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VETERANS HEALTH ADMINISTRATION

Financial Efficiency Inspection of the VA North Texas Health Care System

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Executive Summary

The VA Office of Inspector General (OIG) conducted this inspection to assess the oversight and stewardship of funds by the VA North Texas Health Care System and to identify potential cost efficiencies in carrying out healthcare system functions.[1] To accomplish this goal, the OIG identified four financial activities and administrative processes—(1) use of managerial cost accounting information, (2) open obligations oversight, (3) purchase card use, and (4) inventory and supply chain management—that draw on considerable VA financial resources to determine whether the healthcare system had appropriate controls and oversight in place, and made recommendations to promote the responsible use of VA's appropriated funds.

What the Inspection Found

The team conducted its inspection from June 2023 to January 2024, including a site visit at the VA North Texas Health Care System during the week of June 26, 2023; interviewed healthcare system leaders and staff; and reviewed data, supporting documents, and processes related to the healthcare system's financial efficiency. The inspection is limited in scope and not intended to be a comprehensive review of all financial operations at the facility. For more information about the inspection's scope and methodology, see appendixes A and B.

The team identified several opportunities for improvement in the areas inspected:

Use of managerial cost accounting information. The inspection team used Financial Management System (FMS) reports to identify that healthcare system obligations grew by almost $304.3 million (20 percent) from about $1.5 billion in fiscal year (FY) 2020 to more than $1.8 billion in FY 2022. The team reviewed the healthcare system's monthly budget updates for September 2022 and FY 2023. This reporting provided evidence that the healthcare system is using financial information to compare budgeted amounts to actual results as described in VA policy.

The inspection team also compared healthcare system financial management practices with federal financial accounting standards. Using document reviews and interviews with healthcare system leaders, the inspection team determined that the healthcare system's managerial cost accounting information was not used for the essential purposes of performance measurement, budgeting, and cost control, or for making economic choices as described in the federal financial accounting standards. The OIG therefore found the use of cost accounting information could be improved at the healthcare system. Specifically, the healthcare system did not always use cost

[1] The North Texas Health Care System serves veterans at 16 locations, which include the Dallas VA Medical Center, Garland VA Medical Center, Sam Rayburn Memorial Veterans Center in Bonham, and community-based outpatient clinics in Dallas, Decatur, Denton, Fort Worth, Granbury, Grand Prairie, Greenville, Plano, Sherman, and Tyler.

accounting information to enhance efficiency, help reduce costs, or inform business decisions. Further, the OIG determined that managerial cost accounting is not a fundamental part of financial management activities at the healthcare system and the cost accounting data were not always accurate. The healthcare system did not provide evidence that cost accounting information or reports were used consistently to enhance efficiency, help reduce costs, or inform business decisions as described in VA policy.[2]

Open obligation oversight. The inspection team evaluated whether the healthcare system followed VA policy by performing monthly reviews and reconciliations of sampled open obligations to ensure they were valid and should remain open and to reconcile end dates and order amounts between the FMS and the Integrated Funds Distribution, Control Point Activity, Accounting and Procurement System (IFCAP).[3] The OIG found that the healthcare system did not always comply with policy to perform monthly reviews and deobligate funds that were no longer needed.[4] Further, the team's review of the reconciliation of FMS and IFCAP noted that, generally, the end dates and order amounts matched. However, as part of the end dates review, the team identified where the healthcare system used funds obligated for a future fiscal year to pay for current-year services, which may have violated the "purpose" statute and the "bona fide needs" rule.[5] As a result of the healthcare system's lack of monthly follow-up and reconciliations, the team conservatively estimated that almost $14 million in open obligations were invalid.[6] Of those, the team conservatively estimated that just over $12.2 million should have been deobligated and could have been put to better use.[7]

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[2] VA Financial Policy, "Managerial Cost Accounting (MCA)," in vol. 13, *Cost Accounting* (December 2019), chap. 3.

[3] Open obligations include those obligations that are not considered closed or complete and have a balance associated with them, whether undelivered or unpaid. Both FMS and IFCAP are accounting systems, with FMS considered the primary one that interfaces with IFCAP. A transaction's end date (which is critical to determining whether an obligation should remain open) may be modified due to delays or scope changes. The modification may not be recorded in both systems because staff can manually change end dates in one system without changing them in the other. VA Financial Policy, "Obligations Policy," in vol. 2, *Appropriations, Funds and Related Information* (April 2022), chap. 5.

[4] Deobligation means a cancelation or downward adjustment of previously incurred obligations. VA Financial Policy, *"Obligations Policy."*

[5] 31 U.S.C. § 1301(a), known as the "purpose" statute, states that, except as otherwise provided by law, appropriations shall be applied only to the objects for which the appropriations were made. 31 U.S.C. 1502(a), or the "bona fide needs" rule, states that an appropriation may be obligated only to meet a legitimate need arising during the appropriation's period of availability.

[6] The inspection team considered obligations as invalid when the healthcare system could either not provide documentation that services still needed the funds or confirmed the funds were no longer needed.

[7] Deobligation means a cancellation or downward adjustment of previously incurred obligations. VA Financial Policy, "Obligations Policy." The better use of funds is related to various open obligation monitoring and administrative deficiencies identified in the sampled obligations. This amount includes at least $633,000 from undelivered orders, an estimated $11.4 million from accruals, and undelivered orders totaling over $186,000 due to end-date discrepancies, which brought the total monetary benefits to just over $12.2 million.

Purchase card use. The team examined whether healthcare system staff complied with purchase card program policies and procedures and considered using contracts for frequently purchased goods or services—a process known as strategic sourcing—to provide optimal savings to VA. The inspection team identified a statistical sample of 66 purchase card transactions totaling about $292,000 from May 1, 2022, through March 31, 2023, and reviewed whether the sampled transactions were processed in compliance with VA policy concerning prior approvals, prompt reconciliations, record retention, and segregation of duties throughout the transaction process.[8] Based on the results of the sample, the OIG projected errors could exist in approximately 25,000 of 86,659 transactions, or 29 percent, totaling approximately $24.1 million in questioned costs.[9] The OIG also determined that contracts could have been considered for an estimated 15,900 transactions totaling at least $15.4 million. The violations included lack of supporting documentation and untimely reconciliations.

Forty-one of the 66 sampled transactions, totaling about $244,200, were also reviewed to determine if cardholders intentionally split a single purchase into two or more purchases to avoid exceeding the micropurchase threshold. After reviewing transaction documentation and interviewing cardholders and approving officials, the OIG projected that at least 221 transactions totaling at least $898,000 were split. Interviewees said this was done to circumvent the slow contracting process and obtain the products faster. Cardholders and approving officials did not always ensure compliance throughout the transaction process and fulfill roles and responsibilities in accordance with VA policy.[10] VA Form 0242, which delegates authority to an individual to use a VA purchase card, was maintained by the healthcare system for each cardholder in the inspection sample.[11]

Inventory and supply chain management. The inspection team evaluated whether staff managed the healthcare system's supply chain operations effectively using the days-of-stock-on-hand performance metric, a nationally set level of inventory for expendable Medical Surgical Prime Vendor (MSPV) program items and non-MSPV items that facilitates

[8] VA Financial Policy, "Government Purchase Card for Micro-Purchases," in vol. 16, *Charge Card Programs* (May 2022), chap. 1B.

[9] 2 C.F.R. § 200.1. "Questioned cost means a cost that is questioned by the auditor because of an audit finding: (1) Which resulted from a violation or possible violation of a statute, regulation, or the terms and conditions of a Federal award, including for funds used to match Federal funds; (2) Where the costs, at the time of the audit, are not supported by adequate documentation; or (3) Where the costs incurred appear unreasonable and do not reflect the actions a prudent person would take in the circumstances. (4) Questioned costs are not an improper payment until reviewed and confirmed to be improper as defined in OMB Circular A–123 appendix C." Purchase card transactions with multiple types of noncompliance issues were only included once for the purposes of calculating this projection. Consideration was also given to margin of error and median confidence level when projecting questioned costs. For additional information regarding projection totals, see appendixes A and B.

[10] VA Financial Policy, "Government Purchase Card for Micro-Purchases."

[11] VA Financial Policy, "Government Purchase Card for Micro-Purchases."

efficient purchasing and use of supplies.[12] The OIG found the healthcare system could benefit from improving the efficiency of inventory oversight by ensuring inventory values are recorded correctly in the Generic Inventory Package. Specifically, healthcare system supply chain management staff failed to adequately monitor conversion factors entered in the inventory system and properly record the distribution of supplies for two inventory areas reviewed by the inspection team.[13] This led to increased reliance on manual counts and inaccurate inventory values, which required manual adjustments to correctly record inventory in the Generic Inventory Package. The OIG found the healthcare system did not conduct thorough supply chain management oversight or establish and follow inventory procedures.

What the OIG Recommended

The OIG made 9 recommendations for improvement: eight to the healthcare system director, and one to the Veterans Integrated Service Network (VISN) 17 director. The intent is for system leaders to use these recommendations as a road map to improve financial operations. The recommendations address issues that, if left unattended, may eventually interfere with financial efficiency practices and the stewardship of VA resources.

In the area of managerial cost accounting information, the OIG recommended the healthcare system director establish a plan to use VA's cost accounting system information and align financial management practices with federal financial accounting standards. Healthcare system staff should also promptly respond to and correct issues identified during managerial cost accounting audits.

Staff should also be made aware of policy requirements to review open obligations, and the healthcare system director should consult with the Office of General Counsel and the Office of Acquisitions, Logistics and Construction to determine if any further actions are necessary, including contract modifications to remedy and prevent future violations of the purpose statute and bona fide needs rule.

To strengthen oversight of purchase card transactions, the OIG recommended the healthcare system director establish controls to ensure cardholders comply with record retention requirements, confirm approving officials and cardholders review purchases for VA policy compliance, and ensure contracting is used when it is in the best interest of the government. The

[12] MSPV is a national program providing a customized distribution system to meet or exceed facility requirements through an efficient, cost-effective, just-in-time distribution catalog ordering process.

[13] A conversion factor is a number used to convert a measured quantity to a different unit of measure without changing the relative amount. In the Generic Inventory Package, a conversion factor is a number used to change the unit of receipt to the unit of issue.

OIG further recommended that the VISN 17 director require cardholders to submit ratification requests for any identified unauthorized commitments.[14]

For inventory and supply management, the healthcare system director should ensure all necessary reports are monitored routinely, all supply chain performance measures are maintained in compliance with policy, and data in the Generic Inventory Package are accurate and reliable.

VA Comments and OIG Response

The executive medical center director of the North Texas VA Health Care System concurred with all eight recommendations addressed to the healthcare system and provided corrective action plans. The VISN 17 director concurred with the recommendation addressed to VISN 17 and with the action plan provided by the executive medical center director. The OIG considers all recommendations open. The OIG will monitor the implementation of the planned actions and will close the recommendations when the North Texas VA Health Care System provides sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified. Appendix D includes the healthcare system executive medical center director's comments.

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[14] FAR 1.602-3 (August 2022). "Ratification of unauthorized commitments" defines ratification as the act of approving an unauthorized commitment by an official who has the authority to do so.

Contents

Abbreviations

FMS	Financial Management System
FORCE	Forecast of Opportunities and Requirements Center for Excellence
FY	fiscal year
IFCAP	Integrated Funds Distribution, Control Point Activity, Accounting and Procurement System
MSPV	Medical Surgical Prime Vendor
OIG	Office of Inspector General
OPES	Office of Productivity, Efficiency and Staffing
SCCOP	Supply Chain Common Operating Picture
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducts financial efficiency inspections to assess stewardship and oversight of funds at VA healthcare systems and to identify opportunities to achieve cost efficiencies. Inspection teams identify and examine financial activities that are under the healthcare system's control and can be compared to Veterans Health Administration (VHA) healthcare systems similar in size and complexity to promote best practices.

This inspection focused on the VA North Texas Health Care System. The OIG assessed four financial activities and administrative processes to determine whether appropriate controls and oversight were in place from October 2021 through June 2023:

I. **Use of managerial cost accounting information.** Managerial cost accounting identifies, measures, and analyzes cost information to help managers make informed decisions about allocating federal resources, authorizing and modifying programs, and evaluating program performance. The team evaluated how VA North Texas Health Care System officials used VA's managerial cost accounting system to identify the cost of goods and services, review available workload data, identify alternatives to reduce costs, enhance efficiency, and make effective business decisions. Using reliable and timely cost information when making spending decisions helps to achieve the expected results and reduces the risk of waste and inefficiency.

II. **Open obligations oversight.** An obligation is a legally binding commitment of appropriated funds for goods or services.[15] Open obligations include those that are not considered closed or complete and have an unliquidated balance associated with them.[16] They can be either undelivered orders or delivered unpaid orders, known as accruals.[17] VA financial policy requires all finance offices with open obligations perform monthly reviews to ensure that their obligations are valid, beginning and ending dates are accurate, and open and accrued balances are accurate and agree with source documents, such as contracts and purchase orders, receiving reports, invoices, and payments.[18] VA is also required to deobligate stale obligations not established by a contracting officer unless the

[15] VA Financial Policy, "Obligations Policy," in vol. 2, *Appropriations, Funds, and Related Information* (April 2022), chap. 5.

[16] The term "unliquidated financial obligation" means an obligation incurred by a nonfederal entity that has not been paid (liquidated) or for which the expenditure has not been recorded. 2 C.F.R. § 200.1 (2021).

[17] Undelivered orders are supplies and services that have been approved and awarded on an obligation but have not been delivered to or accepted by the government. This includes any orders for which advance payment has been made, but delivery or performance has not yet occurred.

[18] VA Financial Policy, "Obligations Policy."

initiating service can demonstrate that the obligations are valid and should remain open.[19] For obligations established by a contracting officer, the initiating service must coordinate necessary actions to deobligate with the logistics and acquisitions office. The inspection team evaluated whether the healthcare system performed monthly reviews and reconciliations of sampled obligations to ensure validity of the balance and prompt deobligation of excess funds. Any excess funds should be promptly deobligated, as failure to do so increases the risk that unused funds will not be reallocated for other goods and services to benefit veterans or will be returned to the US Department of Treasury. The proper management of accruals helps prevent the disbursement of funds for goods or services not received and also helps prevent misstatements in VA's annual financial statements.

III. **Purchase card use.** VA's Government Purchase Card Program was established to reduce administrative costs related to the acquisition of goods and services. The inspection team examined whether healthcare system staff complied with purchase card program policies and procedures and considered using contracts for frequently purchased goods or services, a process known as strategic sourcing. When used properly, purchase cards can help facilities simplify acquisition procedures and provide an efficient vehicle for obtaining goods and services directly from vendors. Documenting transactions as required helps VA identify potential fraud, waste, and abuse. Using contracts for common purchases has several benefits, such as allowing VA to optimize purchasing power and obtain competitive pricing.

IV. **Inventory and supply chain management.** Supply chain management integrates and aligns people, processes, and systems to manage all product and service planning, sourcing, purchasing, delivery, receiving, and disposal. VHA policy requires medical facilities to establish, operate, and maintain a supply chain management program that is effective, cost-efficient, transparent, and responsive to customer requirements and to continually identify ways to ensure high-quality veteran care.[20] The inspection team evaluated whether the healthcare system managed supply chain operations effectively using the days-of-stock-on-hand performance metric, a nationally set level of inventory for expendable Medical Surgical Prime Vendor (MSPV) program items and non-MSPV items that facilitates efficient purchasing and use of supplies.[21] To evaluate whether the system complied with policies and procedures, the team assessed data validity and identified if any inventory factors affected the healthcare system's supply chain

[19] A stale obligation is more than 90 days beyond the period of performance end date or has had no activity in the past 90 days.

[20] VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

[21] MSPV is a national program providing a customized distribution system to meet or exceed facility requirements through an efficient, cost-effective, just-in-time distribution catalog ordering process.

management. Unreliable inventory data can lead to the purchase of unnecessary supplies, overstocking, and spoilage. More importantly, errors indicating that supplies are available when they are not could adversely affect the healthcare system's ability to effectively plan and budget for the purchase of supplies to operate and meet patient care needs.

