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VETERANS HEALTH ADMINISTRATION

Financial Efficiency Review of the VA Cincinnati Healthcare System

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Executive Summary

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

The review team looked at the following four areas 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.

II. **Purchase card use.** The VA Government Purchase Card Program was established to reduce administrative costs related to the acquisition of goods and services. When used properly, purchase cards can help facilities simplify acquisition procedures and provide an efficient vehicle for obtaining goods and services directly from vendors. Documenting transactions as required helps VA and other oversight authorities identify potential fraud, waste, and abuse. Using contracts for common purchases has several benefits, such as allowing VA to optimize purchasing power and obtain competitive pricing. The team examined whether the healthcare system's purchase card program ensured compliance with policies and procedures, and focused on the consideration of contracts for commonly purchased products, known as strategic sourcing, to provide optimal savings to VA.

III. **Medical/Surgical Prime Vendor–Next Generation (MSPV-NG) program use.** The MSPV-NG program provides a collection of contracts with selected vendors that enables VA to streamline supply-chain management for an array of medical, surgical, dental, and select prosthetic and laboratory supplies. The program achieves long-term savings by

[1] The VA Cincinnati Healthcare System provides health care services at 10 locations serving a 15-county area in Ohio, Kentucky, and Indiana. Facilities include two hospitals: Cincinnati VA Medical Center and Cincinnati VA Medical Center–Fort Thomas. The healthcare system has six community-based outpatient clinics in Cincinnati, Ohio, and other locations in Ohio, Kentucky, and Indiana. It also has a wellness center and eye center.

using a just-in-time logistics approach. VA medical facilities are required to use MSPV-NG contracts for products that are available through the program, which appear on a list called a formulary. The Medical Supplies Program Office (MSPO) recommends that each medical center purchase at least 90 percent of the supplies on the formulary from the program's assigned prime vendor.[2] The review team examined whether the healthcare system met Veterans Health Administration (VHA) goals for using the program.

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

The review team selected these areas based on an analysis of VA data from the Office of Productivity, Efficiency & Staffing (OPES) efficiency opportunity grid, the Supply Chain Common Operating Picture (SCCOP), and reports from the Veterans Health Administration (VHA) Support Service Center (VSSC). The efficiency opportunity grid was used to obtain information on pharmacy operations, SCCOP was used for MSPV-NG information, Financial Management System (FMS) and VSSC reports were used for open obligations, and US Bank data were used for purchase card transactions.

The team reviewed data from fiscal year (FY) 2019 through FY 2021 and conducted a site visit during the week of December 6, 2021. For more information about the review's scope and methodology, see appendixes B and C.

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

What the Review Found

According to VSSC data, the healthcare system's medical-care budget increased by over $130 million, or about 27 percent between FY 2019 and FY 2021. At the same time, the number of unique patients decreased by about 4.6 percent or 2,000 patients. The chief financial officer told the review team that some of the budget increase was due to COVID-19 appropriations that were used for equipment, including increased purchases of personal protective equipment and to ensure the facility was able to maintain optimal operation during the COVID-19 pandemic. The budget for community care services, which increased by almost $65.7 million, or about 133 percent, between FY 2019 and FY 2021 accounted for just over 50 percent of the overall medical-care budget increase. Of the $65.7 million, $33.2 million was specifically used to

[2] Medical Supplies Program Office, "The Formulary Utilization Metric: A Deep Dive Explanation," accessed May 6, 2021, https://vaww.va.gov/plo/docs/mspo/mspvFormularyUtilizationMetricOverview.pdf.

support operations during the pandemic and included the use of COVID-19 appropriations. Nonrecurring maintenance increased by just over $17 million, or just over 13 percent, and equipment costs and COVID-19 costs each increased by about $13.9 million. These four areas constitute a total of just over $110.6 million or about 85 percent of the just under $130 million increase in the healthcare system's medical-care budget from FY 2019 to FY 2021. Appendix A has additional details about the facilities' resources and workload.

I. **Open obligations oversight**. The OIG found reviews were not completed for nine inactive obligations from a judgmental sample of 20 obligations that totaled about $7.2 million from September 30, 2021, selected from a universe of 20 obligations totaling about $12.6 million. According to the chief financial officer, the healthcare system placed more focus on addressing open obligations that were 90 days past their period of performance end date than on those that had no expenditure activity for more than 90 days due to VHA financial indicators focusing more on evaluating period of performance end dates. One of the obligations had residual funds totaling about $2,000 that should have been deobligated. Failure to properly manage open obligations risks those funds not being used in the year they were appropriated, as required. If unspent, these one-year funds cannot be used for other goods or services to support veterans.

   The review team selected and evaluated seven additional open obligations to determine if end dates were accurate and 10 additional samples to determine if order amounts were accurate and reconciled between VA's FMS and the Integrated Funds Distribution, Control Point Activity, Accounting and Procurement System (IFCAP). The OIG found two of the seven reviewed contained end-date discrepancies that had existed for three months or more with variances of 1,095 and 1,308 days, respectively. These oversight errors were corrected after the review team site visit. For seven of the 10 obligations reviewed, FMS and IFCAP reflected continued discrepancies in order amounts with an unreconciled amount totaling about $597,000. Most of these discrepancies remained undetected because pharmaceutical reconciliations were not performed properly.

II. **Purchase card use.** The review team evaluated a judgmental sample of 36 purchase card transactions from October 1, 2020, through September 30, 2021, totaling just under $189,000.[3] The OIG found that the healthcare system did not comply with VA policy for three of the 36 sampled transactions (about 8 percent), totaling about $10,200. Specifically, the purchase cardholders did not obtain prior approval or record purchase orders prior to making purchases and did not maintain supporting documentation for those purchases. Staff did employ strategic sourcing and properly maintained supporting documentation for 35 of the 36 transactions sampled totaling just under $188,000 for FY 2021. One sampled transaction for just over $880 did not have supporting

[3] A judgmental sample is a nonstatistical sample selected based on auditors' opinions, experience, and knowledge.

documentation. The purchase card program coordinator assigned to the facility performed required quarterly audits to evaluate and improve the effectiveness of internal controls; however, the audit process did not detect the instance of the purchase without supporting documentation. This particular audit process was not designed to identify all discrepancies, but the OIG did not find evidence that this was a pervasive problem.

III. **Use of the MSPV-NG program.** The OIG found that the healthcare system did not meet the formulary utilization goal recommended by the VA Medical Supplies Program Office (MSPO) to purchase 90 percent of formulary items from the MSPV-NG prime vendor. The healthcare system's utilization rate was only 54 percent on average, falling short of the 90 percent goal. The lower utilization rates occurring both before and during the COVID-19 pandemic resulted from Concordance, the MSPV-NG prime vendor. Employees said the short supply and high demand for personal protective equipment and other supplies during the pandemic added to the need to go to other vendors. The OIG also found that the healthcare system spent just under $68,000 more for 6,000 supply items purchased from October 1, 2020, through September 30, 2021, from nonprime vendor sources because of these issues.[4] Additionally, the healthcare system did not submit contract waiver requests for these items as required by VA policy because its leaders found the forms to be time-consuming, and it was hard to get instruction or approvals.

    As a result of not having a contracting officer's representative for much of the review period, the healthcare system did not fully use available reporting tools to provide feedback on the prime vendor's performance to assist with solving identified issues. These tools are important because they ensure VHA has the information needed to take corrective action.

IV. **Pharmacy operations**. The healthcare system could improve pharmacy efficiency by narrowing the gap between observed and expected drug costs, bringing the turnover rates closer to the VHA-recommended level and meeting requirements for noncontrolled drug line audits. Failure to follow these procedures could lead to unnecessary spending on drugs, increased risk of diversion, and the risk that veterans may not get the drugs they need in a timely manner.

    According to the OPES model, from FY 2019 to FY 2020 the healthcare system narrowed the gap between actual and expected drug costs from almost $9.5 million to about $8.5 million. However, this improvement reversed significantly in FY 2021, when

[4] Out of a team-selected judgmental sample of 40 purchasing records, two were cancelled by the vendor. Therefore, the 38 remaining items, which covered 19 frequently acquired formulary supply items and were ordered 6,000 times in total from vendors other than the prime vendor, were selected for facility review and comment. Two VA orders for 168 items were later cancelled.

actual drug costs exceeded expected drug costs by almost $9.8 million.[5] The chief of pharmacy said a review of costs found a few key drug classes, such as ophthalmic and sedative drugs, were much higher in FY 2020 as compared to similar complexity medical centers.

Low inventory turnover rates can indicate inefficient use of financial resources. In FY 2021, the healthcare system's pharmacy prime vendor reported an inventory turnover of 7.25 times compared to the VHA average of 7.75 times and VHA's recommended level of 12 times. The OIG found the healthcare system did not fully use reports from the prime vendor software package, manage drug inventories, or adjust stock levels in accordance with VHA policy. Pharmacy personnel said they were estimating the number of drugs needed to fill shelves instead of analyzing data from handheld barcode readers and using a want list instead of more accurate inventory management tools.[6]

VHA policy requires quarterly noncontrolled drug line audits for specific drugs identified as potentially being at high risk for diversion. In reviewing the healthcare system's audits for FY 2021, the OIG found that six of 25 reported variances between the actual and predicted amount of on-hand inventory were calculated incorrectly, and the reviews performed were inadequate. This was in part due to a discrepancy between VHA policy and the Pharmacy Benefits Management online tool that has since been corrected.

What the OIG Recommended

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

The OIG recommended the healthcare system director ensure finance office staff review open obligations and pharmacy reconciliations as required.

Regarding use of the MSPV-NG program, the OIG recommended the director develop a plan to work with the prime vendor to address having adequate stock to meet the system's needs. The director should also ensure the healthcare system submits MSPV-NG waiver requests and obtains approval before purchasing available formulary items from nonprime vendor sources. Logistics staff and the contracting officer's representative use the tools available to inform the

[5] The OPES Pharmacy Expenditure model uses the terms "observed minus expected" and "potential opportunity" to describe the gap between a facility's actual drug costs and expected drug costs. This difference represents the amount associated with potential efficiency improvements.

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

MSPO and Strategic Acquisition Center of prime vendor performance issues and concerns and challenges.

For pharmacy operations, the healthcare system director should develop formal processes for achieving identified efficiency targets and use available data to make business decisions. In addition, the director should develop and implement a plan to increase inventory turnover closer to the VHA-recommended level, and a plan to complete facility-based inventory audits of noncontrolled drug line items in compliance with Veterans Health Administration policy.

Management Comments and OIG Response

The director of the VA Cincinnati Healthcare 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 Cincinnati Healthcare System provides sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified. Appendix E includes the medical center director's comments.

LARRY M. REINKEMEYER
Assistant Inspector General
for Audits and Evaluations

Contents

Abbreviations

COR	contracting officer's representative
FMS	Financial Management System
FY	fiscal year
IFCAP	Integrated Funds Distribution, Control Point Activity, Accounting and Procurement System
MSPO	Medical Supplies Program Office
MSPV-NG	Medical/Surgical Prime Vendor–Next Generation
OIG	Office of Inspector General
OPES	Office of Productivity, Efficiency & Staffing
SCCOP	Supply Chain Common Operating Picture
VHA	Veterans Health Administration
VSSC	VHA Support Services Center

Introduction

The VA Office of Inspector General (OIG) conducts financial efficiency reviews to assess the oversight and stewardship of funds used by VA healthcare facilities and to identify opportunities to achieve cost efficiencies. To promote best practices, OIG review teams identify and examine financial activities that are under the healthcare facility's control and can be compared to VA healthcare facilities similar in size and complexity.[7]

This review focused on the VA Cincinnati Healthcare System and assessed the system's effectiveness in four areas:

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 use.** The VA Government Purchase Card Program was established to reduce administrative costs related to the acquisition of goods and services. When used properly, purchase cards can help facilities simplify acquisition procedures and provide an efficient vehicle for obtaining goods and services directly from vendors. Documenting transactions as required helps VA and other oversight authorities identify potential fraud, waste, and abuse. Using contracts for common purchases has several benefits, such as allowing VA to optimize purchasing power and obtain competitive pricing. The team examined whether the healthcare system's purchase card program ensured compliance with policies and procedures and focused on the consideration of contracts for commonly purchased products, known as strategic sourcing, to provide optimal savings to VA.

