



DEPARTMENT OF VETERANS AFFAIRS  
**OFFICE OF INSPECTOR GENERAL**

*Office of Audits and Evaluations*

VETERANS HEALTH ADMINISTRATION

Financial Efficiency Review of  
the VA Black Hills Health  
Care System in South  
Dakota



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## Executive Summary

The VA Office of Inspector General (OIG) conducted this review to assess the stewardship and oversight of funds by the VA Black Hills Health Care System in South Dakota and to identify potential cost efficiencies in carrying out medical center functions.<sup>1</sup> 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 four financial activities and administrative processes to determine whether the healthcare system had appropriate controls and oversight in place:

- I. **Open obligations oversight.** An obligation is a legally binding commitment of appropriated funds for goods or services. Open obligations include those obligations that are not considered closed or complete and have a balance associated with them, whether undelivered or unpaid. Open obligations should be reviewed by the healthcare system finance office to ensure that beginning and ending dates are accurate; open balances are accurate and agree with source documents, such as contracts and purchase orders, receiving reports, invoices, and payments; and obligations beyond 90 days of the period of performance end date or without activity in the past 90 days are valid and should remain open. The review team evaluated whether the healthcare system performed monthly reviews and reconciliations of sampled obligations.
- II. **Purchase card use.** The VA Government Purchase Card Program was established to reduce administrative costs related to the acquisition of goods and services. When used properly, purchase cards can help facilities simplify acquisition procedures and efficiently obtain goods and services directly from vendors. The team examined whether the healthcare system's purchase card program ensured compliance with policies and procedures that reduce the risk of error, fraud, waste, or abuse. The review team evaluated whether the healthcare system (1) adhered to strategic sourcing guidelines and considered establishing contracts when making purchases and (2) properly documented sampled transactions.<sup>2</sup> 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.

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<sup>1</sup> The healthcare system consists of two VA medical centers in Fort Meade and in Hot Springs, South Dakota. For more information about the healthcare system budget, capacity, and daily census, see appendix A.

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

- III. **Inventory and supply management.** Supply chain management is the integration and alignment of people, processes, and systems across the supply chain to manage all product/service planning, sourcing, purchasing, delivering, receiving, and disposal activities. Veterans Health Administration (VHA) policy requires medical facilities to establish, operate, and maintain a supply chain management program that is effective, cost-efficient, transparent, and responsive to customer requirements and to continually identify ways to ensure high-quality veteran care. The team evaluated whether the healthcare system managed its supply chain operations effectively using the days-of-stock-on-hand performance metric.
- IV. **Pharmacy operations.** 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.<sup>3</sup> 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 obtained and used the facility rankings from the stochastic frontier analysis model in the efficiency opportunity grid to assist in selecting facilities for the financial efficiency reviews. VHA developed the efficiency opportunity grid, a collection of 12 statistical models, to give facility leaders insight into areas of opportunity for improving efficiency.<sup>4</sup>

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

## What the Review Found

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

- I. **Open obligations oversight.** As of August 2021, the healthcare system had 60 inactive obligations totaling almost \$14.2 million. Of the 60 obligations identified, 26 obligations totaling over \$12.9 million had no activity for 181 days or more. The review team performed data analysis and selected 20 inactive obligations as of August 2021 that had been inactive for more than 90 days, totaling almost \$13.9 million. The team examined whether the healthcare system performed required reviews to assess the validity and necessity of the remaining funds associated with each obligation. The team was not able to verify that a review was completed on 18 of these 20 obligations. Additionally, five of

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<sup>3</sup> The inventory turnover rate is the number of times inventory is replaced during the year. Low inventory turnover rates indicate inefficient use of financial resources.

<sup>4</sup> See appendix B for a full description of the review's scope and methodology and appendix C for details on the review's sampling.

the 20 obligations had residual funds totaling almost \$34,300 that should have been deobligated.

According to finance office personnel, this occurred because workload was not realigned after a decrease in staff, reviewing inactivity was not a priority, and the amount of work required to review inactivity each month would be too much for the remaining staff. The priority was to review and improve financial indicators, not to ensure all aspects of financial policy were addressed.<sup>5</sup> However, failure to properly manage open obligations increases the risk of also failing to spend appropriations within the associated fiscal year and repurpose funds to benefit veterans.<sup>6</sup>

The review team selected and evaluated seven open obligations with 11 modified end dates in VA's Financial Management System (FMS) to determine whether the modifications were valid and supported. The team found one erroneous modification, which has since been corrected. If the end date has passed and the obligation is no longer valid, those funds could be deobligated and used elsewhere.

The review team selected and evaluated 28 additional open obligations to determine if end dates and order amounts were accurate and reconciled between FMS and the Integrated Funds Distribution, Control Point Activity, Accounting and Procurement system (IFCAP).<sup>7</sup> Nine of these sampled obligations contained end-date discrepancies that had existed for three months or more, with variances between systems ranging from 41 to 913 days. The team determined that seven of the nine obligation end-date discrepancies were corrected. However, one discrepancy was the result of a contract modification to extend the end date that had not been entered into IFCAP for almost one year, and another had an invalid accrual balance of about \$61,286 after the end date had passed. The team determined FMS and IFCAP reflected end-date discrepancies for two of the nine obligations reviewed. The healthcare facility indicated both entry errors were uncorrectable due to a system limitation that does not allow for end-date changes in IFCAP for Form 1358 obligations.<sup>8</sup> The remaining 19 sampled obligations contained order amount discrepancies that had existed for three months or more and totaled about \$1.5 million. The team also determined FMS and IFCAP reflected continued discrepancies in order amounts for 15 of 19 obligations reviewed, with an unreconciled

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<sup>5</sup> Financial indicators are a means of evaluating performance and promoting improvements in financial management in VHA. Each indicator assesses VHA compliance with policy requirements and provides information on how well facilities are executing allocated funds and using resources. Financial indicators applicable to open obligations are "Aging of Orders—Count" and "Aging of Orders—Dollar Value."

<sup>6</sup> Appendix D presents estimated monetary benefits associated with these obligations.

<sup>7</sup> IFCAP handles the processing of certified invoices and electronic transmission of receiving documents to FMS. In addition, IFCAP automatically transfers obligation information back to the control point balance.

<sup>8</sup> VA Financial Policy, vol. 2, chap. 6, app. A, "VA Form 1358 Approved Uses," October 2020. VA offices may use VA Form 1358 as an obligation control document only for certain limited uses.

amount totaling almost \$1.9 million.<sup>9</sup> Nine of the 15 obligations had order amount discrepancies due to accounting entry errors or accrued funds that were no longer needed that resulted in approximately \$78,900 that could have been deobligated in FMS. These discrepancies occurred because the finance office does not reconcile order amounts between systems, as required. The supervisory accountant confirmed the finance office does not use VA's FMS-to-IFCAP reconciliation report.<sup>10</sup> Had the finance office staff monitored discrepancies in the end dates and order amounts, they could have identified and corrected the accrual and entry errors in a timely manner, therefore freeing funds to be used for other purposes to benefit veterans.

- II. **Purchase card use.** The review team evaluated a judgmental sample of 36 purchase card transactions totaling approximately \$143,000 from March 1, 2020, through August 31, 2021.<sup>11</sup> The review team assessed whether the sampled transactions were processed in compliance with VA policy including prior approvals, prompt reconciliations, and segregation of duties throughout the transaction process.<sup>12</sup> The team determined that for eight of the 36 sampled transactions (22 percent), totaling almost \$42,500, the facility did not comply with VA policy. Specifically, the purchase card transactions were not reconciled and approved by the 15th day of the month after the closing of the previous month's billing cycle. The team further assessed potential split purchases and whether cardholders adhered to strategic sourcing guidelines.<sup>13</sup> Strategic sourcing ensures VA is obtaining the most competitive prices for goods and services. The team did not find any split purchases in the review sample, but contracts could have been considered for 19 of the 36 sampled transactions (53 percent), totaling almost \$111,000. These issues occurred because cardholders and approving officials did not work together to ensure compliance throughout the transaction process and that roles and responsibilities were carried out in accordance with VA policy.

The facility's purchase card coordinator conducted quarterly purchase card internal audits during fiscal year (FY) 2021, and the quarterly purchase card certification reports were

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<sup>9</sup> The difference between the sample population value of \$1.5 million for 19 obligations and the reviewed value of \$1.9 million for 15 sampled obligations is caused by a timing difference between the date the review team selected the sample and when the facility provided evidence for review.

<sup>10</sup> The monthly report assists facilities in reconciling FMS obligation data with the source data from IFCAP in accordance with financial policies.

<sup>11</sup> A judgmental sample is a nonstatistical sample selected based on auditors' opinion, experience, and knowledge.

<sup>12</sup> VA Financial Policy, "Government Purchase Card for Micro-Purchases." VA requires that the duties of the cardholder, approving official, requesting official, and receiving official be segregated. An agency/organization program coordinator cannot be a cardholder or an approving official. No one person may order, receive, certify funds, and approve their own card purchases.

<sup>13</sup> VA Financial Policy, "Government Purchase Card for Micro-Purchases." Purchases that exceed the cardholder's single purchase threshold cannot be made on purchase cards. Split purchases occur when a cardholder circumvents this requirement by dividing a single purchase or need into two or more smaller purchases.

completed on time and routed through the chain of command. Quarterly purchase card audits are intended to evaluate and improve the effectiveness of internal controls and compliance with regulations and policies.

The healthcare system provided the requested supporting documentation for all 36 sampled transactions. However, five of 17 cardholders responsible for the 36 transactions had a VA Form 0242 with an inaccurate approving official or a missing alternate approving official. An approved VA Form 0242 is used to delegate authority to an individual to use the purchase card to procure and pay for goods and services. Form 0242 also establishes purchase limits and certifies that cardholders and approving officials understand the policies and regulations governing the purchase card program.

