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PURCHASING PERSPECTIVE: VA'S PROSTHETICS PARADOX

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

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CONTENTS

May 30, 2012

	Page
Purchasing Perspective: VA's Prosthetics Paradox	1

OPENING STATEMENTS

Chairman Bill Johnson	1
Prepared Statement of Chairman Johnson	33
Hon. Joe Donnelly	3

WITNESSES

Michael Oros, Board Member, American Orthotic and Prosthetics Association	4
Prepared Statement of Mr. Oros	34
Daniel Shaw, Managing Partner, Academy Medical, LLC	6
Prepared Statement of Mr. Shaw	39
Accompanied by:	
Steven Kent, Director of Government Sales, Academy Medical, LLC	
Stephen Schurr, Consultant, Academy Medical, LLC	
Dr. Charles Scoville, Chief of Amputee Patient Care Service, Walter Reed National Military Medical Center, U.S. Department of Defense	16
Prepared Statement of Dr. Scoville	41
Linda Halliday, Assistant Inspector General for Audits and Evaluations, Office of Inspector General, U.S. Department of Veterans Affairs	18
Prepared Statement of Ms. Halliday	43
Accompanied by:	
Nick Dahl, Director of Bedford Office of Audits and Evaluations, Office of Inspector General, U.S. Department of Veterans Affairs	
Kent Wrathall, Director of Atlanta Office of Audits and Evaluations, Office of Inspector General, U.S. Department of Veterans Affairs	
Philip Matkovsky, Assistant Deputy Under Secretary for Health for Administrative Operations, Veterans Health Administration, U.S. Department of Veterans Affairs	24
Prepared Statement of Mr. Matkovsky	47
Accompanied by:	
Dr. Lucille Beck, Chief Consultant, Rehabilitation Services; Director, Audiology and Speech Pathology; and Acting Chief Consultant, Prosthetic and Sensory Aids Service, Veterans Health Administration, U.S. Department of Veterans Affairs	
Norbert Doyle, Chief Procurement Logistics Officer, Veterans Health Administration, U.S. Department of Veterans Affairs	
Ford Heard, Associate Deputy Assistant Secretary, Office of Acquisitions and Logistics, U.S. Department of Veterans Affairs	

SUBMISSIONS FOR THE RECORD

Orthotic and Prosthetic Alliance	50
National Association for the Advancement of Orthotics and Prosthetics.	52

Page

MATERIAL SUBMITTED FOR THE RECORD

Letter from Hon. Bill Johnson, Chairman. Subcommittee on Oversight and Investigations to Mr. George Opfer, Inspector General, U.S. Department of Veterans Affair 55
Response from Mr. George Opfer, Inspector General, U.S. Department of Veterans Affair to Hon. Bill Johnson, Chairman. Subcommittee on Oversight and Investigations 56

PURCHASING PERSPECTIVE: VA'S PROSTHETICS PARADOX

WEDNESDAY, MAY 30, 2012

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
Washington, D.C.

The Subcommittee met, pursuant to notice, at 4:00 p.m., in Room 334, Cannon House Office Building, Hon. Bill Johnson [Chairman of the Subcommittee] presiding.

Present: Representatives Johnson, Benishek, Donnelly, and Barrow.

OPENING STATEMENT OF CHAIRMAN BILL JOHNSON

Mr. JOHNSON. Good afternoon. I would like to welcome everyone to today's hearing titled: Purchasing Perspective: VA's Prosthetics Paradox.

Section 8123 of Title 38, Procurement of Prosthetic Appliances, states the following: "The Secretary may procure prosthetic appliances and necessary services required in the fitting, supplying, and training and use of prosthetic appliances by purchase, manufacture, contract, or in such other manner as the Secretary may determine to be proper without regard to any other provision of law."

Section 8123 originated in 1958, over 15 years before Federal Acquisition Regulations, or the FAR, were codified in law and has been slightly amended a handful of times since then.

In March of this year, I sent a letter to the Secretary regarding the VA's procurement of biologics over the open market instead of from better-known small businesses already on the Federal supply schedule. One specific example I brought to the Secretary's attention involved a company that supplied biologics.

In the timely response I received from Deputy Secretary Gould, I was informed that the VA considered biologics to fall under its lengthy and broad definition of prosthetics; and, therefore, it could acquire biologics through Section 8123 as it clearly had been doing.

Those last words, and I quote, "without regard to any other provision of law," mean at least to the VA that it does not have to follow Federal Acquisition Regulations, VA Acquisition Regulations, the VAR, or the Competition and Contracting Act. This interpretation was made clear in the Deputy Secretary's letter.

In addition to informing the Oversight Investigation Subcommittee that the VA considered biologics as prosthetics, other answers throughout the Deputy Secretary's letter prompted several important follow-up questions which were relayed to the VA on

March 28th. One part of the letter immediately following the interpretation that purchases made under Section 8123 were not subject to acquisition regulations stated that the VA would work on, and I quote, "guidance to ensure that prosthetics purchasing agents and logisticians conform with VAR to the maximum extent practicable."

I have to wonder why the VA explicitly and publicly ignores the acquisition regulations when making these Section 8123 purchases but now will attempt to comply with them.

Among my follow-up questions was a request for a copy of the VA's guidance in how it would ensure purchasing agents follow the VAR. Just yesterday, a response to that and the other questions was provided. It is interesting that only now is the VA working to ensure that purchases using Section 8123 are documented and in line with the FAR and the VAR. After all, the VA has had nearly three decades to work on this.

Failing to document purchases under Section 8123, as acknowledged in the answers I received yesterday, is a reckless use of taxpayer dollars. To us on this Committee, it appears as though the VA operates as it sees fit until attention is called to its operation.

What the Deputy Secretary's letter did not address is the VA's use of a VHA directive, and I quote, "Prosthetics Simplified Acquisition Procedures Training" that was issued July 16, 2003, and expired July 31st, 2008. An updated directive would probably have been useful over the last 4 years as the VA increased its prosthetics spending by 80 percent. However, we have seen no such update and have even learned that those in the field at the VA's central office has instructed VISNs to continue following it.

That expired directive contains important language stating that Section 8123 was only to be used as a last resort, reinforcing the importance of compliance with Federal Acquisition Regulations. However, this Subcommittee has found substantial evidence of VA purchasing agents using Section 8123 as a first resort. Given the broad language it contains, one can see why this easier approach can be so tempting, and it is certainly not the first time we have seen VA purchasers opting for the easy route.

While there are over 100 definitions for prosthetics throughout the Federal Government, the definition used by the VA is a full paragraph in length. As we will hear today, some of the items falling under this broad definition do not sound like prosthetics to anyone except the VA.

The VHA handbook's definition of prosthetic appliance is as follows: all aids, devices, parts, or accessories which patients require to replace, support, or substitute for impaired or missing anatomical parts of the body. The items include artificial limbs, terminal devices, stump socks, braces, hearing aids and batteries, cosmetic, facial, or body restorations, optical devices, manual or motorized wheelchairs, orthopedic shoes, and similar items. Perhaps this overly broad definition is a contributing factor to the VA's inability to effectively manage its prosthetics inventories.

As one of the members of the first panel will note, the definition is confusing, and I am concerned that confusion is widespread inside the VA as well as outside of it. Recent audits from the VA's Office of Inspector General have substantiated that the Department does not effectively manage its prosthetic supply, nor does it

have adequate control over its payments when procuring prosthetics. Given what we already know and what we will hear today, these findings are not surprising.

A tailored definition of prosthetics is just one way the VA can better track and manage its prosthetics acquisition. For instance, the broad inclusion of durable medical equipment under its prosthetics definition could encourage the misuse of Section 8123 authority. In addition, as the IG noted about the VA's overpayments, excess inventories, and failure to receive the best value, and I quote, "strengthening controls over these actions should not compromise the quality of the prosthetic limbs provided to veterans."

In short, the VA can be a better steward of taxpayer dollars while still providing veterans timely access to care, including in the area of prosthetics.

Another way the VA can better manage the billions spent in prosthetics every year is to actually enforce the acquisition regulations that apply to Section 8123. In the response I received yesterday, the VA still fails to acknowledge the abuse of Section 8123 and the blatant circumvention of the FAR and the VAR by VA employees. We know the problem exists. Now is the time to fix it. If employees in the past have failed to follow internal guidance, then perhaps a legislative clarification is necessary to ensure best value for taxpayer dollars.

Lastly, before simply reorganizing employee structures and moving chess pieces around on the board, I am requesting here today that the VA present to this Committee in detail its plan to improve its acquisition of prosthetics and the specific reasons for the changes before putting the plan in place. This effort at transparency will help both veterans and Congress see that meaningful reform is taking place.

Mr. JOHNSON. With that, I now recognize the Ranking Member for his opening statement.

[THE PREPARED STATEMENT OF HON. JOHNSON APPEARS IN THE APPENDIX]

OPENING STATEMENT OF HON. JOE DONNELLY

Mr. DONNELLY. Thank you, Mr. Chairman.

In response to the First and Second World Wars, physical, occupational, and rehabilitation therapy was introduced to respond to the needs of injured servicemembers. With the high number of servicemembers whose lives were altered due to limb loss from combat trauma, the Department of Veterans Affairs needed to provide assistive devices to help servicemembers and veterans lead a meaningful and independent lifestyle.

VA now contracts with many companies across the country to provide prosthetics, including companies in my home State of Indiana, which is an important medical device hub. For example, Zimmer, in Warsaw, has a contract covering primary hip and knee implants; and I know the company is proud of its good working relationship with both the VA and DoD.

Today, we have the opportunity to discuss VA's prosthetic acquisition and procurement policies. Following the Subcommittee on Health's hearing on May 16th, further discussion is needed on VA's prosthetic and orthotic purchasing. Over half a century ago, Con-

gress gave VA the authority under Title 38, Section 8123, to pass over Federal Acquisition Regulations and purchase state-of-the-art prosthetic limbs efficiently and quickly. This exemption is written into VA acquisition regulations.

By enacting Section 8123 exempting procurement of prosthetic limbs from other laws, VA would have the ability to provide veterans with services and prosthetic devices needed to obtain a lifestyle similar to the one they lived pre-injury. While Section 8123 may provide the flexibility the Veterans Health Administration needs to respond to veterans, we must also ensure this flexibility is used properly and not as a means of bypassing Federal Acquisition Regulations.

Finally, I hope that by reviewing the Department of Defense prosthetic process we may gain further insight on how to improve VA's prosthetic procurement policies.

I look forward to hearing from the VA, DoD, and other witnesses on how we can find this balance.

Thank you, and I yield back.

Mr. JOHNSON. Thank you.

We are now going to welcome the first panel to the witness table. We will hear from Mr. Michael Oros, a member of the Board of Directors of the American Orthotic and Prosthetics Association, and Mr. Daniel Shaw, managing partner of Academy Medical, LLC.

Both of your complete written statements will be made part of the hearing record.

You can come to the table, please.

Mr. Oros, you are now recognized for 5 minutes, sir.

STATEMENTS OF MICHAEL OROS, BOARD MEMBER, AMERICAN ORTHOTIC AND PROSTHETICS ASSOCIATION; AND DANIEL SHAW, MANAGING PARTNER, ACADEMY MEDICAL, LLC, ACCOMPANIED BY STEVEN KENT, DIRECTOR OF GOVERNMENT SALES, ACADEMY MEDICAL, LLC, AND STEPHEN SCHURR, CONSULTANT, ACADEMY MEDICAL, LLC

STATEMENT OF MICHAEL OROS

Mr. OROS. Good afternoon and thank you for the invitation to testify on procurement of prosthetic and orthotic care for our veterans.

My name is Michael Oros, and I am a member of the American Orthotic and Prosthetics Association's Board of Directors. I am also a licensed clinical prosthetist and the President of Scheck and Siress, a leading provider of orthotic and prosthetic services in the State of Illinois.

My experience is with a subset of the VA's "prosthetic" services. If you asked someone on the street what a prosthesis is, the response would probably be an artificial leg or possibly an arm. If you talked about an orthosis, a few individuals with family members who have had a traumatic brain injury or a stroke might be able to describe a custom-made and fitted device to help damaged limbs function properly. I am fairly certain that nobody would suggest a seeing eye dog, wheelchair, or many of the other items that are in the VA's "prosthetics" budget.

Why does this matter? AOPA's concern is that an overly broad definition of prosthetics leads to policies that are inappropriate when it comes time to deliver replacement limbs and orthopedic devices. The result is barriers to care for veterans with limb loss who need prosthetics to provide for their families and to live their everyday lives.

Only 2 weeks ago, Health Subcommittee Chairwoman Buerkle held a hearing on prosthetics as traditionally understood and defined. During that hearing, the chief procurement officer testified that because changes in procurement policies applied only to items that cost $3,000 or more, those changes would not apply to 97 percent of the prosthetics budget.

While I am sure that statement is accurate, it is also unhelpful. Nearly all the components of a basic prosthetic limb cost more than $3,000. So policies that do not apply to 97 percent of the VA's prosthetic purchasing program can still delay vitally needed care for our veterans with limb loss.

Congress authorized the VA to go to great lengths to ensure veterans access to prosthetic services in his or her community. If you are a veteran in need of prosthetic care, VA has been given legal authority to do what it takes to secure prosthetics and orthotics from the provider of the veteran's choice.

AOPA urges this Subcommittee to do everything in its power to ensure that the necessary procurement legislation, authority, and policies remain in place to guarantee the veterans' right to choose their own provider. It seems like we shouldn't have to urge the Committee to remain vigilant on this point, but we do, because AOPA shares the concerns of several veteran service organizations that the veterans' choice of providers is being eroded.

There are real and increasing barriers being erected to non-VA-provided care. For one example: One veteran was recently told how he could receive a high-tech knee only from the VA services department that was more than 2 hours away, and not from the community-based prosthetist whom had been caring for him for more than 11 years. After much pushback from the veteran and his local prosthetist, the VA offered two solutions: one, he could receive the knee from the VA that was more than 2 hours away, or his local prosthetist could resubmit all the paperwork and it would take up to 3 months' time for the approval to come through. That veteran finally switched to the VA for care because he was tired of arguing for his own rights.

AOPA doesn't believe this is an isolated incident, and I could go on with similar stories. The question really is, is why is the VA establishing policies to undermine the veteran's choice?

It has been suggested by some the cost may be a factor. A recent IG audit claimed that the average cost of a prosthetic limb fabricated by the VA in-house is about 25 percent of what an outside contractor charges. That analysis almost certainly fails to take into consideration VA staff salaries, benefits, facility, and administrative costs. Community-based providers working under contract with the VA provide high-quality care to veterans at rates below the industry standards that have been approved by Medicare.

The goal of procurement systems for prosthetics and orthotics should be to deliver the highest-quality timely prosthetic and

orthotic care possible to all veterans, regardless of their age, their geographic location, their ability or willingness to become the "squeaky wheel" and demand appropriate care.

Procurement policies should ensure four basic elements:

Veterans have access to the prosthetics provider of their choice without having to overcome artificial and unnecessary barriers.

Veterans must be able to receive timely care from the provider, whether that provider is VA or an independent practice.

The prosthetist serving those veterans should not simply have the minimum certifications and qualifications needed, but actually have the training and experience to meet the specialized needs of veterans. This will become more and more of a challenge for the VA and for independent O&P practices as the requirement for a master's degree as an entry level is implemented.

Contracting and other policies should require the measurement and continuous improvement of veterans' outcomes until each veteran achieves their highest level of restored function.

Mr. Chairman, members of the Committee, thank you very much for the invitation to testify and for your commitment to providing the highest-quality prosthetic and orthotic care to our Nation's veterans. I look forward to answering any questions that you may have.

[THE PREPARED STATEMENT OF MR. OROS APPEARS IN THE APPENDIX]

Mr. JOHNSON. Thank you, Mr. Oros.

Mr. Shaw, you are now recognized for 5 minutes.

STATEMENT OF DANIEL SHAW

Mr. SHAW. Mr. Chairman, Ranking Member Donnelly, members of the Subcommittee, thank you for the opportunity to appear before you today to discuss the Department of Veterans Affairs prosthetic purchasing practices and their impact on Academy Medical, a VA-verified veteran-owned small business.

My name is Daniel Shaw; and I am the managing partner of Academy Medical, located in Wellington, Florida. Academy is a reliable source of supply of biologics and holds a mandatory source Federal Supply Schedule, FSS, contract, issued by VA's National Acquisition Center. My fellow managing partner and I graduated from the U.S. Naval Academy in 1991. Academy Medical is so named to pay homage to our alma mater.

Accompanying me here today is Mr. Steven Kent, our director of government sales, and Mr. Stephen Schurr, a subject matter expert in the field of biologics.

My original testimony here today is pleasantly overtaken by events. By memorandum dated May 23, 2012, the Veterans Health Administration notified VHA procurement and prosthetic personnel engaged in the ordering of biological implants of its policy on ordering biological implants using the FSS program. We are very pleased with this change in VHA's position, one which levels the playing field and respects the mandatory source nature of VA's FSS program. We have worked long and hard to get VHA to adopt this policy. I have a copy of the policy and would like to offer it for inclusion in the record of today's hearing.

[THE ATTACHMENT APPEARS IN THE APPENDIX]

Mr. SHAW. We hope the Subcommittee will encourage the VA to formalize this VHA policy memorandum by having it codified to amend the VA Acquisition Regulations. Policy of this magnitude should be formalized for perpetuity, as policies are easily forgotten as time goes on or through leadership changes. This is especially true given there is likely to be a short- and long-term resistance to this policy, especially by purchase card holders.

One concern we have is whether the VHA policy applies to all biological implant procurements, to include those acquired as micropurchases by government purchase card holders. We estimate nearly 95 percent of biological implants are acquired by purchase card holders who are neither trained nor nuanced in the use of FSS contracts. This will have a major impact on the success or failure of VHA's policies from a supplier perspective and could potentially result in no improvement for FSS contract holders.

How VHA will implement, monitor, and enforce compliance with this policy is still unclear. The policy memorandum is silent on this.

We hope this new VHA policy will make a difference. We estimate VA purchases approximately $175 million annually in biologics. This will be a nice cost-savings for the taxpayer.

In addition, if VA makes better use of the schedule's program, it will avoid Competition in Contracting Act violations. It will be assured of receiving high-quality products and also reap the revenue from the FSS program industrial funding fee used to fund its supply chain management operations.

What is hurting Academy is VHA's use of authority granted under Section 8123, Title 38, United States Code. Although VHA's new policy for the procurement of biological implants is welcome news to us and other FSS contract holders, Section 8123 still looms large as long as this authority exists and is likely to be applied to open market procurements for biologics not procured through the FSS program.

We recently learned VA determined and subsequently notified this Subcommittee the authorities in Section 8123 trump even the Veterans First Contracting Program authorities contained in Sections 8127 and 8128. The unprecedented and extraordinary contracting authorities granted to VA under its Veterans Contracting Program were effective June, 2007. It would seem in passing Public Law 109-461 the Veterans Benefits, Healthcare and Information Technology Act of 2006, Congress would have specifically exempted Section 8123 procurements from Sections 502 and 503 Public Law 109-461, but it did not. In light of VHA's new biological implant procurement policy, this issue needs to be addressed, given that non-FSS biological procurements will be conducted on the open market.

In closing, Mr. Chairman, the use of VHA's new biological implant procurement policy gives us hope and levels the playing field, and for that we are truly grateful. We seek only to be a reliable source of supply of biological implants, to be treated respectfully, and given the opportunity we have earned to be VA's industry partner. We have no axe to grind. We simply have a business to run and will work to create an environment that engenders trust, mu-

tual respect, and cooperation as VA provides its services to America's heroes.

Thank you, sir, for your distinguished leadership and for that of the Subcommittee. We hope to match our private-sector success in the VA marketplace. We never sought an adversarial relationship with VA. We seek only to be trusted business partners with VA and to be given the respect and opportunity we have earned.

Thank you for holding this hearing, Mr. Chairman. We will be happy to respond to any questions you or your Subcommittee's members may have.

[THE PREPARED STATEMENT OF MR. SHAW APPEARS IN THE APPENDIX]

Mr. JOHNSON. Thank you, Mr. Shaw.

We will now begin with questions, and I will yield myself 5 minutes.

Mr. Shaw, who is the national regulatory agency for biologics throughout the country?

Mr. SCHURR. If I may, the FDA is not a formal regulation body. It is the American Association of Tissue Banks. It is a voluntary regulatory body.

Mr. JOHNSON. Okay. Could you briefly explain some of the criteria that the Association of Tissue Banks, AATB, has to ensure patient safety?

Mr. SCHURR. Yes, sir. The AATB monitors that there are safety regulations such as testing for each donor through a variety of tests, the cancers, the HIV, hepatitis, various screenings to make sure that each donor is safe to move on to processing.

Mr. JOHNSON. And I am sorry. Let's go back. Mr. Schurr, and Mr. Kent, for the record, would you tell us where you are from, and who you represent?

Mr. SCHURR. Yes, sir. My name is Stephen Schurr. I am a consultant with Academy Medical. I am a subject matter expert with a long history in biologics.

Mr. JOHNSON. Okay.

Mr. KENT. I am Steven Kent. I am from Wellington, Florida, and I am the Director of government sales for Academy Medical.

Mr. JOHNSON. Okay, thank you.

How can a surgeon or VA facility be assured that the biologics they purchase are indeed safe for the patient?

Mr. SCHURR. All biologic companies that are in the hospital systems and are to serve patients and are implanted into patients follow the AATB guidelines. Therefore, all are deemed safe.

Mr. JOHNSON. How can or do biologics vary from manufacturer to manufacturer?

Mr. SCHURR. All biologic companies share. There is just a handful of donor facilities that supply the processing plants. So pretty much they all come from the same sources.

Mr. JOHNSON. Okay. Where do biologics manufacturers procure their donors?

Mr. SCHURR. Again, there is a handful of donor facilities that dispense and supply the donors to the processing facilities and they move on to the biologic companies.

