DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

VETERANS HEALTH ADMINISTRATION

Financial Efficiency Review of the Eastern Oklahoma VA Health Care System

Executive Summary

The VA Office of Inspector General (OIG) conducted this review to assess the oversight and stewardship of funds by the Eastern Oklahoma VA Health Care 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.   **Open obligations oversight.** Obligations are considered open if they have an associated balance, whether undelivered or unpaid. The healthcare system finance office should review open obligations to ensure that (1) beginning and ending dates are accurate; (2) open balances are accurate and agree with source documents, such as receiving reports, invoices, and payments; and (3) obligations without activity in the past 90 days are valid and should remain open. The team's review focused on whether the healthcare system performed monthly reviews and reconciliations to ensure that obligations with no activity for more than 90 days were valid and should remain open, and whether evidence from the healthcare system supported changes to the period of performance end date. Failure to properly maintain open obligations leaves funds attached to orders that could be used for other purposes to benefit veterans.

II. **Purchase card use.** The VA Government Purchase Card program was established to reduce administrative costs related to the acquisition of goods and services. When used properly, purchase cards can help facilities simplify acquisition procedures and provide an efficient vehicle for obtaining goods and services directly from vendors. The review team evaluated whether the healthcare system (1) adhered to strategic sourcing guidelines and considered whether to obtain contracts when making purchases and (2) properly documented transactions.[2] Documenting transactions as required helps VA and other oversight entities identify potential fraud, waste, and abuse. Using contracts for common purchases has several benefits, such as allowing VA to optimize purchasing power and obtain competitive pricing.

III. **Administrative staffing levels and accuracy of labor costs.** Administrative staff include positions such as medical support assistants, administrative officers, and human

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[1] The healthcare system consists of the Jack C. Montgomery VA Medical Center in Muskogee and outpatient clinics located in Tulsa, Muskogee, McAlester, Idabel, and Vinita. For more information about the healthcare system budget, capacity, and daily census, see appendix A.

[2] VA Financial Policy, vol. XVI, chap. 1B, "Government Purchase Card for Micro-Purchases," October 22, 2019. This policy defines strategic sourcing as ensuring employees obtain proper contracts when procuring goods and services on a regular basis.

resource specialists. A healthcare system that has more administrative staff than others of similar size and complexity may not be cost efficient. The review team examined whether the healthcare system managed its administrative staffing levels effectively and tracked the related labor costs accurately.

IV. **Pharmacy operations and cost avoidance efforts.** An efficient healthcare system anticipates how much drugs will cost and when inventory needs to be restocked by analyzing available data, such as prime vendor inventory management reports and inventory turnover rates.[3] Doing so helps ensure that the system makes the best use of appropriated funds and has inventory when needed. The team evaluated whether the healthcare system managed its pharmacy operations effectively and provided adequate oversight of inventory management.

The OIG selected these areas based on an analysis of VA data from the Office of Productivity, Efficiency & Staffing (OPES) Efficiency Opportunity Grid, the Supply Chain Common Operating Picture, and reports from VA's Financial Management System. The OIG compiled this data for all VA medical centers. The Efficiency Opportunity Grid was used to obtain information on pharmacy operations and administrative staffing, Financial Management System reports were used for open obligations, and US Bank data was used for purchase cards. Supply Chain Common Operating Picture data was used to gather information for the Medical/Surgical Prime Vendor program, but this review did not assess the use of that program.

The OIG evaluated financial efficiency practices related to the identified areas for fiscal year (FY) 2020. The team conducted its review from February 2021 through September 2021, which included a virtual site visit during the week of February 1, 2021. For more information about the review's scope and methodology, see appendixes B and C.

The findings and recommendations in this report should help the healthcare system identify opportunities for improved oversight and ensure the appropriate use of funds.

What the Review Found

Although the OIG found the healthcare system's leaders have taken several actions to strengthen oversight, the team identified several opportunities for improvement:

I. **Open obligations oversight.** The healthcare system had 90 open obligations totaling approximately $55 million with no activity in 90 days. The review team performed data analysis and selected for further review 10 of these inactive obligations totaling approximately $51.4 million to determine if the healthcare system performed required reviews to assess the validity and necessity of the remaining funds associated with each

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

obligation. The team was not able to verify that staff reviewed any of these 10 obligations as required by VA policy.[4]

In addition, the review team selected 12 different obligations to determine if the ending dates were accurate and identified three of the 12 obligations totaling $130,062 that did not have an accurate end date recorded in VA's Financial Management System.

Generally, this occurred because the healthcare system staff were unaware of policy to identify and review open obligations with a last activity date greater than 90 days and did not have a process in place to ensure obligation dates were accurate. Failure to conduct reviews leaves the facility vulnerable to the risk that those funds cannot be reobligated and used for other goods or services in that fiscal year to support veterans.

II.   **Purchase card use.** The review team determined that, contrary to VA policy, contracts were not used when procuring goods and services on a regular basis for 21 of the 33 sampled FY 2020 transactions (64 percent), totaling approximately $146,000. Instead of establishing contracts for commonly purchased goods, staff used purchase cards. This occurred, in part, because cardholders and approving officials were not working together to properly review the purchases and communicating accordingly with contracting staff to utilize contracts for commonly ordered goods and services when appropriate.

Furthermore, 20 of the 33 transactions sampled were missing some required supporting documentation to verify that purchase card transactions were properly approved and payments were accurate. Due to inadequate supporting documentation among sampled transactions, the healthcare system had at least $95,000 of questioned costs.[5]

The review team also found that, in FY 2020, quarterly internal audits for the purchase card program were not completed on time. The National Contracting Office 19 purchase card program supervisor reported a delay for the completion of the audits because of a confusion regarding due dates, from a separate deliverable routed to the national program manager with a similar subject matter but an extended submission timeline following the close of the quarter. Failure to conduct internal reviews in a timely manner leaves the facility vulnerable to the risk of error, fraud, waste, or abuse within the purchase card program. The team identified 24 of the 33 transactions sampled as potential split

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[4] VA Financial Policies and Procedures, vol. 2, chap. 5, "Obligations Policy," January 2018, updated in August 2018.

[5] Per 2 C.F.R. § 200.84, the term *questioned cost* means a cost that is questioned by the auditor because of an audit finding where the costs, at the time of the audit, are not supported by adequate documentation.

purchases during the same period, resulting in approximately $167,000 of potentially unauthorized commitments.[6]

III.   **Administrative staffing levels and accuracy of labor costs.** The healthcare system had 39 more full-time equivalent (FTE) administrative staff than expected in FY 2020, according to an administrative staffing model developed by OPES in VHA.[7] The difference between the observed and expected number of administrative FTEs signifies the potential opportunity to improve efficiency and should be used as a starting point for deeper examination.[8] The OIG found healthcare system leaders have taken several actions to strengthen oversight of administrative staffing efficiency. Staff assigned to the Care Coordination Management cost center used daily reports to track administrative workload, such as consult status, number of phone calls taken along with answer and abandon rate, and number of scheduled appointments.[9] The healthcare system also has a resource management committee that reviews and approves position requests, and the finance office tracks overtime and premium pay for service lines. The OIG also found that salary cost data and labor mapping reviews were conducted as required to ensure labor costs were recorded correctly.

IV.   **Pharmacy operations and cost avoidance efforts**. The healthcare system could improve pharmacy efficiency by narrowing the gap between the facility's observed drug costs and expected drug costs, bringing the turnover rates closer to the VHA-recommended level, and following the required process for buying drugs that are not listed on VA's formulary. The VA national formulary is a listing of products, such as drugs and drug-related supplies, that must be available for prescription at all VA medical facilities.

The healthcare system averaged just under $7 million in opportunity for potential cost savings, which is the difference between expected and observed drug costs, for each of the last three fiscal years, reporting almost $5.6 million in opportunity for FY 2019 and increasing to approximately $8.7 million for FY 2020. The healthcare system used the Lost Opportunity Cost Report, provided by the national Pharmacy Benefits Management

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[6] A split purchase occurs when a cardholder circumvents the single purchase threshold limit by dividing a single purchase or need into two or more smaller purchases. According to VA Directive 7401.7, *Unauthorized Commitments and Ratification*, an unauthorized commitment is a purchase made by a government representative who lacks the authority to bind the government or who exceeds his or her delegated authority, or purchases made that are not in accordance with the Federal Acquisition Regulation and the VA Acquisition Regulation.

[7] One FTE is equivalent to one employee working full time. The number of administrative FTEs is from the OPES administrative staffing model, which includes administrative and clerical personnel, as well as administrative-mapped FTEs.

[8] Additional scrutiny is warranted given the high cost of salaries—in this case, about $3.1 million for the 39 administrative FTEs based on the average salary for administrative staff in FY 2020.

[9] Cost centers are codes that help VA correctly identify and record costs. Staff assigned to the Care Coordination Management cost center handle referrals for clinical care, which include scheduling and results follow-up.

office to the Veterans Integrated Service Network and the healthcare system, to evaluate initiatives for cost-saving opportunities.[10] However, the acting chief of pharmacy reported that management and staff were not familiar with business and efficiency reports related to pharmacy operations and, as a result, no dedicated efforts, such as action plans, benchmarking, or workgroups, have been taken to address the known inefficiencies.

