendors to re-negotiate prices for the opportunity to sell their products locally. Local procurement officials have boasted of the cost savings they have achieved by entering into separate agreements with FSS vendors at prices that were some percentage less than the FSS price. While these contracts may appear to be cost-effective for the local facility, they are not cost-effective for the VA or the Government as a whole. As with the large surgical supply company discussed above, when a vendor knows it will be required to enter into separate local contracts with Government facilities, it will not offer MFC on the FSS. Therefore, any savings that are achieved at the local level are most likely eliminated by the higher prices being paid on the larger volume of sales under the FSS. It is also questionable whether local contracts actually achieve a cost savings. The anticipated cost savings are usually calculated by taking the difference between the FSS price and the local contract price. Costs to the local facility, such as contract award and administration costs are not factored into the reported savings. These administrative costs mitigate any expected savings.

In comparing FSS and other contracts awarded by VA, we have identified important benefits and protections that FSS contracts provide the Government purchaser that are not found in other Government contracts. These include:

- FSS vendors are required to disclose specific information relating to the discounts and concessions given to their commercial customers. These disclosures place the contracting officer in the best position to determine price reasonableness and ensure the Government negotiates best prices. Such disclosures are not required on other Government contracts.

- FSS contracts contain clauses not found in other Government contracts, including national contracts awarded by VA, that protect the Government's interest over the term of the contract. The price reduction clause requires the vendor to offer price reductions it offers to an agreed upon comparable commercial customer or category of customer. This clause ensures that the Government maintains commercially favorable pricing throughout the term of the contract. Price reduction clauses are found in most commercial contracts. FSS contracts also contain clauses that allow the Government to review the vendor's records before and after a contract is awarded. Additionally, the vendor is accountable to reimburse the Government for overcharges incurred as the result of the vendor's failure to provide accurate, complete or current sales and marketing data during contract negotiations or failure to comply with the terms and conditions of the price reduction clause.

Since 1993, the OIG, in conjunction with the Office of Acquisition and Materiel Management (OA&MM), has collected in excess of $161 million for overcharges relating to defective pricing and price reduction violations. Most of the money collected was returned to VA's Supply Fund. In addition, since 1994, pre-award reviews of manufacturers' offers have identified potential contract savings of over $373 million. Accordingly, pre and post-award reviews are cost–effective tools that are critical to negotiate the best possible contract terms and ensure government interests are protected during the term of the contract. Due to resource limitations, we are currently only able to conduct pre-award reviews on Medical/surgical contracts greater than $3 million, pharmaceutical contracts greater than $5 million, and post-award reviews on overcharges that manufacturers voluntarily disclose.

- FSS contracts provide VA facilities with a wide choice in pharmaceuticals, medical/surgical supplies, and equipment to better meet the needs of the veteran patient. Having the items on contract enables healthcare providers to purchase what they need, when they need it and in small or large quantities at a negotiated price. When contracts are not in place, procurement of items may be delayed while prices are negotiated or facilities will pay higher prices by purchasing on the open market.

- FSS contracts are also beneficial to vendors. This method of contracting allows multiple vendors the opportunity to sell their products to Government users. In many cases, the system allows smaller vendors the opportunity to do business with the Government, which might otherwise not be available if the vendor is always in competition with larger suppliers.

The FSS is not unlike commercial buying practices in the healthcare industry. We have identified both a local and a state government that have contracting programs for their covered facilities that mirror FSS. Private medical providers have recognized that MFC pricing is rarely, if ever, offered to individual hospitals, medical facilities, or physicians and that it is more cost efficient, both in price negotiation and administrative cost savings, to negotiate one contract that covers a number of entities than for each entity to contract individually. Most vendors offer their best discounts and concessions to entities such as buying groups that represent member facilities and other providers. As with the FSS system, these buying groups rely on the aggregate buying power of the individual members to negotiate more favorable pricing. In our pre- and post-award reviews, we have not identified a single hospital or provider as MFC.

No Incentive to Negotiate Prices

Numerous vendors have decided not to submit a proposal for an FSS contract, or not include high-dollar sales items in contracts. These vendors have stated that there is no incentive to negotiate a contract when they can sell open market to the medical centers at any price. VA procurement and payment records confirm that contractors have been able to sell large dollar volumes of their products open market to VA facilities.

For example, a pre-award review of a proposal for a vendor that sells orthopedic implants showed that the vendor's offer of a 10-percent discount off list price was significantly less than discounts given to their most favored customers, which ranged from 25.48 percent to 41.75 percent in four categories of products. The pre-award review further identified an anticipated cost savings of approximately $3.1 million over the life of the contract if the FSS prices were comparable to the vendor's MFC prices.[1] When the NAC contracting officer attempted to negotiate MFC pricing, the contractor withdrew its offer and stated that it could sell open-market without a decrease in sales. VA procurement records confirm the vendor's prediction. Combined purchase card and VA medical center payment records show that VA medical centers purchased approximately $6.9 million via open-market purchases from this vendor in Calendar Year (CY) 2000.[2] We identified sales to 101 VA medical centers. Sixteen medical centers purchased more than $130,000 with 8 of the 16 showing purchases that exceeded $250,000. The $6.9 million in sales represents VA purchases only; it does not include sales to other Government entities that traditionally purchase off the FSS.

In another matter, a large manufacturer of medical/surgical supplies, whose product line includes cardiac stents, was awarded two FSS contracts in FY 1991. When one of the contracts expired in December 1999, the vendor chose not to submit a proposal for a new contract. The second contract was extended through September 2000, but only contained 16 small dollar accessory items. VA's Procurement History File (PHF) showed that this vendor's FSS sales for FY 1999 totaled $7.6 million compared to $22.7 million in open-market sales. VA payment records for CY 2000 show approximately $42 million in purchases by 114 VA medical centers of which only $306,000 was identified as FSS.

Purchase card and direct payment records for purchases from this company identified 13 medical centers whose purchases exceeded $1 million each, with 2 of the 13 medical centers having purchased over $2 million each. Combined, the 13 medical centers purchased $18,084,921,

[1] If awarded, the expected annual sales were approximately $6 million.
[2] Purchase card records show purchases totaling $5.2 million and Financial Management System payment records show $1.7 million in payments directly to the vendor.

which represents 43 percent of the vendor's total sales for CY 2000. PHF data for the 4th quarter of CY 2000 showed $4.7 million in reported sales to this vendor of which $1.33 million (28 percent) was purchased by 6 medical centers. According to the PHF, the 6 facilities purchased $1 million in open-market purchases compared to $334,000 in contract sales.[3] One medical center reported $143,000 in FSS sales. We compared the FSS product list with the products the medical center identified as FSS sales and found that none of the items listed as FSS sales was on contract.[4]

Our Combined Assessment Program (CAP) reviews at 2 New York VA medical centers, identified 70 separate purchases of cardiac stents for more than $850,000 in a 15-month period. All of the purchases were open market and the medical centers paid list price. The items were not on FSS or other national contracts, the medical centers did not issue a solicitation to obtain competitive pricing, and there was no evidence of price negotiation. Similar non-competitive purchases of cardiac stents were identified during a CAP review at a VAMC in New Jersey, and in our review of purchase card transactions and the PHF. Discussions with the NAC revealed that none of the manufacturers of cardiac stents included these items on their FSS contracts and at least one contractor removed stents from its FSS contract. One manufacturer of cardiac stents that does not have an FSS or other VA contract sold approximately $25 million of its product to VA medical centers in CY 2000.[5] Another manufacturer sold $24.4 million to VA medical centers in CY 2000 of which only $247,000 were FSS sales.[6] [7]

CAP reviews have consistently identified purchases of items such as pharmaceuticals and prosthetics that are not on contract and for which there was no competition or other evidence of price negotiation. One New York VA medical center purchased significant amounts of prosthetics open market from a single non-FSS vendor. There was no competition and no justification for sole source selection. We determined that comparable items were on FSS at prices that ranged from 20-40 percent less than the medical center paid for the items. Since our report was issued, many manufacturers have submitted an FSS proposal, or indicated a desire to do so, in anticipation that FSS would become a mandatory procurement source.

Purchasing Prohibited Contract Items on the Open-Market Undermines the Integrity of the Program

Our reviews have shown that vendors were able to sell to the Government products in significant volumes that were not manufactured in the United States or a designated country, as defined by the Buy America Act, 41 U.S.C. §10a-10d, or Trade Agreements Act, 19 U.S.C. § 2401 et. seq., and their implementing regulations. These vendors would not be able to sell these items on FSS or other Government contracts with values over the statutory or regulatory thresholds because they would be required to certify the place of manufacture and that the products included on the contract complied with both Acts.[8] [9] One of the advantages vendors have when selling open market is there are no contract terms and conditions, including Buy America Act or Trade Agreements Act clauses. Therefore, the vendor can sell and VA does buy without restriction items that would otherwise be prohibited. The implementation of Government policy and Government contracting in general is seriously undermined if vendors can sell otherwise

[3] One of the medical centers had awarded two competitive contracts to this vendor. One contract was for cardiopulmonary bypass supply packs and the other for pacemakers.

[4] We have questioned the completeness and accuracy of the information in the PHF. The information contained in the files is provided by the individual medical centers. It is not clear that all purchases, particularly purchase card transactions are included. In addition, we have found items that were identified as being on contract when, in fact, they were not. However, the inaccuracies in the system tend to understate, not overstate, the number of transactions and the volume of sales purchased using an FSS or other contract.

[5] VA payment files show approximately $20 million in purchase card transactions and an additional $5 million in direct payments.

[6] Payment records show approximately $15 million in purchase card transactions and an additional $9.1 million in direct payments.

