Department of Veterans Affairs

OFFICE OF INSPECTOR GENERAL

Evaluation Of The Department Of Veterans Affairs Purchasing Practices

The Department of Veterans Affairs is not leveraging its buying power to obtain the best prices for items purchased.

Report No.: 01-01855-75

Date: May 15, 2001

Office of Inspector General
Washington DC 20420

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington DC 20420

Memorandum to The Secretary of Veterans Affairs (00)

Evaluation Of
VA Purchasing Practices

1. To assist you in the management of the Department of Veterans Affairs (VA) acquisition process, the Office of Inspector General (OIG) performed an analysis of data obtained during various OIG reviews relating to (i) vendors selling medical/surgical supplies and equipment, (ii) vendors selling pharmaceuticals to VA medical centers and (iii) the purchasing practices employed by VA's medical centers. Our analysis of VA's open-market buying and contracting practices, and our review of commercial buying and selling practices, has led us to the conclusion that VA is not leveraging its purchasing power through prudent acquisition practices to obtain best prices considering the volume of items purchased.

2. As a result of making Federal Supply Schedule (FSS) contracts non-mandatory sources of supply, there has been an increase in open-market purchases by VA medical centers, often without attempts by the centers to either negotiate prices or determine price reasonableness. The term "open-market" describes the purchase of goods and services that are not on contract. In increasing numbers, vendors have (i) withdrawn high-volume medical supply items from FSS contracts, (ii) refused to negotiate in good faith, (iii) cancelled contracts or (iv) not submitted proposals for FSS contracts. Notwithstanding the fact that these vendors no longer have contracts, they have not lost their VA market share because they continue to sell in large volumes to individual VA medical centers. In addition, they can sell products made in non-designated countries directly to VA facilities that they cannot sell on FSS or other contracts because of the Trade Agreements Act requirements. Also, our review of purchase card records, invoices, purchase orders, procurement history files and other related records, lead us to believe that VHA is purchasing open-market healthcare items in amounts greater than the 20-percent maximum allowed under Title 38 U.S.C. §8125(b)(3)(A). These conditions are a result of the widespread and essentially unmonitored, use of purchase cards in conjunction with the decentralization of purchasing authority to VA medical centers.

3. To alleviate these conditions and improve VA's buying practices, we believe VA management should consider the following: (i) that VA facilities be required to purchase items that are on national contracts, such as FSS, and that the FSS and other national

contracts be mandatory sources of medical/surgical supplies and equipment and pharmaceuticals unless otherwise determined by the Department's Procurement Executive; (ii) that local contracts be specifically prohibited unless authorized by the Department's Procurement Executive or designee; (iii) that VA implement a program to monitor local purchasing and hold local officials accountable for not complying with provisions in the Veterans Administration Acquisition Regulations (VAAR) and Federal Acquisition Regulations (FAR); and (iv) that policy be made limiting contracts with distributors to distribution services only unless the distributor can show that it is responsible for negotiating and establishing prices for items it distributes to the manufacturers' commercial customers.

4. This report was prepared as a result of our conversation on April 12, 2001, and is provided for your use and information. Although not required, any comments that you or your senior procurement officials choose to provide would be appreciated.

(Original signed by:)

RICHARD J. GRIFFIN
Inspector General

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RESULTS

During the past few years the effectiveness and integrity of the Federal Supply Schedule (FSS) program has deteriorated. Due to legislative initiatives requiring acquisition streamlining and reform, FSS is no longer a mandatory source. As a result, a growing number of vendors have cancelled existing contracts, decided not to submit proposals, removed high-dollar sales items from the contract or simply refused to offer Most Favored Customer (MFC) pricing. When the latter occurs, VA's National Acquisition Center (NAC) contracting officials are left in the difficult position of either (i) not awarding the contract, or specific line items, thus allowing the vendor to sell open-market to Government customers at higher prices than those offered under the solicitation, or (ii) accepting the prices offered with the knowledge that the Government is not being offered fair and reasonable prices. A vendor's ability to sell open-market in significant volumes effectively eliminates the Government's ability to leverage prices using its aggregate buying power.

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

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

(2) Vendors without contracts know that they can sell at any price to the medical facilities that simply place orders and make no attempt to negotiate prices. With simplified acquisition procedures, micro-threshold purchases, and the extensive use of purchase cards, open-market purchases have become widespread.

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

(4) Vendors can sell their products through distributors holding FSS contracts and thus avoid offering the Government MFC prices and shield themselves from pre- and post-award reviews of their pricing practices.