In addition, the healthcare system's turnover rate for pharmacy inventory could be improved. An inventory turnover rate is the number of times inventory is used during the year and is the primary measure to monitor the effectiveness of inventory management. Low pharmacy inventory turnover rates can indicate inefficient use of financial resources as it relates to pharmaceuticals purchased and held in stock at the healthcare facility. In FY 2020, the healthcare system reported an inventory turn of 5.6 compared to the recommended level of 12. Furthermore, the healthcare system did not run required monthly inventory management reports from the prime vendor software package, utilize data for inventory management, or adjust stock levels in accordance with VHA policy. Generally, this occurred because the previous associate pharmacy chief was responsible for many of the inventory management practices, and adequate training, oversight, and inventory management practices were not established prior to his retirement. In addition, the acting pharmacy chief was not familiar with inventory management practices and VHA policy requirements prior to taking the position in June 2020. Failure to use inventory management reports could result in inaccurate reorder points and insufficient inventory levels to meet patient needs.

Finally, the healthcare system did not follow the nonformulary request process when buying drugs not listed on the VA national formulary.[11] The team determined that "quick orders"—orders that circumvented the nonformulary approval process—were set up for specialty care services, leading healthcare system staff to purchase high-cost drugs other than from the VA national formulary. For example, one service was approved to spend $250 on an inhaler not on the formulary when a $25 inhaler was an option on the formulary. The pharmacy leaders and staff were not aware that bypassing the approval process was not allowed and against VA policy until August 2020 when this process was stopped. Failure to follow the nonformulary approval process can lead to unnecessary spending within the pharmacy program.

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[10] VHA is organized into 18 regional networks called Veterans Integrated Service Networks that manage and oversee medical facilities in their specified geographic areas.

[11] VA National Formulary is a listing of products (e.g., drugs and drug-related supplies) that must be available for prescription at all medical facilities.

What the OIG Recommended

The OIG made nine recommendations for improvement to the healthcare system director and one to the networking contracting office. 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 the healthcare system director (1) ensure staff are made aware of policy requirements for open obligations and reviews are conducted as required.

To strengthen oversight of purchase card transactions, the OIG recommended the director of contracting for the Network Contracting Office 19, VA Rocky Mountain Network (2) develop checks on the successful completion of quarterly audits as required by the Veterans Health Administration's standard operating procedure, "Internal Audits—Purchase Cards and Convenience Checks." The OIG recommended the healthcare system director (3) establish controls to confirm that approving officials and purchase cardholders review their proposed purchases and make sure contracting is used when it is in the best interest of the government, (4) ensure cardholders comply with record retention requirements as stated in VA financial policy, and (5) develop measures to confirm completed VA Form 0242 submissions are accurate and updated for all cardholders.

The OIG did not make any recommendations for administrative staffing or accuracy of labor costs.

The OIG made four recommendations regarding pharmacy operations. The healthcare system director should (6) develop formalized processes for achieving identified efficiency targets and use available pharmacy data to make business decisions, (7) develop and implement a plan to increase inventory turnover closer to the VHA-recommended level, (8) develop and implement a plan to complete facility-based inventory audits of noncontrolled drug line items in compliance with VHA policy, and (9) establish measures to improve compliance with the nonformulary request process.

Management Comments

The director of the Eastern Oklahoma VA Health Care System concurred with all recommendations, provided responsive corrective action plans, and requested closure of recommendations 2 and 5. The director of contracting for Network Contracting Office 19, VA Rocky Mountain Network concurred with recommendation 2 and with the response provided by the director of the Eastern Oklahoma VA Health Care System.

The OIG considers all recommendations still open. The OIG will monitor the implementation of all planned actions and will close the recommendations when the Eastern Oklahoma VA Health

Care System and the Network Contracting Office 19 provide sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified. Appendix E includes the director of contracting's comments and appendix F includes the facility director's comments.

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Contents

Abbreviations

FTE	full-time equivalent
FY	fiscal year
IFCAP	Integrated Funds Distribution, Control Point Activity, Accounting and Procurement
OIG	Office of Inspector General
OPES	VHA Office of Productivity, Efficiency & Staffing
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducts financial efficiency reviews to assess oversight and stewardship of funds at VA healthcare systems and to identify opportunities to achieve cost efficiencies. Review teams identify and examine areas that draw on considerable VA financial resources and can be compared to healthcare systems similar in size and complexity across VA to promote best practices.[12]

This review focused on the Eastern Oklahoma VA Health Care System to assess the following four financial activities and administrative processes during fiscal year (FY) 2020 and determine whether appropriate oversight and controls were in place:

I. **Open obligations oversight.** Obligations are considered open if there is an associated balance, whether undelivered or unpaid. Open obligations should be reviewed by the healthcare system finance office to ensure that beginning and ending dates are accurate; open balances are accurate and agree with source documents, such as receiving reports, invoices, and payments; and obligations without activity in the past 90 days are valid and should remain open.

II. **Purchase card usage.** The team examined a sample of the healthcare system's purchase card transactions for compliance with policies and procedures that reduce the risk of error, fraud, waste, and abuse. The review also focused on whether contracts and other mechanisms were considered for commonly purchased products to ensure optimal savings to VA.

III. **Administrative staffing levels and accuracy of labor costs.** Having a large number of administrative staff in health care is often associated with cost inefficiency.[13] The team identified opportunities to potentially improve the efficiency of full-time equivalent (FTE) staff and evaluated whether the healthcare system recorded administrative labor costs correctly.

IV. **Pharmacy operations and cost avoidance.** The review team assessed whether the healthcare system complied with applicable policies and used cost and performance data to track progress toward goals developed by the national Pharmacy Benefits Management office, improve pharmacy program operations, and identify and correct problems.

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

[13] "VHA Office of Productivity, Efficiency & Staffing, Administrative Staffing Model," accessed June 8, 2021, http://opes.vssc.med.va.gov/Pages/Administrative-Staffing-Model.aspx. (This is an internal VA website not publicly accessible.)

Eastern Oklahoma VA Health Care System

The Eastern Oklahoma VA Health Care System serves veterans in 25 counties in eastern Oklahoma with an estimated veteran population of more than 51,000. The parent facility is the Jack C. Montgomery VA Medical Center in Muskogee, which offers a variety of primary and secondary levels of inpatient medical and surgical care, along with outpatient primary and consultative care in medicine, surgery, and psychiatry. The healthcare system has 63 hospital operating beds and is also responsible for community-based outpatient clinics in Muskogee, Tulsa, Idabel, McAlester, and Vinita. A new 180,000-square-foot VA healthcare center—the Ernest Childers VA Health Care Center—opened its doors on July 19, 2021, and replaced another Tulsa clinic that closed on August 8, 2021. In FY 2020, the healthcare system had a medical care budget of approximately $479 million with almost 1,600 FTEs and provided services to over 40,400 veterans. For more information about the healthcare system, see appendix A.

Facility and Efficiency Selection

The review team evaluated VA data to identify those facilities with the greatest potential for financial efficiency improvements. The OIG obtained this data from the VHA Office of Productivity, Efficiency & Staffing (OPES) Efficiency Opportunity Grid, the Supply Chain Common Operating Picture, reports from VA's Financial Management System, and US Bank data from the Corporate Data Warehouse. The OIG compiled this data for all VA medical centers. The Efficiency Opportunity Grid was used to obtain information on pharmacy operations and administrative staffing, VA's Financial Management System reports were used for open obligations, and US Bank data was used for purchase cards. Supply Chain Common Operating Picture data was used to gather information for the Medical/Surgical Prime Vendor program, but this review did not assess the use of that program.

VHA developed the Efficiency Opportunity Grid to give facility leaders insight into areas of opportunity for improving efficiency when compared with other VHA facilities. The Efficiency Opportunity Grid, a collection of 12 statistical models, allows for comparisons between VHA facilities by adjusting data for variations in patient and facility characteristics and geography. The Efficiency Opportunity Grid describes possible inefficiencies and areas of success by showing the difference between a facility's actual costs and expected costs. The team obtained the facility rankings from three Efficiency Opportunity Grid statistical models to assist in the facilities selection: the stochastic frontier analysis model, the administrative staffing model, and the pharmacy expenditure model.

Results and Recommendations

I. Open Obligations Oversight

VA's management of open obligations has been a longstanding problem and was included as a material weakness in VA's FY 2019 and FY 2020 audited financial statements.[14] Additionally, a 2019 OIG report on undelivered orders recommended that VHA ensure that staff conduct reviews and reconcile open orders, identify and deobligate excess funds on those orders, and ensure that staff follow VA policy regarding required reviews of open obligations.[15]

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

- **Inactive obligations.** The review team assessed whether the healthcare system performed monthly reviews and reconciliations for high-dollar obligations to ensure that obligations with no activity for more than 90 days were valid and should remain open.

- **End-date modifications.** The review team identified open obligations with changes to the period of performance end date and reviewed evidence from the healthcare system that supported those changes. The period of performance end date is the date by which the goods or services are to be provided.

Finding 1: Inactive Obligations Were Not Being Reviewed and Some End Dates Were Not Accurate

VA policy requires finance offices to perform monthly reviews and reconciliations of open obligations that have been inactive for more than 90 days to ensure the obligation is still valid and funds are not underused.[16] For these inactive obligations, finance office personnel should verify with the ordering service department or contracting officer, if applicable, that the goods or services have not been received and are still needed. Data from VA's Financial Management System should be reviewed against supporting documentation by the responsible finance office to ensure reports, subsidiary records, and systems reflect proper costing, accurate delivery date or end date, and a correctly calculated unliquidated balance.[17]

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[14] VA OIG, *Audit of VA's Financial Statements for Fiscal Years 2020 and 2019,* Report No. 20-001408-19, November 24, 2020; VA OIG, *Audit of VA's Financial Statements for Fiscal Years 2019 and 2018,* Report No. 19-06453-12, November 19, 2019.

