

LEGISLATIVE HEARING ON H.R. 3497, H.R. 4245,
A DRAFT BILL REGARDING PURCHASE CARD
MISUSE, AND A DRAFT BILL REGARDING THE
MEDICAL SURGICAL PRIME VENDOR PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND
INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
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LEGISLATIVE HEARING ON H.R. 3497, H.R. 4245, A DRAFT BILL REGARDING PURCHASE CARD MISUSE, AND A DRAFT BILL REGARDING THE MEDICAL SURGICAL PRIME VENDOR PROGRAM

Wednesday, March 7, 2018

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON DISABILITY ASSISTANCE
AND MEMORIAL AFFAIRS,
Washington, D.C.

The Subcommittee met, pursuant to notice, at 2:02 p.m., in Room 334, Cannon House Office Building, Hon. Jack Bergman, [Chairman of the Subcommittee] presiding.

Present: Representatives Bergman, Dunn, Arrington, Kuster, Rice, Peters, and Walz.

Also Present: Representative McMorris Rodgers.

OPENING STATEMENT OF JACK BERGMAN, CHAIRMAN

Mr. BERGMAN. Good afternoon. This hearing will come to order. I want to welcome everyone to today's legislative hearing on H.R. 3497, H.R. 4245, a draft bill entitled the Veterans Affairs Purchase Card Misuse Mitigation Act, and a draft bill requiring the Secretary to carry out the Medical Surgical Prime Vendor program using multiple prime vendors.

Before we begin, I would like to ask unanimous consent for our colleague Conference Chair Cathy McMorris Rodgers to sit on the dais and participate in these proceedings when she arrives.

Also, the Veterans of Foreign Wars has informed us that they will provide a statement regarding the hearing, so I ask unanimous consent that it be entered into the record.

Without objection, so ordered.

Mr. BERGMAN. I am also happy to welcome Ranking Member Walz as an ex officio Member of the Subcommittee. Glad you are with us.

Our first two pieces of legislation this afternoon relate to VA's Electronic Health Records Modernization Program. Mrs. McMorris Rodgers will present her legislation, H.R. 3497, upon her arrival.

First, I would like to briefly discuss a bill that I am proud to sponsor with Chairman Roe, as well as Ranking Members Walz and Kuster, H.R. 4245, the Veterans Electronic Health Record Modernization Oversight Act of 2017.

The EHRM program is a potential game changer for VA. If carried out successfully, VA and DoD can finally achieve a seamless lifetime medical record, eliminate the need to fax records back and forth with community providers, and break the ruinous cycle where legacy systems cost of maintenance consumes nearly the entire IT budget.

EHRM is as transformational as it is big and expensive, and Congress needs to keep a watchful eye on it. H.R. 4245 requires VA to provide us with key contracting documents and those that indicate the program's health. It also requires VA to notify Congress of any significant schedule slip, cost increase, loss of data, privacy breach, or other adverse contractual event. Finally, it ensures that my colleagues and I get the information we actually need in a timely fashion, while not directing the VA to spend time and money producing unnecessary reports or duplicative documentation.

Next, I intend to sponsor the Veterans Affairs Purchase Card Misuse Mitigation Act, which is currently in draft form with Miss Rice, Mr. Bost, and Dr. Dunn. This will would require the Secretary to revoke the purchase card or purchase card approval authority for any employee who is found to have knowingly misused the purchase card.

Huge sums of money flow through purchase cards in the VA, about \$4 billion a year as of 2015 the last time GAO did a review, and the volume of spending is poised to grow much larger given that the most recent NDAA increased the micro-purchase transaction limit from \$3,500 to \$10,000.

This Committee heard a great deal about purchase card misuse in 2015; huge amounts of unauthorized commitments were alleged. The Inspector General recently completed his definitive report on the matter and found that the real amounts to be much higher than originally thought. Unauthorized commitments estimated at roughly \$520.7 million for prosthetics, including purchases worth \$256.7 million, for which VA may have paid unnecessarily high prices.

While most of the purchases were necessary supplies that were delivered, we will never know how much money was wasted because a lack of documentation makes drawing firm conclusions frustratingly difficult.

VA tightened its internal controls in response, but we still hear of troubling incidents. The Inspector General recently found widespread split purchasing in the New Jersey Health Care System, more concentrated splitting in VISN 15, and unauthorized commitments and subterfuge about the destruction of records at the VA contracting office in the Bronx.

A few weeks ago, the Office of Special Counsel revealed an apparent scheme by two employees at the Bedford, Massachusetts Medical Center to enrich a family member through purchase card orders. And this very morning the IG released his final report on the Washington, DC Medical Center, finding purchase card misuse, among many other distressing incidents of mismanagement. In DC, 151 people held 283 purchase cards.

Most of the purchase card holders are outside the typical chain of command and their usage cannot be properly tracked.

The IG highlighted many examples of gratuitous waste and one example of outright graft, which I would like to point out that the VISN did discover and address.

This bill attempts to head off purchase card misuse as the micro-purchase threshold increases. As soon as a bona fide investigation determines someone has knowingly misused a purchase card, the card is taken away. The Department can pursue the appropriate disciplinary penalty according to existing policies, but in the meantime the potential for future misuse is eliminated. It is as simple as that.

Finally, I intend to sponsor legislation with Mr. Peters, Mr. Banks, and Dr. Dunn to direct the Secretary to continue carrying out the Medical Surgical Prime Vendor Program using the existing system of regional prime vendors.

At our hearing in December, Committee Members overwhelmingly expressed the view that it would be a mistake for VA to move to a model with one national prime vendor that not only distributes the medical and surgical supplies, but also creates the formulary on VA's behalf and selects the suppliers. I understand VA heard the same message from industry and now does not intend to pursue that model. So I hope to get additional clarity in today's questioning on how the VA still opposes this bill; however, I will defer to my colleagues to elaborate on the draft legislation.

I now yield to Ranking Member Kuster for any opening statement and remarks on today's legislation she may have.

OPENING STATEMENT OF ANN KUSTER, RANKING MEMBER

Ms. KUSTER. Thank you, Chairman Bergman, for holding this hearing, and I would like to welcome Ranking Member Walz and, when she arrives, our esteemed colleague Congresswoman McMorris Rodgers, here to advocate on behalf of the bipartisan legislation that we have before us.

I also want to welcome our witnesses, who are here to provide thoughtful testimony on how we might improve the legislation to ensure that it has the intended effect, which is helping to improve the Veterans Administration and the lives of veterans.

I am proud of the bipartisan oversight and legislative work that we do on this Committee. This Subcommittee serves as a model for how Congress should work, and I should say our Full Committee serves as a model.

Before I turn my remarks on the four bills we have on the agenda today, I do want to take a moment to address the IG report that was released just this morning on the DC VMAC, Washington, DC, and Secretary Shulkin's announcement this morning that VISNs 1, which is New England, 5, which is DC, and 22, the Desert Pacific Health Care Network, will be placed into receivership and Brigadier General Gamble will oversee their restructuring.

This is a critical moment. For those of us in VISN 1 in New England, we have spent the last year-plus working with Secretary Shulkin and the leadership at the VA on some very troubling, disturbing allegations of mismanagement and veterans that had been harmed, not just in Manchester, New Hampshire, where the VA Health Center that I have been working with and vets that I rep-

resent, but also Bedford, Massachusetts, and our colleague Mr. Poliquin has been involved with Maine.

I know that my colleagues from California have had issues in VISN 22 and the whole Committee is aware of the issues in VISN 5.

The DC IG report found that leadership at the medical center, the VISN, and VA Central Office knew about the supply chain and logistics problems at DC VAMC and did not take appropriate steps. The Desert Pacific network includes the Phoenix VA, where we first learned about the secret waiting list that ultimately led to the Choice Program. And in New England, where my constituents receive care, the hospital director at the Manchester VAMC was removed because significant patient care and facility infrastructure concerns were not addressed.

So I would request that our Oversight and Investigation Committee or the Full Committee hold a hearing on leadership failures at the three networks at VA Central Office and that we continue to provide oversight on the plan being developed for restructuring of these organizations, including, as we will discuss today, the VA procurement investigation.

At least seven Members of our Committee represent districts within these three networks and I am sure that many more of our Members have constituents who receive their care there.

Now, returning to the legislation before us today, we address of-the-moment issues for our Subcommittee. Ranking Member Walz's Veterans Electronic Health Record Modernization Oversight Act will ensure that this Committee receives the information we need to conduct proper oversight of this 10-year, \$16 billion project. I think I speak for all of us when I say we have been advocating for an interoperable electronic health record since we were first elected to Congress. Finally, finally, the solution is in sight.

When Secretary Shulkin signs the contract, and we believe that that will happen this month, veterans will finally have the same health care records as the DoD, a modern electronic health record that will meet their health care needs.

The next challenge will be to ensure the VA stays on schedule with its installation and implementation, stays within the budget, and causes the least amount of disruption to patient care. And I know Dr. Roe, our chair, has been admonishing all of us to understand that this will take time and it will be a transition, but it is important that we minimize the disruption.

Our job here is to keep the VA on track and Ranking Member Walz's bill will give us the tools and the information to do just that.

Chairman Bergman and Congresswoman Rice's draft legislation to address purchase card abuse is also much-needed legislation that I hope this Committee will send to the floor without delay.

Yesterday, I publicly revealed my request to Secretary Shulkin to remove Dr. Mayo-Smith as leader of the VA New England Health Care System and he, Secretary Shulkin, did announce this morning that Dr. Mayo-Smith will retire. The issues our Committee has investigated in Bedford and Manchester demonstrate the need for greater accountability and improved leadership.

Purchase card abuse continues to be an issue and just last month we learned in an Office of Special Counsel report that an employee

at the Bedford, Massachusetts VA medical facility abused a purchase card to buy supplies from a family member's business, as my chair has acknowledged. We also learned that this employee was authorized to use a purchase card even after being disciplined for misuse. This is unacceptable and that employee got what amounted to simply a slap on the wrist.

Employees who misuse purchase cards should be held accountable and should be prevented from being a purchase card holder or authorizing official. This legislation will ensure that taxpayer dollars are protected from purchase card misuse. Employees misusing VA purchase cards cannot be trusted as good stewards of taxpayer dollars and I support the legislation tackling this issue.

And, finally, Congressmen Bergman, our chair of the Subcommittee, and Peters have written legislation to ensure VA fixes its Medical Surgical Prime Vendor formulary.

As we heard from the GAO last November, clinicians who treat veterans should be at the center of the decision-making of which supplies should be included in the formulary. This is not a decision that should be outsourced to vendors who have no experience treating patients. This idea to outsource the formulary development suggested by VA goes against best practices in the private and non-profit health care industry. This legislation should ensure that VA follows best practices and sticks to a timeline, so that VA facilities and vendors have a predictable, functional medical surgical supply system.

Thank you, Chairman Bergman, and I yield back.

Mr. BERGMAN. Thank you, Ranking Member Kuster.

And given the Secretary's announcement today regarding adverse actions against three VISN directors, I would be happy to continue working with the Ranking Member and the rest of the Subcommittee to get answers.

I sent a letter with Ranking Member Kuster last month to the VA, which we have yet to receive a response. So we are going to continue working on that.

We will now hear from Ranking Member Walz, speaking in support of H.R. 4245, the Veterans Electronic Health Record Modernization Oversight Act of 2017.

Ranking Member Walz, you are recognized for 5 minutes.

