



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Financial Efficiency Review of
the Southeast Louisiana
Veterans Health Care
System in New Orleans



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Executive Summary

The VA Office of Inspector General (OIG) conducted this review to assess the oversight and stewardship of funds by the Southeast Louisiana Veterans Health Care System (the healthcare system) 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 review assessed the following financial activities and administrative processes to determine whether the healthcare system had appropriate oversight and controls in place:

- I. **Medical/Surgical Prime Vendor-Next Generation (MSPV-NG) Program utilization.**
The MSPV-NG program provides a collection of contracts with selected prime vendors that enables VA to streamline purchasing and just-in-time distribution of an array of medical, surgical, dental, and select prosthetic and laboratory supplies.² Supplies that can be purchased through the program appear on a list called a formulary. The VA Medical Supplies Program Office recommends that each medical center purchase at least 90 percent of requested medical supplies on the formulary from the region's assigned prime vendor.
- II. **Purchase card use.** The review team evaluated a sample of 102 purchase card transactions to determine whether the healthcare system's purchase card payments (1) were adequately monitored and approved to prevent duplicate payments and split purchases (including proper documentation), and (2) used strategic sourcing to save costs by establishing contracts for common purchases.³ Using contracts for common purchases

¹ The healthcare system serves veterans from a 23-parish area in southeast Louisiana. It consists of the New Orleans Veterans Affairs Medical Center and seven community-based clinics in Baton Rouge, Hammond, Slidell, Houma, Franklin, Bogalusa, and St. John Parish.

² *Medline Industries Inc. v. United States*, No. 21-1098, 2021 WL 3483429 (Fed.Cl. July 30, 2021). The OIG is aware that VA announced its plans to eliminate the MSPV program within VA by September 2023, and in its place to purchase medical supplies through the Defense Logistics Agency's MSPV catalog. As a result of this decision, several contractors who provide medical supplies under VA's MSPV filed civil suits in US federal court. On July 30, 2021, Judge Tapp, United States Court of Federal Claims, held that VA's plan to transfer its MSPV requirements to the Defense Logistics Agency was unlawful and permanently enjoined VA from doing so based on the administrative record provided to the court. Some issues raised before the court may still be pending; however, neither the case nor VA's plans to change the way it purchases medical supplies affect this report's substance or recommendations.

³ VA Financial Policy, vol. XVI, chap. 1B, "Government Purchase Card for Micro-Purchases," February 27, 2019. Purchases over the cardholder's micropurchase threshold cannot be made on purchase cards. Split purchases occur when a cardholder circumvents this requirement by dividing a single purchase or need into two or more smaller purchases. Section 010503 of this policy defines strategic sourcing as ensuring employees obtain proper contracts when procuring goods and services on a regular basis.

has benefits, such as allowing VA to leverage purchasing power and obtain competitive pricing.

- III. **Administrative staffing levels and accuracy of labor costs.** Administrative staff provide critical support to clinicians and perform other functions that can affect veterans' prompt access to quality patient care, so staffing levels should be given careful consideration. Still, an excessively large number of administrative staff in health care is increasingly identified with cost inefficiency.⁴ The team determined when closer examination of efficiencies was warranted by comparing the healthcare system's administrative staffing to that of other facilities of similar size and complexity.
- IV. **Pharmacy operations and cost avoidance efforts.** Because pharmacy costs represent a significant percentage of medical care spending, it is important for healthcare system leaders to identify opportunities for safely driving down costs. An efficient healthcare system anticipates how much drugs will cost and when inventory needs to be restocked by analyzing available data, such as inventory management data and turnover rates. Doing so informs cost-savings initiatives and helps ensure that inventory is available when needed.

The OIG selected these areas for review by using the efficiency opportunity grid, a tool developed by the Office of Productivity, Efficiency, and Staffing in the Veterans Health Administration (VHA). The grid helps facility leaders gain insight into areas of opportunity for improving efficiency, identify data quality and validation focus areas, and spot areas of success when compared with other VHA facilities. In its overall VHA efficiency rating, the Southeast Louisiana Veterans Health Care System ranked 134 of 140 compared to other healthcare systems. Other characteristics of the healthcare system are shown in its profile in appendix A. The OIG's review is limited in scope and is not intended to be a comprehensive review of all the system's financial operations.

The OIG evaluated financial efficiency practices related to the identified areas for fiscal year (FY) 2019. The team conducted its review from December 2019 to July 2021, including a site visit during the week of January 27, 2020.⁵

The findings and recommendations in this report should help the healthcare system identify areas of opportunity for improving oversight and the appropriate use of VA funds.

⁴ VHA Office of Productivity, Efficiency & Staffing, Administrative FTE Model, accessed January 22, 2020, <http://opes.vssc.med.va.gov/Pages/Administrative-Staffing-Model.aspx>. (The website is not accessible by the public.)

⁵ For more information about the review's scope and methodology, see appendixes B and C.

What the Review Found

The team identified opportunities for improvement in three of the four areas reviewed:

- I. **Use of the MSPV-NG program.** Because of the prime vendor's inability to fill formulary orders consistently, the healthcare system did not meet its MSPV-NG utilization goal in FY 2019. The healthcare system's utilization rate was 75 percent on average, falling short of the 90 percent goal.⁶

The review team found that the healthcare system did not have a required MSPV-NG contracting officer's representative to monitor prime vendor performance and did not always use or have awareness of some of the tools available to provide feedback on prime vendor performance.

Because supplies were not always available from the prime vendor, they were sometimes purchased from other vendors. As a result, the healthcare system was unable to fully achieve the cost savings associated with the MSPV-NG contract. The review team found that overall for 10 months in FY 2019, the healthcare system spent approximately \$4,000 less for about 565 supply items from non-prime-vendor vendor sources that were used when the prime vendor was unable to meet the healthcare system's demand or because the healthcare facility chose to purchase items from non-prime-vendor sources when prices were less than formulary prices.⁷ Based on the review team's analysis, the healthcare system spent over \$178,000 more for 269 of the items but saved approximately \$183,000 on 296 items.

- II. **Purchase card use.** The review team determined that strategic sourcing (establishing contracts) could have been appropriate but was not pursued for 19 sampled FY 2019 transactions totaling about \$52,055. Instead of referring commonly used goods to a contracting officer in accordance with VA policy, staff made one-off purchases on purchase cards. Finally, FY 2019 quarterly internal audits for the purchase card program were not completed within the required time frame. These audits could have prevented split purchases. During the same fiscal year, the team identified 16 transactions as split purchases, which resulted in unauthorized commitments and improper payments totaling about \$140,016.⁸ These transactions occurred because approving officials failed to

⁶ "The Formulary Utilization Metric: A Deep Dive Explanation," Supply Chain Data and Informatics Office, accessed May 6, 2021, <https://vaww.va.gov/plo/docs/mspo/mspvFormularyUtilizationMetricOverview.pdf>.

⁷ The OIG performed its analysis on 10 months of data because for two months in FY 2019, MSPV-NG formulary utilization purchase data were not available.

⁸ VA Directive 7401.7, *Unauthorized Commitments and Ratification*, October 7, 2004. An unauthorized commitment is an agreement that is not binding on the government solely because the government official who made it lacked the authority to enter into a contract on behalf of the government. This directive further defines ratification as an authorized official converting an unauthorized commitment into a legal contract.

adequately monitor cardholder purchases for compliance with applicable policies and the Federal Acquisition Regulation.⁹

III. Administrative staffing levels and accuracy of labor costs. A VHA efficiency model revealed the healthcare system used 251.6 more administrative full-time equivalents than systems of similar size and complexity in FY 2019, according to an administrative staffing model developed by the Office of Productivity, Efficiency, and Staffing in VHA.¹⁰ According to the healthcare system director, this was due in part to the new New Orleans VA Medical Center becoming operational from FY 2015 through FY 2021 and the healthcare system hiring in anticipation of providing new healthcare services and for projected rather than actual workload.

Healthcare system managers acknowledged having budget and administrative staffing concerns. In response, leaders tasked the resource management committee with making recommendations for allocating budget dollars and full-time equivalents. They enacted healthcare system-wide budget reductions in response to a projected \$64 million budget deficit, which had a positive effect on staffing efficiency. System leaders also created strategic alignments among services and staff to address the VA MISSION Act of 2018 requirements for consolidating community care programs.¹¹

Because the healthcare system has implemented strategies to improve staffing efficiency and management, the OIG did not make any related recommendations. However, healthcare system leaders and service chiefs must continue monitoring their administrative staffing levels as the medical center becomes fully operational.

IV. Pharmacy operations and cost avoidance efforts. The healthcare system spent approximately \$9 million more than similar healthcare systems on prescription drugs in FY 2019, according to the VHA efficiency grid (a collection of 12 statistical models that allow comparisons between VHA facilities). However, the model was not adjusted to consider pharmacy start-up costs related to activating the New Orleans medical center after Hurricane Katrina.

Factors contributing to the healthcare system's pharmacy inefficiency rating related to costs included sometimes inaccurate or outdated prices in the healthcare system's local drug file, and a low annual drug inventory turnover rate (below the goal set by VA's Pharmacy Benefits Management Services). However, the team's review of the healthcare

⁹ FAR 13.003.

¹⁰ Full-time equivalent (FTE) is a term used to quantify employment as a function of hours worked rather than by the number of individual employees. One work year, or one FTE, is typically equivalent to 2,080 hours of work. The number of administrative FTEs is from the administrative staffing model, which includes administrative and clerical personnel, as well as administrative-mapped FTEs.

¹¹ The Maintaining Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182 (2018).

system's activities and plans showed progress in establishing efficiency initiatives, using targeted efficiency metrics, and implementing cost-saving initiatives to convert branded drugs to generic and reduce the overall use of certain medications.

What the OIG Recommended

The OIG made six recommendations for improvement to the healthcare system director. The number of recommendations should not be used, however, as a gauge for the system's overall financial health. The intent is for system leaders to use these recommendations as a road map to improve financial operations. The recommendations address issues that, if left unattended, may eventually interfere with effective financial efficiency practices and the strong stewardship of VA resources.

The OIG recommended that the healthcare system director address available stock issues with the prime vendor. The director should also ensure the MSPV-NG contracting officer's representative and logistics staff comply with VA policy and directives. These include monitoring the prime vendor contract utilization goals and reporting prime vendor performance deficiencies and issues to VA's Medical Supplies Program Office and Strategic Acquisition Center. As to purchase cardholders, the OIG recommended controls to make certain that they submit ratification requests to the director of contracting for the prior unauthorized commitments the OIG team identified.¹² The OIG also recommended that the director of contracting for South Central VA Health Care Network Contracting Office 16 make certain that purchase card audits are performed as required by VHA policy. Regarding staffing, service chiefs must oversee the accuracy of labor costs. Finally, the director is called on to ensure that the facility meets VHA's recommended inventory turnover rate of 12, established by the National Pharmacy Benefits Management program office.

¹² VA Directive 7401.7, *Unauthorized Commitments and Ratification*, defines ratification as an authorized official converting an unauthorized commitment into a legal contract. The directive requires a cardholder who makes an unauthorized commitment to submit a ratification request to the related office of the chief of contracting.

Management Comments

The director of the Southeast Louisiana Veterans Health Care System concurred with all six recommendations and provided corrective action plans that are responsive to the recommendations. The OIG will monitor the implementation of all planned actions and will close the recommendations when the Southeast Louisiana Veterans Health Care System provides sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified. Appendix E includes the full text of the director's comments.



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Abbreviations

COR	contracting officer's representative
FTE	full-time equivalent
FY	fiscal year
GAO	Government Accountability Office
MSPV-NG	Medical/Surgical Prime Vendor-Next Generation
OIG	Office of Inspector General
OPES	Office of Productivity, Efficiency, and Staffing
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

The VA Office of Inspector General (OIG) conducts financial efficiency reviews to assess the oversight and stewardship of funds used by VA healthcare systems and to identify opportunities to achieve cost efficiencies. To promote best practices, OIG review teams identify and examine financial activities that are under the healthcare system's control and can be compared to those of healthcare systems of similar size and complexity across VA.¹³

This review focused on the Southeast Louisiana Veterans Health Care System, which includes the New Orleans VA Medical Center and seven community-based outpatient clinics.

The review team assessed financial activities and administrative processes for fiscal year (FY) 2019 to determine whether appropriate oversight and controls were in place for these four areas:

- I. **Medical/Surgical Prime Vendor-Next Generation (MSPV-NG) Program utilization.** The MSPV-NG program provides a collection of contracts with selected prime vendors that enables VA to streamline supply chain management for an array of medical, surgical, dental, and select prosthetic and laboratory supplies.¹⁴ The program achieves long-term savings by using a “just-in-time” logistics approach.¹⁵ VA medical facilities are required to use MSPV-NG for products that are available through the program, which appear on a list called a formulary. The VA Medical Supplies Program Office recommends that if the supplies that medical facilities wish to buy are on the formulary, each medical center should purchase at least 90 percent of the supplies on the formulary from the region's assigned prime vendor.¹⁶ The review team examined whether the healthcare system met Veterans Health Administration (VHA) goals for utilizing the program.
- II. **Purchase card use.** The team examined whether the healthcare system's purchase card program ensured compliance with policies and procedures that reduce the risk of error, fraud, waste, and abuse. The review focused on determining if payments (1) were

¹³ The Veterans Health Administration 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 Southeast Louisiana Health Care System is rated as a 1b–High Complexity facility.

¹⁴ *Medline Industries Inc. v. United States*, No. 21-1098, 2021 WL 3483429 (Fed.Cl. July 30, 2021). The OIG is aware that VA announced its plans to eliminate the MSPV program by September 2023, and in its place to purchase medical supplies through the Defense Logistics Agency's MSPV catalog. As a result of this decision, several contractors who provide medical supplies under VA's MSPV filed civil suits in US federal court. On July 30, 2021, Judge Tapp, United States Court of Federal Claims, held that VA's plan to transfer its MSPV requirements to the Defense Logistics Agency was unlawful and permanently enjoined VA from doing so based on the administrative record provided to the court. Some issues raised before the court may still be pending; however, neither the case nor VA's plans to change the way it purchases medical supplies affect this report's substance or recommendations.