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

[16] VA Financial Policies and Procedures, vol. 2, chap. 5, "Obligations Policy" January 2018, updated in August 2018.

[17] Per 2 C.F.R. § 200.97, the term *unliquidated balance* means an obligation incurred by a nonfederal entity that has not been paid (liquidated) or for which the expenditure has not been recorded.

Figure 1 shows the number of inactive obligations and dollar amounts for the healthcare system from April 2020 through September 2020.
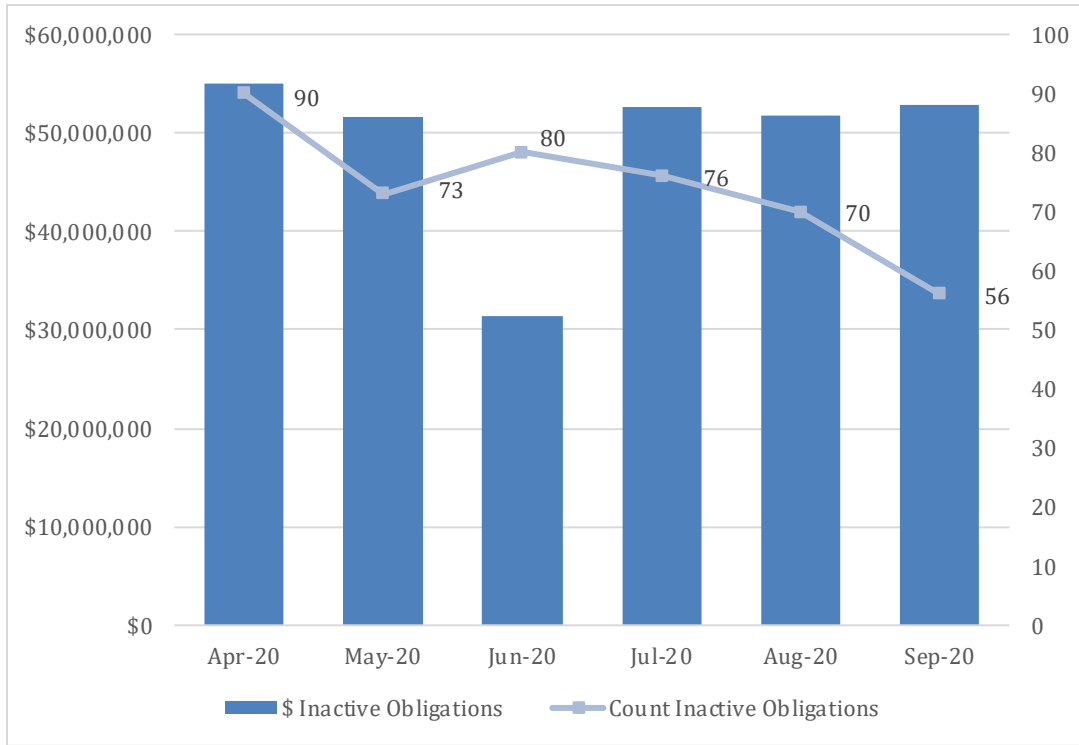
Figure 1. *Analysis of inactive obligations for the Eastern Oklahoma VA Health Care System, April 2020 through September 2020.*

Source: VA Financial Management System F850 Report.

As of April 2020, the healthcare system had 90 obligations totaling approximately $55 million with no activity in more than 90 days. For the 90 obligations identified, 67 obligations totaling almost $54 million had no activity for 181 days or more, with orders dating back to 2016. Figure 2 shows the age and dollar amounts of the inactive obligations as of April 2020.
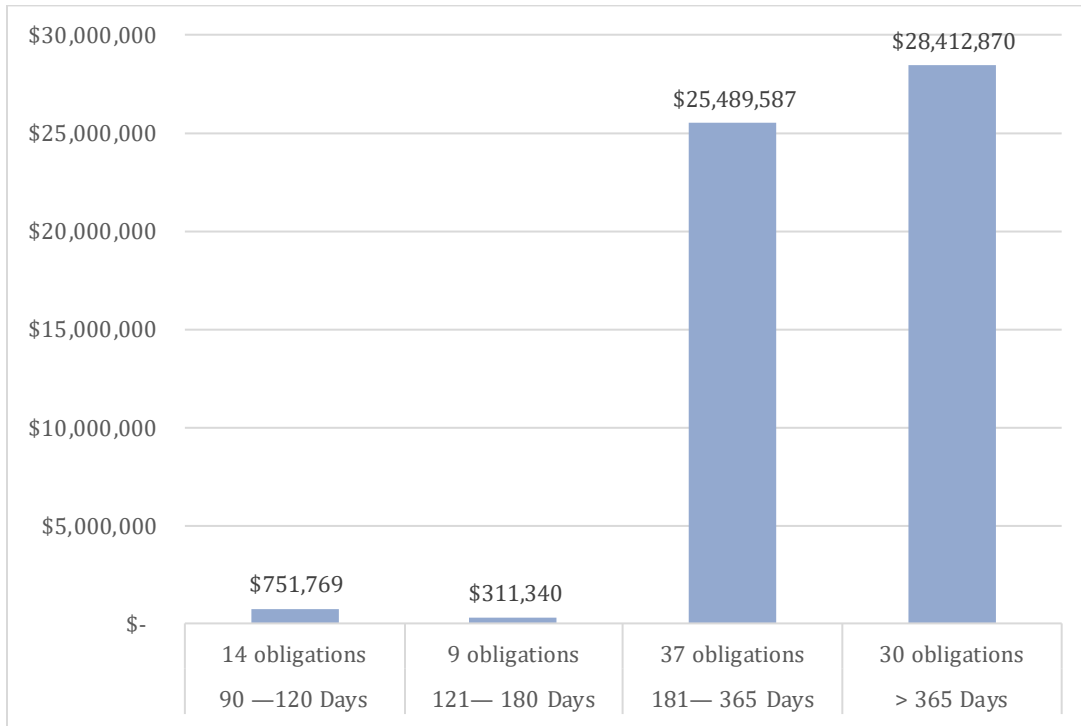
Figure 2. Analysis of inactive obligations for April 2020.
Source: VA Financial Management System F850 Report.

The review team selected 10 obligations from April 2020 with no activity for more than 90 days totaling approximately $51.4 million and assessed whether the healthcare system identified and reviewed them to see if they were still valid and needed to remain open in accordance with VA financial policy.[18] The team was not able to verify that a review was completed on any of these 10 obligations. This occurred because healthcare system staff were unaware of the policy requirement to identify and review open obligations with a last activity date greater than 90 days. In addition, according to the chief finance officer, the initiating services do not respond in a timely manner to requests for monthly reviews and adjustments of open obligations due to competing priorities. The initiating service is the individual or program office that initiated the request for the obligation and must be consulted before an open obligation can be closed. Monthly monitoring, including reconciling outstanding obligations, was not treated as a priority.

For example, one initiating service took approximately three months to fully respond to the finance office and act. The finance office emailed the initiating service on September 3, 2020, requesting seven obligations be reviewed for decrease or closure by September 11, 2020. After two months of no response from the service, the finance office sent a follow-up email on November 18, 2020, requesting the then-current status of the seven obligations. The service

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[18] VA Financial Policies and Procedures, vol. 2, chap. 5, "Obligations Policy" January 2018, updated in August 2018.

responded on November 18 and 19 with the status for five of the seven obligations; however, the finance office reached out to the service again on December 10 requesting that the service act on the obligations, as no action had been taken since the prior email.

The review team selected and evaluated 12 additional open obligations, totaling approximately $1.4 million, to determine if the end dates were accurate and reconciled between the Integrated Funds Distribution, Control Point Activity, Accounting and Procurement (IFCAP) system and VA's Financial Management System. IFCAP handles the processing of certified invoices and receiving documents to the VA Financial Management System. In addition, IFCAP transfers obligation information back to the control point and updates the control point balance automatically.[19]

The team identified three of the 12 obligations totaling $130,062 that did not have accurate end dates recorded in VA's Financial Management System. If the end date has passed and the obligation is no longer valid, those funds could be deobligated and used elsewhere. This occurred because the healthcare system did not have an adequate process in place to ensure obligation dates were accurate. In addition, according to accounting staff, a macro used to reconcile end dates between two systems no longer worked.[20]

Finding 1 Conclusion

The healthcare system personnel were not compliant with VA policies and reported to be unaware of requirements for routine follow-up of open obligations. The review team found open obligations with no activity for more than 90 days were not reviewed for validity and accurate end dates. Failure to properly manage open obligations increases the risk of failing to spend appropriations within the associated fiscal year and leaving funds attached to orders that could be closed and therefore unable to be used for other purposes to benefit veterans. The facility could improve management and oversight of open obligations.

Recommendation 1

The OIG made the following recommendation to the director of the Eastern Oklahoma VA Health Care System:

1. Ensure finance office staff are made aware of policy requirements and reviews are conducted on all open obligations as required by VA Financial Policies and Procedures, vol. 2, chap. 5, "Obligations Policy," January 2018.

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

[20] A macro is a single computer instruction that stands for a sequence of operations.

Management Comments

The director of the Eastern Oklahoma VA Health Care System concurred with recommendation 1. The responses to all report recommendations are provided in full in appendixes E and F.

