Department of Veterans Affairs
Office of Inspector General

Audit of VA Medical Center Procurement of Medical, Prosthetic, and Miscellaneous Operating Supplies

VA could significantly reduce supply costs by using contract sources more effectively and by awarding more national-scope contracts.

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Executive Summary

Introduction

The Office of Inspector General (OIG) performed an audit to determine if VA medical centers (VAMCs) effectively purchased medical, prosthetic, and miscellaneous operating supplies utilizing the best available sources, such as national-scope contracts. In Fiscal Year (FY) 2003, the Veterans Health Administration (VHA) spent $1.56 billion for these categories of supplies.

To determine if VAMCs purchased supplies effectively, we evaluated purchasing practices at 15 representative VAMCs located in 3 Veterans Integrated Service Networks (VISNs). We reviewed about 76,000 purchases of 50 supply products. These purchases were made during the 6-month period October 2001–March 2002 (the last 6-month period for which data was available when we began the audit). Of the $29.2 million that the VAMCs spent on the 50 products, $23.4 million (80.1 percent) was spent on products available from contracts and BPAs, and the remaining $5.8 million (19.9 percent) was spent on products available only from the open market.

In May 2002, the Secretary of Veterans Affairs' Procurement Reform Task Force (PRTF) issued its report, making 65 recommendations to strengthen VA's procurement programs. An important PRTF recommendation was that VAMCs follow a purchasing hierarchy under which VA national committed-use contracts, Federal Supply Schedule (FSS) contracts, and national blanket purchase agreements (BPAs)[1] are the most preferred purchasing sources and the open market is the least preferred source. In November 2002, the hierarchy was incorporated into VA procurement policy, reinforcing the long-standing requirement that VAMCs purchase supplies from the best sources.

The purchases included in our audit were made before the purchasing hierarchy had been incorporated into VA procurement policy. However, VAMCs were still required to minimize open market purchases and effectively use contract and BPA sources. We used the contract tiers in the purchasing hierarchy to describe the results of our analyses. For the purchases reviewed, the best procurement sources in terms of leveraging VA purchasing power and getting the best prices generally reflected the order of precedence prescribed in the hierarchy.

Audit Results

VAMC Purchasing Practices Needed Improvement. As the following audit results show, the 15 VAMCs needed to make more effective use of the best purchasing sources:

- **Large Proportion of Purchases Not from Best Sources.** Of the $23.4 million spent on products available from contracts and BPAs, only $14.2 million (60.7 percent) of these purchases were made from the best contract/BPA sources. The remaining $9.2 million (39.3 percent) was spent on purchases from the open market ($8.0 million; 34.2 percent) and from

[1] BPAs allow VA to purchase FSS products at prices that are further discounted from FSS prices, typically by agreeing to quantity or market share purchase requirements.

higher priced contracts ($1.2 million; 5.1 percent). If hearing aids, the most frequently purchased contract product, were excluded from the analysis, the proportion of best-source purchases decreased significantly from 60.7 to 42.5 percent, and the proportion of open market purchases increased from 34.2 to 50.0 percent.

- **Wide Disparity in Use of Best Purchasing Sources.** VAMC usage of purchasing sources varied significantly, with national committed-use contracts and BPAs being used more effectively than local BPAs, FSS contracts, and local contracts. To illustrate, the 15 VAMCs used national contracts and BPAs for 95.7 percent of purchases that should have been made from these sources, but they used FSS contracts for only 36.7 percent of purchases that should have been made from this source.

- **Local BPAs Not Used Effectively.** The audited VISNs and VAMCs had awarded 24 beneficial local BPAs, offering discounts ranging from 1.0 to 44.9 percent below FSS prices. However, the VAMCs did not effectively use these BPAs. Of the $3.3 million in purchases that should have been made from local BPAs, only $1.3 million (39.4 percent) were made from this source.

- **Better Use of FSS Contracts Needed.** The VAMCs spent $9.0 million for products that should have been purchased from FSS contracts. However, only $3.3 million (36.7 percent) of these purchases were made from this source. Most of the remaining $5.7 million in purchases were from the open market.

- **Some Local Contracts Not Cost Effective.** The VISNs and VAMCs had awarded 19 local contracts. Nine (47.4 percent) of these contracts were beneficial, offering prices ranging from 6.0 to 16.0 percent below open market prices. However, the other 10 contracts (52.6 percent) were not beneficial because they covered products available from other sources (primarily FSS contracts) at equal or lower prices.

- **Lowest Open Market Prices Not Obtained.** The VAMCs made $5.7 million in unavoidable open market purchases, paying various prices for the products purchased. If all these purchases had been made at the lowest available open market prices, the cost would have been $5.0 million (12.3 percent less than actual costs).

Based on the audit results, we estimated that if the 15 VAMCs had made all their purchases from the best sources they would have saved about $2.7 million (9.2 percent of the $29.2 million total cost for the 50 products).

VHA Needs to Fully Implement the Purchasing Hierarchy. To ensure that VAMCs are purchasing supplies from the best sources, VHA needs to develop a strategy to fully implement the use of the purchasing hierarchy. Ineffective purchasing practices occurred primarily because many VAMC purchasers were not aware of the best sources or did not know how to find these sources. Purchasers had not been adequately trained on the use of contracts and BPAs, and VHA had not established adequate controls to monitor and enforce compliance with the requirement to make purchases from the best sources. To address these issues, VHA should require VAMCs to evaluate their purchasing practices and begin the transition to using the best available sources based on the hierarchy. VHA guidance should define the requirements and responsibilities for

using the hierarchy and establish milestones for VISNs and VAMCs to complete key tasks. VAMC purchasers should be specifically trained on the proper use of the various contract and BPA sources. VHA should establish effective controls to monitor and enforce VAMC use of the hierarchy. In addition, to prevent the award of ineffective or unneeded local contracts, VHA should require that proposals for these contracts be reviewed and approved by the VA National Acquisition Center (NAC), as is already required for local BPAs.

VA Needs to Award More National-Scope Contracts and BPAs. VA should work more aggressively to award more national-scope supply contracts that will allow VA to best leverage its buying power and achieve greater contracting efficiencies. During our 6-month review period, all or a significant portion of the product lines for 11 (22.0 percent) of the 50 sample products were not covered by any of the 3 types of national-scope contracts (committed-use, FSS, or BPA) and were only available on the open market. In addition, 34 products (68.0 percent) were not covered by committed-use contracts or BPAs.

Applying a balanced approach that makes the best use of each of the three types of national contracts would best address VA requirements for products that can be standardized and for those that should not be standardized. Since January 2001, VHA has established 88 product user groups to identify products that could be standardized and brought under VA committed-use contracts and BPAs. However, as of August 2003 the work of these groups had resulted in contracts and BPAs for only 25 products. For nonstandardized products, multiple-award FSS contracts allow purchasers a choice of products at prices equal to or better than those of the vendors' most favored customers. These contracts and BPAs have achieved significant savings. VA needs to build on this success and increase efforts to award more committed-use contracts, BPAs, and FSS contracts.

As of October 2003, VHA and Office of Acquisition and Materiel Management (OA&MM) officials could not precisely estimate what proportion of all supply products could be covered by new or improved national-scope contracts. However, they indicated that a 50 percent increase in the number of products covered would be a reasonable starting goal. In our opinion, a reasonable and achievable longer-range goal would be to have 75 percent of supply products covered by national-scope contracts or BPAs.

For each national contract or BPA awarded, the NAC calculates estimated savings rates in comparison to the prices previously paid. Based on these savings rates, we estimated that if 75 percent of the 50 sample products not covered by national-scope contracts had been available from these sources and the 15 VAMCs had used these sources for all of their purchases of the covered products, the 15 VAMCs could have reduced their supply costs by $2.7 million (9.3 percent of the $29.2 million total cost of the 50 products).[2] This cost reduction is in addition to the $2.7 million that the VAMCs could have saved by effectively using the existing best sources.

Improving Procurement Practices Will Significantly Reduce Supply Costs. Implementing the audit recommendations and the related PRTF recommendations will result in significant cost reductions. The audit identified two types of savings that could be achieved–savings from improved purchasing and savings from awarding more national contracts and BPAs. Because it

[2] The 9.3 percent figure is correct when the supply costs are not rounded. See Appendix C, Table 8, page 28.

is not realistic to expect that all VAMC purchases would be made from best sources, we used 80 percent as a reasonable rate of compliance with VHA's goal of purchasing all supplies from the best sources. Applying the 80 percent rate to the $2.7 million purchasing savings and the $2.7 million contracting savings for the 50 products yielded a purchasing savings rate of 8.8 percent and a contracting savings rate of 5.5 percent. Extrapolated to estimated VHA-wide medical care supply expenditures over 5 years (the typical life of national contracts and BPAs), these savings rates equate to cost reductions of about $1.40 billion. (See Appendix C, pages 26–30 for a detailed explanation of how the estimated savings rates and cost reductions were calculated.)

Recommendations

We recommended that the Under Secretary for Health: (a) direct VISNs and VAMCs to fully implement the requirements of the purchasing hierarchy, (b) develop and implement performance monitors to ensure that VAMCs appropriately use each hierarchy source, and (c) issue guidance requiring NAC review and approval of local contracts for supplies.

We also recommended that the Under Secretary for Health and the Assistant Secretary for Management work together to: (a) provide VISN and VAMC purchasing staff training on the principles and requirements of the purchasing hierarchy and (b) increase efforts to award new national-scope contracts and BPAs for supply products.

Under Secretary for Health and Assistant Secretary for Management Comments

The Under Secretary for Health and the Assistant Secretary for Management agreed with the recommendations and provided generally acceptable implementation plans. (See Appendix F, pages 36–42 for the full text of the Under Secretary for Health's comments and Appendix G, pages 43–44 for the full text of the Assistant Secretary for Management's comments.) We will follow up on the planned actions until they are completed.

(original signed by:)
MICHAEL L. STALEY
Assistant Inspector General for Auditing

Results and Recommendations

Improving Procurement Practices Would Reduce Supply Costs

Introduction

VA Supply Purchasing Hierarchy. In June 2001, the Secretary of Veterans Affairs established the PRTF to recommend improvements in VA's procurement programs. The PRTF issued its report in May 2002, making 65 recommendations to leverage VA's buying power, standardize more supply products, and generally strengthen procurement practices. One of the PRTF's most important recommendations was that VA adopt a definitive contract hierarchy that mandates the priority use of national-scope contracts when purchasing supplies. The hierarchy is intended to achieve the substantial price discounts associated with national-level contracts, to minimize open market purchases, and to eliminate redundancies in national and local contracting activities.

From the most to the least preferred source, the hierarchy is organized in three tiers as follows:

Tier One:
a. VA-awarded national committed-use contracts
b. For health care supplies in VA FSS Groups 65 and 66 in the following priority order:
   (1) Nationally awarded BPAs issued against FSS contracts
   (2) Multi-VISN, VISN, or locally awarded BPAs issued against FSS contracts
   (3) FSS purchases

Tier Two:
a. Multi-VISN or VISN contracts for items without national or FSS contracts
b. VAMC contracts not based on FSS contracts

Tier Three: Open market purchases

In November 2002, the hierarchy was incorporated into VA procurement policy. This action formally reinforced VA's long-standing policy that VAMCs should avoid purchasing from open market sources, where prices are usually higher, and instead should purchase from contract and BPA sources that offer better prices.

Audit Approach. To determine if VAMCs purchased supplies from the best sources, we evaluated purchasing practices at 15 representative VAMCs located in 3 VISNs (see Appendix B, page 25). At each VAMC, we reviewed the purchases of 50 commonly used supply products to determine if these purchases were made from the best available sources. The 50 products included various brands, models, and types of 20 medical products (such as scalpels and surgical gloves), 20 prosthetic products (such as hearing aids and wheelchairs), and 10 miscellaneous operating products (such as soap and toner cartridges).

Our review covered 76,395 purchases made by the VAMCs during the 6-month period October 2001–March 2002, the last full 6-month period for which purchase data was available when we began the audit. At the time the purchases were made, the purchasing hierarchy had not been

incorporated into VA procurement policy. However, VAMCs were still required to minimize open market purchases and effectively use contract and BPA sources.

During the review period, the 15 VAMCs spent $29.2 million on purchases of the 50 products, which was 27.8 percent of the $105.2 million that they spent for all medical, prosthetic, and operating supplies during the period. Of the $29.2 million, $23.4 million (80.1 percent) was spent on products available from contracts and BPAs, and the remaining $5.8 million (19.9 percent) was spent on products available only from the open market.

VAMCs Need To Make More Purchases from Best Sources

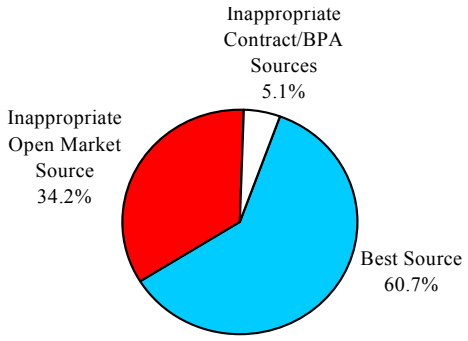
Large Proportion of Purchases Not from Best Sources. The 15 VAMCs reviewed did not effectively use the best contract and BPA sources. As a result, a large proportion of the purchases that could have been made from these sources was instead made from the open market. Of the $23.4 million in purchases of products available from contracts and BPAs, only $14.2 million (60.7 percent) in purchases were made from these sources. Of the remaining $9.2 million (39.3 percent), $8.0 million was spent on open market purchases (34.2 percent of total purchases). The other $1.2 million (5.1 percent) was spent on purchases from higher priced contracts (such as purchases from local contracts when FSS contracts offered better prices).

The proportion of best-source purchases decreased significantly if one product, hearing aids, was excluded from the analysis. Hearing aid purchases totaled $7.4 million, accounting for a disproportionally high 31.6 percent of the $23.4 million spent on products available from contract and BPA sources. In addition, the 15 VAMCs used national contracts for 99.8 percent of hearing aid purchases, a much higher rate of contract usage than for other products.