¹⁵ The “just-in-time” method is an inventory strategy in which materials are only ordered and received as they are needed.

¹⁶ The Formulary Utilization Metric: A Deep Dive Explanation,” Supply Chain Data and Informatics Office, accessed May 6, 2021, <https://vaww.va.gov/plo/docs/mspo/mspvFormularyUtilizationMetricOverview.pdf>.

adequately monitored and approved to prevent duplicate payments and split purchases, and (2) used strategic sourcing to save costs by establishing contracts for common purchases.¹⁷

III. Administrative full-time equivalent (FTE) staffing and accuracy of labor costs.

Administrative staffing is a component of overhead. In health care, large administrative overhead costs are often associated with inefficiency.¹⁸ The team identified opportunities for improvement by comparing the healthcare system's administrative staffing to that of similar VA facilities and evaluated whether the healthcare system recorded administrative labor costs accurately.

IV. Pharmacy operations and cost avoidance efforts. The review team determined whether the healthcare system is following policies and using its data to track progress toward cost-saving goals, improve program operations, and identify and correct problems.

To assess these areas, the review team performed a site visit at the New Orleans VA Medical Center during the week of January 27, 2020; interviewed healthcare system leaders and staff; and reviewed data, supporting documents, and processes related to the healthcare system's financial efficiency.¹⁹ For more information about the review's scope and methodology, see appendix B.

Southeast Louisiana VA Health Care System

The healthcare system serves veterans from a 23-parish area in southeast Louisiana. It consists of the New Orleans VA Medical Center and seven community-based clinics in Baton Rouge, Hammond, Slidell, Houma, Franklin, Bogalusa, and St. John Parish. With a budget of \$574 million and more than 2,700 FTEs, it provided health care to over 46,000 veterans in FY 2019.²⁰ In FY 2020, the system provided health care to over 45,000 veterans, had a budget of \$676 million, and had almost 2,700 FTEs.²¹

¹⁷ Split purchases are purchases that were intentionally modified from a known requirement into two or more purchases or payments with the same purchase date, same purchase card number, and same merchant to circumvent the micropurchase threshold (monetary limit) for a single purchase.

¹⁸ VHA Office of Productivity, Efficiency & Staffing, Administrative FTE Model, accessed January 22, 2020, <http://opes.vssc.med.va.gov/Pages/Administrative-Staffing-Model.aspx>. (The website is not accessible by the public.)

¹⁹ While the OIG conducted a broad review of the identified topics, the complexity and extent of VA healthcare system operations limited the review team's ability to assess all areas of financial management during a limited scope review.

²⁰ Full-time equivalent (FTE) is a term used to quantify employment as a function of hours worked rather than by the number of individual employees. One work year, or one FTE, is typically equivalent to 2,080 hours of work.

²¹ VHA Support Service Center Trip Pack - Operational Statistics Table, accessed November 6, 2020, <https://vssc.med.va.gov/VSSCMainApp/products.aspx>. (The website is not accessible by the public.)

The medical center's complexity level is considered 1b, meaning that the facility has medium-to-high patient volume, high-risk patients, many complex clinical programs, and medium-to-large research and teaching programs.²² After the medical center was destroyed by Hurricane Katrina in 2005, the rebuilt medical center opened in 2016. The center saw its first outpatients on December 5, 2016, and its first inpatients on July 14, 2017. This hospital is approximately 1.6 million square feet and has about 156 hospital beds. By 2021, the medical center plans to be fully operational with the goal of activating all beds and surgical tracks. Figure 1 provides an overview of the timeline associated with the medical center activation.

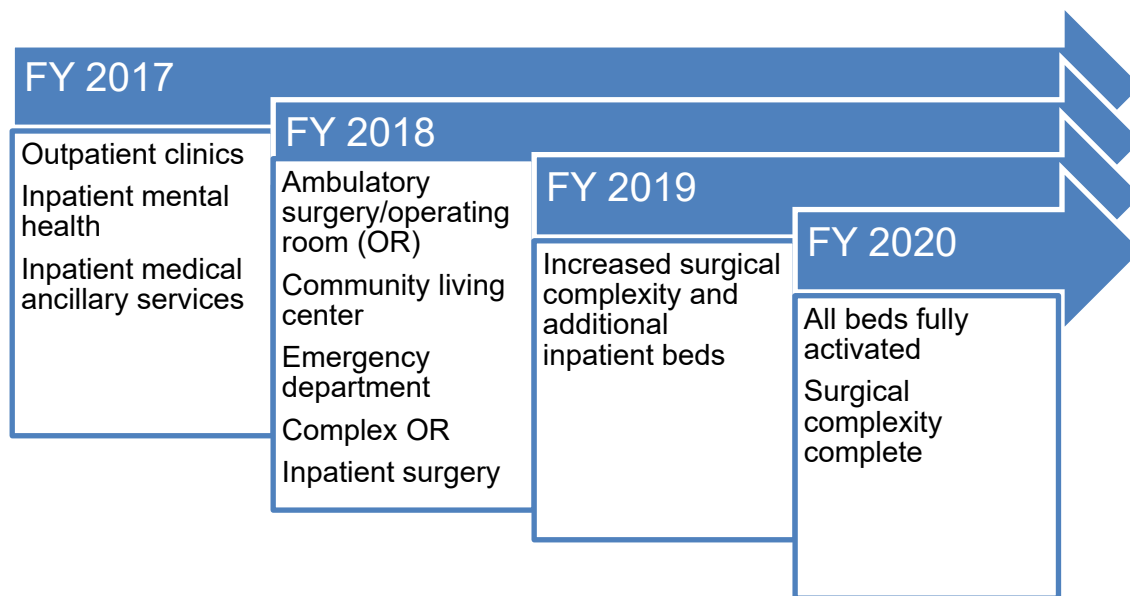


Figure 1. Facility activation workload timeline.

Source: VA OIG analysis of healthcare system director's presentation at entrance conference, January 27, 2020.

As the medical center activation has progressed, the Southeast Louisiana Health Care System has provided more patient services and experienced increases in its healthcare workload, with associated costs and performance challenges. The review team observed the impact of the changing workload on administrative labor levels and pharmacy costs in particular.

For additional background information about the healthcare system, see appendix A.

²² VHA Office of Capital Asset Management Engineering and Support, "VHA Engineering Resourcing and Staffing Study Sponsor Presentation for National Academies Committee," September 26, 2018.

Efficiency Opportunity Grid

The VHA Office of Productivity, Efficiency, and Staffing (OPES) developed the efficiency opportunity grid to give facility leaders insight into areas of opportunity for improving efficiency, identifying data quality and validation focus areas, and spotting areas of success when compared with other VHA facilities. The grid is a collection of 12 statistical models that allow comparisons between VHA facilities by accounting for variations in patient and facility characteristics and geography. OPES adjusts the data in this model for geographic, facility, and patient characteristics to provide more of an “apples to apples” comparison among different VA facilities. It does, however, have a limitation in that OPES is “merely an end-user of data; any data is drawn from the certified financial and workload reports.” The data are presented as one way for “facilities to understand where opportunities exist for efficiency improvement” and “when supplemented with local strategies, can optimize resource deployment.”²³

The review team used models from the grid to assess administrative FTE activity and pharmacy drug costs during the review period. These models identify possible inefficiencies by showing the difference between a healthcare system’s actual and expected costs. This measurement can also be expressed as an “observed to expected” ratio, so VA facilities can be ranked on efficiency. Results from prior years can also be compared to identify favorable or unfavorable trends.

²³ VHA Support Service Center, Efficiency Opportunity Grid (EOG) Model, Data Definitions, accessed June 25, 2021, https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?/MgmtReports/OPES/OPES_EfficiencyOpGrid&rs:Command=Render. (The website is not accessible by the public.)

Results and Recommendations

I. Use of the Medical/Surgical Prime Vendor-Next Generation Program

As previously mentioned, VA medical facilities are required to use the MSPV-NG program for products that are available through it, which appear on a list called a formulary. The VA Medical Supplies Program Office recommends that each medical center purchase at least 90 percent of its medical supplies that are listed on the formulary from the region's assigned prime vendor.²⁴ The Southeast Louisiana Health Care System spent about \$5.7 million during FY 2019 on MSPV-NG purchases with the system's prime vendor, Medline Industries Inc. (Medline).

The review team focused on two areas of MSPV-NG program use:

- **Formulary utilization rate** measures the extent to which facilities use prime vendors for formulary item purchases.
- **Contract performance monitoring** includes oversight of the prime vendor by the facility's contracting officer's representative (COR), as well as the use of tools that allow the healthcare system to provide information on prime vendor performance and MSPV-NG program feedback. One measure of prime vendor performance is the order fulfillment rate, a contractual requirement to fulfill at least 95 percent of orders placed by a facility for items on the formulary.

Finding 1: The Southeast Louisiana VA Healthcare System Was Unable to Meet the MSPV-NG Formulary Utilization Goal, Did Not Have the Required Contracting Representative, and Did Not Use Available Tools to Report Prime Vendor Performance

The healthcare system was not able to meet the 90 percent formulary utilization goal for purchases made through the MSPV-NG contract in FY 2019. Its annual formulary utilization rate was about 75 percent on average, according to the MSPV-NG performance metrics dashboard. According to healthcare system officials interviewed, this occurred because Medline did not have adequate stock on hand to provide supplies when ordered. However, the healthcare system did not consistently report the prime vendor's performance problems using tools provided by the Medical Supplies Program Office. Timely and accurate reporting of problems with a prime vendor are critical for both accountability and remedial action. The unavailability of supplies from the prime vendor resulted in the healthcare system staff needing to purchase supplies from

²⁴ The Medical Supplies Program Office is a VHA entity in the Procurement and Logistics Supply Chain Program Office that is primarily responsible for supporting VHA's healthcare requirements and overseeing strategic sourcing efforts for supplies ordered through the MSPV-NG program. It was formerly known as the Healthcare Commodities Program Office.

other vendors. The team found that for 10 months in FY 2019, the healthcare system purchased 565 supply items listed on the formulary from other vendors. The healthcare system used other vendors because the prime vendor was unable to fill the purchase requests or because non-prime-vendor prices were less than formulary prices.²⁵ Based on the review team's analysis, the healthcare system spent over \$178,000 more for 269 of the items but saved approximately \$183,000 on 296 items. Overall, the healthcare system spent approximately \$4,000 less because it made purchases on the open market rather than through the prime vendor.

MSPV-NG Formulary Utilization

The review team found the healthcare system was not able to meet the recommended goal of purchasing at least 90 percent of its medical supplies from the formulary in any month in FY 2019, according to purchasing data from the Supply Chain Common Operating Picture.²⁶ A 2017 Government Accountability Office (GAO) report concluded that medical centers nationwide were not using the initial formulary list because it did not fully meet medical centers' needs.²⁷ The VHA Medical Supply Program Office maintains the formulary list. According to a 2020 GAO follow-up report, the list contained about 22,000 items as of November 2018, growing from 8,000 items in March 2018.²⁸ However, if a requested item is not available on the formulary list, the purchase from another vendor does not count against the 90 percent utilization rate. The review team interviewed healthcare system logistics managers and staff who stated that constant changes to the formulary impeded their use of the prime vendor. According to the prime vendor, the healthcare system's biggest challenge to formulary utilization was untimely forecasting and communication to the prime vendor of the healthcare system's needs. In the prime vendor representative's opinion, if the healthcare system better communicated its supply needs in a timely manner, the prime vendor would be better able to have supply items in stock when needed.

The annual MSPV-NG utilization rate for the healthcare system ranged from 60 to 85 percent. Figure 2 shows the FY 2019 monthly MSPV-NG formulary utilization rates.

²⁵ The OIG analyzed 10 months of data because for two months in FY 2019, MSPV-NG formulary utilization purchase data were not available.

²⁶ The Supply Chain Common Operating Picture is an interactive dashboard that enables supply chain leaders to observe supply chain metrics at the enterprise, Veterans Integrated Service Network (VISN), and facility level.

²⁷ GAO, *Veterans Affairs Contracting: Improvements in Buying Medical and Surgical Supplies Could Yield Cost Savings and Efficiency*, GAO-18-34, November 2017.

²⁸ GAO, *VA Acquisition Management: Actions Needed to Improve Management of Medical-Surgical Prime Vendor Program and Inform Future Decisions*, GAO-20-487, September 2020.