To address recommendation 1, the director reported that all staff responsible for open obligations oversight will demonstrate knowledge of VHA financial policies and procedures by reading the policy and attesting by signature they have read and understand the policy. In addition, the chief of fiscal services will perform monthly audits of open obligations to ensure validity and accurate end dates until two consecutive quarters have a compliance rate of at least 90 percent.

OIG Response

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

II. Purchase Card Use

The VA Government Purchase Card program was established to reduce the administrative costs related to acquiring goods and services. When used properly, purchase cards can help facilities simplify acquisition procedures and provide an efficient vehicle for obtaining goods and services directly from vendors. In FY 2020, the Eastern Oklahoma VA Health Care system spent approximately $23 million through purchase cards, representing about 33,200 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 safeguard government resources and ensure compliance with policies and procedures that reduce the risk of error, fraud, waste, and abuse.

The team reviewed the following areas:

- **Purchase card transactions.** The review team examined whether the healthcare system ensured that employees considered the most appropriate purchasing mechanism, which entails obtaining proper contracts when procuring goods and services on a regular basis which VA refers to as "strategic sourcing."[21] The use of contracts lowers the risk of split purchases and duplicate payments on purchase cards by reducing open market or individual purchases and enables VA to leverage its purchasing power.

- **Purchase card oversight**. The review team assessed whether the agency/organization purchase card program coordinator provided oversight of the purchase card program by conducting quarterly internal audits. The internal audit is an example of a systematic control that reduces the risk of error, fraud, waste, and abuse within the purchase card program, such as periodic and continuous monitoring, checks and balances, policies, procedures, and segregation of duties.[22]

- **Supporting documentation** is required for purchases to provide assurance of payment accuracy and to justify the need to purchase a good or service. This includes approved purchase requests, purchase orders, receiving reports, and vendor invoices. Supporting documentation enables program oversight which helps identify fraud, waste, and abuse.

Finding 2: The Healthcare System Did Not Always Pursue Strategic Sourcing and Maintain Supporting Documentation

The review team evaluated a judgmental sample of 33 purchase card transactions totaling about $175,000 from FY 2020 to determine whether the healthcare system's purchase card sampled

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[21] Per VA Financial Policy, vol. XVI, chap. 1B, "Government Purchase Card for Micro-Purchases," October 22, 2019. This policy defines strategic sourcing as ensuring employees obtain proper contracts when procuring goods and services on a regular basis.

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

transactions pursued strategic sourcing and properly documented transactions.[23] (See appendix B for more on scope and methodology and appendix C for details on the review's sampling.) The team determined that contracts could have been considered for 21 of the 33 transactions (64 percent), totaling approximately $146,000 due to multiple orders of similar products or services. In addition, 20 of 33 transactions sampled were missing some of the required supporting documentation needed to verify accuracy and approval for the purchase card transactions. The team also identified 24 of the 33 sampled transactions as potential split purchases totaling almost $167,000 of potentially unauthorized commitments.[24]

These issues occurred, in part, because approving officials and cardholders did not consistently retain and subsequently review supporting documentation for purchases as required by policy. Such proper documentation ensures purchases are valid and that approving officials and cardholders make every effort to communicate with the contracting office to consider whether contracts are available or warranted when purchasing goods and services on a regular basis.[25] Additionally, an agency/organization purchase card program coordinator did not submit quarterly internal audits to the medical center director and approving officials, within the required timeframe.[26] Quarterly audits of the purchase card program, as well as more effective reviews by approving officials, could have detected and mitigated the lack of strategic sourcing and documentation issues identified, which resulted in at least $95,000 of questioned costs.[27]

Purchase Card Transactions and Oversight

Pursuant to VA financial policy, VA should enhance its purchasing authority by utilizing strategic sourcing to consider contracting options, which generally provide greater savings to VA than using purchase cards for open market acquisitions without a negotiated price.[28] Approving officials, the agency/organization program coordinator, and cardholders must review purchases to determine when it is in the best interest of the government to obtain contracts and ensure purchasers are obtaining the most competitive prices. Generally, VA should use contracts if the purchase is for an ongoing, repetitive order of goods or services. Contracts must also be used

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

[24] A split purchase occurs when a cardholder circumvents the single purchase threshold limit by dividing a single purchase or need into two or more smaller purchases. According to VA Directive 7401.7, *Unauthorized Commitments and Ratification*, an unauthorized commitment is a purchase made by a government representative who lacks the authority to bind the government or who exceeds his or her delegated authority, or purchases made that are not in accordance with the Federal Acquisition Regulation and the VA Acquisition Regulation.

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

[26] VHA Government Purchase Card Program, Standard Operating Procedure, "Internal Audits—Purchase Cards and Convenience Checks."

[27] Per 2 C.F.R. § 200.84, the term *questioned cost* means a cost that is questioned by the auditor because of an audit finding where the costs, at the time of the audit, are not supported by adequate documentation.

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

when the total value of the requirement exceeds the micropurchase threshold or the cardholder's authorized single purchase limit. Cardholders must not modify a requirement or order into smaller parts to avoid exceeding their purchase card limit; that requires using more formal contracting procedures. The requirement for the goods or services should be communicated to the contracting office for procurement.[29]

The proper way to purchase commonly needed or high-cost goods, particularly those over the purchase card limit, would be to send the service request to the contracting office for purchase. This requires planning to ensure there is sufficient time for a contract to be expanded or established, if none exists, to purchase the products in time for scheduled use. Any VA purchase cardholder who makes an unauthorized commitment, including a split purchase, exceeding his or her level of authority has made an improper payment and must submit a request for ratification to the chief of the contracting office that provides contracting support to the organization involved.[30]

Generally, the improper reliance on purchase cards and any related unauthorized commitments appeared to persist because cardholders and approving officials were not working together to properly review the purchases and communicate accordingly with contracting staff to utilize contracts for commonly ordered goods and services when appropriate.

Moreover, the agency/organization purchase card program coordinator did not complete quarterly purchase card audits that could identify such issues within the required time. Quarterly purchase card audits are intended to evaluate and improve the effectiveness of internal controls and compliance with regulations and policies. Upon completion of the quarterly audit, VHA procedures require the agency/organization purchase card program coordinator to send a formal memo of audit results to the medical center director, with copies to the approving official and/or supervisor, no later than the end of the calendar month after the close of the quarter.[31] The National Contracting Office 19 purchase card program supervisor reported a delay for the completion of the audits because of a confusion regarding due dates, as a result of a separate deliverable that is routed to the national program manager with a similar subject matter but an extended submission timeline following the close of the quarter. The healthcare system missed an opportunity to evaluate the purchase card program and its compliance with regulations and policies, as well as to improve the effectiveness of internal controls.

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

[30] VA Directive 7401.7, *Unauthorized Commitments and Ratification*, defines ratification as an authorized official converting an unauthorized commitment to a legal contract.

[31] VHA Government Purchase Card Program, Standard Operating Procedure, "Internal Audits—Purchase Cards and Convenience Checks."

Supporting Documentation

When the healthcare system buys goods and services using a purchase card, it must maintain supporting documentation, such as approved purchase requests, vendor invoices, purchase orders, and receiving reports, for six years. This documentation verifies that purchase card transactions were properly approved and payments were accurate. Among charge card documents that must be retained is the Governmentwide Purchase Card Certification Form (VA Form 0242). An approved VA Form 0242 is used to delegate authority to an individual to use the purchase card to procure and pay for goods and services. A revised form is required when the approving officer changes, cardholders legally change their names, or the single purchase limit is increased above the originally requested amount.[32]

The review team identified that 20 of the 33 transactions sampled were missing some required supporting documentation, which resulted in at least $95,000 in questioned costs. This occurred because cardholders were not familiar with purchase card policy that details record retention documentation.

Additionally, the team determined that seven out of 13 cardholders responsible for the 33 transactions had an inaccurate VA Form 0242 with missing signatures from approving officials, incorrectly stated spending limits, or approvers listed who no longer worked for VA. The VA Form 0242 is an important control that helps ensure compliance with purchase limits and responsibilities. The accuracy of the VA Form 0242 is essential for holding cardholders and approving officials accountable.

Finding 2 Conclusion

The healthcare system did not always use strategic sourcing. As a result, contracts for commonly used goods were not fully utilized. In addition, some purchase card transactions were missing proper documentation. These issues, which resulted in at least $95,000 of questioned costs, could have been detected by quarterly audits of the purchase card program and more effective reviews by approving officials.

Recommendations 2–5

The OIG made the following recommendations to the director of contracting for Network Contracting Office 19, VA Rocky Mountain Network:

2. Develop checks on the successful completion of quarterly audits of the purchase card program as required by the Veterans Health Administration's standard operating procedure, "Internal Audits—Purchase Cards and Convenience Checks."

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

The OIG made the following recommendations to the director of the Eastern Oklahoma VA Health Care System:

3. Establish controls to confirm approving officials and purchase cardholders review their purchases and make sure contracting is used when it is in the best interests of the government.

4. Ensure cardholders comply with record retention requirements as stated in VA's Financial Policy, vol. XVI, "Charge Card Program."

5. Develop measures to confirm completed VA Form 0242 submissions are accurate and updated for all cardholders.

Management Comments

The director of contracting for Network Contracting Office 19 concurred with recommendation 2. The director of the Eastern Oklahoma VA Health Care System concurred with recommendations 2 through 5 and requested closure of recommendations 2 and 5.