OPENING STATEMENT OF TIM WALZ

Mr. WALZ. Well, thank you, Chairman. Thank you all for being here, but thank you, Chairman, for the courtesy of speaking on this, and to the Ranking Member.

Before we start, I would like to say I thank you, Chairman, for backing. I fully support Ranking Member Kuster's call for a hearing or whatever is necessary on the leadership failures in New England, Capital Region, and Desert Pacific Regions. I believe Secretary Shulkin has taken the right steps of removal, but we need to exercise our oversight authority, which this Subcommittee has proven up to that task.

We also need to keep pressure on the VA to improve DC VA's supply chain management capabilities. We visited about a year ago following the interim report and pushed for more hiring of logistics and HR staff, cleaning of supply spaces that ensure at least enough

supplies to prevent further delays. I want to know and praise the dedicated workers and providers who did ensure that no patients were harmed despite incompetent leadership and supply chain failures at the hospital. Now the VA must work to ensure that every single one of their 40 recommendations of the IG report are followed through and VA is held accountable.

With that, I appreciate the opportunity to speak on H.R. 4245, the Veterans Electronic Health Record Modernization Act. I, along with the Chairman, the Ranking Member and Chairman Roe of the Full Committee, introduced this to ensure that we continue to exercise one of our most important functions, oversight.

And the Ranking Member was right. I was looking back. In March of 2007, sitting right down here, I made the case of an interoperability between records was absolutely critical. I think every one of us who has come here, matriculated in here has said that, and one of the first things we do of getting there. In June of 2017, and many of us will remember that day, the Secretary answered this call and announced VA's intent to adopt the same EHR currently utilized by Department of Defense. Now Congress and veterans are eager to see the implementation of this new system.

Frankly, the future successful delivery of VA and community-based health care services to veterans really rests on the successful implementation of this record management system. In order to deliver on promises that we have made to veterans in regard to accessibility and quality of care, we must ensure VA has every resource necessary to the development of this new system. However, Congress must be able to track these resources and the impact of their progress. In order to be good stewards of the taxpayer money, we must be able to carry out those oversight duties.

This legislation that we are going to talk about simply requires VA to share documents, plans, reports, and information surrounding the adoption and implementation of the new EHR management system. Additionally, the legislation will require VA to notify Congress quickly if there is any significant adverse event such as a cost increase, schedule delay, or breach of security. That is why I really appreciate the support of H.R. 4245 and its inclusion in today's discussion.

I also appreciate the VA's willingness to continue to work with our office to ensure this legislation is clear, reasonable, effective, and can be implemented the way it needs to be. Our intention is not to micro-manage the implementation of this record. Our intent is, is to make sure on something this big and this costly and this important that there is ownership for everyone; that the VSOs are included, which I am glad to see Lou is at the table, this is going to be critical. And I think the Chairman is exactly right. He brings a wealth of knowledge, he has implemented these in the private sector, having watched a large medical institution like the Mayo Clinic institute an upgrade to a new electronic medical record.

We need to keep expectations high of what we are going to achieve, but realistic in that this is going to take time and there are going to be things along the way that need to be addressed. I think the biggest thing this legislation is, is no surprises, Congress being informed, let us know how things are going, so that we can inform veterans.

So, thank you, Chairman and Ranking Member, and I yield back.
Mr. BERGMAN. Thank you, Ranking Member Walz.

Next we will hear from Miss Rice speaking in support of the draft Veterans Affairs Purchase Card Misuse Mitigation Act.

Miss Rice, you are recognized for 5 minutes.

OPENING STATEMENT OF KATHLEEN RICE

Miss RICE. Thank you, Mr. Chairman.

I would like to thank Chairman Bergman and Ranking Member Kuster for including the draft bill regarding purchase card misuse on today's legislative hearing agenda for the Subcommittee on Oversight and Investigations. I would also like to thank all of the witnesses who are here today for your testimony and for sharing your views on the draft legislation.

I appreciate the opportunity to join Chairman Bergman in introducing this important piece of legislation as the lead Democratic sponsor. This bill would prohibit employees at the Department of Veterans Affairs who are found to have knowingly misused VA purchase cards from serving as purchase card holders or approving officials. I believe this legislation is necessary to prevent any future misuse of purchase cards and will provide greater accountability within the VA.

Now, in May of 2015, this Subcommittee held a hearing on waste, fraud, and abuse in the VA's purchase card program, during which alarming testimony was presented about a lack of internal controls at VA that had led to misuse of taxpayer funds through the purchase card program. During the hearing, former Subcommittee Chairman Coffman and I requested that the VA Office of Inspector General review allegations of unauthorized commitments at a VA facility in my home state, New York, in the Bronx.

In reviewing these allegations, the VA OIG determined that the purchase card program manager erroneously reported approximately \$54.4 million of contract purchases in fiscal year 2011 and 2012, because the contract manager did not provide oversight or ensure proper implementation of the required Federal procurement data system reporting.

VA OIG also identified 11 unauthorized commitments totaling about \$457,000 in improper payments for prosthetic purchases that exceeded the warrants of the purchasers.

Purchase card misuse continues to be a problem at VA facilities. In late January of this year, the Office of the Special Counsel released a report finding that a VA employee at a medical center in Massachusetts had misused a purchase card to make nearly \$1 million in improper purchases. Recent examples such as this reveal a need for legislation that will support effective oversight of the purchase card program and help to increase accountability at the VA.

I thank Chairman Bergman for his leadership on this bill to address such cases of purchase card misuse that harm the public trust that VA is properly executing its duties. As Members of the Committee on Veterans Affairs, it is our responsibility to take allegations of waste, fraud, and abuse seriously, and ensure that taxpayer funds are not misused to the detriment of our Nation's veterans.

Thank you, Mr. Chairman, and I yield back.

Mr. BERGMAN. Thank you, Miss Rice.

Now we will hear from Mr. Peters, speaking in support of the draft medical surgical prime vendor legislation.

Mr. Peters, you are recognized for 5 minutes.

OPENING STATEMENT OF SCOTT PETERS

Mr. PETERS. Thank you very much, Mr. Chairman, and thanks to Ranking Member Kuster. And thanks also to Mr. Banks in particular for working with me to improve the Medical Surgical Prime Vendor Program, including the bill we are considering today.

Last November, Mr. Banks and I hosted a successful roundtable with the VA and medical device companies to get feedback on the MSPV Program. We kicked off a good discussion and today we are continuing the conversation to help this program on track with all stakeholders at the table.

This bill will require the VA to award contracts to at least two regional prime vendors for medical supplies, a great first step to improve the MSPV Program by fostering transparency and creating competition to drive prices down. It is also critical that we have doctors, nurses, and other medical professionals advising us on which supplies and devices are needed to create a formulary, so the VA can provide proper care. Ultimately, we want to help the VA to be a better business partner; we know it wants to be a better business partner. We want to give veterans the best treatment by ensuring we get the right people at the table to make these clinical decisions.

I look forward to working on this bill with my colleagues and for further discussions. And, with that, Mr. Chairman, I yield back.

Mr. BERGMAN. Thank you, Mr. Peters.

Well, Mrs. McMorris Rodgers is en route, but since she is not here yet, what we will do is we are going to start. I will do the introduction of the panel and then we will see if she shows up by that time, but the point is, when she arrives, we will stop what we are doing at that point and hear from her.

So, you know, at this point I would like to now welcome the Members of our panel who are seated at the witness table. With us today from VA we have Mr. Fred Mingo, Director of Program Control for the Electronic Health Record Modernization Program. He is accompanied by Mr. Ricky Lemmon, who is the Acting Deputy Chief Procurement Officer for the Veterans Health Administration.

He is also accompanied by Ms. Katrina Tuisamatatele—I think I got close—and her role is the Health Portfolio Director for the Office of Information and Technology.

Also accompanying Mr. Mingo is Mr. John Adams, Director of corporate Travel in the Office of Management, seated back there.

And also on the panel we have Mr. Louis Celli, Director of the Veterans Affairs & Rehabilitation Division at The American Legion. Finally, we have Mr. Scott Denniston, the Executive Director of the National Veterans Small Business Coalition.

Mr. Mingo, you are recognized for 5 minutes.

STATEMENT OF FRED MINGO

Mr. MINGO. Good afternoon, Chairman. Chairman Bergman, Ranking Member Kuster, and Members of the Committee, thank you for this opportunity to present VA's views on pending bills before the Committee.

Joining me today are Ms. Katrina Tuisamatatele, OIT; Mr. John Adams, OM; Mr. Ricky Lemmon, VHA; who can speak more specifically about legislation in their area.

The intent of H.R. 3497 is to provide veterans access to their personal medical history, enabling them to share their medical records with VA and community providers. This legislation directs the Secretary to carry out a pilot program establishing a secure, portable medical records storage device. VA does not support this legislation due to a number of challenges.

First, doctors have been reluctant to accept plug-in electronic devices from patients because of network security and compatibility issues with electronic health records. Second, even with a portable storage device, veterans may not receive a copy of their most current medical record. Depending upon when files are loaded into the device, it may not represent the complete health record, including important doctor's notes or test results ordered from a previous visit.

Lastly, this legislation would take resources away from the VA's current efforts to establish a single electronic health record that is interoperable with DoD and community providers.

VA supports providing veterans access to their medical records and data, and believes that this legislation would not achieve that outcome.

H.R. 4245 requires the VA to submit several project management documents related to the Electronic Health Record Modernization Program. VA supports this legislation and believes transparency is important to the success of the EHRM Program. The EHRM Program Executive Office would like to work with the Committee to develop a mutually agreeable timeline to brief staff on these project management documents. We are committed to providing quality and accurate project management documents to the Committee.

The draft purchase card bill directs the Secretary to prohibit employees found to have knowingly misused a VA purchase card from further serving as a purchase card holder or approving authority. VA supports the draft bill, as it would enhance the Department's efforts to reduce potential fraud, waste, and abuse with the VA charge card program. In addition, it would reduce charge card misuse and minimize costly reconciliation when unauthorized commitments are identified.

VA believes this legislation will support sound charge card program oversight and encourage appropriate staff to strictly adhere to purchasing requirements as outlined in VA financial policy.

Lastly, the draft Medical Surgical Prime Vendor bill would statutorily define the structure of VA's MSPV Program and the number of items provided in its formulary. VA opposes this bill for a number of reasons.

First, Congress has already provided and the Federal Acquisition Regulation has already implemented suitable tools for VA to make sound business decisions in developing the MSPV Program. Sec-

only, agencies are required to conduct market research as part of their acquisition-planning efforts. VA has a further requirement to conduct additional market research to fulfill our mandate under the Veterans First Contracting Program. This market research enables VA to structure acquisitions appropriately based on the number and types of vendors available, the geographic areas they serve, and the need to ensure supply chain availability.

The current MSPV structure is based on a judgment call to apply the criteria provided by Congress and the FAR Council. Legislation that stipulates the MSPV structure eliminates VA's ability to change and develop according to market conditions. Also, legislating the number of formulary items to be contracted within arbitrary timeframes could have unintended consequences.

Mr. Chairman, this concludes my opening statement. We are happy to answer any questions from you or Members of the Committee.

Thank you.

[THE PREPARED STATEMENT OF FRED MINGO IN THE APPENDIX]

Mr. BERGMAN. Thank you, Mr. Mingo.

And we will now hear from Mrs. McMorris Rodgers, who has just joined us, speaking in support of H.R. 3497, the Modernization of Medical Records Access for Veterans Act of 2017.