Facility Profile

The VA North Texas Health Care System, part of Veterans Integrated Service Network (VISN) 17, serves veterans at the Dallas VA Medical Center.[22] The healthcare system also provides services at 11 community-based outpatient clinic locations.[23] The VA North Texas Health Care System has an academic affiliation with several educational institutions and offers associated health training in nursing, psychology, and pharmacy.

[22] VHA divides the United States into 18 Veterans Integrated Service Networks, regional systems that work together to meet local healthcare needs and provide greater access to care.

[23] The VA North Texas Health Care System serves veterans at 16 locations in north Texas. Facilities include Dallas VA Medical Center, Garland VA Medical Center, and Sam Rayburn Memorial Veterans Center in Bonham. The system also operates the North Texas VA Mobile Center for Veterans who are homeless and 11 community-based outpatient clinics in Dallas, Decatur, Denton, (two locations in Fort Worth), Granbury, Grand Prairie, Greenville, Plano, Sherman, and Tyler.

Figure 1 provides general background information for this level 1a, high-complexity healthcare system.[24]

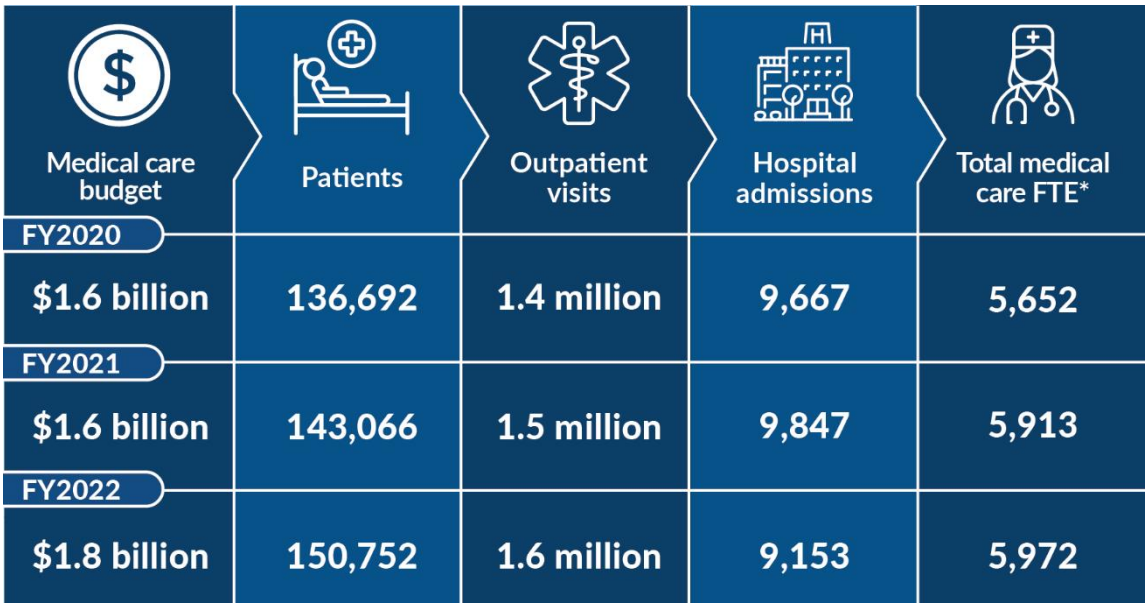

Figure 1. *Facility profile for VA North Texas Health Care System from October 1, 2019, through September 30, 2022.*

Source: VA OIG analysis of VHA Support Service Center, Trip Pack and Operational Statistics report.

Note: The inspection team did not assess VA's data for accuracy or completeness.

** The category of full-time equivalent staff includes both direct medical care positions in budget object code 1000–1099 (Personal Services) and all cost centers.*

Facility Selection

The inspection team evaluated VA data to identify healthcare systems with the greatest potential for financial efficiency improvements based on data from the VHA Office of Productivity, Efficiency and Staffing's (OPES) efficiency opportunity grid. VHA developed the efficiency opportunity grid, a collection of 12 statistical models, to give facility leaders insight into areas of opportunity for improving efficiency. The grid allows users to compare between VHA facilities by adjusting data for variations in patient and facility characteristics and in geography. The grid also describes possible inefficiencies and areas of success by showing the difference between a facility's actual and expected costs. The team used the facility rankings from the stochastic

[24] VHA uses a facility complexity model that classifies facilities as levels 1a, 1b, 1c, 2, or 3, with level 1a being the most complex and level 3 being the least complex. The VA North Texas Health Care System was rated as a level 1a, high-complexity facility.

frontier analysis model in the grid to select facilities for financial efficiency inspections.[25] The inspection, while limited in scope and not intended to be a comprehensive inspection of all financial operations at the VA North Texas Health Care System, aimed to recommend opportunities for process improvement and greater efficiencies and to promote the responsive use of appropriated funds.

[25] Stochastic frontier analysis is a modeling principle to estimate the optimal or minimum cost (input) after controlling for risks and random factors for each VA medical center given a set of outputs and output characteristics. Based on the minimum cost, an efficiency score is derived for each facility; an efficiency score of one is most efficient, and values greater than one are associated with increasing inefficiency.

Results and Recommendations

I. Use of Managerial Cost Accounting Information

VA's financial policy describes managerial cost accounting as a fundamental part of the department's overall financial management activities and states that managerial cost accounting should be integrated with the financial system for expenses, workload, utilization, performance measurement, and reporting.[26] Also, the policy states VA's cost accounting system will be used to help identify cost reduction alternatives and enhance efficiency, and requires VA to use managerial cost accounting information to make business decisions. Managers can measure and analyze cost information to make informed operational decisions and meet the objectives of their organizations. The federal managerial cost accounting standards developed by the Federal Accounting Standards Advisory Board require that each reporting entity accumulate and report the cost of its activities on a regular basis for management information purposes. Cost information, according to these standards, is essential for managers to make economic choices and informed decisions in the areas of performance measurement, budgeting, and cost control.[27] For VA, this applies to critical decisions regarding veteran care, such as deciding to expand services at VA facilities, rather than relying on community care. If healthcare system officials fail to consider reliable and timely cost information for these purposes, they increase the risk of waste or inefficient use of resources, as well as suboptimal results for veterans and other patients.

The inspection team focused on the following areas:

- **Obligation trends.** The team reviewed obligation amounts originating from the Financial Management System (FMS) to identify trends and areas of significant obligation.
- **Healthcare system internal reporting.** The team reviewed cost and performance reports for planning, budgeting, cost reduction, efficiency improvement, and comparing planned-to-actual results. The team used document reviews and interviews to determine whether the healthcare system's use of managerial cost accounting information aligned with federal financial accounting standard practices and VA financial policy.[28]

[26] VA Financial Policy, "Managerial Cost Accounting," in vol. 13, *Cost Accounting* (December 2019), chap. 3.

[27] Federal Accounting Standards Advisory Board (FASAB), *Statement of Federal Financial Accounting Standards 4: Managerial Cost Accounting Standards and Concepts* in FASAB Handbook of Federal Accounting Standards and Other Pronouncements, as Amended, Version 21 (June 30, 2022).

[28] VA Financial Policy, "Managerial Cost Accounting."

Finding 1: The Healthcare System Needs to Improve Its Use of Managerial Cost Accounting Information

The OIG found that the healthcare system could use managerial cost accounting information more effectively to help make financial choices. The healthcare system compared budgeted amounts to actual results each month but did not provide sufficient evidence that internal cost accounting information was consistently used to enhance efficiency, help reduce costs, or inform business decisions. Instead, it primarily focused on ensuring the accuracy of the data. Additionally, the healthcare system can improve its performance measurement process to ensure cost inaccuracies are corrected in a timely manner.

Obligation Trends

According to FMS reports, healthcare system obligations grew by almost $304.3 million (20 percent) from about $1.5 billion in fiscal year (FY) 2020 to over $1.8 billion in FY 2022 (figure 2).

Figure 2. *VA North Texas Health Care System obligations, FY 2020–FY 2022.*
Source: VA OIG analysis of Mainframe FMS and VHA Allocation Resource Center Cube.

The inspection team identified obligation growth in off-station fees and medical care contracts and agreements, representing care provided to veterans through community providers.[29] This

[29] Off-station fees are professional, technical, medical, and nursing service fees paid by VA when a veteran receives health care from a community provider.

accounted for about $202.7 million (67 percent) of the approximately $304.3 million growth. The inspection team confirmed the obligation data with reports provided by VISN 17 leaders.

To understand financial management practices and growth of obligations at the healthcare system, the inspection team requested internal managerial cost accounting reports, analyzed performance measurement data, and conducted interviews with the healthcare system's leaders.

Healthcare System Internal Reporting

The inspection team reviewed monthly budget reports compiled by the healthcare system finance office during FY 2022 and FY 2023. These reports showed estimated revenues and expenses that totaled to either a projected operating surplus or a deficit for the healthcare system. While the OIG noted a just over $9 million surplus on the September 2022 budget update report, the December and March 2023 budget update reports reflected deficits of about $13.5 million and $15 million, respectively. The VISN 17 chief financial officer stated during an interview that the healthcare system would not run out of funds by end of the fiscal year. The team did not test the accuracy or methodology used by the healthcare system to compile these budget projections. However, the OIG determined that these monthly budget reports provided evidence that the healthcare system prepared financial information to compare planned amounts to actual results as described in VA policy.[30]

The team also reviewed the healthcare system-provided managerial cost accounting reports used to reduce costs, enhance efficiency, and inform business decisions as described in VA policy. The information provided by the VISN managerial cost accounting (MCA) coordinator included reports on VISN 17 stop code and specialty outliers, a labor mapping history dashboard, the medical center director's annual certification of use of the managerial cost accounting system, and a Managerial Cost Accounting Dashboard.[31] To gain an understanding of how the healthcare system used managerial cost accounting data to enhance efficiency and reduce costs, the inspection team interviewed healthcare system leaders, the VISN 17 chief financial officer, and two members of the VISN 17 managerial cost accounting team.

The OIG determined that the healthcare system did not have a consistent process in place to use cost accounting data to identify opportunities to reduce costs and enhance efficiency. The healthcare system's assistant financial manager reported they do not use cost accounting information in fiscal operations to reduce costs, enhance efficiency, or make business decisions.

[30] VA Financial Policy, "Managerial Cost Accounting."

[31] VA Financial Policy, "Managerial Cost Accounting." Each year, facilities are required to submit an annual certification of cost that affirms the data within the managerial cost accounting system accurately represent the costs of operations. The facility is required to review stop code and treating specialty costs to determine the accuracy of costs per unit. Stop codes assist VA medical facilities in defining patient workload and serve as a stable identification method that can be used to compare costs between facilities. They are the single and critical designation by which VHA defines outpatient clinical work units for costing purposes.

The VISN 17 chief financial officer stated VISN leaders hold periodic meetings with finance officers and medical center directors within the VISN regarding cost accounting data and that he reviews managerial cost accounting data and reports any cost outliers to the managerial cost accounting coordinator for further inspection.

A health system specialist stated that the healthcare system's managerial cost accounting team assists with various activities such as developing cost centers for national reports, which help with cost accuracy and ensuring encounter forms are correct for new clinics.

The managerial cost accounting coordinator and managerial cost accounting site manager confirmed that their day-to-day activities are primarily focused on the accuracy of data. They stated they have deadlines to complete audits received from VA's Managerial Cost Accounting Office, as well as deadlines to complete their own local reviews and audits to maintain integrity of data. However, the site manager stated he is always open to assisting the healthcare system with interpreting cost accounting data when needed.

After reviewing managerial cost accounting reports and interviewing healthcare system and VISN 17 personnel, the OIG determined that high-level discussions regarding managerial cost accounting data appear to have occurred. Additionally, the OIG determined that the healthcare system focuses on ensuring the cost accounting information is accurate for VA's cost accounting system. However, the healthcare system does not have a consistent process in place to ensure the data are used to reduce costs and enhance efficiency.

Performance Measurement

Federal financial accounting standards state that measuring cost is an integral part of measuring performance in terms of efficiency and cost-effectiveness.[32] Specifically, cost per unit of output is highlighted as a methodology to evaluate the efforts and accomplishments of a government entity. Additionally, VA financial policy states that the managerial cost accounting system will identify the cost of products and services.[33] The VHA Managerial Cost Accounting Office developed a modeling tool to assist cost accounting staff and managers with analyzing their department cost accounting information. The training guide for the model recommends that cost accounting staff analyze cost workload products in various ways. For example, the guide recommends that users sort by cost to determine if products with high costs seem reasonable. The guide states that high-cost products can be considered outliers.

Using the national managerial cost accounting modeling tool, the inspection team identified and analyzed the 10 highest-cost-per-unit products and five high-volume products from the modeling tool's April 2023 product cost report. The OIG determined that the healthcare system reported

[32] FASAB, *Statement of Federal Financial Accounting Standards 4: Managerial Cost Accounting Standards and Concepts*.

[33] VA Financial Policy, "Managerial Cost Accounting."

inaccurate costs for all 10 high-cost products and two of the five high-volume products. After the OIG provided its results to the healthcare system's managerial cost accounting team, these errors were adjusted for correction in the April 2023 product cost report. Example 1 describes one of the high-cost products with inaccurate costs.

Example 1

> *The inspection team's analysis of high-cost products in the April 2023 product cost report showed three 15-minute in-patient encounters with a cost of about $124,864 each. The healthcare system's managerial cost accounting site manager informed the inspection team that the nursing labor cost was recorded in one department, but the workload was being recorded in a different department. The actual cost for each encounter should have been $765.28, leading to a misstatement of about $372,300 in reported costs. The error was corrected, and the cost of $765.28 for each encounter was reflected in the April 2023 product cost report.*

Using this national modeling tool, the team identified 30-minute, primary care visits as a high-volume product. For the period of April 2023, the team identified a volume of 18,703 30-minute, primary care appointments that occurred within the healthcare system, representing a cost of just over $13.4 million. The healthcare system performed these primary care visits in five different clinics with a total cost per visit ranging from about $440 to $1,174. The high-cost and high-volume product analysis was discussed and confirmed with healthcare system managerial cost accounting staff. However, the healthcare system did not perform similar analysis to the costs of high-volume products across different clinics. According to the managerial cost accounting coordinator, the managerial cost accounting team performs audits to identify inaccurate costs in high-cost and high-volume products but does not compare the costs. If the healthcare system performed analysis on high-cost and high-volume products, it could identify opportunities to decrease costs associated with each product.

The managerial cost accounting site manager said inaccurate costs occur when healthcare staff incorrectly record their labor costs and workload information. The site manager said communication issues occurred with healthcare system staff when trying to get the labor cost and workload issues resolved. The managerial cost accounting coordinator provided documentation of discussions with healthcare staff about the results of these audits. The coordinator acknowledged that this process needs some improvement and is considering starting an email group that will include healthcare system leaders to help get these issues resolved in a timely manner.

Budgeting and Cost Control

Federal financial accounting standards state that information on the costs of program activities can be used as a basis to estimate future costs in preparing and reviewing budgets.[34] The standards also state that federal managers can use cost information to control and reduce costs and avoid waste. The VISN 17 finance officer and the North Texas assistant financial manager reported that budgets are based on historical spending and not managerial cost accounting information. Also, the managerial cost accounting coordinator said he believes cost accounting information can help with resource management but is not sure how it could help with budget formulation. Healthcare system leaders should consider implementing federal accounting standards to potentially optimize available financial resources. With the staffing budget being about $857 million (47 percent) of the over $1.8 billion obligated in FY 2022, healthcare system leaders could analyze available cost accounting information and identify opportunities to use available resources as efficiently as possible.