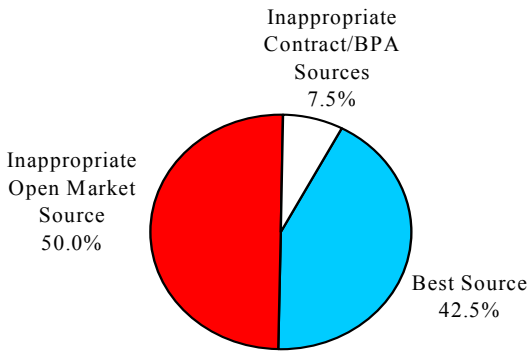
Excluding hearing aids, the 15 VAMCs spent $16.0 million on products available from contract/BPA sources. Only $6.8 million of these purchases were from the best sources, which meant that the proportion of best-source purchases decreased from 60.7 percent with hearing aids included to 42.5 percent with hearing aids excluded. The proportion of inappropriate open market purchases increased from 34.2 percent to 50.0 percent. Figure 1 shows these results:

Figure 1. Distribution of Supply Purchases by Source

With Hearing Aids



Without Hearing Aids

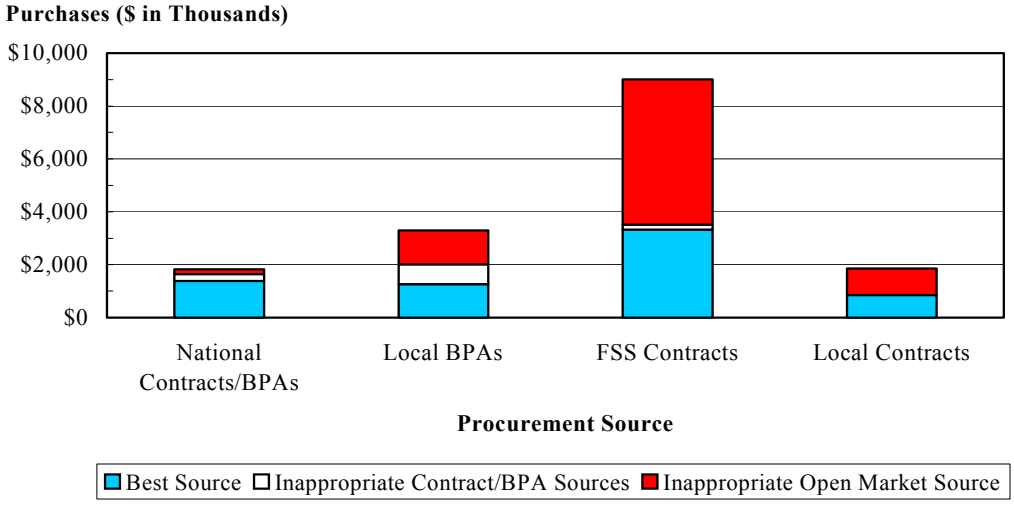


If the VAMCs had made all purchases from the best sources, they could have saved about $2.7 million. However, because it is not realistic to expect that every purchase will be made from the best source, we applied an 80 percent rate of compliance with this goal. When VHA's product user groups recommend a national-scope contract or BPA for a product, they typically estimate that 80 percent of purchases could be made from the contract or BPA. Applying the 80 percent rate to the $2.7 million yields an estimated savings of $2.2 million, or 7.4 percent of the $29.2 million total cost of all supply purchases.[3]

National Contracts and BPAs Used More Effectively than Other Sources. The effectiveness of VAMC usage of the four types of contract/BPA sources varied significantly, with national committed-use contracts and BPAs generally being used more effectively than local BPAs, FSS contracts, and local contracts. To illustrate, the 15 VAMCs should have used national contracts or BPAs for $1.8 million in purchases (excluding hearing aids). They effectively used these sources for $1.4 million (77.8 percent) in purchases and made only $0.4 million (22.2 percent) of these purchases from inappropriate sources. With hearing aids included, the proportion of appropriate purchases from national contracts and BPAs increased from 77.8 to 95.7 percent.

However, of $3.3 million in purchases that should have been made from local BPAs only $1.3 million (39.4 percent) were made from this source, and the remaining $2.0 million (60.6 percent) were made from inappropriate sources. Similarly, of $9.0 million in purchases that should have been made from FSS contracts, only $3.3 million (36.7 percent) were made from this source. The VAMCs made the remaining $5.7 million (63.3 percent) in purchases from inappropriate sources, with $5.5 million (61.1 percent) of these purchases being made from the open market. Figure 2 shows the variances in the usage of contract/BPA sources. The segments of each bar show the amounts of purchases from the best contract/BPA sources versus the amounts of these purchases from inappropriate contract/BPA and open market sources:

Figure 2. Use of Contract/BPA Sources for $16.0 Million in Purchases (excluding Hearing Aids)



The use of the various purchasing sources is discussed in more detail in the following sections.

[3] The 7.4 percent figure is correct when the supply costs are not rounded. See Appendix C, Table 7, page 27.

VA National Committed-Use Contracts and BPAs

Wide Disparity in National Contract and BPA Usage for Different Products. Sixteen of the 50 products were available from 36 different VA-awarded national committed-use contracts or BPAs. (Four of the 16 products were covered by more than 1 contract. These contracts were typically awarded for specific types or models of products.) As Table 1 shows, the usage of contracts and BPAs by the 15 VAMCs varied widely for different products, ranging from 100.0 percent for hearing aids to 39.5 percent for disposable diapers:[4]

Table 1. Percent of Purchases from National Committed-Use Contracts and BPAs

Product	Percent	Product	Percent
Hearing Aids	100.0%	Toilet Tissue	65.7%
Gauze Bandages	99.1%	Nasal Cannulas	65.0%
Blood Glucose Test Strips	91.2%	Body Soap	59.7%
Examination Table Paper	86.2%	TENS Units	59.2%
Slippers	81.0%	Cardiac Catheterization Packs	51.5%
Body Bags	79.8%	Anti-Embolism Stockings	49.0%
Sharps Disposal Containers	75.2%	Manual Wheelchairs	39.7%
Disposable Scalpels	68.6%	Disposable Diapers	39.5%

Hearing Aid Contracts Used Effectively. The VAMCs made the most extensive use of the national contracts for hearing aids.[5] VA's Denver Distribution Center (DDC) had established 17 national contracts offering 383 models of hearing aids. During the 6-month review period, the 15 VAMCs purchased 21,213 hearing aids at a total cost of $7.4 million. All but 32 of these hearing aids were purchased from the national contracts. (These 32 purchases were for specialized hearing aids not available under the contracts.) The extensive use of contracts was facilitated by several factors, including the wide range of products under contract, an efficient electronic system for ordering through the DDC, comprehensive product information, and effective program oversight.

Improvement Needed in Use of National Contracts and BPAs for Some Products. VAMCs needed to better comply with the requirement to purchase from national contracts and BPAs. For the 15 products excluding hearing aids, the VAMCs spent a total of $2.7 million. Of this amount, $1.8 million (66.7 percent) in purchases should have been made from national contracts or BPAs. (The other $0.9 million was spent for product types or models that were not available from these sources.) Of the $1.8 million in purchases that should have been made from national committed-use contracts and BPAs, $1.4 million (77.8 percent) were made from these two sources. The remaining $0.4 million (22.2 percent) in purchases were made from the open

[4] In this report we use the term "product" to refer to broad product lines. Within these lines, there are many specific brands, models, and types of products available from multiple sources. Because of this, some products shown in Table 1 also appear in Tables 2–5, depending on the best source for the specific product type being purchased.

[5] We included hearing aid contracts in the national contract and BPA category. Although these contracts have some characteristics of FSS contracts–multiple award, indefinite order, and indefinite quantity–they are not considered to be FSS contracts because they do not contain certain standard FSS clauses.

market ($0.2 million) and other contract sources ($0.2 million). The following examples illustrate the potential savings if the VAMCs had made more use of national contracts and BPAs.

Liquid Body Soap. The NAC had negotiated two national BPAs for extensive selections of liquid body soap products. The BPA prices were discounted 6.0 to 13.0 percent below vendor FSS prices. Based on an analysis of VA purchasing history, the NAC estimated that using the BPAs would allow VAMCs to save 36.0 to 41.0 percent over prices previously paid. During the 6-month review period, 12 of the 15 VAMCs purchased liquid body soap products with combined costs of $57,872. However, only one VAMC used the BPAs exclusively. Of the 11 other VAMCs, 4 bought only from open market sources, 1 bought from FSS sources, and 6 bought from various combinations of BPA, FSS, and open market sources. If the VAMCs had made all soap purchases from the BPAs, they could have reduced their costs by $9,633, or about 41.0 percent of non-BPA purchases and about 17.0 percent of the total purchases for the 12 VAMCs.

Anti-Embolism Stockings. The NAC had negotiated a national BPA for several types of knee and thigh length anti-embolism stockings. The BPA prices were discounted 14.0 percent below FSS prices. During the review period, 13 of the 15 VAMCs purchased 11,322 pairs of stockings at a total cost of $34,510. Of the 11,322 pairs, 8,108 were available from the BPA. However, 3,128 (38.6 percent) of the 8,108 pairs were purchased from open market or FSS sources instead of the BPA. Of the 12 VAMCs that purchased stockings available from the BPA, 7 purchased only from the BPA, 2 purchased only from open market vendors, 1 purchased from an FSS contract, and 2 purchased from combinations of sources. If the VAMCs had made all purchases from the BPA, they could have saved $3,159, or about 24.7 percent of non-BPA purchase costs and 9.2 percent of total costs.

VAMC staff who purchased from non-BPA sources told us that they were not aware of the BPA or that they usually did not research prices and instead used the last source of purchase.

Local BPAs

Local BPAs Cost-Effective. After national committed-use contracts and BPAs, locally awarded BPAs are the most preferred source for purchases. The 3 VISNs and 15 VAMCs had awarded 24 local BPAs for 13 supply products in our 50-product audit sample. All these BPAs were beneficial, offering discounts ranging from 1.0 percent to 44.9 percent below FSS prices. The VAMCs with access to these BPAs used them for about $1.3 million in purchases. If these purchases had been made at FSS prices, the cost would have been about $1.5 million, so use of the local BPAs saved about $0.2 million (a 13.3 percent savings). (Because these BPAs were locally awarded, all 15 VAMCs did not necessarily have access to them. For example, a VISN had a local BPA for electrosurgical pencils. The VISN's seven VAMCs had access to the BPA, but the eight VAMCs in the other two VISNs did not.) The following examples illustrate the success of local BPAs:

X-Ray Film. Two VISNs had negotiated local BPAs for selected x-ray film products. The two BPAs were with different vendors. One BPA provided for a 14.0 percent discount below FSS prices and required annual purchases of at least $1.0 million to get

the discount. The other BPA provided for a 10.0 percent discount below FSS prices if 80 percent of film purchases were made from the vendor. During the review period, the two VISNs met the discount requirements and reduced film costs by a total of $21,455.

Power Scooters. One VISN had negotiated a local BPA for 10 types of power scooters at prices ranging from 8.0 to 15.0 percent below FSS prices. During the review period, the VISN reduced scooter costs significantly by using the BPA. For example, the VISN paid $324,328 for 202 of the most frequently purchased type of scooter. If the VISN had paid FSS prices, the total cost would have been $359,565. By negotiating the local BPA, the VISN reduced costs for this type of scooter by $35,237, or 9.8 percent. In November 2002, the VISN negotiated another BPA for 20 additional types of scooters at discounts ranging from 10.2 to 16.5 percent below FSS prices.

These local BPAs demonstrated that by consolidating requirements, standardizing products, and agreeing to quantity purchase requirements, VISNs can negotiate significant price reductions. These local BPAs also showed that there is potential for additional national-scope agreements that could achieve additional price reductions and eliminate the redundancies of multiple local contracts with the same vendors or for the same products.

Improvement Needed in Use of Local BPAs. VAMCs did not consistently take advantage of the lower prices offered by local BPAs. The VAMCs with access to these BPAs spent $3.3 million on products available from them. Although all of the $3.3 million in purchases could have been made from the local BPAs, the VAMCs used them for only $1.3 million (39.4 percent) of the purchases. Of the remaining $2.0 million (60.6 percent), $1.3 million was spent on open market purchases, and $0.7 million was spent on purchases from other sources, such as FSS contracts. As Table 2 shows, usage rates for local BPAs ranged from 98.1 percent for x-ray film to 7.6 percent for light fixture ballasts:

Table 2. Percent of Purchases from Local BPAs

Product	No. VAMCs with Access to Local BPA	Percent of Products Purchased from Local BPA
X-Ray Film	8	98.1%
Electrosurgical Pencils	7	86.5%
Toner Cartridges	13	66.5%
Nonabsorbable Sutures	15	59.8%
Body Soap	7	47.6%
Blood Pressure Monitors	5	33.8%
Power Scooters	12	23.8%
Power Wheelchairs	12	20.6%
Surgical Gloves	5	15.5%
Skin Closures	7	15.2%
Disposable Skin Staplers	15	13.3%
Writing Pens	12	11.6%
Light Fixture Ballasts	5	7.6%

The following examples illustrate the ineffective use of local BPAs:

Writing Pens. A VISN had established a mandatory BPA for 167 types of high-use office supplies, including 7 types of writing pens. A VISN product standardization

committee had determined that the seven types of pens met the VISN's needs. The BPA prices for pens were discounted 16.0 to 39.0 percent below FSS prices. During the review period, the VISN spent $11,282 for pens. However, only 22.9 percent of pen purchases ($2,584) were made from the BPA. Three of the VISN's seven VAMCs did not purchase any pens from the BPA. If these VAMCs had used the BPA, costs could have been reduced by $6,166, or 55 percent. VAMC purchasers who did not use the BPA told us they were not aware of it.

Nonabsorbable Sutures. A VISN had established a BPA to purchase nonabsorbable sutures at prices discounted 18 percent below the vendor's FSS prices. To receive the discount, the VISN's five VAMCs had to sign commitments to purchase at least 90 percent of their nonabsorbable sutures from the vendor. Four VAMCs had signed commitments and were receiving the discount. However, procurement staff at the other VAMC told us they were not aware of the requirement to sign a commitment. As a result, the VAMC lost $2,804 in discounts.