[7] This company entered into an FSS contract in October 2000 but cardiac stents are not on the contract.

[8] With the implementation of NAFTA, the Buy America Act is of less significance than the Trade Agreements Act. The Trade Agreements Act waives the application of the Buy America Act to the end products and construction materials of designated countries. 5 C.F.R. §25.403.

[9] The micro-purchase threshold of $2,500 is the statutory threshold for the Buy America Act. The threshold for the Trade Agreements Act is set by regulation and is subject to revision by the U.S. Trade Representative approximately every two years. The 2000 version of the Federal Acquisition Regulation stated that the Trade Agreements Act applied to acquisitions of supplies or services if the estimated value of the acquisition is $177,000. 48 C.F.R. §25.403.

prohibited products in vast quantities to VA and other Government entities on the open market. This has also had a detrimental effect on small businesses because they are not price competitive with vendors that sell products manufactured in non-designated countries.

The OIG first became involved in Buy America and Trade Agreement Act issues in the mid-1990s, when we received complaints from FSS vendors that competitors had items on FSS contracts that were manufactured in non-designated countries. The basis for the complaints was that this gave competitors an unfair market advantage because they could sell products at significantly lower cost (items manufactured in non-designated countries cost less because of reduced manufacturing costs). The products involved included medical/surgical supplies (in particular latex gloves), hand-held surgical instruments, and uniforms. In response, the OIG conducted several investigations that resulted in over $8 million dollars in civil penalties being imposed on the violators. In one case, the contractor was convicted on a criminal fraud charge for actually altering the markings on surgical instruments to make it appear that the items were manufactured in a designated country when, in fact, they were not.

In another case, we received allegations that a large vendor sold items, including hand-held instruments, on FSS that were manufactured in non-designated countries but were marked indicating that they were manufactured in a designated country. The FSS contract included items that the vendor manufactured as well as items the vendor purchased from other manufacturers and resold. We were unable to substantiate or disprove the allegations because we were unable to obtain the actual manufacturing records. As a distributor for these items, the vendor's records were limited to purchase orders and invoices reflecting the purchase of the items from the manufacturer. Unfortunately, we did not have authority to subpoena records from the foreign manufacturer.

Despite the expectation that these actions would let contractors know that VA would hold them accountable for Trade Agreement Act violations, there was an unanticipated negative consequence. Although these and other contractors pulled items manufactured in non-designated countries off contract, procurement records confirm that the vendors continued to sell these products in significant quantities to VA facilities on an open-market basis. We are unable to take any action against these contractors because there are no contracts and the individual sales transactions are usually below the dollar threshold for either Act to apply. Even for sales over the threshold, we could not hold the vendors accountable unless they had a contract with VA containing Buy America Act and Trade Agreements Act clauses. As discussed below, contracts with prime vendors or distributors also provide a mechanism for manufacturers to sell prohibited items to the Government.

One of the items that we received the most complaints about was examining gloves. A review of the PHF disclosed that VA customers purchased the preponderance of examining gloves on an open-market basis. We selected one large medical/surgical supplier for review because of the volume of the gloves sold open market. This company previously had paid over $6 million to settle a civil fraud case involving Trade Agreements Act violations. In discussions with the company, we were advised that it did not include top-selling examining gloves on the company's FSS contract because the items were manufactured in non-designated countries and could not be offered on contract. Using the PHF data, we identified 19 different examining gloves that the company sold to VA customers as open-market items. For the period of July 1998 through June 1999, this company had $14,089,923 in open-market sales of which the examining gloves totaled $1,572,614 or 11 percent of the open-market sales. The open-market sales of the gloves represented about 8 percent of the company's total reported Government sales of $18,754,505.[10] Gloves are but one of many items manufactured in non-designated countries that this company sells open market to VA facilities. By using open-market transactions, the company and VA customers have avoided prohibitions and defeated public policy against purchasing items from non-designated countries.

We identified a second vendor of examining gloves whose reported Government sales for the period July 1998 through June 1999 totaled $45.6 million of which only $7 million (15.3 percent) represented FSS sales. Payment records for CY 2000 showed $33.1 million in sales to VA facilities of which $6.4 million (19 percent) were reported as FSS sales. This vendor's FSS

[10] The open market and total sales figures only include those sales recorded in the PHF. Through various reviews, we have determined that sales information in the PHF is incomplete. In particular, purchase card transactions are frequently not included.

contracts did not contain the vendor's entire product line. A vendor representative informed us that the vendor does not offer more items on the FSS because (i) items are foreign-source products that do not meet FSS requirements; (ii) it is a tedious process to ensure the data provided for an FSS offer is current and complete; and, (iii) tracking price changes for price reduction purposes is a significant administrative burden.

A third vendor we reviewed sold hospital gowns and surgical apparel. This company had an FSS contract from July 1992 to October 1997 when the contract was cancelled at the vendor's request. The vendor only offered about 10 percent of its product line on the contract. Over the life of the contract, the vendor sold almost $13 million to Government customers of which only 27 percent were FSS items. Records show that after the company terminated its FSS contract, it continued to make significant sales to VA customers. We identified four vendors who had comparable items on FSS and compared prices. The prices for the vendor without the FSS contract were lower which generated more sales. Upon request, the vendor provided information regarding the place of manufacture for 10 of the 11 items in our sample. This information revealed that 7 of the 11 items were manufactured in non-designated countries and could not be included on an FSS contract; 2 items appeared to have been partially manufactured in designated countries, but we did not have sufficient information to determine whether they could have been included on FSS. Only one of the items was manufactured in the United States. The ability to sell products manufactured in non-designated countries so readily on an open-market basis to VA facilities, affects the integrity of the FSS system.[11] Vendors are able to obtain a significant sales advantage by selling less expensive foreign made products to the detriment of vendors who comply with Government laws and regulations and market products made in the United States or designated countries.

Vendors are Using Distributors to Avoid Contract Requirements

Some medical/surgical manufacturers that contract directly with and ship directly to their commercial customers, have decided to sell their products to Government entities only through distributors that have FSS contracts. In some cases these distributors do not stock and ship the items, they place orders with the manufacturer and the manufacturer ships directly to Government entities. This practice allows manufacturers to sell their products in significant volumes to Government customers while shielding themselves from audits of pricing violations, and compliance with other FSS contract clauses, including MFC pricing, the price reduction clause, certifications that the products are made in the United States or a designated country, etc.

In the VA pharmaceutical prime vendor program, VA's agreement with the prime vendor or distributor is for distribution services only. VA establishes product prices through separately negotiated contracts between VA and the manufacturers. Commercial customers buy pharmaceuticals using the same process. The manufacturers have separate agreements with the distributors that provide for charge backs to the distributor when it sells to the customer at the price agreed upon by the manufacturer and the customer.

With distributors of medical/surgical products, we are finding that the distributor may establish the price and sell the products to some commercial customers. However, the best prices to commercial customers are generally prices that were the result of separate negotiations and agreements between the commercial customer and the manufacturer; the distributors only provide distribution services and have no control over pricing. These same medical/surgical distributors have, or are in the process of negotiating, FSS contracts that allow them to both establish prices and distribute the product to FSS customers. This represents a significant deviation from commercial practice. Because the data provided during contract negotiations may be limited to the discounts and concessions the distributor negotiates directly with its customers, VA is not in the position to demand the manufacturer's MFC prices. Based on our review of commercial contracts, we are not aware of any case where the distributor offered a Government price equal to or lower than that of the manufacturer's MFC. Distributors have advised us that they cannot sell at a better price unless there is agreement by the manufacturer. As a result, there is no meaningful price negotiation with a distributor.

[11] This vendor also sold open-market by placing pajama tops on contract but not the matching bottoms. To buy a matching set, the Government had to buy open-market.

We are aware of at least two large manufacturers who have chosen to sell to the Government primarily through distributors who have or are trying to negotiate FSS contracts. Both manufacturers were the subject of civil and/or administrative actions for defective pricing and price reduction violations. In one case, our preliminary work on a pre-award review indicates that the Government is the distributor's primary customer[12] and the contract is valued at $70 million. This raises the question of whether the distributor is just a shell to allow the manufacturer to sell its products to the Government on contract and at higher prices than VA would request if the manufacturer negotiated its own FSS contract. Although the provisions of Commercial Sales Practices Format would require a distributor without significant commercial sales to submit data from the manufacturer, any pre- or post-award reviews may be limited to the information contained in the distributor's records.[13] The manufacturer would not be required to open its books and records for a pre- or post-award inspection.

In addition, reviews of VA facilities have disclosed that local contracts have been entered into between the facility and distributors to sell products not on FSS. Absent agreements between the prime vendor and contractors with FSS or other national contracts, and contract provisions that limit the items purchased to those on an FSS or other national contracts, VA will be paying whatever price the distributor is able to obtain for the product plus the distribution fee. This process also artificially inflates the percentage of contract versus non-contract sales for reporting under 38 U.S.C. § 8125(b)(3)(A). Technically, all the items will be purchased through the prime vendor contract even though the Government has not negotiated the prices for each item.

For example, during a contract review, we identified a medical center that wanted to purchase more than $5 million in medical equipment from a particular vendor. To avoid having to issue a solicitation and compete the acquisition, the medical center decided to purchase the equipment through a small or disadvantaged, or 8(a), distributor. We were unable to identify any service or value added by the distributor since the distributor's primary function was to place the order with the manufacturer. The product was shipped directly by the manufacturer to the medical center. The medical center ultimately paid more for the product because prices were not negotiated and the facility paid a distribution fee in addition to the cost of the items. Purchasing items, particularly large dollar items, this way does not encourage vendors to seek FSS or other Government contracts. In addition, using 8(a) sole source contracts with no value added simply to avoid competition is not consistent with the intent of the 8(a) program.

