



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Financial Efficiency
Inspection of the
VA New York Harbor
Healthcare System



MISSION

The mission of the Office of Inspector General is to serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs.

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

FOR MORE
VA OIG REPORTS
CLICK HERE



**Report suspected wrongdoing in VA programs and operations
to the VA OIG Hotline:**

www.va.gov/oig/hotline

1-800-488-8244



Executive Summary

The VA Office of Inspector General (OIG) conducted this inspection to assess the oversight and stewardship of funds by the VA New York Harbor Healthcare System and to identify potential cost efficiencies in carrying out healthcare system functions. To accomplish this goal, the OIG identified areas that draw on considerable VA financial resources and made recommendations to promote the responsible use of VA's appropriated funds.

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

- I. **Open obligations oversight.** An obligation is a legally binding commitment of appropriated funds for goods or services.¹ Open obligations include those 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 those beyond 90 days of the period of performance end date or without activity in the past 90 days are valid and should remain open.² The inspection team evaluated whether the healthcare system performed monthly reviews and reconciliations of sampled obligations.
- II. **Purchase card use.** The VA Government Purchase Card Program was established to reduce administrative costs related to the acquisition of goods and services. When used properly, purchase cards can help healthcare systems simplify acquisition procedures and provide an efficient vehicle for obtaining goods and services directly from vendors. The team examined whether the healthcare system's purchase card program ensured compliance with policies and procedures that reduce the risk of error, fraud, waste, or abuse. The inspection team evaluated whether the healthcare system adhered to strategic sourcing guidelines, considered establishing contracts when making purchases, and properly documented sampled transactions.³ Using contracts for common purchases has several benefits, such as allowing VA to optimize purchasing power and obtain competitive pricing. Documenting transactions as required helps VA and other oversight entities identify potential fraud, waste, and abuse.

¹ VA Financial Policy, "Obligations Policy," in vol. 2, *Appropriations, Funds and Related Information*, May 2021, September 2021, and April 2022, chap. 5.

² VA Financial Policy, "Obligations Policy."

³ VA Financial Policy, "Government Purchase Card for Micro-Purchases," in vol. 16, *Charge Card Programs*, October 22, 2019, and July 14, 2021, chap. 1B. This policy defines "strategic sourcing" as ensuring employees obtain proper contracts when procuring goods and services on a regular basis.

- III. **Medical/Surgical Prime Vendor (MSPV) program use.** The MSPV 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.⁴ The program achieves long-term savings by using a just-in-time logistics approach. VA healthcare systems are required to use MSPV contracts for products that are available through the program, which appear on the MSPV Product List, also referred to as the formulary. The Medical Supplies Program Office (MSPO) recommends that each medical center purchase at least 90 percent of its supplies that are available on the formulary from the assigned prime vendor.⁵ The inspection team examined whether the healthcare system met Veterans Health Administration (VHA) goals for using the program.
- IV. **Pharmacy operations.** An efficient healthcare system anticipates how much drugs will cost and when inventory needs to be restocked by analyzing available data, such as prime vendor inventory management reports and inventory turnover rates.⁶ Doing so helps ensure that the system makes the best use of appropriated funds and has inventory when needed. The team evaluated whether the healthcare system managed its pharmacy operations effectively and provided adequate oversight of inventory management.

The inspection 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 VHA Support Service Center (VSSC). The efficiency opportunity grid was used to obtain information on pharmacy operations, SCCOP was used for MSPV information, Financial Management System (FMS) and VSSC reports were used for open obligations, and US Bank data were used for purchase card transactions. The period of data reviewed by the inspection team varied for each protocol, but was no earlier than May 1, 2021, and no later than July 31, 2022.

The team performed a site visit at the VA New York Harbor Healthcare System during the week of August 15, 2022; interviewed healthcare system leaders and staff; and reviewed data, supporting documents, and processes related to the healthcare system's financial efficiency. For

⁴ The healthcare system was covered by two MSPV contracts during the OIG's review period: the MSPV-Next Generation Bridge (MSPV-NG Bridge; Cardinal Health PV contract 36C10G20D0025), effective April 2020 through November 2021, and MSPV-Generation Z Transition (MSPV-GenZ Transition; Cardinal Health PV contract 36C10X22D0002), effective December 2021 through November 2022.

⁵ "The Formulary Utilization Metric: A Deep Dive Explanation" (web page), VA Medical Supplies Program Office, accessed June 30, 2022, <https://vaww.va.gov/plo/docs/mspo/mspvFormularyUtilizationMetricOverview.pdf>. (This is an internal website not publicly accessible.)

⁶ The inventory turnover rate is the number of times inventory is replaced during the year. Low inventory turnover rates indicate inefficient use of financial resources.

more information about the healthcare system, see appendix A. For more information about the inspection's scope and methodology, see appendixes B and C.

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

What the Inspection Found

According to VSSC data, the healthcare system's medical care budget increased by almost \$48.5 million (about 6.3 percent) between fiscal years (FY) 2019 and 2021. At the same time, the number of unique patients increased by only 736 patients (about 1.5 percent). According to the chief financial officer the healthcare system experienced large fluctuations during the FY 2019 to FY 2021 period in several budget categories, some of which exceeded the overall budget increase of almost \$48.5 million. The chief financial officer said the healthcare system used the FY 2019 to FY 2021 budget increase for COVID-19 costs (almost \$57.6 million), increased spending on the Care in the Community program (about \$15.6 million), equipment (over \$14 million), and nonrecurring maintenance costs (about \$13.5 million). The total increased spending for these four areas totaled almost \$100.8 million; however, the amount of spending attributed to the healthcare system for prosthetics decreased by almost \$51.5 million. According to the healthcare system's chief financial officer, the large decrease occurred because in FY 2019, all Veterans Integrated Service Network (VISN) prosthetics program costs were assigned to the healthcare system, whereas in FY 2020 the healthcare system's costs for prosthetics employees were assigned to the VISN. Appendix A has additional details about the healthcare system's resources and workload.

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

- I. **Open obligations oversight.** As of May 28, 2022, the healthcare system had 840 inactive obligations totaling just over \$53.8 million. Of those, 764 (totaling just under \$33.6 million) had no activity for 181 days or more. The inspection team selected 19 obligations that had been inactive for more than 90 days, totaling almost \$31.5 million, and examined whether the healthcare system performed required reviews to assess the validity and necessity of the remaining funds associated with each. The team was not able to verify that reviews were completed on 10 of the 19 obligations. One of these 19 obligations also had funds totaling just over \$33,500 that were deobligated due to the team's review.

The healthcare system used Undelivered Orders (FMS 850) and Analysis of Open Documents (889B) reports to identify obligations inactive for over 90 days. However, according to finance office personnel, the healthcare system did not complete reviews of all inactive obligations for several reasons: a lack of staffing, a lack of urgency from initiating services, operational disruptions during the COVID-19 pandemic, competing

priorities, and a greater focus on published VHA financial indicators about obligations that were 90 days past their period of performance end date.

The inspection team selected and evaluated 10 additional open obligations to determine if order amounts were accurate and reconciled between FMS and the Integrated Funds Distribution, Control Point Activity, Accounting and Procurement system (IFCAP).⁷ The team determined that IFCAP and FMS order amount discrepancies existed for three months or more for four of 10 obligations reviewed, with unreconciled amounts totaling almost \$14,300. One of these obligations also had an accrued amount of about \$780, which brought the total order amount discrepancies to more than \$15,000. Of the total amount of discrepancies, almost \$14,600 was no longer needed and should have been deobligated in FMS. The fiscal service corrected these four obligations after the inspection team's site visit. These discrepancies occurred because the finance office did not reconcile order amounts between systems as required.⁸ Had the finance office staff properly managed open obligations, they could have reduced the risk of failing to spend appropriations within the associated fiscal year and to repurpose funds to benefit veterans.⁹

II. **Purchase card use.** The team reviewed a statistical sample of 101 purchase card transactions from July 1, 2021, through June 30, 2022, totaling approximately \$375,000, to determine whether transactions were processed in compliance with VA policy.¹⁰ The OIG found that the healthcare system did not always maintain supporting documentation for the sample transactions. Based on the sample review, the team projected cardholders did not have sufficient supporting documentation for about 5,000 of 46,900 transactions, which resulted in approximately \$6.1 million in questioned costs.

The lack of complete documentation occurred because the healthcare system did not maintain copies of purchase card documentation, and purchase card coordinators did not provide adequate oversight of the purchase card program.

The team also assessed whether healthcare system staff obtained prior approval, adhered to segregation of duties throughout the transaction process, and performed reconciliations in compliance with VHA policies that are designed to reduce fraud, waste, and abuse. The team did not find any instances of improper segregation of duties. Based on the sample review, the team projected that cardholders did not obtain prior approval for about 29,400 transactions, resulting in about \$30 million in questioned costs, and cardholders

⁷ IFCAP is used for 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 balance automatically.

⁸ VA Financial Policy, "Obligations Policy."

⁹ Appendix D presents the estimated monetary benefits associated with deobligating these obligations.

¹⁰ VA Financial Policy, "Government Purchase Card for Micro-Purchases."

did not perform reconciliations for about 27,600 transactions, resulting in about \$28.6 million in questioned costs.

The team assessed potential split purchases and whether cardholders adhered to strategic sourcing guidelines.¹¹ The team reviewed transaction documentation and interviewed purchase cardholders and approving officials and determined that none of the transactions were split purchases.

Based on the results of the sample for all areas reviewed, the team projected that the healthcare system had about \$44.1 million in questioned costs on approximately 42,300 of the 46,900 purchase card transactions (about 90 percent) due to noncompliance errors during the 12-month period ending June 30, 2022.¹²

VA Form 0242, the Governmentwide Purchase Card Certification form, delegates authority to an individual to use a VA purchase card. The healthcare system did maintain copies of these forms for each of the 23 cardholders in the inspection team's sample. However, for eight cardholders, the spending limits listed in the 0242 forms did not match spending limits identified in US Bank data. This issue occurred because program coordinators did not provide adequate oversight of the purchase card program.

The inspection team determined that the healthcare system's purchase card coordinator conducted purchase card reviews during the purchase card review period of July 1, 2021, through June 30, 2022, as required by policy.¹³

- III. **MSPV program use.** The healthcare system did not meet the 90 percent formulary utilization goal recommended by the MSPO. The healthcare system's utilization rate, which measures the percent of formulary items purchased from the MSPV prime vendor, averaged only about 45 percent from May 2021 through April 2022. Generally, the lower utilization rate occurred because the healthcare system's logistics staff did not update the item master file to specify Cardinal Health as the default vendor and did not routinely provide Cardinal Health with monthly inventory usage data to ensure items were in stock when needed. The logistics leaders cited additional reasons—including items not being listed in VA's ordering system, staffing shortages, additional training needed for ordering officers, and clinicians pushing back on using items listed on the MSPV Product List—as contributing to lower formulary utilization. Additionally, the OIG found that the healthcare system had an MSPV contracting officer's representative that did not complete

¹¹ A split purchase means modifying a transaction into smaller purchases to avoid exceeding the micro-purchase threshold or a cardholder's single-purchase limits.

¹² When reporting on total errors combined, the OIG uses a projected "overall errors" estimate to avoid double counting transaction amounts. Therefore, the individual questioned cost amounts of \$6.1 million, \$30 million, and \$28.6 million do not add up to \$44.1 million.

¹³ VA Financial Policy, "Government Purchase Card for Micro-Purchases."

important designated duties and did not always use available tools to provide feedback on the prime vendor's performance. The team reviewed a judgmental sample of 30 purchase records and found that, as a result of buying formulary items from nonprime vendors, the system spent about \$53,400 more for about 15,400 supply items purchased from May 1, 2021, through April 30, 2022. Additionally, the inspection team questioned 15 of these transactions for about \$23,700 because the healthcare system did not submit contract waiver requests as required by VA policy. The healthcare system leaders stated they were not aware of the waiver request requirement.¹⁴

- IV. **Pharmacy operations.** The healthcare system could improve pharmacy efficiency by narrowing the gap between observed and expected drug costs, bringing inventory turnover rates closer to the VHA recommended level, meeting requirements for noncontrolled drug line audits, and completing the B09 reconciliation process, which is how VA medical center pharmacies ensure they make correct payments for the drugs they receive.

According to the OPES model, the healthcare system's observed drug costs were higher than expected over a three-year period. For the FY 2020 OPES model, the healthcare system's observed drug costs were about \$4.8 million less than expected. However, in FY 2021 the observed drug costs exceeded the expected amount by over \$670,000, and in FY 2022 were over \$3.3 million higher than expected.¹⁵ The pharmacy chief said that the healthcare system's drug costs were higher than that of many of its peers due to its large population of HIV-positive patients and the cost of prescribing expensive antiviral drugs.

Low inventory turnover rates can indicate inefficient use of financial resources. In August 2022, the pharmacy prime vendor reported an inventory turnover rate of almost 10.5 times for "A" inventory items, compared to the recommended turnover rate of 12–16 times for "A" items. The healthcare system did not use the prime vendor software package to manage drug inventories or adjust stock levels in accordance with VHA policy. For example, calculated reorder points and reorder quantities determined via demand forecasting were not used to manage inventory more accurately as required by policy.¹⁶ Instead, pharmacy drug inventories were managed by walking the floors, observing stock on the shelves, and using color-coded stickers to determine if drugs were

¹⁴ Veterans Health Administration, "Medical/Surgical Prime Vendor (MSPV)" (standard operating procedure), rev. June 2017 accessed June 14, 2022, <https://vaww.va.gov/plo/docs/mspo/mspvWaiverStandardOperatingProcedure.pdf>. (This is an internal website not publicly accessible.)

¹⁵ The OPES pharmacy expenditure model uses the terms "observed minus expected" and "potential opportunity" to describe the gap between a healthcare system's actual and expected drug costs. This difference represents the amount associated with potential efficiency improvements.

¹⁶ VHA Directive 1108.08(1), *VHA Formulary Management Process*, November 2, 2016, amended August 29, 2019.

expiring soon or on backorder. Also, pharmacy personnel did not place bar codes on stock at all locations, use handheld barcode readers, and use the ABC inventory analysis method as required by VHA policy.¹⁷

The healthcare system's reconciliations of the Pharmacy Prime Vendor Line Item Report (B09 reconciliations) did not fully comply with VA policy because the pharmacy service did not always sign and date invoices as evidence of review.¹⁸ Also, pharmacy service personnel did not always provide all supporting documentation, which prevented the inspection team from determining whether reconciliations were being completed fully or on time.

What the OIG Recommended

The OIG made 14 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 and ensure that healthcare system staff are conducting finance quality assurance reviews specific to accounting operations, including the review of undelivered orders, as required by VA policy.

To strengthen oversight of purchase card transactions, the OIG recommended the healthcare system director ensure cardholders comply with record retention, prior approval, and purchase card reconciliation requirements, as required, and ensure cardholders verify that vendors have removed all inappropriate state and local sales taxes from orders. Also, the healthcare system director should ensure authorizing officials are implementing internal controls over government purchase card activities to maintain compliance with the Government Purchase Card Program.

