BUILDING A MORE RESILIENT VA SUPPLY CHAIN

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TUESDAY, JUNE 9, 2020

United States Senate,

Committee on Veterans' Affairs,

Washington, D.C.

The Committee met, pursuant to notice, at 3:02 p.m., in Room SD-430, Dirksen Senate Office Building, Hon. Jerry Moran, Chairman of the Committee, presiding.

Present: Senators Moran, Boozman, Cassidy, Rounds, Tillis, Blackburn, Tester, Brown, Blumenthal, Hirono, Manchin, and Sinema.

OPENING STATEMENT OF CHAIRMAN MORAN

Chairman Moran. Good afternoon, everyone. The Committee will come to order.

Today's hearing is on building a more resilient VA supply chain with a focus on what we have learned from COVID-19's pandemic. A bipartisan enduring priority of this Committee is to ensure that the VA is equipped to fulfill its core mission to deliver timely, high-quality health care to the veterans it was created to serve.

Last August, as the VA entered into partnership with the Defense Logistics Agency to speed acquisition for materiel support, Secretary Wilkie stated, "In the 21st century, an ad hoc supply chain is not sufficient" and "It

does not do justice to those we are sworn to serve."

The VA recognizes the need to build a more resilient supply chain. The question is always "How?" COVID-19 pandemic has put massive stress on the supply chain and created unprecedented global demand for personal protective equipment and other medical supplies.

Inherent fragilities in the just-in-time inventory model have been severely strained in recent months. This confluence of factors has highlighted the need and necessity to reform the VA's procurement organization and process.

The challenge VA confronts is how to strengthen the supply chain in real time, while also making it more resilient and operationally effective in the long term.

I am encouraged to see VA is moving quickly, but there is also a need to be certain that we are strategic in our decision-making.

I understand the need to have more inventory on hand, and reestablishing some form of supply depot may be part of that effort, but we also must take care not to establish parallel and competing supply chains.

Logistics is also fundamental to this equation. Inventory that is unable to move is no use to anyone.

The Veterans Health Administration is saddled with an aging, disparate inventory management system and a medical supply chain that was conceived over 30 years ago. Repeated

reform attempts have too often misfired or added complexity, resulting in time-consuming and error-prone inventory counts.

Transferring supplies between the VA facilities in a different Veteran Integrated Service Networks is also unnecessarily burdensome and difficult. It is a testament to the dedication of VA's clinicians and administrators and staff that they make the system work despite the difficulties.

The Medical Surgical Prime Vendor contracts were once the backbone of this supply chain, but this program has been chaotic since it was relaunched in 2016. And I believe the strategy needs to be reevaluated.

These supply chain issues are not intractable, but they will require sustained attention to develop a modern inventory management system across the enterprise.

This administration has used the Defense Production Act to provide loan guarantees and cost-matching grants to help domestic manufacturers expand their production capacity in response to COVID-19. Many companies have added shifts and reconfigured equipment to boost output. For example, Spirit Aerosystems in Wichita, Kansas, is using the speed of their aircraft manufacturing line to build respirators.

The DPA also allows the Federal Government to allocate materiel and subcontracts on a manufacturer's behalf, and I

commend the administration for doing so when asked.

Under the DPA, Federal agencies can prioritize the delivery of their contracts, but this results in an inherent tradeoff. I would like to understand how the coordination among VA, FEMA, and HHS may be affecting the VA supply chain.

Coordination is key in challenging circumstances, and I believe the VA Secretary should be added to the Defense Production Act Committee to efficiently facilitate veteran care and leverage VA resources.

Senator Tester and I expressed this desire in a letter to President Trump, and it is my understanding the VA concurs. There are substantive suggestions on how to strengthen the VA's medical supply chain, including recommendations from the Commission on Care, the VA's Office of Inspector General, and the Government Accountability Office. Each has called for a more unified supply chain from the VA's Central Office to the medical centers, supported by modern, integrated IT systems.

I am eager to hear the perspective of our witnesses on the second panel as to how the A can rise to this challenge.

The COVID-19 crisis has compounded persistent VA supply chain problems, and there is no better time than the present to address them. It would be a mistake to consider this pandemic transitory and let our guard down.

I look forward to hearing the testimony of our witnesses and working on solutions that can build a more resilient VA supply chain that meets the needs of our Nation's veterans.

I look forward particularly to hearing from Dr. Stone and his colleagues in this first panel, and, Dr. Stone, I take this opportunity to thank you for once again being before our Committee. It has become commonplace, and I appreciate your availability as well as that of your colleagues.

Let me now turn to the Senator from Montana, Senator Tester, the Ranking Member, for his opening statement.

Jon?

OPENING STATEMENT OF SENATOR TESTER

Senator Tester. Thank you. Thank you, Chairman Moran. I appreciate your remarks. I think you are spot on in a number of areas. I am going to touch on just a few of them, and before I start, I want to also welcome Dr. Stone and his leadership team to this hearing.

Look, we have been through some hard times with the COVID-19. It showed where our weaknesses were in our supplies, and quite frankly, it has put a staff of frontline employees that have done an incredible job out there serving not only our veterans but also nonveterans during this pandemic in a difficult situation.

We had austerity measures that were taken in April, and quite frankly, even now, Dr. Stone--and I brought this up in a previous hearing--we are hearing of shortages. We are hearing folks that are asked to reuse their mask, and even in the best of times--even in the worst of times, that is not something we should be doing.

So the bottom line is this hearing's title is "Building a Resilient Supply Chain." The Chairman mentioned in his opening remarks--I do not think we want to have VA setting up a whole bunch of PPE along with HHS doing their own thing with Commerce doing their own thing and FEMA doing their own thing and DoD doing their own thing. Hopefully, everybody is going to be working together, and that is why, by the way, the Chairman and I sent off that letter to the President saying the VA needs to be part of the Defense Production Act Committee, because this needs to be a whole-of-government approach.

Now, make no mistake about it. If our staff needs to have personal protective equipment, they need to have it available, and if the VA cannot depend upon FEMA or HHS to make sure that that personal protective equipment is there or any other equipment as far as that goes, then I get it. You guys have to take care of your own because our veterans are too important to us not.

But the bottom line is that a government that works for

the people works together to work for the people, and that is why I think the Chairman and I feel so strongly about you guys being part of the Defense Production Act Committee. As I said earlier, you have the biggest integrated health care system in this Nation, and if you are not part of the equation, then I do not know who should be a part of that equation. You absolutely should be a part of it.

To add complexity to this whole situation, the VA is putting in three--and maybe more, but three new computer programs to do their outdated IT, one in electronic health records, one with the financial system program, one with dental which is a DoD acquisition program that will, I understand, be replaced not long after you start it. All that has impacts on the supply chain, and how the VA is going to deal with that, it is going to be interesting to hear in this hearing because we spent a fair amount of money over two different administrations on EHR. That is for sure, and making sure that EHR works not only for electronic medical records, but also for making sure that we have the resilient supply chain that we need is critically important.

So I am not going to take up a lot more time. I would just say that I look forward to this hearing. I think it should be a good one. I look forward to figuring out how different agencies could work together to meet the needs. I look forward to hearing from the second panel, how much of

things like masks and shields and gowns, regardless if you are company that is domiciled here, how much of that is made in China.

Quite frankly, we heard stories of China saying, "You know what? This is a pandemic. This stuff is being made here. We are going to take care of ourselves first." I do not deny them that ability, but it shows that we have an inequity in our system. And I believe that much of that personal protective equipment, masks, shields, gowns, those sort of things, need to be built right here in America so that when we need them, we have got them, and we can ramp it up. I will be pushing that moving forward, and hopefully, the folks from 3M and others would agree with that. But we will find that out during the second panel.

With that, Mr. Chairman, I am going to turn it back to you. I look forward to hearing from Dr. Stone and his leadership group, and we will have some good questions for him when he gets done with his presentation.

Thank you.

Chairman Moran. Senator Tester, thank you.

I share your views in regard to the supply chain in China, and I look forward to working with you and our colleagues to accomplish a different circumstance in the near future.

Let me introduce our first panel from the Department of

Veterans Affairs. Dr. Richard Stone is the executive in charge of the Veterans Health Administration. He is accompanied by Ms. Karen Brazell, principal executive director, Office of Acquisition, Logistics, and Construction, and Chief Acquisition Officer and Acting Assistant Secretary for Enterprise Integration--how do you have time to be with us today?--and Ms. Deborah Kramer, Acting Assistant Under Secretary of health and Support Services--just because your title is shorter, I could say the same ting to you, Deborah--and Mr. Andrew Centineo, executive director of the VHA Office of Procurement and Logistics.

I will reserve introductions of our second witness panel representing the Government Accountability Office and industry perspectives and now recognize our lead witness, Dr. Stone, for his opening remarks.

Dr. Stone, as I said earlier, thank you very much for your presence.

STATEMENT OF RICHARD A. STONE, MD, EXECUTIVE IN CHARGE, VETERANS HEALTH ADMINISTRATION; ACCOMPANIED BY KAREN BRAZELL, PRINCIPAL EXECUTIVE DIRECTOR, OFFICE OF ACQUISITION, LOGISTICS, AND CONSTRUCTION AND CHIEF ACQUISITION OFFICER AND ACTING ASSISTANT SECRETARY FOR ENTERPRISE INTEGRATION; DEBORAH KRAMER, ACTING ASSISTANT UNDER SECRETARY FOR HEALTH FOR SUPPORT SERVICES, VHA; AND ANDREW CENTINEO, EXECUTIVE DIRECTOR, PROCUREMENT AND LOGISTICS OFFICE, VHA

Dr. Stone. Chairman Moran, Ranking Member Tester, and distinguished members of this Committee, thank you for the invitation to testify today about VHA's response to COVID-19 and our efforts to build a more resilient supply chain.

You have already introduced my fellow members here. We are all veterans. Andrew has joined us virtually. Andrew has been assigned to FEMA since the beginning of this pandemic as our lead logistician to represent VHA's interest.

Let me say that both Deborah and Andrew have deployed and ben recognized for their work in combat, and I appreciate between the three of them, 60 years of supply chain experience to accompany me here today.

Chairman Moran. Dr. Stone, let me express the Committee's gratitude for yours and their service and

particularly their expertise on this topic, but mostly thank you for your service in caring for our Nation.

Dr. Stone. Thank you, sir.

COVID-19 has forever changed the world's approach to medical supply. For decades, the long-acclaimed just-in-time supply system kept shelves stocked because there was always another delivery of materiel on the way usually from a prime vendor or a manufacturer who acted as an intermediary. The prime vendor is acting as an intermediary between manufacturers and the end user.

This system has not delivered the responsiveness necessary to support the worldwide demand of health providers on medical supplies during this pandemic.

More importantly, the pandemic forced us to recognize that we cannot depend on the global supply chain to equip VA just in time in a future disaster. VA is able to cross-level supplies, equipment, and personnel across our integrated system. No facility at VA ever ran out of protective equipment, and we are taking steps to ensure that we never risk exhaustion of our supplies in future disasters.

We are working diligently to not only prepare for a potential second wave of COVID-19 but also for any other disaster the Nation might face.

As the Secretary told this Committee last week, COVID-

19 has shown the Nation what VA is truly capable of. In executing our fourth mission, VA has demonstrated extraordinary flexibility and responsiveness as we continue to delivery an integrated response to a first-in-a-hundred-year public health event, thus, allowing us to provide health care support to 46 States, Territories, and Tribal regions.

One of the good news stories to come out of this pandemic will be the positioning of the VA firmly at the center of the Nation's response to future public health disasters.

I could not be more proud of the fact that VA employees at every level have served with extraordinary heroism. VA professionals have responded day and night, week after week to save lives and make a difference in this pandemic, including hundreds who have volunteered to travel to the cities most impacted by this disease.

Never in our history has VA's fourth mission to backstop the American health care system been so expansive, and we continue to rally to this cause.

We cannot do our duty to America's veterans without an effective, responsive, and resilient supply chain. As the Nation's largest integrated health system, our demand for a complex combination of expendables, durables, equipment, and computers is unique in American medicine because of our

sheer size.

I want to directly address the negative perception of our relationship with FEMA caused by a published article. At no time did FEMA "take" our supplied. There was a short period of time immediately after the activation of the Defense Production Act that every vendor and supplier in this Nation paused delivery of some materiel to await further guidance. As a result, there was a single week where we simply were not receiving supply orders; therefore, we employed measures to ensure our employees had the PPE needed to be safe. We followed CDC guidance for conservation and prioritization of equipment, and there was never a point that a VA health care worker was put in danger treating COVID-19 patients without the materiel they needed.