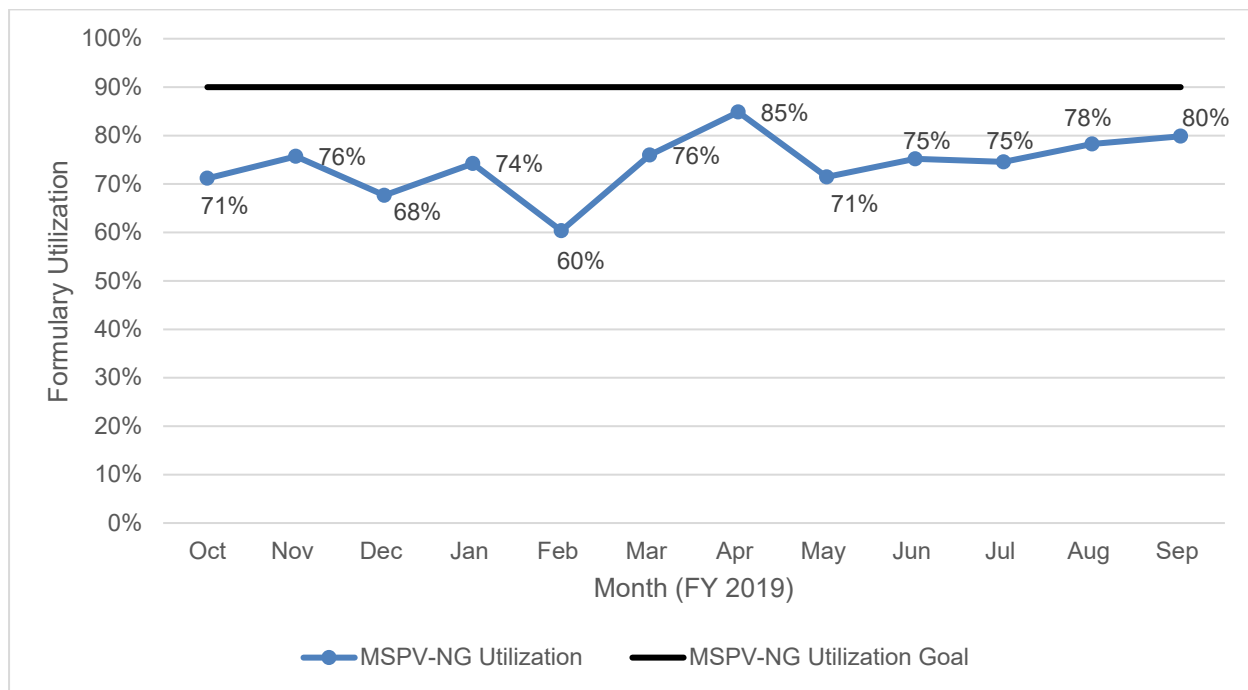


Figure 2. Southeast Louisiana Health Care System FY 2019 MSPV-NG monthly formulary utilization percentages.

Source: VA OIG analysis of the system's formulary utilization data from the Supply Chain Common Operating Picture Med/Surg Prime Vendor [MSPV] Formulary Utilization Report.

The healthcare system spent over \$1.4 million of approximately \$5.7 million (about 25 percent of total potential MSPV-NG spending) using non-prime-vendor sources instead of purchasing from Medline as the prime vendor. The items included medical, surgical, dental, laboratory, and prosthetic supplies. The review team analyzed an FY 2019 MSPV-NG formulary utilization report from the Supply Chain Common Operating Picture to assess the potential difference in prices paid for MSPV-NG items not purchased from the prime vendor that the prime vendor had been required to supply.

The review team found during 10 months in FY 2019, the healthcare system purchased 565 MSPV-NG formulary items from non-prime-vendor sources, rather than purchasing the items through Medline, as required by VHA.²⁹ Based on the review team's analysis, the healthcare system spent over \$178,000 more for 269 of the items but saved approximately \$183,000 on 296 items. Overall, the healthcare system spent approximately \$4,000 less because it made purchases from non-prime vendors rather than through the prime vendor. The team

²⁹ VHA Memorandum, "Use of Medical/Surgical Prime Vendor (MSPV) Contracts is Mandatory," June 22, 2015. "All medical and surgical supplies that are available from MSPV must be ordered from the appropriate contract. **The MSPV is mandatory for use by all VA Medical Centers (VAMCs)**" [emphasis is in the document]. Therefore, when a product is available through the MSPV-NG formulary, VAMC personnel must purchase it through the prime vendor. The OIG performed its analysis for 10 months because for two months in FY 2019, MSPV-NG formulary utilization purchase data were not available.

determined this by comparing prices paid to formulary pricing. The healthcare system also missed other savings and efficiencies associated with purchasing items under the MSPV-NG program, such as lower administrative burden and volume discounts that could be available when leveraging VA's purchasing power.

Generally, the healthcare system's logistics section chief for medical supply distribution attributed the low utilization rate to Medline not having adequate stock in its warehouse to provide supplies when ordered, leading to ordering from non-prime-vendor sources. To support this assertion, the facility provided an open orders report that included reasons items were not available when ordered, the estimated delivery date (if known), and suggested substitutions.

Medline's contractual requirements included maintaining the necessary inventory levels to provide the required supplies to participating facilities and distributing supplies at an unadjusted fill rate of 95 percent.³⁰ The review team analyzed Medline's self-reported monthly fill rates and determined that Medline did not supply the healthcare system's needs at the required 95 percent fill rate for 10 of 12 months in FY 2019. By Medline's own account, it did not always have adequate stock on hand to meet the medical healthcare system's needs, as its self-reported monthly fill rates ranged from a low of 86 percent to a high of 97 percent, averaging 91.5 percent for FY 2019. Figure 3 depicts Medline's self-reported monthly unadjusted fill rates for FY 2019.

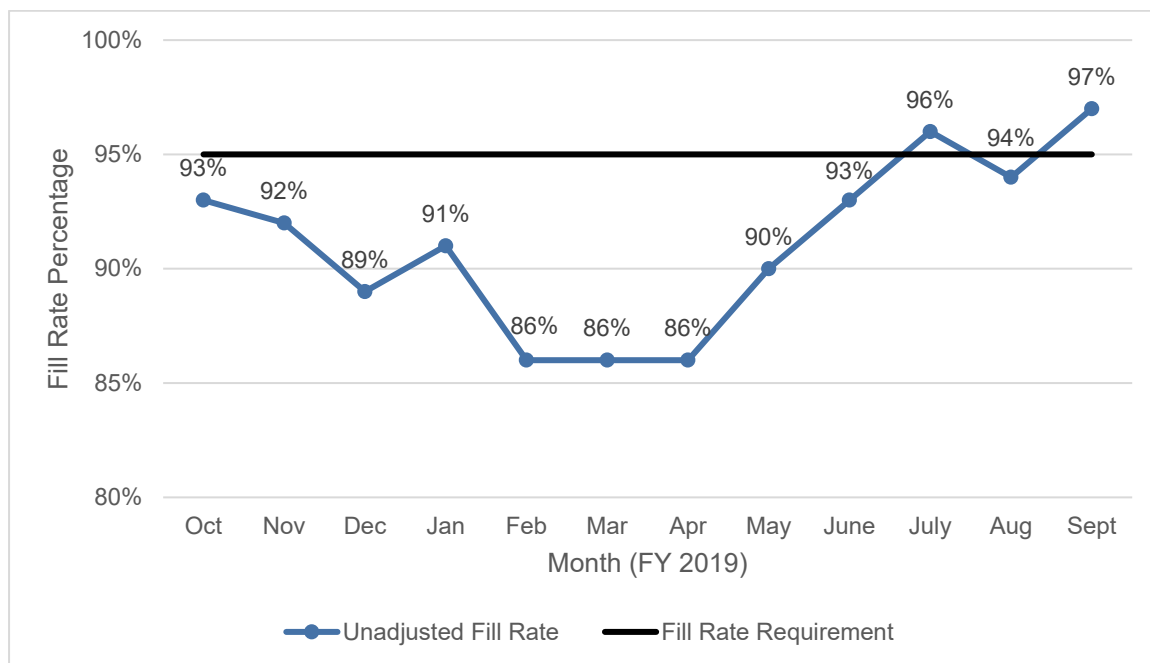


Figure 3. Medline self-reported unadjusted fill rate percentages, FY 2019 (October 2018–September 2019).
Source: VA OIG analysis of Medline's monthly self-reported unadjusted fill rates in Medline's Business Review Report prepared for the healthcare facility.

³⁰ The unadjusted fill rate is the calculation of orders fulfilled against orders requested (meaning any medical/surgical supply item not completely filled at the time of request for any reason counts against this measure).

The healthcare system's logistics managers and staff told the review team that many of the non-prime-vendor purchases were made because Medline could not meet demands. The demand issues involved nonstock items and vendor-direct items (described below with examples), discontinued items, manufacturing backorders, and packaging limitations, such as therapeutic diabetic socks that were not packaged in the sizes or quantities needed by the healthcare system.

- **Nonstock items** are on the formulary, but Medline is not required to stock them in its warehouse because the healthcare system's use is less than the once-per-month ordering threshold. Because there are over 98,000 items on the formulary, Medline and the healthcare system should work together to determine the most frequently used items, so that Medline will keep them on hand in its warehouse. Both healthcare system logistics managers and the Medline representative acknowledged that forecasting these needs is an issue they are working to resolve. In one instance, the healthcare system ordered two cases of sterile gauze sponges from Medline on August 19, 2019. Medline identified the item as nonstock with an estimated delivery date of June 29, 2020, over 10 months after the order was placed.
- **Vendor-direct items** include certain formulary items that some manufacturers do not allow Medline to keep in stock because the manufacturer controls the items for proprietary reasons. In this situation, the healthcare system orders from Medline and then Medline places an order with the vendor to ship directly to the healthcare system. This process causes delays in receiving items, and the healthcare system does not know exactly when the items will be delivered. For example, the healthcare system ordered two catheters from Medline on August 22, 2019; however, these items were vendor-direct purchases and an estimated delivery date was not provided.

The barriers that cause delays and unfilled orders are expected to occur to some degree. This is reflected in the MSPV-NG contract, which allows a 5 percent margin for the prime vendor not filling orders accurately and on time. However, these instances may result in higher costs for the healthcare system when alternate sources need to be used. Further, these barriers can significantly extend estimated delivery dates, thereby negating the benefit of the next-day delivery that is required under the contract.

In addition, the logistics section chief of medical supply distribution advised that the facility often chose to purchase available formulary items from non-prime-vendor sources rather than purchasing the items on the MSPV-NG formulary when non-prime-vendor prices were less than formulary prices, allowing the facility to save money. The review team found that during 10 months in FY 2019, the healthcare system spent about \$183,000 less on 296 non-prime-vendor items when compared to prime vendor pricing. Nevertheless, this practice is not consistent with a VA standard operating procedure that stipulates that the appearance of lower cost for a specific medical facility is not sufficient justification for deviating from the requirement to use MSPV-NG contracts, as the MSPV-NG program is designed to offer benefits

beyond cost.³¹ As part of VA's supply chain modernization efforts, the MSPV-NG vehicle positions VHA to standardize processes, increase clinicians' involvement in sourcing products, reduce the need for facilities to maintain high levels of inventory, enable just-in-time logical unit of measure delivery service, and allow VA to leverage its purchasing power and the use of negotiated rates. The 2020 GAO report states that VA focused on increasing the number of supplies on the formulary, not on cost savings.³²

Contract Performance Monitoring

The review team found that the healthcare system did not have an MSPV-NG COR to monitor prime vendor performance or use the issue management tool or monthly facility execution survey prescribed by the Medical Supplies Program Office to provide feedback on and oversight of prime vendor performance.

MSPV-NG Contract Officer's Representative

Each medical healthcare system is responsible for ensuring it has a certified MSPV-NG COR to help monitor prime vendor contract performance, report risks and issues to the Medical Supplies Program Office, and hold the prime vendor accountable.³³ The Strategic Acquisition Center, within the VA Office of Procurement, Acquisition, and Logistics, is responsible for seeing that each healthcare system has a filled MSPV-NG COR position. The Strategic Acquisition Center also issued and administers the MSPV-NG contract with Medline and is responsible for serving as the contracting office and signing the MSPV-NG COR designation letter.

The review team found that the healthcare system did not have an MSPV-NG COR to monitor prime vendor performance during the OIG review period in FY 2019. The position had been vacant since at least October 2018 because logistics management personnel did not follow through with the Strategic Acquisition Center's requests to fill the position. According to the healthcare system's chief of logistics, the medical healthcare system was not aware of the requirement that it must have at least one MSPV-NG COR. The review team found emails dated April 2016 and October 2018 showing that the Veterans Integrated Service Network (VISN) and the Strategic Acquisition Center did request that the healthcare system nominate an MSPV-NG COR. Due to an administrative oversight, the Strategic Acquisition Center did not follow up after October 2018 to ensure the COR was appointed, according to the center's chief of acquisition services. She also stated that the center will continue to monitor unfilled MSPV-NG COR positions and that it has improved the process for tracking CORs across VHA facilities.

³¹ VHA Medical/Surgical Prime Vendor (MSPV) Standard Operating Procedure (SOP), *Waiver Process and Procedure*, May 2017.

³² GAO, *VA Acquisition Management: Actions Needed to Improve Management of Medical-Surgical Prime Vendor Program and Inform Future Decisions*.

³³ VHA Supply Chain Program Office, Procurement and Logistics Office, *One Book*, April 9, 2019.

The healthcare system's MSPV-NG COR was eventually appointed about one week prior to the team's site visit in January 2020. The review team found that, due to his recent appointment, the COR was not fully aware of how to execute his role and responsibilities as an MSPV-NG COR, such as the process to report issues with prime vendor performance.

Tools for Feedback on Prime Vendor Performance

If prime vendors do not meet their obligations, it is important that facility personnel alert program leaders and other VHA staff. One tool for doing so is the monthly facility execution survey, which informs the Medical Supplies Program Office of the facility's satisfaction with the MSPV-NG program, prime vendors, and formulary. Survey submissions are restricted to the first five days of each month and should be completed by the facility chief supply chain officer. Another method for reporting concerns with the prime vendor's performance is the issue management tool, which is used by CORs and supply chain staff. The review team determined the healthcare system's logistics staff did not complete any monthly facility execution surveys or submit any feedback using the issue management tool during FY 2019. These tools were not used because logistics staff were not aware of them, according to the healthcare system's logistics section chief for medical supply distribution.

Because the healthcare system did not use the available tools to report issues with the prime vendor, the facility could not be assured that VHA had information needed to evaluate the effectiveness of the MSPV-NG program and to oversee Medline's compliance with contractual obligations.

