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VETERANS HEALTH ADMINISTRATION

Financial Efficiency Inspection of the VA Palo Alto Health Care System in California

FINANCIAL INSPECTION | REPORT #22-01565-29 | FEBRUARY 2, 2023

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Executive Summary

The VA Office of Inspector General (OIG) conducted this inspection to assess the stewardship and oversight of funds by the VA Palo Alto Health Care System in California and to identify potential cost efficiencies in carrying out medical center functions.[1] To accomplish this goal, the OIG identified areas that draw on considerable VA financial resources and made recommendations to promote the responsible use of VA's appropriated funds.

This inspection assessed the following four financial activities and administrative processes to determine whether the healthcare system had appropriate controls and oversight in place:

I. **Open obligations oversight.** An obligation is a legally binding commitment of appropriated funds for goods or services. Open obligations include those obligations that are not considered closed or complete and have a balance associated with them, whether undelivered or unpaid. Open obligations should be reviewed by the healthcare system finance office to ensure that beginning and ending dates are accurate, open balances are accurate and agree with source documents (e.g., contracts and purchase orders, receiving reports, invoices, and payments), and those beyond 90 days of the period of performance end date or without activity in the previous 90 days are valid and should remain open. The inspection team evaluated whether the healthcare system performed monthly reviews and reconciliations of sampled obligations.

II. **Purchase card use.** The VA 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 obtain goods and services directly from vendors. The inspection team evaluated whether the healthcare system (1) considered establishing contracts when making purchases, known as strategic sourcing, and (2) properly documented sampled transactions.[2] Using contracts for common purchases has several benefits, such as allowing VA to optimize purchasing power and obtain competitive pricing. Documenting transactions as required helps VA and other oversight entities identify potential fraud, waste, and abuse.

III. **Inventory and supply management.** Supply chain management is the integration and alignment of people, processes, and systems across the supply chain to manage all

[1] The VA Palo Alto Health Care System comprises three inpatient facilities located in Palo Alto, Menlo Park, and Livermore, California, and seven community-based outpatient clinics in San Jose, Capitola, Monterey, Stockton, Modesto, Sonora, and Fremont, California. The VA Palo Alto Health Care System is also home to several regional treatment centers and two residential homes for veterans in the Compensated Work Therapy program. For more information about the healthcare system budget, capacity, and daily census, see appendix A.

[2] VA Financial Policy, vol. 16, chap. 1B, "Government Purchase Card for Micro-Purchases," October 2019 and July 2021. This policy defines "strategic sourcing" as ensuring employees obtain proper contracts when procuring goods and services on a regular basis.

product/service planning, sourcing, purchasing, delivering, receiving, and disposal activities. Veterans Health Administration (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 deliver high-quality care to veterans.[3] The team evaluated whether the healthcare system met the performance metric for days of stock on hand and if supply chain operations were managed effectively.

IV. **Pharmacy operations.** To anticipate how much drugs will cost and when inventory needs to be restocked, an efficient healthcare system analyzes available data, such as prime vendor ABC inventory management reports and inventory turnover rates.[4] Consistent data review ensures that the healthcare system makes the best use of appropriated funds and has inventory when needed. The team evaluated whether the healthcare system managed its pharmacy operations effectively and provided adequate oversight of inventory management.

The OIG selected the VA Palo Alto Health Care System and these administrative processes for inspection based on an analysis of VA data from the VHA Office of Productivity, Efficiency and Staffing (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 team obtained the facility rankings from the stochastic frontier analysis model to assist with selecting facilities for financial efficiency inspections.

The team reviewed data from fiscal year (FY) 2021 and first quarter of FY 2022 if available, as well as conducted a site visit during the week of April 4, 2022. See appendixes B and C for more information about the inspection's scope and methodology. The findings and recommendations in this report should help the healthcare system identify opportunities for improving oversight and for ensuring the appropriate use of funds.

What the Inspection Found

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

I. **Open obligations oversight.** The inspection team analyzed data from July 1 through December 31, 2021, and judgmentally selected the 20 largest open obligations that had been inactive for more than 90 days, totaling almost $20.6 million. The team examined whether the healthcare system finance office performed required reviews to assess the validity and necessity of the remaining funds associated with each obligation. The team

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

[4] The inventory turnover rate is the number of times inventory is replaced during the year. Low inventory turnover rates indicate inefficient use of financial resources.

found that 10 obligations were still within the performance period, whereas the remaining 10 were more than 90 days past the performance period end date. The team was not able to verify that a review was completed on 10 of these 20 inactive obligations, totaling approximately $10.2 million. Per the practice of the VA Palo Alto Health Care System, the review of open obligations is divided among several finance personnel based on the nature of the obligation, but not all personnel were aware of the policy requiring review of inactive obligations.[5] Failure to review inactive obligations increases the risk of also failing to spend appropriations within the associated fiscal year and to repurpose funds to support veterans.

The team reviewed VA's reconciliation reports between the Financial Management System (FMS) and the Integrated Funds Distribution, Control Point Activity, Accounting and Procurement System (IFCAP) and determined that FMS and IFCAP reflected accurate end dates and order amounts for the 10 sampled obligations; however, two of the 10 obligations had residual funds totaling approximately $3,102 that should have been deobligated.[6] For the two obligations with residual funds, the healthcare system did not deobligate purchase orders and obligations when the initiating service had confirmed acceptance of all goods or services and that all invoices had been received and paid. If the end date has passed and the obligation is no longer valid, those funds should be deobligated to allow them to be used elsewhere to benefit veterans.

II. **Purchase card use and oversight.** The team reviewed a statistical sample of 35 purchase card transactions from October 1, 2020, through September 30, 2021, (totaling approximately $165,000) to determine whether transactions were processed in accordance with VA policy. The OIG found that the healthcare system did not always properly maintain supporting documentation for the sampled transactions. The team determined seven of 35 sampled transactions were missing some required documentation. Based on these results, the team projected cardholders may not have sufficient supporting documentation for at least 1,700 of 16,700 transactions, which resulted in at least $6.1 million in questioned costs.[7] This lack of documentation occurred because the healthcare system has not implemented a consistent method for electronically storing purchase card documentation and because approving officials did not ensure cardholders

[5] VA Financial Policy, vol. 2, chap. 5, "Obligations Policy," October 2020.

[6] "FMS to IFCAP Reconciliation Report," VHA, accessed October 1, 2021, https://vssc.med.va.gov/VSSCMainApp/products.aspx?PgmArea=59. (This is an internal VA website not publicly accessible). See appendix D for more information about better use of funds.

[7] The sample population consisted of an estimated 16,700 purchase card transactions from VA Palo Alto Health Care System, totaling approximately $64.5 million. See appendix C for details.

retained sufficient documentation to support purchase card transactions as required by VA policy.[8]

The inspection team also assessed whether healthcare system staff obtained prior approval, adhered to the segregation of duties throughout the transaction process, and provided prompt reconciliations in compliance with VA policy, which is designed to reduce fraud, waste, and abuse.[9] Of the 35 sampled transactions, eight did not meet at least one of the three reviewed requirements. Based on these results, the team projected cardholders may not have obtained prior approval, maintained segregation of duties, and/or performed prompt reconciliation for at least 1,700 of 16,700 transactions, resulting in at least $6.6 million in questioned costs.

The team also assessed potential split purchases (i.e., modifying a transaction into smaller parts to avoid exceeding the micro-purchase threshold or purchase card limit) and whether cardholders adhered to strategic sourcing guidelines.[10] Strategic sourcing ensures VA is obtaining the most competitive prices for goods and services. The team identified potential split purchases for 11 of the 18 sampled transactions. According to the team's projections, cardholders may have made unauthorized commitments for an estimated 620 of 1,000 potential split purchases, resulting in approximately $1.6 million in questioned costs. The team also determined that contracts could have been considered for nine of 35 sampled transactions. As a result, the team projected that cardholders could have garnered additional savings for VA when they purchased items for approximately 510 transactions, totaling at least $779,000. Using contracts for these items could lower the risk of split purchases and potentially optimize VA's purchasing power. These issues occurred because cardholders and approving officials did not work always together to ensure compliance throughout the transaction process and that roles and responsibilities were carried out in accordance with VA policy. Also, they did not communicate with the contracting office to determine if alternative contracting options were warranted or available.

Based on the results of the sample for all areas reviewed, the team projected that the VA Palo Alto Health Care System could have identified noncompliance errors in

[8] VA Financial Policy, "Government Purchase Card for Micro-Purchases." See appendix D for more information about questioned costs.

[9] 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 purchase card purchase.

[10] VA Financial Policy, "Government Purchase Card for Micro-Purchases." "Strategic sourcing" is defined as ensuring employees regularly obtain proper contracts when procuring goods and services on a regular basis.

approximately 7,200 of 16,700 purchase card transactions, totaling approximately $26.9 million in questioned costs.[11]

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 review sample. The healthcare system's purchase card coordinator conducted some purchase card reviews during fiscal year (FY) 2021, as required by policy.[12] However, confirmation was not available to support that any reviews were conducted in the first two quarters of FY 2021. Purchase card reviews are intended to evaluate and improve the effectiveness of internal controls and compliance with regulations and policies.

III. **Inventory and supply management.** The healthcare system could improve the effectiveness and efficiency of inventory management by ensuring stock levels and inventory values are recorded correctly in the Generic Inventory Package system, by establishing local processes and procedures for monitoring inventory reports, and by implementing a plan for staff training to increase awareness of internal controls and data reliability in the inventory system, and take appropriate steps to ensure all supply chain performance measures are maintained in compliance with VA policy.

Expendable supplies purchased through the Medical Surgical Prime Vendor-Next Generation (MSPV-NG) program should have 15 days or less stock on hand, whereas non MSPV-NG items should have 30 days or less stock on hand.[13] During the inspection period, the healthcare system averaged 36 days of stock on hand for MSPV-NG items and 20 days of stock on hand for non MSPV-NG items. Because of the COVID-19 pandemic, the healthcare system received a waiver to suspend days-of-stock-on-hand performance measures from May 7, 2020, through March 31, 2022, and order accordingly to avoid potential shortfalls.

To determine if the healthcare system had excess inventory, the team evaluated the inventory points under the purview of supply chain management. Three of five MSPV-NG inventory points (60 percent), including two top-dollar inventory points in the supply chain management service line, did not meet the days-of-stock-on-hand performance metric. All nine non-MSPV-NG inventory points met the days-of-stock-on-hand performance metric based on data reviewed. Noncompliance with

[11] The figure $26,900,000 is the sample estimate dollar amount for all errors found during this purchase card review. Ninety percent of all possible survey estimates under the same essential conditions would result in estimates between $14,200,000 and $39,500,000, as shown in table C.2 of appendix C.

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

[13] The national MSPV-NG program provides a customized distribution system to meet or exceed facility requirements through a just-in-time distribution catalog ordering process.

the MSPV-NG performance metric was attributed to staffing levels, nonfunctioning storage equipment, training issues, oversight, and data integrity and validity issues.

The inspection team also assessed oversight of required physical inventory of "A" classified items, which are inventory items with the highest 80 percent of annual usage dollars.[14] Physical inventories of "A" classified items must be conducted each quarter, and the review must be documented and signed by the VA medical facility chief supply chain officer, who transmits the report to the facility's Veterans Integrated Service Network (VISN) chief logistics officer and deputy network director.[15] The team found that although physical inventories for "A" classified items were completed, an accompanying memorandum documenting an inventory count was signed by the total supply support section chief instead of the chief supply chain officer, per VHA policy. Additionally, not all required VISN personnel were informed following the completion of inventory counts. The inspection team also found that quarterly physical inventory accuracy rates conducted at one primary inventory point varied significantly from one quarter to the next. The facility's chief of supply chain services is responsible for ensuring compliance with the routing and signing of completed "A" classified physical inventories but did not do so. Failure to properly manage processes and systems and to meet metrics for days of stock on hand across the supply chain results in inefficient management of product and service planning, sourcing, purchasing, delivering, and receiving and could adversely affect patient care.

IV. **Pharmacy operations.** The healthcare system could improve pharmacy efficiency by narrowing the gap between observed and expected drug costs, bringing the turnover rates closer to the VHA-recommended level and meeting requirements for monthly B09 reconciliation reporting.[16] Failure to follow these procedures could lead to unnecessary spending on drugs, increased risk of diversion, and the risk veterans may not get the drugs they need in a timely manner. Using a VA efficiency rating system, the inspection team found that the VA Palo Alto Health Care System had a gap of $5.4 million between the facility's observed and expected drug costs. According to the OPES model (based on FY 2020 data), the healthcare system spent approximately $74.9 million in observed prescription drug costs compared to about $69.5 million in

[14] In the ABC classification method, inventory point items with the highest 80 percent of the inventory annual usage dollars are classified as "A." Items with the next highest 10 percent of inventory annual usage dollars are classified as "B." Lastly, items representing the remaining 10 percent of inventory annual usage dollars are classified as "C."