Economic Choices

Agency and program decisions—such as whether to complete a project in-house or contract it out, to accept or reject a proposal, or to continue or drop a product or service—require cost comparisons among available alternatives. The inspection team asked if the healthcare system performs any analysis comparing the contracted cost of care in the community to the cost of care provided at the healthcare system, also known as a make-or-buy analysis. The VISN 17 finance officer and the managerial cost accounting coordinator reported that high-level meetings about community care costs versus in-house costs do occur. The managerial cost accounting coordinator said his team started to develop a tool for this type of analysis, but they had to prioritize other tasks. He also said it is a challenge to develop this type of tool for decision-makers to use and understand. The coordinator provided a report that compared the volume of community care consults to in-house consults and cost information for paid claims within the healthcare system. However, the report did not contain any make-or-buy analysis. As discussed in the "Obligation Trends" section in Finding 1 of this audit report, community care obligations accounted for just under $202.7 million, or 67 percent, of the about $304.3 million growth between FY 2020 and FY 2022. The use of make-or-buy analyses could have a significant impact on optimizing the resources available to the healthcare system.

[34] FASAB, *Statement of Federal Financial Accounting Standards 4: Managerial Cost Accounting Standards and Concepts*.

Finding 1 Conclusion

VA expects its healthcare systems to use managerial cost accounting information to enhance efficiency, help reduce costs, and make business decisions as described in VA financial policy.[35] The OIG found that leaders of the VA North Texas Health Care System did not provide evidence that managerial cost accounting information is used consistently for those purposes. Additionally, the healthcare system's use of managerial cost accounting information does not fully align with federal financial accounting standard practices regarding performance measurement, budgeting, cost control, and making economic decisions. Furthermore, the OIG found that cost accounting data were not always accurate. Given the significant growth of obligations at the healthcare system, consistent use of managerial cost accounting information could promote more efficient use of taxpayer resources.

Recommendations 1–3

The OIG made the following recommendations to the VA North Texas Health Care System executive medical center director:

1. Establish a plan to use VA's cost accounting system information to identify alternative ways to reduce costs, enhance efficiency, and inform business decisions as identified by VA financial policy.
2. Ensure healthcare system staff responsible for labor cost and workload mapping are responding in a timely manner to the results of managerial cost accounting audits and correcting all identified issues.
3. Consider a plan to align VA North Texas Health Care System financial management practices with federal financial accounting standard practices. This could include using cost information for performance measurement, budgeting, and cost control, and making economic choices.

VA Management Comments

The VA North Texas Health Care System executive medical center director concurred with recommendations 1 through 3. The responses to all report recommendations are provided in full in appendix D.

To address recommendation 1, the executive medical center director reported that the Managerial Cost Accounting Office will continue to work with the Chief Strategy Office and other relevant departments to develop a make-buy model. The healthcare system acknowledges "the inherent complexities and differences" between its data and community care's data, but the system will

[35] VA Financial Policy, "Managerial Cost Accounting."

explore alternatives "that will provide meaningful and valid results into cost reduction and operational efficiency."

To address recommendation 2, the executive medical center director reported that the managerial cost accounting team will escalate unresolved issues and "continue to assure good communication" between managerial cost accounting and the healthcare system's employees.

To address recommendation 3, the managerial cost accounting team will encourage the healthcare system to use the Managerial Cost Accounting Dashboard to review their data and collaborate with the team on any discrepancies found. The healthcare system will also provide training to all new National Labor Mapping Tool users and review audits and outliers monthly.

OIG Response

The healthcare system executive medical center director's action plans are responsive to recommendations 2 and 3. For recommendation 1, the healthcare system will need to develop a plan to show how it will use VA's cost accounting system information to reduce costs, enhance efficiency, and inform business decisions in budgeting and performance measurement. The OIG will monitor implementation of the planned actions and will close the recommendations when the OIG receives sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified.

II. Open Obligations Oversight

VA policy requires finance offices to perform monthly reviews and reconciliations to ensure that their open obligations, including undelivered orders and delivered unpaid orders, known as accruals, are valid.[36] For obligations to remain valid, initiating services must provide responses to the finance office to substantiate the validity of their obligations. If funds remain on the obligation after delivery, the initiating service has confirmed acceptance of all goods or services, and the invoices have been received and paid, the acquisition office will modify the contract or order to reflect the final cost and quantity and decrease the remaining funds on the obligation. Therefore, the healthcare system's finance office personnel should verify with the initiating service or contracting officer, if applicable, to ensure the obligations' period of performance dates are correct and obligation balances are accurate and agree with source documents.[37]

VA's management of open obligations has been a longstanding issue and was included as a significant deficiency in the department's FY 2022 and FY 2021 audited financial statements, and as a material weakness in its FY 2020 audited financial statements.[38] Additionally, a 2019 OIG report on undelivered orders recommended VHA ensure that staff review and reconcile open orders, identify and deobligate excess funds on those orders, and follow VA policy regarding required reviews of open obligations.[39] If reviews are not conducted, the healthcare system risks not being able to deobligate those funds and use them for other goods or services in that fiscal year to support veterans.

The inspection team focused on the following areas related to open obligations:

- **Undelivered orders.** The team assessed whether healthcare system staff performed monthly reviews and reconciliations to ensure that sampled undelivered orders with no activity for more than 90 days were valid and should remain open.

[36] Undelivered orders are supplies and services that have been approved and awarded on an obligation but have not been delivered to or accepted by the government. This includes any orders for which advance payment has been made, but delivery or performance has not yet occurred.

[37] VA Financial Policy, "Obligations Policy."

[38] VA OIG, *Audit of VA's Financial Statements for Fiscal Years 2022 and 2021*, Report No. 22-01155-14, November 15, 2022; VA OIG, *Audit of VA's Financial Statements for Fiscal Years 2021 and 2020*, Report No. 21-01052-33, November 15, 2021; VA OIG, *Audit of VA's Financial Statements for Fiscal Years 2020 and 2019*, Report No. 20-01408-19, November 24, 2020. In the reports, CliftonLarsonAllen LLP defines a material weakness as a deficiency, or combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented or detected and corrected in a timely manner. A significant deficiency is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

[39] VA OIG, *Insufficient Oversight of VA's Undelivered Orders*, Report No. 17-04859-196, December 16, 2019. All recommendations from this report have been implemented and closed.

- **Outstanding accruals.** The team assessed whether the healthcare system performed monthly reviews and reconciliations to ensure that sampled outstanding accrued orders were valid and should remain open.
- **FMS–to–Integrated Funds Distribution, Control Point Activity, Accounting and Procurement System (IFCAP) reconciliations.** The team identified outstanding obligations with end-date or order-amount discrepancies between FMS and IFCAP to ensure healthcare system staff reconciled those discrepancies between the systems for sampled obligations.[40]

Finding 2: The Healthcare System Does Not Always Identify and Review Inactive Obligations, Ensure Accruals Are Proper, or Reconcile End Dates and Amounts

The OIG found healthcare system staff could improve management of open obligations by reviewing all inactive obligations and closing purchase orders and obligations after the initiating service has confirmed acceptance of all goods or services and all invoices have been received and paid. Failure to properly manage open obligations increases the risk of not spending appropriations within the correct fiscal year and potentially leaving funds attached to orders when they could be used for other purposes.

Undelivered Orders

As of April 15, 2023, the healthcare system had 174 undelivered orders valued at just over $29.9 million that had been inactive 90 days or more. Figure 3 shows the number and dollar amounts of inactive obligations for the VA North Texas Health Care System from November 15, 2022, through April 15, 2023.

[40] Both are accounting systems, with FMS considered the primary one that interfaces with IFCAP. A transaction's end date (which is critical to determining whether an obligation should remain open) may be modified due to delays or scope changes. The modification may not be recorded in both systems because staff can manually change end dates in one system without changing them in the other.

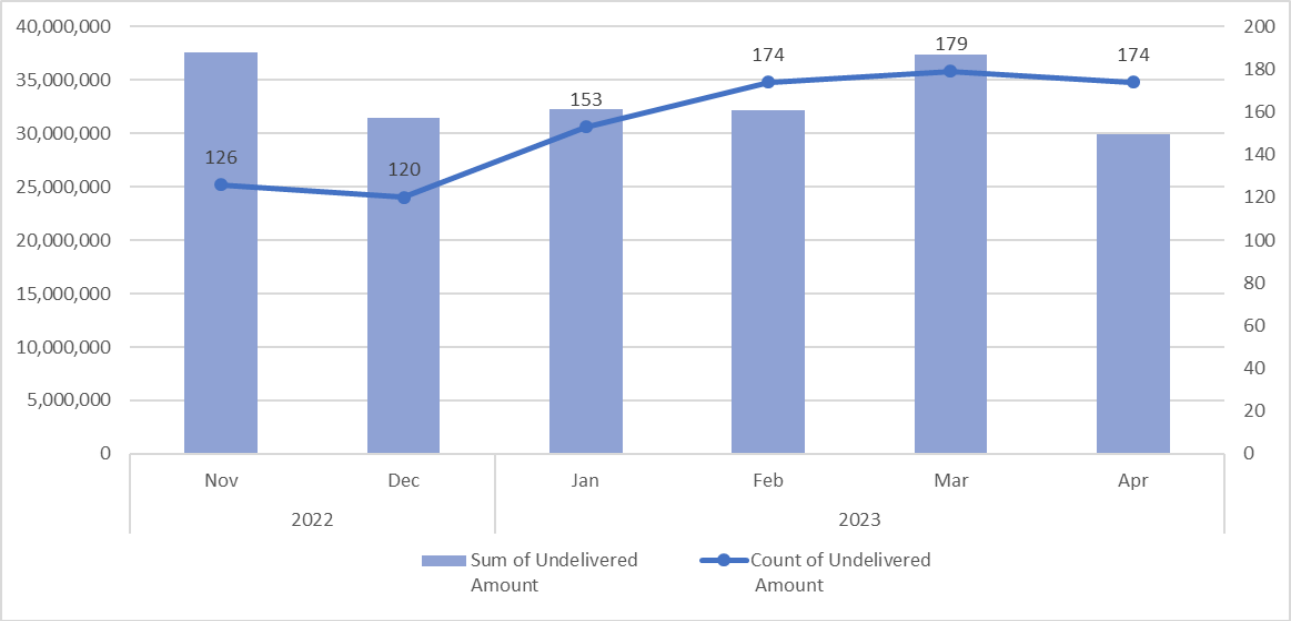

Figure 3. *Number and dollar amount of inactive obligations for VA North Texas Health Care System from November 15, 2022, through April 15, 2023.*

Source: VA OIG analysis of VA FMS F850 Report.

Figure 4 shows the age and dollar amount of the 174 obligations. As shown, 85 obligations totaling almost $20.8 million had no activity for at least 181 days.

Figure 4. *Number and dollar amount of inactive obligations for the VA North Texas Health Care System in April 2023.*

Source: VA OIG analysis of VA FMS F850 Report.

The inspection team analyzed the obligation data and statistically selected 25 inactive obligations open as of April 15, 2023, totaling just under $12.9 million. The team reviewed supporting

documentation to assess whether the healthcare system staff identified and reviewed the sampled obligations to determine if they were still valid and needed to remain open in accordance with VA financial policy.[41] The OIG determined that the healthcare system did not always review undelivered orders and estimated that at least 31 of the 174 obligations (18 percent) totaling at least $633,000 were invalid, should have been deobligated, and could have been put to better use.[42] The OIG considered obligations invalid because the healthcare system either could not provide documentation that services still needed the funds or confirmed the funds were no longer needed.

Example 2

> *One obligation for just under $2,900 should have been deobligated. The purchase order date for this obligation was December 29, 2022, and there was no activity for 154 days through the end date of June 1, 2023.[43] This obligation was for a student grant to attend school; however, the finance office could not confirm if the student attended the school because the initiating service did not follow up. Financial services staff confirmed that the funds were not needed and deobligated the obligation after the team's inspection.*

According to the assistant financial manager, instead of reviewing all inactive obligations, financial services staff were focused on deobligating excess or unneeded funds that were 90 days past their end dates. This focus was based on the healthcare system's "Aging of Orders–Count" financial indicator, which emphasizes the need for the healthcare system to follow up on open orders greater than 90 days past their period of performance end date. Failure to properly manage undelivered orders could increase the risk of failing to spend appropriations within the associated fiscal year and may prevent the healthcare system from obtaining the maximum benefit of any unused funds.

Outstanding Accruals

As of April 15, 2023, the healthcare system had 633 outstanding accruals totaling close to $28 million. Of those outstanding accruals, 365 totaling more than $23 million had been open for

[41] VA Financial Policy, "Obligations Policy."

[42] When reporting on total errors combined, the OIG uses the lower-limit values of the one-sided 90 percent confidence interval as conservative estimates in place of the point estimates due to the low level of precision of the point estimates. Therefore, the inspection team reported actual sample results rather than estimates for better use of funds because of the low sample size and low error count; the estimate also had poor precision due to the low numbers and high variability in sample weights. Appendix B provides additional information on the statistical projections.

[43] The inspection team statistically selected a sample of open obligations with no activity as of April 15, 2023. However, the actual obligation end date could be later than the April 15, 2023.

90 days or more. Figure 5 shows the number and dollar amounts of outstanding accruals for the VA North Texas Health Care System from November 15, 2022, through April 15, 2023.

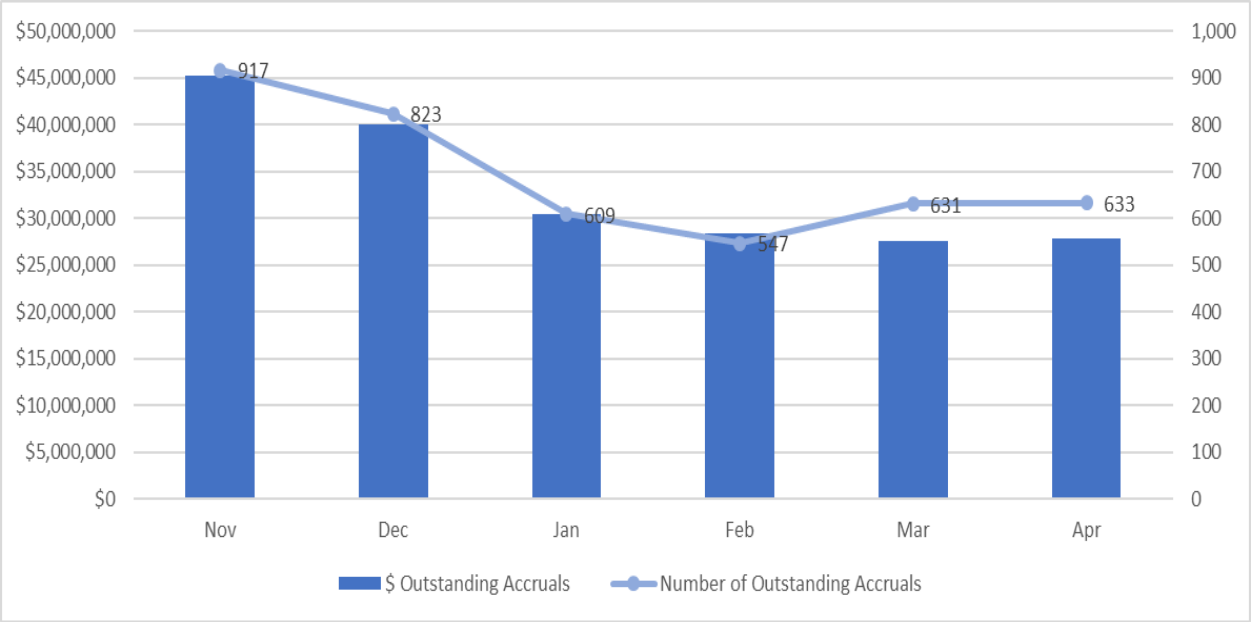

Figure 5. *Number and dollar amount of outstanding accruals for the VA North Texas Health Care System November 15, 2022, through April 15, 2023.*

Source: VA OIG analysis of VA FMS F851 Report.

Figure 6 shows the age and dollar amounts of the 365 outstanding accruals. As shown, 301 accruals totaling just over $20.9 million had been open for 181 days or more.