Finding 1 Conclusion

Due in part to Medline's inability to consistently fill formulary orders, the healthcare system was hindered in meeting its MSPV-NG utilization goal in FY 2019. Other factors included challenges with nonstock and vendor-direct items, the healthcare system purchasing available formulary items from non-prime-vendor sources because prices were less than formulary pricing, and forecasting challenges the facility and prime vendor have had. Healthcare system personnel did not fully utilize or were not aware of some of the available reporting tools to provide feedback on the prime vendor's performance to assist with solving identified issues. These tools are important for the facility to use to ensure VHA has the information needed to take corrective action as appropriate. Although overall estimates of purchases were below prime vendor costs, about \$178,000 in purchases that were on the formulary were not made with the prime vendor. Some of those costs could have been avoided had logistics staff complied with VA policy.

Recommendations 1–2

The OIG made the following recommendations to the director of the Southeast Louisiana Veterans Health Care System:

1. Develop a plan to work with the prime vendor to address having adequate stock from the facility's formulary list in its warehouse to provide supplies when ordered.
2. Ensure logistics staff and the contracting officer's representative use the tools available to inform the Medical Supplies Program Office and Strategic Acquisition Center of prime vendor performance issues.

Management Comments

The director of the Southeast Louisiana VA Health Care System concurred with recommendations 1 and 2. The responses to all report recommendations are provided in full in appendix E.

To address recommendation 1, the healthcare system director reported the facility's associate medical center director is championing efforts with the supply chain management service chief to develop a plan for the COR to work with the prime vendor to complete the monthly prime vendor performance report to help identify trends with stock issues. The COR will also work collaboratively with supervisory inventory management specialists to monitor stock levels to ensure adequate supplies are available from the prime vendor when ordered. For recommendation 2, the director reported the facility's Logistics Service will work closely with the VISN office on all performance concerns under the MSPV contract. The VISN will then communicate significant issues to the prime vendor. The director also reported that the Logistics Service works daily with the MSPV in-house representative to resolve any issues before they become a larger problem requiring higher-level intervention.

OIG Response

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

II. Purchase Card Use

The VA Government Purchase Card Program was established to reduce the 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.³⁴ In FY 2019, purchase cardholders at the healthcare system spent approximately \$38.6 million through purchase cards, representing about 60,874 transactions. The amount and volume of spending through the VA Government Purchase Card Program makes it important to have strong controls over purchase card use to reduce the risk of error, fraud, waste, or abuse.

The OIG team reviewed the following areas:

- **Purchase card transactions.** The review team examined whether the healthcare system used strategic sourcing, particularly for items ordered repeatedly, before using purchase cards. Strategic sourcing is defined as ensuring employees obtain proper contracts when procuring goods and services on a regular basis. This enables VA to leverage its purchasing power and reduce the risk of circumventing contracts for commonly ordered items, split purchases, and duplicate payments on purchase cards.³⁵
 - **Repetitive purchases** are recurring orders of goods or services. Strategic sourcing often results in commonly needed items being purchased under contracts that are subject to greater controls and negotiated prices than purchase cards, in accordance with VA policy. When these repeat purchases exceed the total value of the micropurchase threshold requirement, they should be communicated to contracting staff, instead of being modified for purchase card transactions aimed at avoiding formal contracting procedures.³⁶
 - **Split purchases** occur when a cardholder circumvents the micropurchase threshold requirement by dividing a single purchase or need into two or more smaller purchases.³⁷
 - **Duplicate payments** are charges on the purchase card account that represent multiple billings to the account for the same purchase.

³⁴ FAR 13.003.

³⁵ VA Financial Policy, vol. XVI, chap. 1B, “Government Purchase Card for Micro-Purchases,” sec. 010503, February 27, 2019. This policy defines strategic sourcing as ensuring employees obtain proper contracts when procuring goods and services on a regular basis.

³⁶ VA Financial Policy, “Government Purchase Card for Micro-Purchases,” sec. 010504, “Split Purchase and the Single Purchase Threshold.”

³⁷ VA Financial Policy, “Government Purchase Card for Micro-Purchases,” sec. 0103, “Definitions.”

- **Effectiveness of purchase card oversight.** Systematic controls are needed to reduce the risk of error, fraud, waste, and abuse in the purchase card program (e.g., periodic and continuous monitoring, checks and balances, policies, procedures, and segregation of duties).³⁸ The team examined key oversight roles and responsibilities, particularly whether purchase cardholders' compliance with policies and procedures was directly monitored.

Finding 2: Healthcare System Personnel Did Not Use Processes for Considering Contracting for Commonly Purchased Goods and Purchase Cardholders Made Split Purchases to Avoid Contracting

The review team identified transactions for which cardholders inappropriately used government purchase cards to buy commonly used goods instead of communicating the needs to contracting officers to determine if existing contract vehicles were appropriate to leverage VA's purchasing power. Healthcare system cardholders also used purchase cards inappropriately during FY 2019 by splitting purchases to avoid federal contracting requirements. These practices of buying commonly used goods with purchase cards and splitting purchases were not prevented because approving officials did not adequately monitor cardholder purchases to ensure compliance with the Federal Acquisition Regulation and VA policy.

As a result, the inappropriate use of purchase cards to procure commonly used goods on the open market means the best price may not have been obtained for purchased goods totaling about \$52,055. Cardholders also made split purchases valued at about \$140,016, leading to unauthorized commitments and improper payments. Since these split purchases and repetitive purchases of commonly used goods, totaling about \$192,070, were not procured through strategic sourcing or the resulting formal procurement process, potential cost-saving opportunities (outlined in appendix D) may have been missed.

Purchase Card Transactions

Purchase cardholders have the authority to procure goods and services under the micropurchase limits. The Federal Acquisition Regulation generally defines a micropurchase as an acquisition at or below \$10,000 for goods, \$2,500 for services, and \$2,000 for construction.

The review team developed criteria to group a subset of the purchase card transactions into higher-risk areas, including

- repetitive purchases,
- potential split purchases, and

³⁸ VA Financial Policy, "Government Purchase Card for Micro-Purchases," sec. 0103.

- duplicate payments.

The review team evaluated 102 transactions from this group that totaled approximately \$763,000. The transactions were evaluated based on the cardholder, transaction date, and merchant.

Table 1 summarizes the results from testing ongoing repetitive orders, potential split purchases, and duplicate payments.

Table 1. Summary of Purchase Card Testing

Test description	Population tested	Occurrences
<i>Ongoing/repetitive purchases</i>		
Number of transactions	43	19
Amount	\$104,648	\$52,055*
<i>Potential split purchases</i>		
Number of transactions	24	16
Amount	\$183,395	\$140,016 [†]
<i>Duplicate payments</i>		
Number of transactions	35	0
Amount	\$474,555	\$0
Total transactions	102	35
Total amount	\$762,599	\$192,070

Source: VA OIG analysis of sample transactions.

Note: Numbers may not total precisely due to rounding.

** In the review's split purchase population, the team identified 15 repetitive, ongoing purchases totaling \$20,541 included in the findings for repetitive, ongoing purchases.*

[†] In the review's duplicate payment population, the team identified one split purchase of five transactions totaling \$49,579 included in the findings for split purchases.

Repetitive Purchases

VA uses purchase cards to make ongoing and repetitive orders of goods and services to meet its mission. However, ongoing repetitive orders where the total value exceeds the purchase cardholder's single purchase limit or the micropurchase limit of \$10,000 must be communicated to a contracting office for procurement, per VA policy.³⁹ The contracting office will utilize a

³⁹ VA Financial Policy, "Government Purchase Card for Micro-Purchases", Section 010504.

valid contracting document and consider mandatory procurement sources such as the MSPV-NG contract.

As table 1 above indicates, the review team evaluated a judgmental sample of 43 purchase card transactions totaling \$104,648 to determine if cardholders made purchase card payments for ongoing repetitive orders of goods and services where the requirement exceeded the micropurchase limit, and properly documented transactions. See appendix B for more on scope and methodology, and appendix C for details on the review's sampling. The review team identified 19 of these 43 transactions, totaling about \$52,055, for medical supplies that should have been referred to the contracting office. These 19 transactions resulted in potential lost opportunities for cost savings, as in example 1. The review team also determined that all 43 transactions were properly documented.

Example 1

A purchase cardholder made repeated purchases from one supplier for the same inventory items, such as walkers, chairs, shoes, and hernia briefs. The review team noted this cardholder had 48 purchase card transactions totaling about \$116,000 in FY 2019 with this merchant, and the cardholder confirmed he routinely purchased these items from this merchant. The team's sample included four transactions totaling \$20,541 for orders placed over several weeks. The proper course of action would have been to refer the request to the contracting office for procurement.

Table 2 shows the dates of the purchase orders and the items ordered by the single purchase cardholder with this merchant.

Table 2. Purchase Card Orders for Ongoing Inventory Purchases

Inventory items purchased	Date of purchase order	Amount (dollars)
Orthotic shoes	07/11/2019	6,715
Orthotic shoes	07/25/2019	4,591
Walkers, braces, orthotic shoes, hernia briefs	08/06/2019	3,060
Walkers, braces, orthotic shoes, splints	08/19/2019	6,174
Total		20,541

Source: VA OIG analysis of repetitive ongoing purchases.

Note: Numbers may not total precisely due to rounding.

Split Purchases

As discussed earlier, purchase cardholders may not split a purchase to avoid the requirement to obtain competitive bids for purchases over the micropurchase threshold or to avoid established

purchase limits.⁴⁰ Splitting a purchase in this manner results in an unauthorized commitment by the cardholder. Any VA purchase cardholder who makes an unauthorized commitment, including a split order, 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.⁴¹

Table 1 also noted that the review team evaluated a judgmental sample of 24 transactions with the same cardholder, date, and merchant that exceeded the micropurchase limit in the aggregate. See appendix C for sample selection. The team found that 11 transactions, totaling about \$90,436, were split purchases. An additional five transactions totaling \$49,579 were identified as split purchases in the process of the team's examination of a sample of possible duplicate payments. This resulted in six split purchases (consisting of 16 smaller transactions) totaling about \$140,016. Example 2 shows a purchase for cleaning goods totaling \$18,780 that was split into two smaller transactions that avoided contracting requirements.

Example 2

*A logistics clerk requested cleaning products totaling \$18,780 from a vendor. The two request forms were for \$9,180 and \$9,600, which were approved on the same day. The requirement for cleaning is a single requirement, and since the total cost was known at the time of purchase to exceed the micropurchase threshold for goods of \$10,000, these transactions constitute a split purchase. The proper course of action would have been to forward the service request to the contracting office for purchase.*⁴²

The review team found that lack of planning while opening new facility services during the medical center's activation potentially contributed to the split purchases. Two of the split purchases identified, totaling about \$74,549, were related to supplies to activate the facility's cardiac catheterization lab.

Splitting purchases for the lab's activation was a potentially pervasive issue. Specifically, the logistics section chief for medical supply distribution stated

[A]t the end of the day, during activation, a lot of this is poor planning from an activation perspective. When you look at the dollar value these items are costly in

⁴⁰ VA Financial Policy, "Government Purchase Card for Micro-Purchases," sec. 0103.

⁴¹ VA Directive 7401.7, *Unauthorized Commitments and Ratification*, October 7, 2004. FAR 1.602-3 defines an unauthorized commitment as an agreement that is not binding on the government solely because the government official who made it lacked the authority to enter into a contract on behalf of the government. This directive further defines ratification as an authorized official converting an unauthorized commitment into a legal contract.

⁴² FAR 13.003 prohibits breaking down requirements aggregating more than the micropurchase threshold into several purchases that are less than the applicable threshold merely to avoid any requirement that applies to purchases exceeding the micropurchase threshold.

the aggregate and these things shouldn't have been procured on a purchase card... looks like we activated the [catheterization] lab using purchase cards.⁴³

Duplicate Payments

The review team defined potential duplicate payment bundles as transactions with the same purchase date, merchant, credit card number, and purchase amount.⁴⁴ Applying this definition identified a population of 22,786 potential duplicate transactions totaling about \$3.7 million. The review team evaluated 35 transactions totaling about \$474,555 to determine if they were duplicate payments. As table 1 indicated, the team did not find any duplicate payments.

Purchase Card Oversight

The network purchase card program manager for South Central VA Health Care Network Contracting Office 16 provides oversight of the purchase card program at the healthcare system and other assigned stations. Network Contracting Office 16 assigns a purchase card coordinator for each healthcare system to provide direct oversight of its purchase card program. Both the manager and coordinator are responsible for providing technical guidance for all cardholders and approving officials. They are also responsible for conducting reviews to ensure that purchases are supported by proper documentation, identifying and examining potential split purchases, and identifying and reporting unauthorized commitments. The healthcare system director is responsible for ensuring that purchase cardholders and approving officials are complying with purchase card policy, as well as preventing and mitigating noncompliance.

Prior to the issuance of a purchase card, approving officials must certify that they have read and understood the associated approving official responsibilities and will adhere to the policies and regulations governing procurement. They also acknowledge that failure to do so will cause them to lose their approving official authority. Approving officials are required to authorize and monitor purchase card transactions to ensure that the cardholder complies with VA policy.

The purchase card program manager, purchase card coordinator, approving officials, and cardholders must review purchases to determine the best sourcing for goods or services. Further, VA procedures require that each cardholder be audited by the program coordinator at least once per fiscal year, and approximately 25 percent of cardholders be audited per quarter.⁴⁵ These audit

⁴³ Per the clinical director of the clinical assessment reporting and tracking program, a catheterization laboratory is a procedure room in a hospital or clinic with diagnostic imaging equipment used to visualize the arteries or veins of the body and potentially treat any abnormalities in those structures.

⁴⁴ The review team defined a bundle as a set of transactions, grouped by vendor, fitting the defined criteria (that is, potential split purchases, potential repetitive ongoing transactions, or potential duplicate payments).

⁴⁵ VHA Government Purchase Card Program, Standard Operating Procedure, "Internal Audits—Purchase Cards and Convenience Checks", June 2019.

procedures include ensuring timely recording of the obligation, reconciliation, and approval of charges.