[15] VHA divides the United States into 18 regional networks, known as VISNs. A VISN manages day-to-day functions of medical centers and provides administrative and clinical oversight.

[16] The B09 reconciliation process is how VA medical center pharmacies ensure they are making correct payments for the drugs they receive.

expected drug costs during the inspection period.[17] The chief of pharmacy attributed this gap of increased costs to drug prices increasing exponentially for a smaller amount of patients as compared to solely an increase in high-cost drugs. Despite efforts to implement local cost saving initiatives, the healthcare system still averaged an increase in spending of approximately $4.7 million over the expected budget during the last three fiscal years.

The healthcare system's pharmacy ABC inventory turnover rates could improve. The turnover rate is a measure of the number of times inventory is replaced during the year. In FY 2021, the healthcare system reported average inventory turnover rates of 9.68 for A items, 5.15 for B items, and 3.60 for C items compared to the recommended levels of 12–16 for A items, 6–10 for B items, and 6–10 for C items. The healthcare system attributed the low turnover rates to a tremendous number of medications on long extended backorders. Because of the medication shortages, the facility will purchase these drugs when available, which leads to more medication on the shelves than normal. Low inventory turnover rates could indicate the inefficient use of financial resources and an inability to properly forecast needed drug inventories. Failure to monitor and adjust inventory levels could lead to drug diversion, overstocking, spoilage, and stock shortages, which could adversely affect patient care.[18]

The team found that the healthcare system's B09 reconciliation process was not fully compliant with VA policy. When an order is delivered, the Pharmacy Service should verify that the amount and type of medication matches the invoice (invoices are received at the time the order is delivered) and record the receipt of supplies. The healthcare system did not submit monthly B09 reconciliation packages for five of the 12 months sampled. The healthcare system attributed noncompliance to staffing shortages. Without timely reconciliation reports, the healthcare system has no assurance that the amount paid to the prime vendor agrees with the amount of actual goods received.

What the OIG Recommended

The OIG made nine recommendations for improvement to the healthcare system director and one recommendation to the director of contracting for the Network Contracting Office 21 for the VA Sierra Pacific Network.[19] The number of recommendations should not be used, however, as a gauge of the system's overall financial health. The intent is for system leaders to use these

[17] VHA OPES Efficiency Opportunity Grid FY 2021 (based on 2020 data), accessed February 25, 2022, https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx (This is an internal VA website not publicly accessible).

[18] Drug diversion is when prescription medicines are obtained or used illegally.

[19] The Network Contracting Office 21 for the VA Sierra Pacific Network provides local, regional, and national procurement support to the VA Palo Alto Health Care System and other VISN 21 facilities.

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 strong stewardship of VA resources.

The OIG recommended that the director of the VA Palo Alto Health Care System ensure that healthcare system finance office staff are made aware of policy requirements, that reviews are conducted on all inactive open obligations, and that any identified excess funds are deobligated as required by VA policy.[20]

The OIG also made purchase card oversight-related recommendations to the director of the VA Palo Alto Health Care System to ensure cardholders comply with record retention requirements as stated in VA policy and to establish controls to confirm approving officials and purchase cardholders review purchases properly and make sure contracting is used when it is in the best interest of the government.[21] In addition, purchase cardholders should request approval for any unauthorized payments identified by the OIG team or by the healthcare system's review process. Lastly, the director of contracting for the Network Contracting Office 21 should ensure purchase card reviews are performed as required by policy.[22]

Related to inventory and supply management, the OIG made three recommendations to healthcare system director: (1) initiate and provide training of local supply chain procedures and processes, (2) improve the reliability of data within the Generic Inventory Package system, and (3) ensure compliance with the physical inventory of "A" classified items.

The OIG made two recommendations regarding pharmacy operations. The healthcare system director should continue to develop and implement a plan to increase inventory turnover closer to the recommended rate as established by the Pharmacy Benefits Management Office and should develop and implement a plan to complete monthly B09 reconciliation consistently to ensure discrepancies are corrected in a timely manner.

VA Comments and OIG Response

The director of the VA Palo Alto Health Care System concurred with recommendations 1–4 and 6–10 and provided responsive corrective action plans for each of these recommendations. The director of contracting for the Network Contracting Office 21 concurred with recommendation 5 and provided a responsive corrective action plan. Appendix E includes the healthcare system director's comments, and appendix F includes the director of contracting's comments.

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

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

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

The OIG considers all recommendations open. While the directors of the healthcare system and the Network Contracting Office reported that corrective actions for some of the recommendations were already completed, the OIG has not received any evidence or supporting documentation to evaluate these actions. The OIG will monitor the implementation of all planned actions and will close the recommendations when the VA Palo Alto Health Care System and the Network Contracting Office 21 provide sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified.

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Contents

Abbreviations

FMS	Financial Management System
FTE	full-time equivalent
FY	fiscal year
IFCAP	Integrated Funds Distribution, Control Point Activity, Accounting and Procurement System
MSPV-NG	Medical Surgical Prime Vendor-Next Generation
OIG	Office of Inspector General
OPES	VHA Office of Productivity, Efficiency and Staffing
PBM	Pharmacy Benefits Management
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 healthcare systems similar in size and complexity across VA to promote best practices.[23]

This inspection focused on the VA Palo Alto Health Care System in California. The OIG assessed the following four financial activities and administrative processes to determine whether appropriate controls and oversight were in place from October 2020 through September 2021:

I. **Open obligations oversight.** An obligation is a legally binding commitment of appropriated funds for goods or services. Open obligations include those obligations that are not considered closed or complete and have a balance associated with them, whether undelivered or unpaid. Open obligations should be reviewed by the healthcare system finance office to ensure that beginning and ending dates are accurate, open balances are accurate and agree with source documents (e.g., contracts and purchase orders, receiving reports, invoices, and payments), and those beyond 90 days of the period of performance end date or without activity in the past 90 days are valid and should remain open. The inspection team evaluated whether the healthcare system performed monthly reviews and reconciliations of sampled obligations.

II. **Purchase card usage.** The VA 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. 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 the healthcare system's purchase card program ensured proper supporting documentation for transactions, compliance with policies and procedures and considered using contracts for frequently purchased goods or services, known as strategic sourcing, to provide optimal savings to VA.

III. **Inventory and Supply Management.** The inspection team evaluated whether the healthcare system met performance metrics for days of stock on hand and complied with

[23] The Veterans Health Administration (VHA) uses a facility complexity model that classifies its facilities at levels 1a, 1b, 1c, 2, or 3, with level 1a being the most complex and level 3 being the least complex. The VA Palo Alto Health Care System was rated as a level 1a, high-complexity facility.

policies and procedures for supply chain management. The days-of-stock-on-hand metric promotes inventory level efficiency for items purchased through the Medical Surgical Prime Vendor-Next Generation (MSPV-NG) program as well as non MSPV-NG items.[24] To evaluate supply chain management oversight, the team assessed data validity, identified factors that affected the healthcare system's supply chain management, and reviewed quarterly physical inventories.

IV. **Pharmacy operations.** To anticipate how much drugs will cost and when inventory needs to be restocked, an efficient healthcare system analyzes available data, such as prime vendor inventory management reports and inventory turnover rates. Consistent data review helps ensure that the healthcare system makes the best use of appropriated funds and has inventory when needed. The team assessed whether the healthcare system complied with applicable policies and used cost and performance data to track progress toward goals, improve pharmacy program operations, and identify and correct problems.

To assess these areas, the inspection team performed a site visit at the VA Palo Alto Health Care System during the week of April 4, 2022; interviewed healthcare system leaders and staff; and reviewed data, supporting documents, and processes related to the healthcare system's financial efficiency. The team selected data from fiscal year (FY) 2021 for the review. For more information about the healthcare system, see appendix A. For more information about the inspection's scope and methodology, see appendixes B and C. The findings and recommendations in this report should help the healthcare system identify opportunities for improving oversight and for ensuring the appropriate use of funds.

VA Palo Alto Health Care System

The VA Palo Alto Health Care System is part of the VA Sierra Pacific Network (Veterans Integrated Service Network [VISN] 21), which serves veterans in northern and central California, Nevada, Hawaii, the Philippines, and U.S. territories in the Pacific Basin.[25] It comprises three inpatient facilities located in Palo Alto, Menlo Park, and Livermore, California, and seven community-based outpatient clinics in San Jose, Capitola, Monterey, Stockton, Modesto, Sonora, and Fremont, California.[26]

The VA Palo Alto Health Care System is one of the largest integrated healthcare systems in VA in terms of specialized programs, research, and graduate medical education and is primarily

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

[25] VHA divides the United States into 18 regional networks, known as VISNs, which manage day-to-day functions of medical centers and provide administrative and clinical oversight.

[26] The VA Palo Alto Health Care System is also home to a variety of regional treatment centers and two residential homes for veterans in the Compensated Work Therapy program.

affiliated with Stanford University School of Medicine. Comprehensive health care is provided through primary, tertiary, and long-term care with a focus on medicine, surgery, psychiatry, physical medicine and rehabilitation, neurology, oncology, dentistry, geriatrics, and extended care.

In fiscal year (FY) 2021, the VA Palo Alto Health Care System operated close to 800 hospital beds among its facilities and provided services to approximately 67,000 enrolled veterans. The reported FY 2021 medical care budget exceeded approximately $1.35 billion, a $96 million increase (8 percent) over the FY 2020 budget of approximately $1.25 billion, which was an increase of almost $185 million (17 percent) from the FY 2019 budget of approximately $1.1 billion.

Facility and Review Area Selection

The inspection team identified healthcare systems with the greatest potential for financial efficiency improvements based on data from the Veterans Health Administration (VHA) Office of Productivity, Efficiency and Staffing (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 for comparisons 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 obtained the facility rankings from the stochastic frontier analysis model in the grid to assist in selecting facilities for financial efficiency inspections.[27] The inspection is limited in scope and is not intended to be a comprehensive inspection of all financial operations at the VA Palo Alto Health Care System.

[27] Stochastic frontier analysis is a modeling principle used 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 1 is most efficient, and values greater than 1 are associated with increasing inefficiency.

Results and Recommendations

I. Open Obligations Oversight

VA's management of open obligations has been a long-standing issue and was included as a significant deficiency in VA's FY 2021 audited financial statements and as a material weakness in VA's FY 2019 and FY 2020 audited financial statements.[28] 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.[29] If reviews are not conducted, the facility is vulnerable to the risk that those funds cannot be reobligated and used for other goods or services in that fiscal year to support veterans.

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

- **Inactive obligations.** The inspection team assessed whether the healthcare system performed monthly reviews and reconciliations to ensure that the sampled inactive obligations were valid and should remain open. Inactive obligations have had no activity for more than 90 days.
- **Financial Management System (FMS) to Integrated Funds Distribution, Control Point Activity, Accounting and Procurement (IFCAP) reconciliations.** The team identified open obligations with different end dates or order amounts between FMS and IFCAP to ensure the healthcare system reconciled end dates and order amounts between the systems for the sampled obligations.

Finding 1: Inactive Obligations Were Not Always Being Reviewed, and Some Obligations Were Not Promptly Deobligated

VA policy requires finance offices to perform monthly reviews and reconciliations of open obligations that are beyond 90 days of the period of performance end date or that have been inactive for more than 90 days to ensure the obligation is still valid and that funds are not

[28] 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; VA OIG, Audit of VA's Financial Statements for Fiscal Years 2019 and 2018, Report No. 19-06453-12, November 19, 2019. 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 on a timely basis. 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.

[29] 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.

underutilized.[30] For these obligations, healthcare system finance office personnel should verify with the initiating service or contracting officer, if applicable, that the goods or services have not been received and are still needed. The responsible finance office should review data from VA's FMS against supporting documentation on a monthly basis to ensure reports, subsidiary records, and systems reflect proper costing, an accurate delivery date and end date, and a correctly calculated unliquidated obligation.[31]

Figure 1 shows the number and dollar amounts of inactive obligations for the VA Palo Alto Health Care System from July through December 2021.