Regarding use of the MSPV program, the OIG recommended the director ensure the healthcare system monitors the MSPV formulary for updates, changes supply purchases to the prime vendor in the item master file, and identifies the prime vendor as the mandatory source for these items in the Generic Inventory Package. The director should also develop a plan to improve collaboration

¹⁷ VHA Directive 1108.08(1). The ABC classification method states that inventory items with approximately 70 percent of the inventory dollars and 10 percent of the products are classified as "A." Items with approximately 20 percent of the inventory dollars and 20 percent of products are classified as "B." Lastly, items representing approximately 10 percent of the inventory dollars and 70 percent of the products are classified as "C."

¹⁸ VHA Directive 1108.07(1), *Pharmacy General Requirements*, March 10, 2017, amended January 26, 2021. The chief of pharmacy services is responsible for reviewing the Pharmacy Prime Vendor (PPV) Line Item Report (B09 report) and reconciling the report with VA Form 1358 to ensure that the pharmacy is making correct payments for what is received and there is documented evidence (signature and date) that the review has been completed.

with the prime vendor to ensure adequate stock is available to meet orders and communicate the healthcare system's usage and in-stock timing needs. In addition, the director should ensure a qualified MSPV contracting officer's representative is appointed and performs the required delegated duties; and the healthcare system submits national contract waivers and justifications prior to purchasing available formulary items from nonprime vendor sources. Lastly, the director should ensure prime vendor contract performance issues are routinely reported to the MSPO and Strategic Acquisition Center using established VHA reporting tools.

For pharmacy operations, the OIG recommended that the director 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; a plan to complete healthcare system-based inventory audits of noncontrolled drug line items in compliance with VHA policy; and establish processes to ensure compliance with the VHA directive which requires that B09 reconciliations be signed by the lead pharmacy technician and include appropriate supporting documentation.

VA Management Comments and OIG Response

The director of the VA New York Harbor Healthcare System concurred with all recommendations and provided responsive corrective action plans. Appendix E includes the healthcare system director's comments.

The OIG considers all recommendations open. The director of the healthcare system reported the actions for two of the recommendations were completed during November 2022. However, no evidence or supporting documentation was provided for the OIG to evaluate. The OIG will monitor the implementation of the planned actions and will close the recommendations when the VA New York Harbor Healthcare System provides sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified.



LARRY M. REINKEMEYER
Assistant Inspector General
for Audits and Evaluations

Contents

Executive Summary	i
Introduction.....	1
Results and Recommendations	5
Finding 1: Some Inactive Obligations Were Not Reviewed and Were Not Deobligated	6
Recommendations 1–2.....	10
Finding 2: Processing Purchase Card Transactions Needed Improvement	12
Recommendations 3–5.....	16
Finding 3: The Healthcare System Could Make Improvements Related to Its Management of the MSPV Program.....	18
Recommendations 6–10.....	27
Finding 4: The Healthcare System Could Improve Pharmacy Efficiency and Strengthen Oversight Controls	29
Recommendations 11–14.....	34
Appendix A: Healthcare System Profile.....	36
Appendix B: Scope and Methodology	38
Appendix C: Statistical Sampling Methodology	41
Appendix D: Monetary Benefits in Accordance with Inspector General Act Amendments	47
Appendix E: VA Management Comments, Director, VA New York Harbor Healthcare System.....	48
OIG Contact and Staff Acknowledgments	54
Report Distribution	55

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	Medical/Surgical Prime Vendor
OIG	Office of Inspector General
OPES	Office of Productivity, Efficiency & Staffing
SCCOP	Supply Chain Common Operating Picture
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VSSC	VHA Support Service Center



Introduction

The VA Office of Inspector General (OIG) conducts financial efficiency inspections to assess the oversight and stewardship of funds used by VA healthcare systems and to identify opportunities for achieving cost efficiencies. Inspection teams identify and examine areas that draw on considerable VA financial resources and can be compared to similar healthcare systems in size and complexity across VA to promote best practices.¹⁹

This inspection focused on the VA New York Harbor Healthcare System. The period of data reviewed by the inspection team varied for each protocol, but was no earlier than May 1, 2021, and no later than July 31, 2022. The inspection team assessed the following financial activities and administrative processes to determine whether appropriate oversight and controls were in place for these four areas:

- I. **Open obligations oversight.** An obligation is a legally binding commitment of appropriated funds for goods or services.²⁰ Open obligations include those 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 balance amounts are accurate and agree with source documents, such as contracts, purchase orders, receiving reports, invoices, and payments; and those beyond 90 days of the period of performance end date or without activity in the past 90 days are valid and should remain open.²¹ The inspection team evaluated whether the healthcare system performed monthly reviews and reconciliations of sampled obligations.
- II. **Purchase card use.** The VA Government Purchase Card Program was established to reduce administrative costs related to the acquisition of goods and services.²² When used properly, purchase cards can help healthcare systems 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. 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 regularly purchased products to provide optimal savings

¹⁹ The Veterans Health Administration (VHA) uses a facility complexity model that classifies its facilities at levels 1a, 1b, 1c, 2, or 3, with level 1a being the most complex and level 3 being the least complex. New York Harbor Healthcare System was rated a level 1a, high-complexity facility.

²⁰ VA Financial Policy, "Obligations Policy," in vol. 2, *Appropriations, Funds and Related Information*, May 2021, September 2021, and April 2022, chap. 5.

²¹ VA Financial Policy, "Obligations Policy."

²² VA Financial Policy, in vol. 16, *Charge Card Programs*, October 22, 2019, and July 14, 2021, chap. 1B.

to VA. Using contracts for regular purchases, known as strategic sourcing, has several benefits, such as optimizing purchasing power and obtaining competitive pricing.

- III. **Medical/Surgical Prime Vendor (MSPV) program use.** The MSPV 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 using a just-in-time logistics approach.²³ VA healthcare systems are required to use MSPV contracts for products that are available through the program, which appear on the MSPV Product List, also known as the formulary.²⁴ The Medical Supplies Program Office (MSPO) recommends that each medical center purchase at least 90 percent of its supplies that are available on the formulary from the assigned prime vendor.²⁵ The inspection team examined whether the healthcare system met Veterans Health Administration (VHA) goals for the program.
- IV. **Pharmacy operations.** An efficient healthcare system anticipates how much drugs will cost and when inventory needs to be restocked by analyzing available data, such as prime vendor inventory management reports and inventory turnover rates.²⁶ Doing so helps ensure that the system makes the best use of appropriated funds and has inventory when needed. The team evaluated the following areas: whether the healthcare system complied with VA policies, used cost and performance data to track progress toward goals, improved pharmacy program operations, and identified and corrected problems.

To assess these areas, the team performed a site visit at the VA New York Harbor Healthcare System during the week of August 15, 2022; interviewed healthcare system leaders and staff; and reviewed data, supporting documents, and processes related to the healthcare system's financial efficiency. For more information about the healthcare system, see appendix A. For more information about the inspection's scope and methodology, see appendixes B and C.

²³ The healthcare system was covered by two MSPV contracts during the OIG's review period: the MSPV-Next Generation Bridge (MSPV-NG Bridge; Cardinal Health PV contract 36C10G20D0025), effective April 2020 through November 2021, and MSPV-Generation Z Transition (MSPV-GenZ Transition; Cardinal Health PV contract 36C10X22D0002), effective December 2021 through November 2022.

²⁴ "Medical/Surgical Prime Vendor (MSPV) Program" (web page), VHA Office of Procurement, Acquisition and Logistics, accessed July 5, 2022, <https://www.va.gov/opal/sac/mspvNG.asp>.

²⁵ "The Formulary Utilization Metric: A Deep Dive Explanation" (web page), VA Medical Supplies Program Office, accessed June 30, 2022, <https://vaww.va.gov/plo/docs/mspo/mspvFormularyUtilizationMetricOverview.pdf>. (This is an internal website not publicly accessible.)

²⁶ The inventory turnover rate is the number of times inventory is replaced during the year. Low inventory turnover rates indicate inefficient use of financial resources.

VA New York Harbor Healthcare System

The VA New York Harbor Healthcare System is in Veterans Integrated Service Network (VISN) 2 and provides healthcare services at seven locations in New York City.²⁷ Facilities include three medical centers in Manhattan, Brooklyn, and St. Albans; two community-based outpatient clinics in Harlem and Staten Island; and two mobile clinics. The healthcare system complexity is rated 1a and offers a wide range of health services for veterans in New York City, including primary care, mental health care, specialty care, and social programs.²⁸

The medical facilities in the healthcare system include teaching hospitals that provide a full range of services and have active affiliations with the State University of New York Downstate, New York University School of Medicine, New York University School of Dentistry, and the State University of New York School of Optometry. The healthcare system offers residency programs in general medicine, general surgery, and several specialties.

In fiscal year (FY) 2022, the healthcare system had a medical care budget of approximately \$812.4 million, over 3,000 full-time employees, and provided services to just under 48,900 unique patients.²⁹

Healthcare System and Inspection Area Selection

The inspection team evaluated VA data to identify those healthcare systems with the greatest potential for financial efficiency improvements. The inspection 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 information; Financial Management System (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 healthcare system leaders insight into areas of opportunity for improving efficiency when compared with other VHA healthcare

²⁷ GAO, *Regional Networks Need Improved Oversight and Clearly Defined Roles and Responsibilities*, GAO-19-462, June 2019. VISNs manage regional markets that deliver health care, social services, and support services to veterans. Each VISN is responsible for overseeing medical centers within a defined geographic area. VISNs manage the day-to-day functions of medical centers within their networks through efforts such as periodic strategic, business, and financial planning meetings.

²⁸ VHA Office of Productivity, Efficiency and Staffing, “VHA Facility Complexity Model History,” June 23, 2022. The purpose of the VHA facility complexity model is to establish peer groups based on the complexity of managing the administrative parent facilities. The complexity model designation identifies similarly complex facilities for purposes that include operational decision-making.
<https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?%2fOPES%2fFacilityComplexity%2fFacilityComplexHistory&rs:Command=Render> (This is an internal website not publicly accessible.)

²⁹ For more information about the healthcare system budget, capacity, and daily census, see appendix A.

systems. The grid is a collection of 12 statistical models. It allows for comparisons between VHA healthcare systems 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 healthcare system's actual and expected costs. The team obtained the healthcare system rankings from two statistical models in the grid to assist in selecting healthcare systems for financial inspection: the Stochastic Frontier Analysis model and the pharmacy expenditure model. The team then used a SCCOP report to gather MSPV 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 long-standing problem. It was included as a significant deficiency in VA's FY 2021 audited financial statements and as a material weakness in VA's FY 2019 and FY 2020 audited financial statements.³⁰ Additionally, a 2019 OIG report on undelivered orders found VA did not adequately manage orders to ensure excess funds were deobligated in a timely manner and recommended VHA ensure that staff review and reconcile open orders, identify and deobligated excess funds, and ensure staff follow VA policy regarding required reviews of open obligations.³¹

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

- **Inactive obligations.** The inspection team assessed whether the healthcare system performed monthly reviews and reconciliations to ensure that the sampled inactive obligations were valid and should remain open.³² Inactive obligations have had no activity for more than 90 days.
- **FMS-to-Integrated Funds Distribution, Control Point Activity, Accounting and Procurement (IFCAP) reconciliations.** The team identified open obligations with different order amounts between FMS and IFCAP to ensure the healthcare system reconciled order amounts between the systems for the sampled obligations.
- **Internal obligation reviews.** The team assessed whether the healthcare system performed financial quality assurance reviews for undelivered orders. The review is designed to help managers analyze, evaluate, and report on the healthcare system's financial procedures, accounting records, and internal controls. It can serve as a management tool to identify strengths and weaknesses in VHA financial management operations and to design corrective action plans for findings.

³⁰ VA OIG, [Audit of VA's Financial Statements for Fiscal Years 2021 and 2020](#), Report No. 21-01052-33, November 15, 2021; VA OIG, [Audit of VA's Financial Statements for Fiscal Years 2020 and 2019](#), Report No. 20-01408-19, November 24, 2020; VA OIG, [Audit of VA's Financial Statements for Fiscal Years 2019 and 2018](#), Report No. 19-06453-12, November 19, 2019. A material weakness is a deficiency, or combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented or detected and corrected on a timely basis. A significant deficiency is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

³¹ 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.

³² VA Financial Policy, "Obligations Policy."

Finding 1: Some Inactive Obligations Were Not Reviewed and Were Not Deobligated

VA policy requires finance offices to perform monthly reviews and reconciliations of open obligations that are at least 90 days beyond the period of performance end date or that have been inactive for more than 90 days to ensure the obligation is still valid and that funds are not left unused.³³ For these obligations, finance office personnel should verify with the initiating service or contracting officer that the goods or services have not been received and are still needed. The responsible finance office should also review data from VA’s FMS against supporting documentation monthly to ensure reports, subsidiary records, and systems reflect proper costing, an accurate delivery date or end date, and a correctly calculated unliquidated balance.³⁴ If funds remain on the obligation after the delivery and the initiating service has confirmed acceptance of all goods or services and invoices have been received and paid, the acquisition office will modify the contract or order to reflect the final cost and decrease the remaining funds on the obligation. Figure 1 shows the number and dollar amounts of inactive obligations for the VA New York Harbor Healthcare System from December 2021 through May 2022.

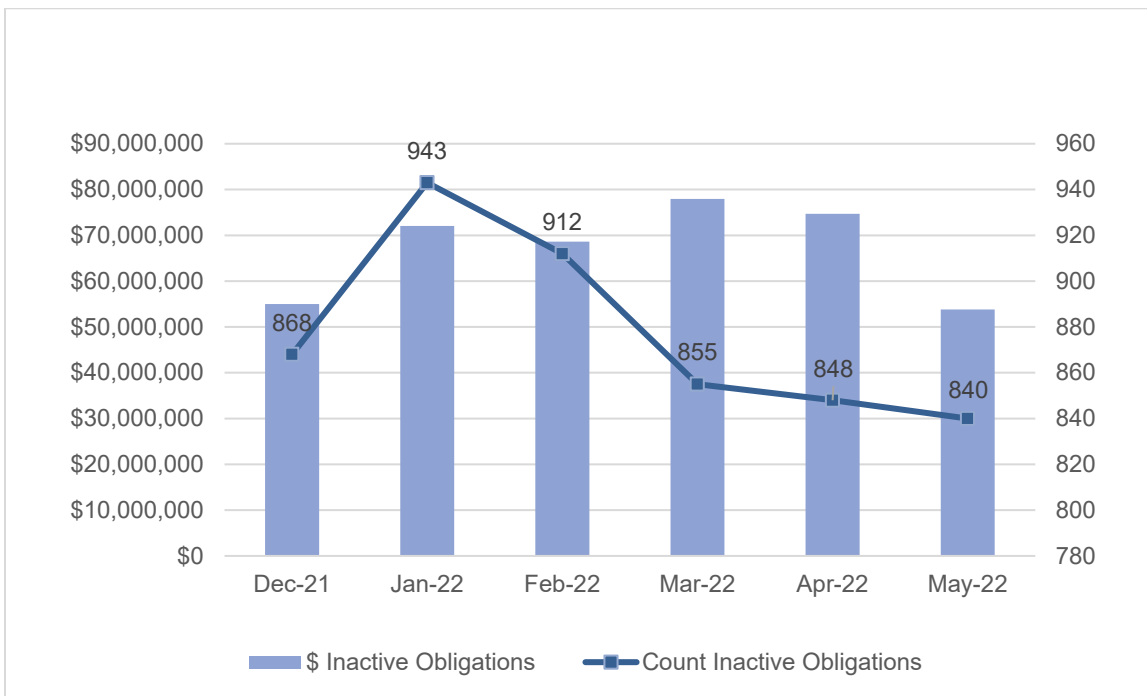


Figure 1. Inactive obligations for the VA New York Harbor Healthcare System, December 2021 through May 2022.