However, the purchase card coordinator who was assigned to the healthcare system by Network Contracting Office 16 in February 2019 stated that she had performed only one of the four quarterly VHA-required audits during the review period, in part because she did not have system access to review purchase card transactions or to perform quarterly audits until approximately April 2019.

The purchase card coordinator also advised that Network Contracting Office 16 had not assigned a purchase card coordinator to the healthcare system from July 2016 until her assignment in February 2019. This resulted in no direct oversight for a significant period, which may have reduced the effectiveness of internal controls and compliance with regulations and policies.

Finding 2 Conclusion

During FY 2019, healthcare system cardholders made unauthorized commitments by splitting purchases totaling about \$140,016. Any unauthorized commitments require ratification by an appropriate authority. Additionally, these cardholders did not use formal contracting procedures to procure commonly used goods even though the procurements in the aggregate were about \$52,055. Overall, approving officials did not adequately monitor purchase card transactions. The purchase card program manager for Network Contracting Office 16 failed to correct the purchase card coordinator's nonperformance of three required purchase card audits. The responsible managers, coordinators, and approving officials can make important improvements that would protect the government's interests when they procure supplies. VA employees have a fundamental responsibility to be effective stewards of taxpayer resources.

Recommendations 3–5

The OIG made the following recommendation to the director of the Southeast Louisiana Veterans Health Care System and the director of contracting for South Central VA Health Care Network Contracting Office 16:

3. Ensure approving officials and cardholders review their purchases and make sure strategic sourcing is used when it is in the best interest of the government.

The OIG made the following recommendation to the director of the Southeast Louisiana Veterans Health Care System:

4. In coordination with the network purchase card program manager, require purchase cardholders to submit ratification requests to the director of contracting for Network Contracting Office 16 for any unauthorized commitments identified.

The OIG made the following recommendation to the director of contracting for South Central VA Health Care Network Contracting Office 16:

5. Ensure quarterly audits of the purchase card program are completed as required by the Veterans Health Administration standard operating procedure, “Internal Audits—Purchase Cards and Convenience Checks.”

Management Comments

The director of the Southeast Louisiana VA Health Care System concurred with recommendations 3–5. The responses to all report recommendations are provided in full in appendix E.

For recommendation 3, the healthcare system director reported the chief logistics officer will ensure approving officials and cardholders review their purchases and make sure strategic sourcing is used when it is in the best interest of the government. The chief logistics officer, along with the medical supply distribution chief, retrained all logistics card holders on the use of PowerBI software. This program enables users to determine the availability of items through various vendors and secure the best pricing. All medical center card holders will receive this training. To address recommendation 4, the director reported that any unauthorized commitment purchases made via government credit card that require a ratification will be submitted to the VA Business Oversight Board per VA Handbook 7401.7. For recommendation 5, the director reported quarterly audits for the purchase card program will be conducted as required through coordination between Logistics, Fiscal Service, and Network Contracting Office 16. The audits will review a random sample of purchase orders of all cardholders, specifically looking for split orders or purchases appearing to exceed the purchase card limit.

OIG Response

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

III. Administrative Staffing Levels

Large administrative overhead in health care is increasingly identified with cost inefficiency. Medical centers can help ensure funds are put to the best use by identifying potential indicators of inefficiencies, such as higher administrative staff levels than those found at VHA facilities similar in size and complexity. A variance in the number of personnel should be a starting point for deeper examination but is not in itself a determining factor. According to human resource staff for the healthcare system, administrative personnel such as medical support assistants, administrative officers, and human resource specialists help clinicians with administrative duties and support core functions such as hiring and training. Administrative personnel may also facilitate care in the community when those services cannot be adequately provided for veterans, particularly those living far from the facility. Accordingly, staffing efficiency numbers should be a starting point for leaders to determine if a problem exists and develop improvement strategies with considerations of impact on veterans' access to quality care. Oversight and controls on labor cost help ensure that accurate data are used for efficiency analysis and improvement.

The OIG team reviewed the following administrative staffing areas:

- **Administrative staffing efficiency** involves comparing the facility's administrative FTE levels with those at comparable facilities.
- **Facility resource management** includes how facilities oversee administrative staffing and address identified problems.
- **Labor cost and mapping reviews** determine whether staff hours and salary were assigned the correct codes in VA's Financial Management System and Decision Support System based on the duties performed. These reviews help ensure that correct information is available for budget decisions and forecasting, and allow facilities to compare data from one period to another.

Finding 3: The Healthcare System Implemented Strategies to Improve Administrative Staffing Efficiencies

According to the FY 2019 administrative staffing model, the healthcare system employed 780.1 administrative FTEs, while the expected number of FTEs for similar facilities was 528.5. Based on this metric, the healthcare system utilized 251.6 more FTEs than similar medical facilities, which suggests that a potential opportunity exists for the healthcare system to optimize administrative staff levels. The difference between the actual and expected number of administrative FTEs represents the potential opportunity for efficiency improvement and should

be a starting point for discussions.⁴⁶ The review team found that the goals for activating the new facility were a driving factor in the higher levels of administrative hiring despite the lack of a proportionate workload.

In addition, the team reviewed data from the administrative staffing tool to identify the three cost centers with the highest administrative FTE variance compared to similar facilities.⁴⁷ Personnel overseeing staffing within these cost centers used available staffing tools to assess the appropriate number of FTEs.⁴⁸

The healthcare system has implemented strategies to improve staffing efficiency and management. Consequently, the OIG did not make any related recommendations. However, healthcare system leaders and service chiefs must continue monitoring their staffing levels to address whether administrative staff levels align with workload and patient care needs when the facility becomes fully operational.

Opportunities for Improvement Identified by the OPES Administrative Staffing Model

According to the administrative staffing model, the Southeast Louisiana Veterans Health Care System used more administrative FTEs from FYs 2017 to 2019 than medical centers similar in size and complexity of services, as shown in figure 4.

⁴⁶ Efficiency Opportunity Grid Fact Sheet, accessed December 19, 2019, <http://raft.vssc.med.va.gov/SelfPacedDocuments/Efficiency%20Opportunity%20Grid%20Fact%20Sheet.pdf>.

⁴⁷ Cost centers are codes that identify the office or suborganization in the accounting record for financial transactions.

⁴⁸ The OPES administrative staffing model is one of many tools that may be used to determine the appropriate number of administrative FTEs.

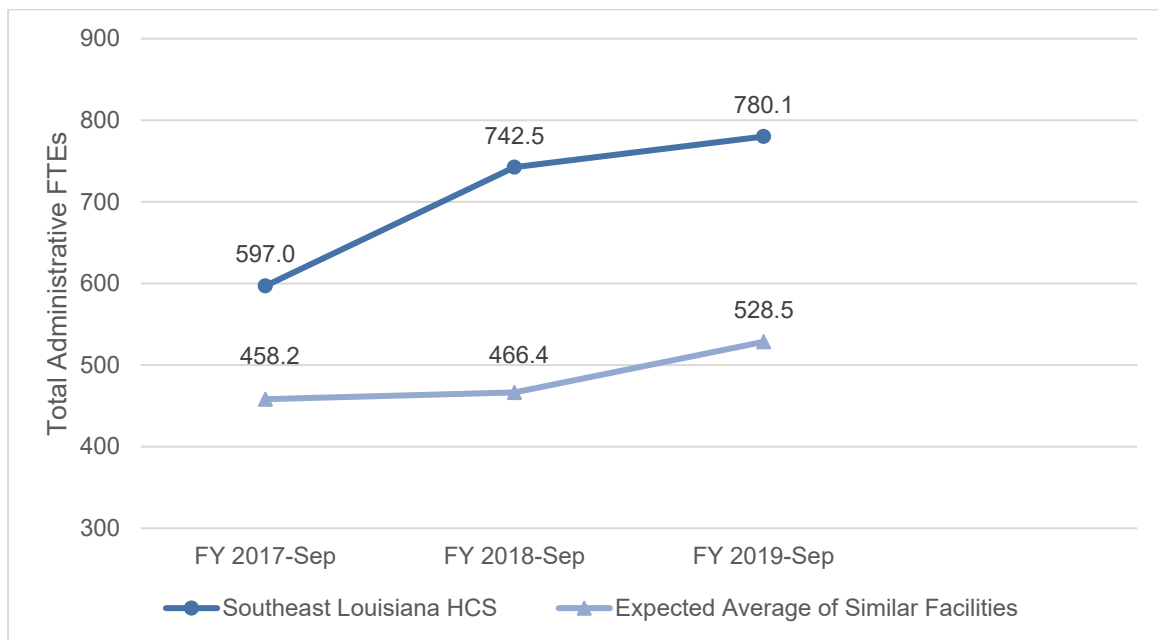


Figure 4. Total administrative FTEs at Southeast Louisiana Veterans Health Care System compared with similar 1b-complexity facilities nationwide, FY 2017–FY 2019.

Source: VA OIG analysis of OPES administrative FTE model data.

This higher-than-expected level of FTEs was mainly due to the priority that healthcare system leaders placed on hiring in anticipation of providing new healthcare services, according to the healthcare system director. In 2015, the healthcare system director issued activation principles that focused on four priorities, one of them being that staff will be hired for training and projected workload. Concurrently, the facility will adjust FTEs based on actual workload and the impact of the VA MISSION Act of 2018. The act was expected to increase administrative workload to help coordinate care in the community that is paid for by VA.

As more of the medical center’s services are activated during FY 2021, healthcare system leaders expect the administrative workload to better align with the number of FTEs, allowing the healthcare system to achieve more efficient administrative FTE metrics.

The administrative staffing model also identified the specific cost centers that supported more administrative FTEs than cost centers at similar facilities. In FY 2019, primary care, police services, and care coordination management were the three cost centers with the largest administrative FTE variances compared with the average of similar VA medical facilities. As shown in figure 5, primary care declined somewhat and police services maintained an above-average administrative FTE variance, while the FTE variance for the care coordination cost center increased sharply during this period.

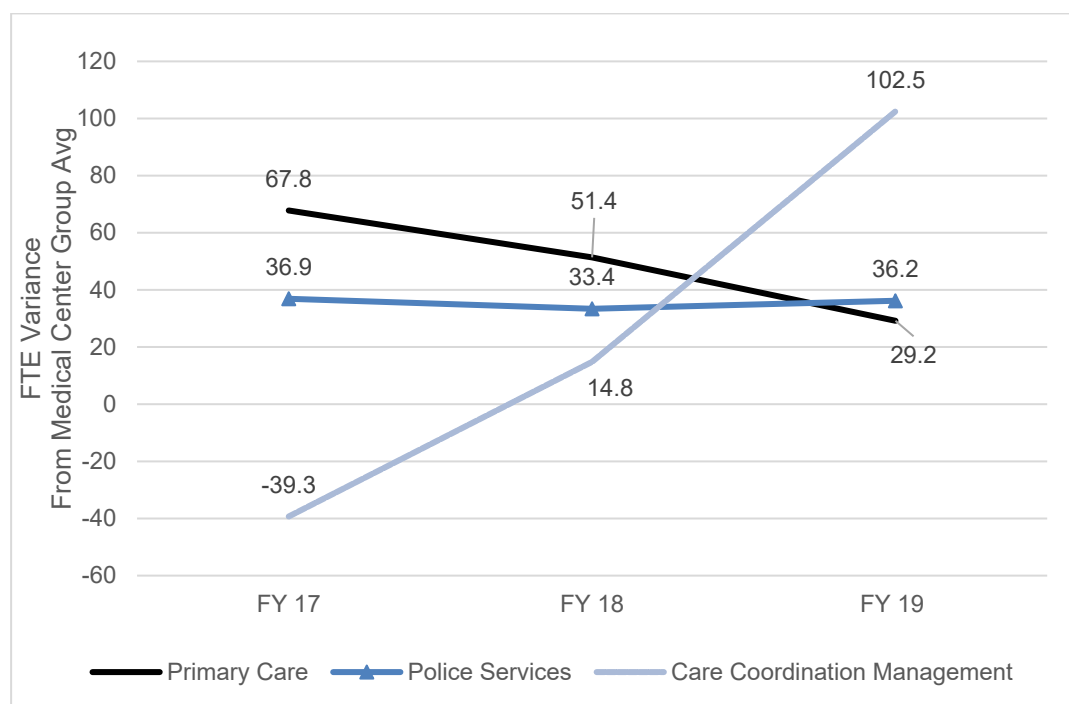


Figure 5. Trend of total administrative FTE variance from the medical center group average from FY 2017 to FY 2019 for the healthcare system's top three cost centers.

Source: VA OIG analysis of VHA administrative staffing model data.

The review team found that the OPES administrative staffing model did not account for the realignment of resources among the healthcare system's cost centers. In addition, the healthcare system's cost center leaders calculated staffing levels using tools with variables that may have differed from those used by OPES to determine administrative staffing levels. For example, the administrative staffing model considers variables related to long-term care, patient age, and travel time and distance, while one of the healthcare system's tools considers how many staff are required to manage call traffic. The differences in these methodologies could provide an explanation for the high variance when compared to other 1b-complexity facilities. Managers engaged in staffing positions within each cost center provided the strategies they used to determine the proper levels and information regarding personnel realignment:

- Primary care.** The healthcare deputy director approved the realignment of approximately 40 FTEs from primary care services in October 2019. According to the healthcare system deputy director, this was the reason primary care variances declined in the administrative staffing model in 2019. The primary care associate chief explained that managers hope to increase total FTEs over the next few years to meet the program initiatives. Primary care personnel work with the resource management committee to fill positions, but hiring has been a challenge because creating new positions is a longer process compared to backfilling vacancies.

- **Police services.** The police service chief implemented an internal staffing tool to compare its law enforcement staffing to those of similar 1b-complexity facilities in VHA and to justify its FTE staffing level. What is considered the necessary staffing level calculated using the internal staffing tool is higher than the level calculated by the OPES model, thereby resulting in the appearance of greater efficiency opportunities when using the OPES model. The internal staffing tool determined that staffing 84 FTEs should be the level needed to operate efficiently. According to the OPES model, the service is operating at a 36 FTE variance higher than similar 1b-complexity facilities.