**III. Inventory and supply management.** The healthcare system provided oversight to maintain stock levels for expendable supply items. However, the healthcare system could improve the effectiveness and efficiency of inventory management by ensuring stock levels and inventory values are recorded correctly in the Generic Inventory Package.<sup>14</sup>

To avoid overstocking or understocking, VHA requires responsible staff to ensure correct reorder points and inventory levels are maintained.<sup>15</sup> Expendable supplies purchased through the Medical Surgical Prime Vendor-Next Generation (MSPV-NG) program should have 15 days or less of stock on hand, whereas non-MSPV-NG items should have 30 days or less of stock on hand.<sup>16</sup> From March 1 to August 31, 2021, the healthcare system had an average of 27.1 days of stock for MSPV-NG items, and an average of 27.5 days of stock for non-MSPV-NG items.<sup>17</sup> Because of the COVID-19 pandemic, the healthcare system received a waiver to suspend days-of-stock-on-hand performance measures from March 3 until June 30, 2021.

To determine if the healthcare system had excess inventory, the review team evaluated a judgmental sample of 20 supply items with the highest dollar value. Of the 20 sampled items, the team found that stock on hand for 11 were above the amount allowed, and inventory entries for eight had conversion factor errors, which led to inaccurate quantities and dollar amounts for supply items in the Generic Inventory Package. Specifically, conversion factor errors caused the inventory value to be overstated by almost \$42,700 for the eight items. This overstatement occurred because VHA removed a requirement to monitor the conversion factor report on a quarterly basis, and staff

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<sup>14</sup> The Generic Inventory Package is the software system authorized to manage the receipt, distribution, and maintenance of expendable supplies used throughout VA.

<sup>15</sup> The reorder point represents the level at which the item is to be replenished.

<sup>16</sup> The MSPV program is national and provides a customized distribution system to meet or exceed facility requirements through a just-in-time distribution catalog ordering process.

<sup>17</sup> Data are obtained from the Supply Chain Common Operating Picture (SCCOP) intranet, an internal VA website that publishes supply chain management benchmarks and reports.

therefore did not review it as frequently as they did previously. Because these errors caused unreliable values of supplies in the Generic Inventory Package, the healthcare system risks being unable to effectively plan and budget for the purchase of supplies to operate and meet patient care needs.

- IV. **Pharmacy operations.** 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 avoiding end-of-year purchases.

For FY 2018 through FY 2020, the healthcare system exceeded expected costs by an average of \$2 million annually, reporting almost \$1.3 million over expected costs for FY 2018 and almost \$2.6 million over expected costs for FY 2020. Pharmacy leaders stated that they were not as familiar with the data as they would like to be. At the time of this review, key pharmacy staff did not have access to all the Office of Productivity, Efficiency and Staffing data used to formulate the models.

In addition, the healthcare system's turnover rate for pharmacy inventory could be improved. The inventory turnover rate is the number of times inventory is replaced 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 and an inability to properly forecast needed drug inventories.

In August 2021, the healthcare system reported an inventory turnover rate of 5.70 times for the Fort Meade VA Medical Center and 4.64 times for the Hot Springs VA Medical Center, compared with the VHA's recommended level of 12 times, as established by the national program office, Pharmacy Benefits Management. According to pharmacy personnel, outpatient pharmacy drug inventories were managed by using a "want list" instead of by using calculated reorder points and reorder quantities determined via demand forecasting for more accurate inventory management as required by policy.<sup>18</sup> Failure to use demand forecasting could result in inaccurate reorder points and insufficient inventory levels to meet patient needs. In addition, pharmacy personnel were not implementing inventory management practices, such as placing bar codes on stock at all locations, using handheld barcode readers, and using the ABC inventory analysis methods, as required by VHA policy.<sup>19</sup>

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<sup>18</sup> VHA Directive 1108.08(1), *VHA Formulary Management Process*, November 2, 2016, amended August 29, 2019.

<sup>19</sup> VHA Directive 1108.08(1). The ABC classification method states that inventory point items with approximately 70 percent of the inventory dollars and 10 percent of the products are classified as "A." Items with approximately 20 percent of the inventory dollars and 20 percent of products are classified as "B." Lastly, items representing approximately 10 percent of the inventory dollars and 70 percent of the products are classified as "C."



## What the OIG Recommended

The OIG made seven recommendations for improvement to the healthcare system director. The number of recommendations should not be used, however, as a gauge of the system's overall financial health. The intent is for system leaders to use these 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 ensuring staff conduct reviews on all open obligations as required.

To strengthen oversight of purchase card transactions, the OIG recommended establishing procedures to ensure cardholders comply with processing requirements, establishing 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, and developing measures to confirm that completed VA Form 0242 submissions are accurate and updated for all cardholders.

Related to inventory and supply management, the OIG recommended ensuring the supply chain management service implements a plan to monitor for and correct unit conversion factor errors consistently and promptly to improve data reliability in the Generic Inventory Package.

The OIG made two recommendations regarding pharmacy operations: developing and implementing a plan to increase inventory turnover closer to the VHA-recommended level and establishing measures to improve compliance with the VHA directive to avoid end-of-year pharmaceutical purchases.

## VA Comments and OIG Response

The director of the VA Black Hills Health Care System concurred with all recommendations and provided responsive corrective action plans. The OIG considers all recommendations open. The OIG will monitor the implementation of all planned actions and close the recommendations when the VA Black Hills Health Care System provides sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified. Appendix E includes the director's comments.



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## Abbreviations

FMS	Financial Management System
FY	fiscal year
IFCAP	Integrated Funds Distribution, Control Point Activity, Accounting and Procurement system
MSPV-NG	Medical Surgical Prime Vendor-Next Generation
OIG	Office of Inspector General
OPES	Office of Productivity, Efficiency and Staffing
SCCOP	Supply Chain Common Operating Picture
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



## Introduction

The VA Office of Inspector General (OIG) conducts financial efficiency reviews to assess stewardship and oversight of funds at VA healthcare systems and to identify opportunities to achieve cost efficiencies. Review teams identify and examine financial activities that are under the healthcare system's control and can be compared across VA healthcare systems similar in size and complexity to promote best practices.<sup>20</sup>

This review focused on the VA Black Hills Health Care System in South Dakota. The OIG assessed the following four financial activities and administrative processes to determine whether appropriate controls and oversight were in place from March through August 2021:

- I. **Open obligations oversight.** An obligation is a legally binding commitment of appropriated funds for goods or services. Open obligations include those obligations that are not considered closed or complete and have a balance associated with them, whether undelivered or unpaid. Open obligations should be reviewed by the healthcare system finance office to ensure that beginning and ending dates are accurate; open balances are accurate and agree with source documents, such as contracts and purchase orders, receiving reports, invoices, and payments; and obligations beyond 90 days of the period of performance end date or without activity in the past 90 days are valid and should remain open.
- II. **Purchase card usage.** The team examined whether the healthcare system's purchase card program ensured compliance with policies and procedures that reduce the risk of error, fraud, waste, and abuse. The review also focused on the use of contracts for repetitively ordered goods or services to garner greater savings for VA.
- III. **Inventory and supply management.** The review team evaluated whether the healthcare system provided oversight to maintain stock levels, complied with policies and procedures, and ensured inventory quantities and values were recorded correctly for expendable items. The review also focused on the days-of-stock-on-hand performance metric, a nationally set level of inventory for expendable Medical Surgical Prime Vendor-Next Generation (MSPV-NG) program items and non-MSPV-NG items that facilitates efficient purchasing and use of supplies.
- IV. **Pharmacy operations.** The review team assessed whether the healthcare system complied with applicable policies and used cost and performance data to track progress

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<sup>20</sup> The Veterans Health Administration (VHA) uses a facility complexity model that classifies its facilities at levels 1a, 1b, 1c, 2, or 3, with level 1a being the most complex and level 3 being the least complex. The VA Black Hills Health Care System was rated as a level 3 (low complexity) facility.

toward goals developed by the national Pharmacy Benefits Management office, improve pharmacy program operations, and identify and correct problems.

To assess these areas, the review team performed a virtual site visit at the VA Black Hills Health Care System during the week of November 15, 2021; interviewed healthcare system leaders and staff; and reviewed data, supporting documents, and processes related to the healthcare system's financial efficiency. For more information about the healthcare system, see appendix A. For more information about the review's scope and methodology, see appendixes B and C.

## **VA Black Hills Health Care System**

The VA Black Hills Health Care System provides primary and secondary medical and surgical care, along with residential rehabilitation treatment program services and extended nursing home care and psychiatric inpatient services for veterans residing in South Dakota and portions of Nebraska, North Dakota, Wyoming, and Montana. Care is delivered through the Fort Meade and Hot Springs VA medical centers, as well as through community-based outpatient clinics in Rapid City, South Dakota; McLaughlin, South Dakota; Mission, South Dakota; Pierre, South Dakota; Pine Ridge, South Dakota; Winner, South Dakota; Gordon, Nebraska; Scottsbluff, Nebraska; and Newcastle, Wyoming. In fiscal year (FY) 2021, the VA Black Hills Health Care System operated 34 hospital beds, with over 1,100 total full-time equivalent staff, and provided services to almost 20,000 veterans. The reported FY 2021 medical care budget exceeded \$314.1 million, an almost \$30.9 million increase (11 percent) over the FY 2020 budget of approximately \$283.2 million and an increase of over \$88.3 million (39 percent) from the FY 2019 budget of approximately \$225.8 million.

## **Facility and Review Area Selection**

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

obtained the facility rankings from the stochastic frontier analysis model in the grid to assist in selecting facilities for financial efficiency reviews.<sup>21</sup>

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<sup>21</sup> Stochastic frontier analysis is a modeling principle used to estimate the optimal or minimum cost (input) after controlling for risks and random factors for each VA medical center given a set of outputs and output characteristics. Based on the minimum cost, an efficiency score is derived for each facility; an efficiency score of 1 is most efficient, and values greater than 1 are associated with increasing inefficiency.

## Results and Recommendations

### I. Open Obligations Oversight

VA's management of open obligations has been a long-standing issue. It was included as a significant deficiency in VA's FY 2021 audited financial statements and as a material weakness in VA's FY 2020 and FY 2019 audited financial statements.<sup>22</sup> Additionally, a 2019 OIG report on undelivered orders recommended VHA ensure that staff review and reconcile open orders, identify and deobligate excess funds on those orders, and ensure that staff follow VA policy regarding required reviews of open obligations.<sup>23</sup> If reviews are not conducted, the facility is vulnerable to the risk that those funds cannot be reobligated and used for other goods or services in that fiscal year to support veterans.