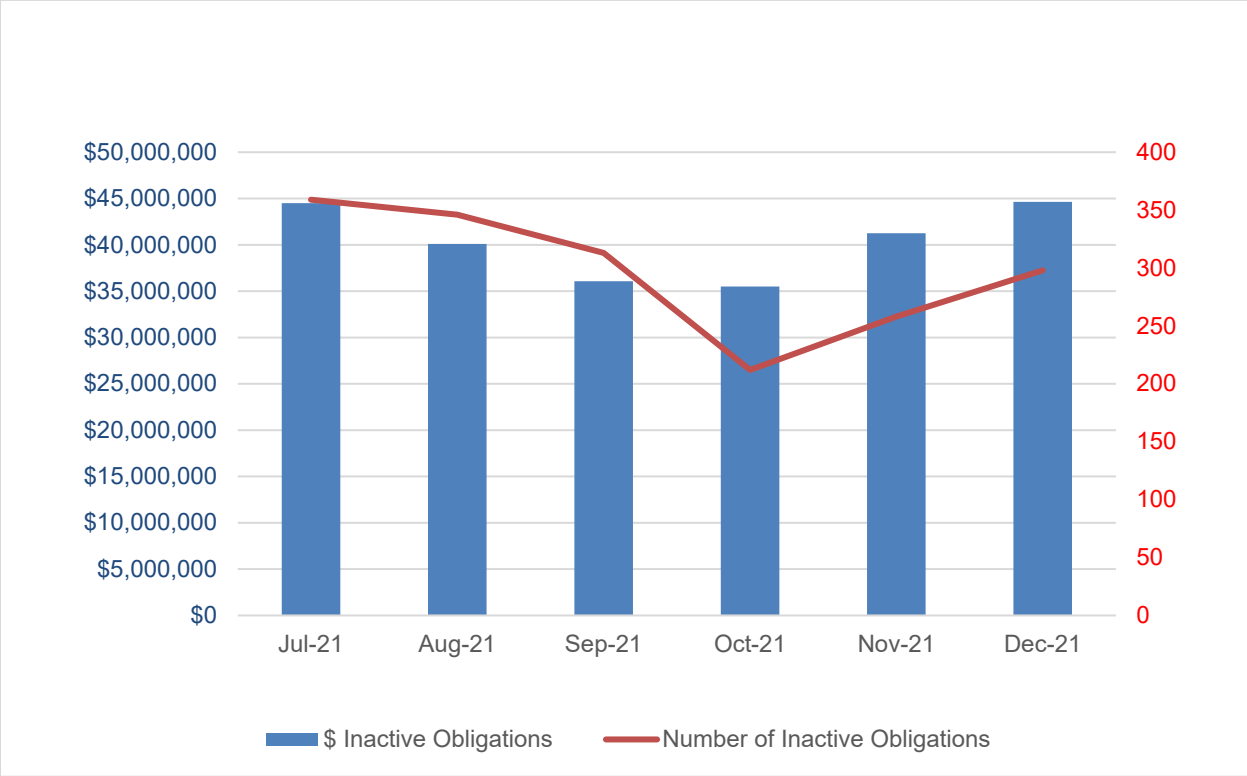

Figure 1. *VA OIG analysis of inactive obligations for the VA Palo Alto Health Care System, July through December 2021.*
Source: VA FMS F850 Report

As of December 2021, the healthcare system had 298 inactive obligations totaling $44.6 million. Figure 2 shows the age and dollar amounts of these obligations. As shown, 130 obligations totaling over $27.4 million had no activity for 181 days or more.

[30] VA Financial Policy, vol. 2, chap. 5, "Obligations Policy," October 2020.

[31] 2 C.F.R. § 200.1. The term "unliquidated obligation" means an obligation incurred by a nonfederal entity that has not been paid (liquidated) or for which the expenditure has not been recorded.

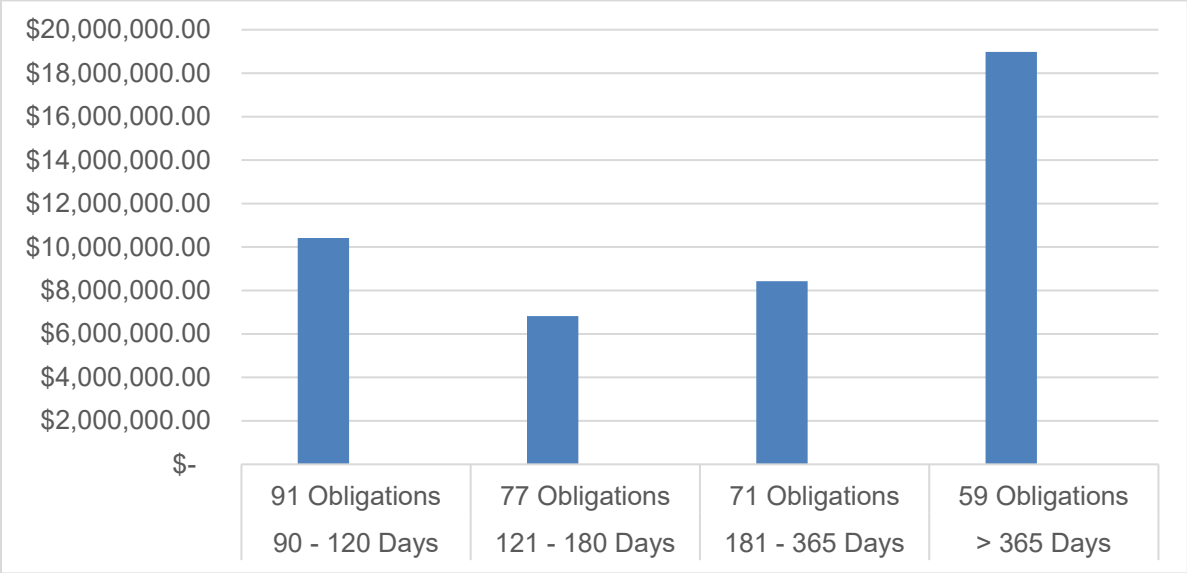

Figure 2. VA OIG analysis of inactive obligations for the VA Palo Alto Health Care System in December 2021.Source: VA FMS F850 Report.

Inactive Obligations

The inspection team performed data analysis and selected 20 inactive obligations as of December 2021 totaling almost $20.6 million. The team reviewed supporting documentation to assess whether the healthcare system identified and reviewed the sampled obligations to determine if they were still valid and needed to remain open in accordance with VA financial policy.[32] Ten obligations were still within the performance period, whereas the remaining 10 were more than 90 days past the performance period end date. The team was not able to verify that a monthly review was completed on the 10 obligations still within the performance period, totaling approximately $10.2 million. See appendix B for additional details on the inspection's scope and methodology and appendix C for details on the inspection's sampling.

VA policy states open obligations should be reviewed by the finance office, in coordination with the initiating service, to ensure that obligations beyond 90 days of the period of performance end date or without activity in the previous 90 days are valid and should remain open.[33] If funds remain on the obligation after the delivery and the initiating service has confirmed acceptance of all goods or services and invoices have been received and paid, the acquisition office should modify the contract or order to reflect the final cost and decrease the remaining funds on the obligation. The review of obligations is divided among several healthcare system personnel depending on the specific type of obligation. According to VA Palo Alto Health Care System finance office personnel, reviews for obligations inactive beyond 90 days were not always

[32] VA Financial Policy, "Obligations Policy."
[33] VA Financial Policy, "Obligations Policy."

conducted due to a lack of awareness of VA policy. The fiscal staff reported that they focused on obligations that are beyond 90 days of the period of performance end date and not on obligations with more than 90 days of inactivity.

End-Date and Order Amount Discrepancies between FMS and IFCAP Reconciliations

IFCAP handles the processing of certified invoices and electronic transmission of receiving documents to FMS. In addition, IFCAP transfers obligation information back to the control point and updates the control point balance automatically.[34] 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. Open obligations should be reviewed monthly by the healthcare facility's finance office, in coordination with the initiating service, to ensure period of performance dates are correct and match in all systems.[35]

The inspection team identified 90 open obligations with end-date discrepancies between FMS and IFCAP for three or more months. The healthcare system reported they had focused on order amount differences between FMS and IFCAP instead of end-date differences. Also, staff reported that a Veterans Health Information Systems and Technology Architecture (VistA) system glitch caused end dates not to reconcile.[36] The healthcare system submits end-date changes on behalf of the services manually via FMS. In these cases, the end dates did not sync because VistA and FMS were not designed to have this functionality. As a result of the OIG's inspection, the Chief Accountant said finance office staff began using the FMS to IFCAP Reconciliation report to compare end dates and work on reconciling them among the systems.

Additionally, the inspection team identified 42 open obligations with order amount discrepancies between FMS and IFCAP for three or more months. To determine if order amounts were accurate and reconciled between the two systems, the team selected and evaluated 10 of these open obligations with order amount discrepancies totaling about $509,000 from VA's FMS to IFCAP Reconciliation reports.[37] The discrepancies were mostly due to timing issues of amounts posting between both systems. Modified order amounts would also cause discrepancies if these modifications were not posted in a timely manner. The team determined that FMS and IFCAP were corrected by the healthcare system before the inspection and reflected correct order

[34] 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.

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

[36] VistA provides an integrated inpatient and outpatient electronic health record for patients and administrative tools to help VA deliver quality care.

[37] FMS to IFCAP Reconciliation Reports, VHA, accessed January 24, 2022, https://vssc.med.va.gov/VSSCMainApp/products.aspx?PgmArea=59 (This is an internal VA website not publicly accessible.)

amounts for all 10 obligations reviewed. During the review of order amounts, the team identified two obligations that had residual funds totaling approximately $3,102 that should have been deobligated in a timely manner after the goods were received.

For the two obligations with residual funds, the healthcare system did not deobligate purchase orders and obligations when the initiating service had confirmed acceptance of all goods or services and that all invoices had been received and paid. The acquisition office should modify the contract or order to reflect the final cost and quantity of the goods or services and decrease the remaining funds on the obligation. The failure to deobligate residual funds occurred due to a lack of communication among contracting staff and service line staff, which caused them not to complete the deobligation in FMS in a timely manner. If the end date has passed and the obligation is no longer valid, those funds should be deobligated and used elsewhere.

Finding 1 Conclusion

Healthcare system personnel were noncompliant with VA policies and reported that lack of VA policy awareness among relevant staff prevented routine follow-up of open obligations. The inspection team found that, specifically for open obligations with no activity for more than 90 days, monthly reviews were not always conducted. Also, the inspection team found that for two obligations with residual balances totaling approximately $3,102, funds were not promptly deobligated after the goods were received. Failure to properly manage open obligations increases the risk of also failing to spend appropriations within the associated fiscal year, leaving funds attached to orders when they could otherwise be used for other purposes to benefit veterans.

Recommendation 1

The OIG made the following recommendation to the director of the VA Palo Alto Health Care System:

1. Ensure that healthcare system finance office staff are made aware of policy requirements and that reviews are conducted on all inactive open obligations, and deobligate any identified excess funds as required by VA Financial Policy, vol. 2, chap. 5, "Obligations Policy."

VA Management Comments

The director of the VA Palo Alto Health Care System concurred with recommendation 1. The responses to all report recommendations are provided in full in appendixes E and F. To address recommendation 1, the director reported healthcare system fiscal staff now review open inactive obligations as a part of normal reviews of all open obligations with no activity for more than 90 days and ensure documentation of follow up.

OIG Response

The healthcare system director's action plan is responsive to the recommendation. Although the director reported the actions were completed in April 2022, the OIG did not receive any evidence or supporting documentation to evaluate these actions. The OIG will monitor implementation of the planned actions and will close the recommendation when it receives sufficient evidence demonstrating progress in addressing the intent of the recommendation and the issues identified.

II. Purchase Card Use

VA established its Government Purchase Card Program to reduce the administrative costs related to acquiring 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 October 1, 2020, through September 30, 2021, the VA Palo Alto Health Care System spent approximately $77.2 million through purchase cards, representing approximately 87,000 transactions. The amount and volume of the healthcare facility's spending through the program make 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.

The team reviewed the following areas:

- **Supporting documentation.** The team examined whether the healthcare system maintained supporting documentation as required for purchases to provide assurance of payment accuracy and the mission-essential need to purchase a good or service. This includes approved purchase requests, purchase orders, vendor invoices, receiving reports, and, when necessary, written justification for purchases from a third-party payer.[38] Supporting documentation enables program oversight and helps prevent fraud, waste, and abuse.
- **Purchase card transactions.** The team reviewed whether the healthcare system processed purchase card transactions in accordance with VA policy, such as whether approving officials prevented split purchases (i.e., when a cardholder intentionally splits a purchase into two or more purchases or payments to avoid exceeding the single purchase limit or micro-purchase threshold). Additionally, the team assessed whether the healthcare system considered obtaining contracts when procuring goods and services on a regular basis, which VA refers to as "strategic sourcing." Using contracts reduces open market or individual purchases and enables VA to leverage its purchasing power.[39]
- **Purchase card oversight.** The team assessed whether approving officials ensured separation of duties, conducted prompt reconciliation of cardholder transactions, and if the purchase card coordinator conducted thorough purchase card reviews.