Mr. JOHNSON. Where exactly do these donors or cadavers, where are they procured from? Do they come from foreign countries or from the U.S.?

Mr. SCHURR. Well, as per the AATB, they all come from the United States.

Mr. JOHNSON. Okay, how do the various biologics manufacturers work cohesively together? Do they commingle?

Mr. SCHURR. They certainly do. They all share in the donor pool.

Mr. JOHNSON. Okay. Do they share and swap products and brands?

Mr. SCHURR. Absolutely.

Mr. JOHNSON. Okay, with regard to traditional biologics, what special training, experience, tooling, or technique is required on behalf of the surgeon to use the various biological brands?

Mr. SCHURR. To my knowledge, all biologics pretty much follow the same technique guides with very little variance.

Mr. JOHNSON. Regardless of the supplier?

Mr. SCHURR. Correct.

Mr. JOHNSON. So, to clarify, you are stating that the surgeon's ability and technique to use brand A over brand B is identical, not altering the surgeon's skills in any way at all that would jeopardize patient safety?

Mr. SCHURR. It is pretty much just how it is prepared in the OR, whether it is rinsed or soaked to rehydrate demineralized bone product, for example. There might be variance in how many minutes that is. It is a small difference.

Mr. JOHNSON. Okay.

Mr. Oros, you talked about four elements of care that in your experience comprise quality.

Mr. OROS. Yes.

Mr. JOHNSON. How does the VA oversee, supervise, and otherwise hold community-based providers accountable for providing quality care to veterans? And how does that compare to the way in-house VA prosthetists are evaluated? I hope I pronounced that right.

Mr. OROS. Prosthetists. It is close enough.

Frankly, the system goes back to a clinic-based system. There aren't really any measured outcomes, if you will, from the time most veterans begin their care, at least in—

I would say my experience is solely with the VA system. They will be seen in an amputee clinic, for example. The prosthesis is prescribed. The patient will receive their service on the outside, and then they will go back for a "clinic checkup". But there is not really any sort of objective measure, if you will, other than asking the patient to walk around a little bit and demonstrate that they can, in fact, move with their prosthesis. But there aren't really any functional outcomes tied to the care that is provided either in-house or outside the system.

Mr. JOHNSON. Okay, I have some additional questions, and we may have a second round for this panel, but at this time I will yield to my colleague, Representative Donnelly, for his questions.

Mr. DONNELLY. Thank you, Mr. Chairman; and, to all of you, thank you for your service to our country.

And, Mr. Shaw, my nephew is a 2005 Academy graduate and flew helicopters in Iraq. And as a Notre Dame graduate, you have been unkind to us in football these past few years.

Thank you very much for being—I am sorry?

Mr. SHAW. That is a long time coming.

Mr. DONNELLY. Yes, it was.

Mr. JOHNSON. I will point out that Ohio State is trying to be unkind to your football team, too.

Mr. DONNELLY. And it was well deserved, Mr. Shaw. Your players were extraordinary to watch every year I have had the chance.

I wanted to ask you, has Section 8123 prevented the VA from providing veterans with assistive devices they may need?

Mr. SHAW. I am not sure I understand the question, sir.

Mr. DONNELLY. Okay, have we been able to get the best products that the vets have needed through Section 8123, or do you think there are some better ways?

Mr. SHAW. I think, as we have discussed, there really is very little difference in the products. And what we have tried to express to the VA is that there is no difference in biologics and particular products that we have on the Federal supply schedule. There is no difference. And our story is that we feel like, as an FSS contract holder, we can provide the same, if not better, products at a much more affordable price to the taxpayer.

Mr. DONNELLY. Okay, Mr. Oros, you indicated that you disagree with the Inspector General's audit which indicated the average cost of a prosthetic limb made by contractors is more expensive than if the VA made it in-house. What do you consider the average cost of a prosthetic limb made by contractors compared to the VA?

Mr. OROS. It is hard to answer that question, only because when you describe a prosthetic limb you could be talking about a simple below-the-knee prosthesis, which might run in the neighborhood of 8 to—

Mr. DONNELLY. Well, I guess I mean on average, if the VA made it or—

Mr. OROS. I think they would be remarkably similar if it was a true apples-to-apples comparison. Because the reality is the component costs should be relatively similar from the manufacturer to either the VA or the outside clinician. And then there are industry standards for what the practitioners make that should be relatively similar. Benefit costs, et cetera, should all be relatively similar.

Mr. DONNELLY. What do you think the comparison, like the audit, what do you think they are missing?

Mr. OROS. Well, at the hearing 2 weeks ago, the IG said—it was actually footnoted in the report—that it really wasn't meant to be an apples-to-apples comparison because—and I am going to paraphrase here—the VA didn't have a good assessment of their own internal costs. And as someone who looks at our business' P&Ls pretty closely, my sense is that, without the costs, for human resources, et cetera, that is a big component of it.

Mr. DONNELLY. Well, let me ask you this: If there is no handle on—if there is no real estimate of the cost, as you said, does any comparison really stand up if the numbers are not the same?

Mr. OROS. In my mind, no.

Mr. DONNELLY. Okay. Well, I yield back. And, again, thank you all for your service to the country; and as you well know, the most important thing we can do is to make sure that every veteran is served properly. So thanks again for what you do.

Mr. JOHNSON. I thank the gentleman for yielding back.

We will go to our colleague now from Michigan, Dr. Benishek.

Mr. BENISHEK. Thank you, gentlemen, for coming and testifying today. I just have a couple of questions.

Mr. Oros, are the people that work at the VA, the orthotists at the VA, are they members of your association, too? I mean, do they have the same access to the same prosthetics as the people on the outside?

Mr. OROS. Yes, they should.

Mr. BENISHEK. Because one of the questions I have, you know, I have done amputations and had to deal with orthotists and had people take care of it, of my patients; and one of the things that you brought up in your testimony was sometimes it is simply the fact of going to the VA. Sometimes there is a travel issue—

Mr. OROS. Yes.

Mr. BENISHEK. —or a comfort issue with the orthotist, you know, the guy is familiar with. Do all of these people already have contracts with the VA? I mean, are we having to deal with the special section a lot dealing with outside orthotists or they have a contract?

Mr. OROS. Actually, the majority of VA care is actually provided outside the VA system through independent, contracted providers.

Mr. BENISHEK. All right. Well, I am just trying to, you know, verify that the VA and the outside providers are providing comparable care. They have access to the highest-quality orthotics and all that.

Mr. OROS. The care should be comparable. It is more a matter of what is the veteran's choice. Is it to receive care locally, or to go to the VA? And I think AOPA's position is that that should be the veteran's choice. And it is fine if it is within the VA system, but it also should be fine if it is outside the system.

Mr. BENISHEK. It seems like your testimony indicates that sometimes the VA seems to discourage the outside presence?

Mr. OROS. That is absolutely the case.

Mr. BENISHEK. All right, so is it the issue that we think that it is just charging—the VA thinks that they are charging too much or they already have their own overhead involved? I mean, is there a reasoning for that that you can—

Mr. OROS. I can't speak for the VA's stated intention or, you know, unintended steering of patient care.

Mr. BENISHEK. Right. Well, I know in my district, you know, I have a very rural district and people have to travel sometimes hours to get to the VA facility, and especially to contract with orthotists it might be even further to go to some specialty clinic, you know, way outside the area. So I think increased access to a local orthotist would be excellent.

Let me ask Mr. Shaw a question. We are talking about biologics. Are you talking about bone implants for the most part?

Mr. SHAW. Yes, sir, bone, any kind of cadaveric device, milled bone, ACL tendons, skin grafts, things of that nature.

Mr. BENISHEK. Okay, so for now we have a contract, where before people were, for the most part, going out of the Section 8123. Is that the issue here?

Mr. SHAW. Yes, sir. We have an FSS contract, and we are one of the few vendors who took the time to get an FSS contract. And we are—our situation is, as we are going out and marketing our contract, we are coming up against leadership that is invoking 8123 and saying that, because with 8123 they don't have to abide by any contract, that our FSS contract is irrelevant for purchase of biologics.

Mr. BENISHEK. I tend to agree with the Chairman on that. I don't believe that really biologics are the same thing as prosthetics, to tell you the truth. And I would prefer to see most people have a contract because—is there a wide variety in the price then, basically? Tell me the variety of prices.

Mr. SHAW. We found that we are probably 20 to 30 percent more affordable than some of our competitors.

Mr. BENISHEK. What percent of the business of the VA is with a contractor like yourself, then? Is it mostly noncontracted 8123?

Mr. SHAW. Yes, sir. It is maybe 97 percent off contract, versus our small 3 percent. We estimate that the VA spends about $175 million annually in biologics. And, to be honest, there has never been a vendor putting these products on contract. And so we have kind of gone through that arduous task of getting it on contract; and we have let the VA know that, hey, we are out here, and as a veteran-owned small business we really want to be your partner. And it has relatively fallen on deaf ears.

Mr. BENISHEK. Is there a different cost structure between your company and the other companies that make the difference in the price that you are aware of?

Mr. SHAW. I can't really speak for my competitors and what their situations are, but I think that if you don't have to—if you are not asked for a discount when someone is swiping a purchase card, then they are not going to get one.

Mr. BENISHEK. So how many different providers are there of these biologics?

Mr. SHAW. Six or eight.

Mr. BENISHEK. All right—throughout the country?

Mr. SHAW. Probably six or eight that are comparable, that are AATB certified, that provide good-quality products.

Mr. BENISHEK. Well, I guess my question to the Committee then would be to, you know, see if we can investigate this a little bit further. I mean, not only does it not seem to be an orthotic to me but just the process itself doesn't seem to be quite right. So I appreciate your testimony.

I see my time is up. Thanks.

Mr. SHAW. Yes, sir.

Mr. JOHNSON. Thank you for yielding back.

We will go to Mr. Barrow from Georgia.

Mr. BARROW. Thank you, Mr. Chairman.

Gentlemen, thank you all for your testimony today.

I want you to pitch that hay down there real low where us goats can get at it, okay?

If I understand the whole purpose of 8123, it is basically to say, with respect to something that is as important as prosthetic devices, money is no object. Cut through all of the red tape. There is no red tape. We are going to spend whatever is necessary to get folks what they need. There is a noble impulse in that, but if I understand what you are saying, we are spending a whole lot more and we are not getting enough value for the taxpayers and benefit for the veterans at the same time. Is that the upshot of this?

Mr. SHAW. Yes, sir.

Mr. BARROW. Help me understand how you would rewrite 8123 in order to make sure that we preserve that prime directive of money is no object when it comes to trying to replace a vital function for folks. We are not going to cut corners. We are also not going to waste money in the process. How would you suggest that we change 8123 so that we can continue to take the attitude of we are going to get whatever you need to the folks who need it, when they need it, but not waste money and get value for the taxpayers and benefit for the vets at the same time. How should we change 8123?

Mr. SHAW. Sir, I don't think you really need 8123. I think most purchases could be—the Federal Acquisition Regulation does a pretty nice job I think for acquisitions of even prosthetic limbs.

Mr. BARROW. Do you have any concerns that the red tape associated with trying to making sure we get stuff off the shelf at the lowest price—bulk rates, discounts, that kind of stuff—isn't going to interfere with folks getting exactly what they need with respect to something that is much more out of the ordinary than something, you know, off the shelf?

Mr. SHAW. There is a VA waiver form—if a clinician were to have a specific appliance that he felt that would be specifically needed for that particular patient, there is a waiver form that is quite easy for them to fill out; and I think that many clinicians are familiar with the waiver form and would most likely fill it out for that patient.

Mr. BARROW. And, in that context, how would things work differently than they do right now, if we did that?

Mr. SHAW. I think what would happen is there would be several contracted vendors, most likely your more reputable manufacturers, and that would be what most guys would most likely use on a straightforward case.

But, again, if you have a patient that needed something in particular, the clinician could fill out a waiver form and the patient would get the care that he needed.

Mr. BARROW. Thank you.

Mr. Oros, same question for you. Do you have anything to add to that?

Mr. OROS. I think there might be a slight difference when it comes to what I will call traditional orthotic and prosthetic care. I will highlight your first comment was to provide whatever is the best for those individual patients, and they are really not commodity services.

Mr. BARROW. Exactly.

Mr. OROS. So to that end, I think you want to eliminate whatever type of barriers. I don't think that you want to lump it in with

something, for example, like biologics. So I would absolutely tighten the definition of 8123 to mean replacement of artificial limbs and orthopedic devices.

Mr. BARROW. How about you, Mr. Shaw? Do you feel the same way? Do you think that would accomplish—

Mr. SHAW. I would agree with that. I think if the Committee felt like there needed to be an 8123 and the leadership at VA felt that 8123 is necessary, I would definitely limit it to a very, very limited access; and I would certainly ensure that it could not be delegated down.

Mr. BARROW. Thank you, gentlemen.

I only have a minute and a half, and I would be happy to yield so much of that time as either the Ranking Member or the Chairman would like to have.

Mr. JOHNSON. I thank the gentleman for yielding back.

We will actually go into a second round. I do have a few more questions, and then we will see if our colleagues have any.

Mr. Oros, you pointed out in your testimony that 80 to 90 percent of veterans' prosthetic and orthotic care is provided by community-based providers. I am sure this is a significant and unwieldy system of contracts for the VA to manage. What in your view is the advantage to veterans of sustaining this contract-based system?

Mr. OROS. It is simply that access to their individual provider.

And the reality of the VA network, you are right. It is unwieldy. But the fact of the matter is that our injured veterans, they might be originally cared for in a VA, in a DoD facility, but they want to go back to their own community and live their own lives; and to have to go to a VA hospital that is 2 hours away is more than an inconvenience.

Mr. JOHNSON. And maybe you have already answered this question in some of your comments, but if you were going to design a system, Mr. Oros, for the VA to evaluate the quality of care provided to veterans, what would you do? What provisions would you put in that system to improve the quality of care for veterans—that veterans receive?

Mr. OROS. I would start to look at the implementation of some functional outcome measurements at the time of the original prescription and then follow it throughout that veteran's care so that you see that there has been restoration of function. And that can be done with validated instruments, and there is also technology available that can support that kind of measurement.

Mr. JOHNSON. Okay, as one of the elements of quality you described the need to educate veterans about their right to choose a provider of prosthetic care. The Committee is starting to hear more and more stories about veterans who say that the VA is creating barriers to their selection of non-VA care. What has been your experience? Have you heard from veterans that this is a growing problem?

Mr. OROS. I have seen it locally. I think what I can speak to most directly to, is, locally, we no longer have access. For at least the last 2 years our company, while we have had a VA contract, has not been invited to that amputee clinic that I referred to previously. Really that's where those referrals are, and the veteran's

ability to communicate with the prosthetist as well as the referring VA physician, are all kind of present in the same building.

Mr. JOHNSON. Okay, here is that word again. From your point of view, what barriers are preventing veterans from selecting a prosthetist of their own choice? Is it just that veterans don't know their rights?

Mr. OROS. I think it is unfamiliarity with their rights.

Mr. JOHNSON. Okay. You talked in your written testimony specifically about older veterans at your practice complaining that there appears to be new administrative hurdles to prevent their continuing to receive care at non-VA facilities. Can you give us some examples?

Mr. OROS. We have seen in our own facility where veterans who have received care from our company for a number of years—and, I have heard similar stories from other providers—veterans have gone back to the VA for other services, prescriptions, et cetera. And the patient has been—I will use the word discovered—to be an amputee, and they have been directed to receive their care within the VA system versus, again, that outside provider.

Mr. JOHNSON. Okay. I yield now to the Ranking Member, see if he has additional questions.

Mr. DONNELLY. No additional questions.

Mr. JOHNSON. Dr. Benishek.

Dr. Benishek, would you have any additional questions?

Mr. BENISHEK. I have a couple of questions here.

Mr. JOHNSON. Okay. Thank you.

Mr. BENISHEK. Mr. Oros, you talked about the quality of the orthotic providers, and your testimony mentioned, you know, a master's degree program.

Mr. OROS. Uh-huh.

Mr. BENISHEK. Is it easy to find people that can do this work? I mean, is there a lot of people out there that do this? I am just kind of curious as to the experience that you have in finding qualified people to do this job.

Mr. OROS. Frankly, there is probably not enough. Between certainly the growing problem we have in this country with diabetes, we have got increasing veteran population, the baby boomers in general. So even the demand for these services are growing, and the reality of it is we have a limited number of schools graduating students that have their training in orthotics and prosthetics. So it is an issue and a concern, yes, but it is one we face in the private practice as well as within the Veterans Administration.

Mr. BENISHEK. Do you think the qualifications for the typical VA orthotist are pretty much the same as the private practice person?

Mr. OROS. I would like to think they are. We have two national credentialing agencies, the American Board for Certification and the BOC. And I believe that both inside and outside the VA they should be—

Mr. BENISHEK. Those folks are members of your—

Mr. OROS. I believe so.

Mr. BENISHEK. Is there ongoing certification required for that?

Mr. OROS. Ongoing continuing education required, yes.

Mr. BENISHEK. Right. Okay.

I think that is about all I want to ask. Thank you very much, sir.

Mr. JOHNSON. I thank the gentleman for yielding back.

Mr. Barrow from Georgia.

Mr. BARROW. I thank the Chairman. And my thanks to the witnesses. I have no further questions.

Mr. JOHNSON. Well, our thanks to the panel. You are now excused. Thank you for your testimony today and for responding to our question.

I now invite the second panel to the witness table.

On our second panel we will hear from Dr. Charles Scoville, Chief of Amputee Patient Care Service at Walter Reed National Military Medical Center; and Ms. Linda Halliday, Assistant Inspector General for Audits and Evaluations at the U.S. Department of Veterans Affairs Office of Inspector General. Ms. Halliday is accompanied today by Mr. Nick Dahl, Director of the Bedford Office of Audits and Evaluations, and Mr. Kent Wrathall, Director of the Atlanta Office of Audits and Evaluations.

Both of your complete written statements will be made part of the hearing record.

Dr. Scoville, you are now recognized for 5 minutes.

STATEMENTS OF CHARLES SCOVILLE, CHIEF OF AMPUTEE PATIENT CARE SERVICE, WALTER REED NATIONAL MILITARY MEDICAL CENTER, U.S. DEPARTMENT OF DEFENSE; AND LINDA HALLIDAY, ASSISTANT INSPECTOR GENERAL FOR AUDITS AND EVALUATIONS, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY NICK DAHL, DIRECTOR OF BEDFORD OFFICE OF AUDITS AND EVALUATIONS, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS, AND KENT WRATHALL, DIRECTOR OF ATLANTA OFFICE OF AUDITS AND EVALUATIONS, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF CHARLES SCOVILLE

Dr. SCOVILLE. Thank you, Chairman Johnson, Ranking Member Donnelly, and distinguished members of the Subcommittee. Thank you for the opportunity to provide a perspective on how the Department of Defense cares for individuals with limb loss and in particular prosthetic care, new technologies and our collaboration between DoD and the Department of Veterans Affairs.

It is always important for us to look back before we look forward, to take lessons—take from lessons learned. The Washington D.C. Times-Herald reported, "In a few days the Army will print a formal regulation which will give officers and enlisted of men who have lost arms, or legs, or both, in the line of duty the opportunity to return to active duty."

This was written in 1951. Fast forward to 2003. We repeated this within the military returning individuals to active duty. To date, we have had over 305 individuals with limb loss who remain on active duty, and over 53 of these have redeployed into Iraq or Afghanistan.

The goal of our program is to return patients to tactical athleticism or to their pre-injury level of activity. The philosophy that we use for that program is to have the patient tell us how far they want to go, and then we work with them to achieve those goals.

DoD has a significantly lower patient population than the VA. Our patients are significantly different than the vast majority of the VA patients. They are young, active servicemembers, frequently with severe trauma and multiple limb loss, that desire and deserve to return to the highest levels of function, including returning to active duty. These servicemembers are strong willed and impressive warriors who challenge us daily to improve how we care for them. We started with the very small decentralized program and have built it into an efficient progressive program recognized as a world leader in amputee care and in meeting our patients needs.

The VA and DoD have long worked together. In 1945, the Army Prosthetic Research Lab was established at Walter Reed Army Medical Center. In 1948, the VA established the Prosthetic Research Department headquartered in New York City VA. Many of the devices they developed together were continuing to be used at the time the current conflict started.

In 2004, Congress provided $2.5 million for prosthetic device technology enhancement and clinical evaluation at Walter Reed and added an additional $10 million in 2005, and the DARPA project for upper extremity prosthetic devices programmed $30 million. Much of the research included partnership with the VA, and we would not have been able to complete the research without this partnership.

For example, the advanced DARPA arms that have been developed have first been tested in VA facilities and then migrated to DoD facilities. And the newest research to help our patients return to the highest levels of function is a study projected to begin either later this year or early next year with the Salt Lake City VA on osseointegration. If this is successful, it will allow patients that are unable to wear prosthetic sockets the opportunity to use prosthetic devices to return to high-end activity.

Several factors help us explain why DoD has led in the efforts to provide prosthetic care for our Wounded Warriors. One of the keys is the interdisciplinary program. We are pulling together providers from a wide range to address the basic patient daily needs. While the standard of care requires the Wounded Warrior is to be seen within 7 days, we at Walter Reed have set the standard, they are seen within 72 hours.

Another factor is the integration of logistics and contracting within prosthetic services. Walter Reed embedded a warranted contract officer in the orthopedic and prosthetic service which enables same-day ordering of new prosthetic devices with next-day delivery. The development of blanket purchase agreements have ensured best value through discount pricing and fixed component costs. The logistics technician embedded within the service provides the ability to warehouse non-patient-specific items for fabrication and custom fitting, further reducing delay and delivery of care.

A third factor in the success of the DoD has been the research efforts in partnership with industry and the VA in providing new devices such as the Genium/X2/X3 microprocessor knees, the BiOM robotic ankle, and Power Knee.