FSS Contracts

Better Use of FSS Contracts Needed. VAMCs did not take full advantage of FSS contracts, the best source for products and product types not available on national committed-use contracts or BPAs. FSS contracts were generally the best source for 36 of the 50 products. (Thirteen of the 36 products were available on both FSS contracts and local BPAs. These BPAs were the best sources for the VAMCs that had access to them. For the VAMCs that did not have access, FSS contracts were the best sources.)

During the review period, the 15 VAMCs spent $9.0 million for the 36 products that should have been purchased from FSS contracts. However, only $3.3 million (36.7 percent) of these purchases were made from this source. Of the remaining $5.7 million (63.3 percent) in purchases, $5.5 million was from the open market (61.1 percent of the $9.0 million total). The other $0.2 million in purchases were made from local contracts with prices that were equal to or higher than FSS prices. (VISNs and VAMCs should not award contracts with prices higher than FSS prices. This issue is discussed on pages 8–10.)

Low Usage of FSS Contracts for Some Products. As Table 3 shows, the usage rates for FSS contracts varied widely, ranging from 100.0 percent for two products to less than 10.0 percent for five products:

Table 3. Percent of Purchases from FSS Contracts

Product	Percent	Product	Percent	Product	Percent
Central Venous Catheters	100.0%	Pulse Oximeter Sensors	59.7%	HVAC Filters	22.5%
Electrosurgical Pencils	100.0%	Power Scooters	59.4%	Disposable Scalpels	19.4%
X-Ray Film	99.3%	Power Wheelchairs	53.6%	Pacemakers	18.8%
Skin Closures	96.4%	Oxygen Concentrators	48.0%	Toilet Tissue	18.5%
Manual Wheelchairs	96.0%	Scooter Lifts	47.3%	Toner Cartridges	15.8%
Writing Pens	93.4%	Electric Beds	42.2%	Implantable Defibrillators	14.9%
Laundry Detergent	80.2%	BIPAP Systems	38.1%	Hip Replacements	14.6%
Pacemaker Leads	68.5%	Nasal Cannulas	35.5%	Closed Circuit TVs	9.6%

Surgical Tape	68.2%	Anti-Embolism Stockings	34.4%	Knee Replacements	6.8%
Disposable Diapers	64.4%	Gauze Bandages	29.5%	Blood Pressure Monitors	4.1%
TENS Units	63.4%	Facial Tissue	28.7%	Light Fixture Ballasts	0.0%
Surgical Gloves	60.2%	CPAP Systems	25.5%	Patient ID Wristbands	0.0%

The following examples illustrate the potential savings if the VAMCs had made better use of FSS contracts:

Blood Pressure Monitors. A VAMC purchased 199 blood pressure monitors at $54.00 each from an open market vendor (total cost = $10,746). The identical monitor was available from an FSS vendor for $28.57. By using the FSS contract, the VAMC could have saved $5,061, or 47.1 percent of actual costs. The purchaser told us that she did not know that the monitors were available from an FSS contract and that she therefore bought from a local vendor the VAMC had used for years.

Surgical Gloves. Of the 10 VAMCs that purchased standard, powder-free surgical gloves, 5 purchased from the open market and 5 used FSS vendors. The 5 VAMCs using the open market purchased 59,250 pairs of gloves at a total cost of $72,550 and paid prices ranging from $0.85 to $2.80 a pair. If these VAMCs had purchased from FSS vendors at the lowest contract price of $0.90 a pair, they could have saved $19,225, or 26.5 percent of actual costs.

Local Contracts

Local contracts are the least preferred contract source but are still better than purchasing from the open market. The audit identified two problems pertaining to local contracts: (1) some contracts were not cost effective because they offered prices higher than those available from other sources and (2) VAMCs did not consistently take advantage of local contracts that did offer good prices.

Some Local Contracts Not Cost Effective. The 3 VISNs and 15 VAMCs had awarded 19 local contracts covering 12 supply products. Nine (47.4 percent) of these contracts were beneficial, covering four products not available on FSS contracts and offering prices ranging from 6.0 to 16.0 percent below open market prices. The other 10 contracts were not cost effective:

- Eight of the 10 contracts were for products available from FSS contracts. The prices offered by seven of these contracts were higher than FSS prices, ranging from 5.4 to 173.7 percent higher. Prices on the other contract were equal to FSS prices, so the contract offered no benefit over FSS contracts.

- One local contract was for a product available from a national contract at a lower price.

- The remaining contract covered a product available only from the open market. However, the contract prices were equal to the vendor's list prices, so the contract offered no benefit.

Instead of saving money, most of these contracts resulted in higher costs. In addition, the VAMCs incurred unnecessary costs to negotiate and administer the unneeded contracts. The problem of ineffective local contracts is illustrated by the following examples:

Continuous Positive Airway Pressure (CPAP) Systems. Unaware that CPAP systems were available from two FSS contracts, a VAMC awarded a local contract for these systems (used in the treatment of sleep apnea disorders). During the first 4 months of our review period, the VAMC bought 34 systems, paying $900 each for 28 units and $800 each for 6 units, for a total cost of $30,000. However, the VAMC could have purchased the identical CPAP system from an FSS contract for $322, or 60.0 to 64.0 percent less than the local contract prices. By not using the FSS contract, the VAMC incurred unnecessary costs of $19,052 (63.5 percent higher than FSS costs). In February 2002, VAMC staff learned about the FSS contract and stopped using the local contract.

Cardiac Catheterization Packs. In 1999, the NAC awarded a national contract for cardiac catheterization packs. The contract allowed VAMCs to customize the packs with a wide range of components to meet specific requirements. In 2000, a VAMC established a local contract for cardiac catheterization packs. The unit price under the local contract was $27.98, 20.0 percent higher than the national contract price of $23.32. During our review period, the VAMC bought 605 packs from the local contract at a total cost of $16,928. The VAMC could have bought comparable packs with the same components from the national contract at a cost of $14,109, saving $2,819. The contracting officer responsible for the local contract told us she was not aware of the national contract.

Based on our interviews with contracting staff, we concluded that they had awarded the ineffective local contracts because they had not done the necessary research to ensure that proposed contract prices were lower than prices available from other sources. VHA needs to issue guidance addressing this problem. In April 2003, VHA issued Directive 2003-018 requiring that all proposed local BPAs be reviewed and approved by the NAC. The purposes of the NAC review are to ensure that the proposed local BPA offers prices lower than FSS prices and to determine if there is potential for negotiating a national BPA. The directive did not require NAC approval for proposed local contracts. To ensure that these contracts are cost effective, VHA should require that they be reviewed and approved by the NAC.

Beneficial Local Contracts Not Used Consistently. Nine of the 19 local contracts, covering 4 products, were cost effective, and the VAMCs with access to these contracts should have used them for all purchases of the 4 products. However, as Table 4 shows, the usage rates for these contracts varied from 100.0 percent (pacemakers) to 30.6 percent (cardiac balloon catheters):

Table 4. Percent of Purchases from Local Contracts

Product	Percent
Pacemakers	100.0%
Pacemaker Leads	90.1%
Bifocal Eyeglasses	47.4%
Cardiac Balloon Catheters	30.6%

The VAMCs should have used the nine contracts for purchases totaling $1.9 million. However, only $0.9 million (47.4 percent) of these purchases were made from the contracts. The remaining $1.0 million in purchases were made from the open market. The following example illustrates the problem of not effectively using local contracts:

Bifocal Eyeglasses. Two of the audited VISNs had local contracts for bifocal eyeglasses. Of the 12 VAMCs in these VISNs, 11 purchased eyeglasses during the review period. Nine of these VAMCs used the local contracts, but the other two VAMCs purchased from open market vendors. The prices paid by these two VAMCs were 12.2 percent and 26.6 percent higher than contract prices. These VAMCs paid $55,333 more than necessary for eyeglasses (23.8 percent higher than contract costs).

Open Market Purchases

The open market is the least preferred source for purchases. However, some open market purchases are unavoidable because the products are not available from contract or BPA sources. (See pages 13–15 for a discussion of the need to award more contracts and BPAs for products now available only from the open market.) When the open market is the only source for a product, VAMCs should perform market research to determine which vendor offers the product at the lowest price. In our sample of 50 products, there were 12 products or product types that were available only from the open market. The VAMCs obtained consistently low prices for only one product, specialized hearing aids not available from national contracts.

The VAMCs made $5.7 million in purchases of the other 11 products and paid various prices for each product. If all these purchases had been made at the lowest prices, the cost would have been $5.0 million, 12.3 percent less than actual costs. Table 5 shows, for each product, the percentage differences between actual costs and the costs that would have been incurred at the lowest prices paid:

Table 5. Percent Difference between Actual and Lowest Costs

Product	Percent	Product	Percent
Implantable Defibrillators	24.5%	Examination Table Paper	8.4%
Bifocal Eyeglasses	17.4%	Coronary Stents	7.4%
Power Scooter Lifts	14.2%	Pulse Oximeter Sensors	6.9%
Closed Circuit TVs	10.6%	Pacemaker Leads	6.5%
Intraocular Lenses	8.8%	Central Venous Catheters	1.9%
Pacemakers	8.6%		

The following examples illustrate the problem of not obtaining low open market prices:

Coronary Stents. There were no contract sources for stents, and VAMCs paid a range of prices for the same brands and models and a wider range of prices for similar types from different suppliers. Nine of the 15 VAMCs purchased 781 stents. For the most frequently purchased brand and model, these VAMCs paid prices ranging from $1,218 to $1,504, a variance of 23.5 percent. (The 9 VAMCs purchased a total of 88 of these stents at a total cost of $114,460 and an average cost of $1,301.) Generally, VAMC purchasers accepted the prices offered by vendors. If all 88 stents had been purchased at the low price of $1,218, the VAMCs would have saved $7,276, or 6.4 percent of total costs.

Intraocular Lenses. During the review period, there were no contract sources for intraocular lenses (IOLs). Five of the 15 VAMCs purchased 298 units of a particular IOL

at prices ranging from $124 to $165 (total costs = $48,793). If all these IOLs had been purchased at $124, the savings would have been $11,841, or 24.3 percent of total costs.

Causes of Ineffective Purchasing Practices

Based on our analysis of purchasing practices for the 50 products and our interviews with 213 VAMC purchasers, we concluded that there were 3 major causes for the ineffective use of contracts and BPAs–purchasers were not adequately trained, compliance with purchasing requirements was not adequately enforced, and a comprehensive FSS database was needed.

Purchasers Not Adequately Trained. Some purchasing staff did not have adequate knowledge of the requirements for using contracts and BPAs.[6] Of the 213 purchasers we interviewed, 186 (87.3 percent) told us that they had received general training on procurement techniques. However, many purchasers had not received specific training on the use of the various types of contracts and BPAs. For example, 77 (36.2 percent) purchasers had not received training on national contracts and BPAs, and 60 (28.2 percent) had not received training on FSS contracts. Because they had not received adequate training, these purchasers often did not know how to determine which products were available from contracts and BPAs and therefore did not know how to compare prices to determine the best sources.

Purchasers working in VAMC procurement activities had generally received more training than those working in other VAMC activities, such as surgery and cardiology. To illustrate, of the 77 purchasers who had not received training on national contracts and BPAs 58 (75.3 percent) worked in activities other than procurement. Similarly, of the 60 purchasers who had not received training on FSS contracts, 46 (76.7 percent) did not work in procurement activities.

Compliance with Purchasing Requirements Not Adequately Enforced. As of August 2003, VHA management had not established adequate controls to monitor and enforce VAMC compliance with the purchasing hierarchy. Both the Prosthetic and Sensory Aids Service Strategic Healthcare Group (PSAS) and Clinical Logistics Office (CLO) had established compliance review programs, with the PSAS reviewing compliance for prosthetic products and the CLO reviewing compliance for all other products. However, both programs covered only compliance with the use of national committed-use contracts and BPAs and did not cover compliance with FSS contracts or the other levels of the purchasing hierarchy.

PSAS Reviews. The PSAS compliance reviews for national contract and BPA products were systematic and effective. For each product, the PSAS sets a goal for the percentage of purchases that should be made from the national sources. Every 3 months all VISNs must send the PSAS a compliance report for each product. The report shows the total costs and quantities of products purchased from all sources and the percentages purchased from national contracts and BPAs. This allows the PSAS to monitor compliance and to identify VISNs that need to improve their performance. For example, according to the PSAS monitoring report for the transcutaneous electrical nerve stimulation (TENS) unit contract for the period October–December 2002, 16 of the 21

[6] As of November 2003, the 15 VAMCs had 1,764 purchase cardholders (with 4,375 cards) who were authorized to make purchases.

VISNs met the 95 percent compliance goal, and the other 5 VISNs achieved compliance rates ranging from 76.5 to 94.5 percent.

CLO Reviews. The CLO compliance reviews for national contracts and BPAs needed improvement. In FY 2000, the CLO completed a review of the use of national contracts and BPAs for non-prosthetic products. This review required all VAMCs to report whether they had used each of the national contracts and BPAs. Unlike the PSAS compliance review, the CLO review did not require VAMCs to provide quantity and cost data on purchases. Without this data, the CLO could not effectively monitor VAMC rates of compliance. As of August 2003, the CLO was making several improvements to their compliance review program. For example, national contract and BPA vendors were providing the CLO with quarterly reports showing product purchase data for each VAMC. The CLO was also developing a PRTF-recommended national item file that will provide product-specific purchase data to use in reviewing VAMC compliance.

Both the PSAS and CLO compliance reviews monitored VAMC use of national contracts and BPAs. However, compliance with other levels of the purchasing hierarchy was not being monitored. For example, VHA did not monitor the use of FSS contracts, the largest and best source for products not available from national contracts and BPAs. As discussed in this report, significant cost savings could be achieved if VAMCs used FSS contracts effectively. To ensure that VAMCs comply with the purchasing hierarchy, VHA needs to perform, for all levels of the hierarchy, compliance reviews similar to those done by PSAS.

Comprehensive FSS Database Needed. In 2000, VHA established and made available on the VA Intranet a database of national contracts and BPAs. Our review of purchases from these sources indicated that VAMCs had made good use of the database. However, VAMC purchasers did not have a database of FSS contracts, a major source for purchases of products not available from national contracts and BPAs. As discussed on page 7, 63.3 percent of purchases that should have been made from FSS contracts were made from inappropriate sources, primarily the open market. This problem could be mitigated if purchasers had a reliable database showing FSS contracts, products, and prices.