[38] VA Financial Policy, vol. 16, chap. 1B, "Government Purchase Card for Micro-Purchases," October 22, 2019, and July 14, 2021. Cardholders will not use third-party payers unless there are no other available vendors. Cardholders will justify in writing if a third-party payer is used and keep documentation identifying the actual vendor providing the item. Examples of third-party payers include PayPal, EMoney, E-Account, Amazon Marketplace, Google Checkout, and Venmo.

[39] VA Financial Policy, "Government Purchase Card for Micro-Purchases." "Strategic sourcing" is defined as ensuring employees regularly obtain proper contracts when procuring goods and services on a regular basis.

These activities are examples of systematic controls that help reduce errors and ensure a facility complies with VA policy.[40]

Finding 2: The Healthcare System Did Not Always Maintain Supporting Documentation or Consider Using Contracts

The team evaluated a sample population of an estimated 16,700 purchase card transactions totaling approximately $64.5 million from October 1, 2020, through September 30, 2021. Of these 16,700 transactions, the team reviewed a statistical sample of 35 transactions, totaling approximately $165,000, to determine whether the VA Palo Alto Health Care System maintained required purchase card transaction documentation and whether transactions were processed in accordance with VA policy.[41] Eighteen of the 35 sampled transactions were also reviewed to determine if cardholders split purchases to circumvent their authorized single purchase limit. Based on the results of the sample, the team projected noncompliance errors could exist in approximately 7,200 of 16,700 (43 percent) purchase card transactions, totaling approximately $26.9 million in questioned costs.[42]

Though healthcare system leaders did oversee the program, the OIG team found that improvements could be made to ensure approving officials, purchase card coordinators, and cardholders review purchases as they were processed and consistently maintain supporting documentation. Reviewing transactions helps ensure that approving officials and cardholders are following policy; reduces the risk of error, fraud, waste, and abuse; and promotes the good stewardship of government money.

Supporting Documentation

Cardholders are required to electronically upload and store supporting documents for purchase card transactions to a VA-approved document-imaging system.[43] When using a purchase card to buy goods and services, healthcare system staff must maintain supporting documentation, such as approved purchase requests, vendor invoices, purchase orders, and receiving reports, for six years. This documentation can be used to verify that purchase card transactions were properly approved and that payments were accurate.

The inspection team determined that seven of the 35 sampled transactions were missing some required supporting documentation. Based on these results, the team projected cardholders may

[40] VA requires that the duties of the cardholder, approving official, requesting official, and receiving official be segregated. An agency/organization program coordinator cannot be a cardholder or an approving official. No one person may order, receive, certify funds, and approve his/her own purchase card purchase.

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

[42] See appendix B for additional details on the review's scope and methodology and appendix C for details on the review's sampling.

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

not have sufficient supporting documentation for at least 1,677 of approximately 16,700 (10 percent) transactions, which resulted in at least $6.1 million in questioned costs. This occurred because the healthcare system has not implemented a consistent method for electronically storing documentation on the Charge Card Portal or another VA-approved document-imaging system. In addition, approving officials did not ensure cardholders retained sufficient documentation to support purchase card transactions.

Purchase Card Transactions

VA policy requires purchase cardholders to meet three requirements when using government purchase cards to acquire goods and services:

- **Prior approval.** Before initiating a purchase, the cardholder must obtain prior approval for the purchase to ensure a valid business need; the approval may vary in form and content but must be retained as supporting documentation.[44]
- **Reconciliation.** Reconciliation of a purchase should be completed by the cardholder and approved by the approving official no later than the 15th calendar day of the month after the closing of the previous month's billing cycle (accounts not reconciled within 30 days of the due date will have their single purchase limit lowered).
- **Segregation of duties.** Healthcare facility staff must maintain segregation of duties to ensure roles and responsibilities do not overlap among the cardholder, approval official, or purchase card coordinator to reduce the risk of fraud, waste, and abuse.

The OIG found that eight of the 35 sampled transactions did not meet at least one of the three reviewed requirements. Based on these results, the team projected cardholders may not have obtained prior approval, performed prompt reconciliation, and/or maintained segregation of duties for at least 1,733 of approximately 16,700 (10 percent) transactions, resulting in at least $6.6 million in questioned costs. These issues occurred because approving officials did not provide sufficient oversight of the transaction process to ensure cardholders were compliant with VA policy. Approving officials must ensure transactions are legal, proper, and mission essential. This includes ensuring that proper approval is obtained before the purchase and that segregation of duties is maintained throughout the transaction process. Also, approving officials are responsible for ensuring timely reconciliation of charges made by cardholders.

[44] VA Financial Policy, "Government Purchase Card for Micro-Purchases." Approval documentation may vary in form and content. Some examples include 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.

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 that are purchased on a recurring or ongoing basis.[45] 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. Generally, VA should use contracts if the purchase is for an ongoing order of goods or services. Contracts must also be used when the total value of the requirement exceeds the micro-purchase threshold or the cardholder's authorized single purchase limit.[46] Cardholders must not modify a requirement or order into smaller parts to avoid exceeding their micro-purchase threshold, purchase card limit, or the use of formal contracting procedures. The requirement for the goods or services should be communicated to the contracting office for procurement.[47]

The team assessed 18 of 35 sampled transactions to determine if cardholders split purchases.[48] After reviewing documentation and interviewing purchase cardholders and approving officials to discuss the transactions, the team found that 11 of 18 sampled transactions were split purchases. As a result, the team projected cardholders may have split purchases and made unauthorized commitments for an estimated 620 of 1,000 potential split purchase transactions, resulting in approximately $1.6 million in questioned costs.[49] The team also determined that nine of 35 sampled transactions could have been procured through contracting to potentially garner additional savings for VA. Based on this sample, the team projected that cardholders could have used contracts for approximately 510 transactions, totaling at least $779,000.

Example 1 illustrates a sampled transaction identified as a split purchase and unauthorized commitment.

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

[46] VHA executive director of the Office of Acquisition and Logistics and senior procurement executive, memo, "Emergency Acquisition Flexibilities – Emergency Assistance Activities in support of Global Pandemic for Coronavirus Disease 2019 (COVID-19)," March 15, 2020. This memo increased the micro-purchase threshold to $20,000 for goods and services purchased in the United States due to the COVID-19 pandemic and has not been rescinded. The previous micro-purchase threshold was $10,000. As of May 2022, all VA purchase card accounts previously set at $20,000 have been reduced to $10,000.

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

[48] VA Financial Policy, "Government Purchase Card for Micro-Purchases." A split purchase occurs when a cardholder intentionally modifies a known single requirement into two or more purchases or payments to avoid exceeding their single purchase limit and/or the micro-purchase threshold.

[49] Unauthorized commitments can occur when a purchase, including a split order, is made by a purchase cardholder or contractor who lacks the authority to bind the government or who exceeds his or her delegated authority.

Example 1

On March 22, 2021, a cardholder placed two separate orders of prescription drugs with the same vendor, both orders costing $7,798.60 for a total of $15,597.20. Both orders were shipped on March 29, 2021, and the cardholder was charged for both purchases on March 31, 2021. Although the purchases were for two separate patients in the VA Palo Alto Health Care System, the total need and cost were known at the time of the purchase to exceed the cardholder's authorized single-purchase limit of $10,000. These transactions represent a split purchase. During the OIG site visit, the cardholder's approving official acknowledged this mistake and reported that moving forward, these prescription drugs will be purchased through the contracting office to avoid future split purchases.

The proper way to purchase frequently needed or high-cost goods above the purchase card limit 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 purchase cardholder who makes an unauthorized commitment, including a split purchase, exceeding his or her level of authority has made an improper payment and must submit a request for ratification to the chief of the contracting office that provides contracting support to the organization involved.[50]

Generally, the improper reliance on purchase cards and any related unauthorized commitments, instead of communicating with the contracting office to establish contracts, appeared to persist at the healthcare system because the approving officials and cardholders did not work together to ensure compliance throughout the transaction process and that roles and responsibilities were carried out in accordance with VA policy. In order to meet the intent of VA policy, cardholder should work with the contracting office to determine if alternative contracting options are warranted or available.

Purchase Card Oversight

Periodic purchase card reviews are intended to evaluate and improve the effectiveness of internal controls and compliance with regulations and policies. VA policy requires the purchase card coordinator and the Financial Services Center to conduct reviews that ensure purchases are properly documented and to identify potential split purchases, unauthorized commitments, fraud, waste, and abuse.[51] The purchase card coordinators should also analyze spending patterns and

[50] VA Directive 7401.7, *Unauthorized Commitments and Ratification*, October 7, 2004. The directive defines ratification as the process by which an authorized official converts an unauthorized commitment to a legal contract.

[51] The Financial Services Center provides an array of financial management, professional, and administrative services to VA.

determine whether cardholders are optimizing purchasing power and cost savings by using strategic sourcing techniques. Lastly, reviewers should identify and report any issues and ensure remediation actions are effective.

During the inspection period, the OIG team determined that the purchase card coordinator conducted some internal purchase card reviews, but confirmation was not available to show that reviews were conducted during the first and second quarter of FY 2021. The healthcare system missed opportunities to conduct internal reviews to identify compliance issues within the purchase card program and continue to improve the effectiveness of internal controls. The NCO 21 Purchase Card Manager acknowledged not conducting internal audits for the first and second quarters of FY 2021 and that in the third and fourth quarter, they started conducting more target based internal audits.

Additionally, the team found that of the 21 cardholders responsible for the 35 sampled transactions, nine had a VA Form 0242 with an inaccurate spending limit compared to the cardholder's US Bank data or a missing alternate approving official. An approved VA Form 0242 is used to delegate authority to an individual to use the purchase card to pay for goods and services. This form also establishes purchase limits and responsibilities and is essential for accountability for cardholders and approving officials. A revised form is required when the approving officer changes, cardholders legally change their names, or the single purchase limit is increased above the originally requested amount.[52]

Finding 2 Conclusion

The healthcare system lacked proper supporting documentation for some of the sampled purchase card transactions. Additionally, some transactions were made without prior approvals, timely reconciliation, and/or segregation of duties. Further, transactions were made that led to split purchases and potentially missed cost savings for frequently used goods. Based on the results of all areas of review for the sample, the team projected that the VA Palo Alto Health Care System could have identified noncompliance errors in approximately 7,200 of 16,700 purchase card transactions, totaling approximately $26,900,000 in questioned costs.[53] These purchase card transactional errors could have been identified with consistent reviews of the purchase card program, internal controls, and effective reconciliation reviews by approving officials to ensure consistent documentation that supports purchase card transactions.

[52] VA Financial Policy, vol. 16, chap. 1A, "Administrative Actions for Government Purchase Cards," June 14, 2018.

[53] Purchase card transactions with multiple types of noncompliance issues were only included once for the purposes of calculating this projection. Consideration was also given for margin of error and median confidence level when projecting questioned costs. The figure $26,900,000 is the sample estimate dollar amount for all errors found during this purchase card review. Ninety percent of all possible survey estimates under the same essential conditions would result in estimates between $14.2 million and $39.5 million, as shown in table C.2. For additional information regarding projection totals, see appendix B and tables C.1 and C.2.

Recommendations 2–4

The OIG made the following recommendations to the director of the VA Palo Alto Health Care System:

2. Ensure cardholders comply with record retention requirements as required by VA Financial Policy, vol. 16, chap. 1B, "Government Purchase Card for Micro-Purchases,"
3. Establish controls to 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.
4. Require purchase cardholders to submit a request for ratification for any unauthorized commitments identified.

Recommendation 5

The OIG made the following recommendation to the director of contracting for the Network Contracting Office 21 for VA Sierra Pacific Network:[54]

5. Ensure purchase card reviews are performed as required by VA Financial Policy, vol. 16, chap. 1B, "Government Purchase Card for Micro-Purchases,"

VA Management Comments

The director of the VA Palo Alto Health Care System concurred with recommendations 2–4. The director of contracting for Network Contracting Office 21 concurred with recommendation 5.

For recommendations 2–4, the director reported that during facility audits, the chief of business and procurement planning worked with the Network Contracting Office 21 government purchase card coordinator to provide additional guidance on program oversight and document retention requirements for cardholders. In October 2022, Network Contracting Office 21 conducted training that included topics such as review requirements for approving official and the ratification process. Cardholders and approving officials were also required to complete formal online training on unauthorized commitments. Ratifications are required to be submitted to the senior executive service deputy executive director for review and approval, and any pending ratifications are discussed at monthly meetings. The director also reported that VISN 21 requires Supply Chain Services to evaluate the need for purchase cards at the application stage and usage of purchase cards for the continued identification of strategic sourcing opportunities. Purchase cards were also evaluated during FY 2022 for inactivity, and 128 were purged as a result.