So the Department uses both civilian and contract prosthetists within our facility, enabling the DoD with the contracts to rapidly expand or contract the staff to meet the basic requirements that we have. The best value is guaranteed within the contracts through pricing proposals provided by the vendor in a bid phase of the procurement. The civilian model has a wide degree of variability in costs based on the use of not otherwise classified codes within the health care common procedure coding system.

The DoD requires offerors to list what not-otherwise-classified procedures and components they propose to bill for and the amount of reimbursement they will seek. The DoD contract officer representative may reject any bid with a not-otherwise-specified code determined to be excessive.

A large percent of our patients receive a significant portion of their care within the Veterans Health Care Administration at VA. This is crucial to the success of both DoD and VA patient care. The DoD does not have the capacity to provide life-long prosthetic care for our Wounded Warriors.

We continue to work closely with the VA, and we have their providers working in our clinics at Walter Reed and in San Antonio. Creates a great relationship where we share knowledge and assist the patients as they transition to long-term care within the VA system. Through our long history of DoD and VA collaborative research and patient care efforts, we continue to meet the needs of our Wounded Warriors and veterans.

Thank you.

[THE PREPARED STATEMENT OF MR. SCOVILLE APPEARS IN THE APPENDIX]

Mr. JOHNSON. Thank you, Dr. Scoville.

Ms. Halliday, you are now recognized for 5 minutes.

STATEMENT OF LINDA HALLIDAY

Ms. HALLIDAY. Chairman Johnson, Ranking Member Donnelly, and members of the Subcommittee, thank you for the opportunity to discuss the results of the OIG reports dealing with how VA acquires prosthetic limbs and manages its prosthetic inventories nationwide. We conducted these audits at the request of the House Veterans Affairs Committee.

I am accompanied by Mr. Nick Dahl, Director of the OIG Bedford Audit office, and Mr. Kent Wrathall, Director of our Atlanta office.

Before I discuss the results of our work, let me make one thing clear. The OIG supports that veterans should be able to receive the limbs that they and their clinicians determine are best for them from the source of their choice, either VA or commercial vendors.

Our audit focused on the effectiveness of VA's acquisitions and contract administration practices. We did not examine nor do we offer an opinion on the definition of the prosthetics or whether the VA labs are the preferred source for prosthetic limbs rather than contract vendors based on cost comparisons or other factors.

In our first report, we evaluated VHA's management and acquisition practices used to buy prosthetic limbs and we examined the procurement practices and costs paid for limbs. We identified opportunities for VHA to improve payment controls to avoid overpaying for prosthetic limbs and improved contract negotiations to obtain the best value for prosthetic limbs purchased from contract vendors.

Overpayments for prosthetic limbs were a systemic issue at all 21 Veteran-Integrated Service Networks. We identified overpayments in 23 percent of the transactions paid in fiscal year 2010. We found VHA overpaid contract vendors about $2.2 million of the total $49.3 million spent on prosthetic limbs in that year.

The overpayments generally occurred because VHA paid vendor invoices that included charges in excess of the prices agreed to in the vendors' contracts with VA. We also found that contracting officers were not always negotiating to obtain the best discount rates with vendors. Without COs negotiating the best discount rate, VHA cannot be assured it receives the best value for prosthetic limbs. We noted that taking action to ensure COs consistently negotiate better discount rates should in no way compromise the quality of prosthetic limbs purchased for veterans.

Ms. HALLIDAY. In addition, prosthetic staff should periodically conduct evaluations to ensure prosthetic labs are operating as effectively and economically as possible.

We found officials suspended the VISN-based review of labs in January 2011 after reviewing only nine of 21 VISNs nationwide. As a result, the prosthetic staff were unsure of its in-house fabrication capabilities and generally lacked the information needed to know if the labs were operating effectively and efficiently.

Our second report provided a comprehensive perspective of the suitability of VHA's prosthetic inventory management policies and procedures. We reported that strengthening VA Medical Centers' management of prosthetic inventories will reduce costs and minimize risks of supply expiration and disruptions to patient care due to supply shortages.

For almost 60 percent of the inventory prosthetic items, VAMCs did not maintain optimal inventory levels. For approximately 93,000 items, we estimated VAMC inventories exceeded current needs for about 43,000 of these items, and inventories on-hand were too low for another 10,000 items. This situation occurred because VA Medical Centers did not consistently apply basic inventory practices and techniques. For example, we found that VAMCs did not set normal, reorder, or emergency stock levels in automated inventory systems for over 90 percent of the prosthetic items.

In conclusion, until VHA improves the acquisition and contract administration practices used to buy prosthetic limbs, VA will not have sufficient assurance that its practices are effective or economical. Improvements in inventory practices and accountability for these inventories needs strengthening, and VHA needs to remain committed to replacing its existing inventory systems with a more modern inventory system by 2015.

We are pleased to see that VA is responding to the issues we identified in our reports and that they agreed with our rec-

ommendations. VA is adopting practices to ensure the financial stewardship of the funding needed for prosthetic care.

Chairman Johnson, my colleagues and I would be happy to answer any questions.

[THE PREPARED STATEMENT OF MS. HALLIDAY APPEARS IN THE APPENDIX]

Mr. JOHNSON. Thank you, Ms. Halliday.

We will now begin with questions, and I recognize myself for 5 minutes. Ms. Halliday, did the Inspector General use the VA's definition for "prosthetic" in its recent audits?

Ms. HALLIDAY. We looked at the definition and I believe in the inventories report we really didn't find any real problems with it because it was defined, and we could then apply it against the purchases we reviewed.

Mr. JOHNSON. Your testimony mentions that overpayments generally occur because VHA paid vendor invoices that included charges in excess of prices agreed to in the vendor's contracts with VA. Did you find any reason as to why or how the VA purchasers failed to obtain best value, even with the contract in place?

Ms. HALLIDAY. Well, the question on the best value led to the contracting officers' not trying to negotiate discount rates. The problem with the overpayments was because the invoices were not receiving adequate review by the COTRs prior to certification for payment so they just were not looking at the invoices in relationship to the terms of the contract.

Mr. JOHNSON. You also discussed how VA purchasing agents, following the terms of contracts would not compromise, I quote, "the quality of the prosthetic limbs provided to veterans." Would the quality of prosthetic limbs decline if purchasing agents followed their training as well as the FAR and the VAR?

Ms. HALLIDAY. No, I don't see any reason for it.

Mr. JOHNSON. Do you know why Prosthetic and Sensory Aid service suspended its review of labs last year after reviewing only nine VISNs?

Mr. DAHL. My understanding is that at the time they made that decision, they weren't sure what the need was for conducting those reviews. There was a change in leadership and they decided that they weren't getting enough information from those reviews to continue them.

Mr. JOHNSON. Why is there such widespread failure to use ECMS?

Ms. HALLIDAY. ECMS is not considered user-friendly. It does take some training. We have actually have had some of our staff get the training. It is difficult to put information in. What we have found through many of our reviews is that VA contracting staff use it as a shell. They will put the basic information in, but they won't put all the information in to give you a good understanding of the contract actions that lead to award and then through contract closeout.

Mr. JOHNSON. Will the VA be able to effectively recover money that it overpaid to vendors?

Ms. HALLIDAY. Yes, they will, because these overpayments were in excess of the contract terms. And we do believe the $2.2 million is a conservative estimate. The VHA staff, and Dr. Beck took action

immediately to start looking to recover those overpayments. Those moneys can then be reprogrammed for more prosthetics' care in VA.

Mr. JOHNSON. Do you think overpayments will cease in the near future?

Ms. HALLIDAY. We would like to see a more rigorous review of invoices against contract terms throughout VA. I think that there is the knowledge now that this is a systemic problem, and I think more attention will be brought to that based on the discussions we have had with VA officials.

Mr. JOHNSON. Turning to the DoD, does the Department of Defense use any mechanism similar to section 8123 of title 38 for its acquisition of prosthetic appliances?

Dr. SCOVILLE. No, it does not have any similar.

Mr. JOHNSON. Do you know whether or not DoD has any kind of procurement statute that allows it to procure items and disregard any other provision of law?

Dr. SCOVILLE. No it does not. We have researched that and there is no similar provision in the DoD.

Mr. JOHNSON. Are there any instances where DoD doesn't document procurements, whether they are on- or off-contract?

Dr. SCOVILLE. None that I am aware of, sir.

Mr. JOHNSON. That is all of my questions. I will yield to the Ranking Member for his questions.

Mr. DONNELLY. Thank you, Mr. Chairman.

Dr. Scoville, when you look at the VA processes, what do you think are some of the best steps that they can take to provide even better care in this area? When you look at how things are done on DoD's side and on the VA side, what are some of the tips you can give us to operate better?

Dr. SCOVILLE. Again, the DoD and VA has a significantly different population as far as the number, the location. We have the advantage that we are treating the newly wounded that have not been out for a long period of time, and can provide the unified care at our facilities, so we don't need to rely on a large nationwide network.

The approach that we found very successful was embedding the warranted contract officers within our facility, which is something the VA is now proposing or looking to do. What that did was it allowed our providers to have more time to work with the patients, and it gave us all the appropriate authorities to do the contracting side, making sure we were hitting all of the requirements, meeting all regulations.

Mr. DONNELLY. Is DoD's definition of "prosthetics" as broad as the VA's?

Dr. SCOVILLE. No. The DoD definition of "prosthetics" is an artificial substitute for a missing body part, determined to be necessary by the Secretary of Defense, because of significant conditions resulting from trauma, congenital abnormalities or disease, and it is limited to artificial limbs, eyes, voice prostheses, ears, nose, and fingers.

Mr. DONNELLY. So by that definition, "biologics" would not be included then?

Dr. SCOVILLE. No, sir.

Mr. DONNELLY. Can you explain why the use of blanket purchase agreements and indefinite delivery, indefinite quantity ensure the best value when acquiring prosthetics?

Dr. SCOVILLE. These are small business set-aside competitive contracts that provide the DoD to look at the cost and make assessment and then select the sole source that will provide the best value to DoD.

Mr. DONNELLY. This will be for Ms. Halliday.

Do you have any opinions, as a result of what you have looked into, as to items the VA may be including in its definition of "prosthetics" that would be better suited for purchase outside of section 8123?

Ms. HALLIDAY. There was a large inventory of prosthetics when we looked at the medical centers. VA really has to take a look at which items are not unique, but just standardized items that you would use on a regular basis. I understand that the VHA is moving in that direction.

There are just so many items. I think when it is unique like a limb, an arm, or extension, they are very specific requirements, and it has to be tailored to the veteran's needs, and the clinicians will work with the veterans. But when we get into the prosthetics inventory within the medical center, there are many items that can be standardized.

Mr. DONNELLY. Thank you. Thank you, Mr. Chairman.

Mr. JOHNSON. Dr. Benishek.

Mr. BENISHEK. Thank you, Mr. Chairman.

Ms. Halliday, I have a couple of questions concerning the overpayment. You said on average there is like a $2,300 overpayment. Was this systemic through all the hospitals you checked? Were there some hospitals that were paying their right amount and then others that weren't? I am just trying to figure out if it is just across the board.

Ms. HALLIDAY. I believe what we said was there was a 23 percent error rate in overpayments. We looked at the contracts within the VISNs and all of the actions to buy the limbs and it was systemic across all 21 of the network offices in VA.

Mr. BENISHEK. So it is apparent that the purchasing agents on the routine didn't look at the contracts at all, then? Is that the impression that you get from looking at how it was done?

Ms. HALLIDAY. The impression we got was that the contracting officers' technical representatives were not doing a good job of reviewing the invoices, once they are submitted by vendors, before they are certified for payment. Clearly, I think, this is called for in the VHA COTR handbook which requires them to do some review of those invoices against the contract terms, and that wasn't happening.

Mr. BENISHEK. Was there some difficulty—you mentioned that the software is difficult to use or to call up these contracts; should these people have this at their fingertips as they are doing this? It seems to me that they would be—having these contracts right available to them and they should know all this as they were doing these reviews, right?

Ms. HALLIDAY. You could get transparency for contract actions if you had a good dedication to using the ECMS system, and you

would be able to find out much more about the progress and what the contract was and the terms, and be able to do these reviews much quicker and better.

Mr. BENISHEK. Is there a defined training level with the competency requirement for the people that do these reviews that include something like that, or are you aware of that?

Ms. HALLIDAY. Yes, there is. For COTRs, which is a contracting officer's technical rep, there is training. It takes them through a process where they are delegated the responsibilities, and the contracting officers will clearly lay out the responsibilities to review such things as the invoices, because normally the COTRs work is after the award of a contract. So they are looking to ensure contract administration actions.

Mr. BENISHEK. So since your investigation, has anyone changed the way they are doing business here? Or is this going on the way it is? Is anyone reviewing the process? Has anyone been reprimanded for not following the rules? Has anything like that occurred?

Ms. HALLIDAY. At this point, I would have to say it is too early for us to assess that. The Department has accepted our recommendations in the report. They are moving forward on some 18 different recommendations to tighten up the controls associated with what we saw as weaknesses in the contract administration. We have to provide time to put all of the controls in place, and then we would come back at a later date and assess the effectiveness of VA's actions.

Mr. BENISHEK. Is there a timeline for that?

Ms. HALLIDAY. Normally, we give the Department a year after we have issued an audit, and I believe our audits were issued in March of this year, so we will be looking to do some testing and follow-up work within the next year.

Mr. BENISHEK. I would be happy to see that report. Thank you. I yield back the remainder of my time.

Mr. JOHNSON. I thank the gentleman for yielding back.

We will go to Mr. Barrow from Georgia.

Mr. BARROW. Thank you Mr. Chairman. Just to follow up a little bit more on the subject of overpayments, Ms. Halliday, just how is the government going to go about getting back some of the money that has been overpaid?

Ms. HALLIDAY. Could you ask that question again, sir? I don't believe I heard you.

Mr. BARROW. Sure. I overheard you saw that we acknowledge that money has been overpaid because some of the officers were not scrutinizing before they were certifying. Some folks got paid something they shouldn't have got paid; I think at one point the subject was touched on. Are we going to walk away from it? And I think I got the impression that somehow we are going to be pursuing recoupment, reimbursement, something, compensation.

Ms. HALLIDAY. It is the responsibility of the contracting officer to make the final determination on funds that have been overpaid and set up bills of collection and work with the vendors to recoup those moneys.

Mr. BARROW. And what if—is there any possibility or likelihood that it might be difficult to recoup the money because some of them

don't want to pay it back? Or is this too small potatoes, with an ongoing book of businesses, for someone to get that kind of a problem?

Ms. HALLIDAY. I think the pressure to maintain ongoing business is really what brings about a cooperative relationship between the vendor and VA.

Mr. BARROW. Glad to hear it. Thank you, ma'am.

Mr. JOHNSON. I thank the gentleman for yielding back.

Our thanks to the panel. You are now excused. And I invite the third panel to the witness table.

Mr. JOHNSON. On this panel we will hear from Mr. Philip Matkovsky, Assistant Deputy Under Secretary for Health for Administrative Operations, Veterans Health Administration.

He is accompanied by Dr. Lucille Beck, Chief Consultant for Rehabilitation Services, Director for Audiology and Speech Pathology and Acting Chief Consultant for Prosthetic and Sensory Aids Service in the Veterans Health Administration. He is also accompanied by Mr. Norbert Doyle, Chief Procurement Logistics Officer for the Veterans Health Administration, and Mr. Ford Heard, Associate Deputy Assistant Secretary in the Department of Veterans Affairs, Office of Acquisitions and Logistics.

Mr. Matkovsky, your complete written statement will be made part of the hearing record, and you are now recognized for 5 minutes.

STATEMENT OF PHILIP MATKOVSKY, ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH FOR ADMINISTRATIVE OPERATIONS, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY DR. LUCILLE BECK, CHIEF CONSULTANT, REHABILITATION SERVICES; DIRECTOR, AUDIOLOGY AND SPEECH PATHOLOGY; AND ACTING CHIEF CONSULTANT, PROSTHETIC AND SENSOR AIDS SERVICE, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; NORBERT DOYLE, CHIEF PROCUREMENT LOGISTICS OFFICER, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND FORD HEARD, ASSOCIATE DEPUTY ASSISTANT SECRETARY, OFFICE OF ACQUISITIONS AND LOGISTICS, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF PHILIP MATKOVSKY

Mr. MATKOVSKY. Chairman Johnson, Ranking Member Donnelly and members of the Subcommittee, thank you for the opportunity to speak about the Department of Veterans Affairs' ability to deliver quality care and acquire prosthetics and other devices for veterans in need of these items.

I am accompanied today by Dr. Lucille Beck, chief consultant, rehabilitation services; and acting chief consultant, prosthetic and sensory aids service. Also, Mr. Norbert Doyle the chief procurement logistics officer; and Mr. Ford Heard, associate deputy assistant secretary for the Office of Acquisitions and Logistics.

VA has been engaging in prudent and appropriate reform to improve the business processes governing the procurement of prosthetic devices for veterans. We are taking great care to ensure that

these changes improve the accountability of these purchases while maintaining the high quality of care and clinical decision-making critical to veterans' health care. Enhancing access and tailoring devices and clinical solutions to the unique needs of veterans is and will remain our chief priority.

In the few minutes I have now, I would like to broadly outline how we are exercising better oversight of our procurement operations and maintaining patient care.

First, VA is transitioning the authority to purchase prosthetics from clinical support to contracting staff. The authority to select the most appropriate prosthetic device remains, however, with the clinical provider and the veteran.

Technologies and equipment must be highly individualized to meet each veteran's unique rehabilitative needs. We are making this transition, though, to bring our practices more in line with Federal and VA acquisition regulations. While these regulations generally require full and open competition and procurement, section 8123, as we have heard today, authorizes VA to limit competition when physicians require specific devices or equipment for patient care. And the FAR and VAR similarly authorize limiting competition under these circumstances.

If the Secretary elects to use section 8123 in this manner, all applicable FAR and VAR requirements must still be followed. When products are generally available and interchangeable, competitive procurements may be more appropriate. VA has aggressively pursued national contracts over the past 10 years for these types of items, achieving cost savings, and to standardize and to find commodities where appropriate.

When we can purchase products, devices or supplies that are generally available and interchangeable, we will comply with the FAR to ensure we are obtaining the best price possible. In the long term, VHA will develop a catalogue of such items to facilitate better, more cost-effective purchasing decisions.

We are also increasing the number of audits of purchases to identify best practices and to conduct better oversight to ensure we are realizing the best value.

As we gather more data on how these changes are working, we can continue to refine and streamline and simplify our processes. We are using new templates, checklists and justifications, and we are improving the communication between staff and leadership so we have a comprehensive view of our procurement activities. We will correct noncompliant contracts as required, and evaluate contract or performance as required by the FAR, and institute collection activities when warranted.

Finally, we are better defining our policies and guidance to the field, strengthening our training programs and increasing oversight and audit functions. We are directing our facilities to reconcile physical inventories and take action to eliminate excess inventories without creating supply shortages. We are reserving our standards for facilities to require at least one prosthetic supply inventory manager to become a certified VA supply chain manager.

In conclusion, VHA's prosthetics and sensory aids service is the largest and most comprehensive provider of prosthetic devices and sensory aids in the world, offering a full range of equipment and

services. VA supports high-quality amputation and prosthetics care by promoting ground-breaking research into new technologies, training a highly qualified cadre of staff in pursuing accreditation of all eligible prosthetic laboratories in VA's amputation system of care. We are improving our oversight and management of prosthetic purchasing and inventory management to better utilize the resources we have been appropriated by Congress as we serve America's veterans. However, we must always ensure our processes do not adversely affect our ability to provide veterans with high-quality individualized and timely prosthetic services they have earned.

We appreciate the opportunity to appear before you today, sir, to discuss this important program. My colleagues and I are prepared to answer your questions.

[THE PREPARED STATEMENT OF MR. MATKOVSKY APPEARS IN THE APPENDIX]

Mr. JOHNSON. Thank you and we will begin with questions. I will recognize myself for 5 minutes.

Is a procurement official responsible for documenting that a procurement is authorized under title 38, section 8123, as outlined in the FAR 6.2, 6.302-1, and 6.302-5?

Mr. MATKOVSKY. Yes, they are.

Mr. JOHNSON. Would the procurement official also be required to document the technical health care and other factors supporting this decision through justification and approval for other than full and open competition in the contract file?

Mr. MATKOVSKY. We expect that the contracting official will document the basis for the sole-source justification and using 8123. Especially as we have developed the templates moving forward, the basis for that justification is clinical indication, as in a physician's prescription, so noted, or a veteran's choice.

Mr. JOHNSON. So the short answer is yes?

Mr. MATKOVSKY. Yes, sir.

Mr. JOHNSON. Why did Deputy Secretary Gould's letter to this Subcommittee in March cite section 8123 and further stated that the VA is not required to document waivers and deviations from the Federal supply schedule when invoking section 8123?

Mr. MATKOVSKY. Sir, I believe the Deputy Secretary's letter was with respect to some specific acquisitions that were cited in the incoming correspondence, and in explaining why we did not actually have to cite or provide a prior waiver request, 8123 was noted as the reason for not requiring a prior waiver from the VAR hierarchy of contracts, sir.

Mr. JOHNSON. Many physicians at the VA are part-time employees and in this capacity can promote companies with which they are associated as consultants. Through section 8123, these physicians can also direct sole-source contracts.

Are VA physicians required to disclose any outside partnerships that could create an ethical or moral dilemma for the VA?

Mr. MATKOVSKY. They are absolutely required to do so, sir.

Mr. JOHNSON. You note the VA's new policy for purchases over $3,000. Approximately 5 percent of biologics cost more than $3,000, so your policy will have minimal bearing on 95 percent of biologics

purchased. Can you describe how your policy will affect the other 95 percent of biologics purchased?

Mr. MATKOVSKY. Well, I don't actually have the specific cost breakout for the biologics themselves. But the $3,000 threshold was noted that it was 97 percent of the cost would below $3,000. Actually the number is a little bit north of 50, 55 percent of all of the prosthetics purchases are greater than $3,000 in cost. It is the number of transactions, is the 3 percent number.