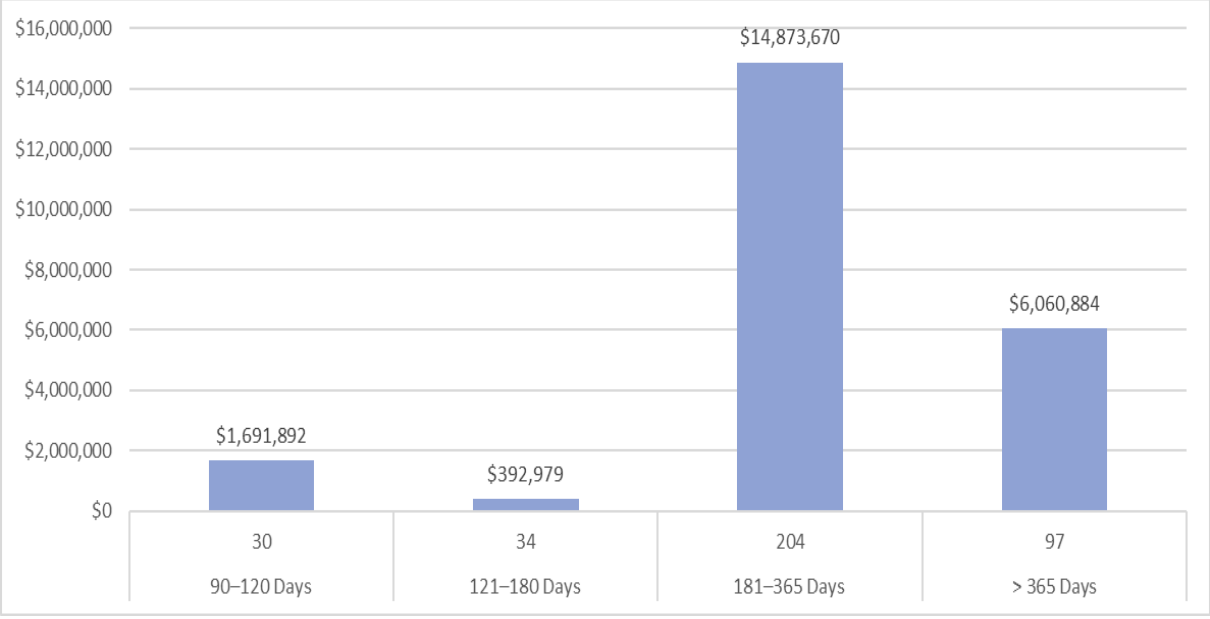

Figure 6. *Outstanding accruals for the VA North Texas Health Care in April 2023.*

Source: VA OIG analysis of VA FMS F851 Report.

The inspection team statistically selected 25 accruals totaling more than $12.2 million. These statistically selected accrual balances had been open between 122 and 1,292 days as of April 15, 2023. The team reviewed supporting documentation to assess whether the healthcare system identified and reviewed the sampled accruals to determine if they were valid and needed to remain open in accordance with VA financial policy.[44] The OIG found that the healthcare system's finance office did not always review accruals monthly and determined that an estimated 210 of the 365 outstanding accruals (58 percent) totaling an estimated $13.4 million were invalid and needed to be reversed. Of the estimated $13.4 million, $11.4 million should have been deobligated and could be put to better use for the healthcare system for approximately 180 of the 210 outstanding accruals (85 percent) because the funds were no longer needed.[45] Examples 3 and 4 show instances of improper accruals.

Example 3

One obligation with a balance of just over $339,000 auto-accrued at the end of the performance period. The balance was invalid for about 12 months past the period of performance end date because the initiating service did not respond to the finance office requests for a status on the obligation. The finance office was compliant with the monthly reviews; however, the service only responded once. Additionally, the finance office did not have in place, per VA policy, an escalation process to notify the healthcare system's associate director about the lack of responsiveness. Timely response is necessary to ensure the prompt deobligation of the improper accrual.

Example 4

One obligation with a balance of more than $2.1 million auto-accrued at the end of the performance period. The balance was invalid for about 10 months after the performance period ended because the initiating service did not follow up with the vendor to ensure all invoices had been received and paid as required by VA financial policy. While the finance office was aware of the improper accrual, it did not always perform follow-up actions to ensure prompt deobligation.

The assistant financial manager attributed the lack of deobligation to staffing shortages due to leave. In addition, they also attributed the inaction to a lack of responses from initiating services, awareness of VA policy of the escalation process, and follow-up by the finance office to ensure initiating services were taking prompt action as required by VA policy. Failure to properly

[44] VA Financial Policy, "Obligations Policy."

[45] Deobligation means a cancellation or downward adjustment of previously incurred obligations. VA Financial Policy, "Obligations Policy."

manage accruals increases the risk of disbursing funds for goods or services not received and may prevent the healthcare system from obtaining the maximum benefit of any unused funds.

Reconciliation of FMS and IFCAP End Dates and Amounts

IFCAP handles the processing of certified invoices and electronic transmission of receipt documents to FMS. In addition, IFCAP transfers obligation information back to the control point and updates the control point balance automatically.[46] Therefore, the end dates in both systems should be the same. However, staff can manually change end dates in one system without changing them in the other. Thus, open obligations should be reviewed monthly by the healthcare system's finance office in coordination with the initiating service to ensure period of performance dates and order amounts are correct and match in all systems.[47]

End-Date Discrepancies

The inspection team analyzed FMS-to-IFCAP reconciliation reports for the period of November 2022 through April 2023 for end-date discrepancies and identified 58 open obligations with end-date discrepancies between FMS and IFCAP for three or more months, totaling just under $85.2 million.[48] To determine if the end dates were accurate and reconciled between the two systems, the team judgmentally selected and evaluated 10 end-date discrepancies, with variances between systems ranging from 187 to 1,822 days, valued at just under $5.9 million. Seven of the 10 samples were flagged to automatically accrue the remaining balance of the obligations at the end of the performance period.[49] Obligations set to automatically accrue in FMS that have inaccurate end dates could result in invalid accruals. The team determined that FMS end dates and IFCAP delivery dates were corrected by the healthcare system prior to the inspection and reflected correct end dates for nine obligations; however, one of the 10 sampled obligations still had an end-date discrepancy between FMS and IFCAP. Although nine obligations had been corrected, the team identified two of those corrected obligations that had outstanding balances totaling $4,500, which were not deobligated. The healthcare system could not provide documentation showing the services were still needed. Due to this lack of documentation, the team determined that $4,500 could be put to better use.

The assistant financial manager reported that the contracting officer entered the wrong end dates in IFCAP, so she asked the contracting officer to correct the errors. Though the finance office

[46] A control point is a financial element used to permit the tracking of monies from an appropriation or fund to a specified service, activity, or purpose.

[47] VA Financial Policy, "Obligations Policy."

[48] "FMS to IFCAP Reconciliation Reports" (web page), VHA Support Service Center, accessed April 19, 2023, https://vssc.med.va.gov/VSSCMainApp/products.aspx?PgmArea=59. (This is an internal VA website not publicly accessible.)

[49] Auto accrual is when an accrual is processed automatically in FMS for the remaining unpaid balance.

submitted documentation showing that FMS end dates generally matched IFCAP delivery dates, the OIG determined that the healthcare system was not in compliance because the team still identified end dates between systems that did not reconcile in accordance with VA financial policy.[50] The supervisory accountant confirmed the finance office did not use VA's FMS-to-IFCAP reconciliation report to identify end-date discrepancies.[51] However, as a result of the OIG's inspection, the assistant financial manager stated the finance office staff will begin using the FMS-to-IFCAP reconciliation report to compare end dates and work on reconciling them among the systems. The failure to ensure correct end dates allows invalid accruals to occur and creates the potential that funds are disbursed for goods or services that were not received.

Potential "Purpose" Statute and "Bona Fide Needs" Rule Violations

During the review of the FMS-to-IFCAP reconciliation for end-date discrepancies, the OIG also found the healthcare system may have violated the "purpose" statute and the "bona fide needs" rule for a service contract that crossed fiscal years.[52] Although the healthcare system is allowed to enter into contracts for services that cross into a new fiscal year, federal law requires that funds should be used only for the purposes for which they were appropriated, and a bona fide need must exist for the requirement in the year that the appropriations are available for obligations.[53] The healthcare system awarded a services contract with a base year and four option years. The OIG found that the healthcare system used funds totaling $15,585 that were obligated for option year one to pay for expenditures incurred during the base year of the contract. The healthcare system also used funds totaling $70,515 that were obligated for option year two to pay for expenditures incurred in option year one. By using this $86,100 from future year funds to pay for services rendered in prior years when those needs did not appear to be directly related to

[50] VA Financial Policy, "Reconciliations," in vol. 1, *General Accounting (*October 2018), chap. 6. The policy requires manual intervention when there is a system rejection to alleviate inconsistencies between two or more systems.

[51] The monthly report assists facilities in reconciling FMS obligation data with the source data from IFCAP in accordance with financial policies.

[52] 31 U.S.C. § 1301(a), known as the "purpose" statute, states that except as otherwise provided by law, appropriations shall be applied only to the objects for which the appropriations were made. 31 U.S.C. 1502(a), or the "bona fide needs" rule, states that to use appropriated funds, a bona fide legitimate need must exist for the requirement in the year that the appropriations are available for obligation.

[53] 41 U.S.C. § 3902; FAR 32.703-3; (1998), 31 U.S.C. § 1301; 31 U.S.C. § 1502(a).

option years one and two, healthcare system officials may have violated the purpose statute and the bona fide needs rule.[54]

Also, by using funds from future obligations, the healthcare system risked not having funds available to pay for goods at the time of delivery or services when rendered. The assistant financial manager concurred with the team's findings and stated this occurred due to an invoice certifier's oversight. Ultimately, financial services staff have the responsibility to implement a system of internal controls to ensure they obligate funds and make payments for a given purpose.[55] Financial services processed expenditure transfers in December 2023 to remedy the violations.

The team also found that the contracting officer's representative prepared a deobligation memo on March 3, 2023, to decrease the remaining balance of approximately $237,000 from option year one. Because this had not been deobligated as of September 6, 2023, and, with the corrections needed to remedy the potential violations of the purpose statute and the bona fide needs rule, the OIG calculated just under $182,000 should have been deobligated and could have been put to better use.[56]

Order Amount Discrepancies

The inspection team analyzed FMS-to-IFCAP reconciliation reports for November 2022 through April 2023 for order amount discrepancies and identified 53 additional open obligations with order amount discrepancies between FMS and IFCAP for three or more months totaling more than $141.2 million. To determine if order amounts were accurate and reconciled between the two systems, the team evaluated 10 of these open obligations totaling just under $100.1 million with order amount discrepancies from the FMS-to-IFCAP reconciliation reports.[57] The OIG found that seven obligations with FMS and IFCAP order amount discrepancies were corrected by the healthcare system prior to the inspection and reflected the correct amounts. However, three of the 10 sampled obligations, valued at just over $92.3 million, still had order amount discrepancies between FMS and IFCAP. The assistant financial manager reported that these order amount discrepancies occurred due to timing differences of when the order amounts posted

[54] The OIG considers only $70,500 as questioned costs because $15,585 is already reported under better use of funds (see footnote 56). 2 C.F.R. § 200.1. "Questioned cost means a cost that is questioned by the auditor because of an audit finding: (1) Which resulted from a violation or possible violation of a statute, regulation, or the terms and conditions of a Federal award, including for funds used to match Federal funds; (2) Where the costs, at the time of the audit, are not supported by adequate documentation; or (3) Where the costs incurred appear unreasonable and do not reflect the actions a prudent person would take in the circumstances. (4) Questioned costs are not an improper payment until reviewed and confirmed to be improper as defined in OMB Circular A–123 appendix C."

[55] VA Financial Policy, "Obligations Policy."

[56] This amount was calculated as follows: $236,585 + $15,585 - $70,515 = $181,655.

[57] "FMS to IFCAP Reconciliation Reports", VHA Support Service Center, accessed April 19, 2023, https://vssc.med.va.gov/VSSCMainApp/products.aspx?PgmArea=59. (This website is not publicly accessible.)

between both systems and due to modifications for order amounts not being posted in a timely manner. The supervisory accountant confirmed the finance office does not use VA's FMS-to-IFCAP reconciliation report to identify order amount discrepancies.[58] However, because of the OIG's inspection, the assistant financial manager stated the finance office staff will begin using the FMS-to-IFCAP reconciliation report to compare order amounts and work on reconciling them between the systems. If finance office staff better managed open obligations, they could have addressed inconsistencies between FMS and IFCAP and reduced the risks of failing to spend appropriations within the associated fiscal year and of funds not being repurposed to benefit veterans.

Finding 2 Conclusion

Healthcare system personnel did not comply with VA policies requiring routine follow-up to improve management and oversight of open obligations and prevent or minimize the possibility of appropriations law violations. The inspection team found that open obligations, including undelivered orders and accruals, were not reviewed for validity, and end dates and order amounts were not always reconciled between systems. Due to the finance office not always performing monthly reviews and reconciliations of open obligations, the team estimated about $14 million in obligations was invalid, of which a conservative estimate of just over $12.2 million should have been deobligated and could have been put to better use.[59] Failure to properly manage open obligations increases the risks that financial statements will be inaccurate and that appropriated funds will be used to pay for goods or services not received or will not be available to benefit veterans.

Recommendations 4–5

The OIG made the following recommendations to the VA North Texas Health Care System executive medical center director:

4. Ensure that healthcare system staff are made aware of policy requirements and the responsible finance office conducts monthly reviews and reconciliations on all open obligations for financial validity and take appropriate actions as required by VA Financial Policy, vol. 2, chap. 5, "Obligations" (2020), updated May 2023.
5. Consult with Office of General Counsel and Office of Acquisitions, Logistics and Construction to determine if any further actions are necessary, including contract

[58] The monthly report assists facilities in reconciling FMS obligation data with the source data from IFCAP in accordance with financial policies.

[59] The better use of funds is related to various open obligation monitoring and administrative deficiencies identified in the sampled obligations. This amount includes at least $633,000 from undelivered orders, an estimated $11.4 million from accruals, and just over $186,000 due to end-date discrepancies which brought the total monetary benefits to a conservative estimate of just over $12.2 million.

modifications, to remedy and prevent future purpose statute and bona fide needs rule violations.

VA Management Comments

The VA North Texas Health Care System executive medical center director concurred with recommendations 4 and 5.

To address recommendation 4, the executive medical center director reported finance staff will inform services of policy requirements via monthly emails and work with contracting officers for timely contract modifications. In addition, the chief financial officer will provide training to finance staff and services on reviewing undelivered orders properly to close them out.[60] The staff will also use the FMS-to-IFCAP reconciliation tool monthly to reconcile obligations and end dates.

To address recommendation 5, the executive medical center director reported finance staff will contact the Office of General Counsel and Office of Acquisitions, Logistics and Construction to determine any actions are necessary, including modifying the contract, to correct and prevent future violations of the purpose statute and the bona fide needs rule.

OIG Response

The healthcare system executive medical center director's action plans are responsive to the recommendations. The OIG will monitor implementation of the planned actions and will close the recommendations when the OIG receives sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified.

[60] VA Management comments did not specify who would provide the training. The OIG learned in subsequent discussion with medical center staff that the chief financial officer would provide it.

III. Purchase Card Use

VA's Government Purchase Card Program was established to reduce administrative costs related to the acquisition of goods and services. When used properly, purchase cards can help facilities simplify acquisition procedures and provide an efficient vehicle for obtaining goods and services directly from vendors. From May 1, 2022, through March 31, 2023, the healthcare system had 87,521 purchase card transactions that totaled just under $83 million. The inspection team removed negative purchase card transaction amounts from the total population of transactions and obtained a population of 86,659 transactions totaling just under $84 million. The amount and volume of spending through the Government Purchase Card Program makes it important to have strong controls over purchase card use to safeguard government resources and ensure compliance with policies and procedures that reduce the risk of error, fraud, waste, and abuse.[61]

Documenting transactions as required helps VA and other oversight authorities identify potential fraud, waste, and abuse. Using contracts for common purchases has several benefits, such as allowing VA to optimize purchasing power and obtain competitive pricing. The team examined whether healthcare system staff complied with purchase card program policies and procedures and considered using contracts for frequently purchased goods or services—a process known as strategic sourcing—to provide optimal savings to VA.