[54] Network Contracting Office 21 for the VA Sierra Pacific Network provides local, regional, and national procurement support to the VA Palo Alto Health Care System and other VISN 21 facilities.

For recommendation 5, the director of contracting for Network Contracting Office 21 reported that the purchase card manager implemented quarterly purchase card reviews in April 2021 to identify compliance issues. The results are collected quarterly by the Network Contracting Office 21 agency organization program coordinator and reported to the VA Palo Alto Health Care System director. This information is retained by the Network Contracting Office 21 agency organization program coordinator and purchase card manager. The Network Contracting Office 21 and VA Palo Alto Health Care System have been compliant with purchase card reviews since April 2021.

OIG Response

The action plans provided by the healthcare system director and the director of contracting for the Network Contracting Office 21 are responsive to the recommendations. Although the directors reported the actions for some of the recommendations were already completed, the OIG did not receive any evidence or supporting documentation to evaluate these actions. 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.

III. Inventory and Supply Management

Supply chain management is the integration and alignment of people, processes, and systems across the supply chain to manage all product and service planning, sourcing, purchasing, delivering, receiving, and disposal activities. 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. Medical facilities are also required to continually identify ways to ensure veterans receive high-quality care.[55] The Generic Inventory Package is the software system authorized to manage the receipt, distribution, and maintenance of expendable supplies used throughout VA. The Generic Inventory Package uses a number called an item master file, created within IFCAP, to store and track information such as the description, vendor details, unit price, and packaging for each item. Per VA policy, it is essential that this information be entered into the IFCAP system completely and correctly. Inventory data, if properly recorded in the Generic Inventory Package, also identify the quantity, dollar values, and specific supply items in stock. Supplies are received at the warehouse and distributed to a primary inventory point and, when available, to a secondary inventory cabinet at a medical facility. Secondary inventory cabinets are maintained by the clinical staff who use these supplies.

The team reviewed the following areas:

- **Stock performance metrics.** The team assessed whether the healthcare system met the performance metric for days of stock on hand. The days-of-stock-on-hand metric promotes inventory level efficiency for items purchased through the MSPV-NG program and non-MSPV-NG items.
- **Supply chain management oversight.** The team assessed data validity, identified factors that affected the healthcare system's supply chain management, and reviewed required quarterly physical inventory for "A" classified items.[56]

Finding 3: The Healthcare System Could Strengthen Local Processes to Ensure Accuracy of Expendable Inventory Data and Complete "A" Classified Physical Inventories in Accordance with VHA Policy

The healthcare system could improve oversight and the accuracy of expendable inventory data stored in the Generic Inventory Package, implement local processes and procedures to ensure all necessary reports are routinely monitored on the Supply Chain Common Operating Picture (SCCOP) dashboard and other published sites or software systems with inventory data, and take appropriate steps to ensure all supply chain performance measures are maintained in compliance

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

[56] "A" classified items, which garner the highest 80 percent of budgeted funding for a given year, are reviewed on a quarterly basis.

with VA policy. Additionally, the healthcare system should ensure that "A" classified item physical inventories are accurate and completed in accordance with VHA policy. Inaccurate physical inventory counts and failure to properly align processes and systems across the supply chain threaten the healthcare system's ability to effectively plan and budget for the purchase of supplies to operate and meet patient care needs.

Days-of-Stock-On-Hand Performance Metrics and Supply Chain Management Oversight

To evaluate performance metrics and supply chain management oversight, the team reviewed the healthcare system's days-of-stock-on-hand levels, assessed the data validity of conversion factors, identified factors that affected the healthcare system's supply chain management, and reviewed quarterly physical inventory documentation.

Days-of-Stock-On-Hand Performance Metrics

The Power Business Intelligence SCCOP dashboard tracks the use of expendable and nonexpendable items. The dashboard, which receives part of its data from the Generic Inventory Package, lists the performance measure for expendable supplies purchased from MSPV-NG as 15 days or less of stock on hand, whereas non MSPV-NG items should have 30 days or less of stock on hand.[57] The inspection team accessed the SCCOP dashboard and downloaded the healthcare system's "MSPV-NG Days of Stock on Hand" and "Non Prime Vendor Days of Stock on Hand" reports for FY 2021, available from December 2020 through September 2021 at the time the data were pulled. The team reviewed the healthcare system's overall performance and primary inventory points within the supply chain management service line and subject to the days-of-stock-on-hand metric to determine if MSPV-NG and non MSPV-NG items met the performance metric.

The team determined that the healthcare system averaged 36 days of stock on hand for MSPV-NG items and 20 days of stock on hand for non-MSPV-NG items during the review period. In response to the COVID-19 pandemic, the healthcare system received a waiver to suspend the corresponding days-of-stock-on-hand performance oversight measures from May 7, 2020, through March 31, 2022.

The inspection team also evaluated a sample of primary inventory points within the supply chain management service line that were subject to days-of-stock-on-hand metrics. The team found three of five MSPV-NG primary inventory points (60 percent), which included two top-dollar

[57] The national MSPV-NG program provides a customized distribution system to meet or exceed facility requirements through a just-in-time distribution catalog ordering process.

points (C-MED-SURG PAD and C-MED-SURG LVD), did not meet the metric.[58] All nine non MSPV-NG primary inventory points within the supply chain management service line met the days-of-stock-on-hand metric. The team also reviewed other data in the SCCOP dashboard that could affect the days-of-stock-on-hand metric.

Data Validity and Conversion Factors

The team assessed the validity of conversion factor data, which can impact the accuracy of days-of-stock-on-hand metrics. The team accessed the SCCOP dashboard to review the healthcare system's Conversion Factor Primary Inventory Report.[59] A unit conversion factor is computed by dividing the quantity purchased by the quantity issued.[60] This factor connects how a supply item is purchased and issued—for example, an item may be purchased by the case but issued individually. A "false" conversion factor may be the result of a conversion being entered in to the SCCOP dashboard incorrectly and could indicate incorrect quantity and value of inventory on hand. As a result, the healthcare system may not have the resources needed to provide care to veterans.

At the time the report was accessed, 546 of 26,206 conversion factors (2 percent) had a false result. Of the false results, 38 items had no conversion factor listed.[61] Although the conversion factor report indicated a low level of conversion factor issues, the chief and deputy chief of supply chain services, as well as staff, reported that data in the Generic Inventory Package (which feeds into SCCOP) were not accurate. The deputy chief of supply chain services advised that conversion factor data pulled from the Generic Inventory Package are not reliable due to insufficient training and staffing shortages that prevent proper oversight and needed corrections. The deputy chief of supply chain services also reported the 2 percent conversion factor false return rate should not be relied upon. Conversion factor data inaccuracies can significantly hinder a healthcare system's ability to meet the performance metric for days of stock on hand.

[58] C-MED-SURG PAD captures any new items added to the Clinical Medical Surgical Palo Alto primary inventory point during the fiscal year at the healthcare system. C-MED-SURG LVD captures any new items added to the Clinical Medical Surgical Livermore primary inventory point during the fiscal year.

[59] The Conversion Factor Primary Inventory Point report was accessed by the review team on March 29, 2022, from the Supply Chain Common Operating Picture dashboard; this report details point-in-time conversion factor data at the healthcare system.

[60] VHA, Integrated Funds Distribution, Control Point Activity, Accounting and Procurement (IFCAP) Version 5.1 Generic Inventory User's Guide, October 2000, rev. October 2011. A conversion factor expresses the ratio between the vendor's unit of measure and the unit of issue and is used it to translate the order quantities into supply station amounts.

[61] When a conversion factor does not equal an item's unit of receipt (i.e., bought by the case) divided by the unit of issue (distributed by the case), it is flagged as a "false" result.

Factors that Affected the Healthcare System's Supply Chain Management

During the site visit, the team interviewed supply chain services leaders and staff to assess factors that affected the healthcare system's oversight controls and efficiency. Many factors, including staffing levels, nonfunctioning storage equipment, and data integrity and validity issues, affected the healthcare system's ability to meet the days-of-stock-on-hand performance levels.

The chief and deputy chief of supply chain services identified staffing shortages as a primary factor affecting inventory and supply management at the healthcare system. According to the chief of supply chain services, in January 2021 there was a reported vacancy rate of 22 percent (27 full-time employees [FTE]), which increased to 25 percent (31 FTE) in January 2022. At the time of the OIG site visit, the VA Palo Alto Health Care System reported a 28 percent vacancy rate (33 FTE). The healthcare system's senior managers are aware of staffing shortages and are working to correct these issues; however, the inability to attract and retain sufficient personnel could hinder consistent oversight.

The healthcare system also reported a lack of local inventory management policies and procedures for training supply management staff. The chief of supply chain services detailed that SCCOP reports, the Generic Inventory Package, and other systems are reviewed by many staff members at inconsistent times, and local processes and procedures have not been formalized.

For example, the chief and deputy chief of supply chain services informed the team that the healthcare system does not have a written policy for dealing with expired or spoiled items. One inventory staff member further stated that even though he made multiple inquiries to determine how to process expired or spoiled items, managers never provided formal instructions. One example of expired and unused inventory items at the facility was 11 cases of detergent, used in cleaning medical instruments, which expired in 2011. The team also learned that 100 unused hand-held scanners were also recently disposed of at the healthcare facility. The current value of these expired and unused inventory items totaled nearly $42,190. Without a formal policy, the healthcare system inefficiently uses stock on hand and space within storage facilities and could inadvertently administer, use, or dispose of expired or unused items.

The chief, deputy chief, and staff of supply chain service also attributed challenges with auto-generation of orders to the inadequate functionality of equipment at the user level. Staff reported the Generic Inventory Package does not consistently interface with secondary inventory cabinets. Rather than scan items as they are removed from the secondary inventory cabinets, supply chain services staff reported relying on manual inventory reviews. The chief of supply chain services reported that competing financial priorities and frequent leadership changes have impeded replacement of secondary inventory cabinets for many years. In March 2022, the healthcare system submitted a $4.6 million procurement request to the contracting office for

VISN 21 to replace secondary inventory cabinets; according to the interim chief of supply chain services, this contract was awarded in July 2022.[62] Using a combination of point-of-use equipment, such as secondary inventory cabinets, and software systems is necessary for the healthcare system to streamline the supply chain for timely delivery of required supplies to the point where those supplies are consumed.

Staff also reported that the healthcare system had inadequate training for using the Generic Inventory Package auto-generation tool and for calculating conversion factors. One staff member informed the team that he made multiple inquiries about his assigned responsibilities with two separate inventory points but never received instructions from managers regarding daily processes and procedures. The chief of supply chain services also stated that although the healthcare system has a Generic Inventory Package training manual, staff were not adequately trained on the system, specifically the auto-generation tool required by policy for the automated ordering of stock items.[63]

In January 2020, the national Office of Logistics and Supply Chain Management Review conducted a Facilities Logistics Inspection Program Review at the VA Palo Alto Health Care System and identified deficiencies.[64] In response to the report findings, VISN 21 dedicated a team of supply chain personnel to the VA Palo Alto Health Care System to assist inventory staff. At the time of the OIG site visit, VISN personnel were preparing to provide formal training to all staff members—from supply distribution to inventory management. Separately, the facility is developing a comprehensive training plan for all supply chain staff which is also expected to include a specific focus on conversion factors.

Quarterly Physical Inventories

The team also assessed oversight related to the required quarterly physical inventory of "A" classified items, which correlate with the highest 80 percent of annual usage dollars.[65] Although the healthcare system conducted these physical inventories, the accompanying memorandums documenting the inventory counts were signed by a section chief instead of by the chief of supply chain services, as required. VHA policy designates the chief supply chain officer as

[62] VHA divides the United States into 18 regional networks, known as VISNs. A VISN manages day-to-day functions of medical centers and provides administrative and clinical oversight.

[63] VHA Directive 1761. Policy requires that inventory managers use the Generic Inventory Package auto-generation option for creating orders to replenish stock. This process calculates the required quantities necessary to bring stock up to the established normal stock level by reviewing preset inventory levels against quantities on hand and identifies those items below the preset levels, so they may be ordered.

[64] Office of Logistics and Supply Chain Management, *Facilities Logistics Inspection Program Review VA Palo Alto Health Care System (640) Palo Alto, California, 20-FLIP-007*, final issue date April 30, 2020.