III. **Medical/Surgical Prime Vendor–Next Generation (MSPV-NG) program use.** The MSPV-NG program provides a collection of contracts with selected vendors that enables VA to streamline supply-chain management for an array of medical, surgical, dental, and select prosthetic and laboratory supplies. The program achieves long-term savings by

[7] The Medical Supplies Program Office is a Veterans Health Administration (VHA) entity in the Procurement & Logistics Office that is primarily responsible for supporting VHA's healthcare requirements and overseeing strategic sourcing efforts for supplies ordered through the MSPV-NG program. It was formerly known as the Healthcare Commodities Program Office. 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. Cincinnati is rated as a level 1b-High Complexity facility.

using a just-in-time logistics approach. VA medical facilities are required to use MSPV-NG contracts for products that are available through the program, which appear on a list called a formulary. The Medical Supplies Program Office (MSPO) recommends that each medical center purchase at least 90 percent of the supplies on the formulary from the program's assigned prime vendor.[8] The review team examined whether the healthcare system met VHA goals for using the program.

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

VA Cincinnati Healthcare System

The VA Cincinnati Healthcare System provides healthcare services at 10 locations, which serve a 15-county area in Ohio, Indiana, and Kentucky. Its facilities include two hospitals: the Cincinnati VA Medical Center in Ohio and the Cincinnati VA Medical Center–Fort Thomas in Kentucky. The healthcare system, which is part of Veterans Integrated Service Network 10, also operates six community-based outpatient clinics in Cincinnati, Ohio, and other locations in Ohio, Kentucky, and Indiana. It also has a wellness center and eye center. Additionally, it has a mobile care unit for veterans who cannot easily visit VA medical centers or clinics and residential care programs for veterans who need assistance with mental health, substance abuse, homelessness, or the risk of becoming homeless, traumatic brain injury, and post-traumatic stress disorder.

In fiscal year (FY) 2021, the Cincinnati healthcare system had a medical-care budget of about $607.5 million, over 2,200 full-time employees, and provided services to over 40,400 unique patients. For more information about the healthcare system, see appendix A.

Facility and Efficiency Selection

The review team evaluated VA data to identify those facilities with the greatest potential for financial efficiency improvements. The review team obtained data from the Office of Productivity, Efficiency & Staffing (OPES) efficiency opportunity grid, data from the Supply Chain Common Operating Picture (SCCOP), reports from the VHA Support Service Center (VSSC) and data from US Bank. The efficiency opportunity grid was used to obtain information on pharmacy operations; SCCOP was used for MSPV-NG information; FMS and VSSC reports were used for open obligations; and US Bank data were used for purchase card transactions.

VHA developed the efficiency opportunity grid to give facility leaders insight into areas of opportunity for improving efficiency when compared with other VHA facilities. The grid is a

[8] Medical Supplies Program Office, "The Formulary Utilization Metric: A Deep Dive Explanation," accessed November 1, 2021, https://vaww.va.gov/plo/docs/mspo/mspvFormularyUtilizationMetricOverview.pdf.

collection of 12 statistical models, which allows for comparisons between VHA facilities by adjusting data for variations in patient, facility, and geographic characteristics. It 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 three statistical models in the grid to assist in selecting facilities for financial efficiency reviews: the Stochastic Frontier Analysis model, the administrative full-time equivalent model, and the pharmacy expenditure model. The team then used a SCCOP report to gather MSPV-NG data for all VA medical centers and rank them by utilization percentages.

Results and Recommendations

I. Open Obligations Oversight

VA's management of open obligations has been a longstanding issue and was included as a significant deficiency in VA's FY 2021 audited financial statements and as a material weakness in VA's FY 2020 and FY 2019 audited financial statements.[9] Additionally, a 2019 VA OIG report on undelivered orders recommended VHA ensure staff review and reconcile open orders, identify and deobligate excess funds on those orders, and ensure staff follow VA policy regarding required reviews of open obligations.[10] If reviews are not conducted, the healthcare system 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.

As stated earlier, obligations not considered closed or complete that have a balance associated with them, whether undelivered or unpaid, should be reviewed by the healthcare system finance office to ensure performance beginning and end dates are accurate, open balances are accurate and agree with source documents, (i.e., receiving reports, invoices, and payments), and obligations without recent activity are still valid and should remain open. Failure to properly manage open obligations leaves funds attached to orders that could be closed and used for other purposes to benefit 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 inactive obligations were valid and should remain open. Obligations are inactive when they have had no activity for more than 90 days.
- **End-date modifications**. The review team identified open obligations with changes to the end date for the period of performance, and reviewed evidence from the healthcare system that supported those changes. The period of performance is the time during which the goods or services are to be provided.

[9] VA OIG, *Audit of VA's Financial Statements for Fiscal Years 2021 and 2020*, Report No. 21-01052-33, November 15, 2021; VA OIG, *Audit of VA's Financial Statements for Fiscal Years 2020 and 2019*, Report No. 20-01408-19, November 24, 2020. 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.

[10] 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.

- **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 VA's FMS and IFCAP to assess whether the healthcare system reconciled end dates and order amounts between the systems for the sampled obligations.

Finding 1: Inactive Obligations Were Not Always Reviewed, and One Was Not Promptly Deobligated

VA policy requires VA finance offices to perform monthly reviews and reconciliations of open obligations that have aged 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 funds are not underused.[11] For these obligations, healthcare system finance office personnel should verify with the initiating service or contracting officer, if applicable, that the goods or services have not been received and are still needed. The responsible finance office should review data from FMS against supporting documentation monthly to ensure reports, subsidiary records, and systems reflect proper costing, accurate delivery dates and end dates, and a correctly calculated unliquidated balance.[12]

Figure 1 shows the healthcare system's inactive obligations from April through September 2021.

[11] VA Financial Policies and Procedures, vol. II, chap. 5, "Obligations Policy," December 2020, May 2021, and September 2021.

[12] Per 2 C.F.R. § 200, the term "unliquidated balance" means an obligation incurred by a nonfederal entity that has not been paid (liquidated) or for which the expenditure has not been recorded.

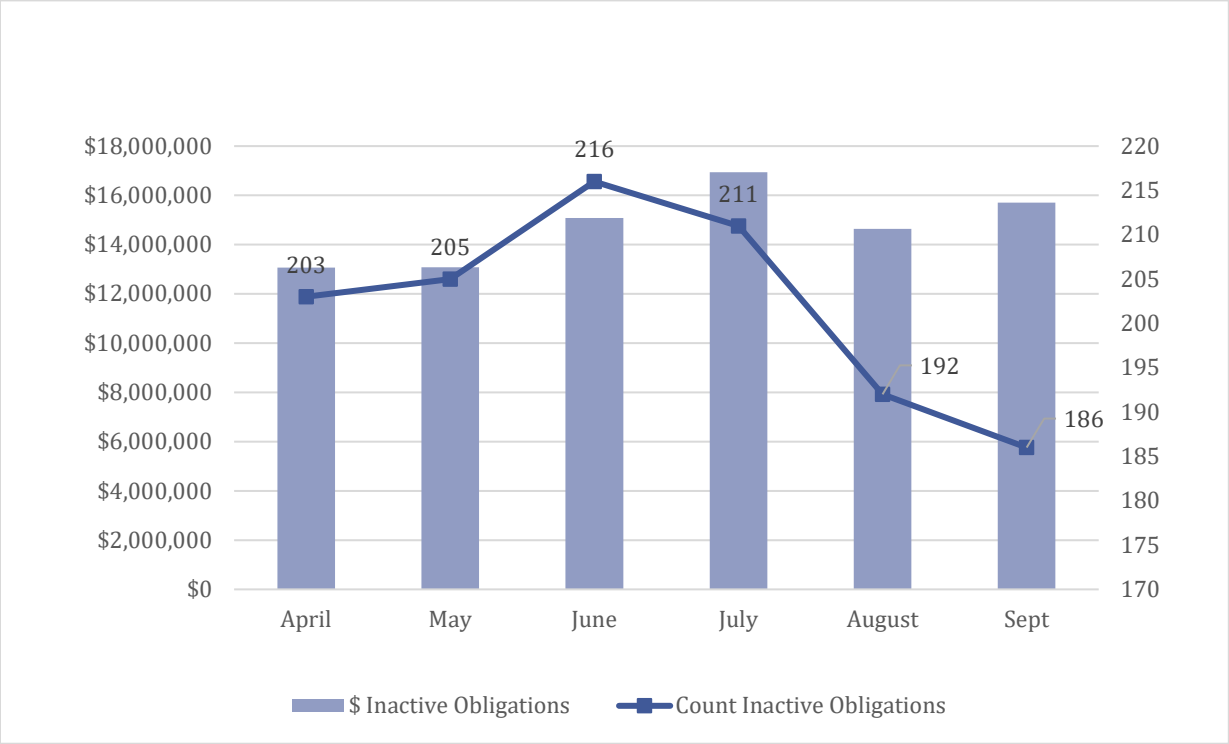

Figure 1. *VA OIG analysis of inactive obligations for the VA Cincinnati Healthcare System, April through September 2021.*

Source: VA FMS F850 Monthly Report.

As of September 30, 2021, the healthcare system had 186 inactive obligations totaling about $15.7 million. Figure 2 shows that 56 of the 96 obligations totaling about $8 million had no activity for over 181 days.

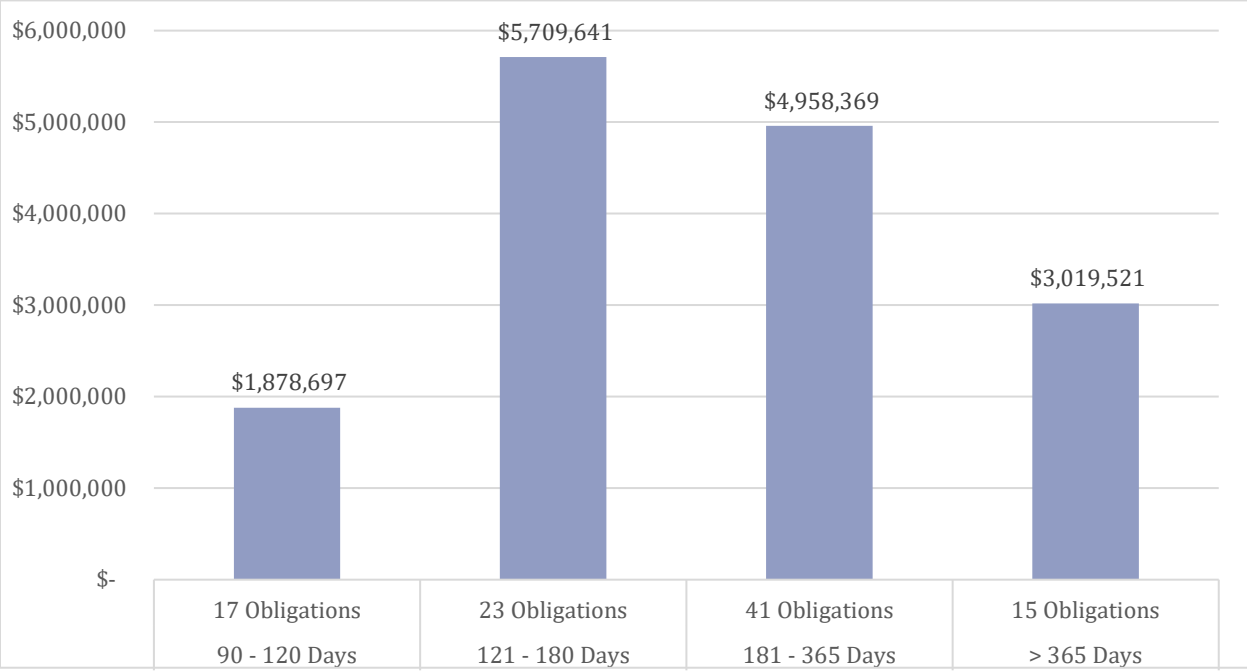

Figure 2. *Inactive obligations as of September 30, 2021.*
Source: VA FMS F850 Report.