The 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 to ensure that the sampled inactive obligations were valid and should remain open. Inactive obligations have had no activity for more than 90 days.
- **End-date modifications.** The team identified open obligations with changes to the period of performance end date and reviewed evidence from the healthcare system that supported those changes for the sampled obligations. The period of performance is the time frame during which the goods or services are to be provided.
- **Financial Management System (FMS) to Integrated Funds Distribution, Control Point Activity, Accounting and Procurement (IFCAP) reconciliations.** The team identified open obligations with different end dates or order amounts between FMS and IFCAP to ensure the healthcare system reconciled end dates and order amounts between the systems for the sampled obligations.

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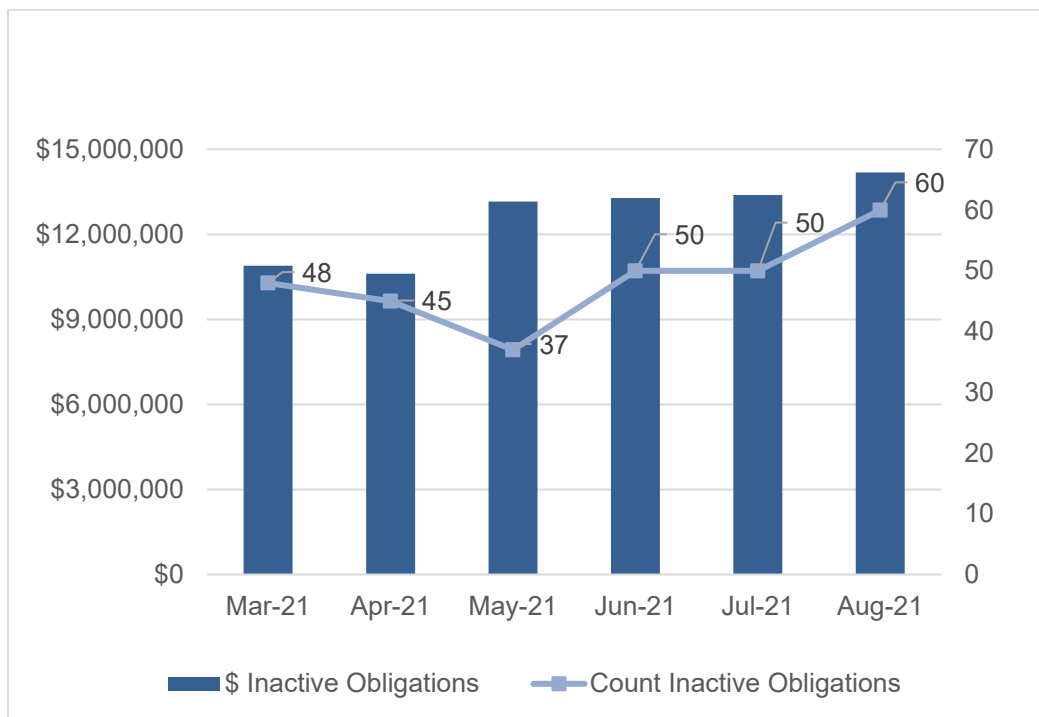
<sup>22</sup> VA OIG, *Audit of VA's Financial Statements for Fiscal Years 2021 and 2020*, Report No. 21-01052-33, November 15, 2021; VA OIG, *Audit of VA's Financial Statements for Fiscal Years 2020 and 2019*, Report No. 20-001408-19, November 24, 2020; VA OIG, *Audit of VA's Financial Statements for Fiscal Years 2019 and 2018*, Report No. 19-06453-12, November 19, 2019. A material weakness is a deficiency, or combination of deficiencies, in an internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented or detected and corrected in a timely manner. A significant deficiency is a deficiency, or a combination of deficiencies, in an internal control that is less severe than a material weakness yet important enough to merit attention by those charged with governance.

<sup>23</sup> VA OIG, *Insufficient Oversight of VA's Undelivered Orders*, Report No. 17-04859-196, December 16, 2019. All recommendations in this report have been implemented and closed.

## Finding 1: Inactive Obligations Were Not Always Reviewed, and Some End Dates Were Not Accurate

VA policy requires finance offices to perform monthly reviews and reconciliations of open obligations that are beyond 90 days of the period of performance end date or that have been inactive for more than 90 days to ensure the obligation is still valid and that funds are not underutilized.<sup>24</sup> For these obligations, finance office personnel should verify with the initiating service or contracting officer, if applicable, that the goods or services have not been received and are still needed. The responsible finance office should review data from VA’s FMS against supporting documentation on a monthly basis to ensure reports, subsidiary records, and systems reflect proper costing, accurate delivery date and end date, and a correctly calculated unliquidated balance.<sup>25</sup>

Figure 1 shows the number and dollar amounts of inactive obligations for the VA Black Hills Health Care System from March through August 2021.



**Figure 1.** VA OIG analysis of inactive obligations for the VA Black Hills Health Care System, March through August 2021.

Source: VA FMS F850 Report.

<sup>24</sup> VA Financial Policy, vol. 2, chap. 5, “Obligations Policy,” May 2021.

<sup>25</sup> 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.



As of August 31, 2021, the healthcare system had 60 inactive obligations totaling almost \$14.2 million. Figure 2 shows the age and dollar amounts of the 60 obligations. As shown, 26 obligations totaling over \$12.9 million had no activity for 181 days or more.



**Figure 2.** VA OIG analysis of inactive obligations for August 2021.

Source: VA FMS F850 Report.

## Inactive Obligations

The review team performed data analysis and selected 20 inactive obligations as of August 31, 2021, totaling almost \$13.9 million. The team reviewed supporting documentation to assess whether the healthcare system identified and reviewed the sampled obligations to determine if they were still valid and needed to remain open in accordance with VA financial policy.<sup>26</sup> Ten obligations were still within the performance period, whereas the remaining 10 were more than 90 days past the performance period end date. See appendix B for additional details on scope and methodology and appendix C for details on the review’s sampling. The team was not able to verify that a review was completed on 18 of these 20 obligations, totaling approximately \$1.5 million. Additionally, five of the 20 obligations had residual funds totaling almost \$34,300 that should have been deobligated.

VA policy states that open obligations should be reviewed by the finance office, in coordination with the initiating service, to ensure that obligations beyond 90 days of the period of performance end date or without activity in the past 90 days are valid and should remain open.<sup>27</sup>

<sup>26</sup> VA Financial Policy, “Obligations Policy.”

<sup>27</sup> VA Financial Policy, “Obligations Policy.”

If funds remain on the obligation after the delivery and the initiating service has confirmed acceptance of all goods or services and invoices have been received and paid, the acquisition office will modify the contract or order to reflect the final cost and decrease the remaining funds on the obligation. According to finance office personnel, workload was not realigned after a decrease in staff to ensure open obligations were being reviewed and reconciled according to policy. The reviews were not done because reviewing inactivity was not a priority, and the amount of work required would be too much each month. The priority was to review and improve financial indicators, not to ensure all aspects of financial policy were addressed.<sup>28</sup>

## **End-Date Modifications**

The review team selected and evaluated seven open obligations with 11 modified end dates in VA's FMS to determine whether the modifications were valid and supported. For the 11 sampled modifications, 10 were valid changes caused by period of performance extensions due to delay and scope changes. One modification made in error has since been corrected. If an end date has passed and the obligation is no longer valid, those funds can be deobligated and used elsewhere by reobligating the funds.

## **End-Date and Order Amount Discrepancies between FMS and IFCAP**

IFCAP handles the processing of certified invoices and electronic transmission of receiving documents to FMS. In addition, IFCAP transfers obligation information back to the control point balance automatically.<sup>29</sup> The end dates in both systems should be the same. However, staff can manually change end dates in one system without changing them in the other. Open obligations should be reviewed by the healthcare facility's finance office on a monthly basis, in coordination with the initiating service, to ensure period of performance dates are correct and match in all systems.<sup>30</sup> The review team selected and evaluated 28 additional open obligations to determine if end dates and order amounts were accurate and reconciled between VA's FMS and IFCAP.

### **End-Date Discrepancies**

Nine of the 28 sampled obligations contained end-date discrepancies that had existed for three months or more, with variances between systems ranging from 41 to 913 days. In September and October 2021, after the review team's sample selection, seven of the nine obligation end-date discrepancies were corrected. Of these seven, one discrepancy was the result of a contract

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<sup>28</sup> Financial indicators are a means of evaluating performance and promoting improvements in financial management within VHA. Each indicator assesses VHA compliance with policy requirements and provides information on how well facilities are executing allocated funds and use of resources. Financial indicators applicable to open obligations are "Aging of Orders – Count" and "Aging of Orders – Dollar Value."

<sup>29</sup> A control point is a financial element used to permit the tracking of monies from an appropriation or fund to a specified service, activity, or purpose.

<sup>30</sup> VA Financial Policy, "Obligations Policy."

modification to extend the end date that had not been entered into IFCAP for almost one year. Another of these seven obligations had an invalid accrual balance of \$61,286 after the end date had passed; this accrual should have been deobligated and closed so that these funds could have been used to serve veterans.<sup>31</sup> The facility advised that this obligation had been closed in FMS in September 2021; however, the end date was not corrected in IFCAP until October 2021. Furthermore, the accrual was not reversed until the review team brought it to the supervisory accountant's attention in November 2021.

The team determined two of the nine reviewed obligations still had end-date discrepancies in FMS and IFCAP. Once the team notified the healthcare system about these two continued discrepancies, finance office staff indicated both discrepancies were entry errors. The discrepancies could not be corrected due to a system limitation that does not allow end-date changes in IFCAP for Form 1358 obligations.<sup>32</sup>

### **Order Amount Discrepancies**

The remaining 19 of the 28 sampled obligations contained order amount discrepancies that had existed for three months or more with differences totaling about \$1.5 million. For 15 of the 19 obligations, the team identified continued order amount discrepancies in FMS and IFCAP. The difference between the amounts recorded in the two systems for these 15 obligations, or the unreconciled amount, totaled almost \$1.9 million.<sup>33</sup> These discrepancies occurred because the finance office does not reconcile order amounts between systems, as required. The supervisory accountant confirmed the finance office does not use VA's FMS-to-IFCAP reconciliation report.<sup>34</sup>

Nine of the 15 obligations had order amount discrepancies due to accounting entry errors or accrued funds that were no longer needed that resulted in approximately \$78,900 that could have been deobligated in FMS. Had the finance office monitored end-date and order amount discrepancies, the accrual and entry errors could have been identified and corrected promptly, therefore freeing funds that could be used for other purposes to benefit veterans.