[65] The ABC classification method states that inventory point items with the highest 80 percent of annual usage dollars are classified as "A." Items with the next highest 10 percent of annual usage dollars are classified as "B." Lastly, items representing the remaining 10 percent of annual usage dollars are classified as "C." Physical inventories of "A" classified items are to be conducted each quarter.

responsible for signing and sending such memorandums to the VISN chief logistics officer and deputy network director.[66] Although the VISN chief logistics officer was notified via email that the counts were completed, this email was not forwarded by the chief of supply chain services. The VISN deputy network director received this information at a monthly meeting. The facility's chief of supply chain services is responsible for ensuring compliance with routing and signing of completed "A" classified physical inventories but did not do so. In addition, the inspection team found that quarterly physical inventory accuracy rates for the Medical/Surgical Palo Alto Division varied significantly from one quarter to the next; the first quarter of FY 2022 had a 97 percent accuracy rate, whereas in the next quarter, the accuracy rate dropped to 12 percent. The chief of supply chain services speculated that the variance could be attributed to staff not reviewing all "A" classified items; because of staffing shortages, staff may have rushed the process and did not perform sufficient counts. Accurate physical inventories are necessary to ensure effective planning and budgeting for proper inventory management.

Finding 3 Conclusion

Supply chain management oversight at the VA Palo Alto Health Care System was not sufficient to ensure the proper oversight of expendable supplies. Establishing local processes and procedures for monitoring SCCOP reports, the Generic Inventory Package, or other software systems as well as developing a plan for staff training could increase the awareness of inventory management controls and increase the data reliability of stock levels within the Generic Inventory Package. Additionally, ensuring that quarterly physical inventory memorandums of "A" classified item are properly completed and made available to the VISN can improve healthcare system efficiency. Lack of local policies and procedures as well as unreliable inventory data can lead to purchasing unnecessary supplies and could adversely affect patient care. By addressing the OIG's recommendations, the healthcare system can more effectively plan and budget for supplies to operate and meet patient care needs.

Recommendations 6–8

The OIG made the following recommendations to the director of the VA Palo Alto Health Care System:

6. Ensure the chief of supply chain services establishes local processes and procedures so that all necessary reports are monitored on Supply Chain Common Operating Picture, the Generic Inventory Package, or other inventory sites or software systems, on a routine basis, as required in the Veterans Health Administration's Directive 1761 *Supply Chain Management Operations*.

[66] At the VA Palo Alto Health Care System, chief of supply chain services is the same as chief of supply chain officer.

7. Ensure supply chain management staff implement a plan for staff training to increase awareness of internal controls and data reliability within the Generic Inventory Package.
8. Ensure the chief of supply chain services signs quarterly physical inventory memorandums of "A" classified items and make them available to Veterans Integrated Service Network personnel as required in the Veterans Health Administration's Directive 1761 *Supply Chain Management Operations*.

VA Management Comments

The director of the VA Palo Alto Health Care System concurred with recommendations 6–8. To address recommendation 6, the director reported they hired a logistics management specialist in September 2022. This additional FTE was added to this section of supply chain service to train and establish routine report monitoring. In addition, a vacant program analyst position was filled in October 2022 to monitor, review, and summarize actions needed based on Supply Chain Common Operating Picture and Generic Inventory Package reports. Data metrics are presented to leaders during the monthly supply chain compliance meeting. Regarding recommendation 7, the director reported Supply Chain and Office of Process Improvement collaborated on developing a training plan matrix. The deputy chief of supply chain service from the Fresno VA was detailed in May–August 2022 to provide training to front-line staff. The logistics management specialist started in September 2022 as a dedicated training resource for staff. This position will provide ongoing staff training and administrative support to the total supply support section. Training will be documented and reported to a supervisory inventory management specialist monthly. A training competency database is also in development. To address recommendation 8, the director reported the facility chief supply chain officer signs quarterly reports, and documents are provided to the VISN.

OIG Response

The healthcare system director's action plans are responsive to the recommendations. Although the director of the healthcare system reported the actions for some of the recommendations were already completed, the OIG received no evidence or supporting documentation to evaluate these actions. 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. Pharmacy Operations

According to the OPES FY 2021 Pharmacy Expenditure Model (based on FY 2020 data), the VA Palo Alto Health Care System spent almost $74.9 million on prescription drugs, which represented about 6 percent of the Palo Alto Health Care System's total budget of approximately $1.3 billion for the year.[67] Because pharmacy expenses account for a substantial percentage of any medical center's budget, it is important for medical center leaders to analyze spending and identify opportunities to use pharmacy dollars more efficiently. The inspection team used the pharmacy cost model in the OPES efficiency grid to identify opportunities for improvement among pharmacy processes.

The team reviewed the following pharmacy areas:

- **OPES pharmacy expenditure data** are designed to allow VHA facilities to track costs and identify potential opportunities for improvement.
- **Inventory turnover rate**, or the number of times inventory is replaced during the year, is the primary measure to monitor the effectiveness of inventory management per VHA policy.[68] Low inventory turnover rates can indicate inefficient use of financial resources.
- **The B09 reconciliation** process is how VA medical center pharmacies ensure they are making correct payments for the drugs they receive. Without this reconciliation process, there is no assurance that the amount paid to the prime vendor agrees with the amount of goods received. These reports are prepared monthly to reconcile pharmaceuticals purchases and ordered with pharmaceuticals that are invoiced and received at the facility. A memorandum and supporting documentation are provided to the Finance Service for review and concurrence. The results of the reviewed reconciliation are to be returned and retained with the Pharmacy Service, and any identified discrepancies are to be corrected in a timely manner.

Finding 4: The Healthcare System Could Improve Pharmacy Efficiency, Increase the Inventory Turnover Rate, and Strengthen Oversight Controls

The inspection team found the healthcare system could improve pharmacy efficiency by narrowing the gap between expected and observed pharmaceutical costs and increasing its ABC inventory turnover rate to meet the VHA-recommended level. In addition, the healthcare system

[67] Office of Productivity, Efficiency & Staffing (OPES) Pharmacy Expenditure Model (based on FY 2020 data), accessed February 25, 2022, http://opes.vssc.med.va.gov/Pages/Pharmacy-Model.aspx (The site is not accessible by the public.)

[68] VHA Directive 1761, *Supply Chain Management Operations,* app. H, December 30, 2020. Inventory turnover is based on total dollar value purchased for the previous 12 months divided by the dollar value of items on the shelf.

did not complete some B09 monthly reconciliations in a timely manner. Failure to properly manage pharmacy operations can lead to increased replenishment costs, overstocking, spoilage, and diversion of drugs and can decrease the funding available to meet other healthcare system and patient care needs.

OPES Pharmacy Expenditure Data

The OPES pharmacy expenditure model identifies variations in pharmacy costs among VHA facilities by VISN 21. According to the OPES FY 2021 model (based on FY 2020 data), the VA Palo Alto Health Care System had approximately $74.9 million in observed drug costs, which is about $5.4 million higher than the $69.5 million in drug costs expected during this period. Based on these numbers, the facility's observed-to-expected ratio was 1.078 for pharmacy drug cost efficiency. Observed-to-expected ratio values greater than 1.0 or positive observed-minus-expected values indicate that the facility has higher utilization/cost than the VHA average.

The VA Palo Alto Health Care System accomplished local savings through comprehensive formulary management practices and various health initiatives. Despite these efforts, the healthcare system still averaged an increase in spending of $4.7 million over the expected budget for the past three fiscal years (figure 3). Pharmacy leaders attribute the spending increases to the growing demands for specialized pharmaceuticals needed by a relatively small population of patients. Spending also increased because of the high cost of new drugs prescribed to treat specific conditions and diseases.[69]

[69] Specialized pharmaceuticals are drugs that are unique to the patient and seek to treat complex specific disease states including chronic and rare conditions.

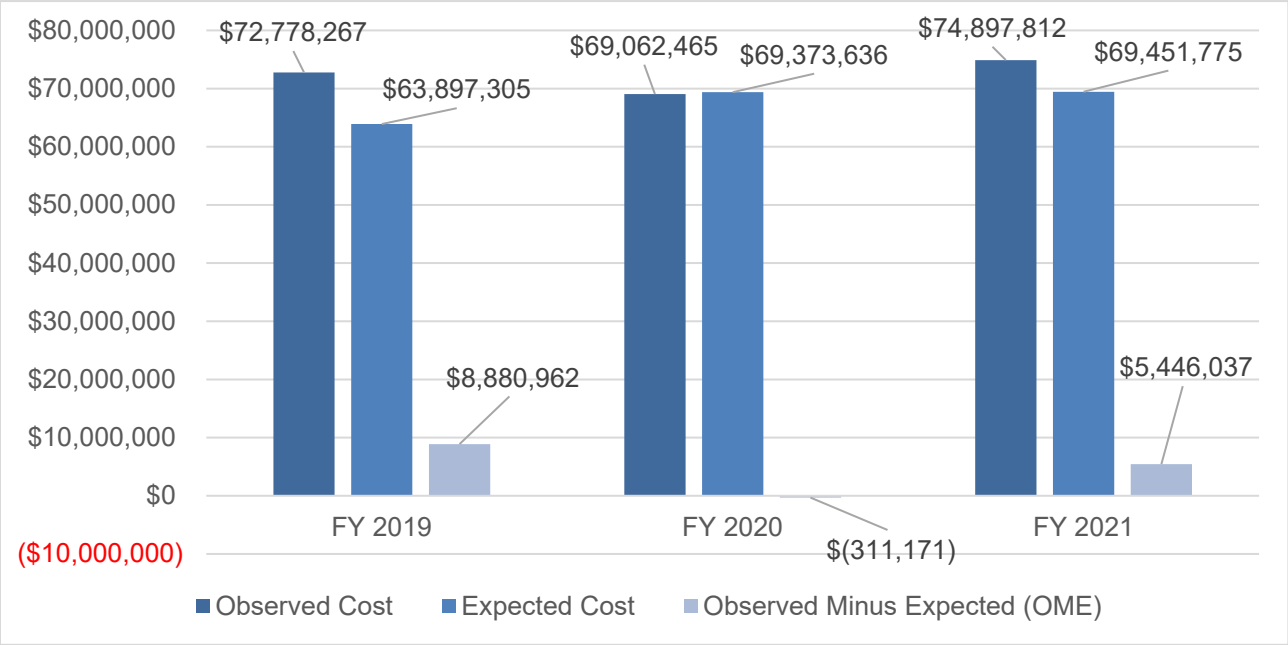

Figure 3. *Observed versus expected drug cost, FY 2019–FY 2021.*
Source: OPES pharmacy expenditure model.
Note: The OPES data models are based on the previous fiscal year data (i.e., the FY 2021 data model was based on FY 2020 data).

Inventory Turnover Rate

VHA policy states that inventory turnover is the primary measure of the effectiveness of inventory management.[70] Increasing the inventory turnover rate decreases inventory carrying cost, which is the cost associated with storing inventory. VHA policy also mandates the use of the Prime Vendor Inventory module to access quarterly inventory turn reports for the management of all VA medical facility pharmacy ABC inventories.[71]

In FY 2021, the VA Palo Alto Health Care System reported average inventory turnover rates of 9.68 for "A" inventory items, 5.15 for "B" items, and 3.60 for "C" items compared to the VHA-recommended levels of 12–16 for "A" items, 6–10 for "B" items, and 6–10 for "C" items.[72] The healthcare system did not meet all established Pharmacy Benefits Management (PBM) program office targets at the Palo Alto, Livermore, and Menlo Park locations. The healthcare system reported inventory turnover rates in the prime vendor's 12 Month Turns

[70] VHA Directive 1761, *Supply Chain Management Operations,* app. H, December 30, 2020.
[71] VHA Directive 1761, *Supply Chain Management Operations,* app. H, December 30, 2020.
[72] VHA Pharmacy Benefits Management email response to questions from VA OIG Office of Financial Inspection, February 2021.

Summary were below the established levels for more than half of the items categorized as A, B, or C.[73]

The chief of pharmacy stated that the current process at the VA Palo Alto Health Care System does not include a review of quarterly reports from the prime vendor to calculate ABC inventory turnover rates that manages their drug inventories. The healthcare system instead consults annual inventory turnover reports following the wall-to-wall inventories. The team determined that increasing the frequency of prime vendor reporting reviews could offer greater purchasing efficiency. The chief of pharmacy reported two challenges related to managing inventory turnover rates: staffing shortages and extended backorders for many medications, including lifesaving and commonly used drugs. Inventory turns are low during periods when pharmaceuticals are on backorder because the facility may place an order but not receive all the requested quantity. Backordered drugs increase the risk that the facility will have minimal stock levels and be unable to fully meet the pharmaceutical needs of patients. Because of the medication shortage, the facility will purchase these drugs when available, which could lead to more medication on the shelves than needed.