Mrs. McMorris Rodgers, you are recognized for 5 minutes.

OPENING STATEMENT OF CATHY MCMORRIS RODGERS

Mrs. MCMORRIS RODGERS. Thank you, Chairman. I appreciate you making the time.

I was on my way over and I was reading "Political Playbook," the Stars and Stripes article about what was just uncovered at the Department of Veterans Affairs here in DC, but what really caught my eye was it talks about more than 1300 boxes containing veterans' personal health and identification information were found unsecured in a warehouse, the hospital basement in a trash bin, according to the report. Millions of dollars were spent without the controls to determine whether the expenses were necessary.

So I want to just start by thanking the Chairman and thank the Ranking Member for holding this important hearing to address a fundamental need that we have within the VA for comprehensive medical records for the veterans. Every day, I hear from veterans in Eastern Washington who are in desperate need for help, and yet so often they feel like when they contact the VA that they are more of a burden than actually having the red carpet rolled out to them.

And sometimes I hear this especially as it relates to obtaining as simple as your mere medical record. I have even heard from providers in the community that I represent who have been frustrated to the point of tears because they are unable to treat veterans because the patient cannot obtain their own medical records. Some veterans have waited more than 2 years to simply get their medical records from the VA.

So this legislation that is before you and I ask for your consideration is simply provides a commonsense, off-the-shelf, bipartisan solution to the problem. It is a pilot project and it directs the Secretary of VA to establish a secure, patient-centered, portable med-

ical records system that would allow veterans to have access to their own comprehensive medical records.

As with most things in the VA, this is not an issue where the wheel must be reinvented, this technology already exists in the private sector. For example, VYRTY. Now, they are a company based out of Washington State, but they have developed a secure, offline data repository with end-to-end encryption and remote record completion.

We have discussed the security concerns that some may have in conversations with the VA Office of Information and Technology, and this Committee, and while these concerns would be valid in other scenarios, the technology that exists and that is in use today is secure and is HIPAA-compliant. It is compatible across all electronic health care systems, including Cerner, and is encrypted end-to-end.

The fact is, it is in use today and it does not make doctors resistant to accepting plug-in electronic devices from patients.

With the technology that is currently deployed, patients have a current copy, the most up-to-date version of their medical records. It is as simple as putting it on a chip that is then portable. Specifically, one of the most important aspects of VYRTY's technology is that they perform record completion. When a patient leaves his or her provider, they are leaving with the most up-to-date medical record information; it is updated immediately.

While the VA Department gives veterans access to the Blue Button Initiative through My Healthy Vet, this puts the burden on the veteran to be responsible for downloading, printing, and bringing their most up-to-date record to their doctor. With VYRTY's technology, the veteran and the provider all have the information on a chip for easy access.

There have also been concerns raised about the Application Performing Interfaces regulations put forth by Health and Human Services. First of all, the VA is not regulated by HHS and VYRTY's technology is already in use today; therefore, it is already up to date and in line with current regulations. It has the capability to be integrated directly and is already supporting direct data feeds in their deployments.

I am disappointed that the VA has chosen to oppose this legislation, that they have chosen to focus on the challenges rather than the opportunity here to offer our veterans high-quality care. Will there be challenges? Yes. But you know what? That shouldn't stop us. It hasn't stopped Americans in the past and it shouldn't stop us today.

My staff and I have held several meetings with the VA's Office of Information and Technology where legislation was discussed, where VYRTY was brought in to demonstrate their technology, and where draft legislation was sent to the VA before introduction for comments and concerns. Additionally, we have in writing that the Office of Information and Technology was supportive of this legislation. In the VA's words, "This looks good to us."

What this bill is proposing is a simple, commonsense, off-the-shelf, readily available solution to a persistent problem. And while I am pleased that the Secretary is serious about modernization of

the EHR system, their approach, not only is the VA Cerner contract currently paused, the implementation period is 10 years.

Since I came to Congress in 2005, the budget for VA has doubled twice, has nearly tripled. It went from 40 to 80 billion, and now 80 billion to 160 billion. The VA has one mission, to serve our veterans, and I fear too often that the veteran is getting lost in all of this and we make it too difficult for them.

So, I thank you for your consideration of this legislation and I just ask that the remainder of my statement be read into the record.

Thank you.

Mr. BERGMAN. Without objection, so ordered.

Thank you, Mrs. McMorris Rodgers.

Next, we are going to hear from Mr. Celli. You are now recognized for 5 minutes.

STATEMENT OF LOUIS CELLI, JR.

Mr. CELLI. The American Legion is proud to offer our position on the four bills being considered today and I will briefly touch on them before I move toward a discussion on the future of the electronic health care records project that ties all of these bills together.

Chairman Bergman, Ranking Member Kuster, and distinguished, dedicated defenders of veterans who proudly serve on this Committee, and on behalf of Denise Rohan, the National Commander of the largest Veterans Service Organization in the United States of America, representing more than two million dues-paying members, and combined with our American Legion family, whose numbers exceed three and a half million voters living in every state and territory in America, it is my duty and honor to present the The American Legion's position on the bills being discussed here today.

The American Legion is unable to support the purchase card draft legislation that congressionally directs VA employee behavior and discipline. We expect the Department to enforce and follow the statute and policies that are currently in place when employees misuse their authority and knowingly put taxpayer dollars at risk. We fully expect the VA to make management decisions and use their staff in a manner that is in keeping with prudent and judicious behavior. And when that behavior breaks down, we look to the VA to use the authority that this Congress has already given the Secretary to hold employees and managers accountable.

We do support the other draft legislation being discussed today that would direct VA to compete prime vendor contracts, because we believe that it will assist VA with ensuring that more prime vendor contracts go to veteran-owned firms. The Department of Veterans Affairs serves veterans and veterans should be given first right of refusal serving their community, provided that the services are on the same or greater quality and that the price is competitive. This theme guides all of The American Legion's policy recommendations regarding VA contracting programs.

I will dedicate the remainder of my time to discussing the VA Electronic Health Care Record Program and the bills that address modernizing VA's primary IT infrastructure program.

The American Legion is unable to support H.R. 3497, the Modernization of Medical Records Access for Veterans Act of 2017, not because we believe that the goal is off-base, but because we believe that this and so much more is already incorporated into the pending EHR contract that the Department is getting ready to memorialize with the Cerner Corporation. As such, The American Legion supports H.R. 5254, but only insofar as it applies to the Cerner agreement and deployment of that EHR program.

The contract that the VA has negotiated with Cerner Corporation will fundamentally change the course of American medical history by providing Government standards for electronic health record communication and transferability, health maintenance, patient access, supply chain management, consults, follow-ups, and much, much more.

The Department of Veterans Affairs and the Department of Defense are setting the stage for governmental interoperability that is poised to eventually become the national standard. Almost everything VA does from this point forward will affect and be affected by this platform, and replacing VISTA and AHLTA are just the beginning.

From here on out, this Committee, as well as the Senate Committee on Veterans Affairs and the House and Senate Armed Services Committee, are going to have to work together to ensure that uniformed American servicemembers and their families are not only provided with a safe and effective transition from DoD to post-service medical care, but that their access to care at VA and in the community are all well-coordinated.

This is the direction that the Committee has directed VA to take. It is long overdue, and this is the direction that the American Legion champions, and this is the project that Secretary Shulkin has led, and is leading to completion.

We, the veteran community and this Committee, are at a critical juncture in time. We have a secretary who is under fire by ideologues who oppose progress, and a Congress, and a community that supports and appreciates the work that he has done on behalf of more than 20 million veterans. Now is not the time to be silent, and I just hope that all—and now is not the time to be silent and just hope it all works out okay.

Now is the time to step up, now is the time to be heard, and now is the time to join the Secretary and be part of this historic change at the Department of Veterans Affairs and set the stage for the largest modernization of medical coordination in American history. Thank you, and I look forward to answering any questions that you may have.

[THE PREPARED STATEMENT OF LOUIS CELLI, JR. APPEARS IN THE APPENDIX]

Mr. BERGMAN. Thank you, Mr. Celli.

Mr. Denniston, you are now recognized for five minutes.

STATEMENT OF SCOTT DENNISTON

Mr. DENNISTON. Good afternoon, Chairman Bergman, Ranking Member Kuster, and distinguished Members of this Subcommittee. On behalf of the members of the National Veterans Small Business

Coalition, I sincerely appreciate the opportunity to discuss the proposed pieces of legislation.

The National Veterans Small Business Coalition is the largest non-profit trade association representing veterans and service-disabled vets in the Federal marketplace as prime and subcontractors. And I request that my remarks and the attachments be made part of the record.

I would like to first address H.R. 3497 and H.R. 4245 dealing with the veteran electronic health records. We believe H.R. 3497 to allow veterans to use a portable medical record storage system is good news for veterans as it allows easier access to their own personal health records. H.R. 4245 appears to address Congress' concerns about the Secretary's announcement of the award to Cerner Corporation for the new electronic health care record.

Our concern with this contract is that the VA is taking a very minimalistic approach to providing subcontracting opportunities for small businesses, including veteran and service-disabled vet small businesses. VA is only requiring the awardee to meet a minimum goal of 17 percent of subcontracting to small business, 5 percent to service-disabled vets, and 7 percent to veterans.

And we know historically that information technology contracts generally provide greater opportunity for subcontracting to small business. As an example, the 2018 goals that the SBA has established with the Department of Defense for subcontracting is 33 percent; Department of Energy, 42 percent; Department of Homeland Security, 40 percent. So we think the VA can do a lot more than what they are proposing.

Also, over the past ten years, the VA has never once achieved its subcontracting goals and negotiated with the Small Business Administration. Given VA's poor track record and the lower goals accepted for this contract, we implore this Committee to include in H.R. 4245 a provision requiring the Secretary of Veterans Affairs to report to Congress on a quarterly basis the accomplishments against the small business subcontracting goal to include subcontract awards to veteran and service-disabled vet businesses.

Next, I would like to address the draft bill regarding employees found to knowingly misuse VA purchase cards. We are in support of the draft. Abuses of purchase card has been widespread, and we think this trend will only continue given the fact that micro-purchase level is being raised from \$3,500 to \$10,000. But we have also found that many times these issues arise due to poorly written policies and training on the part of the VA acquisition leadership, not because of VA employees are dishonest people. So we think that that needs to be addressed as well.

The last draft bill you asked me to discuss directs the VA Secretary to carry out Medical Surgical Prime Vendor Program using multiple prime vendors. Before addressing the specifics of the draft, I want to share with you our observations having lived the current prime vendor program for the past two years in numerous meetings with both Veterans Health Administration and Strategic Acquisition Center leadership.

The current program is being driven for contracting expediency not based on clinical input to improve veteran patient care. There is little to no clinical input, in our opinion. VHA and the SAC ap-

pear to work on conflicting timeframes, there is no strategic plan, determining who is in charge is almost impossible, and rules of engagement appear to change on a weekly basis.

In the Fall of 2017 when we learned that the SAC intended under MSPV 2.0 to award one contract for one prime vendor, we asked what was the position that service-disabled vets were going to play, and were told you are going to be subcontractors.

Again, given the VA's responsibility—or accomplishments in the last ten years when we asked, well, what is going to change, and the VA response to us was, you just have to trust us. Well, we do not trust VA. We do not trust VA to do what is right for service-disabled vets when it comes time for subcontracting. We also think that this is the way VA wants to get around having to deal with the SBA non-manufacturer waiver, which I know that this Committee is aware of.