The team reviewed the following areas for sampled transactions:

- **Purchase card transactions.** The inspection team determined whether the healthcare system processed purchase card transactions in accordance with VA policy, including whether cardholders obtained prior approvals before initiating a purchase and then reconciled their transactions in a timely manner, whether approving officials promptly approved the transactions, and whether staff maintained segregation of duties.[62] The team also assessed if cardholders split purchases—that is, intentionally divided a single purchase into two or more purchases to avoid exceeding the micropurchase threshold. Additionally, the team inquired whether the healthcare system considered obtaining contracts when regularly procuring goods and services, which VA refers to as "strategic sourcing." The use of contracts in place of open market or individual purchases lowers the

[61] VA Financial Policy, "Government Purchase Card for Micro-Purchases," in vol. 16, *Charge Card Programs* (May 11, 2022), chap. 1B.

[62] VA Financial Policy, "Administrative Actions for Government Purchase Cards," in vol. 16, *Charge Card Programs* (June 2018), chap. 1A.

potential risk for split purchases on purchase cards. VA is also able to leverage its purchasing power through the use of competitively priced contracts.[63]

- **Purchase card oversight.** The inspection team assessed whether the healthcare system had purchase card policies in place and maintained accurate VA Form 0242s, as well as whether approving officials were assigned no more than 25 purchase card accounts each.[64] The team also assessed whether the healthcare system's purchase card coordinator provided oversight of the purchase card program by completing purchase card reviews. These activities are examples of systematic controls that help reduce errors and ensure a facility complies with VA policy.[65]
- **Supporting documentation.** The team examined whether the healthcare system maintained supporting documentation, as required, for purchases to provide assurance of payment accuracy and to justify the need to purchase a good or service. This includes approved purchase requests, purchase orders, receiving reports, and vendor invoices.[66] Supporting documentation enables program oversight and helps prevent fraud, waste, and abuse.

Finding 3: The Healthcare System Did Not Always Consider Using Contracts or Maintain Supporting Documentation

The inspection team identified a sample population of 86,659 purchase card transactions (after removing nearly 900 transactions with negative amounts) from May 1, 2022, through March 31, 2023, totaling just under $84 million.[67] From this population, the team reviewed a statistical sample of 66 transactions, totaling about $292,000, to determine whether the healthcare system's personnel processed transactions in accordance with policy, including considering using contracts, providing oversight, and maintaining required supporting documentation.[68] Forty-one of the 66 sampled transactions, totaling about $244,200, were also reviewed to determine if cardholders split purchases to circumvent their micropurchase threshold.[69] See appendix A for a

[63] VA Financial Policy, "Government Purchase Card for Micro-Purchases." This policy defines "strategic sourcing" as ensuring employees obtain proper contracts when regularly procuring goods and services. Purchases that exceed the cardholder's single purchase threshold cannot be made on purchase cards. Split purchases occur when a cardholder circumvents this requirement by dividing a single purchase or need into two or more smaller purchases.

[64] An approved VA Form 0242 is used to delegate authority to an individual to use the purchase card to procure and pay for goods and services.

[65] VA Financial Policy, "Government Purchase Card for Micro-Purchases."

[66] VA Financial Policy, "Government Purchase Card for Micro-Purchases."

[67] The sample transaction purchase dates are between May 1, 2022, and March 31, 2023. During this time, purchase card data were not available for April 1 through May 30, 2023.

[68] VA Financial Policy, "Government Purchase Card for Micro-Purchases."

[69] VA Financial Policy, "Government Purchase Card for Micro-Purchases."

full description of the inspection's scope and methodology and appendix B for details on its sampling. Based on the results of the sample, the team projected errors could exist in approximately 25,000 of 86,659 transactions, or 29 percent, totaling approximately $24.1 million in questioned costs.[70] The OIG projected that at least 221 transactions totaling at least $898,000 were split purchases.

Purchase Card Transactions

VA policy has specific requirements for using a government purchase card to acquire goods and services:[71]

- Prior approval must be obtained to ensure a valid business need before initiating a purchase. Approval may vary in form and content but must be retained as supporting documentation.[72]
- Transactions must be reconciled and approved no later than the 15th calendar day of the month, after the closing of the previous month's billing cycle.[73]
- Segregation of duties must be maintained to ensure roles and responsibilities do not overlap among the cardholder, approval official, or purchase card coordinator and to reduce the risk of fraud, waste, and abuse.[74]

The inspection team assessed the documentation of purchase card transactions provided by healthcare system personnel to determine if these requirements were met.

[70] 2 C.F.R. § 200.1. "Questioned cost means a cost that is questioned by the auditor because of an audit finding: (1) Which resulted from a violation or possible violation of a statute, regulation, or the terms and conditions of a Federal award, including for funds used to match Federal funds; (2) Where the costs, at the time of the audit, are not supported by adequate documentation; or (3) Where the costs incurred appear unreasonable and do not reflect the actions a prudent person would take in the circumstances. (4) Questioned costs are not an improper payment until reviewed and confirmed to be improper as defined in OMB Circular A–123 appendix C." Purchase card transactions with multiple types of noncompliance issues were only included once for the purposes of calculating this projection. Consideration was also given to margin of error and median confidence level when projecting questioned costs. For additional information regarding projection totals, see appendixes A and B.

[71] VA Financial Policy, "Government Purchase Card for Micro-Purchases."

[72] VA Financial Policy, "Government Purchase Card for Micro-Purchases." Some examples of approval documentation are emails, requisitions, memos, consults, or notes. Regardless of the form, the documentation must contain a certification from the requestor that the proposed purchase is for a legitimate government need, not for personal benefit, as well as a list of all items to be purchased. A copy of the approval must be retained as supporting documentation.

[73] VA Financial Policy, "Government Purchase Card for Micro-Purchases."

[74] VA Financial Policy, "Government Purchase Card for Micro-Purchases." VA requires that the duties of the cardholder, approving official, requesting official, and receiving official be segregated. An agency or organization program coordinator cannot be a cardholder or an approving official. No one person may order, receive, certify funds, and approve his or her own card purchases.

The OIG projected transaction reconciliations were not approved in a timely manner for at least 3,600 transactions totaling at least $3.5 million. The lack of prompt approval of reconciliations occurred because approving officials did not ensure that cardholders reconciled charges in a timely manner. Untimely, reconciliations and their related approval create opportunity for data integrity errors and fraud.

The inspection team also assessed if cardholders had split purchases into two or more acquisitions to circumvent their micropurchase threshold. Contracts must be used when the requirement is for an ongoing repetitive order of goods or services and the total value of the requirement exceeds the micropurchase threshold or the cardholder's authorized single purchase limit.[75] Cardholders are instructed not to modify a requirement or split purchases into smaller parts to avoid exceeding their purchase card limit or the use of formal contracting procedures; instead, cardholders should communicate the need for the order of goods or services to the contracting office for procurement.[76]

After reviewing transaction documentation and interviewing cardholders and approving officials, the OIG projected that at least 221 transactions totaling at least $898,000 were split to circumvent the slow contracting process and obtain the products faster. Example 5 describes a split purchase transaction.

Example 5

> *In January 2023, healthcare system staff used a purchase card to purchase items not covered under a contract. Healthcare system staff ordered and paid for the items in increments of about $8,000 and $9,000, that, if combined, would have exceeded their purchase card limit in order to avoid using formal contracting procedures. The cardholder said this occurred because there were so many urgent requests and they were trying to meet the demand.*

The proper way to purchase frequently needed or high-cost goods above the micropurchase threshold is to send the service request to the contracting office for purchase. This requires planning to ensure there is sufficient time for a contract to be expanded—or established if none exists—to purchase the products in time for scheduled use. Any VA cardholder or approving official who makes or certifies a purchase exceeding the micropurchase threshold has created an unauthorized commitment that must be ratified.[77]

[75] VA Financial Policy, "Government Purchase Card for Micro-Purchases."

[76] VA Financial Policy, "Government Purchase Card for Micro-Purchases."

[77] FAR 1.602-3 (August 2022). "Ratification of unauthorized commitments" defines ratification as the act of approving an unauthorized commitment by an official who has the authority to do so.

Use of Contracts

The inspection team also assessed the sampled transactions for evidence that healthcare system staff had considered the most appropriate purchasing mechanism. In accordance with policy, VA cardholders should pursue strategic sourcing—establishing contracts that generally provide greater savings to VA rather than using purchase cards for open market acquisitions without a negotiated price—for goods purchased on a recurring or ongoing basis. Approving officials, the agency or organization program coordinator, and cardholders must review purchases to determine when establishing contracts is in the best interest of the government and must communicate accordingly with the procurement office. Generally, VA should use contracts if the purchase is for an ongoing order of goods or services. However, the OIG determined the healthcare system made an estimated 15,900 transactions totaling approximately $15.4 million through the open market instead of leveraging established contracts that could have resulted in cost savings.

Generally, the improper reliance on purchase cards instead of communicating with the contracting office appeared to persist because the approving officials and cardholders did not ensure compliance throughout the transaction process and fulfill roles and responsibilities in accordance with VA policy. Proper reviews of purchases ensure that every effort is made to consider whether alternative contracts were warranted or available when purchasing goods and services on a regular basis. To meet the intent of VA policy, cardholders and approving officials should work with the contracting office to determine if alternative contracting options are warranted or available.

Purchase Card Oversight

Responsible officials are accountable for compliance with the Government Purchase Card Program and for implementing internal controls to protect and conserve federal funds.[78] Oversight activities such as periodic and continuous monitoring; checks and balances; and policies, procedures, and segregation of duties reduce the risk of error, fraud, waste, and abuse in the purchase card program.

To assess oversight of the program and compliance with VA policy, the inspection team determined whether the healthcare system had purchase card policies in place, assigned approving officials no more than 25 purchase card accounts each, maintained a VA Form 0242 for each cardholder in the inspection sample, and conducted reviews of cardholder transactions. To ensure approving officials can adequately review and verify cardholder transactions, approving officials are limited to no more than 25 purchase card accounts under their purview. VHA prosthetic purchase cards are exempt from this limit and

[78] VA Financial Policy, "Government Purchase Card for Micro-Purchases."

may have a ratio as high as 40 purchase card accounts to one approving official.[79] An approved VA Form 0242 is used to delegate authority to an individual to use the purchase card to procure and pay for goods and services. This form also establishes purchase limits and responsibilities and certifies that cardholders and approving officials understand the policies and regulations governing the purchase card program. A revised form is required when the approving officer changes, cardholders legally change their names, or the single purchase limit is changed from the originally requested amount.

The OIG found that the healthcare system provided oversight of the purchase card program. Specifically, the healthcare system had purchase card policies in place, conducted reviews of cardholder transactions, and assigned approving officials no more than 25 purchase card accounts each. For example, prior to the inspection, the system's assigned purchase card program coordinator formally disciplined one cardholder for making a split purchase. This potential split purchase was included in the sampled transactions and is reflected in the OIG's findings. Additionally, each of the 27 cardholders responsible for the 66 sampled transactions had an accurate VA Form 0242.

Supporting Documentation

VA policy requires cardholders to upload and store supporting documents for purchase card transactions on a VA-approved document-imaging system.[80] When using a purchase card to buy goods and services, healthcare system staff must maintain supporting documentation for six years, such as approved purchase requests, vendor invoices, purchase orders, and receiving reports. This documentation can be used to verify that purchase card transactions were properly approved and that payments were accurate. The OIG projected an estimated 17,200 transactions totaling approximately $16.6 million were missing required supporting documentation.

Finding 3 Conclusion

The healthcare system should be aware of and comply with VA policies on purchase card record retention requirements, split purchases, and use of contracts to strategically source facility needs. Specifically, some transactions were made that led to split purchases and potentially missed cost savings for frequently used goods. Failure to properly manage the purchase card program increases the risk of insufficient documentation, improper purchases, and missed opportunities to optimize cost savings. Based on the results of all areas of review for the sample, the team projected that the healthcare system may have made noncompliance errors in at least 24,957 of 86,659 purchase card transactions, totaling just over $24.1 million in questioned costs.

[79] VA Financial Policy, "Administrative Actions for Government Purchase Cards."
[80] VA Financial Policy, "Government Purchase Card for Micro-Purchases."

Corrective actions should be taken to ensure approving officials and cardholders consistently comply with VA policy.

Recommendations 6–7

The OIG made the following recommendation to the VA North Texas Health Care System executive medical center director:

6. Establish controls to ensure cardholders comply with record retention requirements, confirm approving officials and cardholders review purchases for VA policy compliance, and ensure contracting is used when it is in the best interest of the government.

The OIG made the following recommendation to the VISN-17 director:

7. Require cardholders to submit a request for ratification for any unauthorized commitments identified.

VA Management Comments

The VA North Texas Health Care System executive director concurred with recommendation 6 and the VISN 17 director concurred with recommendation 7.

To address recommendation 6, the executive medical center director reported that the purchasing agent and the inventory managers are required to complete yearly purchase card training and establish a training plan for weekly scheduled training that covers many topics from conversion factors to purchase card reconciliations. Trainings will also focus on record retention. To address recommendation 7, the VISN 17 director reported that purchasing agents or inventory managers will submit a ratification package if internal customers make purchases without preapproval.

OIG Response

VA's action plans are responsive to the recommendations. The OIG will monitor implementation of the planned actions and will close the recommendations when the OIG receives sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified.

IV. Inventory and Supply Chain Management

Supply chain management integrates and aligns people, processes, and systems for product and service planning, sourcing, purchasing, delivery, receiving, and disposal. VHA policy requires medical facilities to establish, operate, and maintain a supply chain management program that is effective, cost-efficient, transparent, and responsive to customer requirements and to continually identify ways to ensure high-quality veteran care.[81]

The Generic Inventory Package is the software system authorized to manage the receipt, distribution, and maintenance of expendable supplies used throughout VA. Inventory data, if properly recorded in this system, should reflect the actual quantities and dollar values of supply items in stock. Supplies are received at the warehouse and stored in a primary inventory point. These supplies are distributed as needed to secondary inventory points, such as storage rooms within the clinical areas that use those items. The team reviewed the following areas:

- **Supply chain management oversight.** The team assessed how the healthcare system ensured whether stock levels and inventory values were accurate for expendable items by analyzing Supply Chain Common Operating Picture (SCCOP) reports for performance metrics for days of stock on hand, conversion factor errors, and the number of manual adjustments made to inventory records. Days of stock on hand is a nationally set level of inventory for MSPV and non-MSPV items that facilitates efficient purchasing and use of supplies. The conversion factor connects how a supply item is purchased and issued—for example, purchased by the case but issued individually. Manual adjustments are used to make corrections to the quantity or value of supplies recorded in the Generic Inventory Package.
- **Inventory data accuracy.** Based on analysis of Supply Chain Data Informatics Office reports and interviews conducted, the team completed a physical count of some of the larger dollar items in two of the primary inventory points to assess accuracy.

Finding 4: The Healthcare System Needs to Improve Oversight of Data in the Generic Inventory Package

The OIG found that the healthcare system's oversight of inventory data needs improvement to ensure values are correctly recorded in the Generic Inventory Package. Specifically, supply chain management staff failed to properly record distribution of supplies for two inventory areas reviewed by the inspection team and did not monitor conversion factors entered in the inventory system. This led to increased reliance on manual counts and inaccurate inventory values, which required manual adjustments to correctly record data in the Generic Inventory Package. The OIG

[81] VHA Directive 1761, *Supply Chain Management Operations,* December 30, 2020.

found that the healthcare system did not conduct thorough supply chain management oversight or establish and follow inventory procedures.