Source: VA OIG analysis of VA FMS 850 Monthly Report.

³³ VA Financial Policy, “Obligations Policy.”

³⁴ 2 C.F.R. § 200.97 (2021). The term “unliquidated balance” means an obligation incurred by a nonfederal entity that has not been paid (liquidated) or for which the expenditure has not been recorded.

As of May 28, 2022, the healthcare system had 840 inactive obligations totaling just over \$53.8 million. Figure 2 shows the age and dollar amounts of the 840 obligations. As shown, 764 obligations totaling just under \$33.6 million had no activity for 181 days or more.

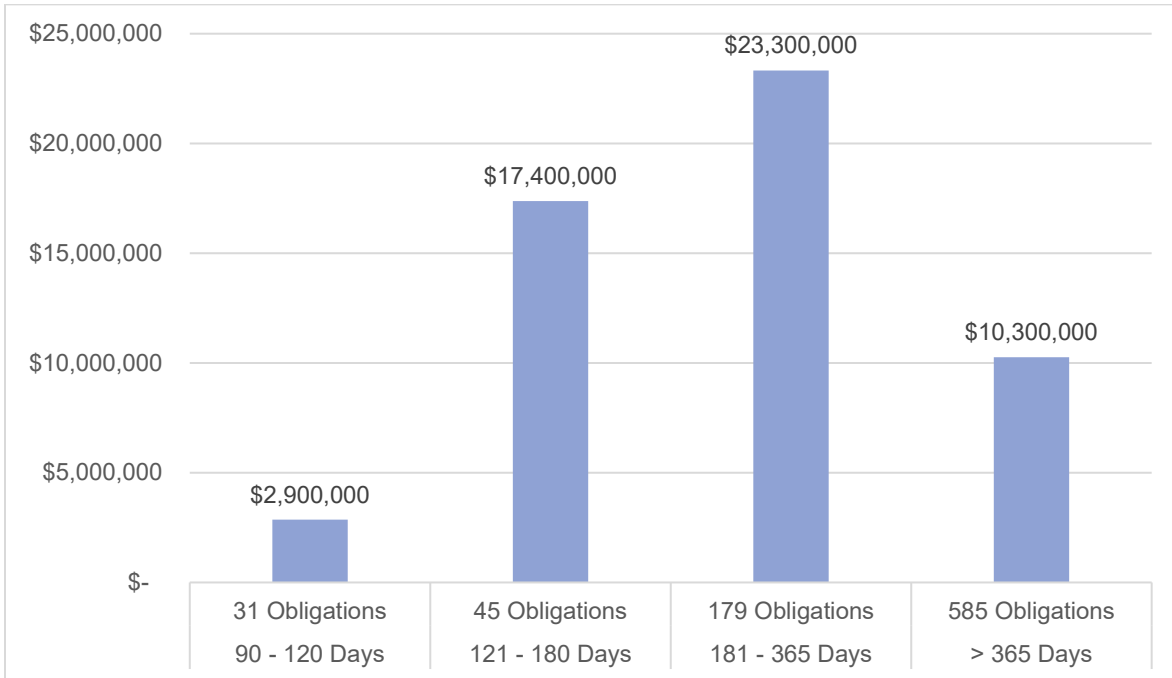


Figure 2. Inactive obligations as of May 2022.
 Source: VA OIG analysis of VA FMS 850 Report.

Inactive Obligations

The inspection team analyzed obligations data and selected 19 obligations that were inactive during the month of May 2022 and that totaled almost \$31.5 million. Appendix B describes the team’s methodology and appendix C describes the inspection’s sampling plans. The team reviewed supporting documentation to assess whether the healthcare system identified and reviewed the sample of obligation records to determine if they were still valid and needed to remain open in accordance with VA financial policy.³⁵ Of the 19 inactive obligations reviewed, 10 were still within the performance period and the other nine were more than 90 days past the performance period end date. The team was not able to verify that reviews were completed for 10 of the 19 obligations, which totaled approximately \$5 million. Additionally, one of the 19 obligations had just over \$33,500 of outstanding funds that should have been deobligated. Failure to properly monitor and make timely adjustments to open obligations increases the risk that some of these funds will not be made available for other purposes to benefit veterans.

³⁵ VA Financial Policy, “Obligations Policy.”

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.³⁶ If funds remain on the obligation after delivery, 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 and decrease the remaining funds on the obligation. The healthcare system used Undelivered Orders (FMS 850) and Analysis of Open Documents (889B) reports to identify obligations inactive for over 90 days. However, according to the chief financial officer and supervisory accountant, 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 were inactive for more than 90 days. Furthermore, the supervisory accountant attributed the lack of review to staffing shortages, a lack of or insufficient response from initiating services, operational disruptions due to COVID-19, and competing priorities.

Order Amount Discrepancies between FMS and IFCAP

IFCAP handles the processing of certified invoices and electronic transmission of receiving documents to FMS. In addition, IFCAP transfers obligation information back to the control point and updates the control point balance automatically.³⁷ The healthcare system's finance office should review open obligations monthly in coordination with the initiating service to ensure reports, subsidiary records, and systems reflect proper costing and to ensure that delivery dates, end dates, period of performance dates, and unliquidated balances are correct and match in all systems.³⁸ The inspection team selected and evaluated 10 additional open obligations to determine if order amounts were accurate and reconciled between VA's FMS and IFCAP.

The team determined that IFCAP and FMS order amount discrepancies existed three months or more for four of 10 obligations reviewed, with unreconciled amounts totaling almost \$14,300. One of these obligations also had an accrued amount of about \$780, which brought the total order amount discrepancies to more than \$15,000. Of the total amount of discrepancies, almost \$14,600 was no longer needed that should have been deobligated in FMS. The discrepancies occurred because the finance office does not reconcile order amounts between systems as required.³⁹ The supervisory accountant confirmed the finance office does not use VA's

³⁶ VA Financial Policy, "Obligations Policy."

³⁷ 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.

³⁸ VA Financial Policy, "Obligations Policy."

³⁹ VA Financial Policy, "Obligations Policy."

FMS-to-IFCAP Reconciliation report.⁴⁰ The fiscal service corrected these four obligations after the inspection team's site visit.

Had the finance office staff properly managed open obligations, they could have reduced the risk of failing to spend appropriations within the associated fiscal year and to repurpose funds to benefit veterans.⁴¹

Internal Obligation Review

VHA policy requires quality assurance reviews to be used for the internal review and evaluation of financial management operating activities occurring within VHA.⁴² Financial quality assurance reviews are a method to evaluate program performance and report on significant VHA financial management activities. Quality assurance reviews are composed of nine review areas, one being the accounting review of undelivered orders by an approving official. Staff conducting the accounting review should ensure that review comments are documented in accordance with VA policy for undelivered orders that are aged over 90 days.⁴³ Furthermore, a random sample of undelivered orders should be examined to ensure all FMS data are valid and fully supported and finance offices should perform monthly reviews and reconciliations of aged and inactive obligations as outlined in VA policy.⁴⁴

The inspection team determined the healthcare system, as well as VISN 2 auditors, did not properly conduct a finance quality assurance review in the third quarter of FY 2022. The healthcare system did not review obligations that were inactive for more than 90 days, as required by VHA Financial Policy, but instead focused only on obligations that were 90 days beyond the period of performance.⁴⁵ Had the healthcare system conducted the quality assurance review of undelivered orders properly, it could have identified areas of VA policy that were not being met, including the review of inactive obligations.

Finding 1 Conclusion

Healthcare system personnel did not comply with VA policies requiring routine follow-up to improve management and oversight of open obligations. The OIG found that open obligations

⁴⁰ The monthly report assists facilities in reconciling FMS obligation data with the source data from IFCAP in accordance with financial policies.

⁴¹ Appendix D presents the estimated monetary benefits associated with deobligating these obligations.

⁴² VHA Directive 1733, *VHA Finance Quality Assurance Reviews*, September 2017.

⁴³ VA Financial Policy, "Obligations Policy."

⁴⁴ VA Financial Quality Assurance Review, "Accounting Operations Review," accessed January 7, 2023, <https://dvagov.sharepoint.com/sites/VHAV1FQAT/SitePages/The-411-On-Quality-Assurance-Reviews.aspx>. The Accounting Operations Review tests for policy compliance, as described in VA Financial Policy, "Obligations Policy," in vol. 2, *Appropriations, Funds, and Related Information*, October 2020, chap. 5.

⁴⁵ VA Financial Policy, "Obligations Policy"; VHA Directive 1733.

with no activity for more than 90 days were not reviewed for validity and that FMS and IFCAP amounts were not always reconciled, resulting in an estimated \$48,100 in better use of funds. In addition, the required quality assurance reviews were not conducted in accordance with VHA policy. Failure to properly manage open obligations increases, rather than decreases, the risk of failing to spend appropriations within the associated fiscal year and to repurpose the funds to benefit veterans.

Recommendations 1–2

The OIG made the following recommendations to the VA New York Harbor Healthcare System director:

1. Ensure that healthcare system finance office staff and initiating services are aware of policy requirements to conduct reviews on all inactive open obligations and deobligate any identified excess funds as required by VA Financial Policy, vol. 2, chap. 5, “Obligations Policy.”
2. Ensure that healthcare system staff are conducting finance quality assurance reviews of obligations that were inactive for more than 90 days, as required by Veterans Health Administration Directive 1733, “VHA Finance Quality Assurance Reviews.”

VA Management Comments

The director of the VA New York Harbor 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 training was provided to accounting staff related to following up on inactive purchase orders. Since then, inactive purchase orders are being reviewed. Additionally, the fiscal service will offer quarterly training to ensure required follow-ups are conducted. For recommendation 2, the director reported that the FY 2022 third-quarter quality assurance review was completed, and the following review was scheduled for the third quarter of FY 2023. Also, the supervisory accountant trained accounting staff on the relevant policy and fiscal service will offer training on required follow-ups on inactive purchase orders.

OIG Response

The healthcare system director’s action plans are responsive to the recommendations. Although the director reported the actions were completed in November 2022, the OIG did not receive any evidence or supporting documentation to evaluate these actions. The OIG will close the recommendations when it receives 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 administrative costs related to acquiring goods and services. When used properly, purchase cards can help healthcare systems simplify acquisition procedures and provide an efficient vehicle for obtaining goods and services directly from vendors. From July 1, 2021, through June 30, 2022, the healthcare system spent over \$48 million using purchase cards, representing over 47,000 transactions. The amount and volume of spending through the Government Purchase Card Program makes it important to have strong controls over purchase card use to safeguard government resources and ensure compliance with policies and procedures that reduce the risk of error, fraud, waste, and abuse.

The team reviewed the following areas for the sampled transactions:

- **Purchase card transactions.** The inspection team examined whether the healthcare system processed purchase card transactions in accordance with VA policy, including whether cardholders obtained prior approvals before initiating a purchase, transactions were reconciled by the cardholder and approved by the approving official in a timely manner, and segregation of duties was maintained.⁴⁶ Additionally, the team inquired whether the healthcare system considered obtaining contracts when procuring particular goods and services on a regular basis, which VA refers to as strategic sourcing. VA can leverage its purchasing power by using competitively priced contracts. 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.⁴⁷
- **Purchase card oversight.** The inspection team assessed whether the healthcare system tracked purchase card training, had purchase card policies in place, assigned no more than 25 purchase card accounts to an approving official, and maintained accurate Governmentwide Purchase Card Certification Forms (VA form 0242).⁴⁸ The team also assessed whether the healthcare system's purchase card coordinator provided oversight of the purchase card program by conducting periodic internal reviews.⁴⁹ These activities are examples of systematic controls that help reduce errors and ensure a healthcare system complies with VA policy.

⁴⁶ VA Financial Policy, "Administrative Actions for Government Purchase Card," in vol. 16, *Charge Card Programs*, June 14, 2018, chap. 1A.

⁴⁷ VA Financial Policy, "Government Purchase Card for Micro-Purchases." This policy defines "strategic sourcing" as ensuring employees obtain proper contracts when regularly procuring goods and services. Purchases that exceed the cardholder's single-purchase threshold cannot be made on purchase cards. Split purchases occur when a cardholder circumvents this requirement by dividing a single purchase or need into two or more smaller purchases.

⁴⁸ An approved VA Form 0242, Governmentwide Purchase Card Certification, is used to delegate authority to an individual to use the purchase card to procure and pay for goods and services.

⁴⁹ VA Financial Policy, "Government Purchase Card for Micro-Purchases."

- **Supporting documentation.** The inspection 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.⁵⁰ Supporting documentation enables program oversight and helps prevent fraud, waste, and abuse.

Finding 2: Processing Purchase Card Transactions Needed Improvement

The inspection team evaluated a population of about 47,500 purchase card transactions from July 1, 2021, through June 30, 2022, which totaled approximately \$48.2 million. Of these transactions, the team reviewed a statistical sample of 101 transactions totaling approximately \$375,000 to determine whether the healthcare system maintained purchase card documentation and whether transactions were processed in accordance with VA policy. See appendix B for a full description of the inspection’s scope and methodology and appendix C for details on its sampling. Based on analysis of the sample, the team projected noncompliance errors in approximately 42,300 purchase card transactions (about 90 percent of transactions), totaling about \$44.1 million in questioned costs.⁵¹

The inspection team observed that cardholders and approving officials were using government purchase cards in support of the agency’s mission and were aware of VA policy requirements for purchase card training, micro-purchase thresholds, and single transaction limits. Also, the purchase card coordinator consistently performed periodic audits of the purchase card program. Although the healthcare system leaders provided program oversight, the OIG found that improvements could be made to ensure that prior approvals were obtained; monthly reconciliations were performed; approving officials, purchase card coordinators, and cardholders reviewed purchases; and supporting documentation was maintained consistently. Reviewing transactions helps ensure that approving officials and cardholders are following policy; reduces the risk of error, fraud, waste, and abuse; and promotes the good stewardship of government money.

⁵⁰ VA Financial Policy, “Government Purchase Card for Micro-Purchases.”