So we have a number of issues with that. Back in October, this Committee had a roundtable and invited a number of groups to participate. And we provided the Committee eight specific recommendations in a letter, and we think that those are still very appropriate.

But one of the things that I do want to mention in the last 30 seconds that I have, is that to show that service-disabled vets can be part of the solution as opposed to the problem—the way that we know that VA looks at service-disabled vets now—we, the National Veterans Small Business Coalition in conjunction with one of our members, Veratics of Florida, is in the process of developing, for the VA's use, an online ordering platform, very similar to Amazon, for medical products all from verified CVE small businesses so that we are going to be able to give the VA a platform that will allow them to buy medical products under the micro-purchase threshold from service-disabled vets at prices much less than they are buying from the prime vendors in the current process. Thank you.

[THE PREPARED STATEMENT OF SCOTT DENNISTON APPEARS IN THE APPENDIX]

Mr. BERGMAN. Thank you, Mr. Denniston.

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

Ranking Member Kuster, you are recognized for five minutes.

Ms. KUSTER. Thank you very much, Chairman Bergman, and I appreciate all the testimony. I am going to start, you were talking—the VA was talking about the Blue Button Initiative for pre-existing program where veterans are able to access, download, and print their own medical records. How does the VA balance the benefit of access to the medical records through the Blue Button Initiative against the costs of lessened security that can result?

Mr. MINGO. Thank you for the question. I will make a comment first because I am a veteran, I downloaded the blue button, my record, and that is how I was really only able to solve my access to my record when I was treated out in town in a Choice related program.

Specifically for that contract, though, and that question, I would like to turn it over to my colleague,

Ms. Katrina Tuisamatatle, who will talk on that area.

Ms. TUISAMATATELE. Can you please repeat the last part of your question regarding security? I did not quite catch that.

Ms. KUSTER. Well, my question is just how do you balance the security concerns with the simplicity and the access?

Ms. TUISAMATATELE. So we meet all of the—we have to go through a rigorous process to meet the security requirements. Not only HIPPA but PII, PHI, and we make sure that those are—we have security teams that actually come out before we give an authority to operate. So for every single product we have, we go through that process. It is you do not get an authority to operate unless you have gone through and made sure that those security measures are met.

Ms. KUSTER. Great. Thank you very much.

Ms. TUISAMATATELE. Thank you.

Ms. KUSTER. This is, again, for the VA on H.R. 4245, again about the veterans electronic health care record modernization. Why do you believe that the deadlines and verbiage in H.R. 4245 should be altered? And, should we incorporate your proposed deadlines, how confident are you that the VA will fully comply with the legislation?

Mr. MINGO. Thank you. We were establishing the program office now for oversight of the actual contract. We have negotiated with Cerner for our contract, we have spent a lot of time in that area. We know these are typical documents that we will put in place to manage a large project. They actually take a lot of time and they take coordination with the Cerner Corporation as well with some of what we are doing in those oversight documents.

This is a large-scoped project. When the Secretary signed the determination and finding, and announced it back in June, at that phase where we would start negotiating with a vendor, a lot of these documents would have already been prepared, and they would have taken time.

When that document—when that was announced, there were four of us in VHA and two in OIT that knew that news was coming. There is a lot of people that we need to put in place, and structure, and on organization to put in place to implement and oversee this program. It just takes us time to pull those together.

Ms. KUSTER. So if we were to incorporate your deadlines, your proposed deadlines, how confident are you that the VA will fully comply?

Mr. MINGO. I am very confident that we would be able to meet those. And some we will have ahead of time, others we would have that are going to just take longer. There is a lot of documents (indiscernible).

Ms. KUSTER. And back to the American Legion. On this same bill, your testimony conveys general opposition to legislation that might impact VA's current efforts to adopt the Cerner electronic health record. Do you have any concerns specific to this bill that we should be keeping in mind if it advances to markup?

Mr. CELLI. So the first thing is we, you know, we completely support the Cerner project. We have been out there to the facility, we have seen an example of how this software can be deployed, we have seen all the different variables of how it can be enhanced.

And we just believe that anything that this Committee does going forward has to take that project in mind.

And as far as timelines go, we absolutely support making sure that VA meet with this Committee on a regular basis to ensure that they are meeting benchmarks and timelines. And if something goes awry, Congress needs to be the first ones to know.

But we also believe that you should be working very closely with VA as you are doing now to ensure that they can meet the timelines that you are asking them to meet. And if they cannot, they need to be able to provide a cogent reason as to why they cannot meet those timelines, and what the timelines should be. Just as you are doing today.

Ms. KUSTER. So my time is up. If anyone else wants to comment on that, we can take it for the record. Thank you. I yield back.

Mr. BERGMAN. Thank you.

Dr. Dunn, you are recognized for five minutes.

Mr. DUNN. Thank you very much, General. And thank you very much for letting me be part of this hearing today, and I want to thank all the witnesses who are here testifying as well.

I would emphasize my support for the purchase card draft bill and the Medical Surgical Prime Vendor draft bill. The purchase card misuse has been a chronic issue with the VA for years, and no one has been held accountable for this misfeasance.

This draft codifies the prohibition of abusing purchases on the—at the expense of the tax payers. Similarly, the Medical Surgical Prime Vendor draft bill keeps the department on track by fixing the current model and ensuring that the current medical formularies are broadened to better serve the patients.

So, Mr. Lemmon, I understand the VA is very close to hiring a permanent director to run the MSPV program. Do you have anything to announce today on that, such as when this person might begin work, and what their qualifications are?

Mr. LEMMON. I do not. We have not hired the person as of today.

Mr. DUNN. Can you share the qualifications for the kind of things you are looking for?

Mr. LEMMON. Well, we are certainly looking for someone that has a background working with clinicians, and doing value analysis, and sourcing clinical products. And my understanding is there are some good applicants. I think we will be able to make a selection on that, but we have not hired the person.

Mr. DUNN. Can you speculate on the timeline?

Mr. LEMMON. I think it will be soon.

Mr. DUNN. Soon. Okay. Thank you. Also, the industry has expressed frustration that the VA only selects a single supplier for each category of medical or surgical supply, and the regulations clearly allow you to select more than one, multiple vendors. Can you explain what the decision—on what basis the decision was made to select—choose a single supplier for each line?

Mr. LEMMON. Well, I believe that goes kind of to the contracting rules, but there are ways to work within the system to select more than one supplier. We try to utilize ordering officers in the facilities so that they can very efficiently order products and services without re-competing the items on a task order level. But there are

ways to address that and still award—make awards with multiple suppliers, and that is the direction we plan to use going forward.

Mr. DUNN. In general, by having multiple suppliers, you get them to compete against each other on price. And I am concerned that you might not be getting that value added if you just have a single supplier. Is that fair?

Mr. LEMMON. Well, I think you want to get the most competitive and the best—drive the best bargain you can when you award the contracts with your suppliers. And then have a system where ordering officers can order very efficiently as the hospitals need the items without running a second round of competition between multiple award—

Mr. DUNN. All right. Pardon me. Sure the competition was in there. Also, we spoke here several months ago, I think it was in December, about items that get into the supply chain that are in the grey zone. All right. So they are not necessarily OEM, and they may not even be authorized OEM parts, and whatnot. We thought we talked about a letter authorization being provided by the distributors from the OEM. Have we taken any actions on that?

Mr. LEMMON. We have. We do have policy on that, and we are strengthening it, and providing guidance to our contracting officers to require distributors that are not manufacturers to prove that they are an authorized distributor of the manufacturer to eliminate the possibility of grey market.

Mr. DUNN. Can you state for a fact that grey market items are actually getting into the supply chain, or is it just something that we suspect?

Mr. LEMMON. I think there have been a very small number of instances where it has happened, but not on any scale.

Mr. DUNN. Do you have any examples?

Mr. LEMMON. I do not have any prepared, but we probably could come back with a small number.

Mr. DUNN. Let me tell you why I ask that, because, you know, in the world of robotic surgery, there are some after-market suppliers that clearly fit into the grey zone, and that can be a lot of money, those parts. Thank you very much. Mr. Chairman, I yield back.

Mr. BERGMAN. Thank you.

Ms. Rice, you are recognized for five minutes.

Ms. RICE. Thank you, Mr. Chairman. Mr. Celli, if you could just expound a little more on your objections to the purchase card bill.

Mr. CELLI. Thank you for asking me that question. So we are never a fan of layering statute on top of statute to control behavior when the VA already has the authority to hold bad actors accountable. Honestly, I find it a bit offensive that the VA is asking for this legislation when they can do the same thing through policy today.

There is no reason at all that the Secretary cannot say, if you have acted in bad conduct with a purchase card, you are hereby suspended from having a purchase card. Why do they need Congress to tell them that?

So we believe that Congress has been very generous with their oversight, and the legislation that they have provided to VA to hold bad actors accountable, and to remove bad actors from the pro-

gram. I just find it difficult to understand why they need additional legislative authority to do something they can already do.

Ms. RICE. Well, clearly they have not done it, and there is—look, my personal feeling is, you give, you know, 10,000 credit cards out, you get what you get. It is like, you know, I think it is just rife for abuse when you give purchasing authority to that many people.

Mr. CELLI. Well, then we are speaking to—

Ms. RICE. Not just the VA, it is in other places. But, I mean, I would assume that there are maybe, you know, labor issues and stuff like that they may constrain the hands of the Secretary of the VA. I do not know. I mean, maybe some people from the VA can talk about what difficulty there is in terms of holding people accountable who are not just one time abusers of the purchasing authority, but multiple time abusers.

Mr. MINGO. I would like my colleague Mr. John Bergman to talk—John Adams to talk to that, please.

Mr. ADAMS. Thank you for the opportunity to address this. I do not know that I can really speak on any labor issues because that is outside of my purview. But we do have somewhere in the neighborhood of 21,500 cards that are being used in the Department. The annual spend, since 2015, I think you mentioned it was \$4 billion, it is up to \$4.2 billion now. That is somewhere in the neighborhood of 6.6 million transactions annually that we do with purchase cards. I think the record speaks for itself as far as the misuse that you have seen.

You know, I come from a DoD financial management background, I have 30 years in the Marine Corps, 12 of which was overseas. I understand the complexities of making payments in a dynamic environment, especially like in a combat zone.

Still, we were able to find there within that environment ways to do it properly and legally without misusing the tools that were provided to us. So I think it is kind of—I am a bit confused as to how we would not support a bill, coming from the VA perspective, to prevent misuse of the purchase cards.

Ms. RICE. So have you made those suggestions about how you did it and how that was more effective than the way it is being done now, or?

Mr. ADAMS. So I am just coming into this role, I assumed it in January, so we are doing a comprehensive review of the policies around the purchase card, and looking at all the metrics that we currently have regarding the purchase card use.

We are trying to do some analytics around things like spend patterns, and anomalies in spend patterns, and those type of things, and doing perhaps some forensic accounting on the data to find ways to try to help the VA manage its purchase cards, the transactions that are being done with it.

Ms. RICE. Well, when that analysis is done, which I think is a great idea because you obviously have experience in this area, I would love for you to share that with this Committee.

Mr. ADAMS. Certainly. Yes, ma'am.

Ms. RICE. Thank you. I yield back.

Mr. BERGMAN. Mr. Peters, you are recognized for five minutes.