I. Local Contracting Practices Make FSS Undesirable to Vendors

In the past few years there has been a movement within VA to decentralize contracting to the Veterans Integrated Systems Networks (VISN) and local medical centers. Individual medical facilities and VISNs began to negotiate separate contracts or purchasing agreements with vendors of commercial item medical/surgical supplies and equipment. Based on discussions with local VA procurement officials, we found that their goal is to obtain better pricing than FSS pricing and thus claim a cost savings. Some contractors have cited this practice as the reason for not seeking an FSS contract or not offering MFC on the FSS contract. In essence, this penalizes VA because VA is no longer buying as an entire system of medical facilities. In these instances, local procurement efforts compromise national objectives and add unnecessary administrative and overhead costs.

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

In another matter, a large surgical supply vendor submitted a proposal offering its products at a 15-percent discount off list price. Based on past purchases by Government facilities, the anticipated FSS contract was valued at $85 million over a 5-year period of time. A pre-award review by the OIG revealed that the vendor's most favored customers were getting significantly larger discounts of up to 42 percent off list price. If the Government received comparable MFC pricing, the identified cost savings would be $8.4 million. Because the review did not identify any significant differences in the buying practices of comparable customers receiving MFC pricing, the OIG recommended that the contracting officer seek discounts comparable to the vendor's MFC. In response to the pre-award review, the vendor refused to offer MFC pricing and stated that: "The VA does not operate as a proprietary hospital chain. The VA Central Office does not enforce/control what individual VA Medical Centers purchase. The Federal Supply Schedule is not a mandatory source of supply." During contract negotiations, the vendor made it clear that it was willing to offer small percentage discounts on the FSS and enter into separate agreements with individual medical centers that "committed" to buying the products. It was determined that this was not cost-effective for the Government because the Department would incur additional administrative costs to negotiate separate agreements with individual facilities. More importantly, overall the Government would pay more for the product because most facilities would not enter into separate agreements; therefore, the vendor would realize a greater profit margin due to the larger volume of FSS sales. Increased profit margins from Government sales help vendors finance deep discounts to lower volume commercial customers.

The advantage of using the FSS is the cost savings to both the vendor and VA. Cost savings are achieved by both parties with the preparation of one solicitation, one offer and undergoing one set of negotiations. It is not cost-effective for each medical center

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

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

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

- FSS contracts contain clauses not found in other Government contracts, including national contracts awarded by VA, that protect the Government's interest over the term of the contract. The price reduction clause requires the vendor to offer price reductions it offers to an agreed upon comparable commercial customer or category of customer. This clause ensures that the Government maintains commercially favorable pricing throughout the term of the contract. Price reduction clauses are found in most commercial contracts. FSS contracts also contain clauses which allow the Government to review the vendor's records before and after a contract is awarded and hold the vendor accountable to reimburse the Government for overcharges incurred as the result of the vendor's failure to provide accurate, complete or current sales and marketing data during contract negotiations or failure to comply with the terms and conditions of the price reduction clause. Since 1993, the OIG, in conjunction with the Office of Acquisition and Materiel Management (OA&MM), has collected in excess of $130 million for overcharges relating to defective pricing and price reduction violations. Most of the money collected was returned to VA's Supply Fund.

- FSS contracts provide VA facilities with a wide choice in pharmaceuticals, medical/surgical supplies, and equipment to better meet the needs of the

veteran patient. Having the items on contract enables healthcare providers to purchase what they need, when they need it and in small or large quantities at a negotiated price. When contracts are not in place, procurement of items may be delayed while prices are negotiated or facilities will pay higher prices by purchasing on the open-market.

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

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

II. There Is No Incentive To Negotiate Prices

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

For example, a pre-award review of a proposal for a vendor that sells orthopedic implants showed that the vendor's offer of a 10-percent discount off list price was significantly less than discounts given to their most favored customers, which ranged from 25.48 percent to 41.75 percent in four categories of products. The pre-award review further identified an anticipated cost savings of approximately $3.1 million over the life of the contract if the FSS prices were comparable to the vendor's MFC prices.[1] When the NAC contracting officer attempted to negotiate MFC pricing, the contractor withdrew its offer and stated that it could sell open-market without a decrease in sales. VA procurement records confirm the vendor's prediction. Combined purchase card and

[1] If awarded, the expected annual sales were approximately $6 million.

VA medical center payment records show that VA medical centers purchased approximately $6.9 million via open-market purchases from this vendor in Calendar Year (CY) 2000.[2] We identified sales to 101 VA medical centers. Sixteen medical centers purchased more than $130,000 with 8 of the 16 showing purchases that exceeded $250,000. The $6.9 million in sales represents VA purchases only; it does not include sales to other Government entities that traditionally purchase off the FSS.