⁵¹ Per 2 C.F.R. § 200.84 (2014), the term “questioned cost” means a cost that is questioned by the auditor because of an audit finding where the cost, at the time of the audit, is not supported by adequate documentation. See appendix D for monetary benefits associated with the questioned costs.

Purchase Card Transactions

VA policy has specific requirements when using a government purchase card to acquire goods and services:

- **Prior approval** is obtained to ensure a valid business need before initiating a purchase.⁵²
- **Reconciliation** of a purchase is approved in a timely manner to help identify fraudulent or erroneous charges and unauthorized commitments.⁵³
- **Segregation of duties** are maintained to ensure roles and responsibilities did not overlap.⁵⁴

The inspection team assessed the purchase card transaction documentation to determine if these requirements were met. Based on the sample review, the team projected those cardholders did not maintain documentation indicating prior approval for about 29,400 transactions, resulting in about \$30 million in questioned costs. Also, cardholders did not reconcile and approve approximately 27,600 transactions by the 15th day of the month after the previous month's billing cycle, resulting in about \$28.6 million in questioned costs. Untimely reconciliation increases the risk of data integrity errors and fraud. These issues occurred because approving officials did not ensure that cardholders maintained all purchase documentation and reconciled charges in a timely manner.⁵⁵ Table 1 shows the results of the sample review.

⁵² VA Financial Policy, "Government Purchase Card for Micro-Purchases." Some examples of approval documentation are emails, requisitions, memos, consults, and notes. Regardless of the form, the documentation must contain a certification from the requestor that the proposed purchase is for a legitimate government need, not for personal benefit, as well as a list of all items to be purchased.

⁵³ VA Financial Policy, "Government Purchase Card for Micro-Purchases."

⁵⁴ VA Financial Policy, "Government Purchase Card for Micro Purchases." An agency/organization program coordinator cannot be a cardholder or an approving official. No one person may order, receive, certify funds, and approve his or her own card purchases.

⁵⁵ VA Financial Policy, "Government Purchase Card for Micro-Purchases."

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

Requirement	Number of noncompliant transactions	Noncompliant transactions
Prior approval	29,400	63%
Reconciliation approved by the 15th day of the month after the closing of the previous month's billing cycle	27,600	59%
Segregation of duties	0 found in sample	Not projected

Source: VA OIG inspection team assessment results for 101 sampled transactions.

Generally, federal purchases are exempt from state and local sales taxes.⁵⁶ The inspection team assessed whether the sampled purchase card transactions included potentially prohibited sales tax. The team identified two of 101 sampled transactions that included sales tax, which totaled about \$400. This occurred because the purchase card coordinator did not adequately review for sales tax charges on purchase card transactions. The VISN 2 purchase card coordinator said the purchasing agent did not fully understand how to handle transactions with sales tax, which was a training deficiency. The team did not calculate projections because of the low number of transactions found.

The inspection team also assessed whether cardholders split purchases into two or more transactions to avoid exceeding the micro-purchase threshold and whether they modified purchases in order to stay within the authorized single-purchase limit.

Contracts must be used when the total value of the requirement exceeds the micro-purchase threshold. Cardholders must not split a requirement into smaller parts to avoid formal contracting procedures; instead, cardholders should communicate the need for the order of goods or services to the contracting office for procurement.⁵⁷ The team selected a statistical sample of 81 transactions totaling approximately \$256,000 to determine if cardholders split purchases. The team reviewed transaction documentation and interviewed purchase cardholders and approving officials, determining that none of the transactions were split or modified purchases.

Lastly, the inspection team inquired whether the healthcare system considered obtaining contracts when procuring goods and services on a regular basis, referred to as strategic sourcing. VA financial policy states that VA must attempt to reduce individual purchases made with purchase cards and pursue strategic sourcing.⁵⁸ By leveraging VA's purchasing power, strategic

⁵⁶ FAR 29.302 (2022).

⁵⁷ VA Financial Policy, "Government Purchase Card for Micro-Purchases."

⁵⁸ VA Financial Policy, "Government Purchase Card for Micro Purchases."

sourcing may offer the most competitive prices. The OIG found overall that the healthcare system sufficiently considered strategic sourcing.

Purchase Card Oversight

Responsible officials are accountable for compliance with the Government Purchase Card Program and for implementing internal controls to protect and conserve federal funds.⁵⁹ Oversight activities include periodic and continuous monitoring; checks and balances; and policies, procedures, and segregation of duties implemented to reduce the risk of error, fraud, waste, and abuse in the purchase card program.⁶⁰

To assess oversight of the program and compliance with VA policy, the inspection team determined whether the healthcare system monitored purchase card training, implemented purchase card policies, assigned no more than 25 purchase card accounts to an approving official, maintained a VA Form 0242 for each cardholder in the inspection sample, and conducted reviews of cardholder transactions.⁶¹ An approved VA Form 0242 is used to delegate authority to an individual to use the purchase card to procure and pay for goods and services. This form also establishes purchase limits and responsibilities and certifies that cardholders and approving officials understand the policies and regulations governing the purchase card program. A revised form is required when the approving officer changes, cardholders change their legal names, or the single-purchase limit is changed from the originally requested amount.⁶²

The VA Form 0242 is an important control that helps ensure compliance with purchase limits and responsibilities. The accuracy of the VA Form 0242 is essential for holding cardholders and approving officials accountable. The healthcare system maintained copies of these forms for each of the 23 cardholders in the inspection team's sample. However, for eight cardholders, the single-transaction spending limits listed in the 0242 forms did not match single-transaction spending limits identified in US Bank data. This occurred because program coordinators did not adequately ensure US Bank data were updated when cardholder single-spending limits changed.

Supporting Documentation

VA policy requires cardholders to upload and electronically store supporting documents for purchase card transactions to a VA-approved document-imaging system.⁶³ When healthcare system staff buy goods and services using a purchase card, they must maintain this documentation, which includes approved purchase requests, vendor invoices, purchase orders,

⁵⁹ VA Financial Policy, "Government Purchase Card for Micro-Purchases."

⁶⁰ VA Financial Policy, "Government Purchase Card for Micro-Purchases."

⁶¹ VA Financial Policy, "Administrative Actions for Government Purchase Cards."

⁶² VA Financial Policy, "Administrative Actions for Government Purchase Cards."

⁶³ VA Financial Policy, "Government Purchase Card for Micro-Purchase."

and receiving reports for six years. This documentation verifies that purchase card transactions were properly approved and that payments were accurate.

The inspection team identified transactions that were missing some required supporting documentation. Based on these results, the team projected those cardholders did not have sufficient supporting documentation for at least 5,000 transactions out of 46,900 transactions, which resulted in at least \$6.1 million in questioned costs. These issues occurred because the healthcare system did not have controls designed to obtain packing slips or receiving reports from vendors that shipped items directly to patients. In addition, approving officials did not ensure cardholders retained sufficient documentation to support purchase card transactions.

Finding 2 Conclusion

A significant number of the sampled purchase card transactions were not supported by evidence of prior approvals and purchase card reconciliations. Also, the healthcare system lacked proper supporting documentation for a significant number of the sampled purchase card transactions. Based on the results of all areas reviewed, the team projected that the healthcare system had noncompliance errors in approximately 42,300 purchase card transactions, totaling an estimated \$44.1 million in questioned costs.⁶⁴ These issues could have been identified with more effective reviews by approving officials and with controls designed to obtain documentation from vendors.

Recommendations 3–5

The OIG made the following recommendations to the VA New York Harbor Healthcare System director:

3. Ensure cardholders comply with record retention, prior approval, and purchase card reconciliation requirements as required by VA Financial Policy, vol. 16, chap. 1B, “Government Purchase Card for Micro-Purchases.”
4. Ensure cardholders verify that vendors have removed all state and local sales taxes from orders, if applicable.
5. Ensure authorizing officials implement internal controls over government purchase card activities to ensure compliance with the Government Purchase Card Program.

⁶⁴ When reporting on total errors combined, the OIG uses a projected “overall errors” estimate to avoid double counting transaction amounts. Therefore, the individual questioned cost amounts of \$6.1 million, \$30 million, and \$28.6 million do not add up to \$44.1 million.

VA Management Comments

The director of the VA New York Harbor Healthcare System concurred with recommendations 3 through 5. To address recommendations 3 and 4, the director reported that the healthcare system is performing refresher training that will stress record retention, prior approval, and purchase card reconciliation requirements as well as ensuring state and local taxes are not paid. To address recommendation 5, the facility will develop updated surveillance procedures to ensure quarterly reviews are conducted to evaluate and improve the effectiveness of internal control and compliance with purchase card regulations and policies.

OIG Response

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

III. Medical/Surgical Prime Vendor Program Use

VHA healthcare system facilities are required to use MSPV for products that are available through the program, which appear on the MSPV Product List.⁶⁵ 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.

According to the MSPV formulary utilization dashboard, the healthcare system spent about \$5 million from May 1, 2021, to April 30, 2022.⁶⁶ The healthcare system's prime vendor is Cardinal Health LLC, which operated under two different MSPV contracts during the review period.⁶⁷

The inspection team focused on three areas of MSPV program use:

- **Formulary utilization rate** measures the extent to which healthcare systems 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 to provide MSPV 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 healthcare system for items on the formulary.

Finding 3: The Healthcare System Could Make Improvements Related to Its Management of the MSPV Program

The healthcare system did not meet the 90 percent formulary utilization goal for purchases made through the MSPV program from May 1, 2021, through April 30, 2022, according to MSPV data from the SCCOP.⁶⁸ Instead, the formulary utilization rate averaged only about 45 percent as

⁶⁵ VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020, p. A-4; "Medical/Surgical Prime Vendor (MSPV) Program" (web page), Office of Procurement, Acquisition and Logistics (OPAL).

⁶⁶ The inspection team did not assess the accuracy of the summary data in the MSPV formulary utilization dashboard.

⁶⁷ MSPV-Next Generation Bridge (MSPV-NG Bridge; Cardinal Health PV contract 36C10G20D0025), effective April 2020 through November 2021, and MSPV-Generation Z Transition (MSPV-GenZ Transition; Cardinal Health PV contract 36C10X22D0002), effective December 2021 through November 2022.

⁶⁸ The SCCOP is an interactive dashboard that enables supply chain leaders to observe supply chain metrics at the enterprise, VISN, and healthcare system levels.

reported by the MSPV performance metrics dashboard. The inspection team did not assess the impact that the COVID-19 pandemic had on the healthcare system's MSPV utilization rates.

Generally, the low utilization rates occurred because healthcare system logistics staff did not update item master files in VA's ordering system to ensure items were included or specify Cardinal Health as the mandatory source.⁶⁹ According to VA policy, healthcare system logistics departments are required to enter all recurring-use medical/surgical items into the item master file, which includes information about an item's description, mandatory source, and vendor.⁷⁰

Also, the healthcare system did not routinely provide Cardinal Health with updated product usage data to help ensure the prime vendor maintained the necessary inventory levels to provide required services to the healthcare system facility. One such performance requirement in Cardinal Health's contract is to maintain inventory levels necessary to provide required supplies at or above a 95 percent unadjusted fill rate.⁷¹

The nonavailability of supplies from the prime vendor resulted in the healthcare system needing to purchase formulary supplies from other vendors. Despite the issue of nonavailable supplies, the healthcare system chief supply chain officer did not document this experience in monthly facility execution surveys, which are used to monitor healthcare system satisfaction with prime vendor performance. According to logistics leaders, other contributing factors included items not being listed in VA's ordering system, staffing shortages, the need for additional ordering officer training, and clinician pushback against guidance to use items from the MSPV Product List.

Because of these issues, the healthcare system paid about \$53,400 more than formulary prices for about 15,400 supply items purchased from nonprime vendor sources from May 1, 2021, through April 30, 2022. Furthermore, the OIG found that the healthcare system did not submit contract waiver requests to describe a valid, justifiable, and appropriate clinical rationale for deviating from using MSPV contracts as required by VA policy.⁷²

Formulary Utilization Rate Challenges

The healthcare system's annual average MSPV utilization rate was about 45 percent, and the monthly average ranged from about 30 percent to about 67 percent during the 12-month OIG

⁶⁹ VHA Directive 1761, p. 4. The item master file is a file within the IFCAP software system that contains item description, mandatory source, vendor, unit price and packaging, and product and manufacturer information. The item master file provides for the extraction of item procurement history to allow for a consistent inventory system.

⁷⁰ VHA Directive 1761, pp. 9 and 34.

⁷¹ The healthcare system was covered by two MSPV contracts during the OIG's review period of May 1, 2021, through April 30, 2022. The MSPV-NG and MSPV-NG Bridge contracts were effective from February 24, 2016, through November 30, 2021, and the MSPV-GenZ Transition contract took effect on December 1, 2021, to provide continued service for the MSPV program. The unadjusted fill rate is the calculation of orders fulfilled against orders requested (i.e., any medical/surgical supply item not completely filled at the time of request for any reason counts against this measure).

⁷² VHA Directive 1761, p. A-5.

review period. Comparatively, formulary utilization rates for VHA overall averaged 58 percent, and VISN 2 averaged 47 percent for the same period. Figure 3 shows the healthcare system’s monthly MSPV formulary utilization rates.

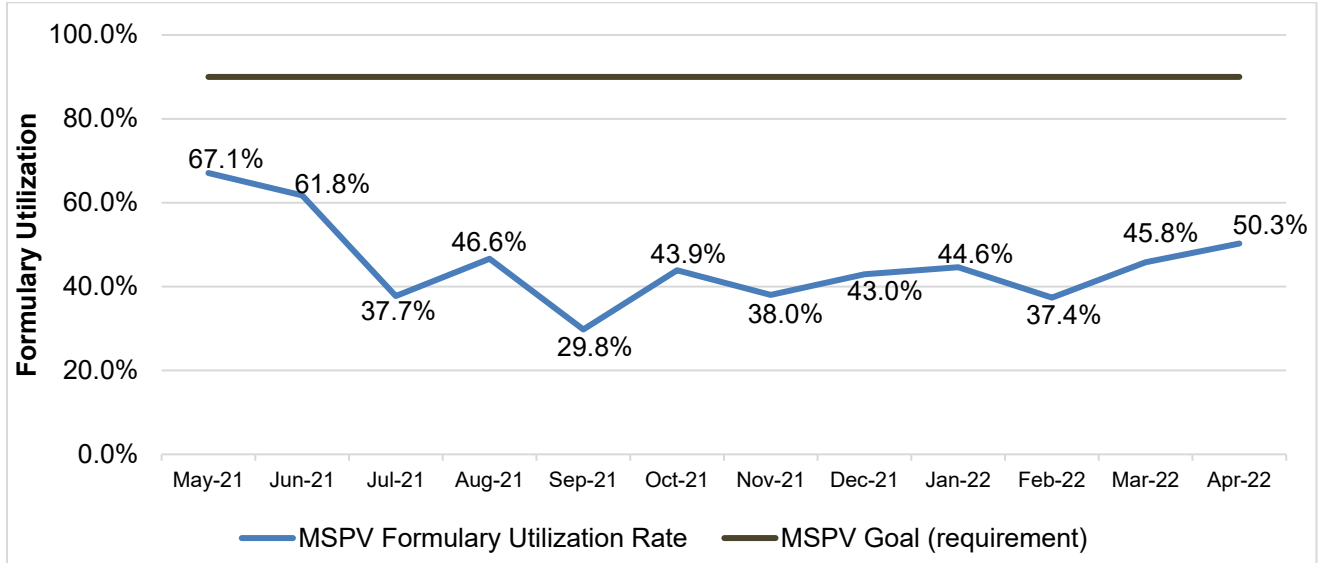


Figure 3. MSPV utilization rate for the VA New York Harbor Healthcare System.
 Source: VA OIG analysis of the healthcare system’s Formulary Utilization Report.