Mr. PETERS. Thank you. I just have a couple questions for Mr. Lemmon, I think. One aspect of the bill we have been discussing

on the MSPV issue, it is not yet in the draft bill, is to require VA employees who conduct formulary analysis or decide which items are going to be included in the formulary have medical expertise that is relevant to those particular items. The concern we hear constantly from the stakeholders is that the wrong people are making medical decisions.

So I just wanted to ask, do you have feelings about the bill language? Have you seen the language? Do you agree? Do you have any objections? Any way you could inform us on that?

Mr. LEMMON. Well, although I support many of the underlying short term objectives in the bill, I oppose legislating it. Now the part regarding involving clinicians in choosing products, I absolutely agree with. And we are working to implement a clinically driven sourcing model with robust structure to assure that product selection is based on clinical decisions.

And so we completely agree with the concept that it should not be contracting people determining what products our doctors should use, it should be the doctors. And we are working very diligently to implement a structure to do that.

Mr. PETERS. So your concern is sort of the maybe the quantitative goals, 20,000 to 33,000 items a year, 30,000 to 50,000 items a year? Okay.

Mr. LEMMON. Yeah. I mean, right now commercial prime vendors they may actually stock 30,000 items in a warehouse. So, you know, to say that we have to contract for 50,000. And, honestly, if you look a few years down the road, if we are successful involving our clinicians like you would like us to, and we would like to, we really think that is going to help reduce the overall formulary from 50,000 potentially to a much smaller number. So I would hate to legislate the actual number of items we should have on contract, that should be driven by clinical need.

Mr. PETERS. Okay. Well, that is helpful, thank you. Mr. Chairman, those are my questions, I yield back.

Mr. BERGMAN. Thank you. I will now yield myself five minutes for questions.

Mr. Mingo, I appreciate you coming to testify about our legislation today. I understand many of your colleagues in the electronic health record modernization program are at the HIMSS conference this week. What an acronym. Secretary Shulkin is delivering the keynote address on Friday. VA has issued a variety of press statements indicating it intends to award the primary contract this month. Do you have any sort of announcement to make, or guidance on when we should expect an announcement?

Mr. MINGO. Chairman, thank you very much for that question. I am as anxious as I think anybody in this room to hear the actual award date. I do not have any specific—

Mr. BERGMAN. Are there any steps—

Mr. MINGO [continued]. —anything else specific.

Mr. BERGMAN [continued]. —that still need to be, any I's needed to be dotted, T's needed to be crossed before the contract is awarded?

Mr. MINGO. There are two additional—sir, I like actually to take that one for the record, if I could, and get back to you.

Mr. BERGMAN. Okay. Also, regarding H.R. 3497. Mr. Mingo, you testified that it would be duplicative of the electronic health record modernization program and divert resources away from it. You note that veterans can already download a copy of their medical records through what VA calls the Blue Button Initiative. Does that include every aspect of a veteran's medical record or just certain documents?

Mr. MINGO. Actually, Chairman, what I would like to do is I would like to take that question for the record and I would like to tie it back to Director Verma's comments that she did make it at the HIMSS conference on Tuesday, where she announced the Blue Button 2.0 Initiative. And there is a—I think there is a very good opportunity for the two agencies to work together in bringing that type of—all the data available for the veterans to gain access, and the clinicians to have access to that record when it is needed, together. So we would like to come back and give you a better answer on that.

Mr. BERGMAN. Okay. And, Mr.—do you say Lemmon, or Lemmon?

Mr. LEMMON. Yes, Lemmon.

Mr. BERGMAN. Lemmon, that is what I thought. Okay. Mr. Lemmon, and you have testified before us before. The National Defense Authorization Act, which was enacted on December the 12th of this past year, increased the micro-purchase threshold, which is also the transaction limit for purchase cards, from \$3,500 to \$10,000. When will this change actually go into effect?

Mr. LEMMON. I cannot give you a date. I will say that agencies have the option to issue a deviation to the far until the regulation changes. My understanding is that the VA Office of Acquisition Policy is in the process of issuing that deviation, and with the Office of Management then implementation will be determined. But I do not know that they—

Mr. BERGMAN. Can you give me kind of like a year?

Mr. LEMMON. I believe with certainty it would be this year, but—

Mr. BERGMAN. Okay. Well, when the transaction limit goes up and we finally get it, you know, in place, you are going to be able to buy a lot more things with the increased dollar amount. Can you give me an idea, has there been any discussion of what types of products that you plan to move over onto purchase cards?

Mr. LEMMON. Well, I think we have to take care. There are areas where it would be helpful now in terms of some prosthetic procurements as well as to help with our med-surg supplies while we are working on a more robust catalog. But where we do not want to go, we do not want to go from \$4 billion of open market spend to \$6 to \$8, we want to put more national contracts in place and drive prices lower. So the goal really is not to explode the purchase card program.

Mr. BERGMAN. Okay. Well, thank you.

Mr. MINGO. I would like to jump in on that question. Sorry, Mr. Chairman, I would like to jump in on that as well because—

Mr. BERGMAN. Are you going to use up the rest of my time here because I got one more question for Mr. Adams?

Mr. MINGO. Well.

Mr. BERGMAN. You can—I mean, go ahead.

Mr. MINGO. Oh. Okay. I was going to say—

Mr. BERGMAN. Unless my colleagues disagree. Can I have a little extra time here to finish my one last question?

Ms. KUSTER. We would grant you the courtesy.

Mr. BERGMAN. Great. Thank you so much. Okay. Be brief.

Mr. MINGO. At the HIMSS Conference, our CIO did announce the use of the micro-purchase, the opportunity for really bringing innovation, which is what we would bring with the new Lighthouse Initiative that you referenced earlier. And that type of threshold would enable those type of purchases as well to bring in innovation meeting the veterans' needs, and pulling those opportunities together.

Mr. BERGMAN. Okay. Thank you. Mr. Adams, VA's policy handbook for the purchase card program sets out penalties for misuse. The first offense ranges from admonishment to removal. The second offense ranges from a seven day suspension to removal. The third offense ranges from a 14 day suspension to removal.

Those are very wide ranges. I would argue an admonishment is not even a real penalty, it is kind of like being grounded without having your allowance taken away. Can you give me some examples of employees being removed for purchase card misuse?

Mr. ADAMS. Unfortunately, Mr. Chairman, I do not have any the detailed data on any employees that may have been removed as a result of that.

Mr. BERGMAN. Do you think there is something that exist in the VA records that you could, regardless, not necessarily names, but numbers, or—

Mr. ADAMS. I believe we could take that for the record.

Mr. BERGMAN. I would appreciate that very much. With that, thank you to my colleagues for allowing me to extend my questions.

Any appetite for a second round, or is everybody okay? All right.

Thank you to the witnesses for your thoughtful input. The panel is now excused.

The testimony provided today is an important contribution as we move forward with the legislation, particularly the two draft bills. The witnesses' expertise is valuable to help us refine and improve the bill texts.

As you are well aware, this Subcommittee's Oversight and Investigations of VA are frequently uncomfortable. So I appreciate VA's willingness to consider the ultimate objectives of today's legislation; improve efficiency, reduce waste, and provide better outcomes for veterans. There was a time when the Department's default posture was to evade congressional scrutiny. I am happy to see the indications of that are beginning to change.

And I wrote a couple extra notes here, Mr. Celli, because you kind of asked the why we doing this. The reason the Committee is put into a position of proposing this legislation is because of VA's track record of accountability has been unaccepted by too many standards, especially those of who have worn the cloth of our Nation.

We know what we sign up to when we swear an oath, and the performance. And so we—well, again, it is we could probably spend time on other things, but we have a performance and accountability problem from the Committee as a whole's view, and espe-

cially Oversight and Investigation. But we are hopeful that with new attitudes, new leadership, and a sense of urgency that I can see beginning to take shape now within the VA gives me cause for hope that the message is getting through as we, the Committee, enable VA to take care of substandard, in some cases, illegal performance. And that is the why.

So having said that, I appreciate the bipartisan cooperation of all the sponsors and cosponsors of today's legislation. I ask unanimous consent that all Members have 5 legislative days to revise and extend their remarks, and include extraneous material.

Without objection, so ordered.

I would like to once again thank all of our witnesses and audience members for joining us here this afternoon. This hearing is now adjourned.

[Whereupon, at 3:11 p.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Fred Mingo

Good morning, Chairman Bergman, Ranking Member Kuster and Members of the Committee. I am pleased to be here today to provide the views of the Department of Veterans Affairs (VA) on pending legislation. With me today are Mr. Ricky Lemmon, Acting Deputy Chief Procurement Officer, Veterans Health Administration, Katrina Tuisamatatele, Health Portfolio Director, Office Information and Technology, and Mr. John Adams, Director of Corporate Travel and Charge Card Service, Office of Management.

H.R. 3497

H.R. 3497, the Modernization of Medical Records Access for Veterans Act of 2017 would direct the Secretary of Veterans Affairs to carry out a pilot program establishing a secure, patient-centered portable medical records storage system that would allow Veterans enrolled in the VA health care system to store and share records of their individual medical history with VA and community health care providers.

Although VA does not support H.R. 3497 as currently drafted, the Department is fully committed to ensuring a Veteran's access to their medical record information as required by the Health Insurance Portability and Accountability Act of 1996 and other existing legislation, and looks forward to further collaboration on the subject. VA understands the intent of the legislation is to provide Veterans with a copy of their most up-to-date medical record; however, the use of a portable device is not the appropriate solution for several reasons. First, challenges related to network security and compatibility with electronic health records systems make doctors resistant to accepting plug-in electronic devices from a patient. Second, even with a portable storage device, Veterans may not always have the most current copy of their record as this depends on when the files are downloaded during the Veteran's visit. It may not reflect the current visit including notes and the results of diagnostic tests that were ordered during the visit. Lastly, the Department of Health and Human Services will be promulgating regulations to require health IT developers to have application programming interfaces (APIs) that enable easy access, use, and exchange of health information, and this technology would obviate the need for, or even the help from, the kind of special purpose storage system that the bill would foster.

Currently, Veterans are already able to download a copy of their medical records through the Blue Button initiative. They could even download them on a community health care provider's computers which would be a lower risk to that provider and to the Veteran. Also, implementation of the contemplated portable medical record storage system would take resources away from VA to support the Electronic Health Record Modernization (EHRM) Program Executive Office (PEO) and duplicate functionality that could ultimately be provided by the new EHR.

VA is happy to work with the Committee to identify opportunities within EHRM PEO Innovations and industry to provide Veterans with an aggregated Personal Health Record (PHR) from multiple EHR systems in the future.

H.R. 4245

H.R. 4245, the Veterans' Electronic Health Record Modernization Oversight Act of 2017, would require VA to submit to designated committees of Congress several project management documents 30 days after enactment, as well as quarterly updates related to the Electronic Health Record Modernization (EHRM) Program. VA would also be required to submit to the designated committees any contract, order, agreement, or modification thereto under the EHRM program within 5 days after award or modification. Lastly, VA would be required to notify congressional committees following significant events including: milestone or deliverable delays of 30 days

or more; equitable adjustments or change orders exceeding \$1 million; any protest, loss of clinical or other data, and breach of patient privacy.

VA supports this legislation and believes transparency is important for the success of the EHRM Program. VA recommends making the following changes in Sec. 2(a) and Sec. 2(b). VA suggests changing the requirement in Sec. 2(a) to provide for submission of program-management documents to the committees no later than 180 days after enactment of the legislation, a more practicable deadline. For Sec. 2(b), VA suggests changing the requirement to provide quarterly updates no later than 60 days after the end of the fiscal quarter. This would allow VA to provide the Committee with more accurate and complete information.