In terms of the biologics themselves, our expectation is that we are asking in this policy moving forward that we document that a waiver from FSS was requested and that part of what we hoped to achieve from this—and we expect to achieve from this—is that we will collect information about why FSS is actually not being selected as a source for biologics or for other items, or national contracts for that matter, and be able to attenuate practice through education, communication in the field as well.

Mr. JOHNSON. Numerous contracts reviewed by this Subcommittee show VA purchasers splitting contracts in order to remain under a specific price threshold for purchase. In one case 12 purchases went to the same company for the same product from the same contracting officer one right after the other.

Why is VHA not aggregating their micropurchases of biologics and other prosthetics appliances to properly follow the FAR and VAR or to be CICA-compliant, notwithstanding the section 8123 authority?

Mr. MATKOVSKY. Sir, it is not appropriate to split transactions to remain below a micropurchase threshold. So if that is occurring, that is not a condoned practice.

Mr. JOHNSON. What, then, would the VHA do to stop that?

Mr. MATKOVSKY. Monitor the action and ensure that—look, every purchase cardholder who is committing a transaction below $3,000 has a supervisor who is supposed to be watching and monitoring that. They should be looking for any split transactions to remain below a threshold. That is an inappropriate action, and I would request taking that item for the record to research it.

Mr. JOHNSON. I appreciate you recognizing that, sir. We have got page after page of examples of that kind of thing. So I would hope that the VHA would take that issue very seriously because we on this Committee do.

Why are some prosthetic items purchased using FAR guidelines and procedures instead of section 8123?

Mr. MATKOVSKY. I will initiate the discussion: 8123 and FAR-VAR are not actually as much in conflict as it seems in prior discussion today. Within FAR, part 6, 302-5, and VAR 8302-5, there is reference to other statutory authority. The question is under what conditions does the physician prescribe a specific product, or does a veteran choice weigh in as the justification for sourcing a particular item, and that is primarily the scenario within which 8123 is used.

VA over a number of years has been awarding national contracts. There are well above 50 national contracts for prosthetic supplies, some of the more high-performing being of course within the assistive audio devices. There are roughly 600 contracts throughout the

country for local regional contracts. All of those are precompeted price-negotiated as well.

The use of 8123, the way we use it is for the source justification for other than full and open, when it is a physician prescription or a veteran choice.

Mr. JOHNSON. Okay. I may have additional questions but I will yield to Mr. Barrow from Georgia at this time.

Mr. BARROW. Thank you, Mr. Chairman. Mr. Matkovsky, when it comes to the exercising discretion under the statute 8123, what problems would you foresee if the VA were to adopt the DoD's definition of prosthetic?

Mr. MATKOVSKY. Thank you for the question. I believe the concern that we would have is many of our veterans whom we serve have come to expect a certain degree of their own choice to be honored in the system, and frankly, the expectation that a physician doesn't have to defend his or her prescription through an administrative process.

My concern would be that the degree of vigilance to ensure that those elements in our system are not lost is what I would worry about, that it would work 90 percent of the time. I would be concerned that as we try to constrain the definition of a prosthetic, our definition is because we have a broad system that is geographically distributed, serves veterans across many ages.

My concern would be that we restrict the ability to source specifically what is for the benefit for a veteran, either through a physician prescription or through the veteran's choice, and that we would overcorrect and lose that dimension, sir.

Mr. BARROW. I get that. I understand what I think the purpose of 8123 is. It is supposed to cut through the red tape, it is supposed to make sure that nothing is going to stand in the way of getting just what the person needs, it is tailored to fit them. But biologics don't seem to fit that definition. That is clearly something that a doctor is going to use, like something that comes off the shelf. How a doctor applies that, of course, is highly individual and specific to the patient and what is pulled off the shelf ain't.

And what I am getting at is the DoD has a definition that seems to be fairly comprehensive and meets what most folks with walking-around sense have an idea of what we are talking about here. You all have a definition; it seems to be much broader than and allows for a whole bunch of slippage. I want to make sure that nothing that we do or nothing that we recommend puts a red-tape barrier between the provider and the veteran, the person who needs the benefit of a device or the technology that we are trying to make available to them.

At the same time, though, I think we have an obligation both to the vet and to the taxpayer to make sure that we are not such a loosey-goosy definition, that we are cutting all kinds of corners and not applying best practices when it comes to making sure we are getting value for the taxpayer. What do you say to that?

Mr. MATKOVSKY. Sir, when we compared our definitions at the Committee's request, we compared our definitions with other entities. And there are some commercial entities that actually use a definition of prosthetics that is comparable to our definition. Kaiser Permanente, for one.

Mr. BARROW. Shouldn't there be folks who would use some that conform to yours? I'm sure there are folks that would use definitions that would be broad enough to conform to yours?

Mr. MATKOVSKY. Correct. But the other thing I wanted to mention as we are committing this warrant transition process, and we are trying to commit that process as carefully as possible, but we are committed to completing it within this fiscal year, there is nothing in the use of a source justification that precludes us from engaging in a price negotiation. A warranted contracting officer is the only person authorized to make a fair and reasonable price determination within the VA. And it is our expectation as we transition, that price negotiation, even when source is under limited or restricted competition, that the price reasonableness determination would still continue; that is, I think, our mechanism that we are trying to use to balance the flexibility granted to source a physician's prescription or veteran's choice with FAR and VAR and procurement reform.

Mr. BARROW. I understand your position. One last question. You heard from representatives of the provider community, you have heard from representatives of DoD, you have heard from representatives of VA-OIG. Is there anything you heard other folks talk about today that you think needs to be amplified or supplemented in order to give us a fuller appreciation of the issues before the Committee? Is there anything that you think needs to be said that has gone unsaid?

Mr. MATKOVSKY. Well, yes. I don't think we heard from the veteran community today, and hearing directly from their concerns. This is not a process, this is not a rule that we invoke to make our life easier. This is a process that is in place to serve our clients. That would be it, sir.

Mr. BARROW. I understand that. I appreciate that. How about any clarification or correction of what you have heard from these other folks?

Mr. MATKOVSKY. I made one clarification point, which is what we are talking about in the warrant transition process, is over 50 percent of the prosthetics spend, and I think that is clarification that we wanted to make sure was understood. So as the warrants transition from the prosthetics community into procurement, that is well over 50, 55 percent of the procurement action in dollars.

The next thing that I would indicate is that part of what our challenge is to ensure that we have available prosthetics timely for veterans. And this notion of "timely" has to be true across the entire system.

Mr. BARROW. Thank you. Mr. Chairman, our time has expired. Thank you, Mr. Matkovsky.

Mr. JOHNSON. I thank the gentleman for yielding.

Mr. Matkovsky, I do have some follow-on questions.

What you are saying here today is the exact opposite of what the Deputy Secretary's letter said in regards to the application of 8123. Why is that?

Mr. MATKOVSKY. Sir, I do not believe it is the exact opposite. I think that with respect to the specific acquisitions that were noted we were asked a specific question about whether or not we had to seek waiver approval prior to sourcing the items that were not on

Federal supply schedule. We cited 8123 as the source justification that would allow us to obviate the need for the waiver.

I do want to emphasize one thing; that what we are doing here today is not something we have just embarked on over the last couple of months. The transition in prosthetics to the procurement community is something that Mr. Doyle and Dr. Beck began in last August and we have been working on. So this is not a new transition for us either.

Mr. JOHNSON. Okay. What policies and processes does the VA have in place for its purchasing officials to determine when—and when not—to use the FAR in purchasing prosthetics?

Mr. MATKOVSKY. Well, we have mentioned a few policies that we have. We have a few policies that actually identify the conditions under which we would apply the 8123 source authority that remains. We also have the VAR which makes explicit reference to 8123 contained within it. We are updating our policies right now to ensure that they are current. We have reason to directives out to the field in the form of memorandum requesting that unless explicitly specified by a physician prescription, that for biologics the VAR hierarchy is to be followed.

Mr. JOHNSON. Okay. Why does the VA not document purchases made under section 8123 in accordance with the FAR?

Mr. MATKOVSKY. I could tell you that on a moving forward basis, all of our procurements that would use 8123 as a source justification will be templated and will contain the basis of justification within them. They will also be within the ECMS system, they will be our procurement contracting officers will actually initiate and conclude those purchase actions within ECMS and would be documented.

Mr. JOHNSON. That would be helpful because for the last 30 years they haven't been documented. The fact that you are going to do it moving forward will certainly be helpful.

Does the VA have record or can it audit purchases made under section 8123?

Mr. MATKOVSKY. On a point forward basis we expect, we don't expect—we expect all of our procurement officials to use ECMS as a contract writing, not as a shell system but as a contract writing system and contain all of their procurement actions and documentation within them. The justification for limited scope competition must be documented and there must be a justification contained in the contract file. That would be an auditable item, and we expect the ability to audit any prosthetics procurement action that contains a less than full and open competition contained within our ECMS system. Sir.

Mr. JOHNSON. Does the VA need section 8123 to acquire prosthetics?

Mr. MATKOVSKY. We believe section 8123 allows us to preserve intact the physician's prescription from their professional opinion and the veteran's choice, and not subject it to a second guess, a request for strengthening the definition or justification. We believe it codifies that for us. It actually, when used appropriately, allows us to actually have a standard basis for the justification for the prescription or veteran choice.

Mr. JOHNSON. How and when did the VA's definition of prosthetics come into use?

Mr. MATKOVSKY. I believe this went over time, but we have in our specific policy documents we have explicit definition of the prosthetics items that are contained in that definition.

Mr. JOHNSON. When was the last time that policy and definition was updated?

Mr. MATKOVSKY. I have to defer to Dr. Beck on this one.

Dr. BECK. Our handbook is from 2001. We have an internal initiative now and are working on updating our regulations.

Mr. JOHNSON. Eleven years. Wow. Does the VA employ VHA directive 2003-037, entitled "Prosthetics Simplified Acquisitions Procedures Training" in its prosthetics acquisition?

Mr. MATKOVSKY. Yes we do, sir.

Mr. JOHNSON. Okay. That directive expired on July 31, 2008.

Mr. MATKOVSKY. That is correct. The directive that has expired, unless explicitly rescinded or replaced by another directive, remains in force until one of those two actions comes about.

Mr. JOHNSON. There we go again. You know, not doing things for 30 years, working off of expired directives, 11 years between reviewing documents. That is part of what has gotten us into this mess now, wouldn't you agree?

Mr. MATKOVSKY. I would say that we do need—

Mr. JOHNSON. You won't run a business that way.

Mr. MATKOVSKY. I would say that we need to strengthen some of our policies now. I would say that the definition—however, 11 years for the definition of a prosthetic, I don't know that that in and of itself, sir, is problematic.

Mr. JOHNSON. Okay. When can this Committee expect to see the full detailed plan on reorganizing your prosthetics purchasing process?

Mr. MATKOVSKY. We are right now—and I will ask Mr. Doyle to elaborate a little bit on this for us—we are in the midst right now, as we testified earlier 2 weeks ago, in the process of transitioning. That process was documented in a plan that was approved by the Senior Procurement Executive within VA, September of last year. We committed to pilot-test that. We did not want to production change this, so we tested in three VISNs, and we are now in the process of completing that transition process. Again, our target date is July 1. We have some additional time built in to ensure that we don't take any unnecessary risks.

Mr. JOHNSON. Let me re-ask my question because it sounds like you are saying that you have already gone into the execution phase of the plan. What I am asking is when can this Committee expect to see the full detailed plan of reorganizing your prosthetics purchasing process?

Mr. MATKOVSKY. We will provide that to the Committee sir.

Mr. JOHNSON. Let me ask it one more time. When?

Mr. MATKOVSKY. I will go back and work on it, as soon as we can, sir. We have been executing—

Mr. JOHNSON. A week? Two weeks?

Mr. MATKOVSKY. I will commit to 2 weeks, sir.

Mr. JOHNSON. Great. Great.

I think those are all my questions. Let me go back to Mr. Barrow for a final round.

Mr. BARROW. I thank you, Mr. Chairman. Mr. Matkovsky, thank you for being here today. I think we have a better understanding of where you are coming from, but I think you also have a better understanding of our concerns as well. And my thanks to you. I would like to thank Dr. Beck, Mr. Doyle, and Mr. Heard also for your service to our country.

I think you get an idea of what we are concerned about. Please work with us. This conversation is not going to end today. We need to make progress on this to make sure you have the flexibility to do what needs to be done when it needs to be done and to make sure we are not going to have any unnecessary waste in this, because it all comes out of the same pocket and ends up affecting the folks we are trying to help ultimately. With that Mr. Chairman I yield back.

Mr. JOHNSON. I thank you for your comments, Mr. Barrow, because, Mr. Matkovsky, I too sense your desire to do the right things, and we are all focused on the same issue here. I know the questioning at times appears potentially confrontational but that is because we have a responsibility here on the O&I Subcommittee to make sure that we are asking the right questions. We don't always get the answers that we want, but I certainly sense the sincerity in what you are trying to do and I appreciate that.

I want to say thanks to the panel, and you are also now excused.

[The panel was excused]

Mr. JOHNSON. The VA's sweeping definition for prosthetics opens the door for confusion. I think we have heard that today. Such an inclusive definition means that small policy changes can have impacts on areas that would not otherwise be impacted under a traditional definition of prosthetic. However, it is also clear that actions by the VA's purchasing agents have greatly reduced the chances for getting the best value in prosthetics acquisition. While some guidance and regulations already existed that would have helped ensure that best value, even those were ignored, time and time again.

As I mentioned earlier, the Committee looks forward to receiving the VA's detailed plan on changes to its acquisition structure for prosthetics before it moves forward. Once again, a partnership between the VA and the Committee can further assure that veterans continue to receive the best care possible.

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

[Whereupon, at 5:45 p.m., the Subcommittee was adjourned.]

APPENDIX

Prepared Statement of Hon. Bill Johnson, Chairman

Good afternoon. I would like to welcome everyone to today's hearing titled: "Purchasing Perspective: VA's Prosthetics Paradox".

Section 8123 of Title 38, "Procurement of Prosthetic Appliances," states the following: The Secretary may procure prosthetic appliances and necessary services required in the fitting, supplying, and training and use of prosthetic appliances by purchase, manufacture, contract, or in such other manner as the Secretary may determine to be proper, without regard to any other provision of law.

Section 8123 originated in 1958, over fifteen years before Federal Acquisition Regulations were codified in law, and has been slightly amended a handful of times since then. In March of this year, I sent a letter to the Secretary regarding the VA's procurement of biologics over the open market instead of from Veteran-owned small businesses already on the Federal Supply Schedule. One specific example I brought to the Secretary's attention involved a company that supplied biologics. In the timely response I received from Deputy Secretary Gould, I was informed that the VA considered biologics to fall under its lengthy and broad definition of prosthetics, and therefore it could acquire biologics through Section 8123, as it clearly had been doing. Those last words- "without regard to any other provision of law"- mean, at least to the VA, that it does not have to follow Federal Acquisition Regulations (FAR), VA Acquisition Regulations (VAAR), or the Competition in Contracting Act. This interpretation was made clear in the Deputy Secretary's letter.

In addition to informing the Oversight and Investigations Subcommittee that the VA considered biologics as prosthetics, other answers throughout the Deputy Secretary's letter prompted several important follow-up questions, which were relayed to the VA on March 28th. One part of the letter, immediately following the interpretation that purchases made under Section 8123 were not subject to acquisition regulations, stated that the VA would work on "guidance to ensure that prosthetics purchasing agents and logisticians conform with VAAR . . . to the maximum extent practicable." I have to wonder why the VA explicitly and publicly ignores acquisition regulations when making these Section 8123 purchases, but now will attempt to comply with them.

Among my follow-up questions was a request for a copy of the VA's guidance in how it would ensure purchasing agents followed the VAAR. Just yesterday, a response to that and the other questions was provided. It is interesting that only now is the VA working to ensure that purchasers using Section 8123 are documented and in line with the FAR and VAAR. After all, the VA has had nearly three decades to work on this. Failing to document purchases under 8123, as acknowledged in the answers I received yesterday, is a reckless use of taxpayer dollars. To us on this Committee, it appears as though the VA operates as it sees fit until attention is called to its operation.

What the Deputy Secretary's letter did not address is the VA's use of a VHA directive, "Prosthetics Simplified Acquisition Procedures Training," that was issued July 16, 2003, and expired July 31, 2008. An updated directive would probably have been useful over the last four years as the VA increased its prosthetics spending by 80 percent. However, we have seen no such update, and have even learned from those in the field that the VA's Central Office has instructed VISNs to continue following it.

That expired directive contains important language stating that Section 8123 was only to be used as a last resort, reinforcing the importance of compliance with Federal Acquisition Regulations. However, this Subcommittee has found substantial evidence of VA purchasing agents using Section 8123 as a first resort. Given the broad language it contains, one can see why this easier approach could be so tempting, and it's certainly not the first time we have seen VA purchasers opting for the easy route.

While there are over 100 definitions for prosthetics throughout the Federal government, the definition used by the VA is a full paragraph in length. As we will hear today, some of the items falling under this broad definition do not sound like a prosthetic to anyone except the VA. The VHA handbook's definition of prosthetic appliance is as follows:

All aids, devices, parts or accessories which patients require to replace, support, or substitute for impaired or missing anatomical parts of the body. The items include artificial limbs, terminal devices, stump socks, braces, hearing aids and batteries, cosmetic facial or body restorations, optical devices, manual or motorized wheelchairs, orthopedic shoes, and similar items.

Perhaps this overly broad definition is a contributing factor to the VA's inability to effectively manage its prosthetics inventories. As one of the members of the first panel will note, the definition is confusing, and I am concerned that confusion is widespread inside the VA as well as outside of it. Recent audits from the VA's Office of Inspector General have substantiated that the Department does not effectively manage its prosthetic supply, nor does it have adequate control over its payments when procuring prosthetics. Given what we already know, and what we will hear today, these findings are not surprising.

A tailored definition of prosthetics is just one way the VA can better track and manage its prosthetics acquisition. For instance, the broad inclusion of durable medical equipment under its "prosthetics" definition could encourage the misuse of the Section 8123 authority. In addition, as the IG noted about the VA's overpayments, excess inventories, and failure to receive the best value: "Strengthening controls over these actions should not compromise the quality of the prosthetic limbs provided to veterans." In short, the VA can be a better steward of taxpayer dollars while still providing veterans timely access to care, including in the area of prosthetics.

Another way the VA can better manage the billions spent in prosthetics every year is to actually enforce the acquisition regulations that apply to Section 8123. In the response I received yesterday, the VA still fails to acknowledge the abuse of Section 8123 and the blatant circumvention of the FAR and the VAAR by VA employees. We know the problem exists; now is the time to fix it. If employees in the past have failed to follow internal guidance, then perhaps a legislative clarification is necessary to ensure best value for taxpayer dollars.

Lastly, before simply reorganizing employee structures and moving chess pieces around on the board, I am requesting here today that the VA present to this Committee, in detail, its plan to improve its acquisition of prosthetics and the specific reasons for the changes before putting the plan in place. This effort at transparency will help both veterans and Congress see that meaningful reform is taking place.

With that, I now recognize the Ranking Member for his opening statement.

Prepared Statement of Michael Oros

Good afternoon Chairman Johnson, Ranking Member Donnelly, and Members of the Subcommittee. Thank you for the opportunity to provide testimony today. The American Orthotic and Prosthetic Association (AOPA) is grateful for your work to ensure that Veterans with limb loss and limb impairment receive state of the art prosthetic and orthotic care. We appreciate the invitation to shed some light on current issues facing the fields of prosthetics and orthotics when it comes to procurement of high quality prosthetic and orthotic care for our Veterans.

My name is Michael Oros, and I am a member of the AOPA Board of Directors. The American Orthotic & Prosthetic Association (AOPA), founded in 1917, is the country's largest national orthotic and prosthetic trade association. Our membership draws from all segments of the field of artificial limbs and customized bracing for the benefit of patients who have experienced limb loss, or limb impairment resulting from a traumatic injury, chronic disease or health condition. AOPA members include patient care facilities, manufacturers and distributors of prostheses (artificial limbs), orthoses (orthopedic braces such as those used by TBI and stroke patients) and related products, and educational and research institutions.

In my day job, I am a licensed prosthetist and President of Scheck and Siress, Inc., a leading provider of O&P services based in Illinois. Like many other community-based providers, Scheck and Siress is committed to serving Veterans, and does so through contracts with the VA. Scheck and Siress is also proud to employ Melissa Stockwell, the first American service woman to lose a limb in Iraq. After sustaining the injury that resulted in her limb loss, Ms. Stockwell went on to become a Paralympic athlete, and had the honor of carrying the American flag at the closing

ceremonies of the Paralympic Games in Beijing. Melissa is now a certified prosthetist, and a member of the staff at Scheck and Siress.

I would like to begin by clarifying that my experience is with, and my comments will pertain to, a fairly small, but vitally important, subset of the goods and services that fall within the scope of "prosthetics" at the VA. If you asked the man on the street what a "prosthesis" is, the response would probably be an artificial leg or arm. If asked about an "orthosis," a few folks with family members who have had Traumatic Brain Injury, stroke, or Multiple Sclerosis might be able to describe a custom-made and fitted device to help damaged limbs function properly. I am certain, however, that nobody would suggest seeing eye dogs, wheelchairs, eyeglasses, hearing aids, or myriad other items that are lumped together by the VA in its "prosthetics" budget.

Why does this matter? I would suggest that the very broad definition of "prosthetics" can lead to confusion and, worse, application of policies that are inappropriate to replacement limbs and orthotics. The result: inappropriate barriers to care for Veterans with limb loss who need timely access to high quality prosthetics in order to go to work, care for their families, and live their everyday lives.