Until July 2003, the only database available for researching FSS contracts was the General Services Administration (GSA) Advantage system, an online FSS market research and product ordering system operated by the GSA. However, as the PRTF report noted, the FSS information in Advantage is not complete, and the system is cumbersome for purchasers to use. In addition, of the 213 purchasers we interviewed, 115 (54.0 percent) had not received training on Advantage.

Because FSS information was not available, purchasers relied heavily on vendors for information. Of the 213 purchasers we interviewed, 125 (58.7 percent) told us they relied primarily on the vendors for contract, product, and price information. Purchasers often followed long-established buying patterns and used the same vendors without considering alternatives. In some cases, purchasers continued to buy from vendors whose FSS contracts had expired or had been cancelled.

In August 2002, the NAC awarded a contract for the development of a Web-based, searchable database that will include comprehensive information on FSS contracts. This project has experienced delays, and as of August 2003 the estimated implementation date for the database was December 2004.

In July 2003, as an interim measure the NAC made a simpler version of the database available for downloading by VAMC purchasing staff. According to NAC officials, the interim database does not have all of the search features of the Web-based database being developed and requires users to download updated databases biweekly. As of September 2003, NAC officials reported that the interim database was not yet being used extensively by VAMCs. Because the NAC had begun work on the database, we did not make any recommendations pertaining to this issue. However, the NAC should follow through and implement the database as soon as possible.

VA Can Better Leverage Its Buying Power by Awarding More National-Scope Contracts and BPAs

Many Products Not Available from National-Scope Contracts. In addition to making more purchases from the available national-scope contracts, VA should work aggressively to award more of these contracts. When supply requirements have been aggregated at the national level and contracts negotiated to meet those requirements, lower prices and greater contracting efficiencies have usually resulted. However, a significant number of products were not covered by national-scope contracts. Of the 50 sample products, there were 12 products or product types (24.0 percent) that were only available on the open market. In addition, the NAC had awarded committed-use contracts or BPAs for 16 (32.0 percent) products, but for only 6 of these products were the contracts or BPAs comprehensive, offering all the brands, models, and types purchased by the 15 VAMCs.

More National Contracts and BPAs Needed for Standardized and Nonstandardized Products. National-scope contracts and BPAs have successfully achieved significant cost reductions. VA needs to build on this success and aggressively increase efforts to award more national contracts and BPAs. In our opinion, applying a balanced approach to product standardization and national contracting that would most effectively utilize the features of committed-use contracts, BPAs, and FSS contacts and would best leverage VA's purchasing power.

For those products now purchased primarily from open market or local contract sources, VA should attempt to negotiate FSS contracts to obtain better pricing. FSS contracts may be the preferable choice among the three types of contracts when product standardization is not feasible, not necessary, or otherwise might not best meet the needs of VAMC clinicians, patients, or other users. FSS works well for the types of products that have many commercially available choices at reasonable prices.

The OIG has previously reported on the need to expand the use of FSS contracts. In a May 2001 report, *Evaluation of Department of Veterans Affairs Purchasing Practices,* the OIG noted that an increasing number of vendors had chosen not to submit proposals for FSS contracts, had

withdrawn high volume products from contracts, or had cancelled contracts.[7] Some of these vendors continued to sell products to VAMCs on the open market. In addition, other vendors indicated that they had not offered most favored customer prices to VA during FSS contract negotiations because they anticipated having to negotiate additional BPAs or contracts with local VAMCs in order to secure purchase commitments. The practice of negotiating numerous local BPAs and contracts with the same vendor is not an efficient contracting approach for VA or vendors. As vendors become aware of VA's new emphasis on national-level contracting and the requirements for VAMCs to make their purchases from these contracts, the NAC should be better able to negotiate FSS contracts for a full range of products at most favored customer or better prices. VAMCs are now required to get approval from the NAC before negotiating local BPAs, which should prevent establishment of unneeded local BPAs. With additional products covered under FSS contracts, the number of open market purchases and local VAMC contracts should be significantly reduced, which would further improve the cost-effectiveness of VA contracting.

For those products that can be standardized, national committed-use contracts or BPAs provide the best contracting alternative. By definition and in practice, national contracts and BPAs achieve favorable pricing because VA agrees to market share or volume purchase commitments involving some degree of product standardization or limitation on the choice of vendors. In January 2001, VHA began a two-track approach for awarding more national committed-use contracts and BPAs for products being evaluated for standardization—one track for prosthetic products and the other for nonprosthetic products. VHA established the Prosthetic Clinical Management Program (PCMP) to coordinate contracting opportunities for prosthetic products. As of August 2003, the PCMP had formed 35 user groups to evaluate the potential for national contracts and BPAs for specific prosthetic products. The work of these groups had resulted in contracts and BPAs with estimated annual cost reductions of $6.6 million for eight products.

In January 2001, VHA issued Directive 1761.1, which established a national policy for standardizing nonprosthetic products. The directive states that the main purpose of product standardization is to make it easier for VA to obtain better pricing through volume purchasing. In addition, the directive established procedures for forming user groups and for reviewing and approving user group recommendations. In July 2003, VHA issued detailed guidance for awarding national contracts and BPAs for nonprosthetic products (VHA Handbook 1761.1).

As of August 2003, VHA had established 14 main product user groups to evaluate the potential for contracts and BPAs for broad lines of nonprosthetic products and 39 user subgroups to evaluate the contract and BPA potential for more specific types of products. The work of the 14 main user groups had resulted in new contracts and BPAs for 17 products. The estimated annual savings associated with these contracts and BPAs was $5.0 million.

In total, VHA had established 88 user groups (35 prosthetic product groups, 14 main nonprosthetic product groups, and 39 subgroups). As of August 2003, the work of these groups had resulted in the award of national contracts and BPAs for 25 products with estimated annual

[7] VA Office of Inspector General, *Evaluation of Department of Veterans Affairs Purchasing Practices*, Report No. 01–01855–75, May 2001.

savings of $11.6 million. However, our audit results indicate that there is significant potential for awarding more national contracts and BPAs and achieving more savings.

The PRTF recommended that VHA focus standardization efforts on the "top 20" non-standardized medical supply products based on total VAMC expenditures. Our sample of 50 products included 12 of these 20 products. As of October 2003, VHA reported that 3 of the 20 products had been standardized and that national contracts and/or BPAs had been awarded. The remaining 17 products were being evaluated by user groups.

As of October 2003, VHA and OA&MM officials could not precisely estimate what proportion of all supply products could be covered by new or improved national-scope contracts. However, they indicated that a 50 percent increase in the number of products covered would be a reasonable starting goal. It is not realistic to expect that all products could or should be covered by national-scope contracts (for example, products that have very limited demand or only localized use). We believe that the 50 percent goal is a reasonable starting point. However, as of October 2003, 40 of our 50 sample products (80 percent) were either already available or were being evaluated for national contracts or BPAs. This indicates that these sources are feasible for a high proportion of supply products. In our opinion, a reasonable and achievable longer-range goal would be to have 75 percent of products covered by national-scope contracts or BPAs.

For each national contract and BPA awarded, the NAC calculates a savings rate that represents the difference between the contract/BPA prices and the prices previously paid. Based on these NAC-reported savings rates, we estimated that if 75 percent of the 50 sample products not covered by national-scope contracts had been available from these sources and VAMCs had used these sources for 80 percent of the purchases of the covered products, the 15 VAMCs could have reduced their supply costs by $2.2 million (7.4 percent of the $29.2 million total cost of the 50 products).[8] This is in addition to the $2.2 million savings that could have been achieved through better use of existing purchasing sources.

Conclusion – VA Should Fully Implement the Purchasing Hierarchy and Award More National Contracts and BPAs

In June 2002, VHA and OA&MM began efforts to implement the recommendations of the PRTF. Since then, they have issued several new procurement policies, including the November 2002 policy formally incorporating the purchasing hierarchy into VA procurement regulations. However, as of August 2003 they had not developed a strategy for implementing the use of the hierarchy. VHA had not trained purchasers on the use of the hierarchy and had not established comprehensive performance monitors to ensure that VISNs and VAMCs followed the hierarchy. Because use of the hierarchy was not fully implemented, the ineffective use of contracts and BPAs and the inordinate dependence on open market sources continued throughout FY 2003 and will persist into FY 2004.

To address this problem, VHA needs to more aggressively develop guidance to help VISNs and VAMCs make the transition from their historical purchasing practices to the effective use of the

[8] The 7.4 percent figure is correct when the supply costs are not rounded. See Appendix C, Table 8, page 28.

purchasing hierarchy. The guidance should both define the requirements and responsibilities for using the hierarchy and establish milestones for VISNs and VAMCs to complete key tasks.

Two tasks are especially important. First, VISNs and VAMCs should be required to systematically evaluate their current practices for purchasing various types of supplies and begin the transition to using the appropriate sources based on the hierarchy. Second, VHA should ensure that VISN and VAMC purchasing staff are properly trained to apply the hierarchy to purchasing decisions and to use information sources to find the best prices. This training should target all staff with significant purchasing responsibilities, not just the purchasing staff assigned to materiel management activities. As appropriate, VHA and OA&MM should work together to develop and provide the training. In addition, to address the problem of ineffective local contracts, VHA should issue guidance requiring VISNs and VAMCs to submit proposed contracts to the NAC for review and approval.

VHA and OA&MM should also work more aggressively to award national contracts and BPAs. This effort should target high-volume, high-cost supplies. VA user groups should conduct thorough market research to determine product and brand selection, identify potential sources of supply, and determine the types of contractual arrangements vendors have established with other high-volume purchasers. In addition, the NAC should strongly encourage vendors to include full product lines and best prices in their offers when negotiating FSS contracts. Achieving prices commensurate with VA's purchasing volume in FSS contracts would lessen the need for many local contracts and open market purchases. Both VA and vendors should benefit from the efficiencies of simplifying the contracting process and eliminating redundant and overlapping contract negotiations.

VHA can further strengthen VA's position in negotiating new contracts by enforcing the use of the hierarchy and allowing purchasers to deviate from it only when properly justified. As necessary, the NAC should conduct outreach with open market vendors to emphasize that VA's purchasing hierarchy will give sales preferences and competitive advantages to vendors that contract with VA over vendors that sell to VA on the open market.

Implementing the audit recommendations and the related PRTF recommendations has significant financial implications for VA. In this report, we discuss the two types of savings that VHA could achieve–savings from better purchasing practices and savings from awarding more national-scope contracts and BPAs. For the 50 products reviewed at the 15 VAMCs, the purchasing savings rate was 7.4 percent (page 3) and the contracting savings rate was also 7.4 percent (page 15). Adjusting these rates to account for the actual proportions of VHA expenditures in the three categories of medical, prosthetic, and miscellaneous operating supplies yields an overall purchasing savings rate of 8.8 percent and a contracting savings rate of 5.5 percent. These savings rates may seem small, but extrapolated to total VHA purchases of medical, prosthetic, and miscellaneous operating supplies they equate to cost reductions of about $213.5 million a year. Over the next 5 years (FYs 2004–2008), taking into account inflation and projected increases in supply usage, the potential savings would be about $1.40 billion.

For More Information

- VA supply costs, recent changes in VA procurement practices, the implementation of the PRTF recommendations, and other background information are discussed in Appendix A, pages 20–24.
- The audit objectives, methodology, and scope are discussed in Appendix B, page 25.
- Our estimate of the savings that could be achieved by improved procurement practices is discussed in Appendix C, pages 26–30.
- Detailed audit results for the 50 sample products are shown in Appendix D, pages 31–34.

Recommendations

1. We recommended that the Under Secretary for Health:

a. Direct the full implementation of the purchasing hierarchy. The directive should outline an implementation strategy and specify procedures and time frames for VISNs and VAMCs to evaluate current purchasing practices and convert to the hierarchy approach.

b. Develop and implement comprehensive performance monitors to ensure that VISNs and VAMCs successfully make the transition to using the purchasing hierarchy and otherwise fully comply with all initiatives aimed at reducing medical care supply costs.

c. Issue guidance requiring NAC review and approval of proposed local contracts for supplies.

2. We recommended that the Under Secretary for Health and the Assistant Secretary for Management work together to:

a. Provide VISN and VAMC purchasing staff training on the principles and requirements of the hierarchy approach and on the use of available sources of information for contracts, products, vendors, and prices.

b. Increase efforts to award more national-scope contracts, including FSS, committed use, and BPAs, for supply products.

Under Secretary for Health Comments

The Under Secretary for Health agreed with the findings and recommendations. He deferred comment on the OIG monetary benefit estimate pending VHA's review of the volume and cost of supplies purchased in FY 2003, including the 50 products reviewed by the OIG. This review, to be completed by June 2004, will provide useful data for determining the effectiveness of current measures to enhance procurement practices. (See Appendix F, pages 36–42, for the complete text of the Under Secretary for Health's comments and implementation plan.)

Implementation Plan

Recommendation 1a. In December 2003, VHA issued a memorandum mandating VAMC use of the purchasing hierarchy. In addition, to improve communication between VA offices and to facilitate implementation of the hierarchy, in February 2004 representatives from the CLO and the PCMP began attending National Acquisition Committee contracting group meetings.

Recommendation 1b. As of February 2004, the PSAS had implemented national contract compliance monitors for prosthetic supplies, and the first report of findings is due on June 30, 2004. To monitor national contract compliance for all other types of supplies, the CLO will develop performance measures by March 31, 2004, with full implementation anticipated by June 2004. Performance monitors for measuring the use of the purchasing hierarchy are dependent on completion of the Core Financial and Logistics System (CoreFLS), the new VA financial management system. As of February 2004, VHA's target date for full implementation of CoreFLS was June 2006.

Recommendation 1c. VHA will establish and mandate VAMC use of a National Prime Vendor Program for medical care supplies. This program will eliminate the need for about 60 percent of local supply contracts. The target date for full implementation of this program is September 2005. In addition, a VA Chief Financial Officer reorganization plan will require VISN Chief Logistics Officers and VISN Contract Managers to enforce compliance with VHA contracting policies, including the review of appropriate VAMC use of local contracts. This reorganization is expected to be completed by October 2004.