The healthcare system spent just under \$6.2 million to purchase more than 64,800 formulary supply items from nonprime vendor sources (just over 55 percent of the total potential MSPV expenditure) instead of purchasing them from Cardinal Health, the prime vendor. The inspection team judgmentally sampled 30 of these purchase records from the SCCOP dashboard to assess why the MSPV contracts were not used. These 30 purchases included 24 frequently acquired formulary supply items covering about 15,400 items in total, at a cost of about \$651,000.

The inspection 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 prime vendor. Table 2 shows the reasons the staff gave for not purchasing these items from the prime vendor.

Table 2. Reason Categories for Sample of Nonprime Vendor Purchases (May 1, 2021, to April 30, 2022)

Reason category	Number of purchases	Number of items	Sample amount	Difference between the order price and MSPV formulary price*
Item or prime vendor not listed in VA’s ordering system	12	14,649	\$449,200	\$33,300

Reason category	Number of purchases	Number of items	Sample amount	Difference between the order price and MSPV formulary price*
Item not listed in prime vendor's ordering system	6	293	\$58,300	\$1,200
VA did not verify item availability prior to ordering	5	55	\$78,100	\$6,200
No reason provided	5	66	\$47,600	\$13,500
Miscellaneous/other	2	360	\$17,500	-\$700
Total	30	15,300	\$650,700	\$53,400

Source: VA OIG analysis of the healthcare system's sample responses.

Note: Values in columns 3 and 5 are rounded and may not sum to totals shown due to rounding.

The healthcare system's logistics staff explained that nonprime vendors were used for 12 of the 30 purchase records reviewed, or more than 14,600 formulary items, because the item or prime vendor was not listed in VA's ordering system. According to VA guidance, once an item appears on the MSPV formulary, logistics staff need to update the healthcare system's item master file, which identifies the vendor from which the items should be purchased.⁷³ However, the medical center's logistics staff did not consistently review the MSPO's monthly updates to the formulary to determine if items previously purchased from nonprime vendor sources had been added. The inspection team compared the prices paid for those items to the prices listed in the MSPV formulary. The healthcare system paid more than \$449,000 for the items from nonprime vendor sources, which is about \$33,300 more than prices listed in the formulary.

To help ensure items are set up in the ordering system, the healthcare system should check the formulary for updates and convert supplies to Cardinal Health, its prime vendor, as soon as possible, including updating the local item master file and changing the mandatory source in the Generic Inventory Package to reflect the prime vendor.⁷⁴ The healthcare system should coordinate with Cardinal Health on the healthcare system's usage and in-stock timing needs.

The healthcare system's logistics staff explained that six of the 30 purchases reviewed, or 293 formulary items, were purchased from nonprime vendor sources because the item was not listed in Cardinal Health's ordering system, which is used as an online research tool to help users determine whether the product is available to order. According to the Cardinal Health on-site representative, prior to placing orders in the VA ordering system, ordering officers should check

⁷³ "The Formulary Utilization Metric: A Deep Dive Explanation" (web page), VA Medical Supplies Program Office.

⁷⁴ The generic inventory package is the software currently utilized for inventory management of stock. The generic inventory package portion of IFCAP is used to manage the receipt, distribution, and maintenance of supplies utilized throughout VA medical facilities.

Cardinal Health's online research tool to determine whether items are available and stocked in Cardinal Health's distribution facility. When items were not listed in Cardinal Marketplace, the healthcare system purchased them from nonprime vendor sources. The healthcare system paid close to \$58,300 for the items from nonprime vendor sources, which is just over \$1,200 more than prices listed in the formulary.

The logistics staff explained that five of the 30 purchases reviewed, or 55 formulary items, were purchased from nonprime vendor sources because the healthcare system did not verify whether the items were available on the MSPV formulary prior to ordering. The inspection team compared the prices paid for those items to the prices listed in the MSPV formulary and found the healthcare system paid more than \$78,100 for the items from nonprime vendor sources, which is close to \$6,200 more than prices listed in the formulary.

The prime vendor cited the healthcare system's poor forecasting of supply needs and failure to routinely inform the prime vendor of anticipated changes in usage trends as reasons for not keeping items in stock. According to the MSPV contracts, the prime vendor must make monthly inventory supply recommendations to the healthcare system. Specifically, the prime vendor must monitor healthcare system demand patterns and provide inventory recommendations to bring new items into stock and remove items that are no longer in demand. The MSPV contract prohibits the prime vendor from making changes to product usage data without documented healthcare system concurrence. As a result, the healthcare system logistics staff should routinely analyze, update, and provide timely feedback to the prime vendor regarding commitment levels for supplies and product usage so that the prime vendor knows what items need to be stocked.

According to the MSPV contracts, the healthcare system's response to the prime vendor's inventory recommendations serves as the healthcare system's best estimate for a 30-day usage time frame. To help mitigate further supply issues, the healthcare system should notify Cardinal Health when new items will be requested along with the estimated demand for each item so inventory can be stocked. The prime vendor reported that the healthcare system did not routinely respond in writing to the prime vendor's monthly inventory recommendations, resulting in the prime vendor not stocking and setting up needed items in its distribution facility. In response, healthcare system logistics leaders explained that although they did not submit recommendation reports for all months, they discussed these needs with a Cardinal Health representative and believed this met their requirement to ensure product availability.

The healthcare system did not provide reasons why five of the 30 purchases reviewed, for 66 formulary items, were purchased from nonprime vendor sources. The inspection team compared the prices paid for those items to the prices listed in the MSPV formulary. The healthcare system paid almost \$47,600 for the items from nonprime vendor sources, which is approximately \$13,500 more than prices listed in the formulary.

Finally, the logistics staff explained that two of the 30 purchases reviewed, or 360 formulary items, were purchased from nonprime vendor sources because items were placed on allocation,

and some were purchased on the national prosthetics contract instead of MSPV. The healthcare system paid more than \$17,500 for the items from nonprime vendor sources, which is about \$700 less than prices listed in the formulary.

Contract Waiver Requests

The OIG also found that the healthcare system did not submit contract waiver requests required by VA policy for 15 of the 30 sampled purchases, or just over 700 formulary items, totaling just over \$147,800.

VA paid over \$139,000 for 14 of the 15 purchases, instead of an amount that would have been approximately \$115,500 if formulary prices were used. The OIG team identified the difference of about \$23,700 as questioned costs because the healthcare system should have purchased the items with formulary pricing. For one of the purchases, the review team did not identify the price difference as a questioned cost because the healthcare system paid approximately \$430 less by purchasing from a nonprime vendor source.

The remaining 15 of 30 purchases, or just over 14,700 items totaling close to \$503,000, did not require waivers because the items were not available from the prime vendor. However, these items were not available from the prime vendor because the healthcare system did not set them up in VA's ordering system. As a result, waiver requests were not required, and the OIG did not question these costs.

The healthcare system's chief supply chain officer told the inspection team that national contract waiver requests were not used because the logistics team was unaware of the requirement. This practice of not using national contract waivers is inconsistent with VHA policy, which requires facilities to submit a national contract waiver request if and when there is a compelling clinical, infrastructural, or other need to deviate from using the MSPV contract to buy medical supplies.⁷⁵ Each waiver request must provide a valid, justifiable, and appropriate rationale for purchases from a nonprime vendor source. VHA headquarters directs that, to the extent permitted by law, VA medical facilities must use the MSPV distribution contracts or other national contracts designated as mandatory in VHA policy to purchase medical supplies. When an item is simultaneously available through an MSPV distribution contract and another mandatory procurement instrument, the MSPV contract must be used.⁷⁶

⁷⁵ Veterans Health Administration, "Medical/Surgical Prime Vendor (MSPV)" (standard operating procedure), rev. May 2017.

⁷⁶ VHA Directive 1761, p. A-5.

The Healthcare System Did Not Routinely Use 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 should be completed by the chief supply chain officer. It informs the MSPO with feedback on the MSPV program and the MSPV prime vendor. The inspection team determined the healthcare system did not complete any monthly facility execution surveys during the OIG review period of May 1, 2021, through April 30, 2022, and did not provide an explanation why the monthly surveys were not completed.

Quarterly evaluation reports are another method for reporting concerns with prime vendor performance. These reports assess a prime vendor's performance in areas such as quality, schedule, management, and regulatory compliance and are required to be completed by contracting officer's representatives (CORs). The team obtained and reviewed quarterly evaluation reports covering seven of the 12 months in the OIG review period of May 1, 2021, through April 30, 2022. However, neither the healthcare system nor VISN 2 officials were able to provide evaluations covering the remaining five months.

The lack of feedback on vendor evaluations can limit the ability of the MSPO and Strategic Acquisition Center to hold Cardinal Health accountable for not meeting its contractual obligations. Healthcare system personnel should routinely 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 and the MSPV program and to remind the prime vendor of its contractual obligations.

MSPV Contracting Officer's Representative

The healthcare system had two appointed CORs during the OIG review period of May 1, 2021, through April 30, 2022. One COR started serving as the facility MSPV COR in April 2021, as documented in her appointment letter. However, the team did not determine the date she stopped serving as the COR. She is no longer with the healthcare system. The inspection team determined that the COR who served from December 1, 2021, through April 30, 2022, did not perform many of the delegated duties and was ostensibly serving in the position in title only. The deputy chief supply chain officer told the review team that this COR was placed in the position because she was the only available person in the healthcare system that met the training and certification requirements to serve as the MSPV COR. Based on interviews with the deputy chief supply chain officer and the COR, most of the COR duties were performed by the deputy chief supply chain officer.

The COR told the inspection team that she did not perform many of the duties she was delegated in writing to do, including directly monitoring contract performance, directly acting as the liaison between the healthcare system and the vendor's on-site representative, documenting the prime vendor's performance issues, directly assisting the contracting officer in resolving issues, maintaining the contract working file, and monitoring any metrics.

Each healthcare system is required to have at least one certified MSPV COR. If the COR does not perform the delegated duties, the MSPV program objectives are at risk because the healthcare system COR is intended to be the eyes and ears of the contracting officer, serve as the official liaison between the healthcare system and the healthcare system's prime vendor, and play a central role in the MSPV program's success by holding the prime vendor accountable for fulfilling its contractual obligations.

Prime Vendor Fill Rates

Cardinal Health's contractual requirements included maintaining necessary inventory levels to provide the required supplies to participating facilities and distributing supplies at an unadjusted fill rate of 95 percent, which is calculated as a percentage of the orders requested that were fulfilled at the time of request. Cardinal Health provided the team with its monthly fill rate report for May 31, 2021, through April 30, 2022. According to this report, the prime vendor's unadjusted fill rate averaged 83 percent, demonstrating that the prime vendor did not meet the required 95 percent fill rate requirement.

The team reviewed this report and found that Cardinal Health's monthly fill rates ranged from a low of about 65 percent to a high of nearly 89 percent, with a 12-month average of 83 percent during the team's review period. Figure 4 shows Cardinal Health's self-reported unadjusted fill rate for the review period.

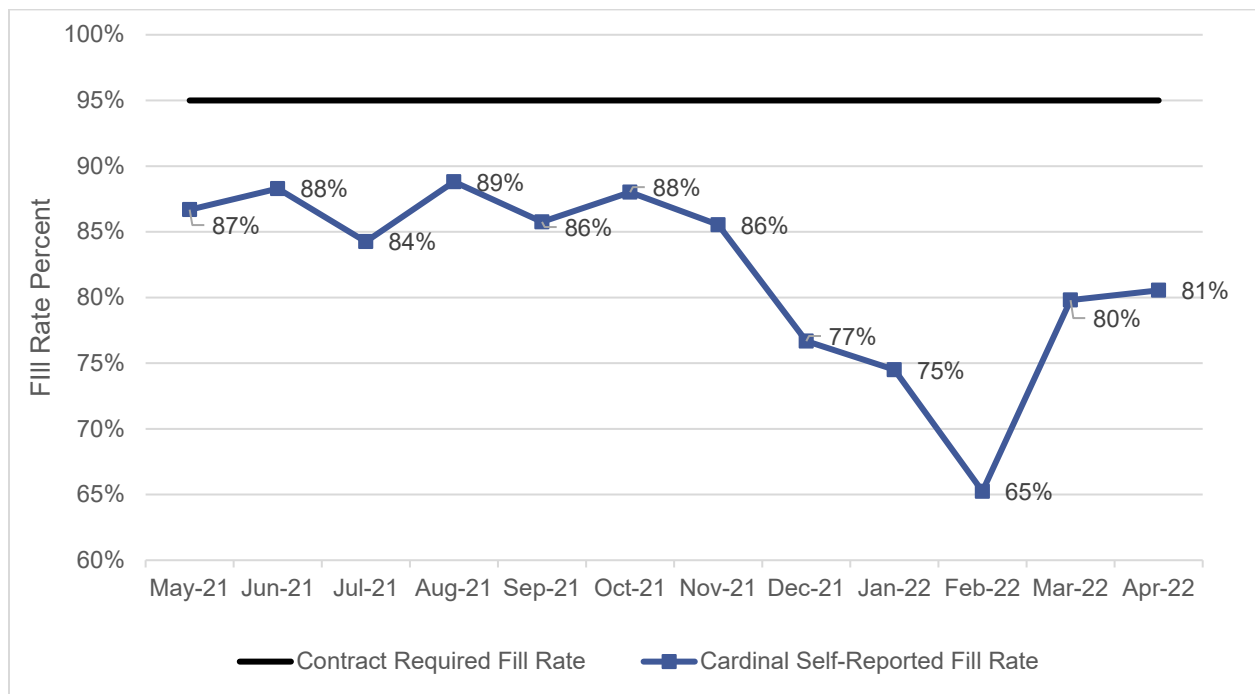


Figure 4. Cardinal Health’s self-reported unadjusted fill rate.

Source: VA OIG analysis of Cardinal Health self-reported unadjusted fill rate percentages, May 1, 2021, through April 30, 2022.

Healthcare system staff said they used other vendors because the prime vendor was unable to fill the purchase requests. The Cardinal Health representative said the healthcare system should notify the prime vendor when new items will be requested and provide an estimated demand for each item to help ensure those items will be stocked.