Inactive Obligations Were Not Always Reviewed

The review team selected 20 inactive open obligations as of September 30, 2021, totaling almost $12.6 million. The team reviewed supporting documentation to determine if the healthcare system assessed the inactive obligations to determine if they were still valid and necessary, in accordance with VA financial policy.[13] Ten obligations were still within the performance period, while the remaining 10 were more than 90 days past the performance period end date.[14] The review team was not able to verify that a review was completed on nine of these 20 obligations, totaling about $7.2 million. Additionally, one of the 20 obligations had residual funds totaling about $2,000 that should have been deobligated.

VA financial policy states that open obligations should be reviewed by the finance office, in coordination with the initiating service, to ensure that obligations aged beyond 90 days of the period of performance end date or without activity in the past 90 days are valid and should remain open.[15] 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 quantity of the

[13] VA Financial Policies and Procedures, vol. II, chap. 5, "Obligations Policy," September 2021.

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

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

goods or services and decrease the remaining funds on the obligation. According to the chief financial officer, the healthcare system placed more focus on addressing funds that were 90 days past their period of performance end date than on open obligations that had no expenditure activity for more than 90 days. This priority reflected the healthcare system's emphasis on improving VHA financial indicators, including those listed in the "Aging of Orders-Count" report that VHA implemented in February 2020.[16] This report provides an aging analysis of open obligations that are greater than 90 days old and provides information on how well facilities are executing allocated funds. The chief financial officer also advised the OIG that contracted equipment orders (of which there were two in the OIG's sample) are not expected to have activity until the end date occurs, and therefore may involve periods of inactivity for more than 90 days. This type of order is typically for one singular item, and the obligation has no activity until equipment is fully received and installed. As a result, the system does not start tracking these orders until the end date has passed.

Obligation End-Date Modifications Were Supported

The review team evaluated a sample of 10 open obligations with end-date modifications in VA's FMS to determine whether the modifications were supported. For the 10 sampled modifications, the healthcare system had evidence to support the change, such as purchase order amendments in FMS.

End-Date and Order Amount Discrepancies between IFCAP and FMS

IFCAP handles the processing of certified invoices and electronic transmission of receiving documents to FMS. In addition, IFCAP transfers obligation information back to the control point and updates the control point balance automatically.[17] 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 finance office, in coordination with the initiating service to ensure period of performance dates are correct and match in all systems.[18] The review team selected and evaluated seven additional open obligations to determine whether end dates were accurate and 10 additional samples to determine whether order amounts were accurate and reconciled between VA's FMS and IFCAP.

[16] VHA Financial Indicators Handbook, FY 2021. 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 using resources. Those financial indicators that are applicable to open obligations report the number of days an order has been open and the count and dollar amount of those orders.

[17] 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.

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

Two of the seven sampled obligations contained end-date discrepancies that existed for three months or more, with variances between the IFCAP and FMS systems being 1,095 and 1,308 days, respectively. According to the chief financial officer, these errors were due to an oversight. Specifically, an IFCAP amendment decreased funds and changed an end date for one order, but the end-date change was not made in the corresponding adjustment to FMS. The other discrepancy was for an order that was purged by the Financial Services Center based on the age of the order. However, this order was still valid because it was for an ongoing project. Once aware of the situation, finance office staff had the order reinstated in IFCAP. These discrepancies were corrected after the review team site visit.

The team also determined FMS and IFCAP reflected continued discrepancies in order amounts for seven of 10 obligations reviewed, with an unreconciled amount totaling about $597,000. Per the chief financial officer, seven of these obligations were for pharmaceutical orders with the prime vendor and the variances were not identified due to pharmaceutical reconciliations being performed improperly.

Per VA procedures, the finance office must verify the unliquidated balance in IFCAP and reconcile it to the outstanding obligation balance in FMS. Discrepancies will be identified and corrected, collaborating with pharmacy service to ensure corrections are made appropriately.[19] Per the chief financial officer, the pharmacy service did complete the B09 reconciliation during the review period, but the finance office wasn't correctly completing the B09 reconciliation by verifying unliquidated balances between IFCAP and FMS. The reconciliation is necessary because payments are made to the prime vendor prior to the facility receiving the pharmaceuticals. Without the reconciliation, there is no assurance that the amount paid to the prime vendor agrees with the amount of actual goods received. These reconciliations help to ensure controls are in place to prevent fraud, waste, and abuse by requiring the pharmacy service to verify that the amount and type of medication received matches the invoices paid.

Finding 1 Conclusion

Failure to properly manage open obligations increases the risk that appropriated funds will not be spent in the associated fiscal year and cannot be used for other purposes to benefit veterans. Healthcare system personnel did not comply with VA policies requiring routine follow-up and could improve management and oversight of open obligations. The healthcare system's process did not ensure a review of all open obligations that were either more than 90 days past their end date or that were inactive for over 90 days. One open obligation had residual funds totaling about $2,000 that should have been deobligated.

[19] VHA Office of Finance, Financial Management & Accounting Systems Alert, vol. 2013, issue 001, "Pharmacy Prime Vendors B09 Reconciliation Standard Operating Procedures, October 3, 2012."

Additionally, the healthcare system did not ensure obligation end dates and purchase order amounts were reconciled between IFCAP and FMS and that the obligations were valid and accurately recorded in IFCAP. As a result, end-date discrepancies between FMS and IFCAP for two obligations of 1,095 and 1,308 days, respectively, and amount discrepancies for seven obligations totaling about $597,000, were not identified. Failure to perform reconciliations of pharmaceutical orders could increase the risk that VA will pay for overcharges, items ordered but not received, or other discrepancies.

Recommendations 1–2

The OIG made the following recommendations to the VA Cincinnati Healthcare System director:

1. Ensure that healthcare system finance office staff are made aware of policy requirements and that reviews are conducted on all inactive open obligations as required by VA Financial Policy, vol. 2, chap. 5, "Obligations Policy."
2. Require the finance office to perform quarterly compliance reviews of pharmacy invoice reconciliations.

VA Management Comments

The director of the VA Cincinnati Healthcare System concurred with recommendations 1 and 2. The responses to all report recommendations are provided in full in appendix E.

To address recommendation 1, the director reported that the healthcare system adjusted its open obligation review process to ensure that open obligations inactive for more than 90 days and open obligations 90 days past their end date are captured as part of the finance service's review process, as required by VA financial policy. VA policy updates will be addressed in weekly section meetings and disseminated to all finance staff immediately. For recommendation 2, the director reported the finance service is currently implementing a standard operating procedure provided by VHA Finance to ensure that unliquidated balances in IFCAP are reconciled to outstanding balances in FMS and that any discrepancies are promptly addressed.

OIG Response

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

II. Purchase Card Use

VA established its Government Purchase Card program to reduce the administrative costs related to the acquisition of goods and services. When used properly, purchase cards can help facilities simplify acquisition procedures and provide an efficient vehicle for obtaining goods and services directly from vendors. In FY 2021, the healthcare system spent about $40 million through purchase cards, representing about 48,500 transactions. The amount and volume of spending through the program makes it important to have strong controls over purchase card use to safeguard government resources and ensure compliance with policies and procedures that reduce the risk of error, fraud, waste, and abuse.

The review team focused on three areas related to purchase cards:

- **Purchase card transactions**. The review team examined whether the healthcare system processed purchase card transactions in accordance with VA policy, such as whether approving officials ensured approvals were obtained, conducted prompt reconciliation of cardholder transactions, and maintained segregation of duties. Additionally, the team inquired as to whether the healthcare system considered obtaining contracts when procuring goods and services on a regular basis, which VA refers to as "strategic sourcing." The use of contracts lowers the risk of split purchases and duplicate payments on purchase cards by reducing open market or individual purchases and enables VA to leverage its purchasing power.[20]
- **Supporting documentation.** The review team examined whether the healthcare system maintained supporting documentation as required for purchases to provide assurance of payment accuracy and the mission-essential need to purchase a good or service. This includes approved purchase requests, purchase orders, receiving reports, vendor invoices and, when necessary, written justification for purchases from a third-party payer.[21] Supporting documentation enables program oversight and helps prevent fraud, waste, and abuse.
- **Purchase card oversight**. The review team assessed whether the healthcare system tracked purchase card training, had purchase card policies in place, assigned approving officials to no more than 25 purchase card accounts, and maintained an accurate VA

[20] VA Financial Policy, vol. XVI, chap. 1B, "Government Purchase Card for Micro-Purchases," October 22, 2019, and VA Financial Policy, vol. XVI, chap. IB, July 14, 2021. Purchases over $10,000—the micropurchase threshold—cannot be made on purchase cards. Split purchases occur when a cardholder circumvents this requirement by dividing a single purchase or need into two or more smaller purchases.

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

Form 0242.[22] The team also assessed whether the healthcare system's purchase card coordinator provided oversight of the purchase card program by conducting quarterly internal audits. These activities are examples of systematic controls that reduce the risk of error and ensure a healthcare system complies with VA policy.[23]

Finding 2: Cardholders Did Not Consistently Obtain Approval before Making Purchases

The review team evaluated a judgmental sample of 36 purchase card transactions totaling just under $189,000 from October 1, 2020, through September 30, 2021, to determine whether the medical center processed transactions in accordance with VA policy and maintained required purchase card transaction documentation.[24] Though healthcare system leaders did oversee the program, the OIG found employees did not consistently process card transactions as required and maintain all documentation.

These issues occurred because approving officials did not closely review purchases as they were processed, and policy was not followed. However, the OIG found that these issues were not pervasive and did not make a related recommendation. Compliance with policies and procedures reduces the risk of fraud, waste, and abuse and enhances the stewardship of government money.

Purchase Card Transactions Were Not Consistently Processed Correctly

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

- *Prior approval* was obtained to ensure a valid business need before initiating a purchase.
- *Reconciliation* of a purchase was approved in a timely manner to help identify fraudulent or erroneous charges and unauthorized commitments.
- *Segregation of duties* were maintained to ensure roles and responsibilities did not overlap.

[22] 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.

[23] VA Financial Policy, vol. XVI, chap. 1B, sec. 0103, October 22, 2019; VA Financial Policy, vol. XVI, chap. 1B, sec. 0103, July 14, 2021.

[24] A judgmental sample is a nonstatistical sample selected based on auditors' opinions, experience, and knowledge.