In fact, the Health Subcommittee saw that confusion on display in its hearing in this very room only two weeks ago. Chairwoman Buerkle held a hearing on "Optimizing Care for Veterans with Prosthetics" on May 16th. During the hearing, she clarified multiple times that the topic of the hearing was prosthetics as traditionally understood and defined. During that hearing, the VA's Chief Procurement and Logistics Officer told the Subcommittee that because changes in procurement policies applied only to items that cost $3,000 or more, those changes would not apply to 97% of the prosthetics budget.

I'm sure that statement is accurate for everything included in the billion –dollar-plus line item described by the VA as "prosthetics." However, for the approximately $58 million portion of that line item spent on replacement limbs and orthoses, that statement is confusing and unhelpful. Virtually every part of even a fairly low-tech prosthetic limb costs more than $3,000. So adopting procurement policies with the understanding that the policy does not apply to 97% of prosthetic purchases can lead to decisions that delay specialized and vitally needed care for Veterans with limb loss or limb impairment. The Veterans we see have already sacrificed enough. They are working hard to put their personal, family and professional lives back together. This task should not be made more difficult by the application of overly broad policies that do not take into consideration the very specialized and unique nature of prosthetics and orthotics.

For prosthetics and orthotics are a very specialized medical service. An artificial leg or arm becomes an extension of the Veteran's body. It needs to be checked and potentially adjusted several times a year to maintain maximum comfort and functionality. If the Veteran loses or gains weight, or as the muscle structure changes, parts of the device may have to be re-fitted. A prosthesis that no longer fits properly or has come out of alignment is not merely an inconvenience; it can cause debilitating pain and complete loss of function.

It is vital that Veterans with limb loss identify and have access to a clinician that they trust, who listens to them and works with them to ensure the best possible fit and function of their artificial limb or orthotic brace. Quite literally, their ability to get out of bed in the morning and go about their lives may depend on that relationship and timely access to appropriate assistance from that orthotic or prosthetic caregiver.

Congress and the VA have acknowledged the vital need for Veterans to have access to a prosthetist they trust by establishing various policies to facilitate Veterans' timely access to prosthetic services.

It is the VA's policy that Veterans may receive prosthetic care from the provider of their choice. To facilitate high quality, timely care in the communities in which Veterans live, the VA maintains contracts with more than 600 independent prosthetic and orthotic providers, in addition to serving Veterans at VA Medical Centers.

But Congress authorized the VA to go even a step further in ensuring Veterans' choice and access. If you are a Veteran in need of prosthetic care, no VA bureaucrat is supposed to limit your choice to a list of "approved" providers that have contracts with the VA. Veterans are supposed to be able to choose the clinician that they work with best, who best meets their needs, and the VA has been given legal authority to do what it takes to secure prosthetics and orthotics from that provider even in the absence of a pre-existing VA contract. Congress acknowledged the unique status, role and needs in prosthetics, and took steps to ensure that procurement policies should facilitate, not stand in the way of, Veteran choice.

AOPA agrees that it is necessary and appropriate for the VA to do whatever it takes to ensure that Veterans can receive their prosthetic and orthotic care from

the provider of their choice. AOPA urges this Subcommittee to do everything in its power to ensure that the necessary procurement authorities, policies and oversight remain in place to guarantee the Veteran's right to choose.

It seems like we shouldn't have to urge the Committee to remain vigilant on this point. But we do, because AOPA shares the concerns of Paralyzed Veterans of America, the Wounded Warrior Project, Disabled Veterans of America and other Veterans Service Organizations that that right to Veterans' choice of providers is being eroded.

Anecdotal evidence from Veterans and providers suggest that there are real, and increasing, procurement barriers to non-VA care being erected.

Two weeks ago, Veteran John Register, a Board Member for the National Association for the Advancement of Orthotics and Prosthetics and a sophisticated Veteran consumer of prosthetics, testified about his difficulty obtaining an advanced knee. He was told that he could not receive the knee from the prosthetics practice he sees, seven minutes from his home. Instead, he was told the only way he could obtain the advanced knee was to go to the VA, seventy miles away. While he is satisfied with the care he received at the VA, and with the advanced knee, he now has to take time off work several times a year to travel more than an hour away to have his new knee checked, adjusted and maintained. This is extremely disruptive, particularly when his own qualified prosthetist is just down the road.

I'm aware of another example that arose with one Veteran who had been working with his independent prosthetist for eleven years. He had never before been to the VA for his prosthesis, in part because it is two hours away. Recently, this Veteran went to the VA amputee clinic for his prosthetics prescription. The clinic prescribed an above knee prosthesis, including an advanced knee. As per protocol and the VA contract, the company submitted L codes for approval through the VA to give him his prescribed prosthesis. The Certified Prosthetist-Orthotist (CPO) who works for the VA saw the codes come across his desk and called the Veteran. The Veteran was told that he had to come to that VA in order to get the prosthesis.

The Veteran preferred to continue to receive his care from the outside provider, because they had taken care of him successfully, close to his home, for more than a decade. He told his prosthetist what was going on, and the contractor contacted the person in charge of prosthetics at that VISN. The contractor was told that the Veteran had received incorrect information, that Veterans have the right to choose, and since the independent firm had been providing this Veteran's care for eleven years he could continue. The VA then put pressure on the Veteran, telling him if he wanted the advanced knee he would still need to come two hours away to the VA. After more pushback, the VA's story changed: the VA told the Veteran he could get the advanced knee immediately, from the VA. The alternative: wait months to get it from his regular prosthetist as the approval process would have to start all over again from the beginning. Ultimately, the Veteran switched to the VA, two hours away, as the VA made him feel that it would be easy and quick to get the technology from the VA, and would be difficult and lengthy to obtain the technology from the community-based provider.

I could go on and on with similar stories. The question is: why is the VA establishing procurement and other administrative policies to undermine Veteran choice?

It has been suggested by some that cost may be a factor. AOPA believes that the vast majority of community-based providers working under contract with the VA provide high quality care to Veterans at highly competitive rates—rates, in fact, that represent an average discount of 10% below the published Medicare fee schedule, which establishes the prevailing industry rate (and is followed by insurance companies and other private sector payers). The IG's recent Audit of the Management and Acquisition of Prosthetic Limbs issued on March 9, 2012, claimed that the average cost of a prosthetic limb fabricated by the VA in house is $2,900, while the average cost of a limb fabricated by a third party contractor was $12,000. We have been unable to determine precisely which costs were taken into account by the IG when making these calculations, but certainly, it fails to take into consideration VA staff salaries, the cost of benefits, facilities, administration and other overhead. In addition, it is not unusual for Veterans with extremely complicated devices to choose community-based providers rather than VA staff, which would skew the cost of devices provided in-house downwards.

The IG's analysis does not present an apples to apples comparison, and the footnote in the report suggests that the difference in price is attributable to private sector profit and overhead. We reject this suggestion, and this analysis. We are disappointed that this statement was not challenged by the VA Prosthetics and Sensory Aids staff before the report was published. This so-called cost comparison offers the Subcommittee and the VA leadership no useful information. We believe that,

with few exceptions, a complete and accurate cost comparison would show that community-based O&P contractors provide excellent value to Veterans and taxpayers.

In fact, forcing Veterans to switch prosthetists can actually generate unnecessary additional costs. In the example I cited, the VA duplicated the socket the community-based practice had made for him, even though his socket was not due for replacement and was functioning well. We have heard of many other cases where the VA essentially requires Veterans to switch to VA facilities, and then provides them with a completely new prosthesis to replace a fully functional, warranteed and effective prosthesis that was made by the community-based provider.

The goal of the procurement system for prosthetics and orthotics should be to deliver the highest quality, timely prosthetic and orthotic care possible to all Veterans, regardless of age, geographic location, ability or willingness to become the squeaky wheel and demand appropriate care. What would such a procurement system drive towards? I'm not certain that I've ever seen an official VA definition of "quality" care, so at the risk of being pushy, I'd like to suggest my own for the purposes of our discussion today. For me, as a practicing clinician who has been taking care of Veterans with limb loss for 26 years, four major elements comprise quality prosthetic care:

1) Access. Veterans must be able to receive care on a timely basis, without waiting for weeks or having to travel hundreds of miles for their prostheses to be checked, adjusted, repaired or replaced.

2) Trust. Veterans must know about and be able to exercise their right to receive care from a provider they trust, who listens to them and works with them to achieve the most functional prosthesis possible. Fitting a good prosthesis is as much art as it is science, and a positive, ongoing working relationship between the Veteran and the prosthetist is an important element of getting it right.

3) Expertise and experience. Clinicians serving Veterans must have the training and clinical know-how to select, custom-build, fit and adjust the best possible prosthetic device to address the complex challenges Veterans with limb loss face every day.

4) Outcomes. The result of high quality prosthetic care is greater comfort, higher activity levels, more independence and greater restoration of function for Veterans with limb loss, so that they can live their everyday lives successfully and continue to do the things they want to do despite the absence of one or more limbs.

VA procurement policies are critical to all four elements of quality. Procurement policies should ensure that:

1) Veterans have access to the prosthetics provider of their choice without having to overcome artificial and unnecessary barriers to care.

2) Veterans can receive timely care from their provider, whether that provider is in the VA or an independent practice, without artificially created hoops or delays established to influence their choice of caregiver.

3) Prosthetists serving Veterans do not just have the minimum certifications and qualifications needed, but actually have the training and experience to meet the specialized needs of Veterans. This will become more and more of a challenge for the VA and for independent O&P practices as the requirement for a master's degree as an entry-level qualification is implemented.

4) Contracting (and other) policies should require measurement, and continuous improvement, of Veteran outcomes until Veterans achieve the highest level of restored function possible for that individual Veteran.

I would like to take a few additional minutes to talk in greater detail about this last point, which AOPA believes is critically important. While AOPA is firm in our belief that the vast majority of private sector clinicians are providing care to Veterans that is as good or better than that they could receive at the VA, we also believe that it is important to hold O&P professionals accountable for the quality of care and the cost of that care. This poses something of a challenge for the VA, due to the fact that there is currently no body of objective, comparative outcomes research to support evidence-based practice in O&P. Currently, the only mechanism used by the VA to evaluate the quality of prosthetic and orthotic services offered by any provider—inside or outside the VA—is the patient satisfaction survey. While community-based providers typically score very highly on such surveys, we know that more could and should be done to evaluate O&P outcomes for Veterans.

For example, the "Amputee Mobility Predictor" and the "Timed Up and Go" are two validated instruments to determine a baseline functional level that could be administered in the prosthetic clinic at the time the prescription is generated. Functional level can then be re-documented at routine intervals during the rehab process to record and evaluate progress in terms of functional activity. **Quality** prosthetic outcomes should mean functional mobility improvements. College Park's iPecs and Orthocare Innovations' Compas systems measure forces and provide objective data

regarding proper alignment. Orthocare Innovations' Stepwatch and Galileo system are another example of a simple data collection device and software application to record real-world activity outside the clinic. Having the ability to "see" our patients' real activity once they leave our facility is the best, most objective and most accurate measure of how successful the rehab process was.

This leads me to my final point. Unlike other health professions, there is no body of comparative outcomes research to guide O&P professionals. Their judgments about which prosthetic device, service or support is most appropriate for which patient is based largely on personal experience and expertise developed over years in the field. However, there is almost no objective research on outcomes to validate or inform that experience.

To give simplest of examples, there are more than 20 prosthetic feet on the market. The lowest tech, least expensive cost about $3,000. A little more than a year ago, CMS approved a foot that costs more than $15,000. Now, there is a new foot that will cost about $125,000. But there is no research to suggest and document which Veteran will benefit most from which foot.

Please do not misunderstand me. I do not believe that cost considerations should guide selection of prosthetic components for Veterans. In some cases, the most expensive foot may restore significant additional functionality. But in other cases, Veterans may actually have better outcomes with less expensive or lower-tech components. It would be helpful to have objective research documenting which Veterans have the best outcomes from which prosthetic devices, services and supports.

There are multiple elements of a coherent O&P research agenda, including but not limited to comparative outcomes of prosthetic components, that are vitally important to ensuring that Veterans receive appropriate, necessary care as well as to eliminating unnecessary future health care costs. An outcomes-based research portfolio, and the resulting body of evidence, in the field of O&P would increase the quality of care for Veterans and others with limb loss. It would give the VA an appropriate management tool for overseeing a decentralized system with procurement of prosthetics and orthotics from more than 600 VA and external sites. It would protect taxpayers by ensuring that patients receive the most appropriate care from the beginning, and that quality and cost effectiveness objectives are attained in a data-driven manner that generates the best possible outcomes. AOPA has invested significantly in the area of outcomes research, having developed two study instruments—accessing data from both patients and their O&P providers on outcomes. AOPA has both spearheaded and supported financially pending comparative effectiveness studies involving dynamic/non-dynamic response prosthetic feet, and microprocessor/non-microprocessor controlled prosthetic knees, and we support an annual program with thousands of dollars in grants from the underlying clinical research that are the building blocks of evidence-based practice. AOPA would greatly welcome and value the opportunity to work with the VA in tracking patient outcomes and comparative effectiveness.

AOPA applauds the VA for working toward this end by joining with the Department of Defense in March of 2010 to hold the joint State of the Art Conference on Orthotics and Prosthetics. This conference generated much discussion related to the creation and execution of an outcomes-based research portfolio in the field of O&P. While the discussion was encouraging, we have been disappointed to see that no progress toward the implementation of the recommendations has been made. No report on the conference has ever been made publicly available, and so far as we can tell, no steps have been taken by the VA or DoD to implement any of the conference recommendations.

Despite the government-wide focus on health care outcomes, there is currently no Federal research agenda on prosthetic and orthotic outcomes. Not at the VA. Not at the DoD. Not at the NIH, the CDC, or NIDRR. AOPA strongly encourages the VA, DoD and NIH to help improve the care for Veterans, servicemembers, and seniors by implementing a robust comparative outcomes research agenda that addresses the questions in the field and helps to inform effective, efficient delivery of O&P care for the Veterans, seniors and civilians with limb loss and limb impairment. We believe this will also yield dividends in assuring that the major technological advances precipitated by research commitments from VA and DoD for Veterans and active duty military are actually pulled through to have a practical impact on care provided to our nation's seniors and other members of the general public.

Mister Chairman, Members of the Committee, thank you very much for the invitation to testify, and for your commitment to providing the highest quality prosthetic and orthotic care to our nation's Veterans. I look forward to answering any questions that you might have.

Prepared Statement of Daniel Shaw

Mr. Chairman, Ranking Member Donnelly, members of the Subcommittee, thank you for the opportunity to appear before you today to discuss the Department of Veterans Affairs (VA) prosthetic purchasing practices and their impact on Academy Medical, a VA-verified Veteran-Owned Small Business.

My name is Dan Shaw, I am the managing partner of Academy Medical, L.L.C. (Academy), located in Wellington, FL. Academy is a reliable source of supply for biologics, and holds a mandatory-source Federal Supply Schedule (FSS) Contract issued by VA's National Acquisition Center. My fellow managing partner, Patrick Papa, and I graduated in 1991 from the U.S. Naval Academy, where we first met in 1987. Academy Medical is so named to pay homage to our Alma Mater. Accompanying me here today is Mr. Steven Kent, our Director of Government Sales, and Mr. Stephen Schurr, a subject matter expert in the field of biologics.

My testimony here today is pleasantly overtaken by events. By memorandum dated May 23, 2012, the Veterans Health Administration (VHA) notified VHA procurement and prosthetics personnel engaged in the ordering of biological implants of its policy on ordering biological implants using the FSS Program. We are very pleased with this change in VHA's position, one which will benefit Academy and other FSS contract holders for biologics—it levels the playing field and respects the mandatory source nature of VA's FSS Program. We have worked long and hard to get VHA to adopt this policy. I have a copy of the policy and would like to offer for inclusion in the record of today's hearing.

We hope the Subcommittee will encourage VA to formalize this VHA policy memorandum by having it formally codified to amend the VA Acquisition Regulations. Policy of this magnitude should be formalized for perpetuity, as policies are easily forgotten as time goes on or through leadership changes. This is especially true given there is likely to be short and long-term resistance to this policy, especially by purchase cardholders.

One concern we hope the Subcommittee will clear up with VA's witness here today, is whether the VHA policy applies to all biological implant procurements, to include those acquired as micropurchases by government purchase cardholders. We estimate nearly 95 percent of biological implants are acquired by purchase cardholders who are neither trained or nuanced in the use of FSS contracts. This will have a major impact on the success or failure of VHA's policy from a supplier perspective, and could potentially result in no improvement for FSS contract holders.

With this new policy will come a new issue: Compliance and Enforcement. While we are elated with and applaud VHA's leadership for the new policy, our experiences show VHA currently fails to follow established waiver. Past performance, as in government contracting, is a good indicator of what can be expected in the future. To that end Mr. Chairman, if this policy is to be effective and successful, VHA have to develop and mechanism to monitor and enforce compliance The policy memorandum is silent on this. We know the devil is always in the details, and hopefully this Subcommittee will consider establishing some type of follow-up on this policy or reporting requirements from VHA in terms of the implementation, monitoring, compliance and enforcement with the program to determine if the spirit and intent of the policy is being embraced and executed.

We hope this new VHA policy will make a difference. We estimate VA purchases approximately $175 million in biologics annually. As of May 23, 2012, we sold only $74,000 in biologics to VA through our VA mandatory source Federal Supply Schedule contract in Fiscal Year 2012. We think this will be a good deal for the taxpayers too. We know we can save them money. In addition, if VA makes better use of the schedules program, it will avoid Competition in Contracting Act (CICA) violations, by fragment . In addition, VA will be assured of receiving high-quality Trade Agreement Act-compliant products and also reap the revenue from the FSS Program Industrial Funding Fee, used to fund its Supply Chain Management Operations.

Academy will continue to take every logical step to be successful in the VA market place. We obtained our verification from VA's Center for Veterans Enterprise, as well as a mandatory-source Federal Supply Schedule contract, yet we continue to struggle in the VA market place. What is hurting Academy, and undoubtedly other Veteran-Owned Small Businesses (VOSBs) and Service-Disabled Veteran Small Businesses (SDVOSBs), is VA's use of authority granted it under Section 8123, Title 38, United States Code. Although VHA's new policy for the procurement of biological implants is welcome news to us and other FSS contract holders, Section 8123 still looms large as long as this authority exists and is likely to be applied to open market procurements for biologics not procured through the FSS Program.

This authority, established in September 1958, grants VA sweeping and unprecedented authorities to acquire "prosthetic appliances" without regard to any other provision of Federal law. Simply put, this authority has become the easiest of easy buttons for VA to use to buy prosthetic appliances. VA is purported to spend about $3.5 billion annually for prosthetic appliances.

Perhaps the Section 8123 authority was needed back in 1958, to assist Orthotist & Prosthetist trying to improve the quality of artificial limbs of World War II and Korean War Veterans upset about substandard appliances. But this was some 25 and a half years before the advent of the Federal Acquisition Regulation (FAR), when the old, arcane procurement system provided users with less flexibility. Clearly the authors of Section 8123 never envisioned a new and ensuing procurement regulatory system such as the FAR would provide such significant flexibility for the government to buy everything from A to Z, including biologics, while simultaneously providing much needed best value and transparency in the procurement process. It is also unlikely they realized VA's spend for prosthetic appliances would approach the significant spend it has today, nor is it likely they envisioned how the definition of prosthetic appliances would grow, now to even include biologics. Biologics were not even introduced into traditional health care practice until the 1960s.

Many current and former government procurement professionals we spoke with opine the FAR's flexibilities actually obviate the need for the authority contained in Section 8123. If the Section 8123 authority is to remain, it should be significantly curtailed or controlled to the highest levels of VA's procurement infrastructure without power to re-delegate this authority. Section 8123 must include the much needed transparency, and it must be the authority of last resort.

VA's formal definition of prosthetic appliances does not officially include biologics. We learned on April 27, 2012, from officials in Veterans Integrated Service Network 8, the VA Sunshine Healthcare Network, that biologics are actually included in the definition of prosthetic appliances. It appears when VHA Directive 2003–037, Prosthetics Simplified Acquisition Procedures Training, Dated July 16, 2003, expired July 31, 2008, the Veterans Health Administration prepared a new and ensuing directive which was never formalized or formally issued. The expired directive set forth procurement procedures for prosthetic appliances, and VA's use of Section 8123 was essentially the authority of last resort to buy prosthetic appliances.

The new, un-issued directive expands the definition of prosthetic appliances to include anything implanted into the body for a period in excess of 30 days. This would include biologics. We have attempted to get the un-issued directive through a Freedom of Information Act request, but were denied because the document is considered "pre-decisional" and is therefore exempt from release. Since VA is using the directive and makes decisions on buying its biologics in accordance with this directive, for nearly four years now, it would seem this is no longer "pre-decisional." Since this is clearly no longer "pre-decisional," we hope the Subcommittee will encourage VHA to formalize this document and make it available to the public, as needed. This provides greater transparency and helps VA's industry partners understand the rules of the road at VA.

We recently learned VA determined and subsequently notified this Subcommittee the authorities in Section 8123 trump even the Veterans First Contracting Program authorities contained in Sections 8127 and 8128. The unprecedented and extraordinary contracting authorities granted to VA under its Veterans Contracting Program were effective June 20, 2007. It would seem in passing Public Law 109–461, the Veterans Benefits, Healthcare and Information Technology Act of 2006, Congress would have specifically exempted Section 8123 procurements from Sections 502 and 503 Public Law 109–461. But it did not. In light of VHA's new biological implant procurement policy, this issue needs to be addressed for non-FSS biological procurements which will be conducted on the open market.

In closing Mr. Chairman, although the U.S. Naval Academy provided us with a stellar education and prepared us for some of the most challenging situations we would face as naval officers, nothing in our time at Annapolis could have adequately prepared us as entrepreneurs for the daunting challenge of dealing with an incalcitrant and non-responsive bureaucracy such as VA. The news of VHA's new biological implant procurement policy gives us hope and levels the playing field, and for that we are very grateful. We seek only to be a reliable source of supply of biological implants, to be treated respectfully and given the opportunity we have earned to be VA's industry partner. We have no ax to grind, we simply have a business to run, and work to create an environment that engenders trust, mutual respect and cooperation, as VA provides its services to America's heroes.