Finding 3 Conclusion

The healthcare system did not meet its MSPV utilization goal from May 1, 2021, through April 30, 2022. This occurred because the healthcare system did not update the local item master file and change the mandatory source in the Generic Inventory Package to reflect the prime vendor, did not routinely provide its prime vendor with inventory usage data and information about the timing for its supply needs, and did not ensure items were properly set up in the ordering system. These steps are intended to help ensure the prime vendor has adequate stock to provide VA with supplies when ordered. Additionally, the healthcare system did not submit waiver requests required by VA policy because staff were unaware of the waiver request requirements. Also, the healthcare system’s MSPV COR did not perform all the delegated duties during the review period; as a result, the healthcare system did not fully use available reporting tools to provide feedback on the prime vendor’s performance and to assist in resolving MSPV utilization 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 by approximately \$53,400 for medical supplies purchased through nonprime vendor sources.

Recommendations 6–10

The OIG made the following recommendations to the VA New York Harbor Healthcare System director:

6. Establish internal controls to help ensure the healthcare system monitors the Medical/Surgical Prime Vendor formulary for updates, converts supplies to the prime vendor in the item master file, identifies the prime vendor as the mandatory source for these items in the Generic Inventory Package, and properly sets up Medical/Surgical Prime Vendor supply items in VA's ordering system.
7. Develop a plan to improve collaboration with the prime vendor and its on-site representative to ensure adequate stock is available to meet orders, reduce the need for the healthcare system to use nonprime vendors, and communicate the healthcare system's usage and in-stock timing needs.
8. Ensure a qualified Medical/Surgical Prime Vendor contracting officer's representative is appointed and performs the required delegated duties.
9. Establish internal controls to help ensure the healthcare system submits national contract waivers and justifications prior to purchasing available formulary items from nonprime vendor sources.
10. Ensure that prime vendor contract performance issues are routinely reported to the Medical Supplies Program Office and Strategic Acquisition Center using established Veterans Health Administration reporting tools.

VA Management Comments

The director of the VA New York Harbor Healthcare System concurred with recommendations 6 through 10. To address recommendation 6, Supply Chain Management (SCM) will use existing resources to monitor MSPV item utilization. In addition, SCM will identify the prime vendor as the mandatory source for national formulary items and will utilize weekly inventory management meetings to identify new items and ensure the on-site representative verifies items and availability through MSPV.

To address recommendation 7, the director reported that SCM will review the facility core item listing monthly to ensure items are available to order through the prime vendor. To address recommendation 8, the director reported that SCM had assigned a COR, with the appropriate warrant, to oversee the MSPV contract and related requirements and report to SCM leaders for review and action.

To address recommendation 9, the director reported that SCM will provide guidance requiring all inventory managers and procurement staff to submit requests for new items through the Clinical

Products Review Committee portal.⁷⁷ The waiver process would then be initiated through the committee process.

To address recommendation 10, the director reported that SCM and the COR will meet with the on-site representative monthly to review the use of the MSPV program to maximize effectiveness.

OIG Response

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

⁷⁷ VHA Directive 1169, *National Pharmacy, Prosthetics, and Logistics Committee*, April 14, 2017. The Clinical Products Review Committee was to be established at each VA medical facility and charged with creating a medical and surgical supply formulary. https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=5383.

IV. Pharmacy Operations

The FY 2022 OPES pharmacy expenditure model, based on FY 2021 VA data, reported that the healthcare system spent almost \$61.7 million on prescription drugs. This spending represented just under 8 percent of the healthcare system's medical care budget of more than \$812.4 million.⁷⁸ Healthcare system leaders should analyze spending and identify opportunities to use pharmacy dollars more efficiently. The inspection team used the pharmacy expenditure 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** is the number of times inventory is used during the year and is the primary measure to monitor the effectiveness of inventory management per VHA policy.⁷⁹ Low inventory turnover rates could indicate inefficient use of financial resources.
- **Noncontrolled drug line audits** are required by VHA policy to be performed quarterly for specific drugs identified as potentially high risk for diversion.⁸⁰
- **The B09 reconciliation process** is how VA medical center pharmacies ensure they make correct payments for the drugs they receive. It is necessary because payments are made to the prime vendor before the drugs are received from the pharmacy prime vendor. Without the reconciliation there is no assurance that the amount paid to the prime vendor is consistent with the amount of goods received.

Finding 4: The Healthcare System Could Improve Pharmacy Efficiency 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, meeting noncontrolled drug line audit requirements, and ensuring

⁷⁸ "FY 2022 Pharmacy Expenditure Model (based on FY 2021 data)" (web page), VA Office of Productivity, Efficiency & Staffing (OPES), accessed July 05, 2022, https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?/MgmtReports/OPES/EOG_Model&rs:Command=Render&rc:Parameters=true&Model=pharm1&VISN=0. (This is an internal website not publicly accessible.)

⁷⁹ VHA Directive 1761. Inventory turnover rates are based on the previous 12 months' purchases divided by the inventory on hand.

⁸⁰ VHA Directive 1108.08(1), *VHA Formulary Management Process*, November 2, 2016, amended August 29, 2019. Diversion means the diversion of controlled substances from legal and medically necessary uses toward uses that are illegal and typically not medically authorized or necessary.

payments to the prime vendor agree with the amount of actual goods received by completing the B09 reconciliation process in accordance with policy.⁸¹ Failure to properly manage pharmacy operations can lead to increased replenishment costs, overstocking, spoilage, and diversion of drugs, and decrease the funding available to meet other healthcare system and patient care needs.

OPES Pharmacy Expenditure Data

The OPES pharmacy expenditure model identifies variations in pharmacy costs among VHA facilities. According to the model, the healthcare system spent about \$3.3 million more in FY 2022 than the expected cost of about \$58.4 million. Based on these numbers, the healthcare system's observed-minus-expected ratio was about 1.06, which ranked it 97th out of 139 VHA facilities for pharmacy drug cost efficiency.⁸² An observed-minus-expected ratio above 1.0 indicates that a healthcare system may have opportunities to reduce its pharmacy costs.

According to the OPES pharmacy expenditure model, the healthcare system has a two-year trend of decreasing efficiency. The FY 2020 model showed that the healthcare system's actual costs were lower than expected costs by more than \$4.8 million. However, the FY 2021 and FY 2022 models showed that the healthcare system exceeded expected costs by approximately \$670,000 and \$3.3 million, respectively. Figure 5 shows the increase in the observed-minus-expected costs for the healthcare system.

⁸¹ VHA Directive 1108.07(1), *Pharmacy General Requirements*, March 10, 2017, amended January 26, 2021. The chief of pharmacy services is responsible for reviewing the Pharmacy Prime Vendor (PPV) Line Item Report (B09 report) and reconciling the report with VA Form 1358 to ensure that the pharmacy is making correct payments for what is received and there is documented evidence (signature and date of review) that it has been completed.

⁸² The OPES pharmacy expenditure model uses the terms "observed minus expected" and "potential opportunity" to describe the gap between a healthcare system's actual and expected drug costs. This difference represents the amount associated with potential efficiency improvements.

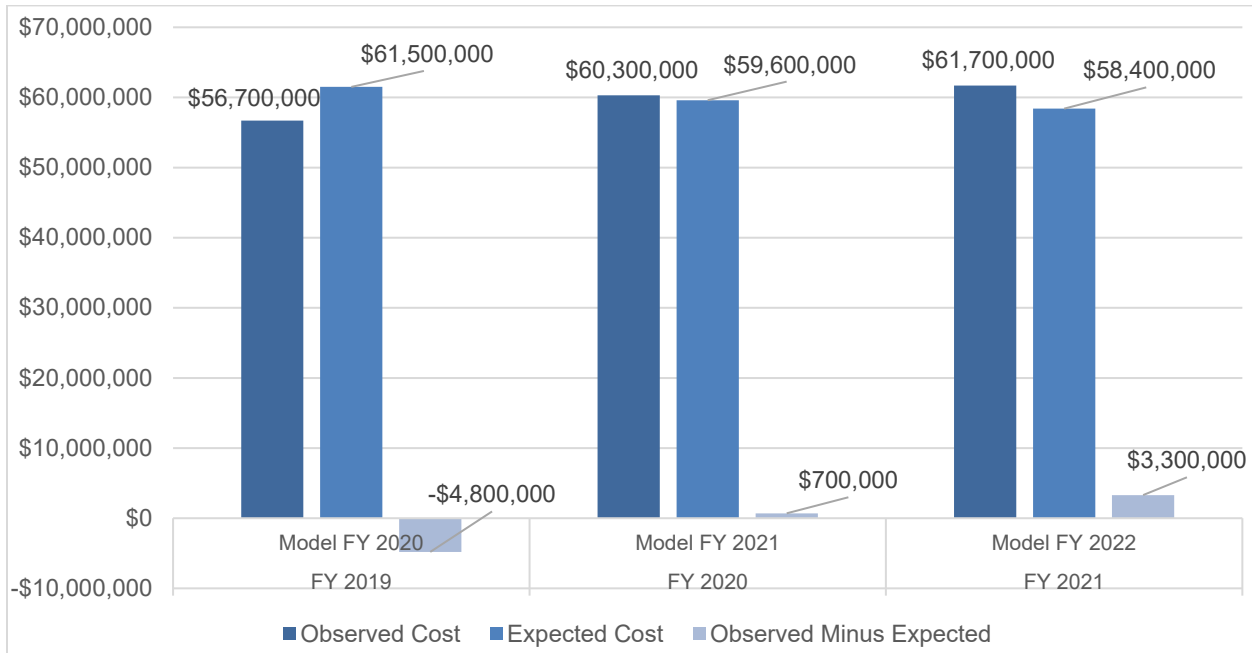


Figure 5. Observed-minus-expected drug cost, FY 2019 through FY 2021.

Source: OPES pharmacy expenditure model.

Note: The OPES data models are based on the previous fiscal year’s data (i.e., the FY 2022 data model was based on FY 2021 data).

The healthcare system achieved 116 percent of the FY 2021 savings opportunities identified by the VA Pharmacy Benefits Management office’s savings opportunities report. Despite these efforts, the healthcare system’s spending still exceeded its expected costs by approximately \$3.3 million in that fiscal year. The chief of pharmacy attributed the spending increases to expensive specialized antiviral drugs. According to the chief, the healthcare system has a high population of HIV-positive patients. Also, the healthcare system includes a teaching hospital affiliated with many academic institutions, and it has many doctors trained in newer, costlier medicines. These doctors tend to prescribe expensive drugs more often. VSSC reports showed that the healthcare system has VA’s second-largest HIV-positive patient population, and almost 25 percent of the healthcare system’s drug spending was on antiviral drugs. The healthcare system increased its spending on antiviral drugs by about \$619,000, or 4.9 percent, from FY 2019 to FY 2021.

Inventory Turnover Rate

VHA adopted ABC classification principles to increase accountability for inventory management and to establish more rigorous requirements for managing higher-dollar-usage inventory items. This method is based on annual inventory usage, in dollars, of all items at a specific inventory point. To establish ABC categories, items are ranked from highest dollar amount of usage to lowest. Items with the highest 80 percent of annual usage are classified as “A” items; the next

highest 10 percent are classified as “B” items; and the remaining 10 percent are classified as “C” items.

Based on VHA policy, which states that inventory turnover is the primary measure of the effectiveness for inventory management, the VA Pharmacy Benefits Management office recommended an annual inventory turnover goal of 12–16 times for items classified as “A.”⁸³ Higher inventory turnover rates are associated with decreased inventory carrying cost, which is the cost associated with holding inventory in storage. On the other hand, 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.

In August 2022, the pharmacy prime vendor reported an inventory turnover rate of almost 10.5 times for “A” inventory items, compared to the recommended turnover rate of 12–16 times for “A” items. The pharmacy chief said inventory turnovers were low due to a shortage of drugs that were unavailable from the pharmacy prime vendor, McKesson.

VHA policy also mandates the use of prime vendor inventory management reports to manage all VA pharmacy inventories.⁸⁴ The inspection 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. The policy requires that reorder points, which represent the level at which inventory items are to be reordered, be established for all primary and secondary inventory items.⁸⁵ However, pharmacy personnel said that although the healthcare system had established reorder points, the actual timing of when to buy those drugs depended on a manual process of visually inspecting the drug inventory bins. Instead of using handheld barcode readers as required by VHA policy, the healthcare system managed the inventory by walking the floors, observing the shelves, and noting the color-coded stickers for various items. For example, a red sticker means a drug is expiring soon; a blue sticker means an item is on backorder. Additionally, pharmacy staff made manual counts to determine the items needed instead of using demand forecasting to help factor trends into the calculation of reorder points and reorder quantities as VHA policy required.⁸⁶ The pharmacy chief said the pharmacy technicians were not proficient with the computer system. He stated that the healthcare system is planning to hire technicians that are more adept with the pharmacy service technology, and they plan to begin using the pharmacy prime vendor’s inventory management system.

⁸³ VHA Directive 1761.

⁸⁴ VHA Directive 1108.08(1).

⁸⁵ VHA Directive 1761.

⁸⁶ VHA Directive 1108.08(1).

Noncontrolled Drug Line Audits

VHA policy requires regular facility-based inventory audits for specific drugs identified as high cost or 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 5 percent require the healthcare system to perform an in-depth review and analysis.⁸⁷

The OIG reviewed the 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 five of the 21 reported variances between the actual and predicted amount of inventory were miscalculated by the reporting tool.
- **Unreported reviews.** VHA policy requires the results of these audits to be reported to healthcare system management through the quality assurance process on a quarterly basis, and quarterly and annual summaries to be reported to the VISN Pharmacy Executive Committee indicating the results of the reviews and any follow-up actions taken.⁸⁸ Interviews with pharmacy staff indicated these requirements were not being followed, and pharmacy leaders and staff were not aware of this noncompliance with VHA policy.

Failure to fully complete these regular inventory audits does not reduce the risk of drug diversion not being detected, drug inventory data being inaccurate, and unnecessary spending occurring in the pharmacy program.

B09 Reconciliation Process

VHA policy requires a review of the B09 report and reconciliation of that report with VA Form 1358 and other supporting documentation.⁸⁹ VA offices may use VA Form 1358 as an obligation control document only for certain limited uses.⁹⁰ The B09 report process ensures that the pharmacy is making correct payments for received items and that there is documented evidence, such as signature and date of review, that each transaction has been completed. The

⁸⁷ VHA Directive 1108.08(1).

⁸⁸ VHA Directive 1108.08(1).

⁸⁹ VHA Directive 1108.07(1).

⁹⁰ VA Financial Policy, "VA Form 1358 Approved Uses," in vol. 2, *Appropriations, Funds and Related Information*, May 2021 and September 2021, chap. 6, app. A.

report is generated weekly and is a summary of multiple invoices. VHA policy requires reconciliation of billing statements, verification of items ordered being received, and certification of accuracy including maintaining supporting documentation such as receipts, invoices, and packing slips.⁹¹ The chief of pharmacy must provide a monthly report, with adequate documentation, to the chief of the fiscal service stating the 1358 forms and B09 reports were reconciled and note any unresolved discrepancies.⁹² VHA policy also states that the pharmacy must maintain separation of duties so that a pharmacy staff member who places an order cannot also receive that order.⁹³ The staff member who establishes the 1358 cannot receive any orders placed to the prime vendor via that 1358.