VA would also like to work with the Committee to ensure that the terminology is consistent with similar terms in the HIPAA Privacy Rule. For example, it appears that the term “breach” in this bill is broader than the similar term “breach of unsecured protected health information” in the HIPAA Privacy Rule. VA believes greater consistency among industry standards would reduce confusion, and improve VA’s interoperability with community providers.

Costs for H.R. 4245 would be minimal as the referenced documents will be drafted as part of the EHRM Program.

H.R. ——— - Draft Bill Misuse of VA Purchase Cards

This draft bill would direct the Secretary of Veterans Affairs to prohibit employees found to have knowingly misused a VA purchase card from further serving as a purchase cardholder or approving official. Such prohibition would be in addition to any other applicable penalty. Under the draft legislation, misuse would mean splitting purchases, exceeding the applicable card limits or purchase thresholds, purchasing any unauthorized item, using a purchase card without being an authorize account holder, and violating ethics standards.

VA supports the draft bill, as it would be consistent with VA efforts to reduce potential fraud, waste, and abuse within the VA charge card program. It would facilitate reduction of charge-card misuse and minimize costly ratifications that are required to be completed when unauthorized commitments are identified. The sanctions identified in the bill would support sound charge card program oversight and encourage cardholders and approving officials to strictly adhere to purchasing requirements, as outlined in VA Financial Policy, Volume XVI, Chapter 1, Government Purchase Card.

VA estimates the cost of enacting the legislation would be minimal.

H.R. ——— - Draft Medical Surgical Prime Vendor Program Bill

This bill would statutorily define the structure of VA’s Medical/Surgical Prime Vendor (MSPV) program and the number of items provided in its formulary within 1 and 2 years after enactment.

VA opposes this bill. Congress has already provided, and the Federal Acquisition Regulation has already implemented, suitable tools to enable VA to make good business judgments in developing the MSPV program as well as other acquisitions. Agencies are required to conduct market research as part of their acquisition planning efforts; and at VA, we have a further need to conduct market research to fulfill our mandate under the Veterans First Contracting Program. Properly conducted market research enables VA to assess the current state of the marketplace and structure the acquisition appropriately based on the number and types of vendors available, the geographic areas they serve, the need to ensure redundancy to avoid interruption in supply, and/or other factors.

In addition, Congress has provided tools for evaluating options for changing the number of vendors in subsequent acquisitions. Statutes on contract bundling and consolidation provide criteria for evaluating potential cost savings or other acquisition benefits to determine if such actions are necessary and justified. They also provide for elevated review of such decisions by the VA Senior Procurement Executive, VA Chief Acquisition Officer, VA Deputy Secretary, and the Administrator of the Small Business Administration.

The current MSPV structure was based on a judgment call to apply the criteria Congress enacted to guide agencies in making these decisions. Legislation eliminating VA’s ability to make such calls could have unintended consequences in preventing VA from adapting to changing market circumstances.

Legislating the number of formulary items to be contracted within arbitrary time periods could also have unintended consequences. Determining the types of items needed and the number of suppliers for each type of item are also judgment calls. In making these judgment calls, VA considers factors such as opportunities for standardization and clinical needs. These judgment calls are additionally informed

by market research as part of the acquisition process. However, adequate market research is necessary to make an informed business decision, and therefore establishing arbitrary timeframes increases the risk of poor business decisions.

Providing broadly applicable criteria to make such judgments, which balance competing interests in public policy as Congress has defined them, is a much more constructive approach than the draft legislation proposes. VA should continue to have the flexibility to make such determinations based on market conditions and prevailing business practices, clinical need, and the like. As markets continue to change and develop, VA needs the ability to change and develop its procurement process accordingly.

This includes our testimony. We appreciate the opportunity to present our views on these bills, and look forward to answering any questions the Committee may have.

Prepared Statement of Louis J. Celli Jr.

Chairman Bergman, Ranking Member Kuster, and distinguished members of the Subcommittee. On behalf of Denise H. Rohan, National Commander of The American Legion; the country's largest patriotic wartime service organization for veterans and our 2 million members; we thank you for inviting The American Legion to present our position on the pending and draft legislation before you today.

H.R. 3497 - Modernization of Medical Records Access for Veterans Act of 2017

To direct the Secretary of Veterans Affairs to carry out a pilot program establishing a secure, patient-centered, portable medical records system, that would allow veterans to have access to their Personal Health Information, and for other purposes.

The American Legion, through resolution, has long endorsed and supported the Department of Veterans Affairs (VA) in creating a Lifetime Electronic Health Records (EHR) system. Additionally, The American Legion has encouraged both the Department of Defense (DoD) and the VA to either use the same EHR system, or, at the very least, systems that were interoperable.

In 2009, The American Legion was pleased when the Obama administration announced that the DoD and the VA would finally create a path to integrate the flow of patients' information between DoD's AHLTA (Armed Forces Health Longitudinal Technology Application) and VA's VistA (Veterans Information System and Technology Architecture) Electronic Health Record (EHR) platforms.¹

In 2015, DoD announced that Cerner was awarded a coveted \$4.3 billion, 10-year contract to overhaul the Pentagon's electronic health records for millions of active military members and retirees. However, around the same time, VA announced it would maintain and modernize VistA.

The American Legion was disappointed in VA's and DoD decisions to go in different directions and voiced concerns about their decision. On June 6, 2017, VA Secretary David Shulkin announced that the VA would adopt the same Cerner EHR system as the DoD during a news briefing at VA's headquarters in Washington, D.C.

The impending contract, that the Department of Veterans affairs is in the final stages of negotiating, will set the standard for record transferability and standardization in America. This new national standard will increase patient access, decrease wait times, and enhance good medicine for all Americans, not just veterans. Congress should refrain from advancing any recommendations or legislation that does not directly support implementation of the VA EHR modernization effort currently being negotiated.

The American Legion understands and applauds the author of H.R. 3497, as the desire to aide veterans all while placing their medical care into the 21st Century is clear. We look forward to engaging Rep. McMorris Rodgers in the future to assist our nation's heroes and their families.

The American Legion Opposes H.R. 3497.

¹ Obama administration announces DOD and VA pathway to an integrated health record - <http://www.ehrscope.com/blog/white-house-announces-plan-to-integrate-dod-and-va-ehrs/>

H.R. 4245 - Veterans' Electronic Health Record Modernization Oversight Act of 2017

To direct the Secretary of Veterans Affairs to submit to Congress certain documents relating to the Electronic Health Record Modernization Program of the Department of Veterans Affairs.

In 2009, The American Legion was pleased when the Obama administration announced that the Departments of Defense (DoD) and Veterans Affairs (VA) would finally create a path to integrate the flow of patients' information between DOD's AHLTA (Armed Forces Health Longitudinal Technology Application) and VA's VistA (Veterans Information System and Technology Architecture) Electronic Health Record (EHR) platforms.²

In 2015, DoD announced that Cerner was awarded a coveted \$4.3 billion, 10-year contract to overhaul the Pentagon's electronic health records for millions of active military members and retirees. However, around the same time, VA announced it would remain with VistA.

The American Legion was disappointed in VA's and DoD decisions to go in different directions and voiced concerns about their decision. On June 6, 2017, VA Secretary David Shulkin announced that the VA intends to adopt the same Cerner EHR system as the DoD during a news briefing at VA's headquarters in Washington, D.C.

"I had said previously that I would be making a decision on our EHR by July 1, and I am honoring that commitment today," Shulkin said. "The health and safety of our veterans is one of our highest national priorities. Having a veteran's complete and accurate health record in a single common EHR system is critical to that care, and to improving patient safety."

Shulkin said VA's current VistA system is in need of major modernizations to keep pace with the improvements in health information technology (IT) and cybersecurity, as software development is not a core competency of VA.³

The Veterans' Electronic Health Record Modernization Oversight Act of 2017 directs VA to provide Congress with its key planning and implementation documents for the EHR replacement project, to provide copies of the contracts, to keep Congress informed on progress and actual costs. The legislation also requires VA to notify Congress quickly in the event of any significant cost increase, schedule delay, loss of veteran health data or breach of privacy.

The American Legion supports VA and the DoD establishing a joint Virtual Lifetime Electronic Health Record (VLER) and the congressional oversight and funding necessary to ensure this most important and massive IT transformation is completed as seamlessly as possible.⁴

The American Legion supports H.R. 4245.

DRAFT BILL

To amend title 38, United States Code, to direct the Secretary of Veterans Affairs to prohibit employees found to have knowingly misused Department of Veterans Affairs purchase cards from serving as purchase card holders or approving officials.

This draft bill prohibits any employee of the Department of Veterans Affairs (VA) who the Secretary or the Inspector General of the Department determines has knowingly misused a purchase card from serving as a purchase cardholder or approving official.

The American Legion leaves employee discipline, and policies to correct agency/employee behavior to the Department. VA's Purchase Card Program is part of the U.S. General Services Administration (GSA) SmartPay Program and conforms to the Federal Acquisition Regulations (FAR).⁵

While the bill would restrict a VA employee from serving as a purchase cardholder or an approving official even in cases where it is the employee's primary duty and in such cases The American Legion sees no provision contained within the legislation that addresses the future job description of the employee.

The objectives of the Purchase Card Program are to:

²Obama administration announces DOD and VA pathway to an integrated health record - <http://www.ehrscope.com/blog/white-house-announces-plan-to-integrate-dod-and-va-ehrs/>

³VA announce the decision to go with Cerner - <https://www.legion.org/veteranshealthcare/237706/%E2%80%98%E2%80%99s-time-move-forward%E2%80%99>

⁴The American Legion Resolution No. 83: Virtual Lifetime Electronic Record

⁵VA Purchase Card Policy <https://www.va.gov/finance/docs/VA-FinancialPolicyVolumeXVICChapter01.pdf>

- Reduce paperwork and administrative costs for the acquisition of supplies and services within the existing FAR;
- Streamline payment procedures and improve cash management practices, such as consolidating payments and reducing petty cash funds; and
- Provide procedural checks and feedback to improve management control.

All cardholders are required to use the purchase card for authorized procurement in accordance with Simplified Acquisition Procedures (FAR Part 13 and Veterans Affairs Acquisition Regulations (VAAR) Part 813.)

In 2017, Veterans Affairs Office of Inspector General (VAOIG) conducted two Audits of VA's Purchase Card program. On June 27, 2017, VAOIG issued report, 15-01227-249, entitled, "Review of Alleged Irregular Use of Purchase Cards by the Engineering Service at the Carl Vinson VA Medical Center in Dublin, Georgia."⁶

VAOIG substantiated the allegation that Dublin VA Medical Center cardholders in Engineering Service made unauthorized commitments by splitting purchases and exceeding micro-purchase limits. Of the 130 sampled purchases made from October 2012 through March 2015, 23 were split purchases that avoided the \$3,000 limit for supplies and 14 were purchases that exceeded the \$2,500 limit for services.

This happened because approving officials did not adequately monitor cardholders to ensure compliance with VA policy.

VAOIG did not substantiate the allegations that cardholders made duplicate payments to Ryland Contracting Incorporated and Sterilizer Technical Specialists. However, VAOIG found cardholders inappropriately made 91 micro-purchases for services received from these vendors without establishing contracts.