Days-of-Stock-On-Hand Metrics Were Not Met

To avoid overstocking or understocking, VHA requires responsible staff to ensure correct reorder points and inventory levels are maintained.[82] VHA also requires the VISN chief logistics officer and healthcare system's chief supply chain officer to set up local processes and procedures to make sure all necessary reports are monitored routinely and all supply chain performance measures are maintained in compliance with performance criteria.[83] For VHA supply chain management, benchmarks and reports are published and tracked in SCCOP.[84] SCCOP reports assist with this requirement by specifying a goal for the number of days of stock a healthcare system should have on hand. From October 2022 through March 2023, the days-of-stock-on-hand goal for MSPV items was to have 30 days or less of stock on hand, and for non-MSPV items to have 45 days or less of stock on hand.[85] The healthcare system met this goal by averaging 29 days' stock for MSPV items and 36 days' stock for non-MSPV items.

While the healthcare system met the performance metrics for overall average of days-of-stock-on-hand, the individual clinical primary inventory points by location did not. The inspection team exported from SCCOP the standard clinical days-of-stock-on-hand summary reports for both MSPV items and non-MSPV items as of June 12, 2023.

Table 1 shows six of the eight clinical primary inventories with MSPV items, or 75 percent, did not meet the 30-day performance metric.

Table 1. MSPV Days of Stock on Hand for Clinical Primary Inventory Point by Location

Inventory point name	MSPV days of stock on hand	Met standard?
Clinic 1 – Prosthetics	138	No
Clinic 2 – Prosthetics	127	No
Clinic 3 – Medical-Surgical	68	No
Clinic 4 – Medical-Surgical	57	No
Clinic 5 – Prosthetics	56	No
Clinic 6 – Medical-Surgical	35	No

[82] VHA Directive 1761. The reorder point represents the level at which the item is to be replenished.

[83] VHA Directive 1761, p. A-3.

[84] VHA Directive 1761, p. A-3.

[85] Power Business Intelligence Supply Chain Common Operating Picture metrics and reports.

Inventory point name	MSPV days of stock on hand	Met standard?
Clinic 7 – Medical-Surgical	24	Yes
Clinic 8 – Medical-Surgical	22	Yes

Source: VA OIG analysis of SCCOP CA2. Standard Clinical Days of Stock on Hand Summary report as of June 12, 2023.

Table 2 shows four of 11 clinical primary inventories with non-MSPV items, or 36 percent, did not meet the 45-day metric.

Table 2. Non-MSPV Days of Stock on Hand for Clinical Primary Inventory Point by Location

Inventory point name	Non-MSPV days of stock on hand	Met standard?
Clinic 1 – Prosthetics	143	No
Clinic 2 – Medical-Surgical	111	No
Clinic 3 – Prosthetics	61	No
Clinic 4 – Medical-Surgical	54	No
Clinic 5 – Prosthetics	45	Yes
Clinic 6 – Medical-Surgical	45	Yes
Clinic 7 – Medical-Surgical	42	Yes
Clinic 8 – Medical-Surgical	41	Yes
Clinic 9 – Prosthetics	30	Yes
Clinic 10 – Laboratory	29	Yes
Clinic 11 – Prosthetics	29	Yes

Source: VA OIG analysis of SCCOP CB5. Standard Clinical Days of Stock on Hand Summary report as of June 12, 2023.

The supply chain management system at the VA North Texas Health Care System contained several inventory points in multiple locations, as noted in tables 2 and 3. The team accessed the SCCOP dashboard on June 12, 2023, and downloaded the "All Days of Stock on Hand Summary by Inventory Point" report, which represented information at a point in time. The team conducted interviews and physical counts at the two largest primary points measured by total value on hand.

A supervisory inventory manager for supply chain management stated that one of the issues with meeting the metrics is not being able to obtain all of the stock needed from the prime vendor. The chief supply chain officer said the MSPV vendor is failing to provide the inventory needed in a timely fashion. For example, an item ordered for the same quantity and price via MSPV could take two weeks to arrive, but the same item ordered on the open market would take only

three to four days to arrive. He also said that sometimes the healthcare system ends up having overstock when they have to order through both MSPV and open market to ensure the receipt of needed supplies.

The inspection team analyzed SCCOP reports and interviewed supply chain management leaders and staff to determine how they ensured stock levels and inventory values were accurate and what challenges they faced. One inventory manager said staff are constantly doing counts because there are so many hands in the inventory all the time, and due to a shortage of supply technicians the inventory system is not always updated when stock is removed from the shelves. The chief of logistics stated that supply chain management relies on Compensated Work Therapy program participants, who are not VA employees, to help with logistics and stock because the facility is very short-handed on supply technicians.[86] Another inventory manager explained that sometimes when an inventory item is issued to a veteran, a prosthetics clerk might record the wrong item in the records because they are selecting it based on the item description rather than the item master file number.[87] This can cause inaccuracies in a patient's records and the inventory system. For example, a prosthetics clerk may issue a four-pronged cane to a veteran but record that they issued a single-pronged cane. These inventory errors could be a reason for the increased reliance on manual inventory counts, manual ordering processes, and incorrect inventory values and quantities in the Generic Inventory Package, which could lead to manual adjustments. One inventory management specialist said proper training would alleviate many of these issues.

Conversion Factors Had Errors

In the Generic Inventory Package, an accurate conversion factor for individual supply items is necessary to determine both the cost and the value of the inventory.[88] The unit conversion factor connects how a supply item is purchased and then distributed for use within the healthcare system.[89] Any calculation error in the conversion factor causes inaccurate quantities and values in the system. For example, if the healthcare system purchased a case of 24 cans of soda for $24 and issued one can at a time, the correct conversion factor is 24 (quantity purchased of 24 divided by quantity issued of one), and, after issuing one can, the inventory quantity and

[86] Compensated Work Therapy is a VA clinical vocational rehabilitation program that provides vocational rehabilitation services; partnerships with business, industry, and government agencies to provide veteran candidates for employment; and employment support to veterans and employers.

[87] The item master file is a file within the IFCAP software program utilized for the storage of item information such as description, mandatory source, vendor, unit price and packaging, and product and manufacturer information.

[88] A conversion factor is a number used to convert a measured quantity to a different unit of measure without changing the relative amount. In the Generic Inventory Package, a conversion factor is a number used to change the unit of receipt to the unit of issue.

[89] The unit conversion factor is computed by dividing the unit of purchase by the unit of issue and equals one when the unit of purchase and the unit of issue are the same.

value should be 23 cans and $23. However, if the conversion factor was incorrectly set at 1, the Generic Inventory Package will remove all 24 cans (one case) after the first issuance of one can, and the inventory value will be $0 with zero quantity in the system. In this scenario, the difference is $23 and 23 cans, requiring the supply chain management staff to manually adjust the quantity and the value of inventory on hand. To reconcile the unit cost when purchased and the unit cost when issued, the supply chain management staff therefore would have to divide the cost of the case by 24 to reach the cost of each unit.

The team analyzed the SCCOP Conversion Factor report for all clinical primary inventory points at the healthcare system. This analysis identified potential conversion factor errors that, if not identified and corrected, can cause the quantity on hand and value of stock in the Generic Inventory Package to be unreliable. Data inaccuracies can affect the healthcare system's ability to meet the performance metric for days of stock on hand. According to SCCOP data, as of June 12, 2023, only 411 of 21,918 supply items had potential conversion factor errors. A supervisory acquisition specialist said that the conversion factor report is pulled at least once a month to monitor what is showing as a false conversion. This inventory manager stated that errors occur when stock is not adjusted correctly in the Generic Inventory Package by how it is purchased versus how it is issued in the inventory system. Supply vendors are not consistent in how they sell stock, such as by the case, box, or package. Therefore, supply chain management staff should ensure purchased items are converted correctly.

Example 6

> *The inspection team discovered a discrepancy with blood gas analyzer sensors. The Supply Chain Data Informatics Office report showed the healthcare system had 40 sensors in the inventory, valued at a cost of $3,968.20 per sensor for a total value on hand of $158,728. However, the conversion was entered in at the cost for a case of sensors (20 sensors per case) instead of at a single price of $198.41 per sensor. This conversion factor error caused the total value on hand to be overstated by $150,791.60. The inventory manager overseeing the medical surgical inventory point concurred that the unit of issue was incorrect due to a conversion error (see table 3).*

Conversion factor errors can lead to the increased reliance on manual inventory counts, manual ordering processes, and incorrect inventory values and quantities in the Generic Inventory Package, which require manual adjustments. The inspection team identified discrepancies in the cost per unit on stock items selected during the physical inventory walk-through. Specifically, there were inventory items valued individually at the cost of a case rather than the per unit cost, overstating the value on hand. While the healthcare system offers and highly recommends that staff complete training on conversion factors, the training is not mandatory.

Errors Led to Frequent Inventory Adjustments

The team analyzed the SCCOP "Generic Inventory Package Adjustments" report for the 90 days prior to June 12, 2023, to determine the number and associated value of adjustments for the clinical inventory points made at the healthcare system. The report showed positive and negative adjustments in the Generic Inventory Package to correct inventory points. Adjustments are made for a variety of reasons, such as items not needed, incorrect supply levels, or costing errors. According to the SCCOP report, healthcare system staff made over 750 adjustments affecting over 78,200 items totaling more than $12 million. There were 467 adjustments affecting over 60,400 items totaling more than $11 million in one clinic location for the medical surgical inventory point alone. Of that $11 million, the inspection team selected one inventory item that in total made up over $10 million in adjustments for patient property bags in just one day. This adjustment was composed of several adjustments caused by a supply technician inaccurately entering the wrong quantity and then trying to fix the error multiple times before it was ultimately corrected. The healthcare system was aware of this adjustment error, and a supervisor in supply chain management remedied the issue before the inspection team's site visit.

Inventory Data Accuracy Needed Improvement

The team selected some larger-dollar-value items in the medical surgical and prosthetics inventory points located in Dallas. During the physical counts in these two inventory storage areas, the inspection team found discrepancies between what was reported in the Generic Inventory Package and what was physically located in the inventory points. The team identified counts and values for the items selected that did not agree with what was reported in the Generic Inventory Package.

Specifically, one medical-surgical inventory point had 81 surgical staplers on-site valued at a total cost of about $15,400, while the inventory system showed 47 valued at a total of about $107,100. This discrepancy caused the value on hand to be overstated by just under $91,700. In addition, the team found similar errors when conducting counts for analyzer sensors, dermal curettes, and sinus blades in the medical-surgical primary inventory (see table 3).

The OIG found that the quantity of items selected in the medical-surgical primary inventory point was overstated in the Generic Inventory Package by just under $415,900. The team selected six inventory items in this location and found that value-on-hand quantities or amounts were inaccurate for four of the six stock items (see table 3).

Table 3. Discrepancies between Generic Inventory Package Data and the Physical Count in Medical-Surgical Dallas Inventory

Item description	Generic Inventory Package data		Physical inventory		Decrease in value on hand
	Quantity	Value on hand	Quantity	Value on hand	
Blood gas analyzer sensor	40	$158,728	40	$7,936	-$150,792
Reload surgical stapler	47	$107,067	81	$15,377	-$91,690
Dermal curette	389	$101,568	7	$1,829	-$99,739
Endosinus blade	73	$92,374	74	$18,728	-$73,646

Source: VA OIG analysis of inventory data versus a physical inventory count.

The team also selected six items to physically count in the Dallas prosthetics space and found that quantities for two stock items were different from the quantities reported in the inventory system, as shown in table 4. The Generic Inventory Package data showed 33 standard hospital beds; however, the inspection team found only 29. This discrepancy caused the value on hand to be overstated by just over $3,500. Finally, the team discovered that the inventory space had five more continuous positive air pressure devices in the storage area than the count stated in the Generic Inventory Package, causing the inventory value to be understated by just under $2,100.

Table 4. Discrepancies between Generic Inventory Package Data and the Physical Count in Prosthetics Dallas Inventory

Item description	Generic Inventory Package data		Physical inventory		Increase/decrease in value on hand
	Quantity	Value on hand	Quantity	Value on hand	
Standard hospital bed	33	$29,258	29	$25,711	–$3,546*
Continuous positive air pressure device	42	$17,609	47	$19,705	$2,096

Source: VA OIG analysis of Prosthetics Dallas inventory data versus a physical inventory count.

** Numbers may not sum due to rounding.*

Supply chain managers acknowledged these errors and made the adjustments needed. According to VHA policy, inventory managers and functional area employees must review inventory points

at least quarterly to ensure correct items and levels are maintained in the Generic Inventory Package.[90]

Finding 4 Conclusion

The healthcare system's oversight of supply chain management can be improved to ensure performance metrics for days of stock on hand are met for all clinical inventory points and inventory data are accurate in the Generic Inventory Package. VHA policy states that Generic Inventory Package information should be complete and accurate.[91] Unreliable inventory data can lead to the purchase of unnecessary supplies, overstocking, and spoilage. Additionally, increased reliance on manual inventory counts, manual ordering processes, and incorrect inventory values and quantities in the Generic Inventory Package could lead to manual adjustments and can affect the healthcare system's performance metrics. More importantly, errors indicating that supplies are available when they are not could adversely affect the healthcare system's ability to effectively plan and budget for the purchase of supplies to operate and meet patient care needs.

Recommendations 8–9

The OIG made the following recommendations to the VA North Texas Health Care System executive medical center director:

8. Develop and implement a plan to ensure data accuracy and reliability in the Generic Inventory Package in accordance with Veterans Health Administration policy.
9. Continue to develop and implement processes to ensure all necessary reports are monitored routinely and appropriate steps are taken to ensure all supply chain performance measures are maintained in compliance with policy.

VA Management Comments

The VA North Texas Health Care System executive medical center director concurred with recommendations 8 and 9.

To address recommendation 8, the executive medical center director reported inventory supervisors will randomly spot-check inventory locations weekly to make sure the inventory counts comply with policy. Supply chain management will adhere to the scheduled dates for conducting physical inventory counts established for fiscal year 2024 as directed by the interim chief supply chain officer's memorandum following VHA Directive 1761 policy.

To address recommendation 9, the executive medical center director reported inventory managers must retain working reports weekly in locations on the ShareDrive so their supervisors

[90] VHA Directive 1761.
[91] VHA Directive 1761.

can monitor their progress. Supply chain managers will continue to monitor inventory items inactive over one year and reassess to ensure the acceptable 10 percent compliance rate is being met. Additionally, supply chain management has service-wide weekly training sessions.

OIG Response

The healthcare system director's action plans are responsive to the recommendations. The OIG will monitor implementation of the planned actions and will close the recommendations when the OIG receives sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified.

Appendix A: Scope and Methodology

Scope

The team conducted its inspection of the VA North Texas Health Care System from June 2023 to January 2024, including a site visit during the week of June 26, 2023. The inspection is limited in scope and is not intended to be a comprehensive inspection of all financial operations at the healthcare system.

Methodology

The inspection team evaluated financial efficiency practices for fiscal year (FY) 2023 related to use of managerial cost accounting information, open obligations, purchase card transactions, and inventory and supply chain management.