The team found that the healthcare system's B09 reconciliation process did not fully comply with VHA policy. The team reviewed three months of invoices from May through July 2022 and found that 30 percent of invoices were not signed and dated. Pharmacy staff attributed this to an oversight. Additionally, the OIG found that the pharmacy service did not always supply supporting documentation to the fiscal service. Without this documentation, the fiscal service could not complete the full reconciliation as required, and the inspection team could not determine if reconciliations were being completed in a timely manner. If reconciliations are not completed, there is no assurance that the amount paid to the prime vendor is consistent with the goods received.

Finding 4 Conclusion

The healthcare system could improve pharmacy efficiency by narrowing the gap between observed and expected drug costs and by increasing its inventory turnover to meet the VHA recommended level. The healthcare system could further improve efficiency by using the specified calculation to accurately determine variances for quarterly noncontrolled drug line audits and complete the B09 reconciliation process to ensure that the amount paid to the prime vendor agrees with the amount of actual goods received. An efficient healthcare system anticipates drug costs and when inventory needs to be restocked, helping ensure that the system makes the best use of appropriated funds and has inventory when needed.

Recommendations 11–14

The OIG made the following recommendations to the VA New York Harbor Healthcare System director:

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

⁹¹ VHA Directive 1108.07(1).

⁹² VHA Directive 1108.07(1).

⁹³ VHA Directive 1108.07(1).

12. Develop and implement a plan to achieve an inventory turnover rate closer to the Veterans Health Administration's recommended level.
13. Develop and implement a plan to report the results of facility-based inventory audits of noncontrolled drug line items, and any follow-up actions taken, as required by Veterans Health Administration policy.
14. Establish processes to ensure compliance with the Veterans Health Administration directive which requires that B09 reconciliations are signed by the lead pharmacy technician and include appropriate supporting documentation.

VA Management Comments

The director of the VA New York Harbor Healthcare System concurred with recommendations 11 through 14. To address recommendation 11, the director reported that the chief of pharmacy would monitor the daily VISN 2 cost-savings report to identify cost-saving opportunities. For recommendation 12, the director reported a plan to increase inventory turnover, with a goal of 12 turns, by reducing medication inventory and using the ABC method to classify and track stock. The healthcare system will also implement barcode scanning and has ordered barcode scanners for all three sites, which the Office of Information and Technology will install once they are received. For recommendation 13, the director will require the pharmacy chief to submit quarterly reports on noncontrolled drug line items to the Pharmacy & Therapeutics Committee and will monitor this inventory using a VA system. For recommendation 14, the director plans to update the B09 reconciliation form with a signature line for pharmacy procurement staff at each campus to complete. The procurement staff who perform the reconciliation monthly must sign and date it, and the chief of pharmacy must cosign.

OIG Response

The healthcare system director's action plans are responsive to the recommendations. The team noted that the healthcare system listed one of these actions as completed in April 2023, and two as completed in May 2023. However, the OIG did not receive any evidence or supporting documentation to evaluate that these three actions were completed. The OIG will monitor implementation of the planned actions and will close the recommendations when the OIG receives sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified.

Appendix A: Healthcare System Profile

Healthcare System Profile

Table A.1 provides general background information for this level 1a, high-complexity facility reporting to VISN 2 leaders.⁹⁴

Table A.1. Healthcare System Profile for the VA New York Harbor Healthcare System (October 1, 2019, through September 30, 2021)

Profile element	Healthcare system data FY 2019	Healthcare system data FY 2020	Healthcare system data FY 2021
Total medical care budget in dollars	\$763,946,446	\$747,223,777	\$812,434,384
Number of:	48,155	45,119	48,891
<ul style="list-style-type: none"> Unique patients 			
<ul style="list-style-type: none"> Outpatient visits 	715,437	631,399	698,184
<ul style="list-style-type: none"> Total Medical Care FTE* 	3,247	3,194	3,069
Type and number of operating beds:	171	171	171
<ul style="list-style-type: none"> Hospital 			
<ul style="list-style-type: none"> Domiciliary 	66	66	66
<ul style="list-style-type: none"> Community Living Center 	179	123	110
Average daily census:	118	99	95
<ul style="list-style-type: none"> Hospital 			
<ul style="list-style-type: none"> Domiciliary 	59	30	9
<ul style="list-style-type: none"> Community Living Center 	179	123	110

Source: VHA Support Service Center, "Trip Pack Operational Statistics Table," accessed April 16, 2022, https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?%2fMgmtReports%2fPocketCard%2fTripPack_OperationalStatisticsTable&rs:Command=Render. (This is an internal website not publicly accessible.)

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

* Total Medical Care Full-time Equivalent (FTE) includes both direct medical care FTEs in budget object code 1000–1099 (Personal Services) and all cost centers.

⁹⁴ 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.

According to VSSC data, the healthcare system's medical care budget increased by almost \$48.5 million (about 6.3 percent) between FY 2019 and FY 2021. At the same time, the number of unique patients increased by almost 740 patients (about 1.5 percent). According to the chief financial officer, the FY 2019 to FY 2021 budget increase was used for COVID-19 costs (almost \$57.6 million), increased spending on the Care in the Community program (about \$15.6 million), equipment (over \$14 million), and nonrecurring maintenance costs (about \$13.5 million). The total increased spending for these four areas totaled almost \$100.8 million; however, spending on prosthetics decreased by almost \$51.5 million. According to the healthcare system's chief financial officer, the large decrease occurred because in FY 2019, all VISN prosthetics program costs were assigned to the healthcare system, whereas in FY 2020, the costs for prosthetics employees were assigned to the VISN, and not the healthcare system.

Appendix B: Scope and Methodology

Scope

The inspection team conducted its work from August 2022 to March 16, 2023, including an on-site visit during the week of August 15, 2022. The inspection is limited in scope and is not intended to be a comprehensive inspection of all financial operations at the VA New York Harbor Healthcare System.

Methodology

The inspection team evaluated open obligations for December 2021 through May 2022, purchase card transactions for July 2021 through June 2022, and MSPV utilization for May 2021 through April 2022. The team also analyzed financial efficiency practices related to the healthcare system's pharmacy costs using the FY 2022 OPES model; however, the FY 2022 data model was based on FY 2021 data from FMS.

To conduct the review, the team

- interviewed healthcare system leaders and staff;
- identified and reviewed applicable laws, regulations, VA policies, operating procedures, and guidelines related to financial efficiency practices for MSPV utilization, overseeing purchase card transactions, monitoring open obligations, and addressing inefficiencies in pharmacy costs;
- statistically sampled 101 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; and
- judgmentally sampled
 - 19 inactive obligations to assess whether the healthcare system identified and reviewed the obligations to determine if they were still valid and needed to remain open in accordance with VA financial policy,
 - 10 obligations with order amount discrepancies identified in VA's FMS-to-IFCAP Reconciliation reports to determine if order amounts were accurate and reconciled between VA's FMS and IFCAP, and
 - 30 purchase records for medical/surgical formulary items to determine why those items were purchased using nonprime vendor sources.

Internal Controls

The team assessed internal controls that were relevant and significant to the objectives of the inspection. This assessment considered the five internal control components identified in the Government Accountability Office’s (GAO) *Standards for Internal Control in the Federal Government*, along with the related principles contained within each component. The five internal control components are control environment, risk assessment, control activities, information and communication, and monitoring.⁹⁵ The team identified internal control weaknesses in all four protocols assessed—open obligations, purchase cards, MSPV, and pharmacy—and proposed recommendations to address the control deficiencies.

Fraud Assessment

The inspection team exercised due diligence in staying alert for the risk that fraud and noncompliance with provisions of laws, regulations, contracts, and grant agreements, significant within the context of the inspection objectives, could occur during this inspection. The OIG did not identify any instances of fraud or potential fraud during this inspection.

Data Reliability

The inspection team used computer-processed data obtained from US Bank files through a corporate data warehouse and the OPES efficiency opportunity grid.⁹⁶ To test for reliability, the team determined whether any data were missing from key fields, including any calculation errors, or were outside the time frame requested. The team also assessed whether the data contained obvious duplication of records, alphabetic or numeric characters in incorrect fields, or illogical relationships among data elements. Furthermore, the team compared purchase order numbers, payment dates, payee names, payment amounts, vendor names, and credit card numbers as provided in the data from the samples reviewed. Testing of the data disclosed that they were sufficiently reliable for the review objectives.

In addition, the team used computer-processed data included in reports from FMS to determine open obligation amounts. The team found that summary-level data were sufficiently reliable for reporting on the healthcare system’s open obligations.

⁹⁵ GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G, September 2014.

⁹⁶ VA Enterprise Architecture Repository (VEAR) VA Systems Inventory (VASI), “Corporate Data Warehouse (CDW) - #1152,” accessed March 15, 2023. The Corporate Data Warehouse is an evolving data repository designed to store and secure data through efficient acquisition, integration, and curation of multisource data sets into one coherent logical data model.

https://vaww.vear.ea.oit.va.gov/#system_and_application_domain_defs_system_23778.htm. (This is an internal website, not publicly accessible.)

Moreover, the team used computer-processed data included reports from the SCCOP dashboard to determine MSPV utilization rates. The dashboard summary-level data were sufficiently reliable for reporting on the healthcare system's MSPV utilization rate.

Government Standards

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

Appendix C: Statistical Sampling Methodology

Open Obligations Oversight

The inspection team evaluated judgmental samples of open obligation transactions to determine if (1) the VA New York Harbor 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 and (2) the healthcare system reconciled order amounts between FMS and IFCAP.

Population

During May 2022, the healthcare system had 840 open obligations, totaling approximately \$53.8 million. Of those open obligations, 764 obligations, totaling approximately \$33.6 million, had no activity for over 181 days. From December 2021 through May 2022, there were 20 obligations with order amount discrepancies between FMS and IFCAP for three or more months.

Sampling Design

The inspection team selected two judgmental samples:

- **Inactive obligations.** The team selected 19 obligations with no activity for more than 90 days from the May 2022 FMS F850 report. This report lists each open obligation and its remaining balance. Ten obligations were still within the performance period, and the remaining nine were more than 90 days past the performance period end date.
- **FMS-to-IFCAP reconciliations.** The team selected 10 obligations with different order amounts between FMS and IFCAP from VA's FMS-to-IFCAP Reconciliation reports for December 2021 through May 2022.

The samples included 29 total open obligations: 19 with no activity for more than 90 days, totaling approximately \$31.5 million, and 10 obligations with different order amounts between FMS and IFCAP, totaling approximately \$3.5 million.

To review the sampled obligations, the team requested supporting documentation for each of the 29 sampled transactions, including monthly reviews and reconciliations, financial system screen prints and reports, and emails related to the obligations.

Projections and Margins of Error

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

Purchase Cards

The inspection team evaluated a statistical sample of purchase card transactions that occurred from July 1, 2021, through June 30, 2022, to determine if (1) the VA New York Harbor Healthcare System reviewed purchase card transactions to ensure they were adequately monitored, approved, and supported by documentation; and (2) the reviewed transactions complied with processes to prevent split purchases and transactions exceeding the cardholder's authorized single-purchase limit and to ensure goods or services were procured using strategic sourcing procedures.

Population

During the inspection period, purchase cardholders at the healthcare system made over 47,000 purchase card transactions totaling approximately \$47 million. From this population, the team developed three strata. The first stratum included potential split transactions that exceeded the micro-purchase threshold with no individual purchase above that threshold and included a total of 77 bundles of transactions composed of 613 individual transactions. The second stratum included potential split transactions that exceeded a cardholder's single-purchase limit and were less than the micro-purchase threshold. This stratum included 300 bundles consisting of 2,228 transactions. The third stratum included non-potential split purchase transactions, about 47,000 transactions greater than or equal to \$0 that did not meet the split definitions.

Sampling Design

For the three strata, samples were selected using probability proportional to size of purchase amount by bundle (for potential split purchases) or individual transaction (for other non-potential split purchases):

- **Potential split purchases exceeded micro-purchase threshold.** The team identified potential split purchases as transactions with the same purchase date, purchase card number, and merchant and an aggregate sum greater than the micro-purchase threshold. The team selected 10 bundles of potential split purchases that included 151 transactions.
- **Potential splits exceeded single-purchase limit.** The team identified potential split purchases as transactions with the same purchase date, purchase card number, and merchant and an aggregate sum greater than the cardholder's authorized single-purchase limit and less than the micro-purchase threshold. The team selected 10 bundles of potential split purchases that included 50 transactions.
- **Non-potential split purchase.** The team selected 20 transactions greater than or equal to \$0 after all potential split purchases were identified.

The statistical sample included 101 total individual transactions: 81 potential split purchase transactions, totaling approximately \$256,000, and 20 non-potential split purchase transactions, totaling approximately \$118,000.

To review the transactions selected in the sample, the team requested supporting documentation for each of the 101 transactions, VA Forms 0242 for all 23 cardholders in the selected transactions, and documentation to support the completion of purchase card reviews.

Projections and Margins of Error

The projection is an estimate of the population value based on the sample. The associated margin of error and confidence interval show the precision of the estimate. If the OIG repeated this audit with multiple sets of samples, the confidence intervals would differ for each sample but would include the true population value 90 percent of the time.

The OIG statistician employed statistical analysis software to calculate estimates, margins of error, and confidence intervals that account for the complexity of the sample design.

The sample size was determined after reviewing the expected precision of the projections based on the sample size, potential error rate, and logistical concerns of the sample review. While precision improves with larger samples, the rate of improvement decreases significantly as more records are added to the sample review.

Figure C.1 shows the effect of progressively larger sample sizes on the margin of error.