To address recommendation 2, the director of contracting concurred with the response provided by the director of the Eastern Oklahoma VA Health Care System that reported the quarterly audit memo dates for fiscal year 2020 were corrected and it was verified that audits were completed in accordance with the VHA audit standard operating procedure. The dates are now being reflected correctly to ensure timely completion and reporting of audits. For recommendation 3, the director of the healthcare system reported that service chiefs and local leadership will increase use of local acquisition utilization specialists to assist in timely annual procurement planning and guidance on the proper acquisition vehicles. To address recommendation 4, the director reported all employees with government purchase cards will complete annual training and have read VA financial policy and attested their understanding. For recommendation 5, the director reported a quarterly review of VA Form 0242s will continue to be conducted and that 0242s are updated as soon as the stakeholders notify the purchase card program of changes.

OIG Response

The action plans the director of contracting and the director of the healthcare system provided are responsive to the recommendations. While the director of contracting concurred with recommendation 2 and the response, and the healthcare system requested the closure of recommendations 2 and 5, the OIG considers the recommendations to be open. The OIG will monitor implementation of the planned actions and will close the recommendations upon receiving sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified.

III. Administrative Staffing Levels and Accuracy of Labor Costs

Large administrative overhead in health care is often associated with cost inefficiency.[33] Medical centers can help ensure funds are put to the best use by identifying potential indicators of inefficiencies, such as more administrative staff than VHA facilities that are similar in size and complexity. Variances in numbers of personnel serve as a starting point for deeper examination but, in themselves, are not determinative of whether the facility had an excessive number of administrative staff. 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 a VA facility cannot adequately provide services for veterans, particularly those living far from the facility. Accordingly, staffing efficiency numbers should be a starting point for leaders to develop improvement strategies that consider 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 review team assessed the following administrative staffing areas:

- **Administrative staffing efficiency** involves comparing the facility's administrative staffing levels with those at comparable facilities.

- **Healthcare system resource management** includes how facilities oversee administrative staffing and address identified problems.

- **Salary cost and labor mapping reviews** determine whether staff hours and salary were assigned the correct codes in VA's Financial Management System and Managerial Cost Accounting System based on the duties performed. This helps ensure that correct information is available for budget decisions and forecasting and allows facilities to compare data from one period to another.

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[33] "VHA Office of Productivity, Efficiency & Staffing, Administrative Staffing Model," accessed June 8, 2021, http://opes.vssc.med.va.gov/Pages/Administrative-Staffing-Model.aspx. (The website is not accessible by the public.)

Finding 3: The Healthcare System Implemented Strategies to Improve Administrative Staffing Efficiency and Recorded Labor Costs Correctly

The healthcare system had 39 more administrative FTE than the expected number in FY 2020, according to the OPES administrative staffing model.[34] The difference between the observed and expected number of administrative FTEs signifies a potential opportunity to improve efficiency and should be used as a starting point for deeper examination.[35] According to the healthcare system leaders, the implementation of the MISSION Act of 2018, in part, increased the number of administrative staff. The MISSION Act expanded veterans' access to community care, which increased the administrative workload tasks, such as reviewing community care referrals. Among the cost centers in the healthcare system, Care Coordination Management, Sterile Processing Service, and Human Resources Management had the largest administrative FTE differences in both FY 2019 and FY 2020 compared to the medical center group average.[36] Care Coordination Management used other tools to assess the appropriate number of FTE, while Sterile Processing Service and Human Resources Management provided explanations for the staff difference. Because the healthcare system has taken steps to strengthen staffing efficiency and management, the OIG did not make any related recommendations.

Administrative Staffing Efficiency

Using the OPES administrative staffing model, the review team compared the healthcare system's observed administrative staffing to the expected staffing, as well as individual service lines' administrative FTE levels to that of similar VA facilities.[37] According to the administrative staffing model, the healthcare system's observed number of administrative FTEs was below the expected administrative FTE level in FY 2018 and FY 2019. However, the difference between the healthcare system's observed administrative FTE level and expected administrative FTE level increased to 39 in FY 2020. Figure 3 shows the differences between the observed and expected levels.

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[34] The FTE units represent equivalent employees working. One FTE is equivalent to one employee working full time. The number of administrative FTE is from the OPES administrative staffing model, which includes administrative and clerical personnel, as well as administrative-mapped FTE. The expected number of administrative FTEs is a predicted value for a facility after accounting for differences in facility, patient, and geographic characteristics.

[35] Additional scrutiny is warranted given the high cost of salaries—in this case, about $3.1 million for the 39 administrative FTEs based on the average salary for administrative staff in FY 2020.

[36] Cost centers are codes that help VA correctly identify and record costs. The medical center group average is the average of a group of VA hospitals that are similar in size and complexity as determined by OPES. The Eastern Oklahoma Health Care System was a 1c high-complexity facility in FY 2020.

[37] The staffing model compares a facility's observed number of administrative FTEs to an expected number and compares the number of administrative FTEs in a cost center to the average of same cost center in similar facilities.
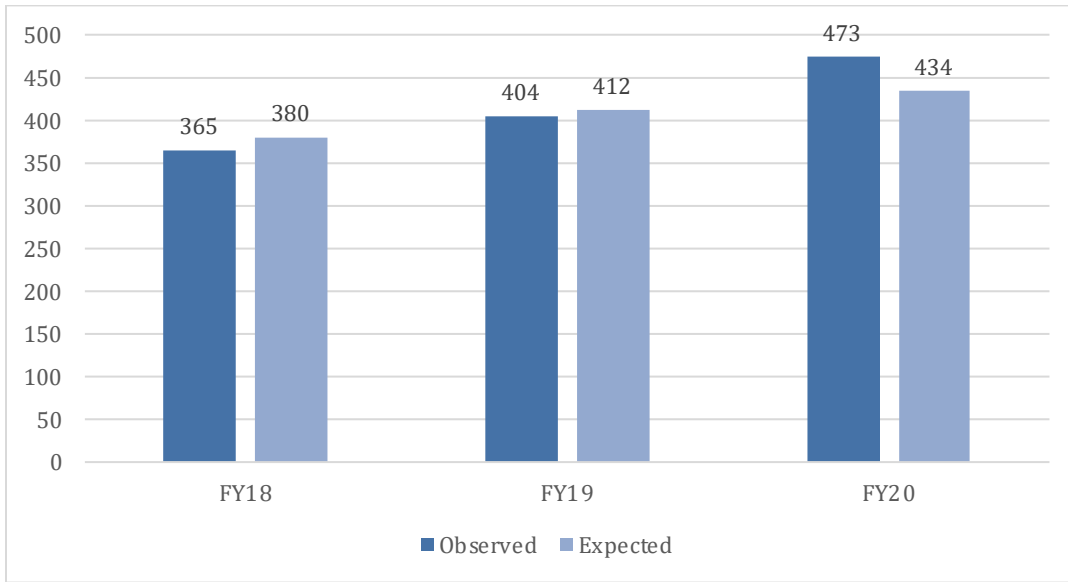
Figure 3. *Observed versus expected administrative FTEs system between FY 2018 and FY 2020.*
Source: OPES Efficiency Opportunity Grid administrative staffing model.

Three cost centers had the largest administrative staffing differences when compared to the average for similar VA medical facilities in both FY 2019 and FY 2020.[38] Table 1 shows the differences for the cost centers in FY 2020.

Table 1. Healthcare System Cost Centers with Biggest Differences Compared to Similar VA Medical Facilities

Cost center	Eastern Oklahoma VA Health Care System	Medical center group average	Difference
Care Coordination Management	172	113	59
Sterile Processing Service	30	2	27
Human Resource Management	23	17	6

Source: OPES Efficiency Opportunity Grid administrative staffing model.
Note: Numbers may not add due to rounding.

Through meetings with service lines and finance office personnel, the review team determined that multiple factors affected the staff level at the service lines in FY 2020.

In addition to the MISSION Act, staff attributed the increase of administrative FTEs for Care Coordination to the COVID-19 pandemic. Staff assigned to the Care Coordination Management cost center handle referrals for clinical care, which include scheduling and results follow-up.

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[38] This is the average for the medical center complexity level group, a group of VA hospitals that are similar in size and complexity as determined by OPES.

During the COVID-19 pandemic, the assistant under secretary for health for operations issued guidance which altered the consult referral management process and increased the number of community care consults. Specifically, the number of community care consults at the healthcare system increased from 27,278 in FY 2018, to 38,197 in FY 2019, to 48,538 in FY 2020.

For Sterile Processing Service, the service itself does not have any administrative staff; however, logistics employees are assigned to this cost center due to the nature of work conducted. VA financial policy states that personal services and other costs associated with the Sterile Processing Service, which include clinical supplies purchased to stock clinics and wards, should be listed under the Sterile Processing Service cost center.[39] As such, the logistics employees who handled clinical supplies were assigned to the Sterile Processing Service.

The human resource service line is no longer under the healthcare system; it was realigned to the Veterans Integrated Service Network (VISN) in FY 2020.[40]

Healthcare System Resource Management

The healthcare system leaders have taken several actions to strengthen oversight of administrative staffing. Care Coordination tracks administrative workload daily using consult status, such as pending, scheduled, closed, number of phone calls taken along with answer and abandon rate, and number of scheduled appointments. The service line uses a staffing tool that generates a recommended number of administrative staff based on the workload.

In addition, the healthcare system has a resource management committee that reviews and approves position requests, and the finance office tracks overtime and premium pay for service lines. According to a healthcare system leader, the healthcare system started using data from OPES, such as Operational Workforce Reports, as well as software called "Forecast," for planning and decision making. The healthcare system leader stated the Forecast software can identify administrative positions that were budgeted and unbudgeted. Using the data gathered in FY 2020, the healthcare system can ramp up to standardize support positions across clinical departments.