To conduct the inspection, the team performed the following:

- Interviewed healthcare system leaders and staff
- Identified and reviewed applicable laws, regulations, VA policies, operating procedures, and guidelines related to use of managerial cost accounting information, open obligations, overseeing purchase card transactions, inventory, and supply chain management
- Statistically selected
    - 50 outstanding obligations (25 undelivered orders and 25 accrued expenses) to assess whether the healthcare system identified and reviewed the obligations to determine if they were valid and needed to remain open in accordance with VA financial policy
    - 66 purchase card transactions to determine if there was proper oversight and governance of the purchase card program, as well as to assess the risk for illegal, improper, or erroneous purchases
        - To review the transactions selected in the sample, the team requested supporting documentation for each of the 66 transactions, VA Form 0242 for all 27 cardholders associated with the selected transactions, and documentation to support the completion of purchase card reviews.
- Judgmentally selected
    - 10 high-cost products from the Managerial Cost Accounting Office modeling tool's April 2023 product cost report (from a total of 20,949 products available for review)

- 10 obligations with different end dates from VA's Financial Management System (FMS)–to–Integrated Funds Distribution, Control Point Activity, Accounting and Procurement (IFCAP) reconciliation reports to determine if end dates reconciled between VA's FMS and IFCAP
- 10 obligations with different order amounts from VA's FMS-to-IFCAP reconciliation reports to determine if order amounts were subsequently reconciled between VA's FMS and IFCAP
- Two clinical primary inventory points selected by highest total dollar value on hand to determine
  - the top 6 items by total inventory value in each inventory point selected
  - quantity on hand
  - unit of issue

Internal Controls

The inspection team assessed the internal controls of the VA North Texas Health Care System significant to the inspection objective. This included an assessment of the five internal control components that include control environment, risk assessment, control activities, information and communication, and monitoring.[92] In addition, the team reviewed the principles of internal controls as associated with this objective. The team identified internal control weaknesses during this inspection in all four sub-objectives assessed—use of managerial cost accounting information, open obligation oversight, purchase card use, and inventory and supply chain management—and proposed recommendations to address the weaknesses.

Fraud Assessment

The inspection team exercised due diligence in staying alert for the risk that fraud and noncompliance with provisions of laws, regulations, contracts, and grant agreements, significant within the context of the inspection objectives, could occur during this inspection. The team did not identify any instances of fraud or potential fraud during this inspection.

Data Reliability

The inspection team used computer-processed data obtained from US Bank files through a corporate data warehouse, Supply Chain Common Operating Picture reports, FMS reports, and cost accounting data from the Relative Value Unit modeling tool. To test for reliability, the team determined whether any data were missing from key fields, including any calculation errors, or

[92] GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G, September 2014.

were outside the time frame requested. The team also assessed whether the data contained obvious duplication of records, alphabetic or numeric characters in incorrect fields, or illogical relationships among data elements. Furthermore, the team compared purchase identification numbers, purchase dates, cardholder names, payment amounts, and vendor and merchant names as provided in the data received for the samples reviewed. Testing of the data disclosed that they were sufficiently reliable for the inspection objectives.

In addition, the team used computer-processed data included in reports from FMS to determine open obligation amounts. The OIG found that summary-level data were sufficiently reliable for reporting on the healthcare system's open obligations.

Government Standards

The OIG conducted this inspection in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation.*

Appendix B: Statistical Sampling Methodology

Open Obligations

The inspection team evaluated a statistical sample of outstanding accruals and a statistical sample of undelivered orders and accruals as of April 15, 2023, to determine whether the VA North Texas Health Care System performed monthly reviews and reconciliations to ensure that their obligations were valid and should remain open. The team also evaluated a judgmental sample of open obligations as of April 15, 2023, to determine if the end dates and amounts were accurate and reconciled between the FMS and IFCAP.

Population

As of April 15, 2023, the healthcare system had 174 undelivered orders (UDOs) valued at just over $29.9 million that had been inactive for 90 days or more. As of April 15, 2023, the healthcare system had 365 outstanding accruals totaling just over $23 million that had been open 90 days or more. The inspection team also analyzed FMS-to-IFCAP reconciliation reports for the period of November 2022 through April 2023 for end-date and order-amount discrepancies. The team identified 58 open obligations totaling just under $85.2 million with end-date discrepancies and 53 obligations totaling more than $141.2 million with order-amount discrepancies between FMS and IFCAP for three or more months, respectively.

Sampling Design

The inspection team reviewed the following from FMS reports to design its sample

- **Undelivered orders.** The team used a method of probability proportionate to size selection where the probability of selection was based on the number of days open greater than or equal to 90 days and the associated undelivered amount. The sampling design resulted in the review of 25 outstanding undelivered orders from the April 2023 FMS F850 report and allowed the inspection team to project its findings from the sample to the population. The F850 report lists each outstanding undelivered order.
- **Outstanding accruals.** The team used a method of probability proportionate to size selection where the probability of selection was based on the number of days open greater than or equal to 90 days and the associated outstanding balance. The sampling design resulted in the review of 25 outstanding accrued expenses from the April 2023 FMS F851 report and allowed the inspection team to project its findings from the sample to the population. The F851 report lists each accrual and its outstanding balance.

- **FMS-to-IFCAP reconciliations.** The team judgmentally selected 10 obligations with different end dates and 10 with different order amounts between FMS and IFCAP from VA's FMS-to-IFCAP reconciliation reports for April 2023.

The samples included 70 total open obligations: 25 outstanding undelivered orders totaling just under $12.9 million; 25 outstanding accruals totaling more than $12.2 million aged 90 days or more; 10 open obligations with different end dates between FMS and IFCAP totaling just under $5.9 million; and 10 open obligations with different order amounts between FMS and IFCAP totaling just under $100.1 million.

The team requested supporting documentation for each of the 70 sampled transactions, including monthly reviews and reconciliations, financial system screen prints and reports, and emails related to the obligations.

Purchase Cards

The inspection team evaluated a statistical sample of purchase card transactions that occurred from May 1, 2022, through March 31, 2023, to determine if the VA North Texas Health Care System reviewed transactions to (1) ensure they were adequately monitored, approved, and supported by documentation; (2) prevent split purchases; and (3) ensure goods or services were procured using strategic sourcing.

Population

From May 1, 2022, through March 31, 2023, the healthcare system had 87,521 purchase card transactions totaling just under $83 million. From this population, the team developed two strata from which to draw statistical samples. The first stratum included potential split transactions that exceeded the micropurchase threshold in the aggregate but not individually. The stratum included a total of 593 bundles of transactions composed of 2,293 individual transactions totaling approximately $10.1 million. The second stratum included the remaining purchase transactions, 84,373 transactions totaling about $73.7 million.[93]

Sampling Design

For the two strata, 66 sample transactions were selected using probability proportional to size of purchase amount by bundle (for potential split purchases) or by individual transaction (for other purchases).

- **Potential split purchases exceeded the micropurchase threshold.** The team identified potential split purchases as transactions with the same purchase date, purchase card

[93] The statistical sample was selected from positive dollar amount transactions (855 negative transactions such as refunds for disputed transactions and other corrections were excluded).

number, and merchant and a sum greater than the micropurchase threshold. The statistical sample consisted of 12 bundles of potential split purchases that included 41 transactions totaling approximately $244,174.

- **Other purchases.** The team selected 25 transactions totaling about $48,100 greater than or equal to $0 after all potential split purchases were identified.

Weights

Samples were weighted to represent the population from which they were drawn, and the weights were used in the estimate calculations. For example, the team calculated the error rate estimates by first summing the sampling weights for all sample records that contained the given error, then dividing that value by the sum of the weights for all sample records.

Projections and Margins of Error

The projection is an estimate of the population value based on the sample. The associated margin of error and confidence interval show the precision of the estimate. If the OIG repeated this audit with multiple sets of samples, the confidence intervals would differ for each sample but would include the true population value 90 percent of the time.

The OIG statistician employed statistical analysis software to calculate estimates, margins of error, and confidence intervals that account for the complexity of the sample design.

The sample size was determined after reviewing the expected precision of the projections based on the sample size, potential error rate, and logistical concerns of the sample review. While precision improves with larger samples, the rate of improvement decreases significantly as more records are added to the sample review.

Figure B.1 shows the effect of progressively larger sample sizes on the margin of error.

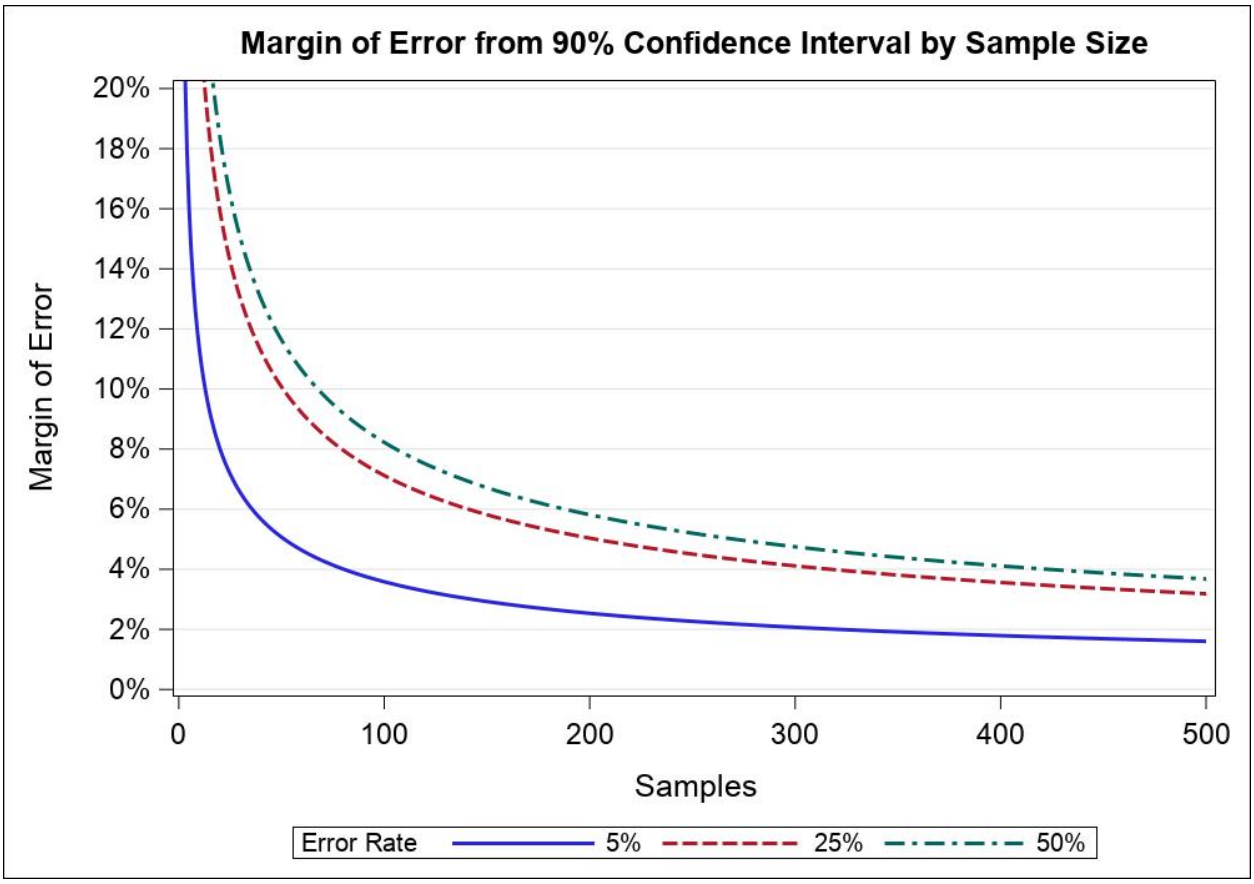

Figure B.1. *Effect of sample size on margin of error.*

Source: OIG statistician's analysis.

Open Obligations Oversight

Tables B.1 and B.2 show statistical projections of undelivered errors and the associated dollar amounts; Tables B.3 and B.4 show statistical projections of accruals and the associated dollar amounts.

Table B.1. Statistical Projections Summary for Undelivered Order Errors

Estimate name	Estimate	90 percent confidence interval				Samples
		Margin of error	Lower limit	Upper limit	One-tailed lower limit	
Overall errors (count)	64	43	21	107	31	6
Overall errors (percent)	37	25	12	61	18	6

Source: VA OIG statistician's analysis and team's review of undelivered orders with balances.

Note: For estimates with poor precision, the one-tailed lower limit for the 90 percent confidence interval is reported. This is a more conservative value than the estimate.

Table B.2. Statistical Projections Summary for Undelivered Order Errors: Dollar Amounts

Estimate name	Estimate	90 percent confidence interval				Samples
		Margin of error	Lower limit	Upper limit	One-tailed lower limit	
Better use of funds	$3,016,677	$3,094,200	$564,412	$6,110,877	$633,317	6

Source: VA OIG statistician's analysis and team's review of undelivered orders with balances.

Note: For estimates with poor precision, the one-tailed lower limit for the 90 percent confidence interval is reported. This is a more conservative value than the estimate.

Table B.3. Statistical Projections Summary for Accrual Errors

Estimate name	Estimate number	90 percent confidence interval			Sample size
		Margin of error	Lower limit	Upper limit	
Overall invalid accrual errors (count)	212	80	131	292	15
Overall invalid accrual errors (percent)	58	22	36	80	15
Overall better use of funds errors (count)	181	84	97	265	14
Overall better use of funds errors (percent)	50	23	27	73	14

Source: VA OIG statistician's analysis and team's review of obligations with accrual balances.

Table B.4. Statistical Projections Summary for Accrual Errors: Dollar Amounts

Estimate name	Estimate number	90 percent confidence interval			Sample size
		Margin of error	Lower limit	Upper limit	
Invalid accruals	$13,359,383	$5,073,578	$8,285,804	$18,432,961	15
Better use of funds	$11,421,241	$5,288,256	$6,132,985	$16,709,497	14

Source: VA OIG statistician's analysis and team's review of obligations with accrual balances.

Purchase Cards

Table B.5 shows purchase card transaction sample errors, and tables B.6 and B.7 show statistical projections of purchase card transaction errors and their dollar amounts.

Table B.5. Purchase Card Transaction Sample Errors

Estimate name	Number of errors	Sample size
Overall errors	22	66
Prompt reconciliation approval	8	66
Strategic sourcing errors	12	66
Supporting documentation	16	66
Potential split purchase	6	41

Source: VA OIG statistician's analysis and team's review of purchase card transactions.

Table B.6. Statistical Projections for Purchase Card Transaction Errors

Estimate name	Estimate number	90 percent confidence interval			
		Margin of error	Lower limit	Upper limit	One-tailed lower limit
Overall errors	24,957	9,884	15,073	34,841	17,288
Prompt reconciliation approval	8,127	5,778	2,350	13,905	3,645
Strategic sourcing errors	15,937	8,087	7,850	24,023	9,662
Supporting documentation	17,189	8,356	8,833	25,545	10,706

Estimate name	Estimate number	90 percent confidence interval			
		Margin of error	Lower limit	Upper limit	One-tailed lower limit
Potential split purchase	453	299	153	752	221

Source: VA OIG statistician's analysis and team's review of purchase card transactions.

Note: For estimates with poor precision, the one-tailed lower limit for the 90 percent confidence interval is reported. This is a more conservative value than the estimate. When reporting on total errors combined, a projected "overall errors" estimate is used to avoid double counting because nine transactions had multiple errors.

Table B.7. Statistical Projections for Purchase Card Transaction Error Dollar Amounts

Estimate name	Estimate amount	90 percent confidence interval			
		Margin of error	Lower limit	Upper limit	One-tailed lower limit
Overall errors	$24,135,627	$9,558,593	$14,577,033	$33,694,220	$16,719,500
Prompt reconciliation	$7,856,949	$5,587,717	$2,272,231	$13,447,664	$3,524,664
Strategic sourcing errors	$15,412,128	$7,820,687	$7,591,440	$23,232,815	$9,344,372
Supporting documentation	$16,623,509	$8,080,834	$8,542,676	$24,704,343	$10,353,917
Potential split purchase	$1,839,095	$1.215,632	$623,463	$3,054,727	$898,357

Source: VA OIG statistician's analysis and team's review of purchase card transactions.

Note: For estimates with poor precision, the one-tailed lower limit for the 90 percent confidence interval is reported. This is a more conservative value than the estimate. When reporting on total errors combined, a projected "overall errors" estimate is used to avoid double counting transaction amounts.