Our relationship to FEMA has always been and remains today strong, collegial, and productive across all levels. The safety of the heroic VA personnel serving our Nation's veterans remains my number one priority.

As I close, I want to thank the Committee for the productive dialogue and strong relationship between our Department and all members of your Committee in response to this pandemic. VA is better positioned today to provide health care services to veterans and support our Nation because of what we have learned in our response to COVID-19.

My colleagues and I look forward to answering your

questions, sir.

[The prepared statement of Dr. Stone follows:]

Chairman Moran. Dr. Stone, again, thank you.

Let me begin a round of questions. Let me first start with building on the current system. Obviously, the VA needs to deal in an all-encompassing, holistic approach to manage its system to make improvements. My question is if you set up supply depots with the existing inventory management system, GIP, I worry that you are building on something that in and of itself is not a very solid foundation.

But my understanding is to implement the new system, the Defense Medical Logistics Standard Support, is expected to take 7 to 8 years.

So how do those two things, the timing of replacing the existing system and the creation of the supply depots, how do they fit together?

Dr. Stone. Sir, we have the prototype sites in Chicago and the Pacific Northwest that we will exercise during this fiscal year for the DMLSS modernization.

You mentioned in your opening statement that the EHRM is the centerpiece of our modernization, but that must be supported by a modernized IT system for logistics and supply as well as a financial modernization system.

I will defer to Deb Kramer and Andrew Centineo for their comments on how we will proceed with this.

We do have funding this year that we are spending on

the DMLSS modernization. We also have requested funds in the '21 year and the '22 year to do this, but the original plan was to go out 7 years in this modernization. This pandemic has revealed that that is too long a time frame for us to execute that.

And I will refer to Ms. Kramer.

Ms. Kramer. Good afternoon, sir.

Chairman Moran. Yes, ma'am.

Ms. Kramer. Yes, sir. We were going to be looking for commercial and potentially Federal partners for the regional readiness centers. The most likely outcome is probably a combined, potentially, DoD commercial sector.

Those organizations already have IT systems. They already use electronic data interchange, or EDI, and through that, we can communicate with the existing VA systems.

You are absolutely right. CHIP is archaic. It is an inventory management system and not a supply chain management system. So we need to get DMLSS out there as well, but we can do the regional readiness centers using our partners' IT system.

Chairman Moran. Ms. Kramer, my impression--you can correct me if I am wrong, but the Department of Veterans Affairs has had significant challenges with IT systems in the past and the present. What assurance should I have that this one is going to be what is needed to solve the problem

and we are going to be able to accomplish the IT system that will go with the changes that you are proposing?

Ms. Kramer. Yes, sir. The fat that we are using DMLSS, which is already in the field in DoD, a proven medical supply chain system, one that I used while I was on active duty, that is what we are doing. We are not doing a one-off. We are not developing our own system. We are going with a proven system, and we are working with DoD to do that implementation.

We are also not doing it ourselves. This is a full partnership with the Department of Defense.

Dr. Stone. Sir, Andrew may have some additional comments.

Chairman Moran. Oh, yes.

Mr. Centineo. Yes, Dr. Stone. Yes, Senator Moran.

In addition to that, you mentioned how can we look at getting supportive energy behind this. The Department of Defense, both the Defense Health Agency, which is the element that supports the IT enabler DMLSS, and the Defense Logistics Agency, which is tied to the supply chain, are both going to be critical for the success moving forward.

You mentioned in the opening remarks a whole-of-government approach. Leveraging this application is certainly a whole-of-government approach, and it will take us well beyond just the supply element. It will also tie

into the equipment. It will tie into the facilities.

Key to this PPE response was obviously our consumables, but we also had an equipment retirement. That certainly would be able to be facilitated through the DMLSS application, being able to see the equipment that we needed, versus having to go through a manual process.

But, certainly, this is not VA alone. This certainly is going to require the partnership through our statute, 8111, to partner with other whole-of-government agencies.

Chairman Moran. Thank you very much.

Maybe this was answered, but, Dr. Stone, you indicated there were two depots planned or in the works, and you mentioned Chicago and the Northwest. Is that the plan?

Dr. Stone. No. Those are the two prototype sites--

Chairman Moran. Prototype sites.

Dr. Stone. --for DMLSS and to expand that relationship with the Defense Logistics Agency as a vendor for us.

Chairman Moran. You absolutely did say that, but I had in my mind the question I had intended to ask you. How many supply depots do you intend to have, and what do you expect their locations to be?

Dr. Stone. So we see four readiness centers, which will not only house equipment for us but also house excess medical equipment that needs biomeds in order to sustain them, like the ventilators you talked about in your opening

statement, as well as to house the four Battelle systems that we have attained from HHS and from FEMA that can sterilize reusable equipment. And we are in the process now of sterilizing masks for future waves.

Chairman Moran. I will take from my vocabulary "depots" and replace it with "readiness centers," which is a much more appealing concept.

Dr. Stone. I think both you and Ranking Member Tester have brought up the point that this should not be independent.

We are a behemoth of health care system. At the height of this pandemic, we were consuming a quarter of a million N95 masks a day. That, when you begin to discuss with any supply chain system, is a daunting amount, and we do believe that our relationship to DoD, which is active--I meet with the DLA director on a monthly basis, also with their acquisition lead every 2 weeks. I also meet with Admiral Polowczyk, the admiral from the FEMA lead who has done the supply chain, on a weekly basis. We are unified in our approach to this but recognize that a future pandemic wave may test all of us in our preparation.

Chairman Moran. Senator Tester?

Senator Tester. Thank you, Mr. Chairman.

So I kind of want to follow up a little bit with you, Dr. Stone, and whoever you want to refer to on DMLSS. DMLSS

is not fully implemented currently. Is it implemented at all?

Ms. Kramer. Sir, we are in the process of implementing it at the Federal Health Care Center, James A. Lovell Federal Health Care Center. That will go live in August of this year. So that will be our first site and followed this fall by two sites in the Northwest.

Senator Tester. Okay. So you talk about how critical this was as it applied to the supply chain. I am not putting words in your mouth now, right? That is what you said, right?

Ms. Kramer. That is correct, sir.

Senator Tester. So when do you anticipate DMLSS will be fully implemented?

Ms. Kramer. Sir, the current schedule calls for a 7-year fielding that would complete the--

Senator Tester. Okay. That is the 7 years that Dr. Stone talked about, because that was my next question. It is too long. Boy, is it ever too long. I mean, we are not talking DHRM. We are not talking the financial system program. We are talking DMLSS, and both of those others impact our supply chain too, correct?

Ms. Kramer. Yes, sir.

Dr. Stone. Yes, sir. That is correct.

Senator Tester. So how do you shorten this up? What

kind of time frame are you looking at? If it is not 7 years, is it 5 years? I assuming working with the private sector is one way to shorten it up, but is there any other way you could shorten it up to get it done quicker? Because, gosh, within the next 7 yeas, we will probably have another pandemic. There is a possibility for a second wave. There is all sorts of bad crap that can happen.

Ms. Kramer. Yes, sir. I think 5 years is perhaps possible, but we have got to talk to our Department of Defense colleagues. They are on the critical path to getting this system fielded. We cannot do it without their support, and we need to understand what their constraints are before we can actually tell you what a realistic schedule would be.

Senator Tester. And it is my understanding the DMLSS is fully operational within DoD, correct?

Ms. Kramer. That is correct.

Dr. Stone. It is the supply chain system, sir, that we use in deployment. All of us are familiar with DMLSS, and it has supported us throughout the years of the war.

Senator Tester. I got it.

But it is also an old system, right, Dr. Stone? I mean, it is also a system that is pretty short term. No? I see someone shaking his head no.

Dr. Stone. Yeah. It is being replaced. Actually, the

next generation of DMLSS--

Senator Tester. Okay.

Dr. Stone. --is going to be called LogiCole, and LogiCole is DMLSS On a cloud-based system--

Senator Tester. I got it. Okay.

Dr. Stone. --which is scheduled to come out in 2022.

Senator Tester. I have go to tell you, there are some things about virtual hearings that I really like. It is when I say something that nobody agrees with and I see two people shaking their head no before you even spoke, Dr. Stone, so that is good. That is good.

Say, tell me where we are at right now, Dr. Stone. What is the current state of the VA's PPE and medical supply chain and reserves? You talked about a second wave. If a second wave happened in 2 weeks, are you set up to take care of it and protect our frontline employees?

Dr. Stone. The answer is yes. Ms. Kramer and her team have developed a manual system that every day is updated from every single medical center in the Nation, and so we are at approximately 30 days on all PPE.

And I will defer to Ms. Kramer and Andrew for--

Senator Tester. Dr. Stone, what does that mean? What does that mean, 30 days? Does that mean you have got a 30-day supply?

Dr. Stone. Yes.

Senator Tester. And you believe that to be adequate?

Dr. Stone. No. I believe that we need to move to a 60-day supply. I believe that for a full second wave, we will need an additional 6 months of supply, and either that can be supplied by the vendors--

Senator Tester. So we are--

Dr. Stone. --a manufacturing system, or must be in our readiness centers.

Senator Tester. So, Dr. Stone, we are not where we need to be?

Dr. Stone. That is correct.

Senator Tester. Okay. So the question is, When are we going to be where we need to be, and what is the issue? It sounds like--and I cannot say this because our cases in Montana are actually going up recently, but it sounds like we are kind of in a dip in this whole COVID-19 thing.

We have seen the cases--I mean, I heard the other day there were no deaths from it in New York City, for example. That is a very good thing.

But the question is, Are we taking advantage of this lag, or are we even seeing all that? You guys are not as busy as you were 2 months ago, are you?

Dr. Stone. So we have seen a reduction in the amount of hospitalization, and therefore, we have seen a reduction in our ICU demand. But what we have not seen is a reduction

in materials that are necessary for us to even reopen our ambulatory services. Every single ambulatory services now needs masks, now needs PPE, needs cleaning materials, the sort of things that you have seated around this room on your desks. We are not--

Senator Tester. So it sounds to me like, Dr. Stone, if we have a second wave, we are going to be back in the same boat we were in April.

Dr. Stone. Well, sir, my job on behalf of the Secretary is to make sure that we do not, and therefore, let me defer to Andrew and Deb to give you some comments on what we are doing to bring us to a readiness for wave two.

Ms. Kramer. Thank you, sir.

We are working with our partners at DoD, FEMA, and Health and Human Services and our commercial partners to get the materiel to build up and to sustain the operations that we currently have today.

But what I need to share with you is that supply chain system is still broken. There is still a tremendous demand on all of PPE, not just in the United States, but worldwide. And the manufacturing capacity has not caught up to the requirement. We are working hard every day to pull materiel in and to sustain operations, and we cannot let down.

And we are going to need your help in helping bring things onshore in terms of manufacturing. We need more 3M

production. We need more production from every N95 mask producer. We need a U.S.-based gown manufacturing capacity here that can support readiness, but the current supply chain is still struggling to support not just our needs but the needs of every health care system and hospital in the country.

Senator Tester. I am going to give this up right now, but as the Chairman already pointed out, I think you have got bipartisan support to give you whatever help you need to make sure that this manufacturing occurs.

I yield, Mr. Chairman. Thank you.

Chairman Moran. You have nothing to yield.

Senator Boozman?

Senator Boozman. Thank you, Mr. Chairman, and thank you all for being here. We really do appreciate you, Dr. Stone, and your team and really all of those throughout the system that are working. They work so very hard, anyway.

In the midst of a pandemic, you mentioned that you truly have a huge system, an unimaginably large health care system. We appreciate all that you have done.

Also, being forward thinking and dealing with the problems of the telehealth, the tele-mental health, all of that has been a great success. Again, that is the ability of your team to really adapt and ramp up. So we appreciate that.

I agree with Senator Tester about the concerns of PPE, but the problem is that as we reopen--I am talking the daycares. They are being required to have all of this stuff, all of our businesses. As we reopen, we are still required--people are getting out more, so they are wearing the stuff more rather than sitting in their homes. So it is just a huge problem with the demand versus what even as we have ramped up, and it does tend to, in my mind, think of the importance of perhaps doing the stockpile that you suggested that we used to do.

Do you need any additional authority to do that?

Dr. Stone. Karen?

Ms. Brazell. Thank you, Senator.

At the time, what I would offer is that at least we have some--the authorities we have in place today will provide what we need, but we do need to make sure that VA is at the table anytime there are discussions with relationship to health care support across the Nation. That is one thing this pandemic has provided, but the authorities we have today will meet our needs.

Dr. Stone. Let me just add, sir, one thing, and that is following Desert Storm, DoD was given a authority called "Warstopper." War stopper allowed them to pre-commit inventory from a manufacturer.