The police service chief believes the police FTEs are at appropriate staffing levels to address structural factors including the number of buildings and parking lots. The healthcare system also has community-based outpatient clinics, which are required to be staffed and secured. Staffing levels are also affected by other external factors, such as the location and crime rate around the facility and related structures, which are not accounted for in the OPES model, according to the police service chief.

- **Care coordination management.** Ninety percent of the healthcare system's patients live within 30 minutes of the system's primary care and mental health services. The healthcare system reorganized its facilities to meet the needs of veterans in the surrounding areas and now offers seven community-based clinics.

To meet the requirements of the VA MISSION Act of 2018, the healthcare system chose to adjust staffing levels in the care coordination programs. Programs providing community-based care were consolidated into one new community care program. In addition, the healthcare system reassigned 50 FTEs from the Baton Rouge, Baton Rouge South, Hammond, and Slidell community-based outpatient clinics and individual personnel from other services to the healthcare system's Medical Administration Service in November 2019. The move consolidated staff whose duties are related to VA MISSION Act of 2018 requirements.

According to the administrative staffing model, care coordination has continued to increase its administrative staffing since FY 2017. The care coordination mission is to ensure veterans receive seamless care either at a VA healthcare system or a community provider. The care coordination administrative personnel are dispersed among various Medical Administrative Service offices, including access/environment, the call center, ambulatory care, community care, and ward administration. Staffing tools are used by these offices to determine administrative staffing needs based on center productivity. For

example, the call center office uses the Erlang C staffing tool to determine staffing levels needed to reach a target answer time.⁴⁹

The chief of the Medical Administrative Service explained that community care is growing in FTEs and will continue to grow in accordance with support for the VA MISSION Act of 2018 and to comply with the Office of Community Care National Staffing Model. According to the healthcare system director, the healthcare system had seen a 41.2 percent increase in consult volume at its community-based outpatient clinics as of January 2020, emphasizing the productivity of its staff level.

Healthcare System Resource Management

In response to an April 2018 VHA memo outlining a comprehensive strategy for addressing efficiency, the Southeast Louisiana Veterans Health Care System identified the management of budget and staffing as a target for efficiency improvement. In response, leaders tasked the resource management committee with making recommendations for allocating budget dollars and FTEs. According to the healthcare system's chief financial officer, healthcare system-wide budget reductions were enacted in response to a projected \$64 million budget deficit, which had a positive effect on staffing efficiency. Included in this strategy was reducing FTEs by 10 percent across the healthcare system, reassigning certain human resources functions to the VISN and not backfilling those positions, monitoring and tracking between fiscal and human resources departments for better new hire projections, and realigning all community care functions to better manage the consolidated community care approach required by the VA MISSION Act of 2018.

In addition, the healthcare system's resource management committee convened regularly regarding the allocation of organizational resources, including FTEs. The 16-member committee is composed of senior leaders, including the deputy director, associate director, chief financial officer, chief of staff, chief of human resources, and four service chiefs. The committee assesses the work design, occupational distribution, supervisory ratio, grade distribution, and staffing requirements for the proposed staffing changes. Although the committee will allow service chiefs to recruit for vacancies in existing positions on their organizational charts, service chiefs must submit request forms for additional hiring.

⁴⁹ "What is an Erlang?" Westbay Engineers, accessed May 19, 2021, <https://www.erlang.com/what-is-an-erlang/>. Erlang C is a formula for modeling systems involving queuing. It is used to estimate how many call center agents are needed to keep the call queue down to manageable levels.

Salary Cost and Labor Mapping Reviews

VA financial policy requires two types of labor cost data review:

1. **Salary cost reviews.** VA financial policy requires that employees' hours and salaries be assigned to the correct cost center using an accurate budget object code.⁵⁰
 - A **cost center** helps VA correctly identify and record costs. Cost centers identify the office and function as part of the accounting record for financial transactions. The accuracy of labor costs in VA's Financial Management System depends on human resources staff selecting the correct cost center.
 - **Budget object codes** reflect the nature of financial transactions. Administrative employees should be assigned to budget object code 1001 or 1002, in accordance with VA financial policy. VA financial policy requires that fiscal personnel record financial obligations and expenditures in accordance with appropriate budget object codes.⁵¹

Budget or accounting staff at each facility are required to review the salary cost data each pay period and promptly address cost center corrections with human resources as needed.⁵² This review ensures cost data are recorded accurately in VA's Financial Management System.

2. **Labor mapping reviews.** VA policy requires service chiefs and organizational leaders to review labor mapping periodically for accuracy and completeness.⁵³ To ensure that VA cost information is accurate, employees must have their hours and salary correctly mapped to the functional cost centers—known as “account level budgeter cost centers”—where they perform their duties.

The review team evaluated salary cost data from VHA's Personnel and Accounting Integrated Data for all employees for pay periods 17–19 of FY 2019 to ensure any errors were promptly addressed. The team noted discrepancies such as incorrect cost center, budget object code, or fund control point, but these corrections were resolved within one to two pay periods.

Further, the review team assessed five cost centers from VHA's National Labor Mapping Tool for pay periods 12–18 of FY 2019 to determine whether certifiers conducted labor mapping reviews. The five cost centers were selected based on the administrative staffing variance, four

⁵⁰ VA Financial Policy, vol. XIII, chap. 2, “Budget Object Codes,” July 23, 2019. Budget object codes correspond to financial obligations according to the nature of the services or items purchased by the federal government.

⁵¹ VA Financial Policy, “Budget Object Codes.”

⁵² VA Financial Policy, vol. XIII, chap. 3, “Managerial Cost Accounting,” February 27, 2019.

⁵³ VA Financial Policy, “Managerial Cost Accounting.”

with the largest variance and one with the smallest when compared with the medical center group average from VHA's OPES administrative staffing model:

- Medical Administrative Service (Care Coordination Management)
- Police Service
- Primary Care
- Office of the Director
- Finance Operations

According to VA financial policy, service chiefs and organizational leaders will periodically review labor mapping for accuracy and completeness.⁵⁴ For the healthcare system, National Labor Mapping Tool guidelines promote monthly labor mapping certification. The review team did not identify any evidence that the labor mapping was inaccurate or incomplete.

Finding 3 Conclusion

The healthcare system had administrative staffing above the average number of FTEs found in VA medical centers of similar size and complexity. The review team found that several factors influenced the healthcare system staffing and workload, specifically in the top three healthcare system cost centers with the highest variance from the average. Activation guidance that the healthcare system director issued in 2015 prioritized hiring staff as the healthcare system constructed the new facility in anticipation of training and workload needs. Healthcare system leaders have taken actions to address inefficiencies by reducing staff and using the resource management committee to monitor and approve staffing requests. The healthcare system has assessed its care in the community programs and implemented the VA MISSION Act of 2018 requirements to consolidate them, but there is still a need for continued improvement and evaluation in healthcare system staffing and budget management. Because the medical facility became more operational during FY 2021, healthcare system leaders expect the administrative workload to normalize, allowing the healthcare system to return to expected levels of administrative staff compared with similar medical facilities. The healthcare system director reported that he is committed to evaluating and monitoring staffing and workload to improve administrative FTE productivity and efficiency.

⁵⁴ VA Financial Policy, "Budget Object Codes."

IV. Pharmacy Operations

In FY 2019, VHA's prescription drug costs were more than \$6.8 billion, about 9.3 percent of VHA's \$73.1 billion in medical care spending that year. In the same year, the healthcare system spent approximately \$70.4 million on prescription drugs, about 12.3 percent of the facility's \$574.3 million medical care budget. Because pharmacy costs are a significant percentage of medical care spending, it is important for healthcare system leaders to identify opportunities to use pharmacy dollars more efficiently. The review team used the pharmacy cost model in the OPES efficiency grid to identify opportunities for improvement in the healthcare system.

The review team assessed pharmacy data, drug file costs, inventory turnover, and cost-saving initiatives:

- **OPES pharmacy expenditure data** help VHA facilities track cost performance and identify potential opportunities for improvement.
- **Costs listed in local drug file** are part of the data that can be used to fill a prescription and include the drug cost. Each healthcare system is responsible for maintaining a local drug file that matches VHA's national drug file. If the files do not match, it could negatively affect the overall reporting of prescription costs per patient by erroneously increasing the cost.
- **Inventory turnover** is the primary measure used to monitor inventory management effectiveness per VHA policy and reflects the number of times inventory is used up during the year.⁵⁵ Low inventory turnover could indicate inefficient use of financial resources.
- **Cost-saving initiatives** are VA medical center action plans to reduce the cost of pharmacy operations and increase efficiency. VA medical centers monitor progress on these initiatives and report on their impact on pharmacy operations' efficiency.

Finding 4: The Healthcare System Improved Pharmacy Efficiency with Cost-Saving Initiatives but Could Increase Its Inventory Turnover Rate

The healthcare system spent approximately \$9 million more than expected on prescription drugs in FY 2019, according to the OPES pharmacy model. However, the model was not adjusted to consider pharmacy start-up costs related to activating the New Orleans medical center after Hurricane Katrina. The healthcare system instead identified areas for improving efficiency and cost savings using alternative tools, such as VISN-proposed cost-saving reporting and inventory turnover metrics, according to the healthcare system's pharmacy services chief and the VISN 16

⁵⁵ VHA Directive 1761(2), *Supply Chain Inventory Management*, app. I, October 24, 2016, amended October 26, 2018. Inventory turnover is calculated by dividing the previous 12-month drug purchase amounts by the inventory amounts on hand.

clinical pharmacist. While healthcare system leaders had concerns about the applicability of the OPES pharmacy model to a newly activated facility, the leaders recognized that opportunities exist for pharmacy cost efficiency improvements. Factors contributing to the healthcare system's inefficient pharmacy cost results include drug prices in the local drug file that were not always accurate and up-to-date and the healthcare system's drug inventory turnover rate being lower than the goal set by VA's Pharmacy Benefits Management Services. Healthcare system leaders acknowledged the need to develop and implement cost-saving initiatives to advance efficient pharmacy operations.

In October 2019, VISN 16 reported that the healthcare system implemented initiatives to achieve approximately \$2.9 million in cost savings, almost \$2 million over its \$929,000 original goal, but acknowledged that further improvements can be made in prescription drug costs.

OPES Pharmacy Expenditure Data

The OPES pharmacy expenditure model, which identifies variations in pharmacy costs among VHA facilities, showed that the healthcare system had about \$70.4 million in drug costs in FY 2019. According to the model, this amount was approximately \$9.3 million higher than the expected costs of about \$61.2 million. Based on these numbers, the healthcare system's observed-to-expected ratio was 1.151, which ranked it 134 out of 140 VHA facilities for pharmacy drug cost efficiency. The healthcare system's observed-to-expected ratio indicated unfavorable year-over-year results from FY 2016 through FY 2018 (108th, 118th, and 124th, respectively), with observed drug costs exceeding expected drug costs by more than \$23.8 million from FY 2016 through FY 2019. The healthcare system's annual drug cost per patient also increased each year from approximately \$1,073 in FY 2016 to about \$1,582 in FY 2019, as shown in figure 6.

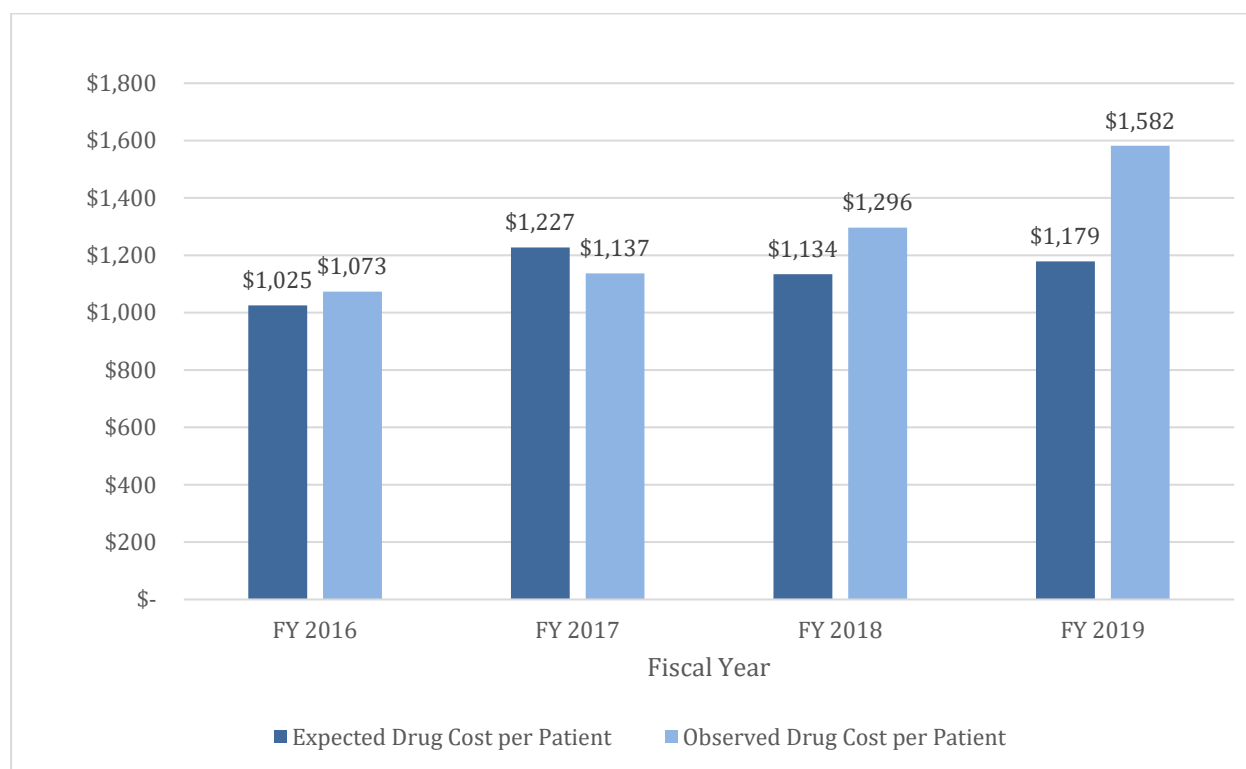


Figure 6. Healthcare system's observed versus expected drug costs per patient, FY 2016–FY 2019.