Thank you for your distinguished leadership and that of this Subcommittee. , our predicament and those of similarly situated VOSBs and SDVSOBs will improve; that we can match our private sector success in the VA market place. We never

sought an adversarial relationship with VA, we seek only to be trusted business partners with VA, to be given the respect and opportunity we have earned.

Thank you for holding this hearing Mr. Chairman. We will be happy to respond to any questions you or the Subcommittee's members have.

Prepared Statement of Dr. Charles Scoville

Chairman Johnson, Ranking Member Donnelly and distinguished members of the Committee. Thank you for the opportunity to provide a perspective on how the Department of Defense (DoD) cares for individuals with limb loss, and in particular prosthetic care, new technologies, and the collaboration between DoD and the Department of Veterans Affairs (VA).

It is always important to look back before looking forward, to take from lessons learned. The Washington D.C. Times-Herald reported "In a few days the Army will print a formal regulation which will give officers and enlisted men who have lost arms, or legs, or both, in the line of duty, the opportunity to return to Active Duty." This was written on November 11, 1951. Fast forward to 2003 and the Army found itself repeating the effort to return individuals with limb loss back to Active Duty. To date we have had over 305 individuals with limb loss on Active Duty, and over 53 of these have deployed again into combat roles in Iraq and Afghanistan.

On January 20, 2004 the Office of the U.S. Army Surgeon General in response to a request from the U.S. Congress as part of the Fiscal Year 2004 Omnibus Bill submitted an infrastructure improvement plan for the U.S. Army Amputee Patient Care Program (USAAPCP). In this we stated "The goal of the USAAPCP is to return patients to "tactical athleticism," or to their pre-injury level of activity. The philosophy of the program is "Tell me how far you want to go, and we will work with you to achieve your goals."

The DoD Amputee Patient Care Program grew over the past 10 years out of necessity to meet the demands of a population that is significantly different from the typical VA patient. At the beginning of current military conflicts, the DoD treated patients with limb loss that primarily resulted from dysvascular disease, diabetes, and tumors. The DoD lagged the VA and many of the activities the VA was doing in the prevention of limb loss. DoD still has a significantly lower patient population than that of the VA. However, we are faced with a population that is much different from the typical patient seen in the VA. Our patients are young, active Service Members, frequently with severe trauma and multiple limb loss, that desire and deserve to be returned to the highest levels of activity and some deserve to be returned to Active Duty. These Service Members are strong-willed, impressive Warriors who challenge us daily to improve how we care for them. We started from a very decentralized, small program and built an efficient, progressive program. We developed a world leading, world recognized program for amputee patient care to meet our patients' needs.

The DoD and the VA have long shared a strong working relationship in caring for our wounded warriors and make significant advances in the care of patients with limb loss through many focused programs. In April of 1945 the National Research Council Advisory, Committee on Artificial Limbs, a technical body within the National Academy of Science, tasked US Army to develop amputee research at its 7 amputee patient care centers. These were very quickly merged into one center, the Army Prosthetic Research Lab (APRL) at Walter Reed Army Medical Center (WRAMC) early in 1946. Shortly thereafter, on March 1, 1946 the Veterans Administration joined forces with the APRL in financing the research. In 1948, the VA established the Prosthetics Research Department headquartered in the NYC VA Center. In 1956 the VA expanded this by supporting the Prosthetics Research Lab (PRL) at Northwestern University. Working together, the DoD and VA efforts lead to many of the prosthetic advances that were still utilized at the beginning of the current conflicts.

In 2004 Congress provided $2.5 million for Prosthetic Device Technology Enhancement and Clinical Evaluation at WRAMC, and added $10 million in 2005. The Military Amputee Research Program was developed to best manage these funds across the DoD. At this same time Defense Advanced Research Projects Agency (DARPA) programmed $30 million for advancements in upper extremity prosthetics. Much of the research that has been completed has been in partnership with the VA, and would not have been easily completed without the VA's involvement. The advanced arms developed through the DARPA project were first tested within the VA facilities. The newest research to help our patients return to the highest levels of function is a study projected to begin in the Salt Lake City VA, late this year or early

in 2013 on osseo-integration. This is based on earlier research which was partially funded by the DoD at the University of Utah. Successful osseo-integration could potentially provide patients that have difficulty wearing the traditional prosthetic socket the opportunity to wear prosthetic devices.

In 2005 $10 million in military construction was reprogrammed to build the Military Advanced Training Center (MATC) at Walter Reed. At the same time the Intrepid Fallen Heroes Fund offered to build the Center for the Intrepid (CFI) in San Antonio, Texas. Shortly thereafter the U.S. Navy dedicated funds to renovate facilities at the Naval Medical Center San Diego to house the Comprehensive Complex and Combat Casualty Care Center. These three phenomenal centers are dedicated to providing world class care to our Wounded Warriors.

Several factors explain why the DoD led efforts to provide prosthetic care for Wounded Warriors. One of the keys is DoD's interdisciplinary program, pulling together a range of providers who work with the patients on a daily basis to address patient needs. While the standard of care requires that a Wounded Warrior be seen within seven days, the standard at Walter Reed National Military Medical Center (WRNMMC) is 72 hours. Another factor has been the integration of logistics and contracting within the prosthetics service at WRNMMC. WRNMMC contracting provided blanket purchasing agreements to simplify the acquisition of all supplies and components required for treatment of the Wounded Warrior. Logistics embedded a warranted contracting officer into the Orthotic & Prosthetic Service at WRNMMC enabling same day ordering with next day delivery of prescribed components. The development of the blanket purchasing agreements insured best value through discounted pricing and fixed component costs. A logistics technician embedded within the Service provides the ability to warehouse non-patient-specific items for fabrication and custom fitting, further reducing delays in the delivery of care.

A third factor is the success of DoD research efforts and partnership with industry that has led to the commercial availability of the Genium/X2/X3 microprocessor knees, the BiOM robotic ankle, and the Power Knee 2. Blanket purchase agreements for these items will not be developed until the technology matures and the price stabilizes. These items are purchased through sole source indefinite duration, indefinite quantity contract vehicles with the only suppliers for these unique medical devices. These contracts minimize delay in the provision of the required components.

Department of the Army civilian prosthetic providers provide the most cost effective delivery of prosthetic patient care. Contract providers enable the DoD to rapidly expand or contract the requirements based on the size of mission at any moment in time. These contracts are small business set-aside, competitively bid contracts with a single provider award. Best value is guaranteed within these contracts through pricing proposals provided by the vendor in the bid phase of the procurement. The civilian model has a wide degree of variability in costs because of the use of "not otherwise classified" codes within the health care common procedure coding system. The DoD requires offerors to list what "not otherwise classified" procedures and components they propose to bill and the amount of reimbursement they that are seeking. DoD contract officer representative (COR) may reject any bid with a 'not otherwise specified code" determined to be excessive.

A large percentage of our patients receive a significant portion of their care through the Veterans Health Administration at VA. This is crucial to the success of both DoD and VA patient care, as the DoD does not have the capacity to provide lifelong prosthetic care to all Wounded Warriors. In the early years of current conflicts, patients reported frustration with long delays in the VA process. Things have improved since the VA expanded its Amputation System of Care, organizing and structuring interdisciplinary care teams, increasing VA/DoD collaboration including advanced technology training initiatives, clinical practice guidelines, the establishment of the DoD–VA Extremity Trauma and Amputation Center of Excellence (EACE), and the development of Regional Amputee Centers (RACs). These initiatives have demonstrated that there is a much closer relationship and greater parity with the DoD advanced rehabilitation centers. We are actively engaged with the transition of our Wounded Warrior amputee patients to VA care and recognize, as reflected in a recent VA Inspector General report, that the care provided by the VA is comprehensive and lifelong.

We continue to work closely with the VA, we have their providers working in our clinics at both the CFI and at the MATC, to create a great relationship where we share knowledge and assist patients as they transition to long term care with the VA system. Through our long history of DoD and VA collaborative research and patient care efforts we are continuing to meet the needs of our Wounded Warriors and Veterans.

Prepared Statement of Linda Halliday

Chairman Johnson, Ranking Member Donnelly, and Members of the Subcommittee, thank you for the opportunity to discuss the results of two recent Office of Inspector General (OIG) reports dealing with prosthetic contracting and supply issues.[1] Based on the Committee's interest in how VA obtains prosthetic limbs and oversees its prosthetic supplies, we conducted audits of how VA acquires prosthetic limbs and manages its prosthetics inventory. I am accompanied by Mr. Nick Dahl, Director of the OIG's Bedford Office of Audits and Evaluations and Mr. Kent Wrathall, Director of the OIG's Atlanta Office of Audits and Evaluations.

Before we discuss the results of our audits, let me make one thing clear: the OIG believes veterans should be able to receive the limbs that their clinicians determine are the best for them whether the source is VA or commercial vendors. Our audits focused on the effectiveness of VA's acquisition and contract administration practices. We did not examine nor do we offer an opinion on whether VA labs are a preferred source of prosthetic limbs rather than contract vendors based on cost comparisons or other factors.

BACKGROUND

The Veterans Health Administration (VHA) defines prosthetics as all aids, devices, parts or accessories which patients require to replace, support, or substitute for impaired or missing anatomical parts of the body. The items include artificial limbs, terminal devices, stump socks, braces, hearing aids and batteries, cosmetic facial or body restorations, optical devices, manual or motorized wheelchairs, orthopedic shoes, and similar items.[2] VA maintains an inventory for most prosthetics items. However, for some prosthetic items, such as artificial limbs, VA Medical Centers (VAMCs) do not maintain inventories and instead order these items, as needed, for individual patients. From fiscal year (FY) 2007 through FY 2011, VHA's prosthetic costs increased from $1.0 billion to $1.8 billion.

VA uses two automated inventory systems to manage prosthetic inventories. VHA's Prosthetic and Sensory Aids Service (PSAS) uses the Prosthetic Inventory Package (PIP) to manage the majority of prosthetic inventories. Supply Processing and Distribution (SPD) Service uses the Generic Inventory Package (GIP) to manage prosthetic supplies stored in Surgery Service.

Three VA organizations have responsibilities related to prosthetic inventory management. PSAS develops policies and procedures for providing prosthetics to veterans. VHA's Procurement and Logistics Office (P&LO) provides VAMCs logistics support and monitors compliance with inventory management policies and procedures. VA's Office of Acquisition, Logistics, and Construction supports VAMCs in acquiring and managing supplies and offers training to VA's acquisition professionals. All three organizations need to work together to provide the leadership and coordinated support needed to manage VA's prosthetic supplies.

AUDIT OF THE MANAGEMENT AND ACQUISITION OF PROSTHETIC LIMBS

In this report, we evaluated VHA's management and acquisition practices used to procure prosthetic limbs, and examined the costs paid for prosthetic limbs. Overpayments for prosthetic limbs were a systemic issue at all 21 Veterans Integrated Service Networks (VISNs). Overall, we identified opportunities for VHA to: (1) improve controls to avoid overpaying for prosthetic limbs, (2) improve contract negotiations to obtain the best value for prosthetic limbs purchased from contract vendors, and (3) identify and assess the adequacy of in-house prosthetic limb fabrication capabilities to be better positioned to make decisions on the effectiveness of its labs.

Improved Internal Controls Needed

We reported VHA's PSAS needed to strengthen payment controls for prosthetic limbs to minimize the risk of overpayments. We identified overpayments in 23 percent of all the transactions paid in FY 2010. VHA overpaid vendors about $2.2 million of the $49.3 million spent on prosthetic limbs in FY 2010. VHA could continue to overpay for prosthetic limbs by about $8.6 million over the next 4 years if it does not take action to strengthen controls. On average, VHA overpaid about $2,350 for each of these prosthetic payments. Overpayments generally occurred because VHA paid vendor invoices that included charges in excess of prices agreed to in the ven-

[1] *Veterans Health Administration—Audit of the Management and Acquisition of Prosthetic Limbs,* March 8, 2012, and *Veterans Health Administration—Audit of Prosthetics Supply Inventory Management,* March 30, 2012.

[2] VHA Handbook 1173.1, *Eligibility,* November 2, 2000.

dors' contracts with VA. Strengthening controls to ensure invoices submitted by vendors are consistent with contract terms should and can be accomplished without compromising the quality of the prosthetic limbs provided to veterans.

At the four VISNs we visited (VISN 1, 8, 12, and 15[3]), we found that Contracting Officer's Technical Representatives (COTRs) either did not conduct reviews of prosthetic limb invoices or conducted only limited reviews of invoices. Instead, Prosthetic Purchasing Agents were reviewing vendor quotes, creating purchase orders, and reviewing invoices prior to making final payments. This is contrary to the Government Accountability Office's *Standards for Internal Controls in Federal Government* that requires key duties and responsibilities be divided to reduce the risk of error or fraud. VHA should ensure responsibility for determining compliance with contract terms and for processing payments is kept separate to better ensure proper segregation of duties. Further, while Prosthetic Purchasing Agents at the four VISNs reported conducting reviews to ensure invoice prices matched Medicare pricing and appropriate vendor discounts, results of our audit revealed these reviews were not effective in preventing overpayments.

Due to the frequency of overpayments, immediate attention is needed to prevent future overpayments and to recover current overpayments. By strengthening internal controls over payments for prosthetic limbs and properly separating duties, PSAS staff have the opportunity to improve their acquisition practices and provide better stewardship of funds.

Actions Needed To Ensure the Best Value When Procuring Prosthetic Limbs

We found that VISN Contracting Officers were not always negotiating to obtain better discount rates with vendors and some items were purchased without specific pricing guidance from either the P&LO or PSAS. Without negotiating for the best discount rates obtainable, VHA cannot be assured it receives the best value for the funds it spends to procure prosthetic limbs. We noted that while strengthening acquisition practices to ensure contracting officers consistently negotiate better discount rates should result in lower costs, it should in no way compromise the quality of prosthetic limbs procured.

We also reported VA paid almost $800,000 for about 400 prosthetic limb items using "not otherwise classified" (NOC) codes in FY 2010. NOC codes are used by VA to classify items that have not yet been classified or priced by Medicare. While this may not be a significant amount in aggregate, the prices paid for individual items that have not yet been classified can be significant. For example, absent pricing guidance VA was paying about $13,700 for a type of Helix joint before it was classified. Once the item was classified, the price dropped to about $4,300. To avoid situations like this, we reported VHA needed to develop guidance to help VISN staff determine reasonable prices for items that Medicare has yet to classify and price.

Improved Prosthetic Limb Fabrication and Acquisition Practices Needed

We did not identify information that showed either how many limbs specific VHA labs could fabricate or how many limbs they should be fabricating. PSAS management did not know the current production capabilities of their labs and could not ensure labs were operating efficiently. VHA guidance states that PSAS should periodically conduct an evaluation to ensure prosthetic labs are operating as effectively and economically as possible. We found that PSAS suspended their review of labs in January 2011 after reviewing only 9 of 21 VISNs. Because reviews of all VISNs were not conducted, PSAS was unaware of its in-house fabrication capabilities and management does not know if labs are operating as effectively and efficiently as possible.

We also reported VISN prosthetic officials did not always identify the appropriate number of contractors needed to provide prosthetic limbs to veterans. VHA guidance recommends three to five vendors receive contract awards depending on the geographic area and workload volume. However, three of four VISN Prosthetic Managers interviewed were under the assumption they were to award contracts to all vendors who responded to their solicitation, provided those vendors met VA's criteria to qualify as a contract vendor. The VHA guidance conflicted with prosthetic limb contract guidance that states maximum flexibility be given to individual medical centers to determine the number of contracts required to meet their needs.

Due to the inconsistencies in the guidance, differing procurement practices existed among the four VISNs visited. Three of the four VISNs did not identify an appropriate number of contract vendors and VISN Contracting Officers made awards to nearly all vendors that submitted proposals, many of which were located in the

[3] VISN 1—New England Healthcare System; VISN 8—VA Sunshine Healthcare Network; VISN 12—VA Great Lakes Health Care System; and VISN 15—VA Heartland Network.

same general areas. As a result, overlaps and gaps in service existed and VISN contracting staff may have been performing unnecessary contract work. Additionally, VHA could not be assured the decision to make contract awards was effectively aligned with workload volume or with what individual medical centers required to meet their needs in serving patients.

We reported VHA lacked the information to know whether its prosthetic limb fabrication and acquisition practices are working as effectively and economically as possible. By evaluating fabrication and acquisition practices, PSAS will be in a better position to know the current capabilities of its labs and to make decisions regarding the number of contracts needed to provide services to veterans in each VISN.

Use of VA's Electronic Contract Management System (eCMS) Needs To Improve

Use of eCMS is mandatory for all procurement actions valued at $25,000 or more. We found that VHA's contracting officers did not consistently use eCMS to document contract awards to prosthetic limb vendors, which was consistent with the findings from our recent audit of VISN contracts.[4] Nearly all of the eCMS contract files for awards made to vendors at the four VISNs visited were missing key acquisition documentation.

Missing documentation included evidence of required contract oversight reviews and determinations of responsibility of the prospective contractors through a check of the Excluded Parties List System. Further, contract invoices were not included in eCMS. As a result, we could not readily verify whether a COTR had reviewed vendor invoices prior to certification to ensure they accurately reflected that goods received were in accordance with contract requirements, including prices charged. The lack of documentation in eCMS adversely affects management's ability to readily assess the quality, timeliness, and administration of contracts.

Recommendations

We made eight recommendations to the Under Secretary of Health. They include strengthening controls over the process for reviewing vendor quotes, purchase orders, and verification of invoices and costs charged by prosthetic limb vendors. In conjunction with this, we recommended VHA take collection action to recover the $2.2 million overpaid to vendors. We also made recommendations to ensure contracting officers conduct price negotiations to obtain the best value for prosthetic limb items and for PSAS to assess the capabilities of VHA's prosthetic labs.

The Under Secretary for Health agreed with our recommendations and presented an action plan. VHA reported that, as part of the reorganization of P&LO, contracting officers or delegated ordering officers will place prosthetic orders above the micro-purchase threshold of $3,000. VHA indicated this change will properly separate acquisition duties for reviewing vendor quotes, purchase orders, and invoices received from prosthetic limb vendors. VHA told us that their Service Area Organization offices will review every prosthetic limb contract to ensure price negotiations have occurred. These controls are critical for VA to receive the best value for prosthetic limbs. It is too early to measure the effectiveness of these changes, however we will follow-up as appropriate.

AUDIT OF VHA'S PROSTHETICS INVENTORY MANAGEMENT

This report provides a comprehensive perspective of the suitability of VHA's prosthetic supply management policies. In assessing VAMC prosthetic inventory management, VHA agreed that inventories maintained above the 30-day level would be considered excessive unless there was evidence VAMCs needed a higher inventory level to meet replenishment and safety requirements. VHA also agreed prosthetic inventory levels of 7 days or less would create a risk of supply shortages.

We found VHA needs to strengthen VAMC management of prosthetic supply inventories to avoid disruption to patients, to avoid spending funds on excess supplies, and to minimize risks related to supply shortages. Further, because of weak inventory management practices, losses associated with diversion could go undetected. VHA needs to improve the completeness of its inventory information and standardize annual physical inventory requirements.

Inventory Systems Are Not Integrated

VAMC Inventory Managers need real-time information from VA's Integrated Funds Distribution, Control Point Activity, Accounting, and Procurement System

[4] *Veterans Health Administration—Audit of Veterans Integrated Service Network Contracts,* December 1, 2011. This audit examined whether VHA's new contract oversight structure and review processes were effective in improving VISN procurement practices. Despite the new contract oversight structure, we still identified recurring systemic deficiencies associated with acquisition planning, contract award, and contract administration.

(IFCAP) and its Computerized Patient Record System (CPRS) to keep PIP quantities accurate and manage prosthetic inventories effectively. However, VHA's PIP does not integrate with IFCAP and CPRS. As a result, when warehouse staff record received supplies in IFCAP and when clinical staff record used supplies in CPRS, PIP is not automatically updated. Consequently, staff must manually record all supplies received and used in PIP. This work is labor-intensive and reduces the time staff have to actively manage supply inventories, and introduces errors into these systems.

Inefficiencies from Using Two Inventory Systems

VHA policies require VAMCs to use PIP to manage prosthetic supplies and GIP to manage surgical device implants (SDIs). VAMCs use of two inventory systems caused staff confusion about the responsibility for managing SDI inventories and created inefficiencies in managing SDIs stored in Surgery Service closets, crash carts, and operating rooms. As a result, VAMCs did not use either PIP or GIP to manage about 7,000 (28 percent) of 25,000 SDIs. The estimated inventory value for these items was almost $8 million. By replacing PIP and GIP with one automated modern inventory system, VHA can help VAMCs manage these inventories and avoid excess prosthetic inventories and shortages.

Inadequate Staff Training

Inadequate training was a major cause of VAMCs accumulating excess inventory and experiencing supply shortages. VHA's *Inventory Management Handbook* requires staff receive training from qualified instructors on basic inventory management principles, practices, and techniques on how to use PIP and GIP effectively. However, staff at the six VAMCs we visited had not received training from qualified instructors.[5] Because staff did not receive adequate training, they did not consistently apply basic inventory management practices and techniques.

VHA requires VAMCs to complete annual wall-to-wall inventories of quantities on hand with inventory accuracy rates of at least 90 percent. However, none of the six VAMCs we audited had the required documentation of completed physical inventories. VAMCs' failure to consistently complete and document physical inventories was also a contributing cause of reporting inaccurate quantities on hand. When VAMCs do not keep quantities on hand current, the automated inventory systems cannot accurately track item demand, which VAMCs must know in order to establish reasonable stock levels.