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<sup>31</sup> An accrual is an accounting adjustment for expenses that have been incurred but are not yet recorded.

<sup>32</sup> VA Financial Policy, vol. 2, chap. 6, app. A, "VA Form 1358 Approved Uses," October 2020. VA offices may use VA Form 1358 as an obligation control document only for certain limited uses.

<sup>33</sup> The difference between the sample population value of \$1.5 million for 19 obligations and the reviewed value of \$1.9 million for 15 sampled obligations is caused by a timing difference between the date the review team selected the sample and when the facility provided evidence for review.

<sup>34</sup> The monthly report assists facility staff in reconciling FMS obligation data with the source data from IFCAP in accordance with financial policies.

## Finding 1 Conclusion

Healthcare system personnel did not comply with VA policies and reported they were focused on improving financial indicators, not ensuring all aspects of financial policy were followed. The team found that open obligations with no activity for more than 90 days were not reviewed for validity and accurate end dates and that FMS and IFCAP amounts were not always reconciled. Specifically, the review team found 15 obligations totaling over \$174,000 that could have been deobligated: five had no activity for more than 90 days, totaling almost \$34,300, and 10 were not reconciled between FMS and IFCAP, totaling over \$140,000.<sup>35</sup> Failure to properly manage open obligations increases the risk of failing to spend appropriations within the associated fiscal year and to repurpose the funds to benefit veterans.

## Recommendation 1

The OIG made the following recommendation to the director of the VA Black Hills Health Care System:

1. Ensure finance office staff conduct reviews on all inactive open obligations as required by VA Financial Policy, vol. 2, chap. 5, “Obligations Policy.”

## VA Management Comments

The director of the VA Black Hills Health Care System concurred with recommendation 1. The responses to all report recommendations are provided in full in appendix E.

The director reported that current duties and responsibilities have been reviewed and the healthcare system is actively trying to hire an accounting technician to manage this part of their operations. Until such a hire is made, obligation oversight and audit processes are being completed by facility accountants.

## OIG Response

The 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.

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<sup>35</sup> Appendix D presents estimated monetary benefits associated with deobligating these obligations.

## II. Purchase Card Use

The VA Government Purchase Card Program was established to reduce administrative costs related to acquiring goods and services. When used properly, purchase cards can help facilities simplify acquisition procedures and provide an efficient vehicle for obtaining goods and services directly from vendors. From March 1, 2020, through August 31, 2021, the healthcare system spent almost \$5.6 million through purchase cards, representing approximately 10,900 transactions. The amount and volume of spending through the VA Government Purchase Card Program make it important to have strong controls over purchase card use to safeguard government resources and ensure compliance with policies and procedures that reduce the risk of error, fraud, waste, and abuse.

The team reviewed the following areas for the sampled transactions:

- **Purchase card transactions.** The review team determined whether the healthcare system processed purchase card transactions in accordance with VA policy, such as whether cardholders obtained prior approvals before initiating a purchase, transactions were reconciled by the cardholder and approved by the approving official in a timely manner, and segregation of duties were maintained. Additionally, the team asked healthcare system staff whether they considered obtaining contracts when procuring goods and services on a regular basis, which VA refers to as “strategic sourcing.” The use of contracts in place of open market or individual purchases lowers the potential risk for split purchases on purchase cards. VA is also able to leverage its purchasing power through using competitively priced contracts.<sup>36</sup>

**Purchase card oversight.** The review team assessed whether the healthcare system tracked purchase card training, had purchase card policies in place, and maintained an accurate VA Form 0242 and whether approving officials were assigned no more than 25 purchase card accounts. The team also assessed whether the facility’s purchase card coordinator provided oversight of the purchase card program by conducting quarterly internal audits. These activities are examples of systematic controls that help reduce errors and ensure a facility complies with VA policy.

- **Supporting documentation.** Maintaining 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

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<sup>36</sup> VA Financial Policy, vol. 16, chap. 1B, “Government Purchase Card for Micro-Purchases,” October 2019 and July 2021. This policy defines “strategic sourcing” as ensuring employees obtain proper contracts when procuring goods and services on a regular basis. Purchases that exceed the cardholder’s single purchase threshold cannot be made on purchase cards. Split purchases occur when a cardholder circumvents this requirement by dividing a single purchase or need into two or more smaller purchases.

vendor invoices. Supporting documentation enables program oversight and helps prevent fraud, waste, and abuse.

## **Finding 2: The Healthcare System Did Not Always Reconcile Transactions Promptly or Consider Using Contracts**

The review team evaluated a judgmental sample of 36 purchase card transactions totaling approximately \$143,000 from March 1 through August 31, 2021, to determine whether the healthcare system's personnel processed the sampled transactions in accordance with policy, including considering using contracts; provided oversight; and maintained required supporting documentation.<sup>37</sup> See appendix B for a full description of the review's scope and methodology and appendix C for details on the review's sampling. Though healthcare system leaders did oversee the program and maintained supporting documentation for all sampled transactions, the team found that for eight of the 36 sampled transactions reviewed (22 percent), the facility did not process transactions in compliance with VA policy, and contracts could have been considered for 19 of the 36 sampled transactions (53 percent), totaling almost \$111,000.

These issues occurred because approving officials, purchase card coordinators, and cardholders did not work together to adequately review and preapprove requests for goods and services before completing an open-market purchase card transaction. VA policy requires a review to ensure that cardholders properly communicate with the contracting office when a contract is warranted for the purchase of goods or services on a regular basis.<sup>38</sup>

### **Purchase Card Transactions**

When using a government purchase card to acquire goods and services, VA staff must follow policy requirements.<sup>39</sup>

- Purchase card holders should obtain prior approval to ensure a valid business need before initiating a purchase. Approval may vary in form and content but must be retained as supporting documentation.<sup>40</sup>
- Reconciliation of a purchase should occur no later than the 15th calendar day of the month after the closing of the previous month's billing cycle.

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<sup>37</sup> A judgmental sample is a nonstatistical sample selected based on auditors' opinion, experience, and knowledge.

<sup>38</sup> VA Financial Policy, "Government Purchase Card for Micro-Purchases."

<sup>39</sup> VA Financial Policy, "Government Purchase Card for Micro-Purchases."

<sup>40</sup> VA Financial Policy, "Government Purchase Card for Micro-Purchases." Approval documentation may vary in form and content. Some examples include e-mails, requisitions, memos, consults, or notes. Regardless of the form, the documentation must contain a certification from the requestor that the proposed purchase is for a legitimate government need, not for personal benefit, as well as a list of all items to be purchased. A copy of the approval must be retained as supporting documentation.

- There should be a segregation of duties to ensure roles and responsibilities do not overlap among the cardholder, approval official, or purchase card coordinator to reduce the risk of fraud, waste, and abuse.<sup>41</sup>

The review team assessed the documentation of purchase card transactions provided by the facility to determine if these requirements were met. Table 1 shows the results of the sample review. For eight of the 36 sample transactions reviewed (22 percent), totaling almost \$42,500, healthcare system staff did not always process transactions in compliance with VA policy. Specifically, the purchase card transactions were not reconciled and approved by the 15th day of the month after the closing of the previous month’s billing cycle.

**Table 1. Purchase Card Sample Transactions Not in Compliance with VA Policy**

Requirement	Number of noncompliant transactions	Percent of noncompliant transactions
Obtain prior approval	0	0
Have reconciliation approved by the approving official no later than the 15th day of the month after the closing of the previous month’s billing cycle	8	22
Maintain segregation of duties over the transaction	0	0

*Source: VA OIG team assessment results of 36 sampled transactions.*

The review team also assessed if cardholders split purchases into two or more acquisitions to circumvent their authorized single purchase limit. Contracts must be used when the total value of the requirement exceeds the micro-purchase threshold or the cardholder’s authorized single purchase limit. Cardholders are instructed not to modify a requirement or split purchases into smaller parts to avoid exceeding their purchase card limit or the use of formal contracting procedures; instead, cardholders should communicate the need for the order of goods or services to the contracting office for procurement.<sup>42</sup> The team selected six potential split purchase transactions totaling approximately \$19,600 of potential unauthorized commitments. After reviewing transaction documentation and interviewing purchase cardholders and approving

<sup>41</sup> VA Financial Policy, “Government Purchase Card for Micro-Purchases.” VA requires that the duties of the cardholder, approving official, requesting official, and receiving official be segregated. An agency/organization program coordinator cannot be a cardholder or an approving official. No one person may order, receive, certify funds, and approve his/her own card purchases.

<sup>42</sup> VA Financial Policy, “Government Purchase Card for Micro-Purchases.”



officials, the team determined that none of the transactions were modified into smaller parts to avoid exceeding the purchase card limit.

Additionally, the review team assessed the sampled transactions for consideration of the most appropriate purchasing mechanism. In accordance with policy, VA cardholders are instructed to pursue strategic sourcing—establishing contracts that generally provide greater savings to VA rather than using purchase cards for open-market acquisitions without a negotiated price—for goods that are purchased on a recurring or ongoing basis. Approving officials, the agency or organization program coordinator, and cardholders must review purchases to determine when establishing contracts is in the best interest of the government and must communicate accordingly with the procurement office. The team determined that contracts could have been considered for 19 of the 36 sampled transactions (53 percent), totaling almost \$111,000, due to multiple orders of similar products or services. The following examples show transactions in which a contract could have been considered rather than using a purchase card.