When you heard about DoD committing 10 million masks to

FEMA, that came from Warstopper, and what it does is it allows DoD to pre-commit that inventory. It is kept in a warehouse, but the manufacturer actually rotates it and keeps it fresh. So that if it begins to go towards expiration, it is a guarantee at a fraction of the cost to keep that fresh.

We believe having that type of authority would be very beneficial to VA also or to allow us to partner with DoD to actually execute that.

Senator Boozman. That was really going to be my next question. Can you assure us that that would not be the case? Because, sadly, we have had some instances of that during this crisis that we found that the stuff was pretty old and maybe not where we would like for it to be. So that is good to know.

Tell me about the IG report regarding delivery orders and things. There is some concern there. I think they found that a percentage, a significant percentage perhaps, were getting the wrong stuff. I think there was an IG report in December, is that correct, the Medical/Surgical Prime Vendor program?

Dr. Stone. Andrew, do you have that one?

Mr. Centineo. Senator Boozman, I am not quite sure I understood the question. That there was a shortage or an inability to get materiel?

Senator Boozman. They reviewed delivery orders and estimated that the medical centers received incorrect orders about 60 percent of the time, so a significant number.

Dr. Stone. Sir, I am going to have to take that one for the record.

Senator Boozman. Okay.

Dr. Stone. I am not familiar with that report.

Senator Boozman. Very good.

Are you adopting the Department of Defense Medical Logistics Standard Support system? Does that ring true? Are we upgrading that?

Ms. Kramer. Well, we are going to adopt DMLSS. DoD is in the process of doing a tech refresh. That tech refresh is called "LogiCole." So we would begin fielding DMLSS, and then we would switch from DMLSS to LogiCole.

Senator Boozman. So would that help with that kind of a problem?

Ms. Kramer. It would help with that kind of a problem because we have much better ability to track everything that we are doing inside DMLSS. GIP does not give us that opportunity. In f act, our supply techs need to swivel between systems. They have to work in multiple systems at one time for a single order to make things work. In DMLSS, it will all be done in one box.

Senator Boozman. Right.

Ms. Kramer. Much simpler.

Dr. Stone. So, as the Secretary has discussed this extensively in previous testimony, because of this fractured system, a large percentage of our purchases are done locally at medical centers using government purchase cards with literally billions of dollars traversing those government purchase cards. So it is very difficult for us to track those as well as to track the contracts that are being used and to assure the validity and the transparency of the system that you expect.

Senator Boozman. Okay. Thank you, guys. We do appreciate you very much.

Chairman Moran. Senator Boozman, thank you.

Senator Manchin?

Senator Manchin. Thank you all very much. Let me turn on my mic.

Like many of us, I am worried about the surge of cases in the fall and the winter and did not know what you all had planned to do to make sure that every frontline VA employee has the protections.

We have had some complaints, as you know, and you and I have talked about it before, Dr. Stone. It concerns in our VA hospitals that they did not have the proper protection and were not getting as much as they needed and were concerned about their own welfare.

So the gowns and the new masks that they are needing, I am sure you guys have been working on that, and I am hoping that you are able to fulfill that. But do you think the surge would be a strain on basically the supply chain that you have now?

Dr. Stone. Yes. I think the surge is a complete unknown. All we have to go by is what happened in the fall of 1918 with the influenza pandemic where the second wave had a dramatically greater mortality than the first wave.

Senator Manchin. Correct.

Dr. Stone. Certainly, a second wave is not an absolute. Dr. Fauci has said that in his testimony as well as his public statements. It depends on the activity of the American people, and it depends on the virus and--

Senator Manchin. Let me ask this question. Are we moving in an area to be prepared in case it does happen? Do you think that we are as a country? Do you think we are as the Veterans Administration?

Dr. Stone. I think that we are moving in the correct direction in order to develop the resilience that will allow us to meet a second wave. It is why we have now hired over 18,800 employees and continue to hire to prepare for the second wave.

But prior to this, we purchased $10 million a month worth of PPE as the VA. We are now purchasing $100 million

of PPE a month.

Now, certainly, costs have gone up dramatically as part of this, but that does reflect a massive consumption of PPE in which the industrial base of this Nation must be developed in order to develop that.

Ms. Kramer has been--

Senator Manchin. We have been begging the President to do the Defense Production Act on PPEs. We think, first of all, it would hold the price down. Next of all, it would increase the amount of supply all over our country, cannot figure out why we have not moved in that direction.

Dr. Stone. Sir, from our standpoint, every day Andrew and Deb's teams are in discussions with domestic vendors who are making investments in order to move us forward with a domestic supply chain.

The difficulty they have--and you may hear that in your second panel--is when all of this is over, how do they maintain that investment?

I think this is one of the things I would ask you to consider in the Warstopper program that has allowed DoD to do exactly that since Desert Storm for these type of materials.

Senator Manchin. But the Federal Government has a responsibility to make sure that we do have necessary equipment.

Dr. Stone. Yes, sir.

Senator Manchin. Ms. Kramer, would you want to respond to that?

Ms. Kramer. Yes, sir.

I am actually a member of the committee that is working on the next-generation SNS with DoD, with Health and Human Services, with FEMA, and with a number of Executive Branch partners. And they are working very hard on working to set up that industrial base capability that we need.

Senator Manchin. Have you been on that for a while--

Ms. Kramer. I have been on that for about 4 weeks, sir. It is just getting started and--

Senator Manchin. Have you all evaluated how we got behind the curve and got caught so flat-footed?

Ms. Kramer. Well, sir, I think that no one ever--well, I had a chance to speak to a former Chairman of the Joint Chiefs this spring who had called the lead for PPE because he cares about veterans, and he shared that in his war-gaming experience, DoD never played out the biodefense events the whole way to the end, because it was just too hard to do. And what we are going to need to do now, sir, is play it out to the end to see how it really works.

It was a tough problem; it is a tough problem now. And we have a long way to go to bring us back to where we need to be.

Senator Manchin. Are you all looking at basically a deposit, if you will, a depot that we will have for national defense, have the PPEs that we need so we do not have to reply on other nations, other countries?

Ms. Kramer. The Strategic National Stockpile is going to reestablish so that they can meet the second wave and then continue their readiness mission. We would like to work with DoD and our commercial sector partners to do things like the Warstopper program, Vendor-Managed Inventory, smart things that allow us to build up what we need.

But just in time for PPE is not the way to go, because a just-in-time supply chain cannot support a tremendous surge.

Senator Manchin. We know that, yeah.

Ms. Kramer. Yes, sir.

Senator Manchin. We know we have been caught behind, but the bottom line is bring manufacturing back. And unless we are going to have a stockpile, then you are right, Dr. Stone, they are not going to invest in that because they are going to say, "What happens when it goes away?" Well, it is never going to go away. We are going to have to continue to be prepared, and we have not been.

Thank you.

Chairman Moran. Thank you, Senator Manchin.

Senator Rounds?

Senator Rounds. Thank you, Mr. Chairman.

First, to the entire panel, thank you for your service to our veterans and to our country. Thanks for being here to talk today about one of the VA Secretary's top priorities.

I want to ask you about the VA's ongoing issues with its latest prime vendor program model, Next Gen 2.0.

Right now, the tiered acquisition rules give special considerations to certain small businesses. I recognize that that is important, but we also want to be sure that when it comes to large-scale critical missions like the VA supply chain that we are contracting with suppliers who have the experience and capability to deliver, even when times get tough.

But right now, as I understand it, it is up to the individual contracting officer who is reviewing the 2.0 supply contract bids to determine what fair and reasonable pricing is per the Kingdomware Decision that they are--that they are under right now.

This is one of the most important criteria involved in the contract award process. So my question is, What is the VA doing to set up standard criteria for defining fair and reasonable so that when they talk about pricing, we can be sure that these contracts are going to folks who have the

supply and the distribution capability to succeed?

Ms. Brazell. Thank you, Senator.

Fair and reasonable pricing is driven--what we would do is we would look at the market. So a market research is going to drive the prices and who can provide that, being a supplier or a distributor.

I do want to point out, through, that the MSPV 2.0 contract is an active solicitation. So there is not a lot we can go into, other than the fact that we took the lessons learned from the previous MSPV Next Generation and GAO's recommendation as well as Congress, and we brought our clinicians in.

So this time around, it is clinically driven sourcing, and it is going to be competitive. We are going to have tier reviews. So our service-disabled veteran-owned community is your tier one. Your tier two is your veteran-owned small businesses. Then your tier three would be the larger businesses.

Those will all be vetted. They are going to be competitive, and again, the market research is going to drive what would be the fair and reasonable pricing.

Senator Rounds. Let me just kind of follow up a little bit on some examples, perhaps. Let us take PPEs as an example. Let us take the gowns.

Right now, how many different providers, how many

different markets are there for the gowns that you would need?

Ms. Kramer. There are a number, and most of them are located overseas. There is very little cloth textile manufacturing in the United States, and we want to get to more reusables because that reduces the demand on the supply chain.

Senator Rounds. During this pandemic, have you had the opportunity to actually look at or negotiate with any manufacturers or suppliers that would do that within the United States?

Ms. Kramer. Actually, that is something that the SNS Next Generation Committee is doing. So through DoD, they are actually having those discussions right now.

Senator Rounds. Were they successful during this pandemic in making any of that happen within the United States?

Ms. Kramer. I think, sir, that that is a question that is probably addressed to DoD and FEMA.

Senator Rounds. So the VA probably would not be the lead agency in working through any of those? You would be tagging on with what others were doing?

Ms. Kramer. Sir, we would be providing our requirements so that industry would understand what the government requires.

Senator Rounds. Would the same thing be true with regard to other necessary items within the realm of the PPEs--

Ms. Kramer. Yes, sir.

Senator Rounds. --masks, face guards, and so forth?

Ms. Kramer. Yes, sir.

Senator Rounds. Are there any examples where we have actually had progress made after this pandemic or during this pandemic where we started bringing any of those back into the United States?

Ms. Kramer. Again, sir, I am not intimately involved with what DLA is doing with that effort between them. FEMA and they can provide the best answer to that question. It is also under solicitation, so there are some concerns about discussing it in an open forum, sir.

Senator Rounds. Would it be fair to say that making a transition from existing providers to new providers under emergency circumstances leave something to be desired right now?

Ms. Kramer. Well, sir, what we would like to do is the current providers--we would like them to bring things back onshore, do it here.

Senator Rounds. But in order to do that, do not they have to be assured that you would continue to use their resources, even after this pandemic is over? I mean, they

cannot just simply go out and put in whole new lines without having some assurance that you would participate with them for an extended period of time; is that fair?

Dr. Stone. Sir, you are exactly correct in that, and therefore, it has been very slow progress in this during the pandemic to move.

Every bit of domestic manufacturer has been completely overwhelmed by the demand. So if we are up 800, 900, 1,000 percent, so is every other health care system in America.

Let me give you one area of hope, and that is not clearly about PPE. As you know, there has been a worldwide shortage of swabs to do the testing on for COVID. We have been a leader in 3D manufacturing. We have been manufacturing a few thousand swabs a month--I am sorry--a week. We now have a plan in place to expand our swab manufacturing using advanced 3D manufacturing printers to the tune of about 100,000 a week by this fall.

So I think there is hope, but every small manufacturer we deal with in the United States is questioning a capital investment and whether that will be enduring.

Senator Rounds. Mr. Chairman, the only thing I would say--thank you. My time has expired, but I think we really have to talk about during an emergency situation when we run out of supplies. How do we cut through the bureaucracy to actually be able to award contracts on an emergency basis to

individual entities who might very well be perfectly capable of providing, whether it be masks or other gowns and so forth, if allowed to do so in a timely fashion and with the appropriate assurances that it will not be a one-time shot that basically breaks them up in business?

I think we have got--as you say, I think we have got a long way to go, and perhaps the VA could be a part of helping to solve that problem.

Thank you, Mr. Chairman.

Chairman Moran. Thank you, Senator Rounds.

Senator Blumenthal?

Senator Blumenthal. Thank you, Mr. Chairman.

Thank you all for being here.

Dr. Stone, a GAO report last year on VA's Office of Health Equity--I am sure you are familiar with it--made two recommendations. One was to ensure that the VA was collecting reliable racial and ethnic data on veteran patients, and the other was to ensure that any Health Equity action plan included measurable criteria and clear lines of responsibility to specific offices within the VA.

These steps are really important--again, I do not need to tell you why--because racial and ethnic minority veterans currently make up about 22 percent of the total veteran population, and they are projected to make up 40--or almost 40 percent of the total veteran population by 2040.

The VA has identified worse health care outcome for some diseases among minority veterans at VA facilities with recent data showing that COVID-19 is affecting African Americans at a higher rate than any other racial or ethnic population.