Salary Cost and Labor Mapping Reviews

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

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[39] VA Financial Policy, vol. XIII, chap. 1, "Cost Center," app. A, May 2020.

[40] VHA is organized into 18 regional networks called Veterans Integrated Service Networks (VISNs) that manage and oversee medical facilities in their specific geographic areas.

1. **Salary cost reviews.** These reviews determine whether employees' hours and salaries are assigned to the correct cost center using an accurate budget object code.[41]

   - **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, the core accounting system, depends on human resources staff selecting the correct cost center.

   - **Budget object codes** reflect the nature of financial transactions. In accordance with VA financial policy, administrative employees should be assigned to budget object code 1001 or 1002. The policy also requires that finance personnel record financial obligations and expenditures in accordance with appropriate budget object codes.[42]

   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.[43] 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.[44] 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 examined salary cost data reviews at the healthcare system for three pay periods in FY 2020 and labor mapping data reviews for six pay periods in FY 2020. The review team determined that salary cost data and labor mapping reviews were conducted as required to ensure labor costs were recorded correctly.

Finding 3 Conclusion

The healthcare system had higher administrative staffing than the medical center group average of similarly sized facilities, especially with the three cost centers identified above, and some of which can be attributed to the increased need for community care staff. Differences in numbers of personnel should be a starting point for deeper examination but in themselves are not

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[41] VA Financial Policy, vol. XIII, chap. 2, July 2019, and chap. 3, December 2019. Budget object codes correspond to financial obligations according to the nature of the services or items purchased by the federal government.

[42] VA Financial Policy, vol. XIII, chap. 2, "Budget Object Class Codes," July 23, 2019.

[43] VA Financial Policy, vol. XIII, chap. 3, "Managerial Cost Accounting," December 10, 2019.

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

determinative of whether the facility had excess number of administrative staff. The labor costs for these personnel differences are in the millions of dollars and therefore warrant closer scrutiny to ensure the optimization of administrative positions.

Healthcare system leaders have taken actions to monitor administrative staffing efficiency by tracking workload using staffing tools and the resource management committee. The healthcare system's cost center assignment and labor mapping appeared adequate, and no errors were identified. For these reasons, the OIG did not make any related recommendations.

IV. Pharmacy Operations and Cost Avoidance Efforts

In FY 2020, prescription drug spending at the Eastern Oklahoma VA Health Care System exceeded $47 million, which represented almost 10 percent of the healthcare system's $479 million budget. Because pharmacy accounts for a substantial percentage of any given medical center's budget, it is important for medical center leaders to analyze spending and 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 team reviewed the following pharmacy areas:

- **OPES pharmacy expenditure data** are designed to allow VHA facilities to track cost performance and identify potential opportunities for improvement.

- **Cost avoidance initiatives** reflected in VA medical center action plans reduce the cost of pharmacy operations and increase efficiency. VA medical centers monitor progress on these initiatives and report on their contribution toward more efficient pharmacy operations.

- **Inventory turnover rate** (the number of times inventory is used during the year) is the primary measure to monitor the effectiveness of inventory management per VHA policy.[45] (Low inventory turnover rates can indicate inefficient use of financial resources.)

- **Noncontrolled drug line audits** are to be performed quarterly for specific drugs identified as potentially high risk for diversion and are required by VHA policy.[46]

- **The nonformulary request process** is mandatory when prescribing drugs not listed on the VA national formulary. VA providers are required to send nonformulary requests to the pharmacy service. Following this process helps VA improve patient safety, ensure appropriate drug use, and reduce the acquisition cost of drugs when feasible.

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[45] VHA Directive 1761(2), "Supply Chain Inventory Management," app. I, October 24, 2016, amended October 26, 2018. Inventory turnover is based on total dollar value purchased for the year divided by dollar value of items on the shelf.

[46] VHA Directive 1108.08 (1), *VHA Formulary Management Process*, November 2, 2016, amended August 29, 2019.

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

The OIG found the healthcare system could improve pharmacy efficiency and reduce the difference between observed drug costs and expected drug costs, increase inventory turnover closer to the VHA-recommended level, meet noncontrolled drug line audit requirements, and follow the nonformulary request process. Failure to properly manage pharmacy operations can lead to increased replenishment costs, overstocking, spoilage, and diversion of drugs, and decrease the funding available to meet other healthcare system and patient care needs.

OPES Pharmacy Expenditure Data

The OPES pharmacy expenditure model, which identifies variations in pharmacy costs among VHA facilities, showed that the healthcare system could narrow the gap between observed drug costs and expected drug costs. According to the model in FY 2020, the facility had about $47.7 million in drug costs which was approximately $8.7 million higher than the expected costs of about $39 million. Based on these numbers, the facility's observed-to-expected ratio was 1.222, which ranked it 138 out of 139 VHA facilities for pharmacy drug cost efficiency.

From FY 2018 through FY 2020, the healthcare system was averaging just under $7 million in annual potential cost savings, reporting almost $5.6 million in opportunity for FY 2019, and increasing to approximately $8.7 million for FY 2020. The repetitive increases in the observed-minus-expected costs show that the facility has persistent opportunities to reduce pharmacy costs. The review team attributed this to the healthcare system not having dedicated efforts such as action plans, benchmarking, workgroups, or actions taken to address the inefficiencies. Figure 4 shows the observed-to-expected drug costs for the healthcare system.
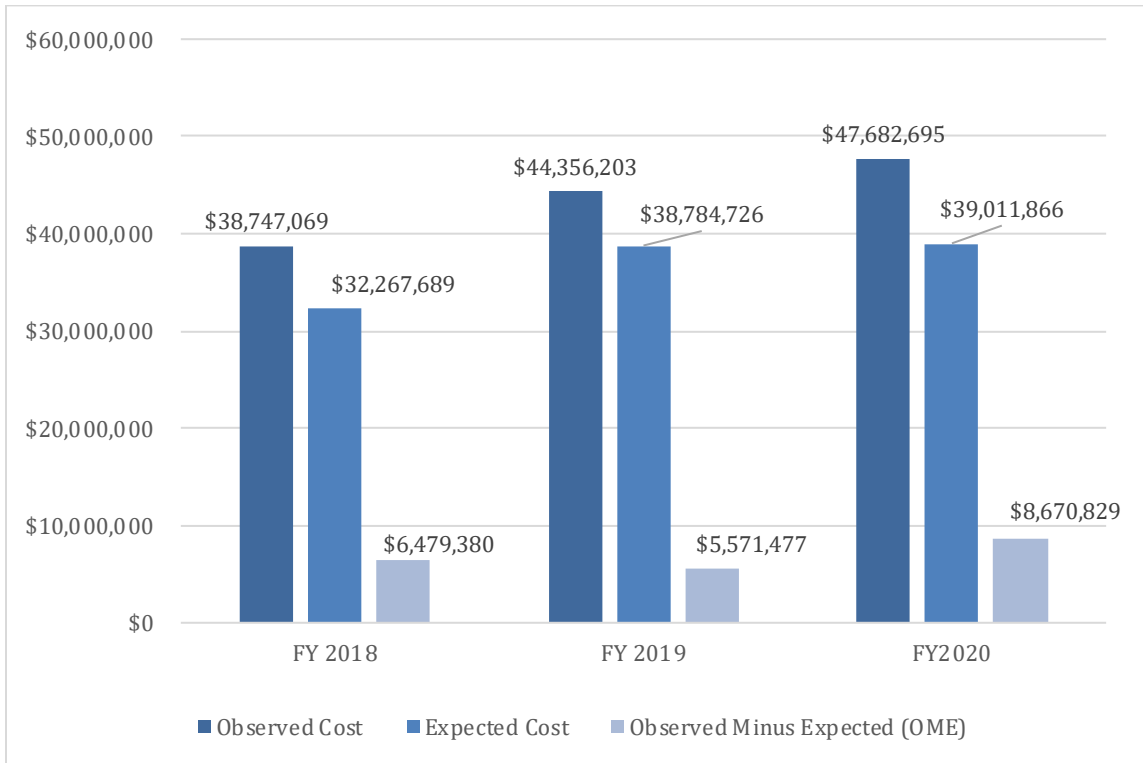
Figure 4. *Observed versus expected drug cost, FYs 2018–2020.*

Source: OPES pharmacy expenditure model.

Note: Numbers may not sum due to rounding.

Note: The OPES data models are based on the previous FY data (e.g., FY 2020 data model was based on FY 2019 data.)

Cost Avoidance Initiatives

Although the healthcare system did not have dedicated workgroups or action plans to address pharmacy efficiency, it did evaluate initiatives for cost-saving opportunities using the Lost Opportunity Cost Report provided by the national Pharmacy Benefits Management office to the VISN and the healthcare system. The review team analyzed the Lost Opportunity Cost Report for the healthcare system for FY 2020 and identified 15 savings opportunity initiatives with a total annual goal of just over $1 million. While the healthcare system achieved its FY 2020 lost opportunity cost goal, 74 percent of the achieved cost avoidance was a result of passive savings. These passive savings require little effort from the facility and are primarily achieved from new generic drugs entering the market. Actions associated with higher effort levels identified in the Lost Opportunity Cost Report include tasks such as changing the preferred package size, quantity, day supply, or strength of drugs. The highest effort levels could require changing the patient to a different drug, provider participation, or monitoring. The FY 2020 Lost Opportunity Cost Report identified that, although the healthcare system had savings in some of the higher

effort categories, it did not meet the savings goals in all identified initiatives, resulting in nearly $600,000 of lost opportunity costs.