### ***Example 1***

*On June 7, 2021, a cardholder paid \$11,347 for office furniture. Further analysis showed the same cardholder had 69 transactions with multiple furniture and office supply vendors during the review period of March through August 2021, totaling over \$233,000.*

### ***Example 2***

*In March 2021, the healthcare system purchased six laptop computers totaling \$9,353 in three transactions. The cardholder obtained quotes from Best Buy but did not try to locate the items on a government-wide or departmental contract.*

Generally, the improper reliance on purchase cards appeared to persist because approving officials did not adequately review purchases to determine if alternative contracting options were warranted or available.

## **Purchase Card Oversight**

Responsible officials are accountable for complying with the government purchase card program and for implementing internal controls to protect and conserve federal funds. Oversight activities (e.g., periodic and continuous monitoring, checks and balances, policies, procedures, and segregation of duties) reduce the risk of error, fraud, waste, and abuse in the purchase card program.

To assess oversight of the program and compliance with VA policy, the review team determined whether the healthcare system tracked purchase card training, had purchase card policies in place, assigned approving officials no more than 25 purchase card accounts, conducted reviews of cardholder transactions and quarterly purchase card certifications, and maintained a VA



Form 0242 for each cardholder in the review sample. An approved VA Form 0242 is used to delegate authority to an individual to use the purchase card to procure and pay for goods and services. This form also establishes purchase limits and responsibilities and certifies that cardholders and approving officials understand the policies and regulations governing the purchase card program. A revised form is required when the approving officer changes, cardholders legally change their names, or the single purchase limit is increased above the originally requested amount.

The review team found that the facility did provide oversight of the purchase card program. Specifically, the facility tracked cardholder training and had purchase card policies in place, and nearly all approving officials managed no more than 25 purchase cardholders. One of the 22 approving officials (4.5 percent) was the assigned alternate for and, according to staff, had to manage a 26th cardholder until the end of the fiscal year because of staff turnover. However, five of 17 cardholders responsible for the 36 sampled transactions had a VA Form 0242 with an inaccurate approving official or missing alternate approving official.

During the review period, the team determined that required quarterly audits of cardholder transactions were conducted. 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 purchase card coordinator to send a formal memo of audit results to the medical center director, with copies to the approving official or supervisor, no later than the end of the month after the close of the quarter.<sup>43</sup> The quarterly purchase card certification reports were completed on time and routed through the chain of command as required.

## Supporting Documentation

VA financial policy requires cardholders to upload and electronically store supporting documents for purchase card transactions to a VA-approved document-imaging system.<sup>44</sup> When healthcare system staff buy goods and services using a purchase card, they 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 that payments were accurate. The healthcare system was able to provide all the requested supporting documentation for all 36 sampled transactions.

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<sup>43</sup> VHA Government Purchase Card Program, “Internal Audits—Purchase Cards and Convenience Checks,” Standard Operating Procedure, June 20, 2019.

<sup>44</sup> VA Financial Policy, “Government Purchase Card for Micro-Purchases.”

## **Finding 2 Conclusion**

The healthcare system provided oversight of the purchase card program and maintained supporting documentation. However, the healthcare system did not always process transactions in compliance with VA policy, consider the most appropriate purchasing mechanism or leverage its purchasing power through using competitively priced contracts, and did not maintain an accurate, up-to-date VA Form 0242 for all cardholders.

## **Recommendations 2–4**

The OIG made the following recommendations to the director of the VA Black Hills Health Care System:

2. Establish procedures to ensure cardholders comply with processing requirements as stated in VA’s Financial Policy, vol. XVI, chap. 1B, “Government Purchase Card for Micro-Purchases.”
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.
4. Develop measures to confirm that completed VA Form 0242 submissions are accurate and updated for all cardholders.

## **VA Management Comments**

The director of the VA Black Hills Health Care System concurred with recommendations 2–4. The director reported that the healthcare system is developing updated processes that will ensure compliance with processing requirements, review purchases for possible contract use, and ensure that all documents required for cardholders and approving officials are complete and accurate. All approving officials and cardholders will be educated on the new processes at the time of implementation and annually thereafter to ensure ongoing sustainment of program requirements.

## **OIG Response**

The 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.

### III. Inventory and Supply Management

Supply chain management is the integration and alignment of people, processes, and systems across the supply chain to manage all product/service planning, sourcing, purchasing, delivering, receiving, and disposal activities. VHA policy requires medical facilities to establish, operate, and maintain a supply chain management program that is effective, cost-efficient, transparent, and responsive to customer requirements and to continually identify ways to support high-quality veteran care.<sup>45</sup> The Generic Inventory Package is the software system authorized to manage the receipt, distribution, and maintenance of expendable supplies used throughout VA. This software system features an item master file, which uses a number for the storage of item information such as the description, vendor, unit price, and packaging to track every supply. Inventory data, if properly recorded in the Generic Inventory Package, identifies the quantity and dollar values of supply items in stock. Supplies are received at the warehouse, distributed to a primary inventory point, and from there to secondary inventory points in the VA medical facility. Secondary locations are generally storage rooms within the clinical areas that use the item.

The team reviewed the following areas:

- **Supply chain management oversight.** The review team assessed whether the healthcare system had excess inventory and ensured stock levels and inventory values were accurate for expendable items by looking at the performance metric for days of stock on hand. Days of stock on hand is a nationally set level of inventory for MSPV-NG and non-MSPV-NG items that facilitates efficient purchasing and use of supplies.<sup>46</sup>
- **Unit conversion factors.** The team identified conversion factor errors that, if not identified and corrected, can cause the quantity on hand and value of supplies in the Generic Inventory Package to be unreliable. The unit conversion factor is required for all supply purchases and connects how a supply item is purchased and how it is issued—for example, purchased by the case but issued individually. If an item is purchased and issued using the same units, the conversion factor is 1.

### Finding 3: The Healthcare System Needs to Improve the Accuracy of Inventory Data and Ensure Conversion Factors Are Correct

The healthcare system provided oversight to maintain stock levels and conducted physical inventory counts as required by VHA policy. However, the healthcare system could improve the effectiveness and efficiency of inventory management by ensuring inventory values are recorded correctly in the Generic Inventory Package. The healthcare system used reports and data in the

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<sup>45</sup> VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

<sup>46</sup> The national MSPV program provides a customized distribution system to meet or exceed facility requirements through a just-in-time distribution catalog ordering process.

Supply Chain Common Operating Picture (SCCOP) to monitor stock levels and met the required accuracy rate for inventory counts as stated in VHA Directive 1761. However, the healthcare system did not always ensure that inventory values recorded in the Generic Inventory Package were accurate—an accurate unit conversion factor is required for all supply purchases to ensure correct quantities and dollar amounts for supply items in the Generic Inventory Package.

The review team evaluated a judgmental sample of 20 supply items with the highest dollar value to determine if the healthcare system had excess inventory. The team found that stock amounts for 11 of the 20 sampled items were above those allowed and that eight of the 20 sampled items had conversion factor errors, which led to inaccurate quantities and dollar amounts in the Generic Inventory Package. The eight conversion factor errors caused inventory values to be overstated by almost \$42,700. This occurred because VHA removed a requirement to monitor the conversion factor report on a quarterly basis; therefore, according to staff, they did not review the report as frequently as they had previously. Because these errors caused the quantities of supplies in the Generic Inventory Package to be unreliable, the healthcare system risks being unable to effectively plan and budget for the purchase of supplies to operate and meet patient care needs.

## Supply Chain Management Oversight

VHA requires medical facilities to establish, operate, and maintain a supply chain management program that is effective, cost-efficient, transparent, and responsive to customer requirements and to continually identify ways to improve in support of high-quality veteran care.<sup>47</sup> To avoid overstocking or understocking, VHA requires responsible staff to ensure correct reorder points and inventory levels are maintained.<sup>48</sup> Expendable supplies purchased through MSPV-NG should have 15 days or less stock on hand, and non-MSPV-NG items should have 30 days or less stock on hand. From March 1 to August 31, 2021, the healthcare system had an average of 27.1 days of stock for MSPV-NG items and an average of 27.5 days of stock for non-MSPV-NG items.<sup>49</sup> Because of the COVID-19 pandemic, the healthcare system received a waiver to suspend days-of-stock-on-hand performance measures from March 3 until June 30, 2021.

The review team evaluated a judgmental sample of 20 supply items with the highest dollar value based on the days-of-stock-on-hand report dated October 26, 2021, to determine if the healthcare system had excess inventory.<sup>50</sup> The 20 supply items included 10 MSPV-NG and

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<sup>47</sup> VHA Directive 1761.

<sup>48</sup> The reorder point represents the level at which the item is to be replenished.

<sup>49</sup> Data are obtained from the SCCOP intranet, which is an internal VA website not accessible by the public that publishes supply chain management benchmarks and reports.

<sup>50</sup> The days-of-stock-on-hand report in SCCOP is a daily report. The team reviewed the October 26, 2021, report because the scheduled site visit was November 15, 2021, and this gave the team three weeks to pull a judgmental sample, review the data, and request supporting documentation from the healthcare system.

10 non-MSPV-NG items for medical surgical supply and environmental management service inventory points, with a total inventory value of over \$139,000. The team determined that eight of the 20 samples had quantities above those allowed, totaling over \$28,400.

The review team interviewed supply chain management leaders and staff to determine how they ensured stock levels and inventory values were accurate and what challenges they faced in managing stock levels. According to supply chain management personnel, the inventory managers ran usage reports and conducted physical inventory counts to monitor stock levels and determine demand and reordering points. Inventory managers used reports from SCCOP on days of stock on hand and inactive supply items to track their performance.<sup>51</sup> However, despite these efforts, inventory managers reported difficulty meeting the 15 days-of-stock-on-hand metric for MSPV-NG items because of continuing short supply and high demand for personal protective equipment, syringes, and blood tubes, which were placed on allocation during the COVID-19 pandemic. The staff explained that Concordance, the prime vendor, set allocation levels for these items based on historical usage. When items are on allocation, the prime vendor limits the amount that a single customer can purchase. With many items backordered and put on allocation, the healthcare system ordered as much as possible to avoid potential shortfalls. As an additional measure to ensure availability, the Veterans Integrated Service Network (VISN) required facilities to keep 60 days of stock on hand for personal protective equipment ordered through MSPV-NG, which resulted in an increased stock levels for certain MSPV-NG items.<sup>52</sup>

During the pandemic, it is understandable that there was an increased need to have extra supplies on hand, and the healthcare system ordered as much as possible to avoid potential shortfalls. The OIG makes no recommendations related to the days of stock on hand at the healthcare system.