In another matter, a large manufacturer of medical/surgical supplies, whose product line includes cardiac stents, was awarded two FSS contracts in FY 1991. When one of the contracts expired in December 1999, the vendor chose not to submit a proposal for a new contract. The second contract was extended through September 2000, but only contained 16 small dollar accessory items. VA's Procurement History File (PHF) showed that this vendor's FSS sales for FY 1999 totaled $7.6 million compared to $22.7 million in open-market sales. VA payment records for CY 2000 show approximately $42 million in sales[3] by 114 VA medical centers of which only $306,000 was identified as FSS.

Further review of purchase card and direct payment records for sales to this company identified 13 medical centers whose purchases exceeded $1 million each, with 2 of the 13 medical centers having purchased over $2 million each. Combined, the 13 medical centers purchased $18,084,921, which represents 43 percent of the vendor's total sales for CY 2000. PHF data for the 4th quarter of CY 2000 showed $4.7 million in reported sales to this vendor of which $1.33 million (28 percent) was purchased by six medical centers. According to the PHF, the six facilities purchased $1 million in open-market purchases compared to $334,000 in contract sales.[4] One medical center reported $143,000 in FSS sales. We compared the FSS product list with the products the medical center identified as FSS sales and found that none of the items listed as FSS sales was on contract.[5]

Our Combined Assessment Program (CAP) reviews at 2 New York VA medical centers, identified 70 separate purchases of cardiac stents for more than $850,000 in a 15-month time period. Further review showed that all of the purchases were open-market and the medical centers paid list price. The items were not on FSS or other national contracts and the medical centers did not issue a solicitation to obtain competitive pricing and there was no evidence of price negotiation. Similar non-competitive purchases of cardiac stents were identified during the CAP review at a VAMC in New Jersey, and in our review of purchase card transactions and the PHF. Discussions with

[2] Purchase card records show purchases totaling $5.2 million and FMS payment records show $1.7 million in payments directly to the vendor.
[3] $26.7 million in purchase card transactions and $15 million in direct vendor payment purchases.
[4] One of the medical centers had awarded two competitive contracts to this vendor. One contract was for cardiopulmonary bypass supply packs and the other for pacemakers.
[5] We have questioned the completeness and accuracy of the information in the PHF. The information contained in the files is provided by the individual medical centers. It is not clear that all purchases, particularly purchase card transactions are included. In addition, we have found items that were identified as being on contract when, in fact, they were not. However, the inaccuracies in the system tend to understate, not overstate, the number of transactions and the volume of sales purchased using an FSS or other contract.

the NAC revealed that none of the manufacturers of cardiac stents included these items on their FSS contracts and at least one contractor removed stents from its FSS contract. One manufacturer, whose product line includes cardiac stents, that does not have an FSS or other VA contract, sold approximately $25 million of its product to VA medical centers in CY 2000. [6] Another manufacturer sold $24.4 million to VA facilities in CY 2000 of which only $247,000 were FSS sales.[7] [8]

CAP reviews have consistently identified purchases of items such as pharmaceuticals and prosthetics that are not on contract and for which there was no competition or other evidence of price negotiation. One New York VA medical center purchased significant amounts of prosthetics open-market from a single non-FSS vendor. There was no competition and no justification for sole source selection. We determined that comparable items were on FSS at prices that ranged from 20-40 percent less than the medical center paid for the items.

III. Purchasing Prohibited Contract Items On The Open-Market Undermines The Integrity Of The Program

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

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

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

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

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

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

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

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

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

One of the items that we received the most complaints about was examining gloves. A review of the PHF disclosed that VA customers purchased the preponderance of examining gloves on an open-market basis. We selected one large medical/surgical supplier for review because of the volume of the gloves sold open-market. This company previously had paid over $6 million to settle a civil fraud case involving Trade Agreements Act violations. In discussions with the company, we were advised that it did not include top-selling examining gloves on the company's FSS contract because the items were manufactured in non-designated countries and could not be offered on contract. Using the PHF data, we identified 19 different examining gloves that the

company sold to VA customers as open-market items. For the period of July 1998 through June 1999, this company had $14,089,923 in open-market sales of which the examining gloves totaled $1,572,614 or 11 percent of the open-market sales. The open-market sales of the gloves represented about 8 percent of the company's total reported Government sales of $18,754,505.[11] Gloves are but one of many items manufactured in non-designated countries that this company sells open-market to VA facilities. By using open-market transactions, the company and VA customers have avoided prohibitions and defeated public policy against purchasing items from non-designated countries.