The OIG determined that three of 36 purchase card transactions, or about 8 percent of those sampled, did not meet those requirements. A single purchase cardholder processed three transactions without prior approval. The transactions totaled about $10,200. In addition, the purchase cardholder did not record purchase orders for these purchases in a VA-approved automated system within one business day of making the purchases, as required by VA policy.[25] Purchase card officials for the healthcare system could not explain why the transactions were processed without prior approval or executed purchase orders. The purchase card coordinator said the cardholder incorrectly processed the monthly reconciliation by reconciling transactions to the wrong purchase orders. These issues occurred because approving officials did not provide sufficient oversight of the transaction process to ensure roles and responsibilities were adhered to in accordance with VA policy.

The review team also assessed if cardholders split purchases into two or more acquisitions to circumvent their authorized single purchase limit. The review team selected 10 potential split purchase bundles (comprising 30 sample transactions) totaling just under $177,000 to determine if cardholders split purchases. The team interviewed staff with purchase cards to garner insight into the bundled transactions. The team's analysis of the 10 bundles did not find any split purchases.

Lastly, the review team inquired whether the healthcare system considered obtaining contracts when procuring goods and services on a regular basis, referred to as "strategic sourcing." The program coordinator, approving officials, and cardholders must review purchases and determine when it is in the best interest of the government to use strategic sourcing, which generally provides greater savings to VA than the use of purchase cards.

VA financial policy states that VA must attempt to reduce individual purchases made with purchase cards and pursue strategic sourcing. By leveraging VA's purchasing power, strategic sourcing may offer the most competitive prices. The review team learned from the prosthetics chief that cardholders are told which vendors they should use before making open market purchases. A cardholder also conveyed to the review team that their purchase card lead emphasizes the use of contracts. The OIG found overall that the consideration of strategic sourcing was sufficient.

Supporting Documentation Was Not Always Maintained

VA financial policy states that cardholders should upload and store supporting documents for purchase card transactions electronically to a VA-approved document-imaging system.[26] When

[25] VA Financial Policy, vol. XVI, chap. 1B, sec. 010505, October 22, 2019; VA Financial Policy, vol. XVI, chap. 1B, sec. 010505, J., July 14, 2021.

[26] VA Financial Policy, vol. XVI, chap. 1B, sec. 010508, C., October 22, 2019; VA Financial Policy, vol. XVI, chap. 1B, sec. 010508, C., July 14, 2021.

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.

The review team determined that one of the 36 sampled transactions was missing documentation. While purchase cardholders generally maintained prior approval, purchase request, purchase order, and vendor invoice documentation for 35 of 36 transactions totaling just under $188,000, they did not maintain documents for one sample transaction, such as the receiving report and the vendor invoice. The healthcare system did not provide mitigating circumstances to explain the lack of supporting documentation.

The OIG found that one transaction for just over $880 was missing documentation such as a receiving report, invoice, and purchase order. The review team did not find documentary evidence that the goods had been received, and therefore could not determine if this was a proper payment. This payment is considered unknown per Office of Management and Budget guidance.[27] When the review team asked about this purchase, the purchase card coordinator could not explain why the cardholder made this purchase without a purchase order or did not retain any supporting documentation. The OIG did not, however, feel a recommendation was warranted as this was the only questionable transaction found.

Oversight of the Purchase Card Program Was Sufficient

Responsible officials are accountable for compliance with the purchase card program and for implementing internal controls to protect and conserve federal funds. Systemic measures, such as periodic and continuous monitoring, checks and balances, policies, procedures, and segregation of duties reduce the risk of error, fraud, waste, and abuse within 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 to 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.[28]

[27] Office of Management and Budget (OMB) Memo M-21-19, "Transmittal of Appendix C to OMB Circular A-123, Requirements for Payment Integrity Improvement," March 5, 2021. "Unknown" is the estimated amount within the agency's improper payment estimate that could be either proper or improper, but the agency is unable to discern whether the payment was proper or improper because of insufficient or lack of documentation.

[28] 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 OIG found that the overall oversight of the purchase card program was sufficient. Specifically, the review team determined the purchase card coordinator ensured purchase cardholders performed required training, approving officials managed no more than 25 purchase cardholders, and VA Form 0242 was maintained for each cardholder.

During the review period, the team determined that required quarterly audits of cardholder transactions were conducted and certification reports were completed on time and routed through the chain of command as required. Upon completion of the quarterly audit, VHA procedures require the purchase card coordinator to send a formal memo of audit results to the healthcare system director, with copies to the approving official or supervisor, no later than the end of the month after the close of the quarter.[29] However, the audit process did not detect the three purchases made without prior approval or executed purchase orders totaling about $10,200. Although quarterly purchase card audits are intended to evaluate and improve the effectiveness of internal controls and compliance with regulations and policies, they do not detect all discrepancies. The OIG did not find evidence that this was a pervasive problem and therefore did not make a recommendation.

Finding 2 Conclusion

Although the OIG identified some instances where the healthcare system did not process card transactions and maintain all documentation as required, these issues were not pervasive. Officials provided oversight of the purchase card program and maintained the supporting documentation. This oversight included quarterly purchase card audits. Nevertheless, the healthcare system did not consistently process transactions according to VA policy, and some transactions were not adequately documented, but because the OIG did not find that this was a pervasive problem, the OIG did not make a recommendation.

[29] VHA Government Purchase Card Program, "Internal Audits—Purchase Cards and Convenience Checks," Standard Operating Procedure, June 20, 2019.

III. Medical Surgical Prime Vendor–Next Generation Program Use

VHA medical facilities are required to use MSPV-NG for products that are available through the program, which appear on a list called a formulary.[30] As previously mentioned, the VA MSPO recommends that each medical center purchase at least 90 percent of medical supplies on the formulary from its assigned regional prime vendor.

During the COVID-19 pandemic, VA recognized that there was increased stress on its supply chain. In March and May of 2020, and again in March 2021, VA issued memos suspending certain performance measures related to medical supply purchases to maintain operations. However, the 90 percent metric was not one of the measures suspended.

According to the MSPV-NG formulary utilization dashboard, the healthcare system spent about $3.7 million through the program from October 1, 2020, to September 30, 2021.[31] The healthcare system's prime vendor is Concordance Healthcare Solutions, LLC, which replaced Kreisers, Inc. in April 2020. According to a press release published in April 2016, Kreiser, Inc. had merged with Seneca Medical Inc. and MMS to form Concordance Healthcare Solutions.[32]

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

- **Formulary utilization rate** measures the extent to which facilities use prime vendors for formulary item purchases.
- **National contract waiver requests** are required when purchasing available formulary items from nonprime vendor sources.
- **Contract performance monitoring** includes a healthcare system's oversight of the prime vendor, as well as the use of reporting tools that allow the healthcare system to report on prime vendor performance and to provide MSPV-NG program feedback. One element of prime vendor performance is the order fulfillment rate, a contractual requirement to fulfill at least 95 percent of monthly orders placed by a facility for items on the formulary.

[30] VHA memo, "Use of Medical/Surgical Prime Vendor (MSPV-NG) Contracts is Mandatory," June 22, 2015.

[31] The OIG team did not assess the accuracy of the summary data in the MSPV-NG formulary utilization dashboard.

[32] PR News "Kreisers, MMS and Seneca Complete Merger" released April 1, 2016. https://www.prnewswire.com/news-releases/kreisers-mms-and-seneca-complete-merger-300244503.html.

Finding 3: The VA Cincinnati Healthcare System Did Not Meet the MSPV-NG Utilization Goal, Did Not Request National Contract Waivers, and Did Not Routinely Use All Reporting Mechanisms on Prime Vendor Performance

The healthcare system did not meet the 90 percent formulary utilization goal for purchases made through the MSPV-NG program from October 1, 2020, through September 30, 2021, according to MSPV-NG data from the SCCOP.[33] Its formulary utilization rate averaged about 54 percent according to the MSPV-NG performance metrics dashboard. The review team did not assess the impact that the COVID-19 pandemic had on the healthcare system's MSPV-NG utilization rates. However, the team did determine that utilization rates have been consistently below the goal, both before and after the onset of the COVID-19 pandemic and its associated supply-chain disruptions. For the 12 months preceding the COVID-19 pandemic (March 2019 through February 2020), the healthcare system's formulary utilization averaged about 69 percent.[34]

Generally, the lower utilization rates occurring both before and during the COVID-19 pandemic resulted from Concordance, the MSPV-NG prime vendor, lacking adequate stock on hand to provide ordered supplies due to supply-chain shortages. Concordance's contract requirements include maintaining the necessary inventory levels to provide the required supplies to participating facilities and distributing supplies at the required unadjusted fill rate.[35] The unavailability of supplies from the prime vendor resulted in the need to purchase formulary supplies from other vendors. Nonetheless, the healthcare system did not complete monthly facility execution surveys to assess the prime vendor's performance and did not use the MSPV-NG issue management tool to report performance-related issues. The OIG also found that the healthcare system spent about $68,000 more for 6,000 supply items purchased from October 1, 2020, through September 30, 2021, from nonprime vendor sources because of these issues.[36] Additionally, the healthcare system did not submit contract waiver requests for these items as required by VA policy.[37]

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[33] The SCCOP is an interactive dashboard that enables supply chain leaders to observe supply chain metrics at the enterprise, veterans integrated service network, and facility levels.

[34] Proclamation 9994 of March 13, 2020, "Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19)," 85 Fed. Reg. 15,337 (March 18, 2020). On March 13, 2020, the President declared a national emergency concerning the COVID-19 pandemic.

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

[36] Out of a team-selected judgmental sample of 40 purchasing records, two were cancelled by the vendor. Therefore, the 38 remaining items, which covered 19 frequently acquired formulary supply items and were ordered 6,000 times in total from vendors other than the prime vendor, were selected for facility review and comment. Two VA orders for 168 items were later cancelled.

[37] VHA Directive 1761, *Supply Chain Management Operations,* December 30, 2020, and Veterans Health Administration, Medical/Surgical Prime Vendor (MSPV) Standard Operating Procedure, rev. May 2017.

Formulary Utilization Rate Challenges

The healthcare system's annual average MSPV-NG utilization rate was about 54 percent, and the monthly average ranged from about 42 percent to about 64 percent during the 12-month OIG review period. Comparatively, formulary utilization rates for VHA overall averaged 63 percent, and VISN 10 averaged 66 percent for the same period. In response to the urgent need and medical supply shortages that medical centers experienced during the pandemic, VA adjusted expectations for medical center inventory and purchasing. For example, a VA memo dated March 15, 2020, provided purchasing flexibilities that included increasing the emergency acquisition threshold for government purchase cards and contracts to expedite the delivery of goods and services.[38] While VA did not specifically suspend the 90 percent formulary utilization goal, the review team determined that the healthcare system's annual average formulary utilization rate decreased from just over 69 percent for the 12 months before the review period to about 54 percent during the period. Figure 3 shows the healthcare system's monthly MSPV-NG formulary utilization rates.