I find it unacceptable that the VA has not implemented any meaningful reforms to address racial disparities within the VA system. You have established the Office of Health Equity to identify and address health care outcome disparities and to develop an action plan, but the GAO report published last year found that there are no clear lines of accountability or measurable data.

So my question is whether you are committed to act on these recommendations, when you will do so, and what immediate steps you can take to change the fact that black Americans are treated differently than others and what we can do in Congress to support you.

Dr. Stone. Senator, when I came back to the VA in 2018, it was about the time that this report was circulating. We established the Office of Health Equity under my principal deputy, Dr. Lieberman.

Right at the beginning of this pandemic, we began sending to the field, information on data on the relative risk of the black male population and the fact that they were testing positive at a higher rate than other ethnic

groups.

What we have not seen is an enhanced death rate, unlike other health care systems, or the broader American population.

This is similar to what we have seen in prostate cancer, in black males enrolled in the VA health care system, where black males in the American public actually die at a higher rate from prostate cancer than do Caucasians or other ethnic groups.

That disparity is erased in the VA. We believe that that is erased in the VA because of our care of the comorbidities that exist with prostate cancer. We do not think that the disease is fundamentally different in black males versus Caucasian males or American Indian males, but we have been able to erase that disparity.

This is an absolute priority for us and reflects the respect that we hold for all veterans and our responsibility to deliver the utmost value in this integrated health care system.

Senator Blumenthal. Do you attribute the absence of different death rates from COVID-19--if I understood you correctly, the death rates are the same for African American veterans as they are for Caucasians? Is that due also to your addressing the comorbidity factors? You just talked about prostate cancer, but is that the same?

Dr. Stone. For COVID, we believe the same thing, but it is too early to absolutely tell.

Since the beginning, our research team has been working this, and it is just too early to get the data out and to really discuss it, but it is an absolute priority. And they are meeting weekly and briefing me biweekly on the results of this.

Steve Lieberman, my deputy, is taking this on a weekly basis and working our way through.

But I think the question that you ask is really about the value of a fully integrated health care system in erasing access to health care problems that exist across American society, and that is the beauty of this system and why all of us choose to work within it.

Senator Blumenthal. I agree totally that the thrust of the question is to address health care inequities, disparities in access to health care generally, which is, in my view, the reason why there are different death rates among black and brown Americans as opposed to others resulting from COVID-19. It is those comorbidity factors, whether it is respiratory problems or diabetes or--you can identify them better than I.

But if the VA is addressing those factors and diminishing disparities, I think that will be important to know.

Dr. Stone. So, with your forbearance, sir, we just took a look at a gene present in prostate cancer that allows the metastasis of prostate cancer and compared that to a gene that is present that opens lung cells to the penetration of COVID. It is that type of research and effort that you allow to go on by funding us in the manner you do that I think carries great hope and shows why all of this interrelates.

Senator Blumenthal. I think that is very important.

One last question, and I am pretty much over time, but since the Chairman is not giving me a negative sign, I am going to go ahead quickly and ask it.

Active COVID-19 cases are on the rise in several States: North Carolina, Arkansas, Alaska, Texas. And my understanding is also on the rise in some VA facilities. Is it on the rise in those States or in other States? Is there an overlap in the incidence of that trend?

Dr. Stone. Sir, as we discussed earlier with your colleague, our number of cases in both our med-surg units and our ICU continues to go down. I had predicted that we would stay at a 500-600 occupancy for COVID. We are down at 345 this morning, and so it continues to go down.

However, you have listed a number of very troublesome States. I would add to that Arizona, which in major areas are seeing an increase in cases. We have not seen that

increase in cases correlate well to the veteran population; therefore, we remain with substantial capacity in those areas that we think the commercial health care systems may call upon us to execute our fourth mission if this wave continues in those multiple States.

Senator Blumenthal. And you may have asked this already, in which case you can just say, "I have answered it." You do not have to be polite. Have you identified the reason for that non-correlation?

Dr. Stone. No, no. But I think it is part of the research that we have to go through.

We have questioned--70 percent of America's veterans have deployed. So they have been exposed to multiple immunizations. We have wondered is there something different about the American veteran that is allowing us to do very well in this.

That said, I think it is too early for me to really extrapolate that, and the researchers will be working on this for a fair length of time.

Senator Blumenthal. Thank you. Thanks very much.

Chairman Moran. Senator Blumenthal, I always look at the clock, and it is an inverse to the respect that one shows the Chairman once it goes beyond 5 minutes.

I recognize now Senator Tillis.

Senator Tillis. Thank you, Chairman Moran. I am sorry

you are not going to be able to see my face. I am having a problem with the camera, but I hope my audio feed is going okay.

Chairman Moran. We hear you well.

Senator Tillis. I have got a real quick question. One question, I know that the DMLSS system of the VA medical center is not going to be implemented, I believe, until 2027, and the DLA is--I guess the VA is going to need to pay the DLA to support the DMLSS system.

The question I had is--we are going to be in a situation. I think there is also a relationship between the EHRM implementation and DMLSS, that they kind of roll out alongside one another. So I am just trying to get my head around some of the sequencing in some of the decisions that you all thought about.

The two questions that I have on the rollout really is, number one, have you all assessed the feasibility of speeding up the DMLSS implementation or the rollout of it? And I know that a part of that depends on the delay that we have seen with the EHRM system, but have you looked at how you sequence those and potentially speed up the rollout? That is one question.

The other question is, Have you all assessed the cost versus benefits to just transitioning all the VMACs to--is it LogiCole?

Dr. Stone. Yes, sir. It is LogiCole.

I am going to defer to Andrew Centineo to give the most depth to this, but our plan has been to field the DMLSS solution no less than 60 days prior to go live of EHRM, so that we would get out of their way.

One of the beauties of doing EHRM is we are upgrading all of our closets, all of our communication closets to accommodate these systems.

There has already been a more rapid effort to improve the closets in EHRM, which would allow DMLSS to go faster. I would not characterize the cost to do that at this point. I think we can work our way through that.

We have money in the '21 and '22 budget, but if we wanted to accelerate it, which we think is appropriate, that would cost additional dollars.

So let me defer to Andrew for additional details.

And I want to make sure, because I made some comments before you go, Andrew. LogiCole is not a new software system. It is simply moving DMLSS to a cloud-based system, and so, Andrew, do you want to go ahead?

Mr. Centineo. Yes, Dr. Stone, I will. Thank you so much, and thank you, Senator Tillis, for the question.

So one of the key elements, as has been discussed here, has been documented in GAO reports, is to be able to have systemic business processes. So DMLSS needs to be the

application. It has been decided to be the application to provide holistic enterprise logistics support.

And I will just quickly touch on a few of the items because I do not want to lose sight of the fact that it will give us supply capability. It will give us enterprise equipment, ordering, receiving, accountability, maintenance. It will provide us facility management to include space or space file. So if we took, for example, today's environment for PPE, the need to expand our negative pressure rooms for patients, having that information resident in DMLSS could have an enterprise pull and an enterprise view for Dr. Stone to look at all of his facilities to say where do I have negative pressure rooms or where do I have capacity.

This enterprise application is fully integrated, unlike the current applications that we have today, AEMS/MERS, GIP, and Maximo, three islands, three completely separate instances across 170 facilities customized at every one of those locations.

So if we just look at the rudimentary business processes, DMLSS will give us the structural foundation to do that.

The question has been raised before. Senator Tillis, a great question. LogiCole is the future advancement. It will give us enhanced enterprise capabilities, but what we need to do is start with the technology that gives us the

business processes and migrating it to that next level, which was already programmed within DoD. It will be nothing more than having it go from a Microsoft Office Version 1.0 to 2.0 with mild enhancements that then the end user will have to get prepared with.

I mentioned it early, and I would like to reiterate the point that this is not a journey for the VA alone. The way it thrusts to enable ourselves to do this is the partnership with the Defense Logistics Agency, which is the supply chain side of the house, and the Defense Health Agency, which is the IT enabler, to bring the capability to our organization.

Dr. Stone talked about funding. Funding is a component of it, but the capability and capacity for DoD to be lock step with us is absolutely something that we will need support with to make sure that we have a fundamental whole-of-government approach that positions VA, DoD, and other partners in the environment of the supply chain specifically for DMLSS for DoD and the VA.

And I would personally ask for consideration from the Committee to look at how we can position ourselves with language to be able to get ourselves in that direction.

Senator Tillis. Well, I would be happy to speak with you about that.

I have got limited time. I can barely see the clock, but one thing I just wanted to bring to your attention more

than anything, we just got a recent announcement from HHS BARDA at Corning, got a $204 million contract to expand production lines for glass vials and preparation in anticipation of the vaccine.

So one of the questions I just had for VA, I would not expect you to answer is here, but just think about it. If you are taking a look at the promising reports that we are getting on the development of a vaccine and a large population and a fair number are in the at-risk category within the VA system, what are you all doing right now thinking through--let us say the clock ticks. We get into September-October. We could potentially have a vaccine that has already got the manufacturing capability to be manufactured at scale. What would you all need to think about now to make sure that you could take full advantage of that?

And then another question around syringes, other vials, other challenges. Are you thinking through the supply chain challenges for the vaccine response to COVID-19?

Ms. Kramer. Yes, sir.

We are working with FEMA and Health and Human Services on this. That is a whole-of-government approach. They are producing it for the Nation, and we will be part of the group that is supported with that.

And we are evaluating our requirements for syringes and

needles to be able to administer those, the vaccine, but we need to understand a little bit more about what FEMA and SNS are doing so we do not duplicate what they are also doing. They are planning on acquiring quite a few syringes and needles.

Dr. Stone. And our medical research team is participating with the development of the vaccine.

Chairman Moran. Senator Tillis, that is an excellent question, and I look forward to hearing more about the plans for utilization of vaccines as they become available. And it is worthy of our Committee spending some time on.

I now recognize Senator Hirono.

Senator Hirono. Thank you, Mr. Chairman.

Tragically, 33 VA employees have died due to COVID-19. Dr. Stone, does the VA have any data or accounting of how many of those employees were working in a facility that had implemented austerity measures with regard to the use of PPEs, and are you concerned that lack of proper PPEs led to employee deaths?

Dr. Stone. Senator, my number one responsibility is the safety of veterans and safety of the employees that have pledged their work lives to the VA.

It is impossible for any of us to understand how these employees got this disease, and we can go through privately the events regarding a number of these.

We had an early death that occurred in someone who was moonlighting in another facility and carried it back to a number of coworkers in an area that really was in no-patient contact.

So to suggest--

Senator Hirono. The record--

Dr. Stone. To suggest--please give me a minute here. To suggest that somehow we have endangered our personnel is just not borne out by the facts. We will be happy to go through and look at every single one. We are doing that at this time, and OSHA is involved in every one of our deaths, and so I appreciate it.

So let me say one other things. In Italy and in Spain, 10 to 15 percent of health care workers actually caught COVID-19. In Detroit, which is one of the few health care systems that has actually talked about their infection rates, their rate of infection is between 2.5 and 4 percent. We are at 0.8 percent on our personnel who have become infected. That to me reflects the fact that we have done a good job of working to protect our workers.

Thank you.

Senator Hirono. ON the other hand, Dr. Stone, at our last hearing, VA acknowledged that it is not there yet with COVID-19 testing for employees, and VA specifically cited a lack of cartridges and swabs.

So you know that there is a very low rate of hospitals testing positive, but then we are told that you are not there yet with regard to adequacy of your testing program.

What is VA doing to procure enough testing supplies for robust testing of VA employees, and when do you expect to have sufficient supplies?

Dr. Stone. So--

Senator Hirono. And once you have enough supplies, will there be restrictions on which VA employees can receive tests?

Dr. Stone. So what we would like to get to and I think what our employees deserve is on-demand testing. We, as of today, are just under 50,000 of our employees have been tested, which is about 17 percent of our workforce. That is dramatically higher than the American population.

We have tested all of our workforce in certain high-risk areas, including our CLCs as well as our spinal cord treatment areas.

We have the capacity at this time to test about 60,000 tests a week. We are running between 600 and 700 employees a day through that testing, and we hope to get there soon. But it is not the equipment that we need. It is really the cartridges and the swabs that we must get to in order to get to the amount of testing that I think both you and I would agree would be the right amount of testing that any

employees could feel safe going home at night, that they are safe for their family.

Senator Hirono. So there is acknowledgement that you do not have enough cartridges and swabs. So are you getting them?

I realize that 50,000, that only represents 17,000 of your workforce, but many of your workforce work directly with patients who are, therefore, in a risk category. So I think it is more important that the people who are working directly with patients in the VA system get tested. So where are you procuring the cartridges and swabs that you need to perform adequate testing?