Low inventory turnover could indicate the inefficient use of financial resources and the inability to properly forecast amounts of drugs to meet patient care needs. The OIG recognizes that the VA Palo Alto Health Care System's current process to track inventory turnover rates incorporates more pharmaceuticals, regardless of the vendor. However, the healthcare system did not review this metric frequently enough to achieve the most efficient forecasting and use of financial resources. Lack of routine review of these metrics could lead to drug diversion, overstocking, spoilage, and increased carrying costs and could increase the potential for drug shortages, which would adversely affect patient care.[74]

B09 Reconciliation

VHA policy states the Pharmacy Service within the VA Palo Alto Health Care System is responsible for preparing a monthly B09 reconciliation package to reconcile the pharmaceuticals purchased and ordered with the pharmaceuticals that are invoiced and received at the facility.[75] A memorandum and corresponding supporting documentation of the reconciliation results should be provided to the Finance Service within the VA Palo Alto Health Care System. The Finance Service is responsible for reviewing the reconciliation package for accuracy, authorization balances, unliquidated balances, and identifying and correcting any discrepancies. The Finance

[73] VHA Directive 1108.08 (1), *VHA Formulary Management Process,* amended August 29, 2019. This directive mandates the ABC inventory analysis method.

[74] Drug diversion is when prescription medicines are obtained or used illegally.

[75] VHA Directive1108.07 (1), *Pharmacy General Requirements,* amended January 26, 2021.

Service should collaborate with the Pharmacy Service to ensure adjustments are made appropriately.

The VA Palo Alto Health Care System did not submit five of the 12 sampled B09 monthly reconciliation packages by the end of the corresponding month. Monthly reconciliation packages were submitted 39–55 days later than required for December, February, April, June, and August of FY 2021. The healthcare system attributed noncompliance with timeliness of the B09 reconciliations to staffing shortages, hurdles to hire additional staff, and prioritization of tasks. B09 reconciliations are necessary because payments are made to the prime vendor before the facility receives the pharmaceuticals. Without timely reconciliations at the end of each month, the healthcare system was unable to ensure that the amount paid to the prime vendor was aligned with the amount of goods received, leaving the facility at risk for errors in monthly activity, obligations, and budgetary reporting.

Finding 4 Conclusion

The healthcare system could improve pharmacy efficiency by narrowing the gap between observed and expected drug costs and by increasing its inventory turnover rate to meet the VHA-recommended level. The healthcare system could further improve efficiency by submitting monthly B09 reconciliations on time to correct any discrepancies appropriately. An efficient healthcare system anticipates how much drugs will cost and when inventory needs to be restocked, which helps ensure that the system makes the best use of appropriated funds and has inventory when needed.

Recommendations 9–10

The OIG made the following recommendation to the director of the VA Palo Alto Health Care System:

9. Develop and implement a plan to increase inventory turnover to meet the level recommended by the Veterans Health Administration Pharmacy Benefits Management Office.
10. Develop and implement a plan to complete monthly B09 reconciliation consistently to ensure discrepancies are corrected in a timely manner.

VA Management Comments

The director of the VA Palo Alto Health Care System concurred with recommendations 9 and 10. To address recommendation 9, the director acknowledged that the facility has identified additional opportunities to improve on "C" inventory items. The facility plans to improve the inventory turnover rate into the 6-10 range by adjusting par levels stored in the MedCarousel and overstock shelves. To address recommendation 10, the director reported that the reconciliation process is conducted daily (as soon as an item is received, it is checked against

the invoice) and on a weekly basis (as soon as the weekly B09 report is available). The reconciliation process ensures the amount paid to the prime vendor aligns with the goods received and that proper documents are retained. The director also reported that monthly reports are now signed in a timely manner.

OIG Response

The healthcare system director's action plans are responsive to the recommendations. Although the director of the healthcare system reported the actions for recommendation 10 were already completed, the OIG received no recent evidence or supporting documentation to evaluate these actions. During the inspection, the healthcare system provided completed reconciliations; however, these reconciliations were not reviewed or signed in a timely manner, which negates the intended purpose of identifying and resolving errors promptly. 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: Healthcare System Profile

Table A.1 provides general background information for the VA Palo Alto Health Care System, a level 1a, high-complexity facility reporting to VISN 21.[76]

Table A.1. Facility Data for VA Palo Alto Health Care System from FY 2019 through September 30, 2021

Item	FY 2019	FY 2020	FY 2021
Total medical care budget	$1,066,677,940	$1,251,290,534	$1,347,023,734
Number of patients	65,446	63,425	68,170
Outpatient visits	790,232	734,542	873,296
Total medical care FTEs*	4,244	4,449	4,788
Number of operating beds:			
Hospital	249	249	237
Community living center	360	360	360
Domiciliary	172	172	172
Average daily census:			
Hospital	156	107	99
Community living center	336	238	197
Domiciliary	122	72	32

Source: *VHA Support Service Center, Trip Pack and Operational Statistics report.*
Note: *The OIG did not assess VA's data for accuracy or completeness.*
******* *This category includes both direct medical care FTEs in budget object code 1000–1099 (Personal Services) and all cost centers.*

According to VHA Support Service Center data, the healthcare system's medical care budget increased by over $280 million, about 26 percent, between FY 2019 and FY 2021, while the number of unique patients increased by about 2,700, which is only about a 4 percent change. The chief of fiscal service concurred with the reported budgetary increases and provided information to the inspection team regarding the facilities' top initiatives garnering the increased funds from FY 2019 to FY 2021, which included COVID-19 pandemic supplemental funds (approximately $81 million), non-VA care in the community for COVID-19 (approximately $40 million), and funds for non-VA care in the community for the current year (approximately $70 million). The healthcare system also concurred with the approximately 4 percent increase in outpatient visits over the inspection period and stated that efforts are ongoing to further understand the recent budgetary increases.

[76] The facility model classifies VHA facilities at levels 1a, 1b, 1c, 2, or 3, with level 1a being the most complex and level 3 being the least complex.

Appendix B: Scope and Methodology

Scope

The team conducted its inspection of the VA Palo Alto Health Care System from April 2022 to November 2022, including a site visit during the week of April 4, 2022. The inspection is limited in scope and is not intended to be a comprehensive inspection of all financial operations at the VA Palo Alto Health Care System.

Methodology

The inspection team evaluated financial efficiency practices for FY 2021, as well as first quarter of FY 2022 if available, related to open obligations, days of stock on hand for expendable supplies, and purchase card transactions. The team also analyzed financial efficiency practices related to the facility's pharmacy costs using the FY 2021 OPES data model; however, the FY 2021 data model was based on FY 2020 data.

To conduct the inspection, the team

- interviewed facility leaders and staff;
- identified and reviewed applicable laws, regulations, VA policies, operating procedures, and guidelines related to managing open obligations, overseeing purchase card transactions, calculating days-of-stock-on-hand metrics, and addressing inefficiencies in pharmacy costs; and
- judgmentally sampled
    - 20 inactive obligations to assess whether the healthcare system identified and reviewed the obligations to determine if they were still valid and needed to remain open in accordance with VA financial policy,
    - 10 obligations with different order amounts from VA's FMS to IFCAP Reconciliation reports to determine if order amounts were accurate and reconciled between VA's FMS and IFCAP, and
- statistically sampled
    - 35 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.

Internal Controls

The inspection team assessed the internal controls of the VA Palo Alto Health Care System significant to the inspection objective. This included an assessment of the five internal control components to include control environment, risk assessment, control activities, information and communication, and monitoring.[77] 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—Open Obligations, Purchase Cards, Inventory and Supply Management, and Pharmacy—and proposed recommendations to address the control deficiencies.

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, a central repository of US bank data that is updated monthly, and the OPES efficiency opportunity grid. To test for reliability, the team determined whether any data were missing from key fields, including any calculation errors, or 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 id numbers, purchase dates, cardholder names, payment amounts, and vendor/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 team 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*.

[77] Government Accountability Office (GAO), *Standards for Internal Control in the Federal Government*, GAO-14-704G, September 2014.

Appendix C: Sampling Methodology

Open Obligations

The team evaluated a judgmental sample of open obligation transactions from July through December 2021 to determine whether (1) the VA Palo Alto Health Care System performed monthly reviews and reconciliations of the reviewed obligations with no activity for more than 90 days to ensure the obligations were valid and should remain open and whether (2) the healthcare system reconciled order amounts between FMS and IFCAP for sampled obligations.

Population

During December 2021, the healthcare system had 1,220 open obligations, totaling approximately $511.6 million. Of those open obligations, 298 obligations, totaling approximately $44.6 million, had no activity for more than 90 days. From July 2021 through December 2021, there were 42 obligations with order amount discrepancies between FMS and IFCAP for three or more months.

Sampling Design

The inspection team selected two judgmental samples:

Inactive obligations. The team selected 20 obligations with no activity for more than 90 days from the December 2021 FMS F850 report. This report lists each open obligation and its remaining balance. Ten obligations were still within the performance period, and the remaining 10 were more than 90 days past the performance period end date.

FMS to IFCAP reconciliations. The team selected 10 obligations with different order amounts between FMS and IFCAP from the VA's FMS to IFCAP Reconciliation reports for July through December 2021.

The samples included 30 total open obligations: 20 with no activity for more than 90 days, totaling approximately $20.6 million; and 10 obligations with different order amounts between FMS and IFCAP, totaling approximately $509,000.

The team requested supporting documentation for each of the 30 sampled transactions, including monthly reviews and reconciliations, financial system screen prints and reports, and emails related to the obligations.

Projections and Margins of Error

The inspection team did not use projections and margins of error because statistical sampling was not used.

Purchase Cards

The inspection team evaluated a statistical sample of FY 2021 purchase card transactions to determine if (1) the VA Palo Alto Health Care System reviewed purchase card payments to ensure they were adequately monitored, approved, and supported by documentation and (2) the reviewed transactions complied with processes to prevent split purchases and transactions exceeding the cardholder's authorized single purchase limit and to ensure goods or services were procured using strategic sourcing procedures.

Population

During FY 2021 (October 1, 2020–September 30, 2021), purchase cardholders at the facility made about 87,000 purchase card transactions totaling approximately $77.2 million. A statistical sample was selected from a subset of all transactions. This sampling frame was developed inclusive of two strata: potential split transactions and non-potential split transactions over $1,000. A total of 260 bundles of transactions were potential split transactions, including about 1,000 individual transactions. The other strata for non-potential split purchase transactions comprised approximately 15,600 transactions.

Sampling Design

For both strata, samples were selected using probability proportional to size, first by total merchant transaction amount to select individual merchants within the strata, and then within merchant by bundle (for potential split purchases) or individual transaction (for other non-potential split purchases):

> **Potential split purchases.** The team identified potential split purchases as transactions with the same purchase date, purchase card number, and merchant and an aggregate sum greater than the cardholder's authorized single procurement limit. The team identified eight bundles of potential split purchases that included 18 transactions.
>
> **Other non-potential split purchase.** Transactions in this stratum are the remaining transactions over $1,000 after potential split purchase transactions were identified.

The statistical sample included 35 total individual transactions: 18 potential split purchase transactions, totaling approximately $79,000, and 17 non-potential split purchase transactions, totaling approximately $86,000.

To review the sampled transactions, the team requested supporting documentation for each of the 35 sampled transactions, VA Form 0242, and documentation to support the completion of purchase card reviews.

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 inspection 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.