Insufficient Oversight

Insufficient VHA Central Office and VISN oversight contributed to VAMCs maintaining excess inventory and supply shortages. VHA's *Inventory Management Handbook* states that GIP will be the source of reported inventory data and lists seven performance metrics VAMCs must report every month. However, because the Handbook does not specifically require VAMCs to extract performance metric data from PIP, VAMCs did not report the required performance metrics for prosthetic inventories.

In addition, VHA's Handbook does not sufficiently define the role of VISN prosthetic representatives' (VPRs) inventory oversight responsibilities. The VPRs, who had jurisdiction over the audited VAMCs, stated they conducted VAMC site visits. However, the frequency of the site visits varied from quarterly to annually and during the site visits VPRs did not consistently perform a complete assessment of prosthetic supply inventory management.

VHA Handbook Inadequacies

Although VHA's *Inventory Management Handbook* provided a reasonable foundation for VAMC management of prosthetic supplies, the Handbook needed more guidance to ensure VAMCs do not accumulate excess supplies or experience supply shortages. We identified several Handbook inadequacies VHA must improve to help ensure VAMCs maintain reasonable inventory levels. For example, the Handbook did not have clear guidance on establishing normal, reorder, and emergency stock levels or timeliness standards for recording supplies received and used in PIP and GIP. A comprehensive and clear Handbook is an essential VHA control to ensure proper stewardship and accountability of VAMC prosthetic inventories.

Recommendations

Our second report made 10 recommendations to the Under Secretary of Health. They include requiring VISN and VAMC Directors to eliminate excess prosthetic in-

[5] VA Medical Centers in Decatur, Georgia; Indianapolis, Indiana; Northampton, Massachusetts; Nashville and Murfreesboro, Tennessee; Salem, Virginia; and Clarksburg, West Virginia.

ventories and avoid prosthetic shortages, developing a plan to implement a modern inventory system, and strengthening management of prosthetic supply inventories. In addition, we recommended VHA officials collaborate with the Executive Director, Office of Acquisition, Logistics, and Construction, to develop a training and certification program for prosthetic supply inventory managers. The Under Secretary for Health agreed with our recommendations and presented an action plan. We will follow-up as appropriate.

CONCLUSION

VA needs to improve contract administration and inventory management practices. Improvements in contract administration and inventory management will help ensure more funds are available for prosthetic care in VA. We expect VA to follow through on its commitment to replace the current inventory systems.

By strengthening internal controls, VA will reduce the financial risks associated with unused prosthetic supply inventories and waste. Until VHA strengthens the management and acquisition practices used to procure prosthetic limbs, VA will not have sufficient assurance that its practices are as effective and economical as possible.

Chairman Johnson, thank you for the opportunity to discuss our work. We would be pleased to answer any questions that you or other members of the Subcommittee may have.

Prepared Statement of Philip Matkovsky

Chairman Johnson, Ranking Member Donnelly, and Members of the Subcommittee: thank you for the opportunity to speak about the Department of Veterans Affairs' (VA) ability to deliver quality care and acquire prosthetics and other devices for Veterans in need of these items. I am accompanied today by Dr. Lucille Beck, Chief Consultant, Rehabilitation Services, Director, Audiology and Speech Pathology, and Acting Chief Consultant, Prosthetics and Sensory Aids Service, Veterans Health Administration; Norbert Doyle, Chief Procurement Logistics Officer, Veterans Health Administration, and Ford Heard, Associate Deputy Assistant Secretary, Office of Acquisition and Logistics.

VA continually strives to improve our programs and we appreciate independent reviews that can validate our successes and offer recommendations for improvement. On March 8, 2012, VA's Office of Inspector General (OIG) published a report on the Management and Acquisition of Prosthetic Limbs. In this Report, OIG found that overpayment for prosthetic limbs was a systemic issue in each Veterans Integrated Service Network (VISN), and that internal controls needed to be strengthened to better control the process. VHA concurred with OIG's recommendations in this report. OIG found that VA spent approximately $54 million on artificial limbs in fiscal year (FY) 2010, including total contracts to vendors valued at close to $49 million. VA acknowledges it could have saved approximately 4 percent, or $2.2 million, by strengthening its internal control processes for prosthetics procurement and has adopted such practices to achieve greater savings.

Later that same month (March 30, 2012), OIG published a second report, an Audit of Prosthetics Supply Inventory Management. In this Report, OIG concluded that VA needs to strengthen management of prosthetic supply inventories at its medical centers and make better use of excess inventories. VHA concurred with OIG's recommendations in this report, and has developed action plans to improve oversight and management processes to better ensure VHA delivers the quality care Veterans deserve while exercising responsible stewardship of prosthetics supplies.

My testimony today will begin by briefly describing initiatives we have taken to improve the quality of care for Veterans in need of prosthetics or devices, as well as how we define this term. It will then cover how VA acquires prosthetics, how VA maintains oversight of its prosthetics acquisitions, and how VA ensures the best value for Veterans and taxpayers when acquiring prosthetics.

Quality of Amputation and Prosthetic Care

VHA's Prosthetic and Sensory Aids Service is the largest and most comprehensive provider of prosthetic devices and sensory aids in the world, offering a full range of equipment and services. All enrolled Veterans may receive any prosthetic item prescribed by a VA clinician, without regard to service-connection, when it is determined to promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practice. "Prosthetic" is a broad term used in VA to describe devices and equipment in the Veteran, on the Veteran, or for the Veteran intended to replace or support missing body parts or function. VA's

definition is similar to that used by other Federal agencies and private health care systems.

Once we have identified eligible Veterans in need of prosthetics and other devices, we can begin providing the specialty care they require. VA has initiatives falling under five general areas to improve the quality and availability of amputation care. These include staffing and community partnerships, accreditation of VA laboratories, improved training for VA staff, greater research into amputation clinical issues, and collaborations with the Department of Defense (DoD). I will briefly discuss each of these in turn.

First, VHA's Prosthetic and Sensory Aids Service has a robust clinical staff of orthotists and prosthetists at more than 75 locations, and also partners with the private sector to provide custom fabrication and fitting of state-of-the-art orthotic and prosthetic devices. VA maintains local contracts with more than 600 accredited Orthotic and Prosthetic (O&P) providers to help deliver care closer to home. Commercial partners help fabricate and fit prosthetic limbs for Veterans across the country. Since its creation in 2009, VA's Amputation System of Care (ASoC) has expanded to deliver more accessible, high quality amputation care and rehabilitation to Veterans across the country. The ASoC utilizes an integrated system of VA physicians, therapists, and prosthetists working together to provide the best devices and state-of-the-art care.

Second, VA promotes the highest standards of professional expertise for its workforce of more than 300 certified prosthetists, orthotists, and fitters. Each VA lab that is eligible for accreditation is accredited either by the American Board for Certification in Orthotics, Prosthetics, and Pedorthics, Inc. (ABC), the Board of Certification/Accreditation International (BOC), or both. This accreditation process ensures quality care and services are provided by trained and educated practitioners.

Third, to support the continued delivery of high quality care, VA has developed a robust staff training program. We offer clinical education, technical education, and business process and policy education, in addition to specialty product training, to help our staff provide better services to Veterans. Further, VA has one of the largest orthotics and prosthetics residency programs in the Nation, with 18 paid residency positions at 11 locations across the country.

Fourth, VA's Office of Research and Development is investing heavily in prosthetics and amputation health care research. It is issuing Requests for Applications for studies to investigate a variety of upper limb amputation technologies and applications. VA also works with DoD to support joint research initiatives to determine the efficacy and incorporation of new technological advances.

Finally, the partnership between VA and DoD extends further to provide a combined, collaborative approach to amputation care by developing a shared Amputation Rehabilitation Clinical Practice Guideline for care following lower limb amputation. VA is supporting DoD by collaborating on the establishment of the Extremity Trauma and Amputation Center of Excellence. The mission of this center encompasses clinical care, including outreach and clinical informatics, education, and research, and is designed to be the lead organization for policy, direction, and oversight in each of these areas. The center is currently being established and will obtain initial operating capacity by the end of this fiscal year.

In summary, VA supports high quality amputation and prosthetics care by promoting ground-breaking research into new technologies, training a highly qualified cadre of staff, and pursuing accreditation of all eligible prosthetic laboratories in VA's Amputation System of Care.

Acquisition of Prosthetics, Oversight of Acquisitions, and Ensuring Best Value

The goal of VHA's Prosthetics and Sensory Aids Service is to provide devices, technologies, and equipment that assist Veterans in achieving maximal levels of independent function and a high quality of life. Technologies and equipment must be highly individualized to meet each Veteran's unique rehabilitative needs. Clinicians determine the prosthetic needs of Veterans as a part of their clinical care, and VA procures the devices necessary to achieve personal clinical outcomes. While our focus is on providing state-of-the-art clinical care, procurement, acquisition, and management policies reflect a complementary and essential piece of this system as well. VA is reforming its procurement practices to obtain better prices and more competition in obtaining the devices and supplies Veterans need where appropriate. We are doing this while maintaining the range of products available to Veterans and the services we offer. While price is an important consideration, our primary focus is on ensuring the product meets the Veteran's needs.

Turning to how we acquire prosthetics, these devices are procured according to the Federal Acquisition Regulations (FAR) and VA Acquisition Regulations (VAAR). Due to the unique needs of Veterans in this area, VA uses its statutory authority

under title 38, United States Code (U.S.C.), section 8123, as a sole source justification when required to ensure a Veteran receives medically needed items. 38 U.S.C. 8123 grants VA authority to procure prosthetics and services in any manner "the Secretary may determine to be proper without regard to any other provision of law." When exercising this authority the Department may "procure prosthetic appliances and necessary services required in the fitting, supplying, and training and use of prosthetic appliances by purchase, manufacture, contract, or in such other manner as the Secretary may determine to be proper." This flexibility was granted to ensure that Veterans receive devices and supplies that are suitable for them and that meet their clinical needs. Many of the products VA purchases are either going to become a part of a Veteran or will be a critical part of their daily lives, helping them walk, work, and interact with their families. The §8123 authority permits VA to limit competition when physicians require specific devices or equipment for patient care. Also, FAR and VAAR authorize limiting competition under these circumstances. If the Secretary elects to use §8123 in this manner, all applicable FAR and VAAR requirements must still be followed.

When products are generally available and interchangeable, competitive procurements may be more appropriate. VA must comply with all applicable FAR and VAAR requirements in such procurements. VA has aggressively pursued national contracts over the past 10 years for these types of items. VHA specifies contract requirements, such as nationally recognized quality and safety standards (e.g., Rehabilitation Engineering Society of North America's standards for wheelchairs and ISO good manufacturing systems for hearing aids), to support a high quality standard of care for rehabilitation products. As a result, Veterans receive high quality devices that are effective and safe. VA also pursues local and regional contracts for items and services, such as home oxygen, artificial limbs, and durable medical equipment (DME). The provision of prosthetic goods and services is complex, as a balance must be maintained between what is clinically indicated while ensuring we realize the best value.

VA also continues to improve how it oversees these acquisitions. For example, VHA is working to place appropriate limits on the use of the title 38 authority so that it secures fair and reasonable prices for products while still delivering state-of-the-art care, and so we can improve opportunities for Veteran-owned and small businesses. VHA is pursuing three strategies to achieve greater cost savings while preserving high quality, patient-centered health care and appropriate clinical determinations. First, we are transitioning who procures this equipment to bring us more in line with the FAR, which requires that only fully trained contracting officers be able to obligate the government for purchases above the micro-purchase threshold of $3,000. This will also allow us to improve our business processes through better contracting practices and increased attention to post-award contract administration, including reconciliation of invoices. Specifically, we are transferring purchasing authority from prosthetics purchasing agents to contracting specialists for any purchase above $3,000 (the micro-purchase threshold). VHA has notified the field that warranted contracting officers will be required to contract for these items. For items less than $3,000, micro-purchase requirements continue to apply. We conducted a pilot program to evaluate the impact of this change from January until March in Veterans Integrated Service Networks (VISN) 6, 11, and 20, and beginning this month, we are transitioning to national implementation. This transition to warranted contracting officers will improve our business practices while ensuring clinical decision-making and treatment plans remain with the Veteran and provider.

VHA is pursuing a phased approach to standardize and define commodities for its products where appropriate. When we can purchase products, devices, or supplies that are generally available and interchangeable, we will comply with the FAR to ensure we are obtaining the best price possible. In the long term, VHA will develop a catalog of such items to facilitate better, more cost effective purchasing decisions. Again, we must balance this goal with quality clinical and patient care.

VHA is updating policies and directives to better guide clinical and procurement staff on the proper use of §8123. These updates will allow us to more accurately and timely provide services to the benefit of Veterans.

VHA is also increasing its audits of purchases to identify best practices and conduct better oversight to ensure we are realizing the best value. As we gather more data on how these changes are working, we can continue to refine and enhance our programs. We are using new templates, checklists, and justifications to streamline and simplify our processes and improve communication between staff and leadership so we have a comprehensive view of our procurement activities. VHA will ensure proper controls are in place to review vendor quotes, purchase orders, and verify invoices and costs by developing a comprehensive database of all existing contracts. We will correct non-compliant contracts as required and evaluate contractor per-

formance as required by the FAR, and institute collection activities when warranted for VA overpayments. To improve the guidance provided to certified prosthetists, we are developing contract templates, clearer guidance, and notices that will be disseminated later this summer to our VISN and facility contracting offices. VHA's Service Area Organizations, which provide support, oversight, and guidance to our facilities, will review the award of every new prosthetic limb base contract to ensure price negotiations took place, and will review a random sample of delivery orders between May and September 2012, to ensure the base contracts include the correct prices. We will determine if base prices can be established following a system-wide review of non-Medicare classified limb items by the end of the fiscal year. In some circumstances, VHA may be better suited to fabricate items in-house. To better identify when we should pursue this approach, we will be contracting for an external review to assess how expanded use of in-house functions would impact patient satisfaction, support Veterans' needs and capabilities, and staffing.

Once VHA has procured devices and supplies, management of our inventories and resources is also essential. In the recently published OIG report auditing VHA's prosthetics and supply inventory management practices, OIG concluded VHA had made overpayments because of inefficiencies in our system and inadequate training and guidance. We appreciate OIG's efforts and recommendations, and in response, we are better defining our policies and guidance to the field, improving our information technology (IT) systems to better track supplies, strengthening our training programs, and increasing oversight and audit functions. We are directing our facilities to reconcile physical inventories and take action to eliminate excess inventories without creating supply shortages. We are revising our standards for facilities to require at least one prosthetic supply inventory manager to become a certified VA Supply Chain Manager. We have developed a patch that is 95 percent complete that will enhance the ability of the prosthetics package to interface with inventory management software, facilitating better information sharing. Through these steps, we will better utilize existing and available resources as we deliver prosthetic and amputation services and products to Veterans.

Conclusion

VA supports high quality amputation and prosthetics care by supporting groundbreaking research into new technologies, training a highly qualified cadre of staff, and pursuing accreditation of all eligible prosthetic laboratories in VA's Amputation System of Care. We are improving our oversight and management of prosthetic purchasing and inventory management to better utilize the resources we have been appropriated by Congress as we serve America's Veterans. High quality patient care is our top priority, but we understand we must pursue this objective in balance with other aims. These aims include: supporting Veteran-owned and service-disabled Veteran-owned small businesses, ensuring responsible fiscal stewardship of the funding provided to VA by Congress, and complying with all applicable laws and regulations in this regard. We appreciate the opportunity to appear before you today to discuss this important program. My colleagues and I are prepared to answer your questions.

Prepared Statement of Orthotic and Prosthetic Alliance

Chairman Johnson, Ranking Member Donnelly, and Members of the Subcommittee:

The five members of the Orthotic and Prosthetic Alliance (O&P Alliance) thank you for this opportunity to submit for the written record testimony on the ability of the Department of Veterans Affairs (VA) to deliver state of the art care to veterans with amputations. The O&P Alliance represents the major organizations representing the clinical, scientific, provider, supplier, business, accreditation, and quality improvement aspects of the O&P field.

One of our Alliance members, AOPA, testified in person at this hearing and another, NAAOP, submitted detailed written testimony on the issues that were the subject of this important hearing. The O&P Alliance submits this brief statement for the record to highlight some of the dialogue that occurred during the hearing itself on 38 U.S.C. Section 8123 as well as the three OIG reports recently issued by the Department of Veterans Affairs, including:

- *Audit of the Management and Acquisition of Prosthetic Limbs,*" Report No. 11–02254–102, March 8, 2012;
- *Healthcare Inspection: Prosthetic Limb Care in VA Facilities,*" Report No. 11–02138–116, March 8, 2012; and,

- *Audit of Prosthetics Supply Inventory Management,* Report No. 11–00312–127, March 30, 2012.

Special Rules of Prosthetic Limb Purchases: Entitled "Procurement of Prosthetic Appliances," 38 U.S.C. § 8123 was enacted in 1958 and was specifically designed to apply to prosthetic limbs provided by the VA to veteran amputees. This section of the law was enacted in response to protests by World War II veterans who marched on Washington D.C. in 1945 waving artificial limbs and protesting the quality of the prostheses provided through the Veterans' Administration relative to those received by civilians. The provision allowed the VA to contract directly with private prosthetists without respect to any other provision of VA acquisition law, thereby cutting through bureaucratic delay. The purpose was to provide the veteran amputee with the high quality, timely prosthetic limb care they needed, when they needed it. The need for the VA to continue meeting this standard continues today and is as important as ever, considering the new wave of injured and amputee veterans created by a decade of war.

Highlights of the VA Hearing Testimony: The O&P Alliance highlights for the Subcommittee the following points to help guide it through its consideration of VA prosthetic procurement:

1. If this Subcommittee contemplates legislative changes to Section 8123, we strongly urge you to preserve the original intent of this provision which, in the end, was designed to empower the VA to cut through bureaucracy and deliver high quality, timely and convenient prosthetic limb care to veteran amputees. This goal remains all the more important today. We are grateful that both witnesses in the first panel of the hearing made this same point to the Subcommittee.

2. A number of the VA witnesses testified during the hearing that the Section 8123 authority to procure prosthetics for veterans is used to ensure full compliance with the physician's prescription as well as veterans' choice. The O&P Alliance believes these are key principles that justify the invocation of this broad authority when the VA purchases prosthetics for injured and amputee veterans.

3. Custom orthotics (orthopedic braces for the back, neck, legs, and arms) is a field closely aligned with prosthetics and has been treated under Section 8123 in the same way as prosthetics. It is critical that Section 8123 applies to injured and amputee veterans who require custom orthotic care in the same way it applies to amputees who require prosthetic limb care.

4. The O&P Alliance questions several conclusions in the VA OIG Report entitled, "Veterans Health Administration: Audit of the Management and Acquisition of Prosthetic Limbs" (11–02254–102). The most egregious conclusion in this report is OIG's calculation of what it spends on prosthetic limb care. The OIG asserts that VA spent $12,000 on average for a prosthesis provided by a contract supplier while the average cost of a prosthesis fabricated in the VHA's prosthetic labs was approximately $2,900. This is a highly suspect calculation of VA's true costs of providing prosthetic care to veteran amputees and sends the erroneous signal that the VA is vastly overpaying for contract prosthetic care. This is simply not the case. It is not clear which costs the OIG factored into its analysis because the report offers no detail on its calculations, but it is highly likely that OIG failed to include the critical costs of labor (salaries for certified prosthetists and technicians), overhead (the costs of maintaining clinical facilities, laboratory machinery, information processing, etc.), and myriad other costs that go into the fabrication and fitting of prosthetic limbs. We note that in the testimony delivered before this Subcommittee at this hearing, the VA OIG essentially conceded the calculations in the report as to the cost of prosthetic limb care were not based on complete information or cost data.

5. The O&P Alliance applauds the dialogue that occurred at the hearing that focused on the importance of certification of prosthetists/orthotists and accreditation of O&P facilities and programs, both internal to the VA and as a requirement in all contracts between the VA and private practitioners. The VA recognizes the two primary accrediting organizations for the O&P field, ABC and BOC (both signatories to this written testimony), and the standards those accreditors require. Professional certification and facility accreditation are important mechanisms to help ensure quality in the provision of orthotic and prosthetic care.

6. The O&P Alliance is also gratified by the dialogue that occurred during the hearing on the issue of veterans' awareness of the processes that determine their access to appropriate prosthetic care. For instance, the hearing exposed that most veterans have little or no idea that the VA is statutorily permitted to contract directly with private prosthetists without respect to compliance with the Federal Acquisition Regulations or the Veterans Affairs Acquisition Regulations (see, 38 U.S.C. Section 8123). This problem could be easily addressed by passage of H.R. 805, the Injured and Amputee Veterans Bill of Rights. This legislation calls for the posting of a list of rights and procedures at every O&P VA clinic across the country and

on the VA Web site so that veterans can understand their rights and the proper procedures, and advocate for the care they need on their own behalf. H.R. 805 is pending before this Subcommittee and the O&P Alliance urges action on this legislation as expeditiously as possible.

7. Finally, we are grateful to you, Mr. Chairman, for insisting that the VA issue within two weeks from the date of the hearing a written plan for its implementation of new procedures for the procurement of prosthetic limbs. There have been numerous changes under discussion by the VA in this regard but very little issued in writing. We hope this document is made public so that all stakeholders, including veterans themselves, can understand the changes taking place in an area that means so much to their ability to function and live fulfilling lives.

Conclusion: The O&P Alliance thanks you, Mr. Chairman, and this Subcommittee for its leadership in examining this critical set of issues. We hope to continue working with this Subcommittee and the VA to help ensure that veterans with amputations and other injuries receive the highest quality prosthetic and orthotic care possible. We call on this Subcommittee to seriously consider passage of H.R. 805, the Injured and Amputee Veterans Bill of Rights, in subsequent legislative hearings as soon as possible, and to ultimately enact this legislation this year. We also look forward to learning more about the VA's specific plans to implement prosthetic procurement changes in a manner that does not impact the quality of care received by veterans who require prosthetic and orthotic care.