Dr. Stone. So these are coming from multiple manufacturers based on the multiple different types of machines that we have.

Ms. Kramer or Andrew, do you have--

Ms. Kramer. Yes, sir.

And they come from a variety of places. Some of these are actually centrally controlled by Health and Human Services and are actually sent out on allocation. Again, these are products where there are shortages nationally. Swabs and these cartridges are not a challenge just for VHA. They are a challenge for many health care systems. So we get that allocation.

As they are able to--the manufacturers are able to

speed up production and as we develop, there is only two--three swab manufacturers that I am aware of in the world: one in Italy, one here in the United States, one in China. We are hoping more people get into that market and begin producing more swabs that would actually relieve some of the shortages that we are experiencing today.

Senator Hirono. Well, this is one of the reasons that so many of us have advocated that the President fully utilize the Defense Production Act because it is just unacceptable--that is kind of a nice way of putting it--that a system as large as the VA does not have an adequate amount of these kinds of materials, and yet you have to compete with other systems. Every State is competing for these materials.

I mean, I do not necessarily want to put you on the spot, Dr. Stone, but it would make a lot of sense if the Defense Production Act had been fully mobilized to produce all of these necessary testing supplies. I do not know if you care to answer. Would you care to answer?

Chairman Moran. Senator Hirono, let me see if Dr. Stone wants to say something. If not, we will move on to Senator Cassidy.

Dr. Stone. I think that when you are dealing with a once-in-a-hundred-year pandemic, there are lots of lessons learned. One of them is how we use domestic manufacturing.

Chairman Moran. Senator Cassidy?

Senator Cassidy. Thank you all. Again, Dr. Stone, thank you for the assistance the VA gave to the people in New Orleans, and you all stepped up. When I hear that your infection rate is 0.8 percent, as a physician, that is incredibly impressive, and so let me just say that as well.

Let me get to my question. Here is something. Let me just ask you. The VA clearly has enormous buying power. You can get the lowest price, if you wish, of all products.

Now, I hear from doctors, and they are telling me that they were not necessarily consulted in the decisions made as to what products to purchase.

It comes to mind that when I was practicing medicine, I worked in a State-run hospital, and you know those little packets of K-Y jelly that we use for endoscopy. We put it on the end, and we pass it. Somebody went out and bought a substitute for the normal vendor, and it turns out they only gave three-quarters of the amount per packet. So we ended up using more packets than we would have, even though they got a better price on the packets.

If they had asked a clinician who actually used it, we would have known.

So I am hearing from some of my folks within the VA that these standardization decisions are made as regards to purchasing, but the clinician himself or herself is not

consulted in that decision-making process.

One more thing I will say, I think this is called the Next Generation Medical-Surgical Prime Vendor contracts, and as subsequent, it has not been embraced by the clinicians.

I will also say I had a bill pass in 2018, the VA Medical-Surgical Purchasing Stabilization Act, which was to ensure clinician input on formulary decisions, but again, I am hearing that that has not been implemented as per the purpose of the law.

So, Dr. Stone, what comments do you have on that? How involved are the clinicians in driving the contracting strategy?

Dr. Stone. Senator Cassidy, thank you.

You are talking about clinically driven sourcing, and I think that Andrew Centineo can talk a bit about that, as can Karen.

So, Andrew, do you want to take this?

Mr. Centineo. Yes, Dr. Stone, I will.

Thank you, Senator Cassidy, for the question.

Unequivocally, clinically driven strategic sourcing is at the center of where we are.

True, in our old-generation med-surge prime vendor contracts, that was lacking or perhaps not there.

I would offer that last year, we actually assembled over 150 clinicians as part of the clinically driven

strategic sourcing initiative. That does have clinicians across the entire VA in areas of specialty that are required to be able to help us source our material as we are doing our MSPV 2.0 solicitations. It is with clinical technical review teams before those products are put into the sourcing selection.

We unequivocally have brought in leaders, to include Dr. Paul Varosy, who is one of the premier cardiologists. He is in there leading it from his vantage point, and he is working with the chief medical officers across all of our VISNs to be able to have their input providing clinically driven sourcing.

I would offer you have to have a background in supply and logistics to look at the factors that go in there. We also have to bring in there, how do we bring our buying power.

Although the VA is large, only if we are brought together in a larger entity, if we look at a whole-of-government approach, do we really start to see market share.

If we were to partner with DoD, we would probably get to the 4 to 5 percent market share. That is where we are. Although we have 170 medical facilities, we do not really dominate that much of a market, but we certainly can get buying power by collaborating more closely, but we--

Senator Cassidy. Well, let me ask that because I am

almost out of time. Thank you for that answer, and that is reassuring.

One of the problems we have right now, at least in pharmaceuticals, is that there can be a price driven so low with the sole-source provider that you end up with only one provider of a generic drug.

And I see you nodding your head. This is something we all recognize.

DoD will actually pay a little bit more to make sure that they have at least two providers of a certain widget, if you will, whatever they need to make things happen.

So has there been any consideration for VA to perhaps invest in--as some other big systems are--invest in making sure that we have more than one provider of key elements of that which we need?

And, Karen, you seem teed up to address it.

Ms. Brazell. Yes, Senator Cassidy. Thank you.

I just want to make clear that the current MSPV 2.0 contract is under active solicitation, but I can tell you what they did for MSPV Next Generation.

First and foremost, it was not competitively bid. What they did is too 400,000 items, and we were directed by GAO and, of course, Congress to bring in the clinicians for it to be clinically driven sourcing. So we are down to 22 categories, that each of those categories had a physician as

part of that team in the development process.

Competition is what is going to drive the price, and so this contract is going to be competitively bid. And we are going to have it tier-reviewed. So there will be three different levels of tier review, starting first with our service-disabled, veteran-owned community.

Senator Cassidy. That addressed my first but not my second, but I am out of time. So I will yield back. Thank you.

Chairman Moran. Thank you, Dr. Cassidy.

Now Senator Sinema.

Senator Sinema. Thank you, Mr. Chairman, and thanks to our Ranking Member for holding this hearing.

Thank you to all of our witnesses for being with us today.

This topic is extremely important to ensure VA can protect its staff and the veterans it serves as they continue to treat veterans during the coronavirus pandemic and prepare for future health emergencies that might occur.

My first question is for Dr. Stone. The VA has multiple avenues for procuring medical and surgical equipment and supplies, including government procurement cards for ad hoc purchases.

Given the short supply and high demand for personal protective equipment and other supplies during the pandemic,

facilities have been making purchases in some cases from unknown or new vendors. Some of these purchases result in the VA facilities receiving expired or otherwise compromised supplies.

Does the VA Central Office have a way to identify and track these purchases to ensure that the VA does not spend taxpayer dollars on fraudulent sales?

Dr. Stone. Not as effectively as we should.

Ms. Kramer has been working this.

Ms. Kramer. Yes. And I just actually would like to go back to Senator Cassidy's question to also mention that Warstopper is another way that we can make sure that we can maintain more than one manufacturer out there, but we do not have that authority. And we would need that authority to be able to support two manufacturers, especially if one is offering a significantly lower price.

We have a very difficult time, given the systems that we have at VA, on being able to see the government purchase card orders in real time. We are catching these typically later and typically after someone has reported a problem. That is one of the other big reasons that we need the Defense Medical Logistics Standard Support System because the government purchase cards are put into that system, and it can only be used through that system. And the system will actually stop you from making a purchase where there is

a better source.

We are putting guidance out to support the facilities in terms of how to identify counterfeit products so they do not acquire those, and it sounds like I need to put a little more training out in the field in terms of how to identify manufacturers who can deliver FDA-cleared products.

Senator Sinema. So a follow-up question to that, then. As the VA is moving forward with a plan to modernize the procurement systems, have you considered creating systems that have the capability to prevent flagged vendors from conducting business with the VA while also allowing the incorporation of vetted local suppliers that can provide local VISNs with more flexibility and shorten the supply chain, basically doing two things at once, stopping the guys who are fraudulent so no one else makes that same mistake and then also incentivizing using local folks who are trusted and proven?

Ms. Brazell. Senator, this is Karen Brazell.

Yes. We do have methods. When we have what we call a "bad actor," we flag those. So that message is promulgated throughout the VA, and that messages are sent out from our senior procurement executive.

And then we also flag it in our contract management systems. When we do have those bad actors, we make sure that we communicate to the entire acquisition community at

the VA, what to look for and how to address fraud, waste, and abuse.

Senator Sinema. Thank you.

My office has heard concerns from some VA health care personnel that as PPE shortages increased, they were given less PPE, and they did not understand why one person would receive a surgical mask while someone else would get an N95 respirator.

There were also strong concerns that we heard in our office that new CDC guidelines related to reusing and conserving certain types of PPE put the health of personnel and veterans at risk.

So, Dr. Stone, as part of evaluating the proper use of PPE during this pandemic, can the VA and other Federal agencies work with the CDC to reevaluate their guidelines? And can the VA and other Federal agencies track and evaluate the impact of changing PPE guidelines in the years to come?

Dr. Stone. I think we can, and I think we should. I think that one of the frustrations in a health care system not under stress is that you can throw a lot of things away that have usable life.

I think we saw that with the N95 masks. If I go into a surgery that I need a surgical N95 and that surgery takes 6 hours, I wear that mask for 6 hours, but yet on a floor when we are out in a med-surg floor, in an ICU, we might throw

that mask away in 5 minutes, even if it has not been soiled or contaminated in some manner.

So when we said to employees that you can use a mask for your shift, whether that be 8 or 12 hours, it was done with CDC guidance and only after the CDC guidance, and it was reflecting the fact that studies have shown that those masks will work for that 8 to 12 hours.

So there was a lot of discomfort in that on the floors, and it has been an education for all of us who for my nearly 40 years of being a physician have just simply thrown those things away when I walked out of a room.

This was different but also reflected the experience that we have around the world as well as the research that has been done demonstrating those material safety.

Senator Sinema. Thank you.

My time has expired. Mr. Chairman, thank you.

Chairman Moran. Senator Sinema, thank you very much.

Now Senator Blackburn.

Senator Blackburn. Thank you, Mr. Chairman, and thank you to each of you for being there.

As we talk about having this inventory system, having the purchasing system, let me ask something I have not heard you mention in this hearing. How many purchasing agents does the VA employ, and where are those agents located?

Ms. Brazell. Thank you, Senator.

Specifically, I can address at least your contracting officers because purchasing agents may be like GPC cardholders vice a contracting officer.

So within the VA, we have at least 3,300 contracting officers geographically dispersed. The proponent of them reside in VHA. So about 2,200 of those contracting officers reside in VHA to make those decisions and award contracts.

Senator Blackburn. And how many hospitals are in the VA system?

Dr. Stone. 175.

Senator Blackburn. Say that again>

Dr. Stone. 175.

Senator Blackburn. Okay. For 175 hospitals, you have 3,300 purchasing agents, and in addition to that, you have individuals that hold the GPD cards. Am I correct about that?

Dr. Stone. Yeah. I think there are 17,000 GPC cards that are in the field.

Senator Blackburn. Let me ask you this. First of all, let me say your 7-to-8-year implementation plan is just way too long. That means the job is never going to get done, but let me ask those of you on the panel. Have any of you looked at any of the hospital chains, the hospital management companies like HCA or Community Health or LifePoint Health, and looked at their purchasing departments

and the number of people that are there and how they make their purchasing decisions? Have you done a deep dive on this?

Dr. Stone. So I have, and I will defer to everybody else to answer also.

So we took this concept of moving to a more centralized and a more accountable system, and we look at look at Ascension Health, which is about the same size as us and has gone through multiple procurements of other hospitals. We presented this concept to our special medical advisory group, which has a number of health care leaders, including leaders from HCA.

We have dramatically more purchasers of materiel than any of the other commercial health care systems which is--

Senator Blackburn. Probably several hundred-fold.

Dr. Stone. Yes, ma'am.

Senator Blackburn. If most of those have purchasing departments, that would be about 25 people. Am I correct on that?

Dr. Stone. I am not sure it would be that austere.

Senator Blackburn. I think I am correct on that. Yes.

Dr. Stone. But you are correct that we are several-fold greater, and hence, we have a system that does not deliver the transparency or the level of accountability that either you or I would expect.

Senator Blackburn. So looking at that answer--and I know it is difficult to do this by video. So looking at that answer, then before we get going down into replacing any kind of system, we need to look at your structure and find a way for you to, first of all, take you--you would be better served to have 130 people as opposed to 3,300 people. You would be better served not to have 17,000 additional that can go make purchases, but looking at a different way to approach this and doing it more like a hospital system.