Recommendation 2a. As of February 2004, VHA had begun training on the appropriate use of the purchasing hierarchy for all VISN and VAMC employees who purchase supplies. The target date for completing and certifying this training is March 31, 2004.

Recommendation 2b. By June 30, 2004, the CLO will develop a process for reviewing standardization efforts to ensure national-scope contracts are aggressively pursued.

Assistant Secretary for Management Comments

The Assistant Secretary for Management agreed with the findings and recommendations and agreed that savings can be realized by improving procurement practices. (See Appendix G, pages 43–44 for the complete text of the Assistant Secretary for Management's comments and implementation plan.)

Implementation Plan

Recommendation 2a and 2b. As of December 2003, OA&MM had created a new internet website that VAMCs can use to identify national, regional, and local BPAs. In addition, in November 2002, VA issued an information letter requiring VAMCs to review existing NAC contracts before awarding local contracts. In conjunction with VHA, OA&MM will ensure that knowledge of the Web site and information letter is disseminated to field activities through Chief Logistics Office Symposiums, Acquisition Leadership Seminars, and other appropriate methods.

Office of Inspector General Comments

The implementation plans are generally acceptable and we consider the audit issues to be resolved. We will follow up on the implementation of planned actions. As part of this effort, the OIG plans to review local procurement practices during selected VAMC Combined Assessment Program reviews conducted in FYs 2004–2005. The implementation plan for recommendation 1a does not include a detailed strategy for implementing the purchasing hierarchy. Based on our discussions with VHA CLO managers, they plan to include guidance on implementing the purchasing hierarchy as part of the training that will be provided to all VISN and VAMC employees who purchase supplies.

Appendix A

Background

VA Supply Costs

In FY 2003, costs for medical, prosthetic, and miscellaneous operating supplies totaled $1.56 billion. As shown in Table 6, costs for these supplies have increased significantly over the past 5 years. Combined expenditures grew from $1.24 billion in FY 1999 to $1.56 billion in FY 2003, a 25.8 percent increase. Prosthetic supply costs accounted for most of this increase, growing from $402.5 million in FY 1999 to $634.3 in FY 2003, a 57.6 percent increase. Medical supply costs increased from $496.3 million to $570.0 million (14.8 percent increase), and operating supply costs increased from $345.5 million to $357.3 (3.4 percent increase).

Table 6. VA Medical, Prosthetic, and Miscellaneous Operating Supply Expenditures FYs 1999–2003 ($ in Millions)

	Medical		Prosthetic		Misc. Operating		Combined	
FY	Costs	Percent Change	Costs	Percent Change	Costs	Percent Change	Costs	Percent Change
1999	$496.3	–	$402.5	–	$345.5	–	$1,244.3	–
2000	$507.6	2.3%	$465.9	15.7%	$363.6	5.2%	$1,337.1	7.5%
2001	$532.6	4.9%	$520.5	11.7%	$436.1	19.9%	$1,489.2	11.4%
2002	$555.2	4.2%	$578.1	11.1%	$359.6	-17.5%	$1,492.9	0.3%
2003	$570.0	2.7%	$634.3	9.7%	$357.3	-0.6%	$1,561.6	4.6%
5-Year Changes	$73.7	14.8%	$231.8	57.6%	$11.8	3.4%	$317.3	25.5%

VA budget estimates predict that the trend of increasing supply costs will continue. For example, as of January 2004 the VA budget estimate for FY 2004 expenditures for the three supply categories totaled $1.81 billion.

Recent Changes in VA Procurement

Over the past decade, there have been significant changes in the methods that VAMCs use to procure pharmaceuticals and medical, prosthetic, and miscellaneous operating supplies. In 1994, VA closed its centralized supply depot system and decentralized procurement for most types of supplies to the VAMCs. Under the decentralized approach, VAMCs began purchasing supplies directly from vendors instead of requisitioning from depots. Another major change in VAMC procurement methods was the implementation of the Government Purchase Card program, which dispersed purchasing responsibilities away from traditional contracting and purchasing activities to various operating elements within VAMCs.

For pharmaceuticals, VA's largest supply category ($3.01 billion in FY 2002), VA successfully implemented major procurement and distribution improvements by establishing a comprehensive national formulary, negotiating cost-beneficial national contracts with pharmaceutical suppliers, and implementing a prime vendor distribution and ordering system.

VA has not been as successful in improving the procurement of non-pharmaceutical supplies. In FY 2000, VHA and OA&MM implemented the national Medical/Surgical Prime Vendor

(MSPV) Program. The MSPV Program allows VISNs and individual VAMCs to voluntarily commit to using one of two medical/surgical prime vendor contracts for purchasing medical and surgical products. Both contracts include distribution fee markups to FSS contract prices. The distribution fees are intended to cover the prime vendor's costs for ensuring the timely delivery of products. As of August 2003, only 9 of 21 VISNs plus 8 individual VAMCs were participating in the MSPV Program.

As of September 2002, the NAC administered 1,611 VA national-scope contracts, including 1,210 FSS contracts, 321 national contracts and BPAs, and 80 high-tech medical equipment contracts. Total sales over the lives of these contracts were estimated to be $8.19 billion. FY 2002 vendor-reported sales to VA and other Government agency purchasers under these contracts totaled $5.70 billion.

Implementation Status of PRTF Recommendations

In June 2002, VHA, OA&MM, and other VA organizational elements began implementing the PRTF's 65 recommendations to improve procurement practices. As of August 2003, 28 (43.1 percent) of the 65 recommendations had been implemented.

Leveraging VA's Purchasing Power. As of August 2003, VA had issued or was about to issue several new policies to address the PRTF goal of more effectively leveraging VA's purchasing power. For example, by requiring that VAMCs purchase first from national contracts and BPAs, the November 2002 policy formalizing the purchasing hierarchy will help VA provide vendors assurance that contracting with VA will result in substantial sales, which in turn gives vendors an incentive to offer lower prices.

In January 2003, VHA issued a new policy establishing procedures for consolidating high-tech medical equipment procurements. This policy requires that the NAC aggregate VISN requests for all high-tech medical equipment three times per year, allowing the NAC to obtain higher quantity discounts for multiple purchases from the same vendor. In June 2003, the NAC made the first orders under this policy. These orders covered 18 equipment items from 4 different vendors. The cost of these 18 items, if purchased separately, would have totaled $5,713,809. By consolidating the purchases, the NAC obtained prices totaling $5,370,162, saving $343,647 (6.0 percent). As of August 2003, the NAC was in the process of completing the second round of consolidated purchases. VISN requisitions for this round totaled $155.0 million. If the 6.0 percent savings rate is sustained, the savings should be $9.3 million.

VHA has also increased efforts to standardize more medical supplies, which will allow more national contracts. In January 2001, VHA issued a new directive aimed at standardizing supplies and equipment to the maximum extent possible, consistent with clinical and practitioner needs. This policy covered the role of standardization user groups, the product evaluation process, procurement requirements, and procedures for requesting waivers to deviate from purchasing standardized products. In July 2003, VHA revised the handbook related to this policy to provide detailed guidance on the responsibilities of the user groups.

As of August 2003, VHA had established 14 main standardization user groups and 39 subgroups with responsibility for evaluating classes of medical supplies and equipment. These products included the "top 20" non-standardized items identified by the PRTF. Once user groups standardize products, the NAC is responsible for negotiating contracts for these products. VAMCs are then required to purchase from these contracts, therefore aggregating demand to one vendor and one product and allowing VA to get the best prices.

Delays in Developing a Contract Database. As of August 2003, VA had begun two initiatives aimed at making comprehensive contract and product information available to VAMC purchasers. The first initiative is the development of a Web-based, user-friendly searchable database that includes information on products and prices available from FSS vendors as well as from national contracts and BPAs. The second initiative is a "VA Store" within the GSA Advantage online market research and ordering system. These initiatives are critical to improving purchasing practices at the VAMC level.

As a first step in creating the searchable database, in August 2002 the NAC awarded a contract to a health care products distribution company to develop a database covering an estimated 400,000 supply line items available from national contracts and BPAs and NAC-administered FSS contracts. This distributor specializes in creating electronic catalogs for its customers. As of August 2003, development of the database was ongoing. The NAC planned to award a separate contract to develop the software to allow users to easily access the database online. The estimated implementation date for the online database is December 2004. In July 2003, as an interim measure the NAC made a limited version of the FSS contract database available for downloading by VAMCs. The NAC planned to have updated databases available for downloading on a biweekly basis.

The initiative to create a "VA Store" within GSA Advantage was stalled from December 2002 to July 2003 because of an administrative reorganization within GSA. In July 2003, VA and GSA restarted the initiative, agreeing that building the virtual VA Store will be done in two phases. In phase 1, VA will send GSA contract product and pricing data, and GSA will post this information on the VA Store Web site. GSA will also develop system enhancements to make the store easier for purchasers and vendors to use. In phase 2, VA and GSA will work together on additional enhancements to make the VA Store more complete and user-friendly. As of August 2003, the target implementation date for phase 1 was December 2003, and there was no target date for the completion of phase 2.

Previous OIG Reviews of VA Procurement Practices

Since 1995, the OIG has issued five reports that addressed various national supply purchasing and contracting issues:

Evaluation of Selected VA Procurement and Small Business Program Issues (March 2003). This evaluation found that VA contracting officers usually met the requirement that the past performance of vendors bidding for competitive contracts be evaluated as part of the contract award process. However, contracting officers did not routinely evaluate contractor performance when contracts ended. The level of cooperation between the Office of Small and Disadvantaged

Business Utilization and VA procurement officials was generally satisfactory, although there were instances of noncompliance with program review requirements intended to ensure that small businesses were properly considered for VA procurements. In addition, VA did not maintain the management information needed for evaluating the results of small business program reviews. The OIG recommended that: (a) all VA contracting activities be reminded of requirements to conduct performance evaluations when contract work has been completed, (b) small business program review responsibilities and procedures be clarified and updated, and (c) management information be developed.

Evaluation of VA Purchasing Practices (May 2001). This evaluation found that VA had not leveraged its purchasing power to obtain the best prices. When legislative initiatives changed FSS contracts from mandatory to nonmandatory procurement sources, VAMC open market purchases increased significantly and may have exceeded the maximum allowable statutory limits for open market purchases of health care items. For these purchases, VAMCs often did not attempt to negotiate prices or determine price reasonableness. An increasing number of vendors had chosen not to submit proposals for FSS contracts, had withdrawn high volume items from contracts, had not negotiated in good faith, or had cancelled contracts. Many of these vendors continued to sell products to VAMCs on the open market. In addition, some vendors sold products made in non-designated countries that otherwise would have been prohibited under FSS contracts by Trade Agreement Act requirements. The OIG suggested that VA management consider: (a) making national and FSS contracts mandatory sources of supply for medical supplies, equipment, and pharmaceuticals; (b) prohibiting local contracts for commercial items; (c) monitoring local VAMC purchasing practices; and (d) limiting contracts with distributors to distribution services only.

Evaluation of VA Medical Center Management of Prosthetics and Sensory Aids Procurement (October 1999). This limited-scope evaluation found that VISNs and VAMCs had undertaken various initiatives to reduce the prices paid for prosthetic items. The survey of 10 VAMCs found that all had taken or planned to take various cost-control measures for purchasing prosthetic items. All 10 VAMCs reported using various combinations of contracts, including national, FSS, VISN, and local contracts, BPAs, and consignment agreements to purchase prosthetics items. Because many of the initiatives were new, the OIG concluded that further review should be done after the initiatives had been in operation long enough to fully assess their effectiveness.

Audit of Administration of Centralized Contracts, VA National Acquisition Center (May 1996). This audit found that the NAC had effective internal controls for contract solicitations, negotiations, and awards. However, the NAC's source of data for verifying vendor sales, the VA Integrated Supply Management System (ISMS), was not consistently reliable. ISMS data was incomplete and difficult to retrieve. The OIG recommended that VA explore ways to improve the accuracy and use of ISMS data in verifying vendor sales data.

Audit of Medical Supplies Acquisition and Distribution Systems (July 1995). This audit concluded that VA needed to capitalize on its enormous buying power by expanding national contracts and adopting streamlined supply distribution systems. The OIG recommended that VA: (a) increase reliance on national medical supply contracts, (b) improve product

standardization, (c) establish a network of regional buying groups, (d) adopt streamlined distribution processes, and (e) define the roles of national, regional, and local contracting and purchasing activities.

Appendix B

Objectives, Methodology, and Scope

Objectives

The purpose of the audit was to evaluate the practices that VAMCs used to procure medical, prosthetic, and miscellaneous operating supplies. The principal objective was to determine if VAMCs made effective use of contracts and BPAs to purchase supply products.

Methodology and Scope

To evaluate the effectiveness of local procurement activities, we performed onsite audits at 15 VAMCs located in VISNs 8, 12, and 17:

VISN 8	VISN 12	VISN 17
Bay Pines, FL	Hines, IL	Dallas/Bonham, TX
Gainesville/Lake City, FL	Westside/Lakeside, IL	San Antonio/Kerrville, TX
Miami, FL	North Chicago, IL	Temple/Waco, TX
Tampa, FL	Iron Mountain, MI	
West Palm Beach, FL	Madison, WI	
	Milwaukee, WI	
	Tomah, WI	

At each VAMC, we reviewed the purchases of 50 commonly used supply products to determine if the purchases had been made from the best sources. (See Tables 11 and 12, Appendix D, pages 31–34, for a list of the 50 products.) We generally considered the source offering the lowest price to be the best source. However, if the purchase was appropriately made from a small or disadvantaged business we considered this to be the best source, even if another source offered a lower price. At the time the purchases were made, the purchasing hierarchy had not been incorporated into VA procurement policy. Because our analyses showed that the best sources generally followed the hierarchy's order of purchasing priority, we used the hierarchy tiers in describing our audit results.

During the onsite audits, we reviewed VAMC-level acquisition policies and procedures, interviewed 213 purchasers, and discussed purchasing practices with responsible managers. For each of the 50 products, we reviewed procurement histories, purchase orders, invoices, and other records. We discussed products with purchasers and users who were familiar with them. As necessary, we contacted NAC contracting officers and vendors to clarify contract terms and prices. In our opinion, the audit work covering more than 76,000 purchases made by 15 VAMCs in 3 geographically dispersed VISNs provided a reasonable basis for assessing the purchasing practices used VHA-wide.