We are aware that some parties have alleged that our recommendation regarding contracting with distributors would be detrimental to small businesses. We believe that allegation misrepresents the effects of our proposal. The greatest impact would be felt by the large manufacturers that use distributors to avoid giving the government MFC pricing and to avoid complying with other contract terms and conditions such as price reduction and the Buy America and Trade Agreements Act requirements.

Nothing in our proposal would limit distributors, large or small, from having an FSS contract. Our proposal is only intended to ensure the government receives fair prices for the items it buys, and fair prices for value added services. Only a few small businesses could be potentially affected by the proposal. VA records show that in FY 2000, there were 1380 FSS contracts of which 912 (66 percent) were awarded to small businesses. In FY 2001, there were 1186 FSS contracts of which 793 (67 percent) were awarded to small businesses. According to NAC officials, only a few of these small business contractors were engaged in the distributor practices addressed by our recommendation to limit FSS contracts to distribution services. These distributors could continue to have FSS or national contracts under our proposal if they meet requirements.

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[12] The distributor's proposal contains items for two manufacturers. For one manufacturer, the disclosures show $4.3 million in Government sales versus $360,000 in commercial sales. For the larger manufacturer, the one with the previous administrative action, the distributor's disclosures show Government sales of $8.3 million compared to $181,000 in commercial sales.

[13] For FSS contracts with distributors who cannot show significant sales to commercial accounts compared to sales to Government entities, the Commercial Sales Practices Format (CSP-1) states that the distributor "should" provide the manufacturer's information.

OIG Observations on the Purchase Card Program

Vulnerabilities associated with the use of purchase cards are related to the issues discussed above. Government purchase cards were introduced into the Federal Government in the early 1980's. They are an internationally accepted credit card, available to all Federal agencies under a single General Services Administration contract. In 1995, the Federal Acquisition Regulation designated the purchase card as the preferred method to pay for micro-purchases (purchases under $2,500).

There are significant efficiencies and savings associated with use of the purchase card, but not without relatively high internal control risk and vulnerability to fraud and abuse. In particular, improper use can circumvent separation-of-duties procedures designed to deny any one person the ability to make a purchase, pay for the purchase, and account for the receipt of the goods or services.

The Department of Veterans Affairs (VA) began using the purchase card in 1994. The card is mandatory in VA for all micro-purchases and to the maximum extent possible, for all purchases up to the simplified acquisition threshold of $100,000 with appropriate contracting officer warrants. VA-wide use of the purchase card has grown from 170 cards processing 2,400 transactions valued at $567,000 in Fiscal Year (FY) 1994 to over 34,000 cards and approximately 2.5 million transactions valued in excess of $1.4 billion in FY 2001. During FY 2001, 287 VA facilities processed approximately 98 percent of all micro-purchases using the purchase card.

During the period February 1999 through March 2002, the Office of Inspector General (OIG) issued 58 reports addressing VA purchase card activities and systemic deficiencies (deficiencies identified in 7 or more of the 58 reports) were identified at 39 facilities.

- Deficiencies in account reconciliation and certification (27 reports).
- Failure to Solicit Competition (16 reports).
- Split Procurements to Circumvent (8 reports).
- Inappropriate Purchase card use (13 reports).
- Segregation of duties (8 reports).
- Training and warrants (7 reports).
- Accounting and auditing (9 reports).

Account Reconciliation and Certification. Internal control weaknesses were reported in 27 reports. Cardholders did not reconcile (match) payments to charges promptly and approving officials did not certify promptly.

Failure to Solicit Competition. Auditors reported on the need to comply with procurement regulations designed to enhance competitive solicitation in 16 reports. Federal Acquisition Regulations require solicitation of quotes or offers from a reasonable number of sources or sole-source justifications for any purchase of more than $2,500. For example, acquisition personnel at one facility, including 2 purchase cardholders, placed 96 orders totaling approximately $357,000 for hip and knee implants and accompanying components, without soliciting competition. If the purchasing agent had used a FSS vendor for the 96 orders, the medical center could have saved approximately $128,520. At another facility, during the 15-month period ending March 29, 2001, cardholders placed 21 orders totaling $93,000 for prosthetic hip implants and accompanying components using a Government purchase card without soliciting competition. An Acquisition & Materiel Management Service (A&MMS) purchasing agent purchased a prosthetic hip system implant and accompanying components on January 29, 2001, on the open market for $6,738. The price for a comparable prosthetic hip system implant and accompanying components from a FSS vendor would have been $3,618. As a result, VA paid approximately $3,120 (46 percent) more on the open market. If the cardholder had used the FSS vendor for the 21 orders, the facility could have saved approximately $42,780.

Split Procurements. Auditors reported split procurements in eight reports. FAR, 48 C.F.R. 13.003(c) prohibits the division of an acquisition to "avoid any requirement that applies to purchases exceeding the micro-purchase threshold," otherwise called a split procurement. Cardholders cannot make individual purchases exceeding $2,500 unless the Head of the Contracting Activity has given the cardholder an appropriate warrant. For example, at one

facility a cardholder split one order to a vendor totaling $18,435, into 3 orders at $8,423, $1,156, and $8,856, respectively. The cardholder held a $10,000 warrant for single purchases.

Inappropriate Use of the Purchase Card. We identified inappropriate use of purchase cards at 13 facilities. Purchase cards should only be used by government employees, an only for official government business. Additionally, purchase cards may not be used for expenses associated with employee travel, telecommunication services, gasoline for GSA vehicles, and other proscribed items. At one facility, the Purchase Card Coordinator issued cards to an employee of the affiliated non-profit research corporation, as well as University employees working at the research facility. These cardholders made 1,764 purchases valued at approximately $605,000 between October 1999 and February 2001. At another facility, purchase cards were inappropriately used to purchase airline tickets, hotel rooms associated with employee travel, telecommunication services, and movie tickets.

Segregation-of-Duties. Facility Directors needed to ensure segregation-of-duties to reduce the risk of error or fraud. VA policy prohibits a program coordinator from being a cardholder or an approving official to ensure duties are properly segregated. VA policy also requires that different individuals hold the positions of program coordinator, billing office official, and dispute officer. For example, we found that a Purchase Card Coordinator made 1,066 purchases totaling about $157,000 as a cardholder. The Purchase Card Coordinator and alternate Purchase Card Coordinator certified 3,287 transactions, totaling about $840,000 during the same period. At another facility, a cardholder was inappropriately designated as the approving official for two fund control points and the system identified nine approving officials who were no longer VA employees.

Training and Warrants. Cardholders and approving officials were not adequately trained at seven facilities and were not properly warranted at six facilities. At one facility, 9 of 62 cardholders (15 percent) made purchases in excess of $2,500, but were not trained or warranted. At another facility, employees made 72 purchase totaling $428,000 exceeding the $2,500 transaction limit, without appropriate contracting warrants.

Accounting and Auditing. Weaknesses in accounting and auditing oversight were found at nine facilities. For example, at one facility, the Program Coordinator did not audit cardholders' and approving officials' accounts and the Billing Office did not verify or sign off on random monthly quality reviews of credit card purchases. At another facility, monthly audits of purchase card charges were not done for 5 months, during a time the medical center was processing over 10,000 transactions totaling approximately $5.0 million.

Purchase Card Fraud

The following are two examples of credit card fraud recently investigated by the OIG.

A VA employee served as the Surgical Service business manager at a VA medical center and procured items for the service with a government purchase card. The employee fraudulently used the card to purchase laptop computers and peripherals valued at $177,600 at various retail stores. He then sold the computers to an accomplice who in turn sold the computers to various pawnshops. The employee pleaded guilty to theft of government funds and sentencing is pending.

Another VA employee used a government purchase card to fraudulently purchase over $200,000 worth of computers, television sets, stereos, and other items. She sold the equipment to friends or associates for cash, or in some cases, kept the equipment for herself. To perpetrate the fraud she forged the signatures of her supervisors on the credit card bills and falsified receipts. The former employee pleaded guilty to theft of government property.

The OIG is currently preparing a roll-up report on these issues and conducting further evaluation of the use of purchase cards as part of a national assessment of local procurement practices.

Evaluation of the Department Of Veterans Affairs Purchasing Practices, May 2001

At the request of the Secretary of Veterans Affairs, we provided a report on purchase card use, local contracting, decentralization of purchasing authority, and effects on use of the FSS,

including increased costs to the government for medical/surgical items. We issued our report in May 2001, and included four recommendations for improvement.

1. Require VA facilities to purchase items that are on national contracts, such as FSS, by making FSS and other national contracts mandatory sources of medical/surgical supplies and equipment and generic pharmaceuticals unless otherwise determined by the Department's Procurement Executive.
2. Specifically prohibit the award of local contracts for commercial items unless authorized by the Department's Procurement Executive or designee.
3. Implement a program to monitor local purchasing and hold local officials accountable for not complying with VAAR and FAR requirements.
4. Implement a policy limiting contracts with distributors to distribution services only unless the distributor can show that it is responsible for negotiating and establishing prices for the majority of items it distributes to each manufacturer's commercial customers.