On September 2017, VAOIG Issued report, 15-04929-351, entitled "Audit of Purchase Card Use To Procure Prosthetics."⁷

The VA OIG received an allegation in 2015 that the VHA inappropriately used Government purchase cards to procure commonly used prosthetics, instead of establishing contracts that would leverage VHA's purchasing power, and failed to ensure VA received fair and reasonable prices. Furthermore, VHA allegedly did not report purchases in the Federal Procurement Data System (FPDS).

VAOIG substantiated the allegations that for some prosthetic purchases above the micro-purchase limit, VHA did not leverage its purchasing power by establishing contracts and did not ensure fair and reasonable prices were paid. A micro-purchase is an acquisition using simplified acquisition procedures where the aggregate amount does not exceed \$3,500.

VAOIG stated these improper actions occurred because VHA controls did not ensure the Prosthetic and Sensory Aids Service (PSAS) sufficiently analyzed prosthetic purchases to identify commonly used prosthetics and the Procurement and Logistics Office (P&LO) did not adequately monitor Network Contracting Office (NCO) procurement practices to ensure contracts were established. As a result, VAOIG estimated VHA might have paid higher prices for an estimated \$256.7 million in prosthetics purchases during FY 2015 by not establishing contracts.

VAOIG did not substantiate the allegation that VHA failed to report prosthetic procurements in FPDS. We estimated VHA reported about 86,200 of the 87,100 FY 2015 prosthetic purchases (99 percent) in FPDS.

Unauthorized commitments require ratification. According to VAOIG, VHA did not have reasonable assurance that VA medical facilities used taxpayer funds efficiently when procuring prosthetics. In response to the investigation, VHA initiated actions to pursue contracts for commonly used surgical implant prosthetics. In addition, VHA has established pre-authorization procedures and plans to authorize the use of ordering to help mitigate improper payments and unauthorized commitments associated with surgical implants.

Again, The American Legion approaches management of employees with extreme caution when addressing agency/employee behavior related matters. The American Legion could not find any evidence in any of the VAOIG reports that prove that the government spent more money than they otherwise would have, or that any of the purchases would have saved money using more complicated and expensive contracting vehicles.

Since the bill would restrict a VA employee from serving as a purchase cardholder or an approving official if this is one the employee's primary duties, The American Legion is concerned that the bill would limit an employee from performing their assigned duties, which may result in additional and unidentified personnel actions. The American Legion believes VA already has the authority to take action on em-

⁶ VA OIG Report - 15-01227-249 <https://www.va.gov/oig/pubs/VAOIG-15-01217-249.pdf>

⁷ VA OIG Report - 15-04929p351 <https://www.va.gov/oig/pubs/VAOIG-15-04929-351.pdf>

employees who fail to follow VA policies, and is not convinced this legislation is necessary.

The American Legion does not support this draft bill.

DRAFT BILL

To direct the Secretary of Veterans Affairs to carry out the Medical Surgical Prime Vendor program using multiple prime vendors.

In terms of contracting, private sector hospitals use multiple Group Purchasing Organization (GPOs) who bid down the price of manufactured medical equipment. This practice, forces the GPOs to compete among themselves, yielding the lowest possible prices, which is at the benefit of the hospitals, or the general market place. In summary, competition drives down prices.

Utilizing Medical Surgical Prime Vendor (MSPV) Gen2, VA has proposed using only one large single vendor as opposed to the current model of using multiple vendors. When you decide to use only one vendor, prices may be inflated, simply because of the lack of competition. Ensuring there is competition, the VA, and the government as a whole, typically receives better pricing, which is ultimately at the benefit of the U.S. taxpayer.

The American Legion understands the simplification of utilizing only one vendor, however, that does not yield the best result for the veteran, agency or the federal government. Utilizing a singular vendor is easier to deal with, but this procurement shortcut undermines the competitive system, and can result in VA overpaying for equipment or, not being able to obtain quality material necessary to supply the largest medical network that treats veterans.

In the current model that VA is employing, Service Disabled Veteran Owned Small Businesses (SDVOSBs) work with prime vendors, which not only assists and encourages veterans to work in this realm, but also allows for competition and drives down costs. SDVOSBs add value to the procurement process by providing last mile delivery, customer care, and maintenance services for prime vendors.

In short, The American Legion opposes the Department of Veterans Affairs switching to a system that allows them to simply utilize one vendor, and urges Congress to force VA to allow for competitive bidding. Further, The American Legion, by resolution⁸, supports reasonable set-asides of federal procurements and contracts for businesses owned and operated by veterans. Allowing the VA to essentially encourage a monopoly on medical supplies and equipment is not only wrong, but it could also decrease SDVOSB participation, potentially harming the quality care that veterans receive at VA, all while overspending taxpayer funding.

The American Legion supports the draft bill as currently written.

Conclusion

As always, The American Legion thanks this subcommittee for the opportunity to explain the position of the over 2 million veteran members of this organization. For additional information regarding this testimony, please contact Mr. Matthew Shuman at The American Legion's Legislative Division at (202) 861-2700 or Mshuman@legion.org.

Prepared Statement of Scott Denniston

Good afternoon, Chairman Bergman, Ranking Member Kuster, and distinguished members of the Subcommittee. On behalf of the members of the National Veteran Small Business Coalition and all veteran (VOSB) and service-disabled veteran-owned small businesses (SDVOSB) trying to do business with the Department of Veterans Affairs (VA), I sincerely appreciate the opportunity to discuss the proposed pieces of legislation as invited. The National Veteran Small Business Coalition (NVSBC) is the nation's largest non-profit trade association representing veteran and service-disabled veteran-owned small business in the federal marketplace as prime and subcontractors.

I would like to first address HR3497 and HR 4245 dealing with Veterans Electronic Health Records. We believe HR 3497 to allow veterans to use a portable medical records storage system is good news for veterans as it allows easier access to their own personal health records. HR 4245 appears to address Congress' concerns

⁸The American Legion Resolution No. 154: Support Reasonable Set-Aside of Federal Procurements and Contracts for Businesses Owned and Operated by Veterans

regarding the contract the VA Secretary announced last fall which he intends to award to Cerner to modernization of VA's electronic patient health care record systems. Our concern with this contract is VA has taken a very minimalistic approach to providing subcontracting opportunities for small business, including veteran and service-disabled veteran-owned small business. VA only required the awardee to meet the "minimum goals" of 17% to small business, 5% to SDVOSBs and 7% to VOSBs. Information technology contracts such as this, generally provide many opportunities for prime contractors to subcontract to small business including VOSBs and SDVOSBs. For example, the FY 2018 subcontracting goals established by the U.S. Small Business Administration (SBA) for other agencies include the following:

- Department of Defense
33%
- Department of Energy
42%
- Department of Homeland Security
40%

Also, over the past 10 years VA has NEVER once achieved its subcontracting goal negotiated with SBA. Given VA's poor track record and the lower goals accepted for this contract we implore this committee to include in HR 4245 a provision requiring the Secretary of Veterans Affairs to report to Congress on a quarterly basis the accomplishments against the small business subcontracting goals to include subcontract awards to VOSBs and SDVOSBs.

Next, I would like to address the draft bill regarding VA employees found to have knowingly misused VA purchase cards. The NVSBC is fully supportive of this draft. Abuses of purchase cards has been wide-spread. This trend will only continue with the recent raising of the limitations on purchases using the cards from \$3,500.00 to \$10,000.00. We have found that many times these issues arise due to poorly written policies and training on the part of VA acquisition leadership, not because VA employees are dishonest people.

The last draft bill you asked me to discuss directs the Secretary of VA to carry out the Medical Surgical Prime Vendor (MSPV) program using multiple prime vendors. Before addressing the specifics of the draft bill I want to share with you our observations having lived the current prime vendor program for the past two years and numerous meetings with both Veterans Health Administration (VHA) and Strategic Acquisition Center (SAC) leadership. The current program is being driven for contracting expediency, not based on clinical input to improve veteran patient care. There is little to no clinical input in our opinion. VHA and the SAC appear to work on conflicting time frames. There is no strategic plan. Determining who is in charge is impossible. The rules of engagement change on a weekly basis as to acquisition strategies to be used. Frankly we wonder how often VHA and SAC actually communicate needs/requirements and solutions. Also, there appears to be much more communication with the large business community than communication with the VOSB/SDVOSB community. Communication with the VOSB/SDVOSB community is after the fact when we are told what will happen as opposed to having an opportunity to make recommendations to improve the process. VA seems to forget, as veterans and users of the VA health care system we have a personal and vested interest in its success. Also, there is little data available as to products, quantities or delivery requirements VA intends to purchase.

The NVSBC, in representing all VOSBs/SDVOSBs trying to do work with VA would be remiss if we didn't again point out the anti-veteran small business positions expressed by VA's senior acquisition official during this Committee's Veterans First Contracting Program Roundtable held on October 11th, 2017. That official has publically stated numerous times that VOSBs and SDVOSBs add no value, cost more and are administratively burdensome to work with. He further stated his position that VA should not pay a penny more to buy from a VOSB or SDVOSB. This culture as well as the policies implemented by VA limit the opportunities for VOSBs and SDVOSBs to work at VA and fly in the face of the VETS First Contracting Program as well as the U.S. Supreme Court decision in *Kingdomware*. Bottom line; there is a toxic culture in VA, particularly in VA Central Office to working with the veteran small business community.

In the fall of 2017 when we learned the SAC intended, under MSPV 2.0, to award one contract for the MSPV 2.0 program we were appalled. Particularly when we learned the contract would require the MSPV 2.0 contractor to also determine the formulary of products and to also purchase all products to be included on the formulary. We asked what part VOSBs and SDVOSBs would play in MSPV 2.0 and were told they would be subcontractors to the MSPV 2.0 prime. When asked how VETS First would apply to MSPV 2.0 we were told it doesn't as VOSBs and

SDVOSBs would be “subcontractors”. When we asked what type of small business subcontracting plan would be required we were told “don’t know yet”. When we addressed the fact that in the past 10 years VA has NEVER achieved its subcontracting goals we were told “just trust us!”. In addition, relegating VOSBs and SDVOSBs to subcontractors allows VA to avoid the issue of a waiver of the SBA “Non-Manufacturer Rule “. VA has established a policy of requiring HCA approval prior to any contracting officer requesting a waiver from SBA. WE believe this policy to be in direct violation of the Small Business Act. We also know of and appreciate this Committee’s concern over this overly burdensome requirement which we believe is another attempt by VA to circumvent VETS First.

We support the Committee’s position that VA cannot have just one prime vendor. Our experience in the private sector is commercial hospital systems are members of a number of “Group Purchasing Organizations (GPOs). This allows for flexibility of products as well as guarantees product availability while at the same time taking advantage of volume discounts. Commercial hospital systems have learned they need flexibility which doesn’t come from a one supplier solution. We believe VA needs to develop a similar concept. As I stated previously, VA’s plan seems to be driven for the benefit of the contracting process, not the needs of veteran’s healthcare needs. We also do not understand why VA does not use the VA Federal Supply Schedule (FSS) contracts as a starting point for formulary products. FSS contracts by definition are considered “fair and reasonable” prices. VA, as well as the large and small business community has put tremendous effort into the success of the FSS program. We do not understand why VA appears to be abandoning FSS?