The audit was performed in accordance with generally accepted government auditing standards. To meet the audit objectives, we used computer-processed procurement data from the VA Procurement History File (PHF) and expenditure data from the VA Financial Management System. We conducted tests to assess the reliability of this data. When the data was reliable, we used it to meet the audit objectives. When we found the data to be unreliable, we used alternative auditing techniques.

Appendix C

Details of Audit

This appendix explains our estimate of the savings that could be achieved by improving purchasing practices and awarding more national-scope contracts and BPAs.

Estimate of Potential Savings from Improved Procurement Practices

The PRTF report did not contain an estimate of the savings that could be achieved by implementing the report's recommendations. Based on our audit results, we estimated that over 5 years (the typical life of national contracts and BPAs) VHA could save about $1.40 billion by improving procurement practices.

Our estimate has two parts: (a) the savings that could be achieved by purchasing from the best sources (purchasing savings) and (b) the savings that could be achieved by awarding and effectively using national-scope contracts and BPAs for more products (contracting savings). To reach the overall savings estimate, we used a 6-step process:

1. **Development of Purchase Data.** None of the 15 VAMCs had complete and accurate purchase data for any of the 50 sampled supply products. To quantify the purchases made by each VAMC, we reviewed PHF data. To correct errors and omissions in the PHF data, we asked each VAMC to research all available records to provide purchase information for the 50 products, including purchase order numbers, vendor names, product descriptions, quantities purchased, unit prices, and total costs.

   We asked VAMC employees familiar with purchasing practices to confirm that the data included all purchases of the sample products, that purchases were for the specific products in the sample, and that product descriptions and other information were accurate. Based on the information obtained, we calculated that during the 6-month review period the 15 VAMCs spent $29,157,713 on the 50 products (rounded to $29.2 million in the report text).

2. **Calculation of Purchasing Savings for the 15 VAMCs.** To calculate the potential purchasing savings for the 15 VAMCs, we compared the prices paid for the 50 products to the prices that would have been paid using the best sources. If all the purchases had been made from the best sources, the VAMCs could have saved $2,691,813, which equated to a 9.2 percent savings rate on the $29,157,713 spent on the 50 products.

   However, since it is not realistic to expect all purchases to be made from the best sources, we applied an 80 percent rate of compliance with VHA's goal of purchasing from the best sources. We considered this to be an achievable compliance rate for two reasons. First, when VHA's product user groups recommend a national contract or BPA for a product, they typically estimate that 80 percent of purchases of that product could be made from the contract or BPA. Second, the 15 VAMCs had exceeded the 80 percent compliance rate for 5 of the 16 sample products covered by national contracts or BPAs. These five products were hearing aids (100.0 percent compliance), gauze bandages (99.1 percent), blood glucose test strips (91.2 percent), examination table paper (86.2 percent), and slippers (81.0 percent).

The VAMCs had approached the 80 percent rate for two other products, body bags (79.8 percent) and sharps disposal containers (75.2 percent).

Applying the 80 percent compliance rate, the purchasing savings for the 50 products was $2,153,450, which was 7.4 percent of the $29,157,173 cost of the products. The $2,153,450 savings consisted of $273,496 for medical products, $1,681,434 for prosthetic products, and $198,520 for miscellaneous operating products. These three savings amounts equated to savings rates of 7.1 percent on the $3,832,267 in total medical product costs; 7.0 percent on the $23,962,851 in total prosthetic product costs; and 14.6 percent on the $1,362,595 in total operating product costs. Table 7 shows the calculation of the purchasing savings for the 50 products:

Table 7. Calculation of Purchasing Savings for the 50 Sample Products for the 15 Audited VAMCs

	Supply Category			
50 Products	**Medical**	**Prosthetic**	**Misc. Operating**	**Combined**
Expenditures	$3,832,267 (100%)	$23,962,851 (100%)	$1,362,595 (100%)	$29,157,713 (100%)
Savings:				
100% Compliance	$341,870 (8.9%)	$2,101,792 (8.8%)	$248,151 (18.2%)	$2,691,813 (9.2%)
80% Compliance	$273,496 (7.1%)	$1,681,434 (7.0%)	$198,520 (14.6%)	$2,153,450 (7.4%)

3. **Calculation of Contracting Savings for the 15 VAMCs.** For each of the 50 products, we determined whether VA had national contracts or BPAs. VA had awarded comprehensive national contracts or BPAs for 6 of the 50 products. These contracts and BPAs covered all the brands and models that VAMCs purchased, so there were no potential contracting savings associated with these products.

   For 10 products, there were national committed-use contracts or BPAs, but these did not include all brands and models that VAMCs purchased. For each of these 10 products, we calculated the potential contracting savings by applying the NAC-reported savings rates for the brands and models available on the national contracts or BPAs to the audited VAMCs' expenditures for brands and models not available on these contracts and BPAs.

   During the review period, there were no national committed-use contracts or BPAs for the remaining 34 products. However, as of July 2003 the NAC had awarded 2 national contracts and 1 BPA covering 3 of these products, so that a total of 19 of the 50 products were covered by contracts (9 medical, 6 prosthetic, and 4 operating products). Based on the NAC-reported savings rates for the contracts and BPAs covering the 19 products, the weighted average savings rates were 15.2 percent for the 9 medical products, 32.9 percent for the 6 prosthetic products, and 23.8 percent for the 4 operating products.

   Using these savings rates, we calculated the potential contracting savings for each of the 34 products not covered by national contracts or BPAs. We did this by first applying the weighted average savings rate for the corresponding supply category to the audited VAMCs' expenditures for each product. We then backed-out (subtracted) the potential purchasing savings for each product calculated in step 2 above.

We next calculated the total potential contracting savings by adding together the potential contracting savings for each of the 50 products. For the 50 products combined, the total estimated contracting savings was $3,619,734, which was 12.4 percent of the $29,157,713 total costs of the 50 products.

However, since it is not realistic to expect that all products could or should be covered by national-scope contracts or BPAs, we applied a 75 percent national contract product coverage rate to the potential contracting savings. As discussed on page 15, in our opinion a reasonable and achievable VHA long-range goal would be to have 75 percent of supply products covered by national-scope contracts or BPAs. Since it also unrealistic to expect that VAMCs could or should use national-scope contracts to purchase 100 percent of the types of products covered by these contracts, we also applied an 80 percent rate of VAMC compliance with using the national-scope contracts. As discussed in step 2 above, in our opinion this is an achievable compliance rate.

After applying the 75 percent national contract product coverage rate and the 80 percent compliance rate, the contracting savings for the 50 products was $2,171,841, which was 7.4 percent of the $29,157,173 cost of the products. The $2,171,841 savings consisted of $98,626 for medical products, $1,993,631 for prosthetic products, and $79,584 for operating products. These three savings amounts equated to savings rates of 2.6 percent on the $3,832,267 in total medical product costs; 8.3 percent on the $23,962,851 in total prosthetic product costs; and 5.8 percent on the $1,362,595 in total operating product costs. Table 8 shows the calculation of the contracting savings for the 50 products:

Table 8. Calculation of Contracting Savings for the 50 Sample Products for the 15 Audited VAMCs

	Supply Category			
50 Products	**Medical**	**Prosthetic**	**Misc. Operating**	**Combined**
Expenditures	$3,832,267 (100%)	$23,962,851 (100%)	$1,362,595 (100%)	$29,157,713 (100%)
Savings:				
Contracts for:				
100% of Products	$164,376 (4.3%)	$3,322,718 (13.9%)	$132,640 (9.7%)	$3,619,734 (12.4%)
75% of Products	$123,282 (3.2%)	$2,492,039 (10.4%)	$99,480 (7.3%)	$2,714,801 (9.3%)
Use of Contracts:				
80% Compliance	$98,626 (2.6%)	$1,993,631 (8.3%)	$79,584 (5.8%)	$2,171,841 (7.4%)

4. **Estimate of Potential Savings for All Products for the 15 VAMCs.** To estimate the potential purchasing and contracting savings for all medical, prosthetic, and miscellaneous operating supply products purchased by the 15 VAMCs, we applied the potential combined purchasing and contracting savings rates for the sample products to the VAMCs' total expenditures for the three categories of products during the 6-month review period.

   For all three categories of products, the purchasing savings was $9,234,084. This equated to an 8.8 percent purchasing savings rate on the VAMCs' total expenditures of $105,171,508 for all medical care products. The contracting savings for all three categories of products was $5,826,772. This equated to a 5.5 percent contracting savings rate. The combined purchasing and contracting savings for all three categories of products was $15,060,856.

This equated to a 14.3 percent combined purchasing and contracting savings rate on the 15 VAMCs' total expenditures of $105,171,508. These calculations are shown in Table 9:

Table 9. Calculation of Potential Purchasing and Contracting Savings for Medical, Prosthetic, and Miscellaneous Operating Supplies for the 15 Audited VAMCs

	Supply Category			
	Medical	**Prosthetic**	**Misc. Operating**	**Combined**
Purchasing Savings				
All Product Expenditures	$40,349,472	$40,720,322	$24,101,714	$105,171,508
50 Product Savings Rates	7.1%	7.0%	14.6%	
Totals–All Product Savings	$2,864,812	$2,850,422	$3,518,850	$9,234,084 (8.8%)
Contracting Savings				
All Product Expenditures	$40,349,472	$40,720,322	$24,101,714	$105,171,508
50 Product Savings Rates	2.6%	8.3%	5.8%	
Totals-All Product Savings	$1,049,086	$3,379,787	$1,397,899	$5,826,772 (5.5%)
Combined Purchasing and Contracting Savings	$3,913,898	$6,230,209	$4,916,749	$15,060,856 (14.3%)

5. **Estimate of Annual VHA-Wide Potential Savings.** To estimate the annual VHA-wide potential savings that would result from improved purchasing and contracting, we applied the 8.8 percent purchasing savings rate and the 5.5 percent contracting savings rate for the 15 VAMCs to VHA's $1,492.9 million ($1.49 billion) in FY 2002 expenditures for medical, prosthetic, and operating supplies. This yielded estimated 1-year VHA-wide purchasing savings of $131.4 million and contracting savings of $82.1 million, for a combined savings of $213.5 million.

6. **Estimate of 5-Year VHA-Wide Potential Savings.** Over 5 years, VHA could save $860.0 million by improving purchasing and $537.5 million by awarding more national contracts and BPAs, for a combined estimated savings of $1,397.5 million ($1.40 billion). We calculated this estimate by applying the 8.8 percent purchasing savings rate and the 5.5 percent contracting savings rate for the 15 VAMCs to estimated expenditures of $9,772.5 million ($9.77 billion) for medical, prosthetic, and operating supplies over the 5-year period FYs 2004–2008.

   During the most recently completed 5-year period (FYs 1998–2003), expenditures for medical care supplies increased by an average of $71.9 million per year. We reached the $9.77 billion estimate of expenditures for the future 5-year period FYs 2004–2008 by applying the $71.9 million average annual increase to VA's FY 2004 budget estimate for medical, prosthetic, and miscellaneous operating supply expenditures. Table 10 shows the calculation of the 5-year potential purchasing and contracting savings for these supplies:

Appendix C

Table 10. Calculation of 5-Year VHA-Wide Potential Purchasing and Contracting Savings for Medical, Prosthetic, and Miscellaneous Operating Supplies ($ in Millions)

	Combined Supply Expenditures/Savings	Calculation Explanation
Historical Expenditures		
FY 1998	$1,202.2	
FY 1999	$1,244.3	$42.1 increase over FY 1998
FY 2000	$1,337.1	$92.8 increase over FY 1999
FY 2001	$1,489.2	$152.1 increase over FY 2000
FY 2002	$1,492.9	$3.7 increase over FY 2001
FY 2003	$1,561.6	$68.7 increase over FY 2002
5-Year Increase	$359.4	$359.4 Total FY 1998–2003 increases
Average Annual Increase	$71.9	$359.4 ÷ 5 years = $71.9
Estimated Future Expenditures		
FY 2004	$1,810.7	FY 2004 VA Budget Estimate
FY 2005	$1,882.6	FY 2004 estimate + $71.9
FY 2006	$1,954.5	FY 2005 estimate + $71.9
FY 2007	$2,026.4	FY 2006 estimate + $71.9
FY 2008	$2,098.3	FY 2007 estimate + $71.9
5-Year Total	$9,772.5	Rounded to $9.77 Billion
5-Year Potential Savings		
Purchasing	$860.0 (8.8%)	$9,772.5 x .088 savings rate
Contracting	$537.5 (5.5%)	$9,772.5 x .055 savings rate
Total	$1,397.5 (14.3%)	Rounded to $1.40 Billion

Appendix D

Audit Results for 50 Sample Supply Products

Tables 11 and 12 show the detailed audit results for each of the 50 sample products. Table 11 shows, by contract hierarchy level, which of the products were available on contracts or BPAs during the 6-month review period October 2001–March 2002. Table 12 shows the potential purchasing and contracting savings for each product at the 15 VAMCs during the review period.

Availability of Products by Contract/BPA Source. The results shown in Table 11 illustrate the need for VA to establish more national contracts and BPAs. Of the 50 sample products, only 16 (32.0 percent) were covered by national contracts or BPAs. The table shows the number of national contracts and BPAs, local BPAs, FSS contracts, and local contracts available for each product. For example, anti-embolism stockings were available on 1 national contract/BPA and 20 FSS contracts.