VA Procurement Reform Task Force

In June 2001, the Secretary of Veterans Affairs chartered the VA Procurement Reform Task Force and charged the task force to "review all facets of VA's acquisition system and to make specific recommendations to me that will optimize the system." The Task Force recently issued its report and made a number of recommendations to achieve five procurement goals:

1. Leverage Purchasing Power of VA
2. Standardize Commodities Within VA
3. Obtain and Improve Comprehensive VA Procurement Information
4. Improve VA Procurement Organizational Effectiveness
5. Ensure a Sufficient and Talented VA Acquisition Workforce

Task Force recommendations associated with Goal 1 - Leverage Purchasing Power of VA, support the findings and conclusions in our May 2001, report and other reports, in particular:

- Benefits of making FSS contracts mandatory sources for procurement of health care supplies.
- The need to monitor compliance with contracting priorities.
- The need to limit contracts with distributors to distribution services only to ensure the government receives fair prices for items it procures.
- The need to monitor the use of purchase cards.

H.R. 3645 - Veterans' Health-Care Items Procurement Reform and Improvement Act Of 2002

The OIG supports the intent and provisions of H.R. 3645. The proposed legislation compliments the recommendations we made in our May 2001 report, the recommendations of the Task Force, and fills in gaps in the authority available to the Secretary to independently implement the recommendations administratively. While the Secretary may have authority to administratively implement a policy mandating the use of FSS and national contracts, it is unclear whether he has authority to independently implement any of the remaining provisions of H.R. 3645 or the Task Force recommendations.

As previously stated, audit rights are key tools to provide contracting officers accurate information with which to negotiate contracts, obtain the best possible prices for its customers, and monitor compliance with the terms and conditions during the term of the contract. As previously stated, these tools have been used to recover over $161 million in overcharges and identify over $373 million in potential cost savings in manufacturers' contract proposals.

Price reduction clauses are also important authorities that compliment the audit tools to ensure VA and OGA customers receive any future price reductions to which they may be entitled. We believe a statutory basis is needed to ensure these important tools and authorities are available to contracting officers and to make optimal use of the authorities. OIG encourages enactment of the proposed legislation.

OIG also supports the provisions of H.R. 3645 that limit contracts with distributors to distribution services only, unless the cited conditions are met. The OIG strongly supports public policy to enhance and affirmatively promote opportunities for small business and nothing in our recommendation or in the proposed legislation is detrimental to that purpose. However, we believe the requirement for 90 percent compliance may be too restrictive, and based on our reviews, we recommend that 75 percent compliance would be more appropriate. We also believe that requiring approval by the Secretary, or if delegated, by the Under Secretary for Health and the Senior Procurement Executive acting jointly, to approve deviation from mandated FSS and national contracts would be administratively too restrictive. We suggest that the approval authority reside with the Procurement Executive, with delegation no more that two levels below the Procurement Executive.

That concludes my testimony. I would be pleased to respond to any questions the committee may have.

STATEMENT OF
CAROL RUTHERFORD, DIRECTOR
VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
TO THE
SUBCOMMITTEE ON HEALTH
COMMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
VETERANS HEALTH-CARE ITEMS PROCUREMENT REFORM AND IMPROVEMENT ACT OF 2002

JUNE 26, 2002

Mr. Chairman and Members of the Subcommittee:

The American Legion appreciates the opportunity to submit testimony on H.R. 3645 "Veterans Health-Care Items Procurement Reform and Improvement Act of 2002".

The average cost of medical care in the United States has risen astronomically over the past several years and The Department of Veterans Affairs (VA) health care system has not been immune to the detrimental effects of these ever increasing costs. Last year, the VA health care system spent over a billion dollars for medical and surgical supplies and equipment. Any cost savings realized through effective procurement reform will indeed serve to improve the overall quality of healthcare provided to America's veterans through the VA healthcare system.

H.R. 3645, VETERANS HEALTH CARE ITEMS PROCUREMENT REFORM AND IMPROVEMENT ACT OF 2002

Section 2. Limitation On Use Of Local Contracts For Department Of Veterans Affairs Procurement Of Health-Care Items.

§ 8125. Procurement of health-care items.

This subsection requires any procurement of a health-care item by any component of the Department of Veterans Affairs (VA) to be made through the use of a Federal Supply Schedule contract or national contract that meets specified requirements, including the presence of pre-award and post-award audit clauses and a price reduction clause. It allows, in limited circumstances including the presence of a medical emergency at a Department medical center, the use of a contract other than the above contracts, as long as the contract meets the requirements.

In May of 2001, the VA Office of Inspector General (OIG) released a report entitled "*Evaluation of VA Purchasing Practices*". The result of this assessment, in brief, was that VA is not

leveraging its purchasing power through judicious procurement practices in order to obtain premium prices, in light of the volume of items purchased. The report recommends that in order to improve VA's buying practices, management at VA should consider the following:

- VA facilities should be required to purchase items that are on national contracts, such as the Federal Supply Schedule (FSS), and that the FSS and other national contracts be mandatory sources of medical/surgical supplies and equipment and pharmaceuticals, unless otherwise determined by the Department's Procurement Executive.

- Local contracts should be specifically prohibited unless authorized by the Department's Procurement Executive or designee.

- VA should implement a program to monitor local purchasing and hold local officials accountable for not complying with provisions in the VA Acquisition Regulations (VAAR) and Federal Acquisition Regulations (FAR).

- Policy should be made limiting contracts with distributors to distribution services only, unless the distributor can show that it is responsible for negotiation and establishing prices for items it distributes to the manufacturers' commercial customers.

According to the VA OIG report, there are advantages and important protections to using the FSS. One big advantage includes a cost saving to both the vendor and VA. Additionally, FSS vendors are required to disclose specific information relating to the discounts and concessions given to their commercial customers. FSS contracts contain clauses not found in other Government contracts, including national contracts awarded by VA, that protect the Government's interest over the term of the contract. The price reduction clause requires the vendor to offer the same type of price reductions it offers to an agreed upon comparable commercial customer or category of customer. This clause ensures that the Government maintains commercially favorable pricing throughout the term of the contract. The FSS contract provides VA facilities with a wide choice in pharmaceuticals, medical/surgical supplies, and equipment to better meet the needs of the veteran patient. Finally, FSS contracts are beneficial to vendors, particularly to the smaller vendors in that it allows them to do business with the Government.

In the case of an emergency, the Act provides for the procurement of a health-care item that is necessary to meet a current near-term medical emergency at a medical center, but is not on an FSS contract, or a national contract. This will allow the flexibility needed at the individual medical centers to provide quality health care to veterans.

The Act requires the presence of pre-award and post award audit clauses. Since the use of these clauses today is not as common as it was five years ago, the amount of money effectively recovered has fallen dramatically. In fiscal year 1997, $35 million dollars was recovered under the audit system compared to only $12 million last year.

The Act would also require the inclusion of a price reduction clause in most VA procurement contracts. Essentially, when a vendor offers a health-care item at a lower price to another buyer

in a commercial contract, VA will benefit from the purchase price reduction and receive the new lower purchase price for a health-care item it has previously agreed to purchase from the vendor.

Finally, the Act provides for some accountability with the requirement of an annual report which includes a status on the implementation of this subsection.

The American Legion supports this Act and believes the intent is positive, in terms of saving money and leveraging the buying power of VA by channeling purchases through the FSS. It also reflects, to a great extent, many of the recommendations of the VA OIG. It will be incumbent upon VA to see to fruition the purpose of this Act.

This concludes our testimony. Thank you again for the opportunity to submit testimony on behalf of The American Legion.

STATEMENT OF

PAUL A. HAYDEN, DEPUTY DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

SUBMITTED TO

SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

H.R. 3645, VETERANS HEALTH CARE ITEMS PROCUREMENT REFORM AND IMPROVEMENT ACT OF 2002

WASHINGTON, DC JUNE 26, 2002

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 2.7 million members of the Veterans of Foreign Wars of the United States (VFW) and our Ladies Auxiliary, I would like to thank you for the opportunity to comment on H.R. 3645, *Veterans Health Care Items Procurement Reform and Improvement Act of 2002.*

Section 2 would limit the Department of Veterans Affairs' (VA) ability to use local contracts for procurement of health-care items by instead requiring VA to utilize the Federal Supply Schedule (FSS) in its health care procurement activities. Four exceptions or exemptions to procuring health-care items from FSS are delineated: near-term medical emergencies, valid clinical needs, sharing agreements between VA and the Department of Defense (DOD), and supporting prime or subcontracts with small business that qualify for preference under existing statute.

The VFW certainly supports the common-sense intent of this legislation. By centralizing health-care items contracting at the national level instead of the local level, VA will be able to leverage its purchasing power resulting in a reduction of overall procurement costs. Thus, better use of taxpayer dollars will generate savings that can then be used to improve access to and quality of care for veterans.

While cost savings and efficiency are something we all can support, the VFW would caution that the individual specialized needs of veterans not be limited in an attempt to standardize commodities within the VA. There are many veterans, especially those veterans with spinal cord injury, blindness, traumatic brain injury, amputation,

serious mental illness, and post-traumatic stress disorder that require a broad array of medical supplies in order to function on a daily basis. Any attempt to restrict access to products that are tailored to their unique needs will ultimately impact their health and rehabilitation.

As a co-author of the *Independent Budget* along with AMVETS, Disabled American Veterans, and the Paralyzed Veterans of America, we have already pointed out our concern regarding a similar decision by the Veterans Health Administration's (VHA) that was designed to improve the quality and accuracy of prosthetic prescriptions by centralizing the prosthetics budget. While supportive of the VHA's intent, it is our opinion that "this program [Prosthetics Clinical Management Program] could be used as a veil to standardize or limit the types of prosthetic devices that a VISN or facility will issue..."