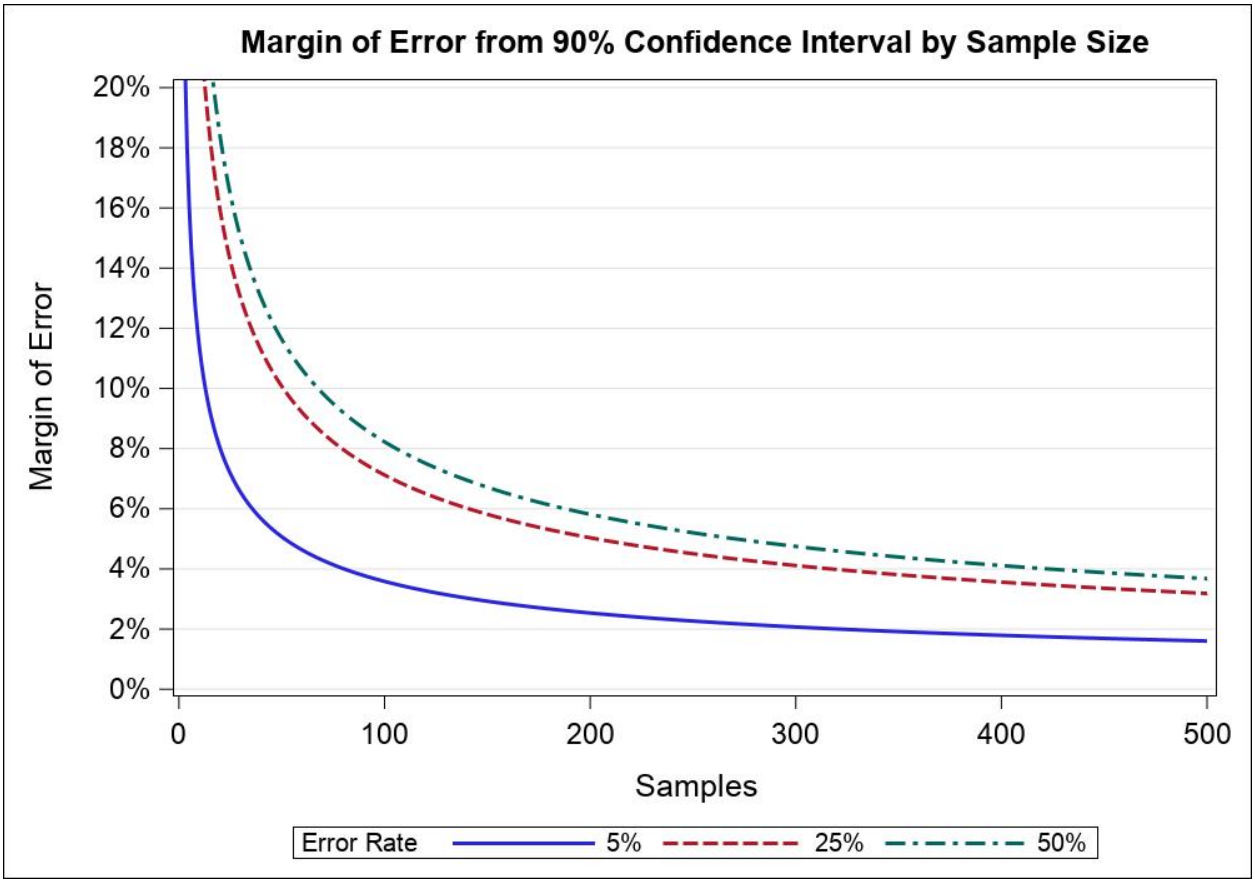

Figure C.1 *Effect of sample size on margin of error.*
Source: OIG statistician's analysis.

Projections

The team reviewed a statistical sample from a population of about 16,700 purchase card transactions, totaling an estimated $64,500,000. Based on the results from the sample, the team

projected that about 7,200 transactions, totaling an estimated $26,900,000, were not processed in accordance with VA policy. Further analysis of the sampled transactions indicated that the VA Palo Alto Health Care System

- may not have supporting documentation for at least 1,700 transactions, totaling at least $6,100,000;
- may not obtained prior approval, reconciled timely, and/or maintained segregation of duties for at least 1,700 transactions, totaling at least $6,600,000;
- may have made split purchases and unauthorized commitments for about 620 transactions, totaling approximately $1,600,000; and
- could have used strategic sourcing to garner additional savings for VA when they purchased items for approximately 510 transactions, totaling at least $779,000.[78]

Tables C.1 and C.2 show statistical projections of purchase card transaction errors and their dollar amounts.

Table C.1. Statistical Projections for Purchase Card Transaction Errors

Estimate name	Estimate number	90 percent confidence interval			Number of errors	Sample size
		Margin of error	Lower limit	Upper limit		
Overall errors (Percent)	7,232 (43)	3,260 (20)	3,972 (23)	10,492 (63)	21	35
Supporting documentation errors (Percent)	3,849 (23)	NA (NA)	1,677 (10)	NA (NA)	7	35
Prior approval/ separation of duties/prompt reconciliation errors (Percent)	3,905 (23)	NA (NA)	1,733 (10)	NA (NA)	8	35
Potential split purchase errors	625	210	414	835	11	18
Potential strategic sourcing errors	511	210	301	721	9	35

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. These projections have "NA" for the margin of error and the upper limit. When reporting on total errors combined, a projected "overall errors" estimate is used to avoid double counting transactions.*
Source: *VA OIG statistician's analysis and team's review of purchase card transactions*

[78] Results for lack of supporting documentation; lack of prior approval, timely reconciliations, and/or segregation of duties; and not using strategic sourcing are conservative estimates based on the lower bound of the projections due to the large margin of error.

Table C.2. Statistical Projections for Purchase Card Transaction Error Dollar Amounts

Estimate name	Estimate number	90 percent confidence interval			Number of errors	Sample size
		Margin of error	Lower limit	Upper limit		
Overall errors	$26,886,136	$12,661,809	$14,224,327	$39,547,945	21	35
Supporting documentation errors	$14,364,314	NA	$6,062,892	NA	7	35
Prior approval/ separation of duties/prompt reconciliation errors	$15,196,567	NA	$6,605,803	NA	8	35
Potential split purchase errors	$1,606,281	$655,822	$950,459	$2,262,102	11	18
Potential strategic sourcing errors	$1,285,025	NA	$778,508	NA	9	35

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. These projections have "NA" for the margin of error and the upper limit. When reporting on total errors combined, a projected "overall errors" estimate is used to avoid double counting transaction amounts.*

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

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

Recommendation	Explanation of Benefits	Better Use of Funds	Questioned Costs[79]
1	Ensure healthcare system finance office staff are made aware of policy requirements and reviews are conducted on all inactive open obligations as required by VA Financial Policy, vol. 2, chap. 5, "Obligations Policy"	$3,102	
2	Ensure cardholders comply with record retention requirements as stated in VA's Financial Policy, vol. 16, chap. 1B, "Government Purchase Card for Micro Purchases"		$26,900,000
	Total	**$3,102**	**$26,900,000**

[79] 2 C.F.R. § 200.1. The term "questioned cost" includes a cost that is questioned by the auditor because of an audit finding where the cost, at the time of the audit, is not supported by adequate documentation.

Appendix E: Management Comments Director, VA Palo Alto Health Care System

Department of Veterans Affairs Memorandum

Date: December 9, 2022

From: Director, VA Palo Alto Health Care System (640/00)

Subj: Draft Report, Financial Efficiency Review of VA Palo Alto Healthcare System in California (Project Number 2022-01565-AE-0067)

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

Finding 1: Inactive Obligations Were Not Always Being Reviewed, and Some Obligations Were Not Promptly Deobligated

Recommendation 1: Ensure that healthcare system finance office staff are made aware of policy requirements and that reviews are conducted on all inactive open obligations, and deobligate any identified excess funds as required by VA Financial Policy, vol. 2, chap. 5, "Obligations Policy."

Concur

Target date for completion: April 2022

Director Comments: Fiscal staff now review open inactive obligations as a part of normal reviews of all aged open obligations, ensuring documentation of follow up.

Finding 2: The Healthcare System Did Not Always Maintain Supporting Documentation or Consider Using Contracts

Recommendation 2: Ensure cardholders comply with record retention requirements as required by VA Financial Policy, vol. 16, chap. 1B, "Government Purchase Card for Micro-Purchases"

Concur

Target date for completion: January 2023

Director Comments: The Chief of the Business and Procurement Planning (B&PP) worked with the NCO-21 Government Purchase Card Coordinator to provide additional facility level oversight to the charge card program. A primary component of the oversight entails that card holders understand and demonstrate document and record log retention according to VA Financial Policy, vol. 16, chap. 1B during NCO-21 led facility sample audits.

Recommendation 3: Establish controls to 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.

Concur

Target date for completion: October 2022

Director Comments: An annual training conducted in October 2022 by NCO-21 via TEAMS covered the requirement of approving officials to review all purchase requests before processing a purchase order. In addition, VISN 21 required that Supply Chain Services review and sign off on GPC applications to

evaluate the need for a charge card or if an opportunity for a contract is imminent. In FY22, 128 accounts were identified and purged out of the system due to inactivity. Local procurement team will continue to work with GPC team to identify strategic sourcing opportunities.

Recommendation 4: Require purchase cardholders to submit a request for ratification for any unauthorized commitments identified.

Concur

Target date for completion: October 2022

Director Comments: In addition to requiring charge card holders and Approving Officials to complete Unauthorized Commitment (UAC) training in TMS, a virtual training conducted by NCO-21 in October 2022 provided education outlying what constitutes a ratification and the ratification process. Pending ratifications are discussed at monthly NCO meeting to ensure timely completion. All ratifications are submitted to the SES Deputy Executive Director for review and approval.

Finding 3: The Healthcare System Could Strengthen Local Processes to Ensure Accuracy of Expendable Inventory Data and Complete "A" Classified Physical Inventories in Accordance with VHA Policy

Recommendation 6: Ensure the chief of supply chain services establishes local processes and procedures so that all necessary reports are monitored on Supply Chain Common Operating Picture, the Generic Inventory Package, or other inventory sites or software systems, on a routine basis, as required in the Veterans Health Administration's Directive 1761 Supply Chain Management Operations.

Concur

Target date for completion: October 2022

Director Comments: Newly hired Logistics Management Specialist started September 2022. This additional FTE was added to this section of supply chain service to train and establish routine report monitoring. In addition, vacant Program Analyst position was filled October 2022 to monitor, review, and provide summary for actions needed based on Supply Chain Common Operating Picture (SCCOP) and Generic Inventory Package (GIP) reports. Data metrics are presented to leadership through Supply Chain Monthly Compliance Meeting.

Recommendation 7: Ensure supply chain management staff implement a plan for staff training to increase awareness of internal controls and data reliability within the Generic Inventory Package.

Concur

Target date for completion: December 2022

Director Comments: Supply Chain and Office of Process Improvement collaborated on the development of a training plan matrix. Deputy Chief of Supply Chain Service from Fresno VA was detailed May - August 2022 to provide training to front-line staff. Logistics Management Specialist started September 2022 as dedicated training resource for staff. This position will provide ongoing staff training and administrative support to Total Supply Support Section. Training will be documented and reported to Supervisory Inventory Management Specialist monthly. Training competency database in development.

Recommendation 8: Ensure the chief of supply chain services signs quarterly physical inventory memorandums of "A" classified items and make them available to Veterans Integrated Service Network

personnel as required in the Veterans Health Administration's Directive 1761 Supply Chain Management Operations.

Concur

Target date for completion: October 2022

Director Comments: Facility Chief Supply Chain Officer signs quarterly reports. Documents are provided to VISN Supply Chain by an upload to the VISN Supply Chain SharePoint site.

Finding 4: The Healthcare System Could Improve Pharmacy Efficiency, Increase the Inventory Turnover Rate, and Strengthen Oversight Controls

Recommendation 9: Develop and implement a plan to increase inventory turnover to meet the level recommended by the Veterans Health Administration Pharmacy Benefits Management Office.

Concur

Target date for completion: March 2023

Director Comments: We acknowledge that we do have additional opportunities to improve on "C" inventory items. We can improve the inventory turn into the 6-10 range by adjusting down par levels stored in the MedCarousel and overstock shelves.

Recommendation 10: Develop and implement a plan to complete monthly B09 reconciliation consistently to ensure discrepancies are corrected in a timely manner.

Concur

Target date for completion: October 2022

Director Comments: The reconciliation process was done daily (as soon as an item is received to check against invoice) and on a weekly basis (as soon as weekly B09 report is available). There is no risk of error as the reconciliation process ensuring the amount paid to the prime vendor is aligned with the goods received and documented. The administrative issue with timeliness of monthly reports being signed has been rectified.

(original signed) by

Lisa M. Howard

Director

The OIG removed point of contact information prior to publication.

Appendix F: VA Management Comments
Director of Contracting, Network Contracting Office 21

Department of Veterans Affairs Memorandum

Date: November 29, 2022

From: Director, Network Contracting Office 21, VA Sierra Pacific Health Care Network

Subj: Draft Report, Financial Efficiency Review of VA Palo Alto Healthcare System in California (Project Number 2022-01565-AE-0067)

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

Finding 2: The Healthcare System Did Not Always Maintain Supporting Documentation or Consider Using Contracts

Recommendation 5: Ensure purchase card reviews are performed as required by VA Financial Policy, vol. 16, chap. 1B, "Government Purchase Card for Micro-Purchases,"

Concur

Target date for completion: July 2021

Director Comments: The NCO 21 Purchase Card Manager implemented quarterly purchase card reviews to identify compliance issues in April 2021. The results are collected quarterly by the NCO 21 Agency Organization Program Coordinator (AOPC) using IFCAP VISTA and reported to the PAVAHCS Director. This information is retained by the NCO 21 AOPC and Purchase Card Manager. The NCO and PAVAHCS have been compliant with purchase card reviews since April 2021.

(original signed) by Brooke Robison
Brooke Robison
Director of Contracting
Network Contracting Office 21 (NCO21)

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

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