Ascension is a good one because they deal with pharmaceuticals. They deal with the hospitals. They deal with clinics. They deal with a variety of facilities within that framework. So you need a structural overhaul before you can even address your problem.

Mr. Chairman, I would recommend that we go back to the drawing board on this and that we work with the VA in a way to get their structural system in order first and then give them a timeline that is going to be more realistic. Seven or 8 months, they ought to be able to do this as opposed to 7 or 8 years.

I yield back.

Chairman Moran. Senator Blackburn, thank you very much.

I would ask our witnesses, Dr. Stone, do you or any of your colleagues want to add anything to what has been said

previously, any opportunity to correct to add or modify any of your testimony?

Dr. Stone. The only addition I would make, sir, is to reemphasize what I said at the opening.

The collegial relationship we have with your Committee and each of the principals is a dynamic and excellent discussion that helps us through all of these issues.

When the Secretary and I came to the VA, we recognized there were three major systems that must be fixed: our information system for collecting clinical records, the EHR; the supply chain; as well as financial modernization.

We have hit today on the second pillar, but in this pandemic, it is that pillar that has really created most risk for us.

We appreciate the manner of the questions and how you have conducted this and look forward to our next discussion.

Chairman Moran. Dr. Stone, thank you to you and your colleagues, and we will now call the second panel for their testimony.

We have with us today: Ms. Shelby Oakley, the Government Accountability Office's director for Contracting and National Security Acquisitions; Mr. Roger Waldron, president of the Coalition for Government Procurement; Mr. Michael McDonald, director of Government Operations at 3M Health Care; and finally, Mr. Kurt Heyssel, a principal with

Sightline Performance Advisors and the former Chief Supply Chain Officer at the Veterans Health Administration.

I am not sure who all are appearing in person and who are appearing by technology.

Thank you very much for joining us today and for providing your testimony and the conversation that I know we will have, and we will begin by recognizing Ms. Oakley.

STATEMENT OF SHELBY OAKLEY, DIRECTOR OF CONTRACTING AND NATIONAL SECURITY ACQUISITIONS, GAO

Ms. Oakley. Thank you.

Mr. Chairman, Ranking Member Tester, and members of the Committee, thank you for having me here today to discuss our observations on VA's medical supply chain and its response to the COVID-19 pandemic.

Like most medical institutions nationwide, VA has faced difficulties obtaining personal protective equipment for its workforce in recent months. VA's existing mechanisms for obtaining medical supplies, such as its Medical-Surgical Prime Vendor program and other national contracts, were not able to meet the demands for PPE at its 170 medical centers.

Global shortages of supplies led VA officials to use whatever means available to obtain supplies, including existing and new contracts and other means such as government purchase cards.

VA mobilized its workforce, and it was--and still is--an all-hands-on-deck effort to respond. I commend VA's contracting and logistics workforces for their tireless efforts.

While some of the challenges VA experienced during the height of the pandemic were a result of an unprepared global supply chain, some were due to longstanding problems with

VA's acquisition management function that we have reported on in our work and that led us to elevate VA's acquisition management to our high-risk list in 2019, problems such as an ineffective program for purchasing medical supplies and old and unreliable systems.

VA has taken steps to address some of its acquisition management challenges, but our ongoing work indicates that some will not go far enough, and others are years away. For example, preliminary observations from our ongoing work show that VA has made improvements to the Medical-Surgical Prime Vendor program that have mitigated a few of the shortcomings we identified in prior work.

These shortcomings, including a limited catalog of supplies, led to low usage of the program by medical centers.

Despite making some improvements, medical center officials report continued challenges, even under normal circumstances, with receiving timely supplies. VA's planned improvements to the program will not likely address these challenges or others.

VA has a just-in-time inventory supply model, a practice employed by many hospital networks. As you can imagine, a strategy premised on historical demand signals, small stocks, and daily deliveries, if disrupted, could quickly lead to a situation where a medical center is

lacking necessary supplies.

VA's current inventory management system does not provide decision-makers with real-time information to monitor and assess supply levels and support critical decisions about where gaps, needs, or surpluses are located.

As early as February, the Nation faced unprecedented supply chain paralysis, bringing VA's lack of visibility into its agencywide inventory of PPE front and center. In March, VA officials implemented a patchwork approach to obtaining information that relies on daily manual reporting from its 170 medical centers on their provisions of PPE for COVID response.

VA has evolved this system over the past few months, for example, by putting in place a dashboard for decision-makers and by issuing guidance to assure more consistent data, but the bottom line remains. Our Nation's largest integrated health care system relies on an antiquated inventory management system that even in the best of circumstances is inefficient.

While VA has improvements planned as part of its supply chain modernization efforts, a recent status update indicates that they are at critical risk of not meeting modernization milestones, even before COVID. For example, VA plans to roll out a Defense Logistics Agency system which provides more real-time inventory management. Technology

integration issues, however, have delayed near-term implementation, and complete implementation throughout the VA hospital enterprise is not planned for at least 7 years.

In conclusion, VA experienced many of the same challenges obtaining PPE as private-sector hospitals and other entities in responding to this devastating pandemic; however, VA was particularly ill-positioned to respond efficiently, given its existing acquisition management and supply chain challenges, despite the valiant efforts of its workforce.

Chairman Moran, Ranking Member Tester, and members of the Committee, this concludes my oral statement. I would be happy to answer any questions that you have.

[The prepared statement of Ms. Oakley follows:]

Chairman Moran. Thank you very much.

Mr. Waldron?

STATEMENT OF ROGER WALDRON, PRESIDENT, COALITION FOR GOVERNMENT PROCUREMENT

Mr. Waldron. Chairman Moran, Ranking Member Tester, and members of the Committee. Thank you for the opportunity to appear before you today to address the challenges facing the Department of Veterans Affairs as it builds a resilient supply chain supporting the health care of our Nation's veterans.

I am Roger Waldron, president of the Coalition for Government Procurement, and our association is pleased that the Committee is focusing on the VA's supply chain and its role in delivering best value health care to veterans.

By way of background, the Coalition is a nonprofit association of small, medium, and large businesses collectively representing more than $145 billion in annual purchases through government contracts for commercial products and services.

Coalition members provide more than $12 billion in medical-surgical products and pharmaceuticals to support health care needs of our Nation's veterans and warfighters.

Today my remarks summarize my written testimony, which has been submitted to the Committee and which I ask to be included in the record.

Chairman Moran. Without objection.

Mr. Waldron. Coalition members strongly support the

VA's efforts to implement a clinically led program office to develop sound requirements. These requirements will define the scope of the VA's formulary and the commercial and medical-surgical products available through the MSPV program, national contracts, and the Federal Supply Schedules.

A clinically led program office serves as a bridge between program entities generating requirements and VA procurement professionals and contractors by identifying, collecting, analyzing, and communicating formulary requirements across the Department and to industry.

Given this central role in the VA logistics supply chain, it is vital that the program office be managed and led by clinicians. This management includes the naming of a medical supply chain leader responsible for formulary management and engagement with industry along with the investment of resources to implement a robust clinically led program office for medical requirements development.

Further, this office should serve as the lead point of contact for industry about new products and innovations. This role would provide industry with a clear, direct channel through which it can engage with the Department and should have the latest developments in the rapidly evolving field of medical and surgical technologies.

Engagement with industry, however, is just one factor

in developing a robust formulary. Input from health care providers and treatment facilities across the VA along with the availability and analysis of transactional data are critical to developing an efficient, effective formulary. The lack of meaningful, accurate purchase data undermines the development of a comprehensive, holistic formulary. In this regard, the current significant reliance on government purchase cards undermines the VA's formulary because it fails to provide such data.

The condition is circular. Treatment centers use the purchase card because items are not on the formulary, and as a result of that use, the VA lacks the data necessary to improve the formulary.

The VA should enhance and expand the formulary to reflect clinical needs. This effort would provide the VA with a sound spend data, and that combined with clinical input can be used to improve the formulary incrementally, standardizing product categories, where appropriate, while providing clinical flexibility and choice in other product categories.

A first step in expanding the formulary would be to allow firms to offer their full product lines rather than picking and choosing subsets of products, lines, or individual products.

Coalition members support the VA's efforts to modernize

its financial and logistics systems. These systems are critical, indeed foundational, to creating, managing, and collecting data to support clinically led sourcing.

With regard to DMLSS, transparency regarding implementation schedule, milestones, and operations will assist all stakeholders in responding to changes in the Federal health care market. The VA's industry partners need to understand the implications for their business of a transition to this new logistics channel.

Correspondingly, all stakeholders will need to understand how the DLA contracts will evolve over time with the expanded scope and increased usage by the VA.

Finally, regarding acquisition generally, streamlining processes and streamlining regulations would help the VA meet its needs. Efficiencies could also be obtained by centralizing procurement operations. This coordinated management would allow the Department to focus on all aspects of the supply chain, including small businesses.

Chairman Moran and Ranking Member Tester, the job is complicated, but the suggestions made here could help the VA improve the supply chain programs that serve our Nation's veterans.

Thank you again for the opportunity to address the Committee. I look forward to answering questions.

[The prepared statement of Mr. Waldron follows:]

Chairman Moran. Thank you for addressing the Committee.

Now Mr. McDonald.

STATEMENT OF MICHAEL McDONALD, DIRECTOR OF GOVERNMENT OPERATIONS, 3M HEALTH CARE

Mr. McDonald. Chairman Moran, Ranking Member Tester, and distinguished members of the Committee, thank you for the opportunity to appear before you today.

Mr. Waldron. I think you have to press that button.

Mr. McDonald. Good afternoon, Chairman Moran, Ranking Member Tester, and distinguished members of the Committee. Thank you for the opportunity to appear before you today . My name is Michael McDonald. "Mac," they call me. I am the director of Government Operations for EM's Health Care Business Group.

Prior to joining 3M in 2013, I served in the United States Army for 30 years. I retired at the rank of colonel. My area of medical specialty was as a medical logistician in the Medical Service Corps.

Arriving here, given my experience, I hope that my testimony today will provide helpful to your Committee and reviews possible steps and strengthens and improves the supply and delivery of medical materiel throughout Veterans Health Administration.

3M is a leading provider of personal protective equipment and medical solutions worldwide for medical professionals, workers, and the public. Besides disposable N95 respirators, we are also a leading manufacturer and

supplier of reusable respirators.

In addition, 3M provides other critical solutions in support of a pandemic response, including hand antiseptics, industrial cleaning, and any microbial testing and monitoring.

3M is playing a unique role in the fight against COVID-19, and it is a responsibility we take seriously. Beginning in January, 3M began increasing its production of N95s and other respirators, doubling its global output. In the United States alone, we activated our surge capacity and made an additional investment, increasing our N95 rate from 22 million per month pre-pandemic to 35 million per month today.

By the end of this month, we will be producing at a rate of 50 million per month, and by the end of October, we will be producing 95 million a month. Total for the annual year projection, we will be producing 1.1 billion N95 respirators. That is four times pre-pandemic production rates.

In addition, 3M has launched a global effort to combat fraud and price gouging and help protect the public against those who seek to exploit the demand of critical 3M products during a pandemic. Most important, 3M has not and will not increase the prices for N95s and other respirators as a result of the pandemic. We have also created and made

available a number of resources to help purchasers of respirators and the public to avoid price gouging and other unlawful activities.

3M and the VA have partnered together for well over 25 years, with 3M providing solutions through multiple contract vehicles and responding to the COVID-19 crisis. The VA has contracted with 3M and additionally has received 1.8 million respirators to date and have contracted for over 25,000 powered air purifiers and 25,000 elastomeric, which are the reusable respirators.

While working with the VA to deliver critical medical supplies during the ongoing COVID-19 pandemic, we observed that there would be value in implementing a clinically integrated supply chain system to ensure systemwide visibility and requirements-driven solutions. Going forward, the concept of a sale to centralize and coordinate acquisition and logistical efforts should be considered as a best practice.

Furthermore, VA should be considered a stockpile program, much like DoD. 3M currently works with the Department of Defense incorporating contingency matters that allows them to work rotatable sticks.

While significant reforms have been adopted to modernize the VA, Medical Surgical Prime Vendor program still remains a work in progress.

Health care supply chain transformation starts with the patient, clinical provider, and reform should aim to address those topics directly, a clinically driven, integrated, and clinical adopted solution where clinicians are involved in the decision-making. Automating systems and the process is just one component of that. Standardizing and simplifying processes will, indeed, increase efficiencies throughout the Department of Veterans Affairs. Besides these and other reforms that are delineated in my written testimony, one key concept in this development of this process is a process map, not 7 years, because this actually began in 2012 when they did a proof of concept with DMLSS at the level facility. So that process map will prove to be very effective.