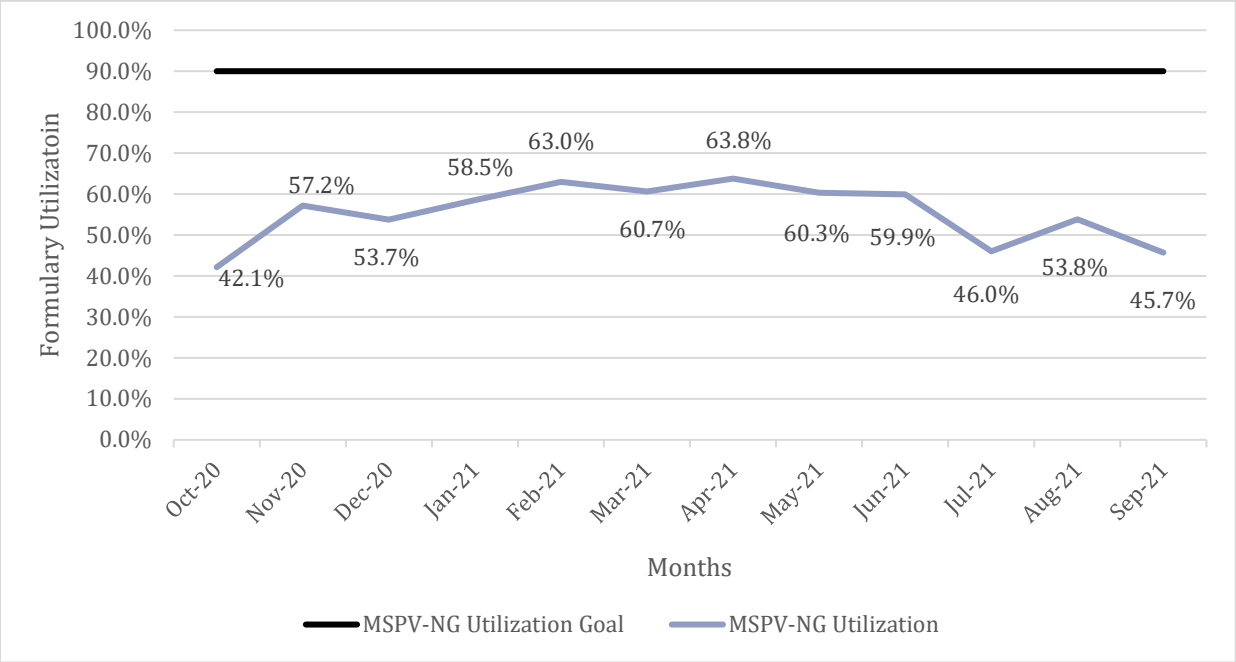

Figure 3. *MSPV-NG Utilization Rate for the VA Cincinnati Healthcare System.*
Source: VA OIG analysis of the healthcare system's Formulary Utilization Report.

The healthcare system spent over $3.1 million purchasing 31,975 formulary supply items from nonprime vendor sources (just under 46 percent of the total potential MSPV-NG expenditure), versus purchasing from Concordance as the prime vendor for supply items. Using the MSPV-NG

[38] VA memo, "Emergency Acquisition Flexibilities—Emergency Assistance Activities in support of Global Pandemic for Coronavirus Disease 2019 (COVID-19)," March 15, 2020.

formulary utilization report from the SCCOP dashboard, the review team judgmentally sampled 40 purchase records of formulary items acquired from nonprime vendor sources to assess why these items were purchased using nonprime vendor sources. The team provided these records to facility staff and requested comments from them to understand why these items were not purchased through the prime vendor and to assess the potential cost differences. These 40 samples cover 20 frequently acquired formulary supply items, purchased 6,168 times in total, at a cost of about $782,000.

The review team interviewed the healthcare system's logistics leaders, managers, and ordering staff to determine what challenges the staff faced when purchasing supplies from the MSPV-NG prime vendor. Table 1 shows the reasons the staff gave for not purchasing these items from the prime vendor.

Table 1. Reason Categories for Sample of Nonprime Vendor Purchases (October 1, 2020, through September 30, 2021)

Reason category	Number of purchases	Number of items	Sample amount	Difference between the order price and MSPV-NG formulary price
Building contingency inventory due to COVID-19 pandemic	15	3,971	$423,828	$104,435
Items were on backorder or allocation limits	21	2,107	$326,549	$(30,415)
Staff believed items were not available from the prime vendor	4	90	$31,296	$795
Total	**40**	**6,168**	**$781,673**	**$74,815**

Source: VA OIG analysis of Cincinnati VA Medical Center sample responses.
Note: Values are rounded.

The healthcare system's logistics staff explained that 15 of the 40 samples reviewed, or 3,971 formulary items, were purchased from nonprime vendor sources because the system was building contingency inventory due to the pandemic. The healthcare system referred to the June 2020 statement by the VA executive in charge that "each VAMC must maintain 60 days of critical materiel (e.g., [personal protective equipment], ventilators/ventilator consumables, and dialysis/dialysis consumables)" as part of its COVID-19 pandemic response.[39] The review team compared the prices paid for those items to the prices listed in the MSPV-NG formulary. The

[39] *Hearing on Building a More Resilient VA Supply Chain, Before the Senate Committee on Veterans' Affairs,* 116th Cong. (June 9, 2020) (statement of Richard A. Stone, M.D., executive in charge, Veterans Health Administration).

healthcare system paid about $424,000 for the items from nonprime vendor sources, which is about $104,000 more when compared to prices listed in the formulary.

The logistics staff explained that 21 of the 40 purchases reviewed, or 2,107 formulary items, were purchased from nonprime vendor sources due to backorders—that is, the good or service could not be filled at the time due to rationing or a lack of available supply. The prime vendor was limiting the amount that a single customer could purchase of the items. In addition to personal protective equipment such as masks and gloves, items such as wound dressings and needles were placed on allocation, or rationed, during the review time frame. Due to the short supply and high demand for personal protective equipment and other supplies during and after the pandemic, the prime vendor maintained these allocations. Consequently, the healthcare system attempted to purchase items from other sources. The review team compared the prices paid for those items to the prices listed in the MSPV-NG formulary. The healthcare system paid about $327,000 for the items from nonprime vendor sources, which is about $30,400 less when compared to prices listed in the formulary.

The chief of logistics also said that some formulary items go on backorder, then become temporarily available on allocation, then return to a backorder status. These changes in availability made it difficult for the healthcare system to obtain items and maintain consistent inventory levels. In addition, the logistics chief believed that the supply issues during the last two years are not just the fault of the prime vendor but are also a reflection of the supply-chain challenges being experienced nationwide. The OIG team reviewed the prime vendor's July, August, and September 2021 allocation reports and determined that some ordered items were on backorder and that Concordance could not always supply items when ordered.[40]

Finally, logistics staff explained that four of the 40 samples reviewed, or 90 formulary items, were purchased from nonprime vendor sources because the logistics staff believed these items were not available from the prime vendor. The review team compared the prices paid for those items to the prices listed in the MSPV-NG formulary. This analysis determined that the healthcare system paid just over $31,000 for the items from nonprime vendor sources, which is just under $800 more when compared to prices listed in the formulary. Using the prices stated in the formulary, these items would have totaled about $30,500.

Prime Vendor Supply-Chain Shortages

The healthcare system's prime vendor, Concordance, described the COVID-19 global pandemic as an ever-evolving situation that caused it to experience higher-than-normal demand for personal protective equipment and other critical related products. As a result, Concordance put inventory management policies into effect. One such policy was to ration personal protective equipment supplies, including gauze sponges, surgical gloves, N95 masks, and Liquid Stuart

[40] According to the logistics staff, an allocation resolution report shows order statuses for backorders.

transport swabs. The prime vendor stated that product availability was extremely volatile, and inventory was being closely monitored and restricted.

According to Concordance, the pandemic resulted in nationwide supply shortages and manufacturer price increases. Therefore, Concordance was not able to maintain sufficient supplies to meet the needs of VA medical centers, resulting in a fill rate of about 91 percent or less. Concordance representatives also explained that the company was experiencing issues with getting items from its own suppliers. For example, one of Concordance's suppliers did not fulfill orders because its price increases were not reflected on the VA contract. The supplier cited financial difficulties and said that it would not accept some orders until the VA contract office updated its pricing to align with the supplier's new prices.

Concordance said the challenge was causing VA medical centers to make purchases directly from the product manufacturer or via the open market. When purchases are made on the open market, such purchases are not bound by contract pricing. The healthcare system's logistics staff told the review team that Concordance did not have adequate stock on hand to provide ordered supplies. The team reviewed the prime vendor's allocation reports and determined that Concordance could not always supply items when ordered. Concordance stated they had recently met with the VA program office to discuss the pricing challenges and agreed to review the current contract pricing and have some items on the pricing list increased. It was anticipated that these adjustments would result in about a 25 percent to 30 percent increase in the fill rate once completed and orders could be fulfilled.

Contract Waiver Requests

The OIG also found that the healthcare system did not submit waiver requests required by VA policy for 15 of the 40 sample items totaling about $228,200, which it purchased from vendors other than the prime vendor. If the healthcare system had paid formulary prices for these 15 purchases, it would have paid just over $237,300, which is just under $9,200 more than nonformulary pricing. However, to ensure that decisions are evidence-based and timely, VA policy states that lower cost is not a sufficient justification for obtaining a waiver. For one of the 15 purchases, the healthcare system paid about $940 more by acquiring the items from a nonprime vendor source than if the items had been purchased with formulary pricing. As a result, the review team identified this expenditure as a questioned cost. For the remaining 14 items, the review team did not identify the price differences as questioned costs because the healthcare system paid about $10,100 less by purchasing from a nonprime vendor source.

For 23 records reviewed, or 5,224 items totaling about $534,000, the supply items were unavailable from the prime vendor due to rationing. The review team excluded two additional purchase orders from its analysis because they were canceled by the vendor. As a result, 25 waiver requests were not required, and the review team did not question these costs.

The chief of logistics said the healthcare system initially tried to follow the waiver policy, but the forms were time-consuming, and it was hard to get the VA Central Office to respond to a request for instruction or approvals. The logistics service felt that the waiver process did not provide any value. Therefore, the staff did not use national waiver requests when purchasing formulary items from nonprime vendor sources. This is not consistent with VHA policy, which stipulates facilities must submit a national contract waiver request when there is a compelling clinical, infrastructural, or other need to not use the MSPV-NG contract to buy medical supplies.[41] Each waiver request must provide a valid, justifiable, and appropriate rationale for purchases from a nonprime vendor source. VHA's headquarters directs that, to the extent permitted by law, VA medical facilities must use the MSPV-NG distribution contracts, in addition to other national contracts designated as mandatory in VHA policy, to purchase medical supplies. When an item is simultaneously available through an MSPV-NG distribution contract and another mandatory procurement instrument, the MSPV-NG contract must be used.[42]

The Healthcare System Did Not Routinely Use All Reporting Mechanisms on Prime Vendor Performance

If prime vendors do not meet their obligations, healthcare system personnel should alert program leaders and other VA procurement offices. One tool for doing so is the monthly facility execution survey, which informs the MSPO of the healthcare system's feedback on the MSPV-NG program and the MSPV-NG prime vendor. Another method for reporting concerns with the prime vendor's performance is the issue management tool used by contracting officer's representatives and supply-chain staff. The review team determined the healthcare system's logistics staff did not complete monthly facility execution surveys or submit feedback using the issue management tool during FY 2021.

The lack of feedback on vendor evaluations limited the ability of the MSPO and Strategic Acquisition Center to hold Concordance accountable for meeting its contractual obligations. Facility personnel should use all available tools to report issues with the prime vendor and provide accurate evaluations and feedback to the MSPO and Strategic Acquisition Center so that officials have the information needed to evaluate the effectiveness of the prime vendor, the MSPV-NG program, and to remind the prime vendor of its contractual obligations.

MSPV-NG Contracting Officer's Representative

According to the logistic chief the healthcare system did not have an MSPV-NG contracting officer's representative (COR) to monitor prime vendor performance during the FY 2021 review

[41] Veterans Health Administration, Medical/Surgical Prime Vendor (MSPV) Standard Operating Procedure, rev. May 2017.