Source: VA OIG analysis of VHA OPES Pharmacy Model.

The healthcare system director attributed the higher-than-expected drug costs to the need to reactivate the medical center following Hurricane Katrina. Medical center activation began in FY 2015 and was to continue through FY 2021. The healthcare system director told the review team that there were significant one-time activation costs. The VISN 16 clinical pharmacist explained that before seeing patients, the medical center needed to build inventories of drugs to meet potential medication needs. These costs worsened its observed-to-expected ratio and rankings because the model was not adjusted to account for these inventory buildup costs, according to the VISN 16 clinical pharmacist. Therefore, comparisons between the Southeast Louisiana Veterans Health Care System and other healthcare systems could be misleading.

Members of the healthcare system's Pharmacy and Therapeutics Committee also described the challenge of managing drug costs after 12 years without a VA medical center in the healthcare system. The pharmacy leaders informed the review team that during this period, many of the medical center's veterans received care from non-VHA providers who tended to prescribe higher-cost, brand-name medications. The team did not review data or speak with non-VHA providers to confirm this view.

Costs Listed in Local Drug File

The VISN 16 clinical pharmacist explained that drugs and supplies on the national formulary are generally covered under VA Pharmacy Benefits Management Services and must be available for

prescription at all VHA facilities. Each healthcare system is responsible for maintaining a local drug file that matches VHA's national drug file. If the local drug file's quantities or prices are incorrect, there could be discrepancies in reported costs.

The healthcare system's drug file was not maintained accurately, and the processes for updating the file were susceptible to data-entry errors, according to the healthcare system's pharmacy informatics/pharmacoeconomic program manager. The program manager and the VISN 16 clinical pharmacist provided the review team with several examples to substantiate their concerns. In one example provided by the chief of pharmacy, an error in the local drug file caused drug costs to be overstated by approximately \$2.9 million. If a procurement pharmacist had not corrected the error by updating the local drug file with accurate pricing, this error could have inflated the overall reporting of prescription costs per patient by erroneously increasing the reported cost. The error occurred when a prime vendor system interface used vendors' invoice data to automatically update the local drug file but misinterpreted the data, resulting in cost errors. A VISN 16 employee identified the error by running a monthly report to look for potential cost outliers, and a healthcare system pharmacy procurement technician subsequently fixed the error. In some cases, the healthcare system's pharmacy employees manually updated the drug file to ensure the cost data for each filled prescription were correct.

To maintain accurate cost information, the healthcare system's chief of pharmacy began meeting weekly with the chief of procurement and respective teams to develop and implement a data-checking process to reduce errors. In addition, the program manager serves as the automated data processing application coordinator, manages the operation of the pharmacy's drug file, and is reviewing local pricing manual inputs. Lastly, the procurement team randomly reviews invoices daily and conducts quality training on the drug accountability software package for staff.

Inventory Turnover Rate

VHA policy states that inventory turnover is the primary measure of inventory management effectiveness.⁵⁶ In addition, managing the cycle of pharmacy inventory purchasing and use helps control pharmacy costs. VHA policy also mandates the use of prime vendor inventory management reports to administer all VA medical facility pharmacy inventories.⁵⁷

The inventory turnover metric is an accurate measure of how well the healthcare system has managed its pharmacy drug inventory levels and how frequently it replenishes its inventory. VHA's recommended inventory turnover rate of 12, which was established by the National Pharmacy Benefits Management program office, is higher than the 6.9 turnovers achieved by the healthcare system in FY 2019. The healthcare system purchased \$22,538,283 in drugs and had

⁵⁶ VHA Directive 1761(2).

⁵⁷ VHA Directive 1761(2).

\$3,264,972 of inventory on hand at the end of the year. The healthcare system reported that the inventory management numbers were affected by over forecasting demand due to activation of the new facility, which led to overordering, excess drug inventory, expired drugs, and spoilage.

In March 2020 the chief of pharmacy stated in an email to the review team that the pharmacy department plans to reach the new VISN 16 goal of 18 inventory turnovers per year by the second quarter of FY 2021. To accomplish this inventory turnover goal, the pharmacy department is working with the procurement team to implement new technologies to assist the pharmacy department with determining better periodic automatic replenishment levels and to streamline the reordering and stocking processes.

Cost-Saving Initiatives

The review team analyzed the FY 2019 Pharmacy Lost Opportunity Cost Report that the VISN clinical pharmacist generates and provides to the healthcare system. The results, dated October 18, 2019, show that the healthcare system had identified a goal of \$929,042 in annual savings and achieved total savings of \$2,916,573 as of the end of the fourth quarter of FY 2019.

The VISN 16 clinical pharmacist is responsible for guiding VISN-level formulary management activities, including cost-saving initiatives. To fulfill this responsibility, the pharmacist serves on national workgroups and collaborates with the healthcare system's pharmacy department to achieve savings. The workgroup researches and recommends opportunities for VHA to use more clinically appropriate and cost-beneficial products in compliance with national VHA guidelines.

The VISN's clinical pharmacist and the healthcare system's chief of pharmacy provided several examples of the healthcare system's 2019 cost-savings efforts. For instance, converting branded oral antidiabetic medications to a clinically appropriate, less expensive drug could have saved approximately \$748,000. The estimated cost savings for converting from branded prostate cancer treatment medication to a less expensive version of the drug was approximately \$227,000. Additionally, savings were recognized from reducing overall use of certain medications.

Finding 4 Conclusion

The pharmacy model rated the healthcare system's pharmacy operations as less efficient than other comparable VHA medical facilities. The rating was based on the ratio of actual prescription drug costs to expected prescription drug costs. The review team found these inefficiencies were due in part to healthcare system inaccuracies in the local drug file, low inventory turnover rates, and facility activation costs. Inaccurate local drug file data caused healthcare system drug costs to be inaccurate, and in some cases overstated. The healthcare system's inventory turnover rate of 6.9 was lower than VHA's goal of 12 inventory turnovers per year due to over forecasting demand, which contributes to overordering, excess inventory, and inventory expiring and spoiling. Further, since the medical center was still in its activation phase, the impact of the pharmacy start-up costs was not accurately reflected in the OPES pharmacy

model. The VISN 16 clinical pharmacist and the healthcare system's pharmacy chief acknowledged that the healthcare system is working to improve the cost, performance, and efficiency of pharmacy operations.

Recommendation 6

The OIG made the following recommendation to the director of the Southeast Louisiana Veterans Health Care System:

6. Ensure that the facility meets the Veterans Health Administration's recommended inventory turnover rate of 12 per year, established by the National Pharmacy Benefits Management program office.

Management Comments

The director of the Southeast Louisiana VA Health Care System concurred with recommendation 6. The responses to all report recommendations are provided in full in appendix E.

To address the recommendation, the healthcare system director reported that pharmacy leaders work with the pharmacy procurement team weekly to review purchasing and inventory management concerns to ensure the facility is on track to meet the VHA-recommended inventory turnover rate of 12 per year.

OIG Response

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

Appendix A: Healthcare System Profile

Healthcare System Profile

Table A.1 provides general background information for this 1b–High Complexity healthcare system reporting to VISN 16.⁵⁸

Table A.1. Healthcare System Profile for Southeast Louisiana Veterans Health Care System (October 1, 2016, through September 30, 2020)

Profile element	Healthcare system data FY 2017	Healthcare system data FY 2018	Healthcare system data FY 2019	Healthcare system data FY 2020
Total medical care budget	\$439,296,199	\$558,306,098	\$574,290,718	\$676,870,601
Number of				
• Unique patients	43,157	44,906	46,854	45,561
• Outpatient visits	577,388	661,620	694,783	0
• Total medical care FTEs*	1,909	2,416	2,720	2,690
Type and number of operating beds				
• Hospital	54	110	116	116
• Community living center	10	40	40	50
Average daily census				
• Hospital	1	25	42	52
• Community living center	0	5	15	23

Source: VHA Support Service Center, Trip Pack and Operational Statistics report.

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

* Total medical care FTEs includes direct medical care FTEs in budget object code 1000–1099 (Personal Services) and includes all cost centers.

⁵⁸ The VHA medical centers are classified according to a facility complexity model. Facilities are categorized into one of five groups: 1a (most complex), 1b, 1c, 2, and 3 (least complex). Because the facility complexity model uses indexes of multiple variables, there is no formula that defines what qualifies as a 1a facility, 1b facility, and so on.

Appendix B: Scope and Methodology

Scope

The review team conducted its review from December 2019 to July 2021, including an on-site visit in January 2020. The team analyzed the healthcare system's financial efficiency practices related to MSPV-NG utilization and purchase card transactions during FY 2019. The team also analyzed financial efficiency practices related to the administrative FTE labor costs and pharmacy costs using the FY 2019 OPES data model; however, the FY 2019 data model was based on FY 2018 data. The review is limited in scope and not intended to be a comprehensive review of all financial operations at the facility.

Methodology

To accomplish its objectives, the review team interviewed healthcare system leaders and staff, as well as individuals from VISN 16, Network Contracting Office 16, the Medical Supplies Program Office, Medline, and the Strategic Acquisition Center. The team also identified and reviewed applicable laws, regulations, VA policies, operating procedures, and guidelines related to financial efficiency practices for utilizing the MSPV-NG program, overseeing purchase card transactions, and addressing inefficiencies in administrative FTE and pharmacy costs.

The review team evaluated 102 purchase card payments to establish 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. Appendix C provides more information on the review team's statistical sampling methodology and results.

Fraud Assessment

The review team assessed the risk that fraud and noncompliance with provisions of laws, regulations, contracts, and grant agreements, significant in the context of the review objectives, could occur during this review. The team exercised due diligence in staying alert to any fraud indicators by asking healthcare system personnel if they were aware of suspected or perpetrated fraud. The OIG did not identify any instances of fraud or potential fraud during this review.

Data Reliability

The review team used computer-processed data from the US Bank computer data warehouse files and the OPES efficiency grid. To test for reliability, the review team determined whether any data were missing from key fields, included any calculation errors, or were outside the time frame requested. The review 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 review team compared purchase order numbers, payment dates,

payee names, payment amounts, vendor ID number, and check numbers as provided in the data received in the samples reviewed. Testing of the data disclosed that they were sufficiently reliable for the review objectives.

In addition, computer-processed data included reports from the Supply Chain Common Operating Picture dashboard to determine MSPV-NG utilization rates. The review team found that detailed data were missing for two months during the fiscal year. However, the dashboard summary level data were sufficiently reliable for reporting on the healthcare system's MSPV-NG utilization rate.

Government Standards

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

Appendix C: Sampling Methodology

Purchase Cards

The review team evaluated a judgmental sample of FY 2019 purchase card transactions to determine if (1) ongoing repetitive orders with the same merchant should have first been referred to a contracting officer, and (2) transactions were adequately monitored and approved to prevent both split purchases exceeding the micropurchase limit in the aggregate and duplicate payments.⁵⁹

Population

During FY 2019, purchase cardholders at the healthcare system made 60,874 purchase card transactions totaling approximately \$38.6 million. The review team developed criteria to group a subset of these transactions into high-risk areas, including repetitive purchases, potential split purchases, and potential duplicate payments.

Sampling Design

The review team identified a sample of FY 2019 purchase card transactions for testing high-risk areas.

Repetitive Purchases

The review team defined repetitive purchases as individual purchase card transactions with the same merchant for recurring, ongoing, and anticipated needs that exceed the micropurchase limit in the aggregate. Applying this definition identified a population 46,165 potential repetitive purchases totaling approximately \$30.5 million. The review team defined a bundle as a set of transactions grouped by vendor fitting the defined criteria (that is, a repetitive purchase). The population was stratified by merchants known to have contracts with VA (as identified by the review team) and those without VA contracts. These two categories were further stratified by the aggregate dollar amount of the transaction bundles. The review team chose a judgmental sample of three bundles of transactions (that included at least 10 transactions) to review as shown in table C.1.

⁵⁹ A judgmental sample is a nonstatistical sample that is selected based on auditors' opinion, experience, and knowledge.

Table C.1. Potential Repetitive Purchases Sample

Contract status	Dollar range	Number of bundles	Number of transactions
Without known contracts	\$24,999 to \$50,000	2	28
With known contracts	\$24,999 to \$50,000	1	15
Total		3	43

Source: VA OIG sample design.

Potential Split Purchases

The review team defined potential split purchases as transactions with the same purchase date, same purchase card number, same merchant, and an aggregate sum of greater than the \$10,000 micropurchase limit. Applying this definition identified a population of 206 bundles of potential split purchases totaling approximately \$4.7 million. The review team defined a bundle as a group of transactions grouped by vendor fitting the defined criteria (that is, potential split purchases).

The population was stratified by merchants known to have contracts with VA (as identified by the review team) and those without VA contracts. These two categories were further stratified by the aggregate dollar amount of the transaction bundles. The review team chose a judgmental sample of 10 bundles to review as shown in table C.2.

Table C.2. Potential Split Purchases Sample

Contract status	Dollar range	Number of bundles	Number of transactions
Without known contracts	\$10,000 to \$19,999	3	6
Without known contracts	\$20,000 to \$24,999	2	7
With known contracts	\$10,000 to \$19,999	3	6
With known contracts	\$20,000 to \$24,999	2	5
Total		10	24

Source: VA OIG sample design.