## Unit Conversion Factors

In the Generic Inventory Package, an accurate conversion factor for individual supply items is necessary to determine both the cost and the value of the inventory. The unit conversion factor connects how a supply item is purchased and used and is computed by dividing the quantity purchased by the quantity issued. The unit conversion factor equals 1 when the unit of purchase and the unit of issue are the same. Any calculation error in the conversion factor causes inaccurate quantities and values in the system. For example, if the healthcare system purchased a case of 10 bottles of water for \$10 and issued one bottle at a time, the correct conversion factor is 10 (quantity purchased of 10 divided by quantity issued of 1), and, after issuing one bottle, the inventory quantity and value should be nine bottles and \$9. However, if the conversion factor was incorrectly set at 1, the Generic Inventory Package will remove all 10 bottles (one case) after

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<sup>51</sup> Inactive items are those items with no use for 90 days or more.

<sup>52</sup> VHA divides the United States into 18 regional networks known as VISNs—regional systems of care working together to better meet local healthcare needs and provide greater access to care.

the first issuance of a bottle, and the inventory value will be \$0 with zero quantity in the system. In this scenario, the difference is \$9 and nine bottles, requiring the supply chain management staff to manually adjust the quantity and the value of inventory on hand. To reconcile the unit cost when purchased and the unit cost when issued, the supply chain management staff therefore had to divide the cost of the case by 10 to reach the cost of each unit. This number is called the conversion factor.

Using the previously identified sample of 20 items, the team determined that eight had conversion factor errors, which led to inaccurate quantities and dollar amounts in the Generic Inventory Package. For example, the healthcare system purchased shopping bags by the package, with 500 units in a package and issued one unit at a time. Therefore, the conversion factor should be 500. However, the conversion factor was incorrectly set as 1, which caused inventory values to be overstated in the system by almost \$10,900. Supply chain management staff acknowledged the conversion factor errors and that these errors changed the valuation of the supply inventory. An accurate unit conversion factor is necessary for the system to automatically compute the correct amount of stock on hand and autogenerate supply purchase orders when the reorder point is met.<sup>53</sup> After the review team brought this issue to the managers' attention in November 2021, they worked to correct the identified errors. Conversion factor errors can lead to the increased reliance on manual inventory counts, manual ordering processes, and incorrect inventory values and quantities in the Generic Inventory Package.

### **Finding 3 Conclusion**

The healthcare system has provided oversight of expendable supplies to avoid stock shortages and ensure that patient needs are met during the pandemic. However, the healthcare system could improve efficiency by improving the accuracy of inventory quantities and values in the Generic Inventory Package. Unreliable inventory data can lead to the purchase of unnecessary supplies. More importantly, errors indicating that supplies are available when they are not could adversely affect the healthcare system's ability to effectively plan and budget for the purchase of supplies to operate and meet patient care needs.

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<sup>53</sup> VHA, Integrated Funds Distribution, Control Point Activity, Accounting and Procurement (IFCAP), Version 5.1, Generic Inventory User's Guide, October 2000, rev. October 2011. The autogenerate function in the Generic Inventory Package identifies all supplies in the inventory system that are at or below the standard reorder point.

## **Recommendation 5**

The OIG made the following recommendation to the director of the VA Black Hills Health Care System:

5. Ensure the supply chain management staff implement a plan to monitor and correct unit conversion factor errors consistently and promptly to improve data reliability in the Generic Inventory Package.

## **VA Management Comments**

The director of the VA Black Hills Health Care System concurred with recommendation 5. The director reported that a process is in development to ensure the conversion factor report and other reports are monitored and worked on a regular basis.

## **OIG Response**

The 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.



## IV. Pharmacy Operations

In FY 2020, prescription drug spending at the VA Black Hills Health Care System was over \$21.7 million, which represented about 8 percent of the healthcare system's \$283.2 million budget. Because pharmacy accounts for a substantial percentage of any medical center's budget, medical center leaders need 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 at 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.
- **Inventory turnover rate**, or the number of times inventory is replaced during the year, is the primary measure to monitor the effectiveness of inventory management per VHA policy.<sup>54</sup> Low inventory turnover rates can indicate inefficient use of financial resources.
- **End-of-year purchases of drugs** can lower the inventory turnover rate and increase the total replenishment cost of pharmacy inventories. These purchases complicate pharmaceutical inventory management and are to be avoided, according to VHA policy and Pharmacy Benefits Management program office guidance.<sup>55</sup>

### Finding 4: The Healthcare System Could Improve Pharmacy Efficiency, Increase Inventory Turnover, and Avoid End-of-Year Purchases

The review team found the VA Black Hills Health Care System could improve pharmacy efficiency and reduce the difference between observed and expected drug costs, achieve an inventory turnover rate closer to the VHA-recommended level, and avoid end-of-year purchases. Failure to properly manage pharmacy operations can lead to increased replenishment costs, overstocking, spoilage, and diversion of drugs and can decrease the funding available to meet other healthcare system and patient care needs.

#### OPES Pharmacy Expenditure Data

The OPES pharmacy expenditure model, which identifies variations in pharmacy costs among VHA facilities, showed that the healthcare system had about \$21.7 million in drug costs in

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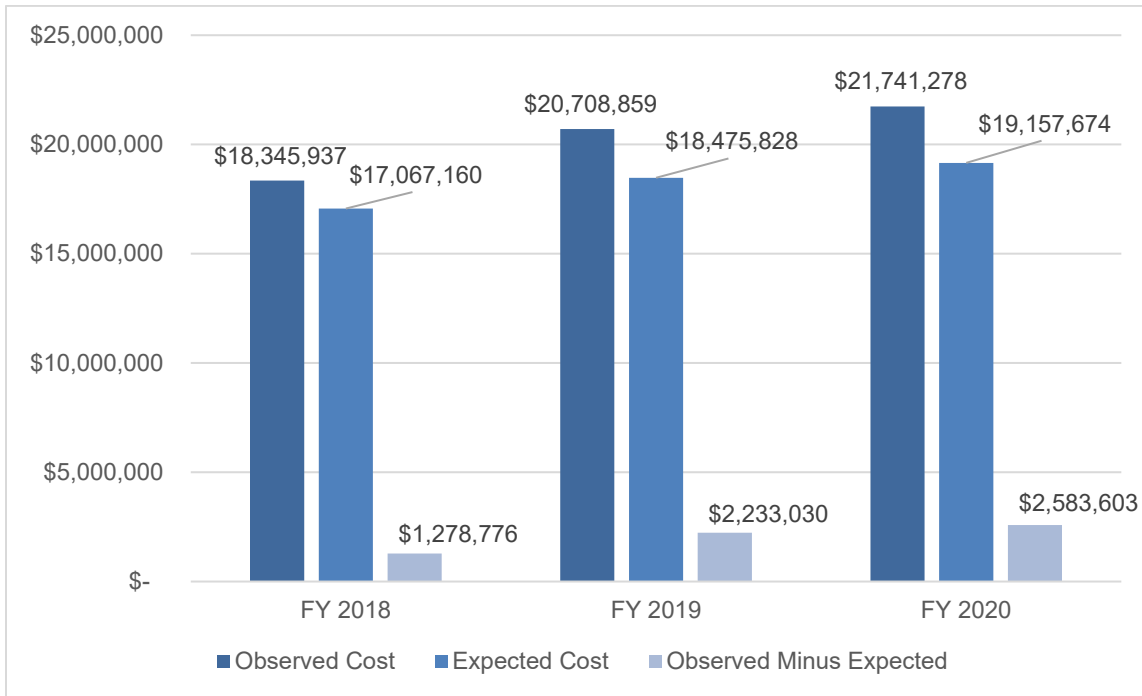
<sup>54</sup> VHA Directive 1761(2), app. H, *Supply Chain Management Operations*, December 30, 2020. Inventory turnover is based on the total dollar value purchased for the year divided by the dollar value of items on the shelf.

<sup>55</sup> VHA Directive 1108.08(1), *VHA Formulary Management Process*, November 2, 2016, amended August 29, 2019; PBM email response to questions from VA OIG regarding the training "Annual Wall to Wall Physical Inventory 2019," March 12, 2020.



FY 2020. According to the model, this amount was approximately \$2.6 million higher than the expected costs of about \$19.2 million. Based on these numbers, the facility’s observed-to-expected ratio was 1.13, which ranked it 123 among 139 VHA facilities for pharmacy drug cost efficiency.

For FY 2018 through FY 2020, the healthcare system exceeded expected costs by an average of \$2 million annually, reporting almost \$1.3 million over expected costs for FY 2018 and almost \$2.6 million over expected costs for FY 2020. Pharmacy leaders stated that they were not as familiar with the data as they would like to be. At the time of this review, key pharmacy staff did not have access to all the OPES data used to formulate the models. Figure 3 shows the increasing difference between observed and expected drug costs for the VA Black Hills Health Care System.



**Figure 3.** Observed versus expected drug cost, FYs 2018–2020.

Source: OPES pharmacy expenditure model.

Note: The OPES data models are based on the previous fiscal year data (i.e., the FY 2021 data model was based on FY 2020 data).

## Inventory Turnover Rate

VHA policy states that inventory turnover is the primary measure of the effectiveness of inventory management.<sup>56</sup> Increasing the inventory turnover rate decreases inventory carrying

<sup>56</sup> VHA Directive 1761, app. H.

cost, the cost associated with storing inventory. VHA policy also mandates the use of prime vendor inventory management reports to manage all VA medical facility pharmacy inventories.<sup>57</sup>

In August 2021, the healthcare system reported inventory turnover rates of 5.70 times for the Fort Meade VA Medical Center and 4.64 times for the Hot Springs VA Medical Center, compared with VHA's recommended level of 12 times established by Pharmacy Benefits Management, the national program office. Low inventory turnover could indicate the inefficient use of financial resources and the inability to properly forecast needed amounts of drugs to meet patient care needs. In addition, pharmacy staff were not implementing inventory management practices, such as placing bar codes on all stock locations, using handheld barcode readers, and using the ABC inventory analysis methods required by VHA policy.<sup>58</sup> Finally, according to pharmacy personnel, before the implementation of the ScriptPro Information Management System in June 2021, outpatient pharmacy drug inventories were managed by a "want list" instead of calculated reorder points and reorder quantities using demand forecasting as required by VHA policy for more accurate inventory management.<sup>59</sup> Demand forecasting applies weighting factors to past purchases and must be used in calculating both the reorder points and reorder quantities for more accurate inventory management.