[42] VHA Directive 1761, *Supply Chain Management Operations,* December 30, 2020; VHA memo, "Use of Medical/Surgical Prime Vendor (MSPV-NG) Contracts is Mandatory," June 22, 2015.

period or use the issues management tool or monthly facility execution survey prescribed by MSPO to provide feedback and oversight on prime vendor performance.

Each healthcare system is responsible for ensuring it has a certified MSPV-NG contracting officer's representative to help monitor prime vendor contract performance, report risks and issues to the MSPO, and hold the prime vendor accountable.[43] The Strategic Acquisition Center within the VA Office of Procurement, Acquisition, and Logistics oversees that each healthcare system has a filled MSPV-NG COR position. The Strategic Acquisition Center also issued and administers the MSPV-NG contract with Concordance and is responsible for serving as the contracting office and signing the letter designating an MSPV-NG COR.

According to the logistics chief, the COR position in Cincinnati had been vacant since April 2019 because logistics managers did not follow through with the Strategic Acquisition Center's requests to fill the position. Also, according to the healthcare system's logistics chief, the Strategic Acquisition Center did not follow up after April 2019 due to an administrative oversight. The logistics chief also said a new MSPV-NG contract is effective December 1, 2021, and a COR has been designated.

Prime Vendor Fill Rates

Concordance's contractual requirements included maintaining the necessary inventory levels to provide the required supplies to participating facilities and distributing supplies at an unadjusted fill rate of 95 percent, calculated as a percentage of the orders requested that were actually fulfilled at the time of request. Concordance provided the team with its monthly fill rate report for October 31, 2020, through September 30, 2021. According to this report, the prime vendor's unadjusted fill rate averaged 91 percent, demonstrating that the prime vendor did not meet the required 95 percent fill rate requirement.

The team reviewed this report and found that Concordance's monthly fill rates ranged from a low of about 88 percent to a high of 95 percent, with a 12-month average of 91 percent during the team's review period. Figure 4 shows Concordance's self-reported unadjusted fill rate for FY 2021.

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

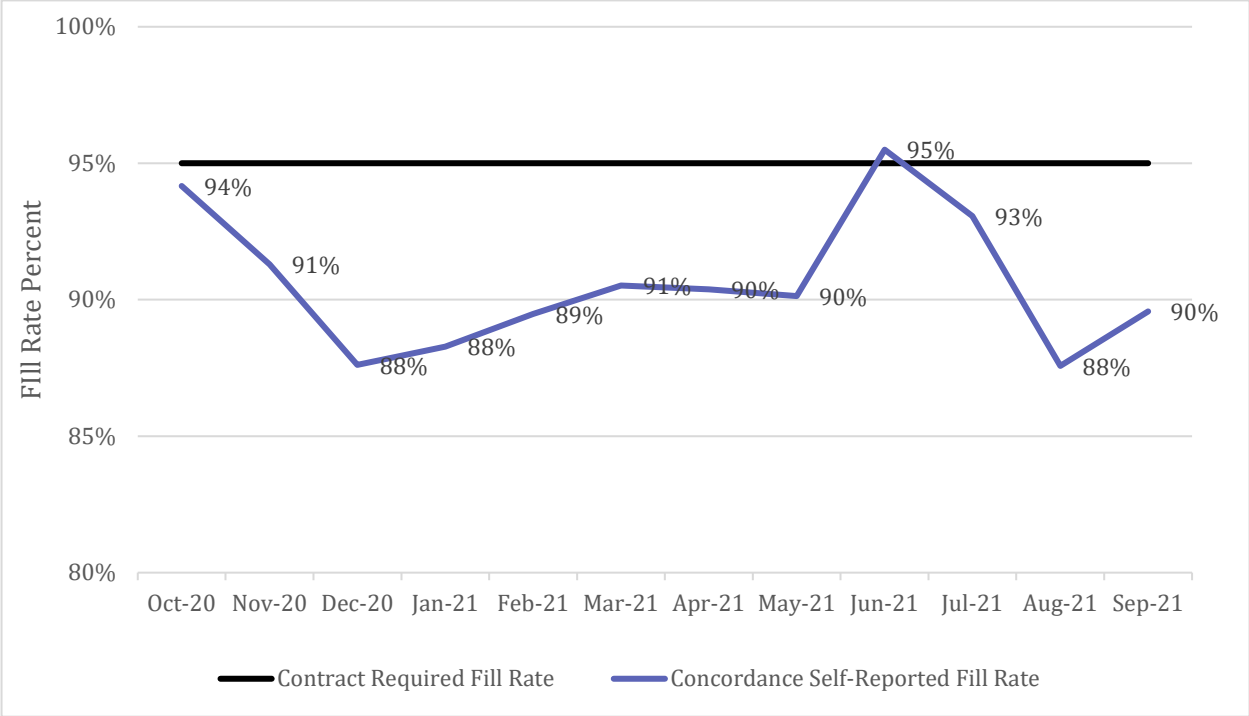

Figure 4. *Concordance Self-Reported Unadjusted Fill Rate Percentages, October 1, 2020, through September 30, 2021.*
Source: VA OIG analysis of the facility's supply-chain measure reports.

Healthcare system staff said they used other vendors because the prime vendor was unable to fill the purchase requests. A Concordance representative explained that it was also experiencing difficulty in getting supplies from its own suppliers. For example, Concordance provided supplier fill rate reports for November 2021 that showed its suppliers were only filling on average about 75 percent of Concordance's requested supply. The Concordance representative said the healthcare system should notify Concordance when new items are going to be requested along with estimated demand for each item as a potential way to mitigate future supply issues because those items can then be stocked.

Finding 3 Conclusion

The healthcare system did not meet its MSPV-NG utilization goal from October 1, 2020, through September 30, 2021, because its prime vendor, Concordance, did not always have adequate stock on hand to provide supplies when ordered. Concordance itself reported it experienced low fill rates from its own suppliers, because the COVID-19 pandemic caused nationwide supply shortages and manufacturer price increases. Additionally, the healthcare system did not submit waiver requests required by VA policy because it found the forms to be time-consuming, and it was hard to get instruction or approvals. As a result of not having a contracting officer's representative during the review period, the healthcare system did not fully use available reporting tools to provide feedback on the prime vendor's performance to assist with solving

identified issues. These tools are important because they ensure VHA has the information needed to take corrective action. Because of these issues, the healthcare system overpaid just over $74,800 for medical supplies purchased through suppliers other than the prime vendor.

Recommendations 3–5

The OIG made the following recommendations to the VA Cincinnati Healthcare System director:

3. Develop a plan to work with the prime vendor to address having adequate stock to meet orders, reducing the need for the healthcare system to use nonprime vendors.
4. Ensure the healthcare system submits Medical/Surgical Prime Vendor–Next Generation waiver requests and obtains approval before purchasing available formulary items from nonprime vendor sources.
5. Ensure logistics staff and the contracting officer's representative use the tools available to inform the Medical Supplies Program Office and Strategic Acquisition Center of prime vendor performance concerns and challenges.

VA Management Comments

The director of the VA Cincinnati Healthcare System concurred with recommendations 3, 4, and 5. To address recommendation 3, the director reported that logistics service will continue using national tools to monitor MSPV-NG compliance and utilization. To record contract compliance issues and to help ensure the prime vendor has adequate stock, the healthcare system now uses the MSPV-NG COR quarterly evaluation forms and the MSPV-NG issue management tool. The director also reported the COR is working more collaboratively with the prime vendor and logistics staff to monitor stock levels and identify trends that will help the prime vendor determine the healthcare system's stock needs.

To address recommendation 4, the director reported that logistics managers will provide standard operating procedures to logistics staff and will conduct training on waiver submission processes. To address recommendation 5, the director reported the prime vendor's contract compliance issues notated in the MSPV-NG COR quarterly evaluation forms and the MSPV-NG issue management tool will be routed through the chief supply chain officer and the associate director for review and will be escalated to the Medical Supplies Program Office when applicable.

OIG Response

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

IV. Pharmacy Operations

The FY 2021 OPES pharmacy expenditure model, based on FY 2020 VA data, reported that the healthcare system spent almost $61.9 million on prescription drugs. This spending represented just over 10 percent of the healthcare system's about $607.5 million medical-care budget.[44] Healthcare system leaders should analyze spending and identify opportunities to use pharmacy dollars more efficiently. The review team used the pharmacy cost model in the OPES efficiency opportunity grid to identify such opportunities.

The team reviewed the following pharmacy areas:

- **OPES pharmacy expenditure data** help VHA facilities track cost performance and identify potential opportunities for improvement.
- **Inventory turnover rate**, the number of times inventory is used during the year, is the primary measure to monitor the effectiveness of inventory management per VHA policy.[45] Low inventory turnover rates indicate inefficient use of financial resources.
- **Noncontrolled drug line audits**, are required by VA policy to be performed quarterly for specific drugs identified as potentially high risk for diversion.[46]

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

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

OPES Pharmacy Expenditure Data

According to the OPES pharmacy expenditure model, the Cincinnati healthcare system spent about $9.8 million higher than the expected costs of about $52.1 million in FY 2021. Based on these numbers, the facility's observed-minus-expected ratio was about 1.19, which ranked it

[44] "FY 2021 Pharmacy Expenditure Model (based on FY 2020 data)," Office of Productivity, Efficiency & Staffing (OPES), accessed October 20, 2021.

[45] VHA Directive 1761, *"Supply Chain Management Operations*,", December 30, 2020. Inventory turnover rates are based on the previous 12-month purchases divided by the inventory on hand.

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

134th out of 139 VHA facilities for pharmacy drug cost efficiency. An observed-minus-expected ratio above 1.0 indicates that a facility may have opportunities to reduce its pharmacy costs.

According to the OPES model, for FY 2019 through FY 2021, the healthcare system exceeded expected costs by an average of $9.2 million annually. Observed costs exceeded expected costs by almost $9.5 million for FY 2019, an amount which decreased to about $8.5 million over expected costs for FY 2020, and then increased again to about $9.8 million over expected costs for FY 2021. Figure 5 shows the observed cost, expected cost, and observed-minus-expected drug costs for FY 2018 through FY 2020.[47] The overall increase in the observed-minus-expected costs suggests the healthcare system can reduce pharmacy costs.