We thank you for the opportunity to submit testimony to this Subcommittee for the written record.

Prepared Statement of National Association For Advancement of Orthotics & Prosthetics

Chairman Johnson, Ranking Member Donnelly, and Members of the Subcommittee:

Thank you for this opportunity to submit for the written record testimony on the ability of the Department of Veterans Affairs (VA) to deliver state of the art care to veterans with amputations. The National Association for the Advancement of Orthotics and Prosthetics (NAAOP) is a non-profit trade association dedicated to educating the public and promoting public policy that is in the interests of orthotic and prosthetic ("O&P") patients and the providers who serve them.

The issues to be addressed in this hearing are critical to the ability of veterans with amputations and other injuries and conditions to live active, fulfilling lives, to live as independently as possible, to participate in community and recreational activities, to raise families, and ultimately to work and participate fully in society.

Office of Inspector General Reports on Prosthetics: We have reviewed the three reports recently issued by the Office of Inspector General and have some general observations to offer. Two reports were issued on March 8th and are entitled, "Veterans Health Administration: Audit of the Management and Acquisition of Prosthetic Limbs," Report No. 11–02254–102, and "Healthcare Inspection: Prosthetic Limb Care in VA Facilities," Report No. 11–02138–116. The third report was issued by the OIG on March 30, 2012 (Report No. 11–00312–127) and is entitled, "Audit of Prosthetics Supply Inventory Management." This report addresses the broader VA prosthetics benefit and goes well beyond limb prosthetics. Before we offer our general observations on these reports, it is important to examine one of this Subcommittee's priorities in this hearing, a close review of 38 U.S.C. Section 8123.

Background on 38 U.S.C. § 8123: 38 U.S.C. § 8123, entitled "Procurement of Prosthetic Appliances," dates back to 1958 when Congress passed the Veterans' Benefits Act to consolidate the laws applicable to the Veterans' Administration passed previously. Section 8123 has only been minimally updated since then to incorporate a few, minor language changes, but the meaning of the provision has not been altered since its original enactment.

The purpose and scope of Section 8123 was confirmed in Comments from the Veterans' Administration in connection with H.R. Report No. 1298 of the 85th Congress, the 1958 Veterans' Benefits Act and in the Senate Report No. 2259 pertaining to the same Act. Many veterans benefits laws were passed in the legislative environment following World War II, and many of those concerning prosthetics for veterans specifically trace their origins to 1945. In that year, World War II veterans marched on Washington D.C. waving artificial limbs and protesting the quality of the prosthetics provided through the Veterans' Administration relative to those received by civilians. The quality of these limbs was viewed by veteran amputees as substandard as the administration had been purchasing these limbs from the lowest

bidder. In response to public outrage, and the need to provide for the increasingly large number of veterans covered by the VA, Congress passed a law creating the Prosthetic Appliance Service in 1945, later expanded in 1948 to the Prosthetics and Sensory Aids Service, and began to invest in research into more advanced limbs.[1] A Committee of veteran amputees was also established in 1945 by then Surgeon General, Major General Paul R. Hawley, to advise the VA on the quality of any new limb types it was considering for its programs.[2]

Laws governing the provision of prosthetic appliances under VA benefits have—from the beginning—included coverage of artificial limbs and still do today. In comparison to the VA's definition of "prosthetics," other Federal health care programs, including Medicare, specifically cover "artificial legs, arms and eyes" in the definition of the term "prosthetics and orthotics." However, durable medical equipment and other prosthetic devices (such as colostomy bags) are covered by separate provisions under Medicare law (See, 42 U.S.C. Section 1861(s)). No matter how the VA has expanded its definition of prosthetic appliances over time, it cannot be denied that artificial limbs were intended to be covered under 38 U.S.C. § 8123, and that the provision of quality prosthetic limb care was—and continues to be—of great importance to Congress and the VA.

If this Subcommittee contemplates legislative changes to Section 8123, we strongly urge you to preserve the original intent of this provision which, in the end, was designed to empower the VA to cut through bureaucracy and get the veteran amputee the quality prosthetic limb care they need, when they need it. This goal remains all the more important with the new wave of veterans with amputations and other injuries and disabilities.

General Observations on the OIG Reports: NAAOP offers the following comments on the three OIG Reports issued in March of this year for the Subcommittee's consideration.

- The term "Prosthetics" is used by the VA to describe a wide variety of devices that have nothing to do with limb prosthetics or artificial limbs. In fact, the data establish that of the $1.8 billion spent by the VA on "prosthetics" in FY 2010, only $54 million (or 3 percent) was spent on prosthetic limbs. This is a relatively small portion of dollars spent by the VA on the broader category of prosthetics.
- The VA's nomenclature (i.e., defining "prosthetics" more broadly than virtually any other health care program or payer, has implications on the VA's use of the authority granted to it in 38 U.S.C. Section 8123, which permits the VA to purchase "prosthetic appliances" without respect to any other provision of law. This provision was enacted in 1958 in direct response to veterans who were not satisfied with the VA's capacity to provide quality prosthetic care in-house. This provision allowed veterans to obtain prosthetic limb services from private prosthetists under contract with the VA without the requirement that VA follow the Federal acquisition regulations in the process. This authority has allowed the VA to provide timely and high quality, convenient prosthetic limb care to veteran amputees for decades since passage of that law. Custom orthotics (orthopedic braces for the back, neck, legs, and arms) is a field closely aligned with prosthetics and has been treated under Section 8123 in much the same way as prosthetics.
- The VA has made a major investment in its internal limb prosthetics capacity since 2009 with the development of the Amputee Systems of Care (ASoC) program, a series of prosthetic centers with differing levels of prosthetic expertise and capacity. The VA has emphasized accreditation of these programs and certification of the professionals in these programs as a measure on quality. The new investments in amputee care are designed to integrate care for veterans and treat the whole patient, not just the prosthetic needs of the amputee. Maintaining internal VA capacity and expertise to treat amputees in an integrated manner is important and the VA should be commended for its commitment and focus on this important population. But this new internal VA capacity does change in any way the legal authority the VA has to contract with qualified, private practitioners who may be located more conveniently to veteran amputees' home and communities.
- We note that despite some internal payment controls that need improvement, the Healthcare Inspection Report (11–02138–116) concludes that the vast majority of veteran amputees have high satisfaction rates with their prosthetic

[1] James McAleer, *Mobility Redux: Post World War II Prosthetics and Functional Aids for Veterans,* 48 J. Rehabilitation Res. & Dev. 2011 WLNR 3664126 (2011)

[2] Charles Hurd, *Veterans to Pass on Artificial Limbs; Committee on Amputees Will Advise Administration on Merits of New Types, N.Y. Times,* Nov. 3 1945

care which are primarily provided by private practitioners under contract with the VA.

- NAAOP questions several conclusions in the VA OIG Report entitled, "Veterans Health Administration: Audit of the Management and Acquisition of Prosthetic Limbs" (11–02254–102).
- NAAOP takes strong issue with the OIG's calculation of the difference in what it asserts it costs the VA to provide a prosthesis, on average, to a veteran through its in-house capability at the Veterans Health Administration (VHA) versus what it costs the VA to purchase an average prosthesis under contract from a private prosthetist. The OIG asserts that VA spent $12,000 on average for a prosthesis while the average cost of a prosthetic limb fabricated in the VHA's prosthetic labs was approximately $2,900. This is a highly suspect calculation of VA's true costs of providing prosthetic care to veteran amputees and sends the erroneous signal that the VA is vastly overpaying for contract prosthetic care. This is simply not the case. It is not clear which costs the OIG factored into its analysis because the report offers no detail on its calculations, but it is highly likely that OIG failed to include the critical costs of labor (salaries for certified prosthetists and technicians), overhead (the costs of maintaining clinical facilities, laboratory machinery, information processing, etc.), and myriad other costs that go into the fabrication and fitting of prosthetic limbs. In fact, if the OIG were to factor into the calculation the recent investments the VA has made on its Amputee Systems of Care initiative, the cost of providing prostheses to veterans through its internal capacity would be significantly higher than calculated. We note that in the testimony delivered before this Subcommittee at this hearing, the VA OIG essentially conceded the calculations in the report as to the cost of prosthetic limb care were not based on complete information or cost data.
- As this Subcommittee examines the implications of Section 8123 on the VA's ability to purchase prosthetics in the most cost-effective manner, it is important to recognize the legitimate role that private prosthetists have played for decades in providing prosthetic care to veterans under contract with the VA. Allowing veterans to access private prosthetists in their own communities preserves quality by allowing choice of provider. The relationship between a prosthetist and a patient can mean all the difference in successful prosthetic rehabilitation. Proximity to care is also very important for veterans. It is important that the VA maintains access to local private prosthetists under contract with the VA to conveniently serve veterans—within the overall plan of care designed by the VA clinical team. Finally, choice of prosthetic technology is critical in order to allow veterans to access the most effective prosthetic alternatives that address their medical and functional needs.
- NAAOP agrees with and strongly supports the recommendation in the Healthcare Inspection Report (11–02138–116) that VA's Under Secretary for Health consider veterans' concerns with the VA approval processes for fee-basis and VA contract care for prosthetic services to meet the needs of veterans with amputations. This is a key area that addresses the satisfaction of prosthetic care among amputee veterans. In fact, there is legislation pending before this Committee that seeks to address this very issue, H.R. 805, the Injured and Amputee Veterans Bill of Rights.

Support for H.R. 805, the Injured and Amputee Veterans Bill of Rights: H.R. 805, the Injured and Amputee Veterans Bill of Rights, has been introduced in the past three Congresses by Ranking Member Bob Filner. In fact, this bill—its predecessor, H.R. 5730—passed the House in December 2010 but the Senate did not have time to act before the 111th Congress adjourned. This legislation proposes the establishment and posting of a "Bill of Rights" for recipients of VA health care who require O&P services. This Bill of Rights will help ensure that all veterans across our country have consistent access to the highest quality of care, timely service, and the most effective and technologically advanced treatments available, all in concert with the enhanced internal capacity of the VA in the prosthetic field. NAAOP believes that adoption of this "Bill of Rights" will establish a consistent set of standards that will form the basis of expectations of all veterans who have incurred an amputation or injury requiring orthotic or prosthetic care.

The bill proposes a straightforward mechanism for "enforcement" of this "Bill of Rights," with an explicit requirement that every O&P clinic and rehabilitation department in every VA facility throughout the country be required to prominently display the list of rights. In addition, the VA's Web sites would also post this Bill of Rights for the interest of injured and amputee veterans. In this manner, veterans across the country would be able to read and understand what they can expect from the VA health care system in terms of their orthotic and prosthetic care. And if a

veteran is not having their orthotic or prosthetic needs met, they will be able to avail themselves of their rights and become their own best advocate. But above all, no veteran will be in the position of resigning him or herself to the fact that they are not functioning well with their O&P care for lack of information about their rights.

This bill would simply condense to writing the O&P rules and procedures that the VA has used for years. An analysis of Congressional testimony delivered in 2008 by the Chief of the VA Prosthetic and Sensory Aids Service before the House Small Business Committee confirms that none of the rights listed in H.R. 805 (and its predecessor, H.R. 5730) would expand the rights the VA has granted veterans for years, including in the area of practitioner choice and choice of prosthetic technology.[3] But the bill would, in fact, put these rights in writing and post them for veterans to see, understand, and employ to help ensure they receive the quality O&P care they need and deserve. This bill would also provide Congress with easy access to the level of compliance with this "Bill of Rights" across the country and could identify particular regions of the country where problems persist.

We understand the Congressional Budget Office gave the bill a nominal "score" in terms of what this would cost the VA. This is because none of the rights in the bill expand the rules and procedures the VA has acknowledged it uses for veterans in need of O&P care. Thirty-five veterans' organizations, rehabilitation associations, and consumer and disability groups support passage of H.R. 805. While passage of H.R. 805 will not solve every problem raised with the current VA prosthetics program, we believe it will have a material effect on the ability of the VA to deliver consistent, state of the art care to all veterans with amputations.

In fact, testimony from this Subcommittee's hearing clearly indicated that rank and file veterans simply do not know that VA law permits them to access prosthetists outside of VA clinics and facilities. H.R. 805 would go a long way toward addressing this lack of knowledge among veterans who require prosthetic and orthotic services and devices.

NAAOP and a number of national O&P associations recently met with senior VA officials in charge of the Prosthetic and Sensory Aids Service. While the VA does not appear to support passage of the legislation, we have agreed to continue discussions to see if there are ways to address issues raised by H.R. 805. But passage of legislation would establish, in law, a baseline of expectations for injured and amputee veterans that would not subject the contents of the "Bill of Rights" to the discretion of future VA administrations.

Conclusion: NAAOP thanks you, Mr. Chairman, and this Subcommittee for examining this critical set of issues. NAAOP hopes to continue working with this Subcommittee and the VA to help ensure that veterans with amputations and other injuries receive the highest quality prosthetic and orthotic benefit possible. We call on this Subcommittee to seriously consider passage of H.R. 805, the Injured and Amputee Veterans Bill of Rights, in subsequent legislative hearings as soon as possible, and to ultimately enact this legislation this year.

We thank you for the opportunity to submit testimony to this Subcommittee for the written record.

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MATERIAL SUBMITTED

Letter from Hon. Bill Johnson, Chairman, Subcommittee on Oversight and Investigations to Mr. George J. Opfer, Inspector General, U.S. Department of Veterans Affairs

June 26, 2012

Mr. George J. Opfer
Inspector General
U.S. Department of Veterans Affairs
801 I Street, NW
Washington DC 20001

Dear Mr. Opfer:

[3] Congressional Testimony of Frederick Downs, House Small Business Committee, Subcommittee on Contracting and Technology, Hearing on Ensuring Continuity of Care for Veteran Amputees; The Role of Small Prosthetic Practices, Serial No. 110–105 (July 16, 2008).

I request your response to the enclosed questions for the record I am submitting in reference to the Oversight and Investigations Subcommittee hearing entitled "Purchasing Perspective: VA's Prosthetics Paradox" that took place on May 30, 2012. The questions are in respect to the audit of the Department of Veterans Affairs management and acquisition of prosthetic limbs. I would appreciate if you could answer the enclosed hearing questions by the close of business on July 31, 2012.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Ms. Bernadine Dotson at *Bernadine.dotson@mail.house.gov*. If you have any questions, please call Mr. Eric Hannel, Majority Staff Director of the Oversight & Investigations Subcommittee, at 202–225–3527.

Sincerely,

Bill Johnson
Chairman
Subcommittee on Oversight & Investigations

Enclosure

BJ/rm

Questions:

1) What data was analyzed to reach the conclusion that the average cost of a prosthesis made by the Department of Veterans Affairs (VA) was approximately one-quarter the cost of a prosthesis made by a contractor?

2) The VA has recently made significant investments in prosthetics, including upgrading labs and hiring new staff in some areas. How are those costs factored into your analysis?

3) What additional information would you have needed to make an apples-to-apples comparison between VA and contractor costs? Do you believe that the VA has the information needed to make an apples-to-apples comparison?

4) How are relative costs tracked and monitored by the VA? Contractor costs are very simple to account for. What steps are taken to ensure that all VA costs are appropriately accounted for?

5) Were any adjustments made to account for the relative complexity of devices provided by VA and contractor staff?

6) VA contractors who have looked at your figures have suggested that the estimated for the VA-made prostheses represents only the direct cost of components, without VA salaries, benefits, facilities, administration, and other costs. Do you have any information to indicate that this suggestion is inaccurate?

7) Footnote 1 in the report suggests that the difference between VA-made and contractor-made prosthetics is due to overhead and profit. What information does the IG have to indicate that these may be the only differences between the two figures? Do you believe that other costs were omitted from the information you analyzed?

8) If the comparison was not an apples-to-apples comparison, what value does that analysis have? What useful information does it provide to the Congress and to the VA?

9) If the comparison was not apples-to- apples, then why was it included in the report?

10) When the draft report that included the $2,900-$12,000 comparison was submitted to Prosthetic and Sensory Aids Service (PSAS) for comments, did PSAS submit comments on that figure? If so, what were the comments?

Response from Mr. George J. Opfer, Inspector General, U.S. Department of Veterans Affairs to Hon. Bill Johnson, Chairman, Subcommittee on Oversight and Investigations

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

July 31, 2012

The Honorable Bill Johnson
Chairman, Subcommittee on
Oversight and Investigations

Committee on Veterans' Affairs
United States House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Enclosed are the Office of Inspector General's responses to the questions for the record from the May 30, 2012, hearing before the Subcommittee, "Purchasing Perspective: VA's Prosthetics Paradox." We appreciate the opportunity to testify on our work in this area.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

/s/

GEORGE J. OPFER

Enclosure

VA Office of Inspector General Responses to Questions for the Record from the May 30, 2012, Hearing Before the Subcommittee on Oversight and Investigations, Committee on Veterans Affairs, United States House of Representatives on "Purchasing Perspective: VA's Prosthetics Paradox"

Question 1: What data was analyzed to reach the conclusion that the average cost of a prosthesis made by the Department of Veterans Affairs (VA) was approximately one-quarter the costs of a prosthesis made by a contractor?

The VA Office of Inspector General (OIG) report, Audit of VHA Acquisition and Management of Prosthetic Limbs, focused on the effectiveness of VA's acquisition and contract administration practices used to procure prosthetic limbs. Our primary focus was the accuracy of the vendor payments. We did not assess the completeness or accuracy of VHA's reported data on the internal costs to fabricate limbs. We presented VA's reported costs as background information in the introduction to our report.

Question 2: The VA has recently made significant investments in prosthetics, including upgrading labs and hiring staff in some areas. How are those costs factored into your analysis?

The costs we reported for prosthetic limbs fabricated at Veterans Health Administration (VHA) labs were included in an Orthotic Laboratory Workorder report provided to us by the Prosthetic and Sensory Aids Service (PSAS). The report summarized and categorized the total quantity, lab hours, labor costs, material costs, and average unit cost for each prosthetic limb fabricated by these labs. We did not assess the impact of any lab upgrades or staff hiring on VHA's reported costs nor did we assess the completeness and accuracy of this data.

Question 3: What additional information would you have needed to make an apples-to-apples comparison between VA and contractor costs? Do you believe that the VA has the information needed to make an apples-to-apples comparison?

While PSAS provided us with an Orthotic Laboratory Workload report that we used to calculate costs for prosthetic limbs manufactured at VHA labs, we determined that PSAS was unaware of their in-house fabrication capabilities because the Chief Consultant of PSAS had not conducted periodic evaluations of labs, as required by VHA Handbook 1173.2, Furnishing Prosthetic Appliances and Services, to ensure the labs were operating as effectively and economically as possible. Until VA tracks all of the necessary information, including general administrative expenses, related to in-house and contractor prosthetic limb fabrication, the OIG and other interested parties will not be able to fully compare VHA and vendor fabrication costs.

Question 4: How are relative costs tracked and monitored by the VA? Contractor costs are very simple to account for. What steps are taken to ensure that all VA costs are appropriately accounted for?

At that time of the OIG's review, costs for limbs fabricated at VHA labs were tracked in the Orthotic Laboratory Workload system. A senior PSAS official provided us with information from this system for FY 2010. This information summarized and categorized the total quantity, lab hours, labor costs, material costs, and average unit cost for each prosthetic limb fabricated by VHA's labs. The same official also provided our auditors with vendors' costs, which included the total quantity and total cost of all prosthetic limbs fabricated by vendors for veterans. After calculating the costs for VHA in-house and vendor fabrication, we contacted this official regarding the significant difference between the two costs. The difference behind the two costs was attributed to vendor costs for materials and profit. Accounting for

VHA's internal costs to fabricate limbs or VHA's process for capturing costs was not within the scope of our audit.

Question 5: Were any adjustments made to account for the relative complexity of devices provided by VA and contractor staff?

We did not make any adjustments to account for the relative complexity of devices provided by VA and contractor staff because it was not in the scope of our audit. Any questions about such adjustments should be addressed by VA.

Question 6: VA contractors who have looked at your figures have suggested that the estimates for the VA-made prosthesis represents only the direct cost of components, without VA salaries, benefits, facilities, administration, and other costs. Do you have any information to indicate that this suggestion is inaccurate?

We reported on data that was provided by PSAS. Any discussion about cost comparisons should be addressed by VA.

Question 7: Footnote 1 in the report suggests that the difference between VA-made and contractor-made prosthetics is due to overhead and profit. What information does the IG have to indicate that these may be the only differences between the two figures? Do you believe that other costs were omitted from the information you analyzed?

A senior PSAS official reported the price discrepancy between VHA in-house fabrication and vendor fabrication was due to material costs and profits. Determining whether the costs VHA reported for fabricating limbs were complete was outside the purview of this audit.

Question 8: If the comparison was not an apples-to-apples comparison, what value does that analysis have? What useful information does it provide to the Congress and to the VA?

Based on the Committee's interest in how VA obtains prosthetic limbs, we conducted an audit of how VA acquires prosthetic limbs. As a result, the OIG reported on VA's prosthetic limb workload (that is, limbs fabricated and costs to fabricate) for FY 2010. In describing VA's prosthetic limb workload, we reported on the funds spent on prosthetic items overall, as well as the funds spent specifically on prosthetic limbs. As the VA acquires limbs through in-house labs and contract vendors, we also reported on workload for those two groups. As noted in our report, VHA does not know their in-house capabilities because they did not do the required evaluations of labs.

Question 9: If the comparison is not apples-to-apples, then why was it included in the report?

See response to Question 8.

Question 10: When the draft report that included the $2,900-$12,000 comparison was submitted to Prosthetic and Sensory Aids Service (PSAS) for comments, did PSAS submit comments on that figure? If so, what were the comments?

The Under Secretary for Health concurred with our findings and recommendations and provided an appropriate action plan. His comments, which are included in our report, did not include any remarks on VA's prosthetic limb workload or the costs included in the draft report.

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