3M is a proud leader and supplier of personal protective equipment and other health care-related solutions to assist not only with the COVID-19 pandemic but also enabling the VA to achieve its main goal and function, to serve our Nation's veterans.

We are committed to continuing to work with and to be a strong partner with the VA as they move forward in their efforts and modernization, their current procurement processes. We are dedicated in serving as a resource in both agency and the Committee during this ongoing process.

I would like to thank you again for this opportunity to

appear before you today and happy to answer any of your questions.

[The prepared statement of Mr. McDonald follows:]

Chairman Moran. I thank you, Mr. McDonald, for appearing before our Committee.

Mr. Kurt Heyssel is recognized.

STATEMENT OF KURT HEYSSEL, FORMER CHIEF SUPPLY CHAIN OFFICER, VETERANS HEALTH ADMINISTRATION

Mr. Heyssel. Thank you, Chairman Moran, Ranking Member Tester, and honored Senators. It is an honor for me to be here today as much as it was when I was originally asked to serve our veterans over 2 years ago. I believe there is no higher mission for this Nation to ensure the care and well-being of those who have served to protect all that we know and love.

A lot has been spoken today regarding various issues facing the VA, and they are all pressing issues. However, I believe a fair amount of what ails the VA supply chain is due to an organizational structure that has evolved over time. The current structure lends itself not to a unity of mission, vision, or a shared sense of purpose, but to operational and functional independence. This creates a bias for action to do what is thought best locally, without thinking of the larger organization and oftentimes without all or much of the information. As a result, any nationwide standards of performance or best practices or efforts to implement systems of management are hard to implement and monitor, which leads to the greatly varying results across the system we see today.

It also takes an enormous effort to create transparency and to understand the big picture facing VHA supply chain.

Oftentimes, the left hand does not know what the right hand is doing.

VA corporate is not in control as it must be to achieve supply chain success. Many large private-sector health systems when faced with this same issue implemented a shared service organization. I believe this is the answer for the VA.

Again, this is not the fault of any one person or group of persons. It took years to become this way, and this situation is, in my opinion, the single largest reason the VHA runs a high risk of failure and often does fail whenever a large systemwide effort is undertaken, and the result is a failure to serve our veterans.

VHA supply chain can and should be much more effective than it is, and the very good news is that this is a fixable condition.

I am anxious to get the conversation started. Thank you so much for your time.

[The prepared statement of Mr. Heyssel follows:]

Chairman Moran. Thank you for your time.

Let me begin with questions, and then I will turn it to Senator Tester.

I assume that you listened to the testimony in the previous panel, Dr. Stone and his colleagues. Let me just ask you. If you were in my place or our place, what did you hear that I should be asking questions about? What did you hear in regard to their plans that raises the significant concerns, any significant concerns? Help me know what it is that we should be observing and pursuing as we continue to look at this issue of procurement.

I ask that of any and all of you.

Mr. Heyssel. Mr. Chairman, if I might?

Chairman Moran. Please.

Mr. Heyssel. This is Kurt Heyssel.

A good bit of time is spent talking about the contracting process and how there are so many contracting officers involved in private sector versus what the VA has.

What does need to be recognized is I think the VHA needs to--or maybe the VAAR or FAR needs to recognize what a source is. A source for anything, be it an N95 respirator or a scalpel or a clip applier is not whoever can sell it to you. The source is the manufacturer.

I think the VA, VHA--and even VHA, all the Federal agencies involved in health care need and should contract

directly with the manufacturer and then hold separate contracts with the people or companies they are choosing to buy from. That is what happens in the private sector. I would have 1,600 contracts with 1,600 different manufacturers, and then I had a contract with my distributor and a contract with then the other independent distributors. We paid a guaranteed price for the suture, and then we paid a guaranteed markup to our distributor, oftentimes anywhere from 1.75 percent to 3 percent.

Then in order for the distributor to stay in business, because the distributor needs to make at least 8.5 percent to keep their doors open, they had a relationship with the manufacturer, and they would pick up back-end money or a rebate from the manufacturer, which was essentially the manufacturer's recognition of the important role the distributor plays. The distributor creates elasticity in the supply chain. The distributor helps the manufacturer by making sure the manufacturer is not managing 5- or 6,000 ship-to's, and the distributors is helping its customer by making sure the health system is not managing 5- or 6,000 purchase-from sites.

So that is something that really would help the VHA incredibly. It would shorten the time needed to make a procurement. It would actually shorten some time needed to make a decision as to what they are going to buy and from

who.

Chairman Moran. Thank you very much.

Others?

Ms. Oakley. This is Shelby.

First off, I would say that, unfortunately, I think the situation that Mr. Heyssel is describing is only going to get worse under the 2.0 contracts, but that gets a little technical. So I am not going to get into that. I can share it with your staff.

But one of the things that I would be asking questions about of VA is, What are their supply chain goals? It seems like, since we have been reviewing their medical supply program over the past several years, that it is a flavor-of-the-week kind of thing where it is one goal one day, one goal the next day, "Oh, wait. We are going to go look at DoD's MSPV program. Maybe that is our panacea," and I think that it has led to a kind of lack of focus on what the actual goals are of the medical supply program within the VA. So I would really be pressing them on all of their different approaches that they are taking to obtain medical supplies and all their pilots that they are going to be holding with regard to DLA's MSPV program and find out what, in fact, is their goal that they are trying to achieve through all of these efforts, because it is taking a lot of time and resources to continue to move forward with MSPV 2.0

and do all these other things on the side as well.

Chairman Moran. Thank you.

Mr. Waldron. Senator, I would just pick up on what Shelby said in talking about goals. I think how you set goals is you have the leadership to focus on a clinically led program office for the Prime Vendor program in particular and establishing the formulary.

The discussion in the last panel was about there were clinicians participating in, quote, the evaluation of offers or looking at products in different categories, but we are thinking about a comprehensive, strategic, overall approach led by a clinician and developing a formulary, which ultimately the goal is to serve our veterans.

So I would focus on that because, at the end of the day, I have worked in procurement for the government for over 20 years. I worked in the private sector. It is foundational, and the key that I always found, regardless of the industry or the sector, it is requirements development is the key to success, successful contract performance on behalf of whatever mission you are performing. And that is what the formulary is about. That is what a clinically led program office is about, overarching approach--and I think it dovetails with what Kurt said as well, an overarching approach to how you serve the veterans across 175 different hospitals and other treatment centers across the board.

Chairman Moran. Thank you.

Mr. McDonald?

Mr. McDonald. Chairman Moran, the aspect that I bring to the table is I actually was part of the DMLSS development process, and prior to that, I worked with the Army's TMIS development system. I have seen what takes change, the necessary elements for change to occur, and you have to have, as we all said, clear goals. But you have to have a milestone and objectives that you want to bring your partners together.

So we had three different stovepipes: Army, Air Force, Navy, et cetera. And how do we get them operating on an integrated, combined, clinically driven system? This is not a short panacea or a quick fix.

To do that implementation at the largest health care system in the United States, 13th largest in the world, it will be a yeoman's challenge to get done, phased in and implemented correctly, but when they are giving you a timeline could it be done faster or can it be done quickly, do you want it right, or will we be back here 5 to 7 years looking for another solution?

So taking a path and commitment and allowing them to establish clear process maps, so regardless who is in this room here today, you hold their feet to the fire for the execution of implementing and integrate clinically accepted

supply chain system, and that will improve the VA's Veterans Health Administration moving forward.

Chairman Moran. Well, thank you all. I may come back to request additional conversation about those topics, but let me now turn to the Ranking Member, Senator Tester.

Senator Tester. Yeah. Thank you, Mr. Chairman.

Look, we will get back to the IT systems here in a second. I have said this before in this Committee and other committees that it seems like every time we deal with IT systems, it ends up costing a lot of money. We end up with a bag of cow manure in the end. I mean, we have been dealing with electronic health records for a long time now, $7 billion right now. We have got nothing to show for it, at least not from my perspective. Let us put it that way.

I am not a techie. So I do not get all this stuff. I do not understand how you cannot take a system that DoD is using and roll it into your agency. I know it is a big agency. It is the second biggest in the government, but I just do not get why it takes 7 years to do that.

So I want to set up timelines, and I want to set up benchmarks, but to be honest with you, I do not want to set up ones that are unreasonable. But I do want to hold these birds accountable, and they know that, by the way. They are watching, and they know this is part of the deal. Moran is the same way I am. We want to make sure we are getting the

biggest bang for the buck, and we want to make sure the doggone thing works for the veterans.

So we may have to have this conversation further because it is unfortunate that we are at the end of the day with you guys.

Mr. McDonald--or, Mac, I want to ask you something. You talked about 95 million masks a month that 3M is putting out. Look, I think 3M is a great company. I am not being critical of 3M at all. You guys run an incredible business. When you talk about 95 million masks being built a month now, that is impressive. The question I have is, Are any of those built in the United States?

Mr. McDonald. Senator Tester, in my previous capacity as a director of logistics at DLA and when this similar, not to this extent, but when we were hit with the avian pandemic flu, we were in the process of acquisitioning for the Department of Defense. As the director, I was saying there was only one company that actually made the mask that we needed, and it was 3M. So I learned in 2005, and hence, here I am in 2020 with that company that never left the United States.

They do have and support regionally accordingly by ensuring that we work with sources locally to ensure that our manufacturing capability can surge much like we did from 22 million, not at 35 million. By the end of this month

with the help of the DFAS through the utilization of Title VII and Title III authorities, accelerating production capability--and we never left. We always maintained manufacturing capability here in the United States, and with the help of the Department of Defense and the Federal Government, we will continue to have those lines now and in the distant future to move forward to support the U.S. as required.

Senator Tester. So when you are talking about 95 million masks being built a month, you are talking about 95 million masks being built in the United States of America a month?

Mr. McDonald. Yes, sir, I am. We currently have--

Senator Tester. That is good. Sorry for cutting you off, but the reason I ask that is because there were--and I believe it was a 3M manufacturing plant in China, and I could be wrong on this. You correct me if I am. That it was basically nationalized by the Chinese government when they needed masks, and they said, "No. We are keeping them here because they are for our people. They are built here. We are keeping them here. You are not shipping them anywhere else in the world, the United States or anywhere else, because we need them."

But what you are saying is you can build domestically, 3M can, 1.1 billion masks a year now, which is more than we

will ever need for a pandemic?

Mr. McDonald. With the additional manufacturers that have come online with 3M under the Title III authorities, by the end of November, we will be producing roughly 95 million masks a month, and yes, we--

Senator Tester. And then those are all domestic? Those are all domestic manufacturers? There are not a bunch of folks from Indonesia or China or Brazil or wherever?

Mr. McDonald. No.

Senator Tester. They are all here?

Mr. McDonald. Yes, sir. Those are all domestic manufacturing plants. We have one, a new one coming online in Aberdeen, and the other one, I believe, is also in South Dakota.

Senator Tester. Look, Montana is a much better place to do business than South Dakota. Rounds is sitting over there.

[Laughter.]

Senator Tester. Well, that is good news. That is really good news.

I mean, that is just one component. I mean, we have also got shields and gowns and all that, but I can take that up via emails with you guys, if you want.

I just have a question, and any of you can answer it. Mac, you have done enough talking. So any of the others who

have not talked yet can answer this. What kind of benchmark should we be setting up for the DMLSS fully integrated into the VA? How long should that take? What is a reasonable timeline?

I am hearing a lot of silence.

Mr. Heyssel. I will take a stab at it. To make a comparison, it took me 6 months to simply upgrade one academic medical center, a couple jumps forward in our Materials Management Information System.

I think 7 years is a long time. I think we could find ways to compress that to 4, maybe 5, but recognizing that the more we compress the implementation timeline, the larger we expand the chances of something going wrong. So we have to find a way to mitigate all those risks.

It can be done any number of ways. I have always been more of a big-bang person than an evolution person, but I think 5 years is probably a doable time frame. There is a lot of training that needs to happen. We have to make sure every facility has the right PCs. Even at this point, when I left as chief supply chain officer, there were facilities in the VA that had not upgraded their PCs to anything that is close to capable of running something as sophisticated as DMLSS. So all of that needs to be taken into consideration.

Senator Tester. Anybody else want to answer that?

Mr. Waldron. Yes, Senator Tester.

I was just going to mention the challenges the government faces in a lot of places--and I think VA is no different--are legacy systems, systems that have been around for 20, 30 years, and trying to modernize or move away from those systems creates huge challenges.