Further, "under VHA Directives 1761.1, prosthetic items intended for direct patient issuance are exempted from the Veterans Health Administration's standardization efforts. The reason for this is that "one size fits all" approach is inappropriate for meeting the medical and personal needs of disabled veterans. However, managers in VHA's local prosthetic programs, as well as some VA clinicians, still encounter internal managerial pressure to standardize some of the prosthetic devices they issue or altogether restrict certain devices from issuance... Disabled veterans must have access to the latest devices and equipment, such as computerized artificial legs and stair climbing and self-balancing wheelchairs and scooters, if they are to lead as full and productive lives as possible." As such, we " remain opposed to any and all initiatives that will result in the standardization of prosthetic devices and sensory aids."

Therefore, the VFW would support amending language to H.R. 3645 that would carve out procurement exemptions for special patient populations such as veterans with spinal cord dysfunction, blindness, amputations, and mental illness and those veterans included in Title 38, Section 1706 (b). Further, we would support language that would allow the VA Advisory Committee on Prosthetics and Special Disability Programs the authority to review and comment on the annual reporting requirements.

Procurement reform should, in part, be clinician and patient driven not just budget driven.

This concludes my statement. I will be happy to respond to any questions you or members of this Subcommittee may have.

STATEMENT OF
JOY J. ILEM
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES
June 26, 2002

Mr. Chairman and Members of the Subcommittee:

I am pleased to present the views of the Disabled American Veterans (DAV) concerning H.R. 3645, the Veterans Health-Care Items Procurement Reform and Improvement Act of 2002, legislation to establish new policy in procurement practices for health care items purchased by the Department of Veterans Affairs (VA). On behalf of the more than 1.24 million members of the DAV and its Women's Auxiliary, we appreciate the opportunity to present our views on this measure introduced by Representative Lane Evans, Ranking Member of the House Veterans Affairs Committee, on January 29, 2002.

Representative Evans' bill, H.R. 3645, would reform VA's procurement practices for the purchasing of VA medical and surgical supplies and equipment by requiring such items to be purchased from the Federal Supply Schedule (FSS) or from national contracts negotiated by VA. This will allow VA to leverage its tremendous purchasing power and obtain the best prices for items purchased. The bill seeks to eliminate existing inefficiencies in VA's acquisition system that allow for multiple, locally negotiated contracts with vendors and distributors. This measure would provide for certain exceptions to the centralized procurement requirement in limited circumstances, such as a medical emergency or if there is a valid clinical need for an item not listed in the FSS or as part of a national contract.

DAV appreciates the introduction of this important measure and its overall objective to improve the Department's complex purchasing system and reform VA procurement practices to achieve the best possible terms and practices in the acquisition of health care items. We agree that the proposed changes may yield cost savings and result in a better-run and more efficient system. We applaud Representative Evans for his efforts and initiative on this issue. We too want to see taxpayer dollars used wisely and in the most efficient manner for VA health care. However, we feel certain provisions in the bill need to be more concise to ensure the complex needs of special patient populations are met. Specifically, we want to ensure that veterans in the core disability groups listed under section 1706(b)(1) of title 38, United States Code, veterans with amputations, spinal cord dysfunction, blindness, and others, have access to a full range of quality prosthetic appliances, and sensory and mobility aids and supplies available in the marketplace to meet their specialized needs.

Although this bill includes language that allows VA to purchase items not listed on the FSS or as part of a national contract if there is a "near-term medical emergency at the medical

center", or "a valid clinical need" for such item, we fear that clinicians may still feel prohibited from doing so. We raised similar concerns after VA went to a standardized pharmaceutical formulary, and some clinicians complained it was very difficult to order medications that were not listed on the formulary. Although VA physicians have the ability to prescribe medications that are not on the formulary if clinically indicated, some physicians still say they feel prohibited from doing so. We do not want clinicians to experience similar problems when trying to acquire prosthetic appliances, sensory and mobility aids and supplies, or other items that are not listed on the FSS for seriously disabled veterans. We want to ensure the language in H.R. 3645 clearly protects authority to provide of the full range of specialized health care items to special disabled veteran populations.

DAV supports the intent of the bill to achieve cost savings and overall improvement of VA's organizational procurement effectiveness. At the same time, we want to ensure that service-connected disabled veterans and other veterans within the core disability groups, especially veterans that need prosthetics and sensory aides, such as blinded veterans, amputees, and veterans with spinal cord injury or dysfunction, have access to the newest technology, and highest quality items available on the market. Providers should have the option to select items based on clinical need, and patients should have access to a variety of devices and supplies that meet their individual needs. Ultimately, the overall health and well being of the patient should be the primary factor for selecting specialized items as determined by both patient and physician. Appropriate management, cost savings, and efficient use of funds are all important issues to consider, but the we must be ever mindful that the system was developed to meet the specialized health care needs of service-connected disabled veterans and veterans with special disabilities.

Specialized items provided by VA have the ability to greatly improve the quality of life for some of our nation's most profoundly disabled veterans. For this reason, we ask the Subcommittee to consider more concise language in the bill that would ensure clinicians have the ability to go outside the supply system to purchase products for veterans with specialized needs.

VA has indicated it is working diligently to improve its procurement practices through the work of the Procurement Reform Task Force (PRTF). This task force, made up of staff familiar with VA's acquisition process, is charged with examining the current system and developing recommendations for improvement. The PRTF has developed a comprehensive set of recommendations to accomplish the Department's goals and has noted that it is aggressively pursuing change to improve VA's acquisition system. Irrespective of the outcome of this bill, we hope VA will continue to pursue its goals for improving its procurement system.

We thank the Subcommittee for holding this hearing and for providing DAV the opportunity to express its views on H.R. 3645. This concludes my testimony. I will be happy to respond to any questions the Subcommittee may have.

STATEMENT FOR THE RECORD

PRESENTED BY

RICHARD B. FULLER

NATIONAL LEGISLATIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

REGARDING

H.R. 3645, THE "VETERANS HEALTH CARE ITEMS PROCUREMENT REFORM AND IMPROVEMENT ACT OF 2002"

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

June 26, 2002

Mr. Chairman, and members of the Subcommittee, Paralyzed Veterans of America (PVA) appreciates this opportunity to comment on H.R. 3645, the "Veterans Health-Care Items Procurement Reform and Improvement Act of 2002." The legislation would alter procurement practices by the Department of Veterans Affairs in purchasing health care items. Except under certain circumstances, the bill would prohibit VA from purchasing any health care item that is not acquired through the use of a Federal Supply Schedule contract or a national contract.

PVA appreciates the intent of the legislation to achieve cost savings by changing or "nationalizing" the procurement of the immense number of health care items, devices and prosthetic equipment purchased each year by the Veterans Health Administration (VHA). We have grave concerns however, that by changing how VA purchases products, the VA will voluntarily or involuntarily proscribe and limit what products it purchases to the great detriment of disabled veterans who use those items on a daily basis.

All of PVA's members are veterans who have sustained catastrophic spinal cord injury or dysfunction. Because of the nature of these disabilities, PVA members require a lifetime of complex multidisciplinary primary, acute and sustaining health care. These services must be complemented by the provision of a broad variety of medical supplies, equipment and prosthetic devices to allow the individual to overcome the challenges of a catastrophic disability on a daily basis. These items range from the obvious provision of a wheelchair and seat cushion, to the not so evident catheters, urine collection equipment, bowel care, hygiene and skin care products that are part of a paraplegics and quadriplegic's routine of daily living. The list of prescribed and over-the -counter supplies are immense. And, the path to successful rehabilitation and good health comes not just with the provision of these products, but in making sure that the products are tailored and prescribed to meet the unique needs, and even preferences, of each individual patient. From this standpoint, variety is a necessary prerequisite. Providers and patients must have a broad array from which to select those products, devices and supplies that address a need that can vary widely from one disabled veteran to the next.

Obviously, one wheelchair, or wheelchair cushion, does not fit all. Wheelchairs must be carefully selected to meet the motor skills of the user as well as basic utility, whether for routine mobility or needed recreation. Wheelchair cushions must be designed and fitted to meet the needs of different sized bodies and different pressure point requirements. An ill-designed or inappropriate cushion can cause a skin breakdown and pressure sore that can cause months of hospitalization, if not death. Catheterization and bowel care are a daily challenge for almost all paraplegic's and quadriplegics. The choice of the appropriate catheter and bowel care equipment is as much a medical decision as one of personal preference for the user. The list of similar examples goes on and on.

The main point PVA would like to make is that any restriction in the availability of these products or limitation in the variety of products available has a direct bearing on the health of the veteran user.

PVA and other veterans service organizations are already concerned by VA initiatives seeking to restrict choice in the field of prosthetics and limit the ability of individual clinicians to provide the full range of equipment suited to meet the veteran's need. The *Independent Budget for Fiscal Year 2003,* co-authored by the AMVETS, Disabled American Veterans, Paralyzed Veterans of America and Veterans of Foreign Wars made the following statement in this regard.

"The Independent Budget VSOs are continuing to monitor the development of VHA's prosthetics clinical management program, (PCMP) which was established in FY 2001 in connection with the decision to fully centralize the prosthetics budget. As part of the PCMP implementation, VHA has strongly recommended that each VISN form a network-level PCMP to review prescription criteria and prosthetic prescriptions within their network. As this program could be used as a veil to standardize or limit the types of prosthetic devices that a VISN or facility will issue to veterans, strong VHA oversight in needed as this program develops."

"One VISN has already developed clinical guidelines on motorized wheelchairs and scooters that are quite restrictive and contain some bizarre provisions. For example, a prescription for a motorized wheelchair or scooter could be refused if there was a recent history of drug or alcohol abuse. In addition, the examiner must clinically assess whether the veteran can have sexual intercourse without stopping or can garden, rake, or weed. The guidelines must assess whether the veteran can shower without stopping, and if the veteran can bowl."