Inventory Turnover Rate

VHA policy states that monitoring inventory turnover is the primary measure of the effectiveness of inventory management.[47] Increasing the inventory turnover rate decreases inventory carrying cost, which is the cost associated with holding inventory in storage. VHA policy also mandates the use of prime vendor inventory management reports to manage all VA medical facility pharmacy inventories.[48]

In FY 2020, the healthcare system reported an inventory turnover of 5.6 compared to the VHA average of 10.6 and VHA's recommended level of 12, as established by the national Pharmacy Benefits Management program office. Low inventory turnover could indicate the inefficient use of financial resources and the inability to properly forecast needed inventories of pharmacy drugs to meet patient care needs. Additionally, the OIG determined that the healthcare system did not run required monthly inventory management reports from the prime vendor software package, use data for inventory management, or adjust stock levels in accordance with VHA policy. According to pharmacy personnel, inventories were being "managed by ear" instead of utilizing demand forecasting as directed by policy.[49] Demand forecasting, in which weighting factors are applied to past purchases, must be utilized in the calculation of both the reorder points and reorder quantities for more accurate inventory management.

According to the acting pharmacy chief, the healthcare system was below the recommended inventory turnover level because the previous associate pharmacy chief was responsible for many of the inventory management practices, and adequate training, oversight, and inventory management practices were not established prior to the associate pharmacy chief's retirement. In addition, the acting pharmacy chief was not familiar with inventory management practices and VHA policy requirements prior to taking the position in June 2020.

Noncontrolled Drug Line Audits

VHA policy states that regular facility-based inventory audits are to be performed for specific drugs identified as potentially high risk for diversion. A manual count of each drug item selected must be completed and compared to reports and other tools selected by local pharmacy management. The variance between the observed and predicted amount on hand for the reporting

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[47] VHA Directive 1761(2).

[48] VHA Directive 1761(2), app. I.

[49] VHA Directive 1108.08(1).

period must be calculated. Variances greater than 5 percent require the healthcare system to perform an in-depth review and analysis.[50]

In reviewing the facility quarterly noncontrolled drug line audits for FY 2020, the team determined that these audits did not meet the requirements of VHA policy. When the review team analyzed FY 2020 calculations, it found that seven of the 20 reported facility calculations were incorrect and that the reviews performed by the facility pharmacist were inadequate. When reviewing the results of the audits, the team found vague language in the comments, such as "may be" and "may have been," when describing the reported cause of a drug audit discrepancy.

In addition, VHA policy requires the results of these audits to be reported to facility management through the quality assurance process on a quarterly basis, and quarterly and annual summaries to be reported to the VISN Pharmacy Executive Committee indicating the results of the reviews and any follow-up actions taken. Interviews with pharmacy staff identified these requirements were not being followed and pharmacy leaders and staff were not aware of this noncompliance with VA policy. Failure to fully complete these regular inventory audits can lead to increased risk of drug diversion, inaccurate drug inventory data, and the potential for unnecessary spending within the pharmacy program.

Nonformulary Request Process

A nonformulary request is a request for a drug that is not listed on the VA national formulary.[51] Providers must submit such requests to the facility's pharmacy for approval. VHA policy states that nonformulary drugs are only to be approved under certain circumstances and that each VA medical facility must have a request process.[52]

The healthcare system did not follow the nonformulary request process when buying drugs not listed on the VA national formulary. The team determined that "quick orders"—orders that circumvent the nonformulary approval process—were set up for specialty care services that lead healthcare system staff to purchase high-cost drugs off the VA national formulary. Quick orders used special prompts that sped up the ordering process by predefining many of the answers that a user would normally have to type in while placing orders. However, the quick order process was set up in a way that did not require the provider to enter a nonformulary request. For example, one service was approved to spend $250 on an inhaler not on the formulary when a $25 substitute inhaler was available on the formulary. The pharmacy leaders and staff were not aware that this was not allowed and against VA policy—until August 2020 when this process was

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[50] VHA Directive 1108.08(1).

[51] VA National Formulary is a listing of products (e.g., drugs and drug-related supplies) that must be available for prescription at all medical facilities.

[52] VHA Directive 1108.08(1).

stopped. Failure to follow the nonformulary approval process can lead to unnecessary spending within the pharmacy program.

Finding 4 Conclusion

The healthcare system needs to improve pharmacy efficiency by taking a more proactive approach in reducing the gap between the facility's observed drug costs and expected drug costs, increasing inventory turnover, and using the prime vendor inventory management reports. An efficient healthcare system anticipates how much drugs will cost and when inventory needs to be restocked. Doing so helps ensure that the system makes the best use of appropriated funds and has inventory when needed.

Recommendations 6–9

The OIG made the following recommendations to the director of the Eastern Oklahoma VA Health Care System:

6. Develop formalized processes for achieving identified efficiency targets and use available pharmacy data to make business decisions.

7. Develop and implement a plan to increase inventory turnover closer to the VHA-recommended level.

8. Develop and implement a plan to complete facility-based inventory audits of noncontrolled drug line items in compliance with VHA policy.

9. Establish measures to improve compliance with the nonformulary request process.

Management Comments

The director of the Eastern Oklahoma VA Health Care System concurred with recommendations 6 through 9. To address recommendation 6, the director reported that the chief of pharmacy contacted OPES and requested a review of the healthcare system's data to verify efficiency data and offer opportunities for improvement. The chief of pharmacy met with chief of primary care and both associate chiefs of primary care to improve prescribing practices by providing education to new providers and reeducate all current providers. For recommendation 7, the director reported that in January 2021 the healthcare system conducted the annual inventory, which reflected an increased inventory turnover rate of 16. The next inventory is scheduled for January 2022. To address recommendation 8, the director reported that all noncontrolled audits were completed, as required by VHA policy, and recent audits identified less than a 5 percent variance. For recommendation 9, the director reported all nonformulary "Quick Orders" were disabled and nonformulary drug requests have since been facilitated by the requesting provider entering a nonformulary consult, which is then reviewed by pharmacy staff for appropriateness.

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

Facility Profile

The table below provides general background information for this 1c high-complexity healthcare system reporting to VISN 19.

Table A.1. Facility Profile for Eastern Oklahoma VA Health Care System (October 1, 2017, through September 30, 2020)

Profile element	Facility data FY 2018	Facility data FY 2019	Facility data FY 2020
Total medical care budget in dollars	$362,716,022	$394,476,762	$479,449,801
Number of: Unique patients	39,617	40,031	40,405
Outpatient visits	473,176	518,149	472,027
Total medical care FTE*	1,428	1,521	1,577
Type and number of operating beds: Hospital	91	63	63
Average daily census: Hospital	54	48	35

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

Appendix B: Scope and Methodology

The OIG conducted its review of the Eastern Oklahoma VA Health Care System from February 2021 to September 2021, including a virtual site visit during the week of February 1, 2021. The review team evaluated financial efficiency practices for FY 2020 related to open obligations, purchase card transactions, and administrative FTE labor costs. The team also analyzed the pharmacy costs using the FY 2021 OPES pharmacy model; however, the FY 2021 data model was based on FY 2020 data.

To conduct the review, the team

- interviewed facility leaders and staff,

- identified and reviewed applicable laws, regulations, VA policies, operating procedures, and guidelines related to using financial efficiency practices for open obligations, overseeing purchase card transactions, and addressing inefficiencies in administrative FTE and pharmacy costs,

- judgmentally sampled 22 total open obligation transactions to determine whether the transactions were reviewed to see if they were still valid and needed to remain open in accordance with VA financial policy, and

- judgmentally sampled 33 purchase card transactions to determine if there was proper oversight and governance of the purchase card program, as well as to assess the risk for illegal, improper, or erroneous purchases.

Data Reliability

The review team used computer-processed data obtained from the US Bank computer data warehouse files and the OPES Efficiency Opportunity Grid. To test for reliability, the team determined whether any data were missing from key fields, included any calculation errors, or were outside the timeframe 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 team compared data to supporting documentation purchase order numbers, payment dates, payee names, payment amounts, vendor ID number, and check number 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 used included reports from VA's Financial Management System to determine open obligation amounts. The team found that summary-level data were sufficiently reliable for reporting on the facility's open obligations.

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

Open Obligations

The review team evaluated a judgmental sample of open obligation transactions from April 2020 through September 2020 to determine if (1) the Eastern Oklahoma VA Health Care System performed monthly reviews and reconciliations of the sampled obligations with no activity for more than 90 days to ensure the obligations were valid and should remain open, and (2) the facility had evidence to support end-date modifications to the period of performance.

Population

During April 2020, the facility had 421 open obligations, totaling approximately $78.3 million. Ninety of those open obligations, totaling approximately $55 million, had no activity for more than 90 days. There were 12 obligations with modified end dates in the population.

Sampling Design

The review team selected two judgmental samples:

- **Inactive Obligations.** The team identified the 10 obligations with the largest undelivered balance with no activity for more than 90 days from the April 2020 Financial Management System F850 report. This report lists each open obligation and its remaining balance.

- **End-Date Modifications.** The team identified 12 obligations with modified end dates to the period of performance for all open obligations from April 2020 through September 2020 Financial Management System F850 reports and reviewed all of them.

The samples included 22 total open obligations: 10 with no activity for more than 90 days, totaling approximately $51.4 million, and 12 with end date modifications, totaling approximately $1.4 million.