Table 11. Availability of Products by Contract/BPA Source

Product	Contract/BPA Source			
	National Contract/BPA	Local BPA	FSS Contract	Local Contract
Total Available (50 Products)	**16 (32.0%)**	**13 (26.0%)**	**43 (86.0%)**	**12 (24.0%)**
Medical Supplies (20 Products)				
Anti-Embolism Stockings	Yes – 1	No	Yes – 20	No
Balloon Catheters (Cardiac)	No	No	No	Yes – 3
Blood Glucose Test Strips	Yes – 3	No	Yes – 19	No
Cardiac Catheterization Packs	Yes – 1	No	No	Yes – 1
Central Venous Catheter Kits	No	No	Yes – 2	No
Disposable Diapers (Adult)	Yes – 1	No	Yes – 12	No
Electrosurgical Pencils	No	Yes – 1	Yes – 3	No
Examination Table Paper	Yes – 1	No	Yes – 1	No
Gauze Bandages	Yes – 1	No	Yes – 33	No
Nasal Cannulas (Disposable)	Yes – 1	No	Yes – 26	No
Patient Identification Wristbands	No	No	Yes – 2	Yes – 1
Pulse Oximeter Sensors	No	No	Yes – 1	No
Scalpels (Disposable)	Yes – 1	No	Yes – 21	No
Sharps Disposal Containers	Yes – 1	No	Yes – 6	No
Skin Closures	No	Yes – 1	Yes – 8	No
Skin Staplers (Disposable)	No	Yes – 1	Yes – 12	No
Surgical Gloves (Latex)	No	Yes – 1	Yes – 14	Yes – 1
Surgical Tape (Cloth)	No	No	Yes – 17	No
Sutures (Nonabsorbable)	No	Yes – 6	Yes – 10	No
X-Ray Film	No	Yes – 2	Yes – 5	No
Subtotals – Medical Supplies	**9 (45.0%)**	**6 (30.0%)**	**18 (90.0%)**	**4 (20.0%)**

Appendix D

Table 11 – Continued

Product	Contract/BPA Source			
	National Contract/BPA	Local BPA	FSS Contract	Local Contract
Prosthetic Supplies (20 Products)				
BIPAP Machines	No	No	Yes – 2	No
Blood Pressure Monitors	No	Yes – 1	Yes – 9	No
Closed Circuit Televisions	No	No	Yes – 1	Yes – 1
CPAP Machines	No	No	Yes – 2	Yes – 1
Coronary Stents	No	No	No	No
Electric Beds	No	No	Yes – 1	Yes – 3
Eyeglasses (Bifocals)	No	No	No	Yes – 4
Intraocular Lenses	No	No	No	No
Hearing Aids	Yes – 17	No	No	No
Hip Replacements (Left)	No	No	Yes – 3	No
Implantable Defibrillators	No	No	Yes – 2	No
Knee Replacements (Left)	No	No	Yes – 3	No
Oxygen Concentrators	No	No	Yes – 1	No
Pacemakers	No	No	Yes – 3	Yes – 1
Pacemaker Leads	No	No	Yes – 4	Yes – 1
Scooters	No	Yes – 3	Yes – 11	No
Scooter Lifts	No	No	Yes – 3	No
TENS Units	Yes – 1	No	Yes – 4	No
Wheelchairs (Power)	No	Yes – 2	Yes – 14	No
Wheelchairs (Manual)	Yes – 1	No	Yes – 9	No
Subtotals – Prosthetic Supplies	**3 (15.0%)**	**3 (15.0%)**	**16 (80.0%)**	**6 (30.0%)**
Operating Supplies (10 Products)				
HVAC Filters	No	No	Yes – 6	Yes – 1
Ballasts	No	Yes – 1	Yes – 16	No
Body Bags	Yes – 1	No	No	No
Body Soap	Yes – 2	Yes – 1	Yes – 28	No
Facial Tissue	No	No	Yes – 41	No
Laundry Detergent	No	No	Yes – 5	No
Slippers	Yes – 2	No	Yes – 10	No
Toilet Tissue	Yes – 1	No	Yes – 10	No
Toner Cartridges	No	Yes – 2	Yes – 175	Yes – 1
Writing Pens	No	Yes – 2	Yes – 35	No
Subtotals – Operating Supplies	**4 (40.0%)**	**4 (40.0%)**	**9 (90.0%)**	**2 (20.0%)**

Appendix D

Purchasing and Contracting Savings. Table 12 shows, for each of the 50 sample products, the potential purchasing and contracting savings that the 15 audited VAMCs could have achieved during the 6-month review period. The potential purchasing savings for all 50 products was about $2.7 million, and the potential contracting savings was about $3.6 million, for a total potential savings of about $6.3 million. Purchasing savings are the savings that the VAMCs could have achieved by purchasing the products from the best available sources. Contracting savings are the savings that could have been achieved if VA had awarded, and VAMCs had effectively used, more national contracts and BPAs.

Table 12. Purchasing and Contracting Savings

Product	Total Costs	Cost Savings					
		Purchasing		Contracting		Total	
		Amount	Percent	Amount	Percent	Amount	Percent
Totals (50 Products)	**$29,157,713**	**$2,691,813**	**9.2%**	**$3,619,734**	**12.4%**	**$6,311,547**	**21.6%**
Medical Supplies (20 Products)							
Anti-Embolism Stockings	$34,510	$3,821	11.1%	$1,660	4.8%	$5,481	15.9%
Balloon Catheters (Cardiac)	349,890	37,181	10.6%	15,986	4.6%	53,167	15.2%
Blood Glucose Test Strips	814,173	72,134	8.9%	0	0.0%	72,134	8.9%
Cardiac Catheterization Packs	215,959	26,914	12.5%	0	0.0%	26,914	12.5%
Central Venous Catheter Kits	157,083	0	0.0%	23,869	15.2%	23,869	15.2%
Disposable Diapers (Adult)	398,355	1,846	0.5%	29,992	7.5%	31,838	8.0%
Electrosurgical Pencils	35,225	3,191	9.1%	2,162	6.1%	5,353	15.2%
Examination Table Paper	38,862	2,556	6.6%	436	1.1%	2,992	7.7%
Gauze Bandages	146,719	1,069	0.7%	282	0.2%	1,351	0.9%
Nasal Cannulas (Disposable)	42,971	2,136	5.0%	3,854	8.9%	5,990	13.9%
Patient Identification Wristbands	31,807	18,434	58.0%	927	2.9%	19,361	60.9%
Pulse Oximeter Sensors	225,829	11,600	5.1%	22,716	10.1%	34,316	15.2%
Scalpels (Disposable)	15,822	1,383	8.7%	2,247	14.2%	3,630	22.9%
Sharps Disposal Containers	100,244	872	0.9%	0	0.0%	872	0.9%
Skin Closures	24,867	4,710	18.9%	1,397	5.7%	6,107	24.6%
Skin Staplers (Disposable)	63,729	8,826	13.8%	858	1.4%	9,684	15.2%
Surgical Gloves (Latex)	302,633	102,717	33.9%	13,857	4.6%	116,574	38.5%
Surgical Tape (Cloth)	88,618	10,843	12.2%	2,623	3.0%	13,466	15.2%
Sutures (Nonabsorbable)	261,462	31,637	12.1%	8,093	3.1%	39,730	15.2%
X-Ray Film	483,509	0	0.0%	33,362	6.9%	33,362	6.9%
Subtotals – Medical Supplies	**$3,832,267**	**$341,870**	**8.9%**	**$164,376**	**4.3%**	**$506,246**	**13.2%**
Prosthetic Supplies (20 Products)							
BIPAP Machines	$183,440	$19,265	10.5%	$19,257	10.5%	$38,522	21.0%
Blood Pressure Monitors	466,533	82,111	17.6%	58,782	12.6%	140,893	30.2%
Closed Circuit Televisions	630,670	144,718	22.9%	123,947	19.7%	268,665	42.6%
CPAP Systems	430,399	33,499	7.8%	107,936	25.1%	141,435	32.9%
Coronary Stents	1,180,475	87,682	7.4%	300,238	25.5%	387,920	32.9%

Appendix D

Table 12 – Continued

Product	Total Costs	Cost Savings					
		Purchasing		Contracting		Total	
		Amount	Percent	Amount	Percent	Amount	Percent
Prosthetic Supplies –Continued							
Electric Beds	$419,283	$26,880	6.4%	$110,902	26.5%	$137,782	32.9%
Eyeglasses (Bifocals)	1,870,318	297,831	15.9%	316,781	17.0%	614,612	32.9%
Hearing Aids	7,432,860	0	0.0%	0	0.0%	0	0.0%
Hip Replacements (Left)	981,356	172,719	17.6%	149,768	15.3%	322,487	32.9%
Implantable Defibrillators	1,607,640	188,470	11.7%	339,822	21.2%	528,292	32.9%
Intraocular Lenses	238,069	21,026	8.8%	57,207	24.1%	78,233	32.9%
Knee Replacements (Left)	1,164,216	259,620	22.3%	122,957	10.6%	382,577	32.9%
Oxygen Concentrators	182,049	11,252	6.2%	48,572	26.7%	59,824	32.9%
Pacemaker Leads	281,190	17,715	6.3%	74,688	26.6%	92,403	32.9%
Pacemakers	1,542,199	104,870	6.8%	401,918	26.1%	506,788	32.9%
Scooter Lifts	1,255,461	171,780	13.7%	240,782	19.2%	412,562	32.9%
Scooters	1,164,849	222,412	19.1%	160,373	13.8%	382,785	32.9%
TENS Units	169,630	14,618	8.6%	29,147	17.2%	43,765	25.8%
Wheelchairs (Manual)	387,905	3,879	1.0%	100,855	26.0%	104,734	27.0%
Wheelchairs (Power)	2,374,309	221,445	9.3%	558,785	23.6%	780,230	32.9%
Subtotals – Prosthetic Supplies	**$23,962,851**	**$2,101,792**	**8.8%**	**$3,322,718**	**13.9%**	**$5,424,510**	**22.7%**
Operating Supplies (10 Products)							
HVAC Filters	$123,130	$24,665	20.0%	$4,640	3.8%	$29,305	23.8%
Ballasts	29,788	3,962	13.3%	3,128	10.5%	7,090	23.8%
Body Bags	11,135	784	7.0%	0	0.0%	784	7.0%
Body Soap	62,280	9,633	15.5%	1,577	2.5%	11,210	18.0%
Facial Tissue	61,935	17,543	28.3%	5,425	8.8%	22,968	37.1%
Laundry Detergent	54,992	16,500	30.0%	4,704	8.6%	21,204	38.6%
Slippers	60,693	5,156	8.5%	0	0.0%	5,156	8.5%
Toilet Tissue	154,509	5,067	3.3%	5,039	3.3%	10,106	6.6%
Toner Cartridges	731,254	154,295	21.1%	70,504	9.6%	224,799	30.7%
Writing Pens	72,879	10,546	14.5%	37,624	51.6%	48,170	66.1%
Subtotals – Operating Supplies	**$1,362,595**	**$248,151**	**18.2%**	**$132,640**	**9.7%**	**$380,791**	**27.9%**

Appendix E

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit	Better Use of Funds
1a–1c and 2a	Improve purchasing practices by issuing guidance, providing training, and monitoring compliance with the purchasing hierarchy.	$860.0 million
2b	Increase efforts to award more national-scope contracts for supplies.	$537.5 million
	Total	$1,397.5 million ($1.40 billion)

Appendix F

Under Secretary for Health Comments

Department of Veterans Affairs

Memorandum

Date: FEB 24, 2004

From: Under Secretary for Health (10/10B5)

Subj: OIG Draft Report, *Audit of VA Medical Center Procurement of Medical, Prosthetic, and Miscellaneous Operating Supplies,* Project No. 2002-01481-R8-091 (EDMS Folder 251209)

To: Assistant Inspector General for Auditing (52VH)

1. Appropriate program offices have reviewed this draft report and we concur with the recommendations. Our plan for corrective action is attached, as is a supplemental submission of technical comments that are provided for additional clarification to the action plan. Regarding the estimate of monetary benefits, OIG has agreed that the $1,639.5 million FY 2003 costs shown in Table 10 of the draft report should be reduced by $77.9 million because of a double counting of these costs in the FY 2003 total. Therefore, it will change the FY 2003 costs shown in Table 10 of the report to $1,561.6 million, and the 5-year potential savings to $1.40 billion.[9] We will need additional time to study the information provided before concurring with your estimate of monetary benefit. We plan to charge a workgroup to review the information and provide their conclusions and recommendations for my consideration. The workgroup is expected to complete its work in the third quarter of FY 2004. In addition, using OIG's methodology, VHA is reviewing the volume and dollar amounts for supplies purchased in FY 2003, including the 50 items reviewed by the OIG. This review, is also expected to be completed in the third quarter of FY 2004, will provide data useful for determining the effectiveness of measures currently in place to enhance procurement practices.

2. Your audit report focused on purchase data from October 2001 to March. Since that time, VHA has taken significant steps to improve procurement practices, and we are already addressing many of the recommendations. For example, VHA issued a memorandum in December 2003 (attached) to the field mandating the use of the purchasing hierarchy. Training on the appropriate use of the contract hierarchy for all the field staff who purchase supplies and materials is scheduled to be completed and certified as completed by March 24, 2004. In addition, a representative of the Prosthetics Clinical Management group (PCM) has started attending the Clinical Logistics Office (CLO) Standardization group meetings, and likewise, a representative of the CLO Standardization group has started attending the National Acquisition Center (NAC) meetings. Improving communication between these groups is to ensure that national contracts are standardized when possible and that the contracts emphasize meeting the needs of the majority of patients, with quality first and pricing based on national volume.

[9] OIG Note: The $77.9 million figure refers to an error that VHA made in its reported supply expenditures for FY 2003. After the draft report was issued for comment, VHA discovered this error and reported it to us. To account for this error, we recalculated the potential savings shown in the draft report, resulting in the $1.40 billion savings shown in the final report.

Appendix F

Page 2
Assistant Inspector General for Auditing (52)

3. The Prosthetic and Sensory Aid Strategic Health Care Group (PSAS SHD) plans to have at least 85 percent of purchased prosthetic devices on A national contract in five years. PSAS SHD is also currently collecting data on compliance with VHA Directive 03-037, dated July 13, 2003 (Attachment B), that requires a standardized training program to improve prosthetics purchasing agent procurement authority above the $2,500 micro-purchase threshold. The compliance monitors have already been implemented, and the first report of findings is due by the end of the third quarter of FY 2004. VHA's Clinical Logistics Office will complete development of performance measures on the use of national contracts by March 31, 2004, with their implementation anticipated by June 2004. To further improve national compliance monitoring, the Clinical Logistics Office will soon hire an Acquisition Systems Analyst with specific job responsibility for supporting Network contracting and logistics management teams in the development and implementation of effective performance monitors.