Under VHA Directives 1761.1, prosthetic items intended for direct patient issuance are exempted from VHA's standardization efforts. The reason for this is that a "one size fits all" approach is inappropriate for meeting the medical and personal needs of disabled veterans. However, managers in VHA's local prosthetics programs, as well as some VA clinicians, still encounter internal managerial pressure to standardize some of the prosthetic devices they issue or altogether restrict certain devices from issuance. This

is a matter of grave concern for the IBVSOs and we remain opposed to any and all initiatives that will result in the standardization of prosthetic devices and sensory aids."

In conclusion, this section makes the additional argument against standardization.

"Finally, considerable advances are still being made in prosthetics technology that will continue to dramatically enhance the lives of disabled veterans. VA was once the world leader in developing new prosthetics devices. VHA is still a major player in this type of research, from funding research to assisting with clinical trials for new devices. Formulary-type scenarios for standardizing prosthetics will likely cause advances in prosthetic technologies to stagnate to a considerable degree because VA has such a major influence on the market. Disabled veterans must have access to the latest devices and equipment, such as computerized artificial legs and stair climbing and self-balancing wheelchairs and scooters, if they are to lead as full and productive lives as possible."

PVA is concerned that the provisions in H.R. 3645 which, for the most part, limit the procurement of health care items to only those items that are listed in Federal Supply Schedule contracts or national contracts, very well could serve the purpose of limiting the availability of the full array of products available. This we believe is the wrong signal to send to a VA that is already looking to standardization to achieve cost savings in many areas of prosthetics and equipment procurement. A supply schedule, like a formulary, is only as good as the people who determine what is on the list and what is not.

PVA had expressed serious concerns in the past about the restrictive nature of VA's original pharmaceutical formulary proposal as not fully meeting the scope of need of PVA members. After expressing those concerns, we reached agreement with the Department of Veterans Affairs to have a directive sent to the field to broaden the scope of those pharmaceuticals available to veterans with complex disabilities such as spinal

cord injury. Section (b)1 of H.R. 3645 seems to provide an exception to allow a clinician to go outside a Federal Supply Schedule contract or national contract if there is a "valid clinical need." We appreciate this exception provided in the legislation, but believe that the terms "valid" and "clinical" are too vague to provide any flexibility when matched against the larger intent of the legislation. "Clinical" could encompass those items that might address a medical need. The word "valid" could be interpreted by an accountant responding only to the cost of an item. We believe, as written, this section gives insufficient support to the clinician seeking to prescribe what may be outside a federal supply schedule or national contract list, but which may be most appropriate for a seriously disabled veteran.

If this legislation is to proceed, we strongly recommend the language in this section be carefully reviewed, amended and strengthened to give the maximum authority and flexibility to individual clinicians in prescribing whatever they feel is necessary and appropriate for veterans with specialized needs.

This concludes my statement for the record. I will be happy to respond to any questions you may have.

Statement of

VIETNAM VETERANS OF AMERICA

Submitted for the record by

Richard Weidman
Director of Government Relations

Before the
House Veterans Affairs Subcommittee on Health

Regarding
H.R. 3645, the "Veterans Health Care Items Procurement Reform and Improvement Act of 2002"

June 26, 2002

Vietnam Veterans of America

House Veterans
Affairs Subcommittee on Health
June 26, 2002

Mr. Chairman, my name is Rick Weidman, and I serve as Director of Government Relations for Vietnam Veterans of America (VVA). On behalf of VVA, I thank you for this opportunity to express our views on the issue of much needed procurement reform at the United States Department of Veterans Affairs (VA), as well as elsewhere in the Federal government.

VVA very strongly favors the intent of H.R. 3645, the "Veterans Health Care Items Procurement Reform and Improvement Act of 2002. VVA commends Mr. Evans, Mr. Filner, and the other original co-sponsors (as well as their staff) for all of the hard work that led to development of this important initiative. In general, VVA supports the bill as written, but would like to see some additional provisions inserted into the final version of the bill.

VVA has testified for years about the need for more accountability on the part of VA for how effectively and efficiently they spend the funds allocated to them, particularly to the Veterans Health Administration (VHA). VVA believes that not enough is spent on the VHA. However, VVA is just as concerned about management accountability for delivery of health care in their area of operations, particularly the way in which money is allocated at the Veterans Integrated Services Network (VISN) level and at the VA Medical Center level.

VVA recommends that report language be included in the FY 2003 budget that VA produce a financial tracking system that is accurate by FY 2005, and that there be clear milestones and objectives toward this end that must be met in FY 03 and FY 04. Progress in achieving these milestones must be demonstrated to the Congress before anyone in management of Information Technology of the administrative and "business" areas of the Veterans Health Administration (VHA) get a bonus or presidential award.

VVA recommends that VA be required to produce a "real-time" Management Information System" (MIS) that works accurately by FY 2005, with similar milestones and consequences if those milestones are not met in FY 03 and FY 04. Further, VVA recommends that all bonuses and clear measurable criteria for bonuses for GS14/15 and SES personnel be fully transparent to the veteran users of the medical system and to the public.

The abuses that H.R. 3645 is designed to correct are part of the same corporate culture that the above recommendations are designed to address. This is a corporate culture that is bereft of any passion for the VA's mission: to properly assist the men and women who have been harmed or injured by military service. It is a corporate culture that would give bonuses to VISN Directors who have so utterly ignored their responsibility to veterans in the hospitals under their control that lice infect their bodies. This is the same corporate culture that would give maximum bonuses to SES Regional Office (RO) Directors whose

RO is an absolute disaster. (VVA hopes that the practice of awarding merit bonuses as "sharing of the spoils" will come to an end under Admiral Cooper.)

The abuse of the procurement system in many VISNs resembles what those of us who grew up in New York refer to as "brother-in-law" contracts. These are contracts that one lets to one's never-do-well brother-in-law or to organized crime and other shady characters for the basest of motives. The design of H.R. 3645 is such that it is intended to force letting contracts back onto the nationally negotiated schedules at the lowest possible price. The effort is to get the best possible deal for the VA as the steward of the Veterans' Hospital.

VVA agrees with the intent of forcing the use of a Federal Supply Schedule contracts or national contracts, except in certain situations as indicated in Section 8125 of Section 2 of the proposed legislation, in order to insure that taxpayer dollars be stretched to secure the greatest amount of good. Apparently, many contracts have been let at the local and VISN level that do not meet anyone's test of proper federal procurement or any of the tenets of the Government Results and Performance Act (GPRA). Under 8125(b)(1)(D) on page 3, lines through 10, VVA urges in the strongest possible terms adding a provision that requires the contracting with service-disabled owned and operated businesses, irrespective of any other section of federal law, in the letting of local contracts. Any exception to the above should be made in individual cases expressly by the Secretary of Veterans Affairs.

VVA also urges an additional provision requiring that all national contracts entered into by the National Acquisition Center of the Department of Veterans Affairs or another Department Procurement activity be required to adhere to the goal to award 3% of all prime contracts to service-disabled-veteran owned and operated businesses, and that all prime contractors be held to a standard of subcontracting not less than 3% of the total contract with service-disabled-veteran owned and operated businesses. For this purpose, such service-disabled-veteran owned and operated businesses shall have relaxed cost parity of up to 10%.

Public Law 106-50, the Veterans Entrepreneurship & Small Business Act of 1999, was enacted on August 17, 1999. The bill in the House was drafted by House Small Business Committee staff, with Veterans Affairs Committee staff from both sides of the aisle actively participating in the effort. In short, this law was as much a product of this committee as it was of the Small Business Committee.

Public Law 106-50 raised expectations of service-disabled veterans all across the country, prompting many to stretch their investments in their businesses to the maximum and beyond, based on the promises of the U.S. Congress contained that law. Thanks to the nonfeasance, dilatory tactics, and just plain hubris and sloth of the Small Business Administration and others in the Executive Branch under two successive administrations,

the procurement goals at federal departments and agencies envisioned by that law are thus far a total failure, including at the VA.

While VVA believes that Secretary Principi truly wants to dramatically increase purchases of goods and services from service-disabled-veteran owned and operated small businesses, the effort has thus far yielded a result of about .25 of 1% in the latest figures. (This figure may be somewhat low, as it is an "unscrubbed" first year data collection figure. However, VVA is certain that even the VA is far from meeting the minimum level of 3% in prime contracts and 3% minimum in subcontracts for each prime contract.)

VVA believes that this lack of progress is due to several things, one of which is addressed in the bill as drafted: namely, the capriciousness of locally awarded contracts in some places that results in overpriced items that should cost far less and in freezing out those businesses that are not part of the club of good old boys and gals who have been doing business with local procurement officials for years. By and large, this does not include service-disabled businesses.

The General Services Administration (GSA) schedule is designed in such a way that small businesses, particularly service-disabled veteran-owned businesses, can and are virtually excluded by very large companies. Once on the schedule, there is no renewal or "sunset" for such federal suppliers, so they have literally told service-disabled businesses owners that they "do not need disabled veterans." In other words, they do not have to be concerned with any subcontracting, much less with service-disabled-veteran owned enterprises (SDVBE). VVA believes that this must change, and this bill may be one way to start addressing this need. To limit procurement to national contracts and schedules that are clearly discriminating against disabled-veteran business owners is just plain wrong.

There are four pressing needs in VVA's view, Mr. Chairman. One, there is the need to change the corporate culture of VA, especially VHA, to one of true accountability for the effectiveness and efficiency of the delivery of vitally needed services to veterans. A key element of this effort is to ensure that local procurement operations are not needlessly spending more than is needed to secure medical items, pharmaceuticals, and other goods and services for VA hospitals. This proposed legislation, if properly modified, could be a first step toward preventing such abuses at the local and regional level.