To review the sampled obligations, the team requested supporting documentation for each of the 22 sampled transactions, including monthly reviews and reconciliations, financial system screen prints and reports, and emails related to the obligations.

Purchase Cards

The review team evaluated a judgmental sample of FY 2020 purchase card transactions to determine if (1) the Eastern Oklahoma VA Health Care System's reviewed purchase card payments were adequately approved and supported by documentation as well as (2) the reviewed transactions complied with processes to prevent split purchases, transactions exceeding the

cardholder's authorized single purchase limit, and to ensure goods or services were procured using proper strategic sourcing procedures.

Population

During FY 2020, purchase cardholders at the facility made about 33,200 purchase card transactions totaling approximately $23 million. There was a total of 51 bundles of transactions that could be potential split transactions; this included 150 individual transactions. The other potential high-risk transactions were selected from the remaining 33,200 transactions.

Sampling Design

The review team selected two judgmental samples:

- **Potential split purchases.** The team identified 24 transactions with the same purchase date, purchase card number, and merchant, and an aggregate sum greater than the cardholder's authorized single limit.

- **Other potential high-risk purchase areas.** The team identified nine transactions that involved an area of potential risk, such as merchants not commonly associated with a medical facility, purchases that included sales tax, or timing of purchases.

The sample included 33 total individual transactions, 24 potential split purchase transactions totaling approximately $167,000, and nine high-risk transactions totaling approximately $8,000 in spending.

To review the sampled transactions, the team requested supporting documentation for each of the 33 sampled transactions, VA Form 0242s, completion certificates for purchase card training for the sampled cardholders, and quarterly purchase card audits.

Projections and Margins of Error

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

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

Recommendation	Explanation of Benefits	Better Use of Funds	Questioned Costs[53]
5	Ensure cardholders comply with record retention requirements as stated in VA's Financial Policy, vol. XVI, "Charge Card Program."		$95,000
	Total		**$95,000**

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[53] As stated earlier, per 2 C.F.R. § 200.84, the term *questioned cost* includes a cost that is questioned by the auditor because of an audit finding where the costs, at the time of the audit, are not supported by adequate documentation.

Appendix E: Management Comments, Director of Contracting, Network Contracting Office 19

Department of Veterans Affairs Memorandum

Date: November 12, 2021

From: VISN 19 Contracting Office

Subj: Draft Report, Financial Efficiency Review of the Eastern Oklahoma VA Health Care System (2021-00942-AE-0034)

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

1. I have read and concur with the findings and the response to Recommendation 2, in the OIG Report entitled, Draft Report, Financial Efficiency Review of the Eastern Oklahoma VA Health Care System (2021-00942-AE-0034).

(Original signed by)

Albert Williams

Director of Contracting

Network Contracting Office 19

Appendix F: Management Comments, Director, Eastern Oklahoma VA Health Care System

Department of Veterans Affairs Memorandum

Date: November 12, 2021

From: Director, Eastern Oklahoma VA Health Care System (623/00)

Subj: Draft Report, Financial Efficiency Review of the Eastern Oklahoma VA Health Care System (2021-00942-AE-0034)

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

1. I have read and concur with the findings and recommendations in the OIG Report entitled, *Draft Report, Financial Efficiency Review of the Eastern Oklahoma VA Health Care System (2021-00942-AE-0034).*

2. My response to each report recommendation can be found in the attached document.

3. If there are any questions regarding the responses to the recommendations or any additional information is required, please contact the Chief of Quality, Safety and Value.

(Original signed by)

Mark E. Morgan, MHA FACHE

Attachments (1)

Attachment

Recommendation 1

Ensure finance office staff are made aware of policy requirements and reviews are conducted on all open obligations as required by VA Financial Policies and Procedures, vol. 2, chap. 5, "Obligations Policy" January 2018.

Healthcare system concurred.

Target date for completion: June 30, 2022

Healthcare system response: All staff responsible for open obligations oversite will demonstrate knowledge of VHA VA Financial Policies and Procedures, vol 2, chap 5, "Obligations Policy", January 2018, updated in August 2018, by reading the policy and attesting by signature they have read and understand said policy. The Chief of Fiscal Services will perform monthly audits of open obligations to ensure validity, accurate end dates. And those which exceed 90 days have been validated to ensure obligations are still accurate and have legitimate length of inactivity. The audit will continue until two consecutive quarters have a compliance rate of at least 90%. The denominator will be the number of open obligations and the numerator will be the number open obligations with activity at least every 90 days.

Recommendation 2 – VISN 19

Develop checks on the successful completion of quarterly audits of the purchase card program as required by the Veterans Health Administration's standard operating procedure, "Internal Audits— Purchase Cards and Convenience Checks."

Healthcare system concurred.

Target date for completion: July 31, 2021

Healthcare system response: The quarterly audit memo dates for FY20 were corrected and it was verified that audits were completed in accordance with VHA Audit SOP. The SOP was provided to card holders and approving officials as well as the facility director. The dates are now being reflected correctly to ensure timely completion and reporting of audits. Request closure.

Recommendation 3

Establish controls to confirm approving officials and purchase cardholders review their purchases and make sure contracting is used when it is in the best interest of the government.

Healthcare system concurred.

Target date for completion: June 30, 2022

Healthcare system response: Service Chiefs and local leadership will increase utilization of local AUS (Acquisition Utilization Specialist) to assist in timely annual procurement planning and guidance on the proper acquisition vehicles (contracts or Government Purchase Card) Approving Officials have the responsibility to approve all purchase card transactions prior to purchase. Approving Official must increase their awareness of reoccurring requirements and assess the needs going forward. Stakeholders will increase their use of various resources for guidance on proper use and source selection, to include NCO19 purchase card program coordinators, local AUS and contracting points of contacts.

Recommendation 4

Ensure cardholders comply with record retention requirements as stated in VA's Financial Policy, vol. XVI, "Charge Card Program."

Healthcare system concurred.

Target date for completion: November 19, 2021

Healthcare system response: All Eastern Oklahoma Veterans Administration Health Care System employees with Government Purchase Cards complete annual TMS training for use of said card. All employees with Government Purchase Cards have read VA Financial Policy, vol. XVI, chap. 1A, "Administrative Actions for Government Purchase Cards," June 14, 2018 and attested their understanding by signing of referenced policy.

Recommendation 5

Develop measures to confirm completed VA Form 0242 submissions are accurate and

Healthcare system concurred.

Target date for completion: October 31, 2021

Healthcare system response: 0242's are updated as soon as the stakeholders notify the purchase card program of changes to single limits, changes in card holders names, Administrative Officers (AO) and Associate Administrative Officer's (AAO). In response to the findings, 0242s dated prior to the purchase in question were provided which is in line with other audit methods, subsequently update 0242's was provided to the auditor reflecting the changes in AO's and AAO's contained in the Charge Card Portal (CCP). Regarding the single purchase limits discrepancies on the original submitted 0242's the below attachments outlined allowances regarding 10K and Covid 20K limits.   A quarterly review of 0242's will continue to be conducted. All limits have been updated in the new Charge Card Portal (CCP). Request Closure

Recommendation 6

Develop formalized processes for achieving identified efficiency targets and use available pharmacy data to make business decisions.

Healthcare system concurred.

Target date for completion: June 30, 2022

Healthcare system response Chief of Pharmacy contacted OPES October 5, 2021 and requested review Eastern Oklahoma Veterans Administration Health Care System data and verify efficiency data and offer opportunities for improvement. OPES projected December 1, 2021 as estimated date in which Eastern Oklahoma Veterans Administration Health Care System would receive their final report. September 28, 2021, Chief of Pharmacy met with Chief of Primary Care, and both Associate Chiefs of Primary care to improve prescribing practices by providing VIONE education to new providers and reeducate all current providers.

Recommendation 7

Develop and implement a plan to increase inventory turnover closer to the VHA-recommended level.

Healthcare system concurred.

Target date for completion: January 31, 2022

Healthcare system response: In FY 2020, the healthcare system reported an inventory turn of 5.6 compared to the VHA average of 10.6 and VHA's recommended level of 12, as established by the national Pharmacy Benefits Management program office. In January 2021, Eastern Oklahoma Veterans Administration Health Care System conducted the annual inventory and reflected an inventory turn rate of 16. The next inventory is scheduled for January 2022.

Recommendation 8

Develop and implement a plan to complete facility-based inventory audits of noncontrolled drug line items in compliance with VHA policy.

Healthcare system concurred.

Target date for completion: January 31, 2022

Healthcare system response: All noncontrolled audits were completed as required by VHA policy.

On January 8, 2021 All Eastern Oklahoma Veterans Administration Health Care System exceeded five percent due to a noncontrolled drug being expired and returned via reverse distributer. Subsequent noncontrolled audits demonstrate less than a five percent variance with April 9, 2021 reflecting a 0.1 percent variance, July 8, 2021 0.6 percent variance, October 8, 2021 with a variance of 0.2 percent.

Recommendation 9

Establish measures to improve compliance with the nonformulary request process.

Healthcare system concurred.

Target date for completion: January 31, 2022

Healthcare system response: All nonformulary "Quick Orders" were disabled on September 1, 2020. All nonformulary drug requests have since been facilitated by the requesting provider entering a nonformulary consult which is then reviewed by pharmacy staff for appropriateness. An appeals process was voted on during the July 28, 2021 Pharmacy and Therapeutics Committee meeting, approved, and implemented for nonformulary denials.

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

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