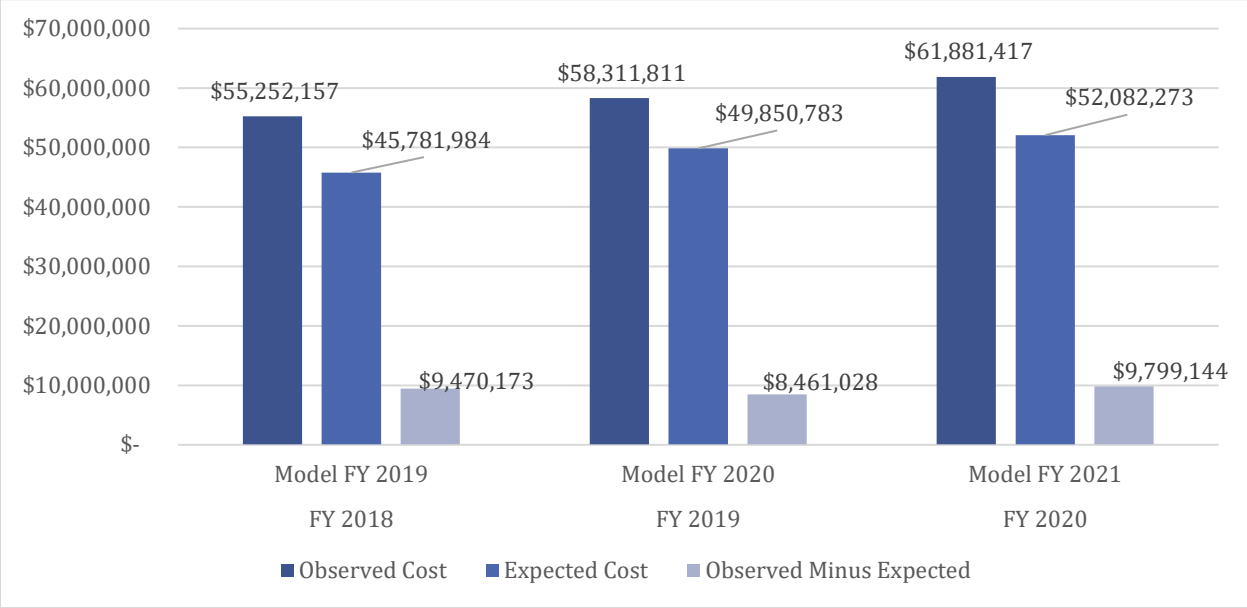

Figure 5. *Observed versus expected drug cost, FYs 2018–2020 and OPES model for FY 2019-FY 2021.*
Source: OPES pharmacy expenditure model.
Note: The OPES data models are based on the previous FY data (i.e., the FY 2021 data model was based on FY 2020 data).

The chief of pharmacy stated that the pharmacy service reviewed drug costs and found a few key drug classes with costs significantly higher than similar level 1b complexity medical centers in FY 2020. One example was ophthalmic drugs. The average fill cost per dose for this drug category was $436.64 at the facility in FY 2020, versus $78.61 for all similar facilities. The healthcare system uses these retinal agents for procedures performed at the facility, whereas many other VA facilities sent these procedures out for community care.

[47] The OPES pharmacy expenditure model uses the terms "observed minus expected" and "potential opportunity" to describe the gap between a facility's actual drug costs and expected drug costs. This difference represents the amount associated with potential efficiency improvements.

The chief of pharmacy identified sedative drugs as another example. The average fill cost per dose for this drug category was $33.72 for the facility, versus $11.47 for all similar level 1b facilities. The pharmacy chief said that the facility has undertaken significant efforts to decrease inappropriate combination use of sedatives in FY 2020, and that in FY 2021, this category of drugs was no longer an outlier and was below the national average.

Inventory Turnover Rate

VHA policy says inventory turnover is the primary measure of the effectiveness of inventory management.[48] Increasing the inventory turnover rate decreases inventory carrying cost, which is the cost associated with holding inventory in storage. In FY 2021, the pharmacy prime vendor reported an inventory turnover rate of 7.25 times for the healthcare system compared to the VHA average of 7.75 times and VHA's recommended level of 12 times, as established by the national Pharmacy Benefits Management program office. Low inventory turnover could indicate the inefficient use of financial resources and the inability to properly forecast the needed amount of pharmacy drugs to meet patient care needs.

VHA policy also mandates the use of prime vendor inventory management reports to manage all VA medical facility pharmacy inventories.[49] The review team determined that the healthcare system did not fully use inventory reports from the prime vendor to manage drug inventories or adjust stock levels in accordance with VHA policy. Reorder points represent the level at which inventory items are to be reordered and VA policy requires that reorder point levels be established for all primary and secondary inventory items.[50] However, pharmacy personnel said that though the healthcare system had reorder points to determine the quantity of drugs that should be purchased, the actual timing of when to buy those drugs depended on a manual process of visually inspecting the drug inventory bins. According to pharmacy personnel, instead of using handheld barcode readers as required by VHA policy, the healthcare system was using an "eyeball" approach, estimating the amount needed to fill the shelves. Additionally, pharmacy technician staff were using a wish list of needed items rather than calculated reorder points and quantities and demand forecasting, as required by policy.[51] The assistant chief of pharmacy explained that the healthcare system, in August 2021, hired a procurement program manager responsible for supervising procurement activities and helping improve inventory turnover.

[48] VHA Directive 1761.

[49] VHA Directive 1761.

[50] VHA Directive 1761.

[51] VHA Directive 1108.08(1).

Noncontrolled Drug Line Audits

VHA policy requires regular facility-based inventory audits for specific drugs identified as potentially at high risk for diversion. A manual count of each drug item selected must be completed and compared to reports and other tools chosen by local pharmacy managers. The variance between the observed and predicted amount on hand for the reporting period must be calculated. Variances greater than five percent require the healthcare system to perform an in-depth review and analysis.[52]

The OIG reviewed the Cincinnati healthcare system's quarterly noncontrolled drug line audits for FY 2021 and determined that they did not meet VHA policy requirements. The team identified the following issues:

- **Inaccurate calculations.** The team reviewed a Pharmacy Benefits Management reporting tool to assess the healthcare system's quarterly counts of noncontrolled drugs. The team found that for six of 25 records the Pharmacy Benefits Management tool miscalculated the difference between the actual and predicted amount of drugs on hand.
- **Missed reviews.** VHA policy says the healthcare system must complete an in-depth review if the variance between the actual and predicted amount of inventory on hand is greater than five percent.[53] Cincinnati pharmacy personnel said they used an online tool provided by the Pharmacy Benefits Management program office to complete this quarterly audit. However, the Pharmacy Benefits Management online tool showed that an in-depth review was only required if the variance is greater than 10 percent. Therefore, the healthcare system did not comply with VHA policy due to contradictory VHA and Pharmacy Benefits Management guidance. Pharmacy Benefits Management personnel confirmed that the online tool did not align with VHA policy for the review period. The review team was informed that in September 2021 the Pharmacy Benefits Management online tool was updated to align with VHA policy.
- **Unreported reviews.** VHA policy requires the results of these audits to be reported to healthcare system managers through the quality assurance process on a quarterly basis, and quarterly and annual summaries to be reported to the Veterans Integrated Service Network Pharmacy Executive Committee indicating the results of the reviews and any follow-up actions taken.[54] Interviews with pharmacy staff indicated these requirements were not fully being followed. Though the pharmacy sends quarterly reports to the facility's Pharmacy and Therapeutics Committee, staff were not forwarding quarterly and annual reports to the Veterans Integrated Service Network Pharmacy Executive

[52] VHA Directive 1108.08(1).
[53] VHA Directive 1108.08(1).
[54] VHA Directive 1108.08(1).

Committee. Pharmacy leaders and staff were not aware of this noncompliance with VA policy.

Failure to fully complete these regular inventory audits can increase the risk of drug diversion, inaccurate drug inventory data, and unnecessary spending in the pharmacy program.

Finding 4 Conclusion

The healthcare system needs to improve pharmacy efficiency by taking a more proactive approach in reducing the gap between actual drug costs and expected drug costs, increasing the inventory turnover, ensuring the use of the prime vendor inventory management reports to manage drug inventory, and in meeting noncontrolled drug line audit requirements. An efficient healthcare system anticipates how much drugs will cost and when inventory needs to be restocked to help ensure that the system makes the best use of appropriated funds and has inventory when needed.

Recommendations 6–8

The OIG made the following recommendations to the VA Cincinnati Healthcare System director:

6. Develop formalized processes for monitoring and achieving identified efficiency targets and use available pharmacy data to make business decisions.
7. Develop and implement a plan to increase inventory turnover to the Veterans Health Administration-recommended level.
8. Develop and implement a plan to complete facility-based inventory audits of noncontrolled drug line items in compliance with Veterans Health Administration policy.

VA Management Comments

The director of the VA Cincinnati Healthcare System concurred with recommendations 6, 7, and 8. To address recommendation 6, the director reported that key pharmacy personnel will continue meeting with OPES staff, community care staff, Decision Support System leaders, and the national Pharmacy Benefits Management staff to review data sources that identify efficiency targets and to address any potential outliers or data issues. Pharmacy staff have implemented data validation and efficiency identification strategies, which will be reviewed quarterly by pharmacy and clinical leaders to ensure that potential issues are addressed to improve pharmacy efficiency.

For recommendation 7, the director reported that a pharmacy inventory manager has been hired. The manager will review and address potential issues with reorder points, reorder quantities, and drug inventory scanning. To ensure staff manage procurements properly and increase inventory turnover levels, pharmacy leaders will continue to require training for the procurement team. The

chief of pharmacy is also evaluating automation processes that will provide a perpetual inventory for noncontrolled medications.

In response to recommendation 8, the director reported that all facility-based inventory audits of noncontrolled drugs are being completed on a quarterly basis as required with the results and action plans being reported to medical center leaders via the Pharmacy and Therapeutics Committee. To be fully compliant with VHA Directive 1108.08, pharmacy staff are now working with the Pharmacy Benefits Management office and the VISN 10 pharmacy executive to establish a direct reporting mechanism to the VISN Pharmacy Executive Committee.

OIG Response

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

Appendix A: Facility Profile

Facility Profile

Table A.1 provides general background information for this level 1b-High Complexity facility reporting to Veterans Integrated Service Network 10 leaders.[55]

Table A.1. Healthcare System Profile for the Cincinnati, VA Medical Center (October 1, 2019, through September 30, 2021)

Profile element	Facility data FY 2019	Facility data FY 2020	Facility data FY 2021
Total cost	$477,527,792	$564,423,286	$607,508,256
Number of unique patients	42,377	39,660	40,422
Outpatient visits	383,421	334,798	409,954
Total medical care full-time equivalent positions*	2,163	2,225	2,223
Type and number of operating beds:			
• Hospital	116	116	116
• Domiciliary operating beds	107	107	107
• Community Living Center	64	64	64
Average daily census:			
• Hospital	68	57	55
• Domiciliary operating beds	96	49	24
• Community Living Center	55	45	33

Source: VSSC, Trip Pack and Operational Statistics report.
Note: The OIG did not assess VA's data for accuracy or completeness.
Note: Values are rounded.
** Total Medical Care full-time equivalent positions includes direct medical care positions in budget object code 1000-1099 (Personal Services) and includes all cost centers.*

According to VSSC data, the healthcare system's medical-care budget increased by just under $130 million, or about 27 percent between FY 2019 and FY 2021. At the same time, the number of unique patients decreased by about 4.6 percent or 2,000 patients. The chief financial officer told the review team that the budget increase was due to COVID-19 appropriations that were used for equipment, including increased purchases of personal protective equipment. The budget for community care services, which increased by almost $65.7 million, or about 133 percent

[55] 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.

between FY 2019 and FY 2021 accounted for just over 50 percent of the overall medical-care budget increase. Of the $65.7 million, $33.2 million was specifically used to support operations during the pandemic and included the use of COVID-19 appropriations. Nonrecurring maintenance increased by just over $17 million, or just over 13 percent, and equipment costs and COVID-19 costs each increased by about $13.9 million. These four areas constitute a total of about $110.6 million or about 85 percent of the just under $130 million increase in the healthcare system's medical-care budget from FY 2019 to FY 2021.

Appendix B: Scope and Methodology

The OIG team conducted its review of the Cincinnati VA Medical Center in Ohio from December 2021 to June 2022, including an onsite visit during the week of December 6, 2021. The review team evaluated MSPV-NG utilization and purchase card transactions for October 1, 2020, through September 30, 2021, and for open obligations for April through September 2021. 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 financial efficiency practices for MSPV-NG utilization, overseeing purchase card transactions, monitoring open obligations, and addressing inefficiencies in pharmacy costs,
- judgmentally sampled 20 inactive obligations from the monthly FMS 850 report (which lists each open obligation and its remaining balance), 10 obligations to review end-date modifications from April through September 2021, and 17 obligations with end-date or amount discrepancies between FMS and IFCAP from May through September 2021; and judgmentally sampled 20 inactive obligations from the FMS 850 report, 10 obligations to review end-date modifications from April through September 2021, and 17 obligations with end-date or amount discrepancies between FMS and IFCAP from May through September 2021, and
- judgmentally sampled 36 purchase card transactions to determine if there was proper oversight and governance of the purchase card program, as well as to assess the risk for illegal, improper, or erroneous purchases.