I think your question fundamentally should go directly to the VA. One of the things that our members are very interested in is transparency from the VA with regard to the rollout of DMLSS. What are the steps necessary? What are the expectations? What does the training look like for the hospitals that are going to be utilizing the new system?

Companies need to understand that timeline, just like Congress does, because companies want to be able to serve the VA and be able to react and respond.

So I think it would be great to have the VA lay out their implementation plan so we all could take a look.

Senator Tester. I am way, way, way over time, but thank you, Mr. Chairman. I want to thank all of you.

Mr. Chairman, I just might add this is really a good panel, and we did not get them--at least I did not get the challenges as far as the questions. I hope they will accept some written questions in the free time that I have got to be able to answer those.

Chairman Moran. Senator Tester, you are over time, but you are welcome to remain over time if you would like to ask

another question.

Senator Tester. Well, I mean, I appreciate that. I think most of it has to do with--Mac answered my question on the masks being built here.

I would ask that same question for shields. I would ask the same question for gowns. I would ask that same question for test kits. I would ask the same question for media that revolves around that. But I do not know that 3M does all those things.

Chairman Moran. I do not know whether that was rhetorical or not, Mr. MacDonald.

Mr. McDonald. Sir, we do not do gowns at this time.

Senator Tester. Right. And it is the same thing on all of them. I think the masks are good news. Those N95 respirators are good news that we have got them built here. We need to do the same thing with those gowns.

Somebody mentioned--I believe it was on this panel--that said we need to--no. I think it was actually on the previous one. We need to work with gowns that are washable and can be reused because that helps with the supply chain. I agree with that, but the truth is we have got to get them built first.

Anyway, thank you, Mr. Chairman.

Chairman Moran. Thank you, Senator Tester.

Let me follow up with a few more things. Mr. Waldron,

let me start with you. At least there are reports of bidding between various Federal and private entities, Federal, State, and local businesses for the same equipment, and tell me whether that is true.

One of the primary purposes of FEMA task force and the Defense Production Act was to prevent bidding wars. Has it worked? Do you want to shift to Mr. McDonald?

Mr. Waldron. What I have heard from members is around the issue of communication on the Federal level because our members focus primarily on the Federal level, and just, I guess, two things. One, understanding where the requirements are coming from and who is coordinating them, and I think the government over time has done a better and better job of that, the initial--just like this has not happened for 100 years, right? So we are all reacting, adjusting, and changing direction, and just the focus on a national strategy across a government versus local entities, you know, going out to buy because they are a local facility, needs the product immediately, and how you find that right balance. And I think that is kind of where the communication between the government and the producers of product could be a bit more focused. But that is just sort of a general reaction.

I think overall, the performances have improved over time in terms of that communication.

Chairman Moran. Are there circumstances in which an entity has a contract, in your case, a Federal entity or, in other cases, a private company has a contract to be supplied, but the market forces change, the circumstances change, and you can make more money selling to someone else that you have not previously contracted for? You do not have more to sell. You just have a better buyer, a buyer that is willing to pay a higher price than what you previously contracted for.

Mr. Waldron. Sure.

Chairman Moran. Is that a problem? Is that real or just kind of talk?

Mr. Waldron. I have not--our members have not reported that they have had that kind of issue.

My reaction to that is it goes to the idea, if you have a government and the government orders from you, there are consequences for not fulfilling that order at the price that has been negotiated in the contract.

Companies sign up to that. They have their obligations under the contract. Orders are placed. They have to fulfill those orders. Otherwise, bad things happen to them in terms of their contract performance and that sort of thing. That is part of the remedy, and other things that would be in this context would be the Defense Production Act and utilization of that. That creates priorities.

I think one of the things that I have heard is it is very effective and it works when the government sits down with a major supplier and works through those supply issues and figures out how to proceed forward, not necessarily a meeting immediately going to issuing a rated order under the Defense Production Act. That way, the company understands the expectations, understands how to react quicker. You have worked together initially before you have actually placed the order and move forward from that perspective.

Chairman Moran. Let me see if I can paraphrase what you are saying because this has become--I do not know whether it is a political conversation, but it has become a topic of conversation among colleagues.

You are saying that while the Defense Production Act can get a company's attention, rather than its full implementation or its full force and effect, that conversations, discussions, you can reach a better result?

Mr. Waldron. The Defense Production Act will get the full attention of a company. Let me assure you of that. That is not what I was trying to say.

What I was trying to say is that there are multiple ways to go about attacking the supply issue. You can issue rated orders and more forward immediately. The company has to react to that. There are other people's orders who would go to the back of the line because of the rated order.

Having conversations and that communication between government and industry in partnership to address that planning goes a long way to ensuring you will meet the Federal Government's requirements and at the same time be able to adjust and meet those order orders as well.

SO I am promoting the idea of communication between government and industry, especially in our current context.

Chairman Moran. I was trying to give you the opportunity to do that, but I must have inartfully asked my question. I was not suggesting that you did not believe the Defense Production Act was sufficient to get somebody's attention.

Mr. Waldron. yes.

Chairman Moran. But its full authorities forcing somebody to do something may not be the best way to get the result that you are looking for and also may be damaging to others who are trying to acquire, in this case, personal protection equipment for their own and very valid uses. Is that a better summary?

Mr. Waldron. That is a fair way to look at it. One size does not fit all in the supply chain, and there is going to be different companies and different situations as well. And there are going to be different obligations between the government and the producer as well. So, yeah, that is a fair, a good characterization of it.

Chairman Moran. Ms. Oakley, I cannot tell if your hand is up, but I guess your finger is on the button.

Ms. Oakley. Yeah. I just wanted to comment on how it worked with the Medical-Surgical Prime Vendor program contracts, and I think that while Mr. Waldron is correct, you are signed up to a government contract, you have to fulfill those needs. But those supply contracts are based upon demand signals. So your historical demand signals are what drives what those prime vendors have in stock for you.

So what you saw at the beginning of the pandemic was this surging increase in demand from the VA contracts, from the VA medical centers, that was not supported by those prime vendor contracts because they did not have that demand signal in the past.

So then what ended up happening was that VA ended up getting its allocation, its percentage of business that they were typically for whatever supplier through that prime vendor. So that is where you saw some of the challenges with meeting those surge-in-demand needs from VA. So that is just kind of how it worked, at least initially, under the prime vendor contracts.

Chairman Moran. Thank you for that.

Mr. Heyssel. Mr. Chairman?

Chairman Moran. Yes.

Mr. Heyssel. This is Kurt Heyssel.

Chairman Moran. Yes, sir.

Mr. Heyssel. If I might give one brief statement. What happened with the health care supply chain since December-January was a test I have never seen before. Everybody from the manufacturer through the distributor to the health care provider was caught flat-footed. I am not sure there is anything that could have been done to avoid what we went through.

We all said after the end of the avian flu, "Oh, we will never be caught flat-footed again," and slowly but surely, as organizations do, we tend to forget.

But even if we had stayed prepared at the level we were for the avian flu, it would not have even touched the need created over the last 5, 6 months.

Chairman Moran. Thank you.

There sometimes are the answers that nothing is going to work perfectly in the circumstances that we are in, and we are all looking for ways to make certain that everything works just as we wish it would.

I think maybe this is my concluding question. I will ask this of Mr. Heyssel. It seems to me that the VA is attempting to blend a just-in-time inventory system with a depot system. If we look back at the VA supply chain compared to other large health organizations, what are the strategic factors that need to be considered here?

Mr. Heyssel. It was the first I had really heard of the depot system was today, and if I heard it correctly, they are talking about four strategically located centers around the Nation to hold emergency stockpiles, which is something that I believe other private health care systems do to be sure they have at least a month's worth of supply on hand to handle something like this.

The just-in-time approach has been working for years in the private sector. The just-in-time approach, I believe, is the least costly of all the methods of acquiring what is needed to adequately care for our patients, care for the veteran, care for any patient.

The notion that the VA should--I do not know if anybody is discussing it, but just in case they are, the notion that the VA should move back to what was the old system in 1992 of the VA doing its own acquisition and distribution throughout the system is probably a sizeable mistake.

Certainly, you cannot do it without a system with at least the sophistication of DMLSS, but it is redundant. It actually adds a lawyer of cost for the supplies to the VA.

If you recall, I said the average distributor needs to make about an 8.5 percent margin to keep the doors open. So that can be applied to the costs of running those depots and the self-distribution around the Nation to feed the VA its products, and then you have the heightened risk of unused

inventory spoiling, unused inventory going unused, inventory going unused, and that money not being put to good use. I just do not think that is the way it should be.

The distributors today are incredibly sophisticated. Cardinal, Owens & Minor, Concordance, Medline, you name it, they have the information systems set up. They have the logistics set up to do an amazing amount of work on behalf of the VA.

There is one distributor out there who can handle pretty much all of the health system's orthopedic implant needs and ships sterile containers of implants to the hospital according to the surgical schedule. That sort of partnership between distributor and health care provider and manufacturer is really what is needed rather than taking a step back into the '90s and having distribution centers pretty much around the United States.

Chairman Moran. Let me ask you about another partnership. It seems a natural fit--but I want you to tell me whether it is or is not--that we model ourselves or partner with the Department of Defense at the VA, and we see that in a number of circumstances and certainly trying to get an integrated health care system that takes care of a veteran from service to post--I should not say it that way--to being a veteran as compared to being a member of the active military. Is that a model that we should at least

initially assume is a pretty good idea when it comes to the VA?

Mr. Heyssel. I do believe it should be investigated. I think it should be investigated in depth.

If you were to bring the VA and the Department of Defense together in such a manner, using the same information system, DMLSS, you then have the power to aggregate the purchasing volume across both networks of care, and the supply cost should drop. That would be a very good thing, but it would also require that clinicians from both organizations be heavily involved in the choice of products being selected and purchased.

You want to offer alternatives, but you do not want the Wild West, and you do not want the VHA using 15 different things and Department of Defense using 15 different things in the OR, all that do the same thing. Then you lose your leverage with the manufacturers.

But I think it is a model that must be investigated. VHA, DLA have already proven that they are pretty good at what they do. When I was with Owens & Minor, I worked very closely with Langley Air Force Base and Portsmouth Naval Medical Center. As a representative, I got to know their processes very well, and they were on top of the game.

So I think it should be investigated closely.

Chairman Moran. Ms. Oakley--Senator Tester, I am going

to conclude, but, Ms. Oakley, in your reviews and observations, I guess I will not ask you to--I do not know that it is a fair question to ask you to compare how DoD operates as compared to the Department of Veterans Affairs, and they are both large organizations, huge organizations. Is there ever a sense that the Department of Veterans Affairs is so large that we cannot get the services, the efficiency--we cannot get the VA to operate the way that we want it, just because of the size, or is size always to our advantage?

Ms. Oakley. I do not think that that should be the excuse for the VA not to be able to operate efficiently and effectively.

I think it really harkens back to part of what Mr. Heyssel was saying. Structurally, they have a lot of challenges with regard to executing and efficient procurement function within the organization, and part of that is driven by the fact that VHA drives so much of the procurement dollars within the Department of Veterans Affairs.

So I think from my perspective, it is less about how large VA is, and it is more about how leadership plans and implements large-scale change and transformation within the organization, and how even in the short time that I have been doing this work over the past 5 years, I have seen a

number of different things come and go. So I think there is something to be said for laying out that plan for transformation and putting milestones associated with it and being held accountable to making those changes.

There is nothing wrong with modeling themselves after DoD or leveraging what they can from DoD, but there is stuff to be learned.

In fact, in our ongoing work on the MSPV program, we are taking a look at VA's pilot program where they are going to be using DLA's MSPV program. It is a very limited pilot at this point, but one of our preliminary findings is showing they do not even have a plan in place for assessing the outcomes of the pilot, to know is this something that we should do, is this something that we can scale within the Department of Veterans Affairs and apply to all of VA.

And I think just--I have to mention it because I am from the Contracting and National Security Acquisitions Team. VA does also have very specific procurement requirements that it has to abide by in the Kingdomware requirements, and that makes that kind of collaboration a little bit more challenging than DoD collaborating with any other organization.

Chairman Moran. I make it a practice of asking any witnesses before our Committee if they have something they would like to augment what they said, correct what they

said, add to what they said, anything that you would like to make clear for us or improve what you thought you said, which is always a chance I wish I had. Are we good?

[No response.]

Chairman Moran. Senator Tester?

[No response.]

Chairman Moran. All right. We will conclude this hearing, then. I thank you for joining us. Thank you for the opportunity to learn from you.

The hearing record will remain open for 5 legislative days, should any member wish to add a written statement or submit a question for the record.

With that, this hearing is now adjourned. Thank you.

[Whereupon, at 5:29 p.m., the Committee was adjourned.]