We fully support the draft bill provisions that the prime vendor should not be the decider of the formulary nor of the suppliers of the products. We strongly suggest this Committee direct VHA and SAC leadership to define requirements, develop a process for clinical input and develop a strategic plan for moving forward with MSPV 2.0. The plan must include how VA intends to provide opportunities for VOSBs and SDVOSBs as required by VETS First. This plan should then be shared with industry, large business and small business for comments and suggestions. We believe this will provide better outcomes for all parties.

During this Committee’s roundtable on the VETS First program on October 11th, 2017, Chairman Bergman invited participants to provide recommendations to the Committee for improving VETS First at VA. NVSBC provided 8 specific recommendations in a letter to this Committee dated October 17, 2017. These recommendations are still relevant today and I would encourage the Committee to consider the recommendations moving forward. I have provided a copy of our letter with my testimony. We are also available to meet and discuss any of the recommendations with any member of the Committee.

I also want to bring to the Committee’s attention a solution to the micro-purchase program NVSBC has been developing for the past year. VA, buy their own statistics spends approximately \$4 billion per year under micro-purchases using purchase cards. In the future this amount will sky rocket as the micro-purchase threshold in VA is being raised from \$3,500 to \$10,000. VA policy exempts micro-purchases from the VETS First program. This is in spite of the U.S. Supreme Court decision in *Kingdomware* where the court determined all “contract actions” are subject to VETS First. Micro-purchases meet the Federal Acquisition Regulations (FAR) definition of a “contract action”.

Over the past year, NVSBC has met with VA leaders from VHA, SAC, and the Office of Small Business Programs (OSDBU) to discuss how to provide more micro-purchase opportunities to the VOSB and SDVOSB community. These discussions have led NVSBC to develop in conjunction with an NVSBC member, Veratics of Indian Beach, FL, an electronic ordering platform, similar to Amazon, called “Go VETS”. Our vision is all VA verified VOSBs and SDVOSBs who can provide products to VA under the micro-purchase threshold will upload their products on the platform. VA purchasing personnel will then have a “one stop, easy button” to purchase products, using their purchase cards, from verified VOSBs and SDVOSBs. We are starting in the medical products area as it represents the greatest spend and VA is currently buying many of these products from the 4 current Medical Surgical Prime Vendors, and many times at inflated costs. As we fine tune the platform other product lines will be added from verified VOSBs and SDVOSBs. As you can imagine we have overcome many obstacles to get to this point, but we are optimistic we can have “Go VETS” operational in 90 days. We are also encouraged by the fact that many VA officials with whom we have discussed this platform over the past year are warming to the idea and see its value. We are happy to demo “Go VETS” to the Committee as well as provide updates on our progress. We are very excited by the potential to provide many more opportunities to VOSBs and SDVOSBs.

Mr. Chairman, Ranking Member, and Members of the Committee, this concludes my statement. Thank you for the opportunity to testify before the Committee today. I am happy to respond to any questions or comments you may have.

Statements For The Record

Ken Wiseman

Chairman Bergman, Ranking Member Kuster, and Members of the Subcommittee, on behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and its Auxiliary, I would like to thank you for the opportunity to submit testimony regarding legislation pending before this committee.

H.R. 3497, Modernization of Medical Records Access for Veterans Act of 2017

This legislation would provide a portable “credit card sized” health record for veterans. While this sounds appealing, the VFW is very concerned about this bill and opposes its passage.

The act of a veteran accessing their record and getting a copy is something they can already do. Veterans have the ability to get copies by using their My HealtheVet account. After logging into their account, the first page a veteran sees offers a selection of four large “buttons” and accessing their medical record is the fourth option. VFW staff tested the ability to download their record using this method, and in less than 90 seconds an electronic version had been downloaded. For those who do not use My HealtheVet, a hard copy can be obtained by the veteran from their local Department of Veterans Affairs (VA) Medical Center. As such, the VFW does not see how this improves the access a veteran has to VA.

To ensure that the veteran’s medical record follows them after military service, VA has recently begun the process of adopting a commercial off-the-shelf system for the future electronic health record. The Electronic Health Record Modernization Program (EHRMP) will allow veterans to have more access to their medical records. This legislation allows the discharging service member to electronically “carry” their record to VA and for various portions of VA to interact with itself and with community care providers while caring for the veteran. The VFW believes H.R. 3497 could create a competing medical record that would prevent VA and the veteran from having all needed information on one platform, thus slowing the delivery of care. Because of a lack of vital information, this could lead to decisions being made that could harm the health of the veteran.

In looking at our first two concerns together, the VFW worries about interoperability between the device that would be created and other VA systems, and security of the information stored on it. There is no requirement for the device to ever be connected to, or even interoperable with, the electronic health record that will result from EHRMP. A lost device could also lead to compromised information and this is a real threat in the modern day.

Finally, the VFW opposes this bill because it specifically bans new appropriations for implementation. Unfunded mandates harm other programs by forcing VA to take money from other parts of its IT budget. The VFW is already concerned about VA’s IT budget funding levels. This legislation would cause VA to divert precious and limited resources from other programs, thus hindering modernization of IT capabilities and implementation of EHRMP.

H.R. 4245, Veterans’ Electronic Health Record Modernization Oversight Act of 2017

The VFW is strongly supportive of VA’s goal to have a medical record that is interoperable with DOD, so that as a service member becomes a veteran, their health history follows them. The work to accomplish such a major project is not something to be taken lightly, and the VFW supports efforts to ensure oversight of the project. The VFW supports H.R. 4245, which would help accomplish this goal.

The VFW is concerned by testimony regarding EHRMP as it relates to ensuring the project stays on budget on and on time. We know that Secretary of Veterans Affairs Shulkin has taken steps to ensure this project results in a program that is truly interoperable, and we support this as well. Only regular oversight, reports on actions, and explanations of why deviations from set plans were allowed, will ensure the project succeeds. Further, tracking of associated expenditures will ensure that other IT projects will not be starved of funding by movement of funds within the

budget for IT programs at VA. We applaud the bipartisan work on this legislation and urge quick passage.

Draft Bill to Restrict Purchase Card Abuse

The VFW supports any actions necessary to ensure VA employees are using purchase cards responsibly. Fraud, waste, and abuse of government funds are detrimental to the overall success of VA's mission. If any employees are found to knowingly use purchase cards maliciously, then the right to use those cards must be revoked. We support removal of purchase card authority for employees who maliciously or irresponsibly abuse them.

Draft Bill to Use Regional Medical Surgical Prime Vendors

The VFW sees value with the intent of this proposed bill. We always encourage the expansion of opportunities for Veteran Owned Small Businesses to compete for contracts with VA, but we also see value in having a single supplier if the situation is necessary. Mandating VA to use regional prime vendors could have a positive impact on competition in the market place; however, we would not want to see it negatively impact overall cost. The VFW does not have a position on this bill.

Congresswoman Cathy McMorris Rodgers

I'd like to thank Chairman Bergman and Ranking Member Kuster for holding this important legislative hearing to address the fundamental need for comprehensive medical records for veterans.

Every day, I hear from veterans in Eastern Washington who are in desperate need of help from the VA, yet so often they are not receiving the help they need or deserve.

The VA's sole mission is to serve our veterans. Instead of having the red carpet rolled out for them, veterans are treated like a burden.

This includes veterans attempting to simply obtain their medical records from the VA. I have even heard from providers in the community who have been frustrated to the point of tears because they are unable to treat veterans because the patient cannot obtain his own medical records. Some veterans have waited more than two years to simply get their medical records from the VA. That is unacceptable.

But there is an easy, common sense, off-the-shelf solution for this problem.

My bill, introduced along with Congressman Seth Moulton, is a bipartisan, readily available solution to this problem. It directs the Secretary of the VA to establish a secure, patient-centered, portable medical records systems that would allow veterans to have access to their own comprehensive medical records.

As with most things in the VA, this is not an issue where the wheel must be reinvented to fix the issue. Commercial, off-the-shelf solutions already exist in the private sector. This kind of technology is already out there, deployed in hospitals in the private sector.

For example: VYRTY, a company based out of Washington state, is a secure off-line data repository, with end-to-end encryption and remote record completion. VYRTY is a fully secure, portable, and HIPAA compliant health record management system that is currently deployed in Washington state—with Evergreen Health Partners, Evergreen Health Hospital, Halvorson Cancer Center, and the Seattle Cancer Care Alliance, and growing—and is interoperable across 89 different health records (EHR's)/platforms.

VA Concern: Challenges related to network security and compatibility with electronic health records systems make doctors resistant to accepting plug-in electronic devices from a patient.

We have discussed the security concerns that some may have in conversations with the VA Office of Information and Technology (OI&T) and the VA Committee.

While these concerns would be valid on other scenarios, the technology that exists and that is in use today is secure and is HIPAA compliant. It is compatible across all electronic health records systems, including Cerner, and is encrypted end-to-end.

The fact that it is in use today shows that it does not make doctors resistant to accepting plug-in electronic devices from patients.

VA Concern: Even with a portable storage device, veterans may not always have the most current copy of their record as this depends on when the files are downloaded during the Veteran's visit. It may not reflect the current visit including notes and the results of diagnostic tests that were ordered during the visit.

With the technology that is currently deployed, patients have a current copy and the most up-to-date version of their medical record. Specifically, one of the important aspects of VYRTY's technology is that they perform record completion. When a patient leaves his or her provider, they are leaving with the most up-to-date medical record information because it is updated immediately.

While the VA Department gives veterans access to the Blue Button Initiative through MyHealtheVet, this means that the veteran is constantly downloading, printing, and taking their latest record every time they go to an outside provider or to a different VA facility, or they're waiting for a document to download while sitting in a provider's office. This puts the burden on the veteran to be responsible for printing and bringing their most up-to-date records.

With the VYRTY's technology, the veteran and the provider have all of the information on a chip which then just has to be handed to the doctor. That's it.

VA Concern: the Department of Health and Human Services will be promulgating regulations to require health IT developers to have application programming interfaces (APIs) that enable easy access, use, and exchange of health information, and this technology would obviate the need for, or even the help from, the kind of special purpose storage system that the bill would foster.

First of all, the VA is not regulated by HHS.

Additionally, And again, the technology that this legislation references, is already in use today, therefore it is already up-to-date and in line with current regulations.

VYRTY has the capability to be integrated directly—and is already supporting direct data feeds in their deployments. The card that is used by VYRTY is a personal repository of all patients' records. It doesn't matter whether those records are coming from an EHR through the "print" functionality or through application programming interfaces (API) level integration. VYRTY has an offline storage capability—with online synchronization capabilities—that deliver stored copies of the records between points of service.

Closing

I am disappointed and concerned by the VA Department's decision to oppose the legislation—that they've chosen to focus on the challenges rather than the opportunities to offer our veterans high quality care.

My staff and I have held several meeting with the VA's Office of Information and Technology (OI&T), where legislation was discussed, where VYRTY was brought in to demonstrate their technology, and where the draft legislation was sent to the VA before introduction for comments and concerns, yet we have—IN WRITING—that the OI&T was supportive of the legislation. In the VA's words: "this looks good to us here."

What this bill is proposing is a common sense, off-the-shelf, readily available solution to a persistent problem among veterans today.

While I am pleased that the Secretary is serious about modernization of the EHR system within the VA, but not only is the VA-Cerner contract currently paused, the implementation period is ten years.

Since I came to Congress in 2005, the budget for the VA Department has nearly tripled, yet the problems persist.

The VA has one mission - to serve our veterans, and right now, the VA has lost sight of that mission.

Thank you, Chairman Bergman and Ranking Member Kuster.

I yield back.