Two, VVA believes that there is a need to closely examine the national contracts and the national schedules, especially pricing practices and possible limiting of supplies of key items. While the same may also hold true of other key medical supplies and equipment, it is certainly true that extraordinarily high prices and extreme shortages of some medications is an area VVA is sure merits very close congressional scrutiny.

An example of this is that the price of pegylated interferon hepatitis C virus (HCV) treatment is reportedly over $25,000 per veteran for each course of treatment. Even at this extraordinary price, VA claims that they cannot secure enough of the drug from the manufacturer to eliminate at least a three-month backlog of veterans determined to be good candidates for treatment to receive the drug. The fault lies either in the manufacturer withholding the medication by artificially limiting supplies, or by VA limiting supply of the medication because they do not have the money to pay for it. In either case, it is a procurement problem of grave proportions that is jeopardizing the lives of veterans diagnosed by the VA with hepatitis C.

Third, there is a pressing need to examine all national contracts and the Federal Supply schedule as to pricing, quality, appropriateness, and fairness to small business on a regular and recurrent basis. This is particularly true as to the inclusion of small businesses in the mix of firms, especially service-disabled-veteran owned enterprises (SDVBE). Unless there is equity at the outset in these national contracts and GSA schedules we will never achieve the target of 22% of all federal procurement being from small businesses and a minimum of 3% of all prime contracts go to SDVBE and that a minimum of 3% of all prime contracts subcontracts with SDVBE.

Fourth, VVA urges the Committee to use the Report of Secretary Principi's Procurement Reform Task Force, which was completed in May as a basis for much of your further work that needs to be done in this area.

The Procurement Task Force set five worthy goals: 1) Leverage purchasing power of VA. 2) Standardize commodities within VA. 3) Obtain and improve comprehensive VA procurement information. 4) Improve VA procurement organizational effectiveness. 5) Ensure a sufficient and talented VA acquisition workforce.

VVA would respectfully suggest that there should be two further goals; namely, 6) Ensure that small business goals of 22% for all small businesses and at least a minimum of 3% of all primes and of all subcontracts go to SDVBE be achieved at every level of VA. 7) Ensure that every tool is employed so that managers at every level of the procurement system are held fully accountable for the effectiveness and efficiency of their area of operations.

The details of this 60-page report (with an additional 15 pages of useful appendices) should prove to be of assistance to you in your work in this area, which is so vital in bringing true accountability to the Veterans Health Administration. While we need sharply increased resources in the veterans health care system, we also must do all possible to ensure that every dollar is spent wisely and well.

In addition to the points made above, VVA urges that the Committee build in strong reporting requirements on a regular basis, as well as specific timetables and measurable

objectives to any legislation that you report to the full Congress, this last point being very important in the case of procurement reform.

Lastly, VVA urges that the full Committee, and its subcommittees examine how well Public Law 106-50 is working three years after enactment. VVA believes, along with our colleagues at the other major veteran and small business organizations, that major additions to the 1999 law are in order to make the congressional vision a reality.

Mr. Chairman, on behalf of Vietnam Veterans of America, I thank you and your distinguished colleagues for the opportunity to respectfully offer our suggestions in regard to H.R. 3645, the "Veterans Health-Care Items Procurement Reform and Improvement Act of 2002."

Vietnam Veterans of America

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A Not-For-Profit Veterans Service Organization Chartered by the United States Congress

VIETNAM VETERANS OF AMERICA
Funding Statement
June 26, 2002

The national organization Vietnam Veterans of America (VVA) is a non-profit veterans membership organization registered as a 501(c)(19) with the Internal Revenue Service. VVA is also appropriately registered with the Secretary of the Senate and the Clerk of the House of Representatives in compliance with the Lobbying Disclosure Act of 1995.

VVA is not currently in receipt of any federal grant or contract, other than the routine allocation of office space and associated resources in VA Regional Offices for outreach and direct services through its Veterans Benefits Program (Service Representatives). This is also true of the previous two fiscal years.

For Further Information, Contact:
Director of Government Relations
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BLINDED VETERANS ASSOCIATION
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STATEMENT FOR THE RECORD

Regarding

H.R. 3465, Veterans Health Care Items Procurement Reform

By

Thomas H. Miller
Executive Director
Blinded Veterans Association

Submitted to

House Committee on Veterans Affairs

June 26, 2002

Thank you for this opportunity to present the views of the Blinded Veterans Association, the only federally chartered veterans organization exclusively dedicated to serving the needs of our Nation's blinded veterans, on H. R. 3645, Veterans Health-Care Items Procurement Reform and Improvement Act of 2002. BVA commends Ranking member Evans for introducing this important legislation. Although BVA understands the intent of this legislation, we believe it is lacking in consideration of both veterans with special disabilities and small businesses.

General Omar Bradley, U.S. Army and VA Administrator (1945-1947), said, "We are dealing with veterans, not procedures, with their problems, not ours." This quotation, now on the cover of the 2002 Edition of the Federal Benefits for Veterans and Dependents handbook, is a good reminder to those who seem to moving VA towards a "one size fits all" mentality.

While we understand and support the movement to run VA more efficiently and agree with the recommendations of the Procurement Task Force, BVA feels that a reminder is needed that we are dealing with America's veterans, who have unique needs. As an example, the following is a list of goals established by the VA Procurement Task Force.

1) Leverage purchasing power of VA.
2) Standardize commodities within VA.
3) Obtain and improve comprehensive VA procurement information
4) Improve VA procurement organizational effectiveness
5) Ensure a sufficient and talented VA acquisition workforce.

Nowhere in this list is the word veteran mentioned. Efficiency and cost savings are honorable goals, but not at the expense of veterans. BVA is concerned about meeting individual needs of veterans, especially those with special needs and those that use prosthetics and sensory aides. There are caveats built into this legislation: "Loopholes" for emergencies, clinical need, small businesses, etc. These "loopholes," we believe, should be the focus of this legislation. When the pharmaceutical formulary was developed, VSOs were assured that if an off-formulary medication was needed, there was a simple procedure to enable a doctor to prescribe that medication. It was not long before we began to hear the horror stories about how many hoops a prescribing physician would have to jump through in order to procure an off-formulary medication for a patient. So many hoops appeared that doctors just stopped prescribing off-formulary medications, even if it meant giving a patient a less effective medication that could have met the individual need of that veteran.

BVA asks this Committee to guarantee that we will not hear these stories with medical products, especially products and sensory aides. Just because a product is on the Federal Supply Schedule does not necessarily guarantee it is the highest quality product. It simply means a company had the time, patience, and knowledge to acquire a Schedule, and the workers and time to maintain it. An easy way to order non-Schedule products and services must be established. Often times, a "waiver" process is available, but employees fear they will be reprimanded or somehow punished if they use the alternative process, even if the intent is to meet a legitimate need.

This legislation virtually shuts out small business. Meeting federally mandated requirements and goals for small business is a Government-wide problem. BVA is disappointed that there is not more emphasis on meeting the small business goals, especially the veteran-owned goals established in PL 106-50, Veterans Entrepreneurship and Small Business Development Act of 1999. We envision a time when a majority of products procured by the Department of Veterans Affairs, used for the care of veterans, are acquired from Veteran-Owned businesses.

Most of the companies that currently provide products for the blind and visually impaired are small businesses, with perhaps a few mid-sized businesses mixed in. Each year BVA holds a trade show in conjunction with its national convention. A majority, if not all, of BVA's exhibitors DO NOT hold a FSS. BVA fears that the vast number of choices and products offered to blinded veterans will shrink dramatically.

Once again, BVA understands the intent of this legislation and is well aware of the need to make buying practices more uniform. In this important procurement reform process, BVA urges this Committee to protect the quality of services and products for our veterans, especially those with special disabilities. Also, small businesses, especially veteran-owned businesses, should not be forgotten in this process. Thank you for this opportunity to express our views. Please do not hesitate to contact us if you have any question or need further information.

WRITTEN TESTIMONY SUBMITTED BY

Terry Baker
Executive Director
Veterans Aimed Toward Awareness, Inc.

Committee on Veteran Affairs
Subcommittee on Health

U.S. House of Representatives

26 June 2002

Honorable Chairman Moran, Ranking Member Filner, and Distinguished Members of the Subcommittee:

I am pleased to provide testimony today on behalf of the Veterans Aimed Toward Awareness (VATA), a member-run organization of veterans and their families who provide outreach and advocacy activities for the men and women who served in our nation's military services. VATA seeks political and social change within the veteran's health system, the community, our state, and our country. We seek to speak with one voice while never losing sight that each person is a unique individual with personal health and emotional needs. We believe that all people have the right to be free from chronic illnesses that rob them of productive and satisfying lives. We believe that certain conditions, including diabetes, Hepatitis C, substance abuse, and dependency disorders have profound consequences on productive living in our community. We seek to create awareness around these conditions, and also to promote better public health approaches toward prevention, treatment and control of chronic conditions as they pertain to the veterans health system.

VATA MISSION

VATA has had increasing success accomplishing its mission since its conception in 1998. The year 2000 was an exceptional one for VATA as we formalized our message, mobilized large numbers of veterans to fight for increased awareness and treatment by the VA for Hepatitis C and related conditions, and educated policy makers through testimony before the Veteran Committee of the U.S. House of Representatives and in two appearances before the House Government Reform Committee. Through alliances with 2000 Miss America Heather French and the Miss America Foundation, VATA also was able to develop outreach initiatives targeted at homeless veterans in order to offer some measure of hope for lifestyle and behaviors improvement.