Appendix C: Monetary Benefits in Accordance with Inspector General Act Amendments

Recommendation	Explanation of benefits	Better use of funds	Questioned costs[94]
4	Ensure that healthcare system staff are made aware of policy requirements and the responsible fiscal office conducts reviews on all open obligations.	$12,200,000	$0
5	Consult with Office of General Counsel and legal Office of Acquisitions, Logistics and Construction to determine if any further actions are necessary, including contract modifications.	$0	$70,500
7–8	Ensure cardholders comply with record retention, prior approval, and purchase card reconciliation requirements as required by VA Financial Policy, vol. 16, chap. 1B, "Government Purchase Card for Micro-Purchases."	$0	$24,100,000
	Total	**$12,200,000**	**$24,200,000***

Note: The better use of funds for recommendation 4 is related to various open obligation monitoring and administrative deficiencies identified in the sampled obligations. This amount includes at least $633,000 from undelivered orders, an estimated $11.4 million from accruals, and undelivered orders of just over $186,000 due to end-date discrepancies which brought the total monetary benefits to a conservative estimate of just over $12.2 million. The questioned costs for recommendation 5 are related to the purpose statue and bona fide needs rule violations. The team identified improper obligations and expenditures in the amount of $86,100. However, this amount was reduced by $15,585 to prevent the possibility of double counting funds between better use of funds and questioned costs identified in this inspection report.

** Numbers may not sum due to rounding.*

[94] The OIG questions costs when VA action or inaction (such as spending or failure to fully compensate eligible beneficiaries) is determined by the OIG to violate a provision of law, regulation, contract, grant, cooperative agreement, or other agreement; when costs are not supported by adequate documentation; or when they are expended for purposes that are unnecessary or unreasonable under governing authorities. Within questioned costs, the OIG must, as required by section 405 of the IG Act, report unsupported costs. Unsupported costs are those determined by the OIG to lack adequate documentation at the time of the audit. Of the $24,200,000 in questioned costs, $16,600,000 was unsupported.

Appendix D: VA Management Comments

Department of Veterans Affairs Memorandum

Date: March 1, 2024

From: Executive Medical Center Director (00)

Subj: Financial Efficiency Inspection of the VA North Texas Health Care System VA Management Comments.

To: Assistant Inspector General for Audits and Evaluations (52)

Thru: Chief Financial Officer, VISN 17 (10N17)
Deputy Executive Director (00D)
Associate Director, Resources (001)
Chief Financial Officer, Fiscal Service (04)

VA North Texas Health Care System has reviewed the draft report for the Financial Efficiency Inspection of the VA North Texas Healthcare System and provides the below responses (Implementation Plan attachment E).

Finding 1: The Healthcare System Needs to Improve Its Use of Managerial Cost Accounting Information.

Recommendations 1-3

1. Establish a plan to use VA's cost accounting system information to identify alternative ways to reduce cost, enhance efficiency, and inform business decisions as identified by VA financial policy.
2. Ensure healthcare system staff responsible for labor cost and workload mapping are responding in a timely manner to the results of managerial cost accounting audits and correcting all identified issues.
3. Consider a plan to align VA North Texas Heath Care System financial management practices with federal financial accounting standard practices. This could include using cost information for performance measurement, budgeting, and cost control, and making economic choices.

Finding 2: The Healthcare System Does Not Always Identify and Review Inactive Obligations, Ensure Accruals Are Proper, or Reconcile End Dates and Amounts. The Chief Financial Manager concurs with this finding.

Recommendations 4-5

4. Ensure that healthcare system staff are made aware of policy requirements and the responsible finance office conducts monthly reviews and reconciliations on all open obligations for financial validity and take appropriate actions as required by VA Financial Policy, vol. II chap. 5, "Obligations" (2020), updated May 2023. The Chief Financial Manager concurs with recommendation #4.
5. Consult with Office of General Counsel and Office of Acquisitions, Logistic and Construction to determine if any further actions are necessary, including contract modification, to remedy and

prevent future Purpose Statute and bona fide needs rule violations. The Chief Financial Manager concurs with recommendation #5.

Finding 3: The Healthcare System Did Not Always Consider Using Contracts or Maintain Supporting Documentation. The Chief Supply Chain Officer concurs with this finding.

Recommendations 6-7

6. Establish controls to ensure cardholders comply with record retention requirements, confirm approving officials and purchase cardholders review purchases for VA policy compliance and ensure contracting is used when it is in the best interest of the government. The Supply Chief Supply Chain Officer concurs with recommendation #6.
7. Require purchase cardholders to submit a request for ratification for any unauthorized commitments identified. The Chief Supply Chain Officer concurs with recommendation #7.

Finding 4: The Healthcare System Needs to Improve Oversight of Data in the Generic Inventory Package. The Chief Supply Chain Officer concurs with this finding.

Recommendations 8-9

8. Develop and implement a plan to ensure data accuracy and reliability in the Generic Inventory Package in accordance with Veteran Health Administration policy. The Chief Supply Chain Officer concurs with recommendation #8.
9. Continue to develop and implement processes to ensure all necessary reports are monitored routinely and appropriate steps are taken to ensure all supply chain performance measures ae maintained in compliance with policy. The Chief Supply Chain Officer concurs with recommendation #9.

(Original signed by)

Jason Cave, J.D. SES

Executive Medical Center Director

Wendell E. Jones

VISN 17 Network Director - VHA

Attachment

Attachment

VA North Texas Health Care System

Implementation Plan

Attachment E

OIG Report Financial Efficiency Inspection of the VA North Texas Health Care System

Date of Draft Report: January 30, 2024

VA Comments: VA concurs with the OIG recommendations and will take the following action to address all 9 recommendations.

Recommendation 1. Establish a plan to use VA's cost accounting system information to identify alternative ways to reduce cost, enhance efficiency, and inform business decisions as identified by VA financial policy.

Action Plan: MCAO has been working in collaboration with leaders from the Chief Strategy Office, OPES, IVC, and other relevant departments to develop a make-buy model, but they have encountered challenges and have achieved only limited success. It is important to note that currently, there is not a universally recognized "gold standard" make/buy model within the VHA. While our workload capacity model effectively identifies where workload should be kept in-house versus care provided in the community, it is essential to acknowledge the inherent complexities and differences in our data compared to community care data. As a result, attempting to apply a make vs buy model to our situation would lead to unreliable and invalid results due to the inability to measure apples to apples accurately. VISN 17 remains committed to exploring alternative approaches and are consistently looking for ways that will provide meaningful and valid results into cost reduction and operational efficiency. MCA will actively continue to use reports, resources, and other information to help meet Finance Policy for business and operational efficiencies.

Status: Continued – In Progress

Target Completion Date: July 1, 2024

Recommendation 2. Ensure healthcare system staff responsible for labor cost and workload mapping are responding in a timely manner to the results of managerial cost accounting audits and correcting all identified issues.

Action Plan: The site manager mentioned that there were communication issues with healthcare staff when resolving labor cost and workload issues. We do have a clear chain of command for issue escalation, but this was a very new MCA site manager and did not raise this when unable to resolve this at his level and did not use the required group email that would have allowed leaders to see the communication break-down that kept the labor mapping issue from resolution. We have made this a re-emphasis with our MCA team to properly escalate unresolved issues and to use the proper group emails. We continue to assure good communication occurs between MCA and Dallas employees.

Status: Continually working to ensure all staff members are trained and monitored for correct labor mapping.

Target Completion Date: March 1, 2024

Recommendation 3. Consider a plan to align VA North Texas Heath Care System financial management practices with federal financial accounting standard practices. This could include using cost information for performance measurement, budgeting, and cost control, and making economic choices.

Action Plan: Our MCA team is readily available and encourages customers to reach out and learn MCA data. We will encourage the services to use the Managerial Cost Accounting Dashboard (MCAD) to review their data and collaborate with us on any discrepancies they or we find. We provide labor mapping training to all new NLMT users to ensure they are given necessary information. Monthly we are reviewing audits and outliers, reaching out to the services with questions and recommendations for improvement.

Status: In progress

Target Completion Date: July 1, 2024

Recommendation 4. Ensure that healthcare system staff are made aware of policy requirements and the responsible finance office conducts monthly reviews and reconciliations on all open obligations for financial validity and take appropriate actions as required by VA Financial Policy, vol. II chap. 5, "Obligations" (2020), updated May 2023.

Action Plan: Continue to send monthly emails notifications to initiating services identifying open obligations greater than 90 days past end date or no activity and provide a response to Finance by the 15th of the month. In addition, we will work with Contracting officers to process contract modifications and cancel orders for goods or services that are no longer needed within five calendar days of being notified by the initiating service. Finance will track and monitor the services responses and escalate to the Medical Center Director as appropriate. These actions reflect Finance responsibilities, per VA Finance Policy Volume II Chapter 5, to manage aging obligations.

Training will be provided to Finance staff and Services on how to review the various types of undelivered orders and identify the steps (processing receiving reports, decrease adjustment, request vendor invoices, contract modifications) to close them out. On a monthly basis, Finance service will begin utilizing the FMS to IFCAP reconciliation tool to reconcile obligations to ensure the amounts and end dates reconcile.

Status: Creating a Undelivered Orders (UDO) training plan and schedule; reviewing current UDO tracking process and follow-up action; and training staff on the FMS/IFCAP reconciliation tool.

Target Completion Date: June 30, 2024

Recommendation 5. Consult with Office of General Counsel and Office of Acquisitions, Logistic and Construction to determine if any further actions are necessary, including contract modification, to remedy and prevent future Purpose Statute and bona fide needs rule violations.

Action Plan: Reach out to the Office of General Counsel and Office of Acquisitions, Logistic and Construction (via email) to determine if any further actions are necessary, including modification, to remedy and prevent future purpose statute and bona find needs rule violations.

Status: In progress (email sent 2/22/2024)

Target Completion Date: March 29, 2024

Recommendation 6. Establish controls to ensure cardholders comply with record retention requirements, confirm approving officials and purchase cardholders review purchases for VA policy compliance and ensure contracting is used when it is in the best interest of the government.

Action Plan: Within Supply Chain Management Service, the purchasing agent and the inventory managers are required to complete yearly purchase card training. An established training plan has a weekly scheduled training that covers many topics from conversion factors to purchase card reconciliations. Approximately 40 % of our medical supplies are covered under the Prime Vendor (MSPV) contract. VISN 17 has the highest MSPV utilization rate, and within VISN 17- North Texas has the highest MSPV utilization rate. Electronic Catalog (ECAT) is encouraged and has been utilized to the extent that it can be. There are many items on Electronic Catalog (ECAT) that is prohibited for VHA Supply Chain Management to order. This limits and defeats the purpose of having a tool that allows for multiple agency contracts to be utilized to save government funds and conserve contracting manpower on creating contracts for items that already have national contract in place. The purchase ceiling for ECAT (Simplified Acquisition Threshold) is $250K, however in the past Supply Chain Management Service could request a waiver to exceed that, but that has been terminated therefor making the purchasing process more cumbersome. Many items with a high price point are required in bulk exceed the simplified acquisition threshold (SAT) and must be purchased via contracting negating the purpose of the multiple agency contracts that are displayed on Electronic Catalog (ECAT). The establishment of new contracts are encouraged at North Texas however, it can be a challenge to get the buy-in of the subject matter experts to take part in the FORCE package submission process and to assign a dedicated Contracting Officer Representatives (CORs) who are familiar with the products and the procedures/ projects the items are being requested for. VA North Texas Healthcare System continues to create new contracts for many items- we have more than 7000 items in our inventory. As the second largest 1A facility in the nation that offer a large range of services and complex modalities the aim is to standardize via contracts as opportunities present themselves; for example, several contracts were submitted for the Catheterization Laboratory (Cath Lab) that was rejected by the local contracting office because it was reported the Strategic Acquisition Center (SAC) was creating national contracts.

The Purchase Card Coordinator completed a 30% audit on retention requirements in September after a series of training sessions held every Friday in August 2023. All cardholders were present at the training sessions, except for two who were on extended leave. The audit identified the need for additional training, not only for cardholders but also for the Approving Officials. Further audit reviews are being conducted to ensure compliance and prevent a return to old practices. Approving officials are now actively involved in ensuring record retention. Training sessions are now held twice a month, focusing on record retention, reviewing purchases for VA policy compliance, and disputing incorrect charges.

The AUS staff has developed templates to enhance the support in transmitting requirements to the Contracting Office. It has been observed that the issue persists and as of March 5, 2024, it has been identified that the 2237 process of splitting requirements by Engineering is still being submitted, while Logistics has taken additional measures by assigning only two cardholders to Engineering. In order to address the ongoing problem, a request has been initiated for further training with Engineering. There is a need for additional maintenance contracts at North Texas. The approving officials are diligently examining purchases and if the known requirements exceed the single purchase limit, they are returning the 2237's to the requesting services.

Improved controls have been put in place and the number of purchase cards has been decreased. Currently, all services, with the exception of prosthetics, dental, pharmacy, and credentialing, are required to submit credit applications through Logistics. If Logistics is able to provide support, the applications are approved. This change was initiated in November, and the only new accounts created have been for the Logistics department.

Status: Consignment agreements are now simplified and NTX is currently working with local vendors to get more consignments in place.

Target Completion Date: June 30, 2024

Recommendation 7. Require purchase cardholders to submit a request for ratification for any unauthorized commitments identified.

Action Plan: Once it is discovered by Supply Chain Management Purchasing Agents or Inventory Managers that an internal customer has committed the government to a service and/or purchased a product without pre-approval and a funding document, they are notified by the Supply Chain Management Supervisor(s) that they must submit a ratification package.

Status: Currently Ongoing Process in Supply Chain Management Service

Target Completion Date: Immediately Identified and Ratification Process Initiated

Recommendation 8. Develop and implement a plan to ensure data accuracy and reliability in the Generic Inventory Package in accordance with Veteran Health Administration policy.

Action Plan: Inventory Managers run their autogen every morning to obtain their group category order(s). The Inventory Managers then physically confirm that what the system says is correct- because human error can occur. Supply Technicians and Compensated Work Therapy (CWT) individuals make mistakes on occasion when charging out and restocking locations. Inventory Managers physically inspect the location to ensure the system generated order amount(s) can fit in the location and the amount needed is accurate. Once they confirm, supervisors sign off on the needed quantities outlined on their autogen- this serves as their supporting documentation for need of item(s). The inventory manager is then authorized to place their orders using the system generated 2237. Inventory Managers are to run the auto-level setter tool every quarter to ensure that what the system has identified as the needed level based on the usage is established in the system and physically on-hand. ABC Inventory schedule adhere to the standard outlined in VHA Directive 1761. Weekly random spot checks on inventory locations are conducted by Supervisors to ensure that the inventory counts comply.

Status: In progress

Target Completion Date: Complete and ongoing - See attached VHA Directive 1761 referencing mandatory ABC Inventory Schedules.

Recommendation 9. Continue to develop and implement processes to ensure all necessary reports are monitored routinely and appropriate steps are taken to ensure all supply chain performance measures are maintained in compliance with policy.

Action Plan: All inventory managers are to file their working reports weekly in their designated folder on the ShareDrive for their supervisors to monitor their progress. Supply Chain Management has a service wide training plan. The classes take place once a week. The curriculum covers all reports, to include long supply, due-in, and inactive items. Currently according to the SCCOP Dashboard, NTX Dallas is in the green on the following metrics: Days of Stock On-hand: MSPV and Non-MSPV, ODI Accuracy, EX Null Fields, NTX Mandatory Fields, CSN Accuracy, NTX Valid Status, Inv Lost /Stolen, MSPV Formulary (usage), Class I Recalls, Other Class Recalls. The two categories that are slightly outside the range is Equipment Inventory Accountability (13 months) out of the 35,733 pieces of equipment NTX is accountable for approximately 675 are not compliant. Leaving NTX at a compliance rate of 98.15%. The second category slightly outside the compliance rate is items inactive over 1 year. The acceptable percentage is 10% and NTX is currently at 11.4%. This is an ongoing issue that must tempered with the consideration of policy and patient care. Some items are essential for the hospital to always have one in stock in case a situation presents itself without warning/planning and the unique or specialty item is

needed to care for a patient. The metrics of inactivity is continuously monitored and reassessed with the clinical staff.

Status: Currently Ongoing Process in Supply Chain Management Service

Target Completion Date: June 30, 2024

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

OIG Contact and Staff Acknowledgments

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