4. You recommend that proposed local supply contracts be first approved by the National Acquisition Center. We believe mechanisms currently in development will address the intent of this recommendation. A CLO workgroup has been established to develop a Statement of Work (SOW) for a VHA mandated National Prime Vendor Program. Once fully implemented by the end of FY 2005, this program will eliminate the need for approximately 60 percent of local contracts. In addition, the VA Chief Financial Officer reorganization plan proposes realignment of responsibility for the Network CLO and Contract Managers (NCM). These positions would be responsible for the enforcement of compliance with contracting policies, including use of local contracts. In addition, VHA Directive 2003-018 and VHA Handbook 1761.1, issued in FY 2003, require the Chief Clinical Logistic Office, in coordination with the National Acquisition Center, to review VISN and multi-VISN standardization contracts for national expansion. The CLO will now review proposed Blanket Purchase Agreements before they are submitted to the NAC for approval. Lastly, 14 product lines and 39 CLO user groups were established in FY 2003 to roll-up and evaluate data nationally on medical and surgical supply purchases. These groups will help to ensure that cost-effective purchasing practices are in place.

5. Thank you for the opportunity to review the draft report. We appreciate the contribution of your audit team in helping us focus on opportunities for improvement in our procurement processes. If you have any questions, please contact Margaret M. Seleski, Director, Management Review Service (10B5), Office of the Under Secretary for Health, at (202) 273-8360.

(Original signed by:)
Robert H. Roswell, M.D.

Attachment

Appendix F

Action Plan for OIG Draft Report, Audit of VA Medical Center Procurement of Medical, Prosthetic, and Misc. Operating Supplies, November 19, 2003 OIG Project No. 2002-01481-R8-091

Recommendation 1a

The Under Secretary for Health needs to direct the full implementation of the purchasing hierarchy. The directive should outline an implementation strategy and specify procedures and time frames for VISNs and VAMCs to evaluate current purchasing practices and convert to the hierarchy approach. VHA Concurs.

Goal. Fully implement the purchasing hierarchy.

Strategy. Issue memorandum to the field mandating the use of the purchasing hierarchy by November 24, 2003.

Measure. N/A

Actual. Memorandum was issued on December 4, 2003 by 10N/10F

Strategy. Certify training on the appropriate use of the contract hierarchy to all field staff who purchase supplies and materials.

Measure. N/A

Actual. Training to be completed by March 31, 2004

Strategy. Improve communication between the current VHA Clinical Logistics Office (CLO) Standardization group and Prosthetics Clinical Management (PCM) process National Acquisition Committee (NAC) contracting groups. This improved communication and sharing of information is to ensure that the development of national contracts is standardized when possible and that the contracts emphasize meeting the needs of the majority of patients, with quality first and pricing based on national volume.

Measure. N/A

Actual. A representative of PCM has started attending the Clinical Logistics Office Standardization group meetings, and likewise, a representative of the CLO Standardization group has started attending the NAC meetings.

Recommendation 1b

The Under Secretary for Health needs to develop and implement comprehensive performance monitors to ensure that VISNs and VAMCs successfully make the transition to using the purchasing hierarchy and otherwise fully comply with all initiatives aimed at reducing medical care supply costs. VHA concurs.

Goal. Improve compliance with the use of the contracting hierarchy, as a means of transitioning to using the purchasing hierarchy.

Strategy. The VHA Clinical Logistics Office will develop and implement performance measures to measure compliance with the use of the national contracts.

Measure. To be developed.

Actual. Development of performance measures for compliance with the use of the national contracts is on-going and anticipated completion is March 31, 2004.

Strategy. Performance monitors for measuring the use of the purchasing hierarchy are dependent on the completion of CoreFLS, the new VA financial management system. CoreFLS is currently under development. For this reason, these performance monitors cannot be developed at this time.[1]

Measure. To be developed.

Actual. Implementation of the performance monitors for compliance with the use of the national purchasing hierarchy to begin when CoreFLS is expected to be operational: June 30, 2006.

Strategy. Hire an Acquisition Systems Analyst with one of the specific job duties being to support Network contracting and logistics management teams in the development and implementation of effective performance monitors to ensure strict compliance by all VHA procurement and contracting personnel with the VA contract hierarchy.

Measure. N/A

Actual. This position is planned to be filled no later than March 31, 2004. Implementation of the performance monitors to ensure strict compliance with the use of VA's contract hierarchy is expected to begin June 30, 2004.

Strategy. Although the monitoring process is continuous, the Prosthetic and Sensory Aids Service Strategic Health Care Group (PSAS SHG) will continue tracking national contract compliance at the facility and Network levels and submitting quarterly reports to the Deputy Under Secretary for Health for Operations and Management.

Measure. Network Directors will maintain compliance with national contracts for prosthetic devices when the contracts are implemented.

Target. 95 percent compliance.

Actual. Copies of Network compliance in using the available national contracts as of the end of FY 2003 compliance rates are provided as an Attachment A to this action sheet. Of the eight national contracts monitors, the Networks as a whole, achieve the 95 percent compliance rate on four of the eight contracts.

Recommendation 1c

The Under Secretary for Health needs to issue guidance requiring NAC review and approval of proposed local contracts for supplies. VHA concurs.

[1] It should be noted that micro-purchases under $2,500 do not reserve the use of a mandatory source, as per FAR.

Goal. Ensure that local contracts for supplies are reviewed and approved.

Strategy. VHA will mandate a National Prime Vendor program. Once fully implemented, this program will eliminate the need for approximately 60% of local contracts.

Measure. N/A

Actual. A Clinical Logistics Office (CLO) workgroup has been established for developing the Statement of Work for the Prime Vendor program. Completion of the Statement of Work is to be completed by January 2005. The full implementation of this program is expected by the end of FY 2005.

Strategy. The VA Chief Financial Officer reorganization plan includes the current reorganization of Network Chief Logistics Officers (CLO) and Network Contract Managers (NCM). These positions will be responsible for the enforcement of and compliance with contracting policies, and for the appropriate determination to use local contracts. This responsibility is included in the new NCM and CLO position descriptions.

Measure. N/A

Actual. The position descriptions have been sent forward to Human Resources. Target completion date is October 2004, pending the approval of the job descriptions and recruitment process under the CFO reorganization implementation plan.

Strategy. VHA Directive 2003-018 and VHA Handbook 1761.1, issued in FY 2003, require Clinical Logistics Office, in coordination with the National Acquisition Center (NAC), to review VISN and multi-VISN standardization contracts for national expansion. Additionally, 14 product lines and 39 user groups were established in FY 2003 to rollup data nationally on medical and surgical supply purchases, in coordination with the NAC.

Actual. Review of VISN and multi-VISN standardization contracts for national expansion by the NAC and the Clinical Logistics Office to begin by June 30, 2004. Monitoring of the rolled up national data on medical and surgical supply purchases by the 14 product lines and 39 user groups, in coordination with the NAC, is currently occurring There are currently 129 national product lines contracts in place for 2,390 line items.

Strategy. VHA will monitor “best practices” in local contracts, seeking opportunities to identify those that might be expanded into national contracts, as an added function of the NCM and CLO position descriptions, with bi-annual “best practice” reporting to the VHA CLO.

Actual. The position descriptions have been sent forward to Human Resources. Target completion date is October 2004, pending the approval of the job descriptions and recruitment process under the CFO reorganization implementation plan. Monitors will be developed once the NCM and CLO positions have been approved and recruited.

Recommendation 2a

The Under Secretary for Health and the Assistant Secretary for Management work together to provide VISN and VAMC purchasing staff training on the principles and requirements of the hierarchy approach and on the use of available sources of information for contracts, products, vendors, and prices. VHA concurs.

Goal. Ensure appropriate training of purchasing staff in requirements and principles of the hierarchy approach and available sources for purchases.

Strategy. Training on the appropriate use of the contract hierarchy is planned for all field staff members who purchase supplies and materials.

Measure. N/A

Actual. Training is underway. A copy of the memorandum sent to Network Directors by the Deputy Under Secretary for Health for Operations and Management dated December 4, 2003, directing them to certify this training completed by March 31, 2004, is provided as Attachment C to this action plan.

Strategy. PSAS SHG is currently collecting data on compliance with VHA Directive 2003-037: "Prosthetics Simplified Acquisition Procedures Training (SAP), "dated July 16, 2003. A copy of this Directive is provided as Attachment B. This directive provides a standardized training program to improve Prosthetics Purchasing Agent procurement authority above the $2,500 micro-purchase threshold.

Actual. Data is already being compiled on assessing who has completed the standardized training and who needs to take it. Target date for a report on compliance with this directive is due the end of the third quarter of FY 2004. It will be shared with the Clinical Logistics Office that is responsible for this directive and enforcing it is carried out.

Recommendation 2b

The Under Secretary for Health and the Assistant Secretary for Management work together to increase efforts to award more national-scope contracts, including FSS, committed use, and BPAs, for supply products. VHA concurs.

Goal. Increase the number of national scope contracts as appropriate.

Strategy. PSAS SHG plans to have at least 85% of purchased prosthetic devices on a National Contract.

Measure. 85% compliance with the use of the national contracts on purchased prosthetic devices.

Target. Achieve 85% compliance by the end of FY 2009.

Actual. Since January 2001, the PSAS has awarded ten National contracts.[2] Effective September 1, 2003, VA has a U.S. government courtesy price for the drug eluding coronary stent that applies to both direct purchases and purchases through consignment. PSAS SHG is in the process of developing national contracts as appropriate for the other prosthetic devices mentioned in the OIG audit, including eyeglasses, manual wheelchairs, and intraocular lenses.

[2] They are: blood pressure monitors, transcutaneous electric nerve stimulators, erection devices, closed circuit televisions, positive airway pressure machines (continuous and bi-level), pacemakers/ICDs, power scooters, walkers and aids for the blind.

Appendix F

Strategy. 95% compliance rate by Networks with existing Network Director performance monitor that states: "When National contracts for prosthetic devices are implemented, facilities will maintain at least a 95% compliance rate, unless a valid reason exists otherwise."

Measure. PSAS SHG will continue to monitor compliance with the existing Network Director performance monitor that stipulates that facilities will maintain at least a 95% compliance rate, in the use of the national contracts for prosthetic devices when they are implemented. Networks that fail to achieve this compliance rate are required to submit an action plan to PSAS SHG describing specific measures to be taken to improve Network performance.

Target. A 95 percent compliance rate will be achieved by the Networks on this performance measure by the end of FY 2005.

Actual. Copies of Network compliance to this performance monitor as of the end of FY 2003 are provided as Attachment A to this action sheet. Of the eight national contracts for prosthetic devices, the Networks achieved the 95% compliance rate on four of the contracts, as of end of FY 2003 cumulative reports.

Strategy. VHA Directive 03-018, dated July 17, 2003 states: "It is VHA policy to standardize to the maximum extent possible, the types and kinds of supplies and equipment it purchases, consistent with clinical and practitioner needs. Items designated as VHA standard items are considered mandatory for use by all VHA activities.

Measure. To be developed.

Actual. CLO will have the proposed process for reviewing the standardization of contracts completed by June 30, 2004. Monitors for reviewing standardization of purchases are to be implemented by end of FY 2004.

Appendix G

Assistant Secretary for Management Comments

Department of Veterans Affairs

Memorandum

Date: DEC 29 2003

From: Deputy Assistant Secretary for Acquisition and Materiel Management (049)

Subj: Draft Report: Audit of VA Medical Center Procurement of Medical, Prosthetic, and Miscellaneous Operating Supplies (Project No. 2002-01481-R8-091)

To: Assistant Inspector General for Auditing (52VH)

The Office of Acquisition and Materiel Management (OA&MM) concurs with the content of Audit of VA Medical Center Procurement of Medical, Prosthetic, and Miscellaneous Operating Supplies Draft Report with the following comments:

- Recommendation 1.c. which states "Issue guidance requiring NAC review and approval of proposed local contracts for supplies."
    - The NAC's expertise and niche are in establishing nationwide contracts for health care related products and services. It is recommended that facilities submit to the NAC, for information purposes only, those local contracts that pertain to Federal Supply Classes 65 (Medical and Surgical Supplies) and 66 (Laboratory). Once received, the NAC will review the local awards to potentially establish a National Contract or a Contract under Federal Supply Classes 65 and 66. The original intent of the Procurement Reform Task Force (PRTF) was to have OA&MM and the Veterans Health Administration (VHA) establish policies, procedures, and oversight as it pertains to VA's Federal Supply Schedule under Federal Supply Classes 65 and 66.
- Mechanisms in Place
    - OA&MM has created a new Blanket Purchase Agreement (BPA) website in accordance with PRTF Recommendation 1.1.4. VHA customers can identify various BPAs already in place either at the national, regional or local level. Department of Veterans Affairs Medical Centers (VAMC) who may be contemplating a BPA can review this site and request more information from the facility/location with a BPA for similar items or request to be added to an existing BPA.

2.

Assistant Inspector General for Auditing (52VH)

- The new Information Letter (IL) 049-03-1, Priorities for use of Government Supply Sources, dated November 20, 2002, requires VAMCs to review existing NAC contracts and programs and document findings before executing any local or open market contract.

- Timeliness of Report
  - The OIG review consisted primarily of purchases and contracts performed by the VAMCs prior to the issuance of the IL. VHA is ultimately responsible for providing oversight and compliance to the IL at the local level.

- Projected Reduction in Supply Costs
  - The Office of Acquisitions agrees that savings can be realized by improving procurement practices described in the draft report. However, the validity of the projected cost savings of $1.5 billion over 5 years is questionable since cost savings is based on extrapolated projected cost savings from 15 acquisition facilities throughout VA. The type and quantity of supplies and services bought from one VAMC to another may vary.

- VA Needs to Award More National-Scope Contracts and BPAs.
  - This recommendation is consistent with Goal Number 1 Leverage Purchasing Power of VA in the Secretary's PRTF Report. However, this initiative should be executed in concert with current anti-bundling legislation.

- Action to be completed by OA&MM
  - In conjunction with VHA, OA&MM will ensure that knowledge of the IL and website is disseminated to field activities through outreach at Chief Logistics Office Symposiums; Acquisition Leadership Seminars; and any other appropriate vehicles.

(Original signed by:)
David S. Derr

Automated VA Form 2105

Appendix H

OIG Contact and Staff Acknowledgments

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Appendix I

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