Pharmacy officials said that because procurement staffing levels were low, the supervisory procurement technician had to assist with ordering inventory. As such, this did not allow time for the inventory analysis and management required by policy. Pharmacy personnel also pointed to the rural location of the healthcare system as a cause for low inventory turnover rates: it carries more stock on hand because the prime vendor is in Denver, Colorado, and winter road conditions sometimes prevent deliveries for up to five days. Finally, personnel stated that they did not have labels affixed to stock at all locations and were unable to use handheld scanners due to construction that started in 2017.

## End-of-Year Purchases of Drugs

VHA policy states that "end-of-year purchases make pharmaceutical inventories increasingly difficult to manage and need to be avoided."<sup>60</sup> Furthermore, Pharmacy Benefits Management

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<sup>57</sup> VHA Directive 1761, app. H.

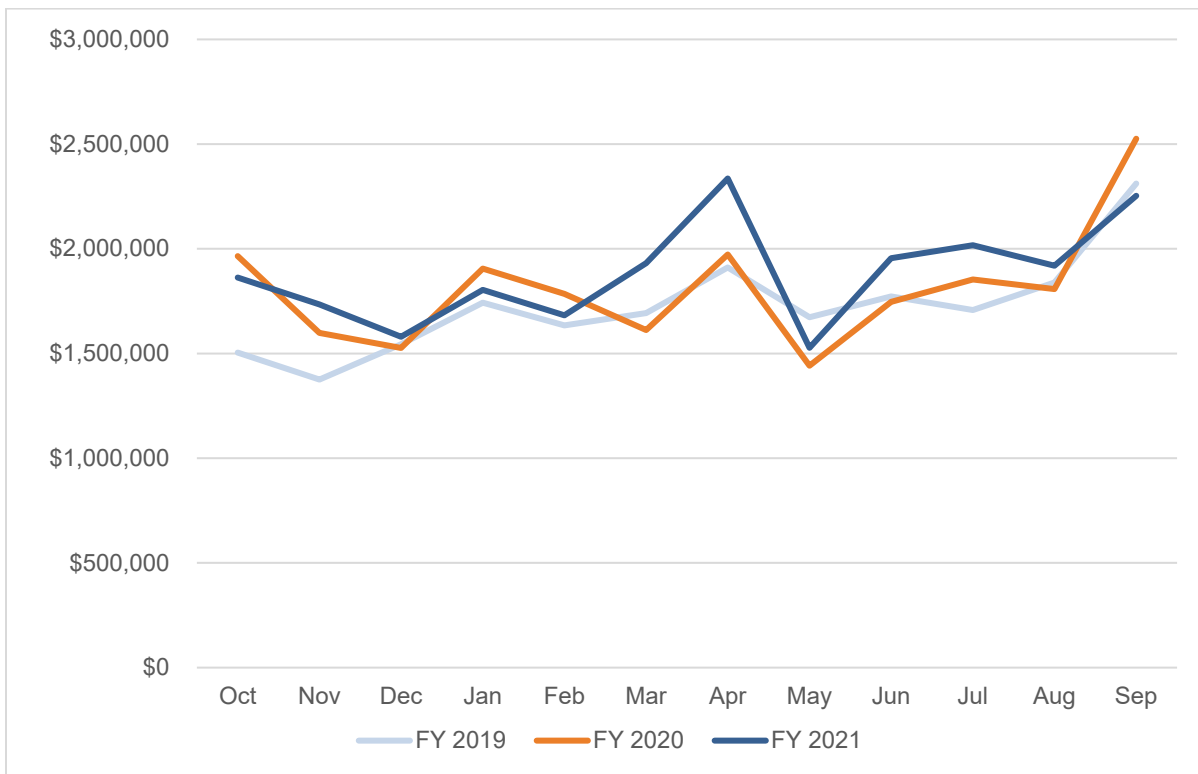
<sup>58</sup> VHA Directive 1108.08(1). The ABC classification method states that inventory point items with approximately 70 percent of the inventory dollars and 10 percent of the products are classified as "A." Items with approximately 20 percent of the inventory dollars and 20 percent of products are classified as "B." Lastly, items representing approximately 10 percent of the inventory dollars and 70 percent of the products are classified as "C."

<sup>59</sup> VHA Directive 1108.08(1). The ScriptPro Inventory Management system provides real-time inventory tracking, order generation, electronic transmission, and inventory receiving for outpatient pharmacies.

<sup>60</sup> VHA Directive 1108.08(1). The directive does not indicate the number of days before the end of the year after which purchases should not be made.

guidance confirmed that end-of-year purchases can skew the reported inventory turnover rate, affecting the validity of that measure.

The OIG found that the healthcare system had sharp increases in expenditures made in September in each of the fiscal years analyzed (figure 4). The healthcare system averaged \$1.8 million in monthly drug expenditures during the first 11 months of FY 2021. In the last month of FY 2021, the healthcare system reported about \$2.3 million in drug expenditures. In FY 2020 the healthcare system averaged \$1.7 million in monthly drug expenditures during the first 11 months and reported \$2.5 million in drug expenditures for the last month of FY 2020. Figure 4 shows the September spike in monthly reported drug expenditures from FY 2019 through FY 2021.



**Figure 4.** Healthcare system monthly drug expenditure data for FY 2019 through FY 2021 (October 2019-September 2021).

Source: OIG analysis of VA FMS (FMS 830/887 report).

To confirm the identified pattern of end-of-year purchasing of drugs, the review team interviewed pharmacy managers and staff. The pharmacy chief stated that a request comes from healthcare system’s fiscal office and gives the pharmacy department only a few days’ notice that there is money to spend. According to the chief, these end-of-year purchases are focused on high-cost, low-use drugs that the healthcare system plans to use before the annual wall-to-wall inventory. According to spreadsheets provided by pharmacy personnel, end-of-year purchases

totaled more than \$1.1 million over the three-year period reviewed. These purchases can reduce the inventory turnover rate and increase the carrying cost of pharmacy inventories.

## **Finding 4 Conclusion**

The healthcare system needs to improve pharmacy efficiency by proactively reducing the gap between the facility's observed drug costs and expected drug costs. To further improve efficiency, healthcare system managers could increase inventory turnover and decrease end-of-year purchases. An efficient healthcare system anticipates how much drugs will cost and when inventory needs to be restocked, helping ensure that the system makes the best use of appropriated funds and has inventory when needed.

## **Recommendations 6–7**

The OIG made the following recommendations to the director of the VA Black Hills Health Care System:

6. Develop and implement a plan to achieve an inventory turnover rate closer to the Veterans Health Administration-recommended level.
7. Establish measures to improve compliance with the Veterans Health Administration directive to avoid end-of-year pharmaceutical purchases.

## **VA Management Comments**

The director of the VA Black Hills Health Care System concurred with recommendations 6 and 7. For recommendation 6, the director reported that the healthcare system completed implementation of the ScriptPro Inventory Management System in 2021 and determined that, based on the annual wall-to-wall inventory completed in February 2022, this system has improved inventory turnover rates. The director also reported the healthcare system is updating processes to improve inventory turnover.

For recommendation 7, the director reported that the healthcare system is developing new operational guidance regarding end-of-year pharmacy purchasing.

## **OIG Response**

The 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

Table A.1 provides general background information for this level 3 (low complexity) facility in VISN 23.<sup>61</sup>

**Table A.1. Facility Data for VA Black Hills Health Care System as of September 30, 2021**

Item	FY 2019	FY 2020	FY 2021
Total medical care budget	\$225,781,296	\$283,207,840	\$314,092,544
Number of patients	19,942	19,205	19,976
Outpatient visits	240,604	207,925	234,770
Total medical care full-time equivalent staff	1,173	1,134	1,150
Number of operating beds:			
Hospital	34	34	34
Community living center	104	104	104
Domiciliary	112	112	112
Average daily census:			
Hospital	12	10	12
Community living center	63	52	43
Domiciliary	80	44	33

Source: VHA Support Service Center, Trip Pack - Operational Statistics Table.

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

According to data from VHA's Support Service Center, the healthcare system's medical care budget increased by over \$88.3 million, or about 39 percent, between FY 2019 and FY 2021, while the number of patients increased by only 34, which is less than a 1 percent change. The chief financial officer told the review team that the some of the budget increase was due to a COVID-19 appropriation that was used for medical supplies, COVID-19 stations, and contracts for gate security and screening. Also, the healthcare system has been renovating the Medical-Surgical building to upgrade the endoscopy suite and sterile processing areas.

<sup>61</sup> The facility complexity model classifies VHA facilities at levels 1a, 1b, 1c, 2, or 3, with level 1a being the most complex and level 3 being the least complex.

## Appendix B: Scope and Methodology

### Scope

The OIG conducted its review of the VA Black Hills Health Care System from November 2021 to May 2022, including a virtual site visit during the week of November 15, 2021. The review team evaluated financial efficiency practices for FY 2021 related to open obligations, purchase card transactions, and days of stock on hand for expendable supplies. The team also analyzed financial efficiency practices related to the facility's pharmacy costs using the FY 2021 OPES data model; however, the FY 2021 data model was based on FY 2020 data.

To conduct the review, the team

- interviewed facility leaders and staff;
- identified and reviewed applicable laws, regulations, VA policies, operating procedures, and guidelines related to managing open obligations, overseeing purchase card transactions, calculating days of stock on hand, and addressing inefficiencies in pharmacy costs;
- judgmentally sampled 20 inactive obligations to assess whether the healthcare system identified and reviewed the obligations to determine if they were still valid and needed to remain open in accordance with VA financial policy, sampled seven obligations to review end-date modifications, and selected 28 obligations with different end dates or order amounts between FMS and IFCAP to determine if required reconciliations were done;
- judgmentally sampled 36 purchase card transactions to determine if there was proper oversight and governance of the purchase card program and to assess the risk for illegal, improper, or erroneous purchases; and
- judgmentally sampled 20 supply items from the top two inventory points with the highest dollar value (by inventory on hand value) to determine if the healthcare system met performance metrics and had excess inventory.