Potential Duplicate Payments

The review team defined potential duplicate payments as transactions with the same purchase date, merchant, credit card number, and purchase amount. Applying this definition identified a

population of 5,231 bundles of 22,786 potential duplicate transactions, totaling approximately \$3.7 million. The review team defined a bundle as transactions grouped by the vendor and fitting the defined criteria (that is, potential duplicate payments). The population was stratified by dollar amount of the bundle. The review team selected a judgmental sample of 16 bundles composed of 35 transactions, totaling approximately \$474,555, to determine if duplicate payments occurred. Table C.3 details the sample.

Table C.3. Potential Duplicate Payments Sample

Dollar range	Number of bundles	Number of transactions
> \$35,000	1	2
\$15,000 to \$24,999	1	2
\$10,000 to \$14,999	11	22
\$5,000 to \$9,999	1	5
\$0 to \$4,999	2	4
Total	16	35

Source: VA OIG sample design.

The team reviewed 102 transactions across all three samples, totaling about \$762,598.

Projections and Margins of Error

The review team did not use projections and margins of error because a statistical sample was not conducted.

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

Recommendation	Explanation of Benefits	Better Use of Funds	Questioned Costs
Recommendations 3–4	Southeast Louisiana Veterans Health Care System cardholders used purchase cards inappropriately by splitting six purchases that avoided federal contracting requirements during FY 2019. The review team identified 19 transactions, totaling about \$52,055, where cardholders inappropriately used government purchase cards to buy commonly used goods instead of communicating the needs to contracting officers to determine if existing contracts could be employed that would leverage purchasing power per VA policy.		\$192,070
	Total		\$192,070

Appendix E: Management Comments

Department of Veterans Affairs Memorandum

Date: August 10, 2021

From: Medical Center Director (629/00)

Subj: Financial Efficiency Review of the Southeast Louisiana Veterans Health Care System in New Orleans Project # 2020-00971-BA-0002

To: VA Office of Inspector General
Assistant Inspector General for Audits and Evaluations (52)
Deputy Assistant Inspector General for Audits and Evaluations (52)
Director, Financial Inspections Division (52C05)

1. Use of the MSPV-NG Program:

CONCLUSION: (Line 400):

Due in part to Medline's inability to consistently fill formulary orders, the health care system was hindered in meeting its MSPV-NG utilization goal in FY 2019. Other factors included challenges with nonstock and vendor-directed items, the health care system purchasing available formulary items from non-prime vendor sources because prices were less than formulary pricing and challenges the facility and prime vendor have had with forecasting.

- Health care system personnel did not fully utilize or even have awareness of some of the available reporting tools to provide feedback on the prime vendor's performance to assist with solving identified issues. These tools are important for the facility to use going forward to ensure VHA has the information needed to take corrective action as appropriate.
- Although overall estimates of purchases were below prime vendor costs, about \$178,000 in purchases that were on the formulary were not made with the prime vendor. Some of those costs could have been avoided had logistics staff complied with VA policy.

OIG Recommendations (1-2):

1. Develop a plan to work with the prime vendor to address having adequate stock from the facility's formulary list in its warehouse to provide supplies when ordered.
2. Ensure logistics staff and the contracting officer's representative use the tools available to inform the Medical Supplies Program Office and Strategic Acquisition Center of prime vendor performance issues.

Management Comments:

Recommendation #1: Develop a plan to work with the prime vendor to address having adequate stock from the facility's formulary list in its warehouse to provide supplies when ordered.

Concur

Target Date for Completion: 9/17/2021

Status: Open

The Facility's Associate Medical Center Director is championing efforts with Supply Chain Management Service Chief to develop a plan for the COR to work with Prime Vendor to complete the monthly Prime Vendor Performance Report to help identify trends with stock issues. The COR will

also work collaboratively with the Supervisory Inventory Management Specialists to monitor stock levels to assure adequate supplies are available from the Prime Vendor when ordered.

Recommendation #2: Ensure logistics staff and the contracting officer's representative use the tools available to inform the Medical Supplies Program Office and Strategic Acquisition Center of prime vendor performance issues.

Concur

Target Date for Completion: 9/30/2021

Status: Open

The NOLA Logistics Service will work closely with the VISN CLO office on all performance issues/concerns as they relate to navigation of the MSPV contract. The VISN will then communicate significant issues to the prime vendor. Logistics service works daily with the MSPV "in house" representative to iron out any issues before they become a larger problem requiring higher level intervention.

2. Purchase Card Use:

CONCLUSION: (Line 595):

- During FY 2019, health care system cardholders made unauthorized commitments by splitting purchases totaling about \$140,016. Any unauthorized commitments require ratification by an appropriate authority.
- Additionally, these cardholders did not use formal contracting procedures to procure commonly used goods even though the procurements in the aggregate were about \$52,055.
- Overall, approving officials did not adequately monitor purchase card transactions.
- The purchase card program manager for the Network Contracting Office failed to correct the office purchase card coordinator's nonperformance of three required purchase card audits.
- The responsible managers, coordinators, and approving officials can make important improvements that would protect the government's interests when they procure supplies. VA employees have a fundamental responsibility to be effective stewards of taxpayer resources.

OIG Recommendations (3-5):

3. Ensure approving officials and cardholders review their purchases and make sure strategic sourcing is used when it is in the best interest of the government.
4. In coordination with the network purchase card program manager, require purchase cardholders to submit ratification requests to the director of contracting for Network Contracting Office 16 for any unauthorized commitments identified.
5. Ensure quarterly audits of the purchase card program are completed as required by the VHA standard operating procedure, "Internal Audits-Purchase Cards and Convenience Checks

Management Comments:

Recommendation #3: Ensure approving officials and cardholders review their purchases and make sure strategic sourcing is used when it is in the best interest of the government,

Concur

Target Date for Completion: 9/17/2021

Status: Open

The Chief Logistics Officer (CLO) will ensure approving officials and cardholders review their purchases and make sure strategic sourcing is used when it is in the best interest of the government. The CLO, along with the Medical Supply Distribution (MSD) Chief, re-trained all logistics card holders on the use of the PowerBI software. This program enables users to determine the availability of items through various vendors and secure the best pricing. All medical center card holders will receive this training.

Recommendation #4: In coordination with the network purchase card program manager, require purchase cardholders to submit ratification requests to the director of contracting for Network Contracting Office 16 for any unauthorized commitments identified.

Concur

Target Date for Completion: 10/22/2021

Status: Open

Any Unauthorized Commitment (UAC) purchases made via government credit card that require a ratification will be submitted to the VA Business Oversight Board (BOB) per the VA Handbook 7401.7.

Recommendation #5: Ensure quarterly audits of the purchase card program are completed as required by the VHA standard operating procedure, "Internal Audits-Purchase Cards and Convenience Checks

Concur

Target Date for Completion: 9/17/2021

Status: Open

Quarterly audits for the purchase card program will be conducted as required through Coordination between Logistics, Fiscal Service, and the Network Contracting Office. The audit will review a random sample size of purchase orders of all cardholders, specifically looking for split orders or purchases appearing to exceed the purchase card limit.

3. The Health Care System Implemented Strategies to Improve Administrative Staffing Efficiencies:

CONCLUSION: (Line 819):

The health care system had administrative staffing above the average number of FTEs found in VA medical centers of similar size and complexity. The review team found that external factors influenced the health care system staffing and workload, specifically in the top three health care system cost centers with the highest variance from the average. Activation guidance that the health care system director issued in 2015 prioritized hiring staff as it constructed the new facility in anticipation of training and workload needs. Health care system leaders have taken actions to address inefficiencies by reducing staff and using the resource management committee to monitor and approve staffing requests. The health care system has assessed its care in the community programs and implemented the MISSION Act of 2018 requirements to consolidate them, but there is still a need for continued improvement and evaluation within the health care system staffing and budget management. As the medical facility becomes more operational during FY 2021, health care system leaders expect the administrative workload to normalize, allowing the health care system to return to expected levels of administrative staff compared with similar medical facilities. The health care system director reported that he is committed to evaluating and monitoring staffing and workload to improve administrative FTE productivity and efficiency.

OIG Recommendations: None –

The health care system has implemented strategies to improve staffing efficiency and management. However, health care system leaders and service chiefs must continue monitoring their staffing levels

to address whether administrative staff levels align with workload and patient care needs when the facility becomes fully operational.

Management Comments:

Concur

The health care system continues to review staffing levels to other comparable facilities within its complexity level and has gained efficiencies by reducing full-time equivalent employee (FTEE) in line with right-sizing operations where there are opportunities for savings. Productivity, FTEE, and costing data is being used to conduct service specific reviews as to achieve optimized staffing levels.

Our productivity measured by FTEE per workload units generated is current ranked at 10th of 21 for comparable 1B hospitals indicating that we are average and in line with other comparable health care systems. (Source: UCR5: Total Adjusted FTE Per 1,000 Adjusted FacWork (Productivity). Cumulative Data Through FY 2021 M5. Complexity Level: 1B High Detail)

4. Pharmacy operations and cost avoidance efforts:

CONCLUSION: (Line 972):

- The pharmacy model rated the health care system's pharmacy operations as less efficient than other comparable VHA medical facilities. The rating was based on the ratio of actual prescription drug costs to expected prescription drug costs. The review team found these inefficiencies were due in part to health care system inaccuracies in the local drug file, low inventory turnover rates, and facility activation costs.
- Inaccurate local drug file data caused health care system drug costs to be inaccurate, and in some cases overstated.
- The health care system's inventory turnover rate of 6.9 was lower than VHA's goal of 12 inventory turnovers per year due to over-forecasting demand, which contributes to overordering and excess drug inventory. Excess inventory in turns increases the risk of drugs expiring before they are used and inventory spoiling.
- Further, since the medical center was still in its activation phase, the impact of the pharmacy startup costs was not accurately reflected in the OPES pharmacy model. The VISN 16 clinical pharmacist and the health care system's pharmacy chief acknowledged that the health care system is working to improve the cost, performance, and efficiency of pharmacy operations.

OIG Recommendations (6):

6. Ensure that the facility meets the VHA recommended inventory turnover rate of 12, established by the National Pharmacy Benefits Management Program Office.

Management Comments:

Recommendation #6: Ensure that the facility meets the VHA recommended inventory turnover rate of 12, established by the National Pharmacy Benefits Management Program Office.

Concur

Target Date for Completion: 2/28/2022

Status: Open

Pharmacy Leadership works with the Pharmacy Procurement team weekly to review purchasing and inventory management concerns to ensure the facility is on track to meet the VHA recommended inventory turnover rate of 12 as established by the National Pharmacy Benefits Management

Program Office. Inventory turns are affected by large year-end purchases, low return to wholesaler process and over-ordering medium to slow mover items. We are currently re-educating our procurement teams to ensure continued compliance with weekly Procurement meetings with staff to review returns, PAR level management, and monitoring and auditing of processes by Pharmacy leadership for ordering procedures and stock management checklists. These actions will continue to provide greater visibility of operations as well as facilitate greater efficiencies overall.

Current facility inventory turnover rate (8/5/2021) noted Increase from 6.59 to 9.06 for the last 12 months.

Fernando O. Rivera, FACHE

SLVHCS Medical Center Director

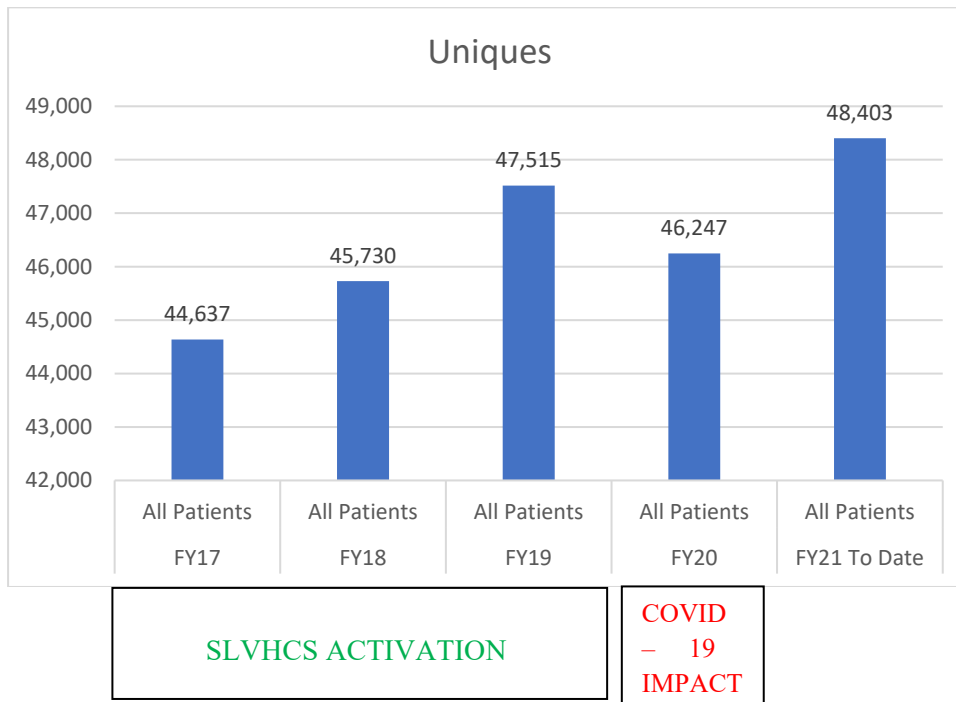
Southeast Louisiana Veterans Health Care System

Total Patient Growth Data FY17-FY21:

Strong growth FY17-FY20. Covid-19 pandemic restrictions impacted growth in FY20. FY21 illustrates return to growth pattern.

[VA-Prod-BI Office \(BIW03\)](#)

Data Source Unique Patient Cube



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

OIG Contact and Staff Acknowledgments

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