Data Reliability

Computer-processed data used by the OIG included reports from VA's FMS to determine open obligation amounts. The team found that summary-level data were sufficiently reliable for reporting on the facility's open obligations.

The review team also used computer-processed data obtained from US Bank files. To test for reliability, the team determined whether any data were missing from key fields, included any calculation errors, or were outside the timeframe requested. The team also compared purchase order numbers, payment dates, payee names, payment amounts, and purchase ID number as provided in the data received in the samples reviewed. Testing of the data disclosed that they were sufficiently reliable for the review objectives.

In addition, computer-processed data included reports from the SCCOP dashboard to determine MSPV-NG utilization rates. The dashboard summary-level data were sufficiently reliable for reporting on the facility's MSPV-NG utilization rate.

To test for reliability, the team determined whether any data were missing from key fields, included any calculation errors, or were outside the timeframe requested. The review team also assessed whether the data contained obvious duplication of records, alphabetic or numeric characters in incorrect fields, or illogical relationships among data elements. Testing of the data disclosed that they were sufficiently reliable and documented for the review objectives.

Government Standards

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

Appendix C: Sampling Methodology

Open Obligations Oversight

The review team evaluated judgmental samples of open obligation transactions to determine if (1) the VA Cincinnati Healthcare 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, and (3) the facility reconciled end dates and order amounts between FMS and IFCAP.

Population

As of September 30, 2021, the facility had 707 open obligations, totaling about $93.6 million. Of those open obligations, 186 obligations, totaling about $15.7 million, were inactive. From April through September 2021, there were 45 obligations with 48 end-date modifications. From May through September 2021, there were 38 obligations with end-date discrepancies between FMS and IFCAP outstanding for three or more months. Additionally, there were 45 obligations with order amount discrepancies 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 September 2021 FMS F850 report. Ten obligations were still within the performance period, while the remaining 10 were more than 90 days past the performance period end date.
- **End-date modifications.** The team selected 10 obligations with modified end dates to the period of performance for all open obligations from FMS F850 reports for April 2021 through September 2021.
- **FMS to IFCAP reconciliations.** The team selected 17 obligations with different dates or order amounts between FMS and IFCAP from the FMS to IFCAP reconciliation reports for May through August 2021. Seven obligations had end-date discrepancies and 10 obligations had order amount discrepancies.

The samples included 47 total open obligations: 20 with no activity for more than 90 days, (10 obligations were still within the performance period, while the remaining 10 were more than 90 days past the performance period end date) totaling about $12.6 million; 10 with end-date modifications, totaling about $3.9 million; and 17 obligations with end-date or order amount discrepancies between FMS and IFCAP.

To review the sampled obligations, the team requested supporting documentation for each of the 47 sampled transactions, including monthly reviews and reconciliations, and financial system screen prints and reports related to the obligations.

Projections and Margins of Error

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

Purchase Card Use

The review team evaluated a judgmental sample of FY 2021 purchase card transactions to determine if (1) the facility was complying with VA policy; and (2) the facility's purchase card payments were adequately monitored to prevent split purchases. The review team interviewed officials to determine if ongoing repetitive orders with the same merchant, exceeding the micropurchase limit in aggregate, were procured using strategic sourcing procedures.

Population

During FY 2021, purchase cardholders at the facility made about 48,500 purchase card transactions totaling about $40 million.

Sampling Design

The review team developed a judgmental sample of 36 high-risk transactional areas that identified potential split purchases. The team defined potential split purchases as transactions with the same purchase date, purchase card number, and merchant, and an aggregate sum of greater than the cardholder's micro-purchase limit.

In applying this definition, the team identified 911 potential split purchases totaling about $1.8 million. The team then judgmentally selected 10 bundles of transactions.[56] This sample of 10 bundles included 30 total individual transactions amounting to just under $177,000 in spending.

To review the sampled transactions, the team requested supporting documentation for each of the 30 sampled transactions. For the cardholders for these samples, the team also requested their VA Form 0242 and certificates for completed purchase card training.

[56] The review team defined a bundle as a group of transactions grouped by vendor fitting the defined criteria of potential split purchases.

Projections and Margins of Error

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

MSPV-NG Program Use

The review team evaluated a judgmental sample of purchase records of formulary items acquired by the healthcare system during the period of October 1, 2020, through September 30, 2021, to determine why these items were purchased using nonprime vendor sources.

Population

From October 1, 2020, through September 30, 2021, the healthcare system spent about $3.1 million purchasing 31,975 formulary supply items from nonprime vendor sources.

Sampling Design

The review team selected a judgmental sample of 40 records, totaling about $781,700 of purchases from vendors other than the prime vendor.

To review the sampled purchase records, the team requested supporting documentation from the healthcare system for each of the 40 sampled transactions, including purchase orders, invoices, receiving reports, and explanations as to why it purchased these items using a source other than the MSPV-NG prime vendor.

Projections and Margins of Error

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

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

Recommendation	Explanation of Benefits	Better Use of Funds	Questioned Costs
1	Ensure that healthcare system finance office staff are made aware of policy requirements and that reviews are conducted on all inactive open obligations as required by VA Financial Policy, vol. 2, chap. 5, "Obligations Policy."	$2,000	
4	The Cincinnati healthcare system needs to ensure that national contract waiver requests are submitted before purchasing available formulary supply items from nonprime vendor sources.		$940
	Total	**$2,000**	**$940**

Appendix E: Management Comments

Department of Veterans Affairs Memorandum

Date: August 3, 2022

From: Director, Cincinnati VA Medical Center

Subj: Draft Report, Financial Efficiency Review of the Cincinnati VA Medical Center in Ohio (Project Number 2022-00208-AE-0011)

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

Finding 1: Inactive Obligations Were Not Always Reviewed, and One was Not Promptly Deobligated

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

Concur

Target date for completion: October 15, 2022

Director Comments

The Cincinnati VA Health Care System concurs with the recommendation. Finance Service has adjusted its open obligation review process to ensure that orders that are both inactive and aged are captured as part of finance's review process. This adjustment to the 889B review will allow the facility to be in full compliance regarding conducting reviews of inactive open obligations as required by VA Financial Policy, Volume 2, Chapter 5. VA policy updates will also be addressed in weekly section meetings and disseminated to all Finance Staff immediately upon receipt. Finances Service has created a new folder in its shared network folder to store all policy updates going forward.

Recommendation 2: Require the finance office to perform quarterly compliance reviews of pharmacy invoice reconciliations.

Concur

Target date for completion: October 15, 2022

Director Comments

The Cincinnati VA Health Care System concurs with the recommendation. Finance is currently implementing a standard operating procedure provided from VHA Finance to ensure that unliquidated balances in IFCAP are reconciled to outstanding balances in FMS and that any discrepancies are promptly addressed.

Finding 3: The VA Cincinnati Healthcare System Did Not Meet the MSPV-NG Utilization Goal, Did Not Request National Contract Waivers, and Did Not Routinely Use All Reporting Mechanisms on Prime Vendor Performance

Recommendation 3: Develop a plan to work with the prime vendor to address having adequate stock to meet orders, reducing the need for the healthcare system to use nonprime vendors.

Concur

Target date for completion: October 15, 2022

Director Comments

The Cincinnati VA Healthcare System concurs with the recommendation. The chief supply chain officer reported that logistics will continue to use national tools available to them to monitor MSPV compliance and utilization. The healthcare system is now notating contract compliance issues using the MSPV COR quarterly evaluation forms and via the MSPV issue management tool to help provide corrective action in the future regarding the prime vendor having adequate stock. The COR is also working more collaboratively with the prime vendor and logistics staff to monitor stock levels and identify trends that will assist with allowing the prime vendor to know the healthcare system's stock needs.

Recommendation 4: Ensure the healthcare system submits Medical/Surgical Prime Vendor–Next Generation waiver requests and obtains approval before purchasing available formulary items from nonprime vendor sources.

Concur

Target date for completion: October 15, 2022

Director Comments

The Cincinnati VA Healthcare System concurs with the recommendation. Logistics management will provide applicable references/SOPs to logistics staff and will be conducting training on waiver submission processes. Cincinnati VA Healthcare System will also ensure drop ship items that may be available via the MSPV, but don't meet the operational needs of the medical center, have an applicable waiver request processed as well. Logistics management is currently working with the MSPV contract holder and logistics staff to begin discussions on streamlining the drop shipment processes for future MSPV contract requirements.

Recommendation 5: Ensure logistics staff and the contracting officer's representative use the tools available to inform the Medical Supplies Program Office and Strategic Acquisition Center of prime vendor performance concerns and challenges.

Concur
Target date for completion: October 15, 2022

Director Comments

The Cincinnati VA Healthcare System concurs with the recommendation. Logistics is notating all contract compliance issues with the Prime Vendor by completing MSPV COR quarterly evaluation forms and via the MSPV issue management tool. All contract compliance issues will be routed through the chief supply chain officer and the associate director for review and will be escalated to the Medical Supplies Program Office when applicable.

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

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

Concur
Target date for completion: October 15, 2022

Director Comments

The Cincinnati VA Healthcare System concurs with the recommendation. Key pharmacy personnel will continue to meet with OPES staff, Community Care Staff, DSS leadership, and national pharmacy

benefits management staff to review various sources of data that identify efficiency targets and to address any potential outliers or data issues. Pharmacy staff have implemented strategies internally for data validation and efficiency identification and will be reviewed by pharmacy leadership and appropriate clinical leadership quarterly to ensure that any potential issues are addressed to improve pharmacy efficiencies.

Recommendation 7: Develop and implement a plan to increase inventory turnover to the Veterans Health Administration-recommended level.

Concur
Target date for completion: October 15, 2022

Director Comments

The Cincinnati VA Healthcare System concurs with the recommendation. A pharmacy inventory manager has been hired that will review and address any potential issues with reorder points, reorder quantities, and scanning of drug inventory. Training will continue to be given to the procurement team by pharmacy leadership to ensure that procurements are being managed accordingly and that inventory turnover levels are increased. The Chief of pharmacy is also evaluating pharmacy automation processes that will provide a perpetual inventory for non-controlled medications.

Recommendation 8: Develop and implement a plan to complete facility-based inventory audits of noncontrolled drug line items in compliance with Veterans Health Administration policy.

Concur
Target date for completion: October 15, 2022

Director Comments

The Cincinnati VA Healthcare System concurs with the recommendation. All Facility based inventory audits of noncontrolled drug items are being completed on a quarterly basis as required with the results and action plans being reported to Medical Center Leadership via the Pharmacy and Therapeutics Committee. To be fully compliant with VHA Directive 1108.08, pharmacy is now working with pharmacy benefit management and the VISN 10 pharmacy executive to establish a direct reporting mechanism to the VISN Pharmacy Executive Committee.

(Original signed by)

T. Jane Johnson

Executive Medical Center Director

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

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Review Team	Anthony Leigh, Director Angela Billups Steven Flores Nathan Fong Gurpreet Kaur Athenia Rosolowski
Other Contributors	Dan Blodgett Dyanne Griffith Charles Hoskinson

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