### Data Reliability

The review team used computer-processed data obtained from U.S. Bank files through a corporate data warehouse 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 time frame requested. The review team also assessed whether the data contained obvious duplication of records, alphabetic or numeric characters in incorrect fields, or illogical relationships among data elements. Furthermore, the team compared purchase order numbers, payment dates, payee names, and payment amounts, as provided in the data received in

the samples reviewed. Testing of the data disclosed that they were sufficiently reliable for the review objectives.

The team also used computer-processed data from VA FMS reports 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: Statistical Sampling Methodology

### Open Obligations

The review team evaluated a judgmental sample of open obligation transactions from March through August 2021 to determine if (1) the VA Black Hills Health Care System performed monthly reviews and reconciliations of the reviewed obligations with no activity for more than 90 days to ensure the obligations were valid and should remain open, (2) the facility had evidence to support end-date modifications to the period of performance for reviewed obligations, and (3) the facility reconciled end dates and order amounts between FMS and IFCAP for reviewed obligations.<sup>62</sup>

### Population

During August 2021, the facility had 391 open obligations, totaling approximately \$27.3 million. Of those open obligations, 60 obligations, totaling approximately \$14.2 million, had no activity for more than 90 days. From March through August 2021, there were 14 obligations, totaling over \$17.2 million, with end-date modifications. From May through August 2021, there were 10 obligations with end-date discrepancies outstanding for three or more months between FMS and IFCAP. Additionally, there were 21 obligations with order amount discrepancies for three or more months between FMS and IFCAP.

### Sampling Design

The review team selected three judgmental samples:

- **Inactive obligations.** The team selected 20 obligations with no activity for more than 90 days from the August 2021 FMS F850 report. This report lists each open obligation and its remaining balance. Ten obligations were still within the performance period, whereas the remaining 10 were more than 90 days past the performance period end date.
- **End-date modifications.** The team selected seven obligations with 11 modified end dates to the period of performance for all open obligations from FMS F850 reports for March through August 2021.
- **FMS-to-IFCAP reconciliations.** The team selected 28 obligations with different end dates or order amounts between FMS and IFCAP from VA's FMS-to-IFCAP reconciliation reports for May through August 2021. Nine obligations had end-date discrepancies, and 19 obligations had order amount discrepancies.

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<sup>62</sup> The judgmental sample of open obligations for item 3 was limited to May through August 2021.



The samples included 55 total open obligations: 20 obligations with no activity for more than 90 days, totaling almost \$13.9 million; seven obligations with 11 end-date modifications, totaling approximately \$612,000; nine with end-date discrepancies; and 19 with order amount discrepancies, totaling approximately \$23.8 million.

To review the sampled obligations, the team requested supporting documentation for each of the 55 sampled transactions, including monthly reviews and reconciliations, financial system screen prints and reports, and emails related to the obligations.

## Projections and Margins of Error

The review team did not use projections or margins of error because statistical sampling was not used.

## Purchase Cards

The review team evaluated a judgmental sample of purchase card transactions made from March through August 2021 to determine if (1) the VA Black Hills Health Care System's sampled purchase card transactions were adequately monitored, approved, and supported by documentation and (2) the reviewed transactions complied with processes to prevent split purchases and transactions exceeding the cardholder's authorized single purchase limit and to ensure goods or services were procured using strategic sourcing procedures.

## Population

From March through August 2021, purchase cardholders at the facility made approximately 10,900 purchase card transactions totaling approximately \$5.6 million. Three bundles of transactions were identified as potential split transactions, including six individual transactions. The other potential high-risk transactions were selected from the remaining transactions.

## Sampling Design

The review team selected two judgmental samples:

- **Potential split purchases.** The team identified three bundles (six transactions) with the same purchase date, purchase card number, and merchant, and an aggregate sum greater than the cardholder's authorized single purchase limit.
- **Other potential high-risk purchase areas.** The team identified 30 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 36 total individual transactions: six potential split purchase transactions totaling approximately \$19,600 and 30 high-risk transactions totaling approximately \$123,700.

To review the sampled transactions, the team requested supporting documentation for each of the 36 sampled transactions, VA Form 0242 for cardholders, and documentation to support the completion of quarterly purchase card audits.

## **Projections and Margins of Error**

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

## **Inventory and Supply Management**

The review team evaluated a judgmental sample of supply items for October 2021 to determine if the healthcare system had excess inventory.

### **Population**

As of October 26, 2021, the healthcare system had 23 inventory points, with \$665,902 of reported total value of inventory on hand. There were 10 inventory points beginning with ## and 13 regular inventory points. Because performance metrics do not apply to inventory points beginning with ##, the team excluded these inventory points from the review.<sup>63</sup> Two of the 13 regular inventory points accounted for over 40 percent of the total value of inventory on hand with totals of \$177,456 and \$92,478 respectively; therefore, the team focused the analysis on these two.

### **Sampling Design**

The review team selected and evaluated a judgmental sample of 20 supply items from the top two inventory points with the highest dollar value (by inventory on hand value) to determine if the healthcare system met performance metrics and had excess inventory.

To review the sampled supply items, the team used the average daily value usage from the days-of-stock-on-hand report and the 15/30 days performance metrics to determine the maximum allowable inventory. The difference between “current value on hand” and “maximum allowable inventory” is inventory above the recommended stock level (excess inventory). Several items did not have average daily usage for the past 90 days; therefore, the team was unable to compute excess inventory.

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<sup>63</sup> VHA Directive 1761. A ## will be placed in front of the primary name for the inventory points that are not part of the two mandatory categories reported in performance measures.

## **Projections and Margins of Error**

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

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

Recommendation	Explanation of Benefits	Better Use of Funds	Questioned Costs
1	Ensure finance office staff are made aware of policy requirements and reviews are conducted on all inactive open obligations as required by VA Financial Policy, vol. 2, chap. 5, "Obligations Policy."	\$174,468	
	<b>Total</b>	<b>\$174,468</b>	

## Appendix E: Management Comments

Department of Veterans Affairs Memorandum

Date: June 14, 2022

From: Director, VA Black Hills Healthcare System (568/00)

Subj: Healthcare Review- Financial Efficiency Review of the VA Black Hills Health Care System (2022-00066-AE-0006)

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

Cc:

Thru: Director, VA Midwest Healthcare Network (10N23)

This Memorandum contains the Director responses to the OIG recommendations following the draft report for the Financial Efficiency Review of the VA Black Hills Health Care System.

### Facility Director's Response

#### Recommendation 1

The OIG made the following recommendation to the director of the VA Black Hills Health Care System:

Ensure finance office staff conduct reviews on all inactive open obligations as required by VA Financial Policy, vol. 2, chap. 5, "Obligations Policy."

#### Director Comments

Concur. The VA Black Hills Healthcare System Director has reviewed current duties and responsibilities within the Finance Service Line to address this deficiency. Actions being actively pursued to rehire an accounting technician to manage this crucial aspect of our operations. In the interim, aging obligation oversight and audit processes are being completed daily by facility accountants until such time as the aging obligations accounting technician can be hired.

Target date for completion: November 1, 2022

#### Recommendations 2 - 4

The OIG made the following recommendations to the director of the VA Black Hills Health Care System:

2. Establish procedures to ensure cardholders comply with processing requirements as stated in VA's Financial Policy, vol. XVI, chap. 1B, "Government Purchase Card for Micro-Purchases."

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.

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

#### Director Comments

Concur with recommendations 2-4. The VA Black Hills Health Care System, in coordination with VISN 23, is developing updated processes that will provide better oversight of the purchase card program. In the new processes, approving officials will ensure timely compliance by cardholders with processing requirements; purchase reviews for possible contract use; and ensure that all documents required for

cardholders and approving officials are complete and accurate. All approving officials and cardholders will be educated on the new processes at the time of implementation and annually thereafter to ensure ongoing sustainment of program requirements.

Target date for completion: October 1, 2022

#### Recommendation 5

The OIG made the following recommendation to the director of the VA Black Hills Health Care System:

5. Ensure the supply chain management staff implement a plan to monitor and correct unit conversion factor errors consistently and promptly to improve data reliability in the Generic Inventory Package.

#### Director Comments

Concur. The VA Black Hills Health Care System requirement to review conversion factor report was removed from VHA Directive 1761, December 30, 2020, however, the data is now published and tracked on the Supply Chain Common Operating Picture intranet site. A local process to ensure this, and other reports are monitored and worked on a regular basis and data is in compliance, are in development.

Target date for completion: August 1, 2022

#### Recommendations 6–7

The OIG made the following recommendations to the director of the VA Black Hills Health Care System:

6. Develop and implement a plan to achieve an inventory turnover rate closer to the Veterans Health Administration-recommended level.

7. Establish measures to improve compliance with the VHA directive to avoid end-of-year pharmaceutical purchases.

#### Director Comments

Concur with recommendations 6-7. The VA Black Hills Health Care System has developed and implemented a plan to achieve improvement in Pharmacy inventory turnover. Implementation of ScriptPro Inventory Management System (SIMS) was completed in 2021 and has assisted in the improvement of inventory turnover. In February 2022, an annual wall-to-wall review demonstrated inventory turns were improved from 4.64 at Hot Springs in 2021 to 7.3 at HS in 2022 and at Fort Meade from 5.7 in 2021 to 10.6 in 2022. VA Black Hills Health Care System is updating processes to improve pharmacy efficiency in observed and expected drug costs, improving inventory turnover and limiting end-of-year purchases. VA Black Hills Health Care System is developing new operational guidance regarding end-of-year pharmacy purchasing.

Target date for completion: July 15, 2022

(Original signed by)

Lisa R. Curnes, MHA

Medical Center Director/CEO

VA Black Hills Health Care System, Fort Meade/Hot Springs

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

## OIG Contact and Staff Acknowledgments

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Director, VA Black Hills Health Care System

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