We identified a second vendor of examining gloves whose reported Government sales for the period July 1998 through June 1999 totaled $45.6 million of which only $7 million (15.3 percent) represented FSS sales. Payment records for CY 2000 showed $33.1 million in sales to VA facilities of which $6.4 million (19 percent) were reported as FSS sales. This vendor's FSS contracts did not contain the vendor's entire product line. A vendor representative informed us that the vendor does not offer more items on the FSS because (i) items are foreign-source products that do not meet FSS requirements; (ii) it is a tedious process to ensure the data provided for an FSS offer is current and complete; and, (iii) tracking price changes for price reduction purposes is a significant administrative burden.

A third vendor we reviewed sold hospital gowns and surgical apparel. This company had an FSS contract from July 1992 to October 1997 when the contract was cancelled at the vendor's request. The vendor only offered about 10 percent of its product line on the contract. Over the life of the contract, the vendor sold almost $13 million to Government customers of which only 27 percent were FSS items. Records show that after the company terminated its FSS contract, it continued to make significant sales to VA customers. We identified four vendors who had comparable items on FSS and compared prices. The prices for the vendor without the FSS contract were lower which generated more sales. Upon request, the vendor provided information regarding the place of manufacture for 10 of the 11 items in our sample. This information revealed that 7 of the 11 items were manufactured in non-designated countries and could not be included on an FSS contract; 2 items appeared to have been partially manufactured in designated countries, but we did not have sufficient information to determine whether they could have been included on FSS. Only one of the items was manufactured in the United States. The ability to sell products manufactured in non-designated countries so readily on an open-market basis to VA facilities, affects the integrity of the FSS system.[12] Vendors are able to obtain a significant sales advantage by selling less expensive foreign made products to the detriment of vendors who comply with Government laws and regulations and market products made in the United States or designated countries.

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

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

IV. Vendors Are Using Distributors to Avoid Contract Requirements

Some medical/surgical vendors that contract directly with their commercial customers but distribute their products through distributors have chosen to sell their products to Government entities only through distributors who have FSS contracts. This process allows vendors to sell their products in significant volumes to Government customers while shielding themselves from audits of pricing violations, and compliance with other FSS contract clauses, including the price reduction clause and certifications that the products are made in the United States or a designated country.

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

We are aware of at least two large manufacturers who have chosen to sell to the Government primarily through distributors who have or are trying to negotiate FSS contracts. Both manufacturers were the subject of civil and/or administrative actions for defective pricing and price reduction violations. In one case, our preliminary work on a pre-award review indicates that the Government is the distributor's primary customer[13] and the contract is valued at $70 million. This raises the question of whether the distributor is just a shell to allow the manufacturer to sell its products to the Government on contract and at higher prices than VA would request if the manufacturer negotiated its own FSS contract. Although the provisions of Commercial Sales Practices Format

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

would require a distributor without significant commercial sales to submit data from the manufacturer, any pre- or post-award reviews may be limited to the information contained in the distributor's records.[14] The manufacturer would not be required to open its books and records for a pre- or post-award inspection.

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

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

V. Considerations for Improving VA Buying Practices

To alleviate the conditions described above and improve VA buying practices, we believe that VA management should consider the following:

1. Require VA facilities to purchase items that are on national contracts, such as FSS, by making FSS and other national contracts mandatory sources of medical/surgical supplies and equipment and generic pharmaceuticals unless otherwise determined by the Department's Procurement Executive.

2. Specifically prohibit the award of local contracts for commercial items unless authorized by the Department's Procurement Executive or designee.

3. Implement a program to monitor local purchasing and hold local officials accountable for not complying with VAAR and FAR requirements.

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

4. Implement a policy limiting contracts with distributors to distribution services only unless the distributor can show that it is responsible for negotiating and establishing prices for the majority of items it distributes to each manufacturer's commercial customers.

OBJECTIVE AND SCOPE

Objective

The purpose of the evaluation was to provide an analysis of our observations on the effect that the use of purchase cards and local contracting in connection with the decentralization of purchasing authority has had on the use of the Federal Supply Schedule and the resulting increase in costs to the Government for medical/surgical supplies and equipment.

Scope

This evaluation is a summary and analysis of data obtained during various Office of Inspector General (OIG) reviews relating to vendors selling medical/surgical supplies and equipment and pharmaceuticals to VA medical centers and the purchasing practices of these facilities. The data was obtained through a number of OIG activities including: pre- and post-award reviews of Federal Supply Schedule (FSS) contracts, Combined Assessment Program (CAP) reviews, investigations of Hotline complaints regarding individual contractors and medical center contracting practices, and operational audits.

BACKGROUND

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

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

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

Report Distribution

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