Because of the dramatic number of veterans who have been recently diagnosed with diabetes, we are particularly interested in any reforms that may have a positive or negative impact in the delivery of services to this veteran population. For this reason, VATA created a consortium of state chapters of some of the nation's leading veterans organizations to work together in expressing concerns about this proposal and urging the Secretary of the VA to maintain the current system for blood glucose testing supplies and monitoring equipment.

VA STANDARDIZATION EFFORTS – THE SPECIAL CASE OF DIABETES EQUIPMENT AND SUPPLIES

As an organization, we commend the VA's recent efforts to develop a comprehensive strategy for providing cost savings and efficiency to the national veteran health care system. We recognize that considerable research contributed to the final report of the Department of Veteran Affairs' Procurement Reform Task Force, and we applaud the agency's commitment to reducing costs while maintaining the quality and efficiency of the veteran health care system. However, VATA is concerned about the VA's standardization of certain medical technologies and products may adversely impact quality. While the organization understands

that standardization is an appropriate cost-saving method with respect to certain medical commodities, VATA is extremely alarmed by the VA's attempts to create a national standardization process for several medical diagnostic devices. Specifically, we are concerned about the standardization of medical devices necessary to improving the quality of health of veterans with chronic conditions and requiring patient education for operation.

Unlike drug therapies, these medical devices are valuable only through patient and provider feedback. Because of its large role in the health care industry, the VA may actually hinder access to innovative technology by inadvertently standardizing technology that could in fact be improved upon in a competitive market of multiple suppliers. The lack of innovation could jeopardize the maintenance of good health practices for patients and providers.

The remainder of this testimony provides a case study of the current standardization policy on blood glucose monitoring technologies, and makes the case against further standardization or creation of a national uniform policy with respect to diabetes monitoring technologies and supplies. Furthermore, VATA supports the idea of not only maintaining the current level of standardization with respect to diabetes monitoring technologies, but also of utilizing this system as a model for other monitoring technologies and diagnostic devices the VA is considering for standardization.

IMPACT OF STANDARDIZATION ON DIABETES COMMUNITY

In 1996, the U.S. Department of Veterans Affairs announced its intent to significantly increase the use of single award, national contracts. In conjunction with this general goal, the VA is currently considering a proposal to standardize all utilization of blood glucose testing supplies and monitoring equipment within the VA Hospital System to one single supplier. Because of the dramatic number of veterans who have been diagnosed with diabetes, we are particularly concerned about this development. The proposal to standardize diabetes equipment makes less sense in light of the savings that have already been achieved in the diabetes equipment and supply area by the 21 Veterans Integrated Service Networks (VISNs).

Currently, the 21 VISNs retain the autonomy to negotiate with any individual diabetes equipment manufacturer. Indeed, we noted with interest that the June 3 report of the VA Procurement Reform Task Force cited significant savings that have been achieved in the pharmacy benefit arena. Currently, blood glucose equipment and supplies fall in the PBM class in which they negotiate contracts with providers of blood glucose monitoring technologies. This PBM program has worked because it fairly balances the goals of reducing costs and ensuring top-quality health care to veterans. Because the networks choose the best products at the best prices, the values of competition, choice, and quality of care are promoted rather than compromised.

In addition to the savings that have already been achieved, we were pleased to see that blood glucose monitoring technologies were <u>not</u> included in the Task Force's top 20 products list recommended for national standardization. However, we are concerned to hear reports that the VA's Clinical Logistics Department is still considering recommendations to create a national

standardization policy for blood glucose monitoring supplies and equipment. This would have potentially devastating impacts on both the providers of diabetes education and training, as well as on veterans with diabetes.

CONSEQUENCES OF A NATIONAL STANDARDIZATION POLICY FOR DIABETES MONITORING TECHNOLOGIES & SUPPLIES

There are an estimated 2 million veterans living with diabetes, thousands of whom already experience tremendous difficulties with the necessary technicalities and schedules for their testing. Because of the nature and continuous need for blood glucose testing and monitoring in veterans with diabetes, it is imperative that they are properly trained and technically proficient with the supplies and equipment they use. Our concerns fall into three categories:

1. Retraining Veterans and Compliance

There are serious medical implications for attempting to standardize the purchasing process for blood glucose products, as it would require the retraining of up to 500,000 veterans (most of whom are elderly). If vulnerable veterans believe that their diabetes equipment has changed, continuity of successfully managing diabetes and preventing its complications is threatened. That is, if veterans are unable to obtain supplies that they are familiar and comfortable with, they are less likely to continue with a particular treatment regimen. Some products and technologies are better suited for some patients than others. For example, a veteran with poor vision needs a glucose monitor with oversized readout or even audio readout.

2. Impact on VA Nurses

Additionally, this retraining extends well beyond the patient. A national standardization policy of diabetes monitoring equipment and supplies would also create the onerous task of retraining nursing staff to utilize one set of products over another. Diabetes educators working for the VA health care system emphatically believe that such a change in the current standardization policy of blood glucose monitoring technologies will place an impossible goal on them to retrain so many veterans. (For the record, we have attached a petition signed by the leading diabetes educators of 16 VISNs in opposition to further standardization of blood glucose monitoring supplies and equipment). The Congress and the VA must both understand that diabetes educators perform a variety of services and functions beyond training veterans to monitor their blood glucose levels. Such a change in policy will greatly deteriorate their ability to provide other important activities, including nutrition and physical education classes, home visits, and provider/practitioner training.

Unlike the Medicare and Medicaid systems, because the VA is not only the purchaser, but also the provider of health care equipment, the responsibility and costs associated with retraining diabetes educators, nursing staff, and physicians on new technologies lies solely with the VA. While in the past, manufacturers of blood glucose technologies have assumed many of the costs associated with a transfer from one technology to another, retraining has proven to be a

time-consuming endeavor ultimately born by the VA. The costs for the VA system are so enormous in moving to a national policy that this option is unwise.

3. Future Innovation Hindered

Standardization will grant quasi-monopoly status to the vendor and hinder future innovation for patients. As noted above, some products and technologies are better suited for some patients than others. A single national award for a non-commodity item removes the incentive to make beneficial improvements and replace patient's outdated devices.

CONCLUSION

For the reasons outlined above, we believe it is in the best interest of veterans to halt further standardization of blood glucose monitoring supplies and equipment. This necessary monitoring equipment has already been standardized at the VISN level, and provides a fair and balanced approach toward achieving cost savings without risking patient's choice and quality of care. We appreciate the attempts, and numerous successes, of the Department of Veterans Affairs to strengthen the national veteran health care system. However, we encourage Congress and the VA to consider utilizing the current system of selecting diabetes equipment and supplies as a model for other medical device technologies impacting a large veteran patient population.

Diabetes is the main cause of kidney failure and new onset blindness in adults and a major cause of heart disease, limb and digit amputation and stroke. Diabetes costs the nation about $100 billion each year. The unintended consequences of a drop off in blood glucose monitoring and compliance are too great to proceed toward a single national award for these products.

Statement of Joseph Forney

My name is Joseph Forney, I am a Service Disabled Veteran Small Business owner (SDVOSB) from the state of California.

I would like to thank Congressman Simpson and the other members of this committee for holding this hearing today.
I would like to submit my written testimony for the record, and then share with the committee my experiences and concerns regarding the 3% procurement goal for participation by Service-Disabled Veteran-owned small-business concerns in Federal contracting and subcontracting.

Public Law 106-50, (The Veterans Entrepreneurship and Small Business Act of 1999) was signed into law, 17 August 1999, by former President Clinton. The bill, H.R.1568, authored by Congressman Jim Talent had 57 co-sponsors and passed both bodies of Congress unanimously.

According to the Federal Procurement Data Center (FPDC), 29 out of 50 federal agencies reported spending "0" dollars with Service Disabled Veteran owned Small Businesses. Two of these agencies, the U.S. Small Business Administration (SBA) and the Department of Labor, are among the very agencies specifically charged with fostering federal procurement opportunities for SDVOSBs per P.L. 106-50. In stark contrast to these Agencies' failed programs for SDVOSBs, they exceeded procurement goals for other targeted groups.

Another agency that stands out, the Department of Defense, the agency responsible for the creation of Disabled Veterans, reported spending less than 2/10 of 1 percent since the law was passed. The other and perhaps the most egregious statistic is the fact that the Department of Veterans Affairs, the agency charged with the care and well-being of Veterans, reported spending less than 0.25 percent. One other notable Federal entity that reported "0" participation was the Office of the President.

The inability to meet these modest procurement goals clearly shows that this committee needs to take immediate and decisive action.
If the commander-in-chief (Office of the Presidency), Small Business (SBA), and the Department of Labor, after nearly four years report that

all of their efforts have resulted in "0" procurement dollars spent with Service Disabled Veterans, more enforceable legislation is warranted immediately.

Procedures are needed to insure that Veterans rehabilitation programs will be enforced. To illustrate this lack of inclusion by eligible Veterans, in 2002, Lockheed-Martin was awarded the contract to build the F-35 Joint Strike Fighter, valued at $285 Billion and not one dollar was designated for subcontracting with SDVOSBs.

Today, thousands of America's finest men and women are massing on the Iraqi border for a potential armed conflict. Many more Americans in uniform are still patrolling areas across the world, bringing to justice those who have, and would, do great harm to all of America.

I respectfully request that this committee be the vehicle and catalyst for ensuring that the Federal Government realigns its priorities when seeking to render procurement and small business assistance to Veteran small business owners. It is time to correct this error. Mr. Chairman, I would like to again thank the committee for this opportunity to speak, and I stand ready for any questions that you and your colleagues may have for me.

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