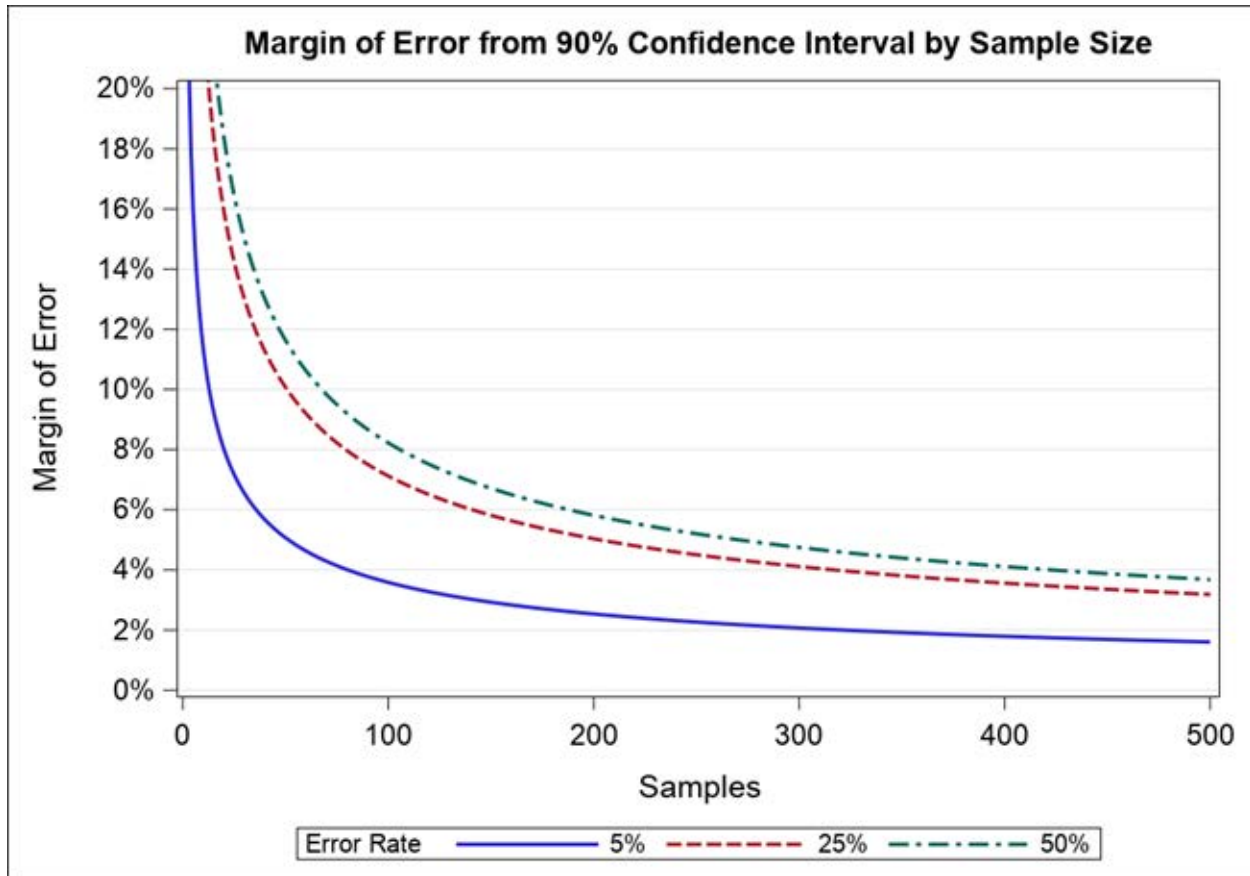


Figure C.1. Effect of sample size on margin of error.
 Source: OIG statistician’s analysis.

Projections

The team reviewed a statistical sample from a population of about 47,000 purchase card transactions with positive amounts totaling approximately \$47 million. Based on the results, the team projected that about 42,300 transactions totaling an estimated \$44.1 million were not processed in accordance with VA policy. Further analysis of the sampled transactions indicated that the VA New York Harbor Healthcare System

- did not have supporting documentation for at least 5,000 transactions totaling at least \$6.1 million,⁹⁷
- did not obtain prior approval for approximately 29,400 transactions totaling about \$30 million, and

⁹⁷ Results of lack of supporting documentation are conservative estimates based on the lower bound of the projections due to the larger margins of error.

- did not have reconciliations for approximately 27,600 transactions totaling about \$28.6 million.

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

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

Estimate name	Estimate	90 percent confidence interval				Sample Size
		Margin of error	Lower limit	Upper limit	One-tailed lower limit	
Overall errors (percent)	42,268 (90%)	5,302 (10%)	36,966 (79%)	47,571 (100%)	NA	98
Supporting documentation errors	10,526	7,049	3,477	17,575	5,049	41
Prior approval errors (percent)	29,408 (63%)	8,339 (18%)	21,069 (45%)	37,747 (80%)	NA	54
Reconciliation errors (percent)	27,612 (59%)	8,533 (18%)	19,079 (41%)	36,146 (77%)	NA	68

Source: VA OIG statistician’s analysis and team’s review of purchase card transactions.

Note: For estimates with poor precision, the one-tailed lower limit for the 90 percent confidence interval is reported. This is a more conservative value than the estimate. When reporting on total errors combined, a projected “overall errors” estimate is used to avoid double counting transaction amounts.

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

Estimate name	Estimate	90 percent confidence interval				Sample size
		Margin of error	Lower limit	Upper limit	One-tailed lower limit	
Overall errors	\$44,098,113	\$5,364,009	\$38,734,104	\$49,462,122	NA	98
Supporting documentation errors	\$11,604,899	\$7,128,517	\$4,476,382	\$18,733,416	\$6,066,034	41
Prior approval errors	\$30,008,849	\$8,414,536	\$21,594,313	\$38,423,385	NA	54
Reconciliation errors	\$28,552,870	\$8,612,580	\$19,940,289	\$37,165,450	NA	68

Source: VA OIG statistician’s analysis and team’s review of purchase card transactions.

Note: For estimates with poor precision, the one-tailed lower limit for the 90 percent confidence interval is reported. This is a more conservative value than the estimate. When reporting on total errors combined, a projected “overall errors” estimate is used to avoid double counting transaction amounts.

MSPV Program Use

The inspection team evaluated a judgmental sample of purchase records of formulary items acquired by the healthcare system during the period of May 1, 2021, through April 30, 2022, to determine why these items were purchased using nonprime vendor sources.

Population

During the review period, the healthcare system spent about \$6.2 million purchasing more than 64,800 formulary supply items from nonprime vendor sources.

Sampling Design

The inspection team selected a judgmental sample of 30 records, totaling about \$650,719 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 30 sampled transactions, including purchase orders, invoices, receiving reports, and explanations as to why it purchased these items using a source other than the MSPV prime vendor.

Projections and Margins of Error

The inspection 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 ⁹⁸
1	Ensure that healthcare system finance office staff and initiating services are made aware of policy requirements to conduct reviews on all inactive open obligations and deobligate any identified excess funds as required by VA Financial Policy, vol. 2, chap. 5, "Obligations Policy."	\$48,100	
2	Ensure cardholders comply with record retention, prior approval, and purchase card reconciliation requirements as required by VA Financial Policy, vol. 16, chap. 1B, "Government Purchase Card for Micro-Purchases."		\$44,098,113*
3	Ensure cardholders verify that vendors have removed all state and local sales taxes from orders, if applicable.	\$400	
9	Establish internal controls to help ensure the healthcare system submits national contract waivers and justifications prior to purchasing available formulary items from nonprime vendor sources.		\$23,700
	Total	\$48,500	\$44,121,813

* When reporting on combined monetary benefits, the OIG reduced amounts for errors in multiple categories to avoid double counting transaction amounts.

⁹⁸ 2 C.F.R. § 200.84. The term "questioned cost" includes a cost that is questioned by the auditor because of an audit finding where the cost, at the time of the audit, is not supported by adequate documentation.

Appendix E: VA Management Comments, Director, VA New York Harbor Healthcare System

Department of Veterans Affairs Memorandum

Date: April 24, 2023

From: Director, VA New York Harbor Healthcare System (630)

Subj: OIG Financial Efficiency Inspection NY Harbor-Transmittal Memo and Draft Report

To: Director, Financial Inspections Division, Office of the Inspector General

I have reviewed the draft report – OIG Financial Efficiency Inspection of the VA NY Harbor Healthcare System in New York. I concur with the findings and recommendations.

I appreciate the opportunity for this review as a continuing process to improve the care to our Veterans.

Thank you.

(Original signed by)

Timothy H. Graham

Executive Director

Financial Efficiency Inspection of VA New York Harbor Health Care System

Recommendation 1: Ensure that healthcare system finance office staff and initiating services are aware of policy requirements to conduct reviews on all inactive open obligations and de-obligate any identified excess funds as required by VA Financial Policy, vol. 2, chap. 5, “Obligations Policy.”

VA New York Harbor Health Care System concurs with this finding and recommendation.

Target date for completion: November 4, 2022

Action Plan: Supervisory Accountant conducted a training session for accounting staff regarding the financial policy, including VA Financial Policy, Volume 2, Chapter 5, “Obligation Policy”, on following up on inactive purchase orders on November 4, 2022. Since then, inactive purchase orders are being reviewed by the accountant staff using the F850, F851 and 889B reports. These follow up are done every month, with emails being sent to services and contracting.

Fiscal Service will conduct trainings on this policy and its requirements each quarter to ensure that the required follow ups are being done.

Recommendation 2: Ensure that healthcare system staff are conducting finance quality assurance reviews of obligations that were inactive for more than 90 days, as required by Veterans Health Administration Directive 1733, “VHA Finance Quality Assurance Reviews.”

VA New York Harbor Health Care System concurs with this finding and recommendation.

Target date for completion: November 4, 2022

Action Plan: VISN 2 FQAM internal auditors conducts the Quality Assurance audits for Sta 630. The last Accounting Operations Review (AOR) Quality Assurance audit was done by VISN 2 in the 3QTR FY2022. The next Accounting Operations Review (AOR) Quality Assurance will be done in the 3QTR FY2023.

Supervisory Accountant conducted a training session for accounting staff regarding the financial policy, including VA Financial Policy, Volume 2, Chapter 5, “Obligation Policy”, on following up on inactive purchase orders on November 4, 2022. Fiscal Service will conduct trainings on this policy and its requirements for follow ups on inactive purchase orders with over 90 days of inactivity each quarter.

Recommendation 3: Ensure cardholders comply with record retention, prior approval, and purchase card reconciliation requirements as required by VA Financial Policy, vol. 16, chap. 1B, “Government Purchase Card for Micro-Purchases.”

VA New York Harbor Health Care System concurs with this finding and recommendation.

Target date for completion: June 30, 2023

Action Plan: The purchase card manager or designee will host refresher training for all cardholders. The training will stress record retention, prior approval, and purchase card reconciliation requirements. The refresher training will be made mandatory by the Medical Center Director. All training will take place by June 30, 2023.

Recommendation 4: Ensure cardholders verify that vendors have removed all state and local sales taxes from orders, if applicable.

VA New York Harbor Health Care System concurs with this finding and recommendation.

Target date for completion: June 30, 2023

Action Plan: Refresher training will include a focus on the need to ensure state and local taxes are not paid. Additionally, during account/transaction audits, invoices will be reviewed to ensure no taxes were paid. All refresher training will be completed by June 30, 2023. Reviews will begin on June 1, 2023, with the goal of reviewing each cardholder once a year.

Recommendation 5: Ensure authorizing officials implement internal controls over government purchase card activities to ensure compliance with the government purchase card program.

VA New York Harbor Health Care System concurs with this finding and recommendation.

Target date for completion: August 31, 2023

Action Plan: The Director of Contracting, Deputy Director of Contracting, Purchase Card Manager, along with VISN 2 Fiscal representatives and selected Approving Officials, will collaborate to develop a comprehensive surveillance standard operating procedure for the VISN/NCO 2 purchase card program. The procedure will ensure account reviews are conducted to evaluate and improve the effectiveness of internal controls and compliance with existing Government Purchase Card regulations and policies. Each quarter review results will be documented and reported to management officials advising them of the overall health of the purchase card program and to identify areas for improvement.

The surveillance standard operating procedure will be written, reviewed, and implemented by May 31, 2023. Reviews to ensure all documents are continued in each file will begin on June 1, 2023, with the intent to complete reviews on, at least, 10% of all cardholders by June 30, 2023. Beginning in the 4th quarter, the goal will be to review 25% of cardholders each quarter so all cardholders are reviewed once a year.

Recommendation 6: Establish internal controls to help ensure the healthcare system monitors the Medical/Surgical Prime Vendor formulary for updates, converts supplies to the prime vendor in the item master file, identifies the prime vendor as the mandatory source for these items in the generic inventory package, and properly sets up Medical/Surgical Prime Vendor supply items in VA's ordering system.

VA New York Harbor Health Care System concurs with this finding and recommendation.

Target date for completion: August 31, 2023

Action Plan: Supply Chain Management (SCM) will establish mechanisms that utilize the available tools (to include Power BI Production SCCOP Dashboard MSPV Formulary Utilization report, Power BI PVCart Dashboard, and VA Supply Chain Master Catalog) to monitor MSPV item utilization for the healthcare system. In addition, SCM will identify items which are part of the national formulary to ensure these items are entered into the generic inventory package indicating they are MSPV mandatory source items. SCM will utilize the weekly inventory management meetings to identify any new item requests from medical center clinicians and ensure that the facility onsite representative verifies item availability through MSPV.

Recommendation 7: Develop a plan to improve collaboration with the prime vendor and its onsite representative to ensure adequate stock is available to meet orders, reduce the need for the healthcare system to use nonprime vendors, and communicate the healthcare system's usage and in-stock timing needs.

VA New York Harbor Health Care System concurs with this finding and recommendation.

Target date for completion: May 31, 2023

Action Plan: SCM will complete monthly review of the MSPV Facility Core Item Listing provided by the MSPV onsite representative for the medical center to ensure items are available for procurement as needed through the prime vendor. Item usage will be reviewed utilizing the monthly report and adjustments requested as needed to ensure availability of supplies at MSPV distribution point.

Recommendation 8: Ensure a qualified Medical/Surgical Prime Vendor contracting officer's representative is appointed and performs the required delegated duties.

VA New York Harbor Health Care System concurs with this finding and recommendation.

Target date for completion: April 30, 2023

Action Plan: SCM has assigned a Contracting Officer Representative to oversee the MSPV contract and associated reporting requirements. This individual holds the required warrant and will report all pertinent information to SCM leadership for review and action. In addition, COR will attend quarterly MSPV review meetings held by SCM and MSPV representatives. All required MSPV reports will be completed and submitted by designated COR as mandated by national program. In addition, COR will maintain electronic copy of all report submissions for the duration of the contract.

Monthly: Review data and submissions with SCM Chief and Deputy Chief to include MSPV Monthly Facility Execution Survey, MSPV Facility Core Item Listing, and Monthly Performance and Metrics report relating to MSPV-CH performance. COR will provide Review of all data with onsite representative in scheduled monthly meetings.

Recommendation 9: Establish internal controls to help ensure the healthcare system submits national contract waivers and justifications prior to purchasing available formulary items from nonprime vendor sources.

VA New York Harbor Health Care System concurs with this finding and recommendation.

Target date for completion: June 30, 2023

Action Plan: SCM leadership will put guidance in place requiring all inventory managers and procurement staff within supply chain service to submit any requests for new items through the CPRC portal to ensure items are reviewed for appropriate use and proper sourcing. Waiver process would then be initiated through the committee process. Any request for alternative products to those on formulary must be approved by the Chief or Deputy Chief prior to procurement. If waiver is required, it will be forwarded to the corresponding Service Chief for action through the waiver process.

CPRC Committee reviews requests for new commodities for the medical center and will therefore be responsible for initiating any waiver requests when a request is placed for a commodity (similar) to one already available through MSPV. If committee determines there is validity to the request for the non-formulary item, they will assist the requesting service with initiating the process for requesting waiver through National Program Office. CPRC will track request through process and report program office decision as soon as it is provided.

Recommendation 10: Ensure that prime vendor contract performance issues are routinely reported to the Medical Supplies Program Office and Strategic Acquisition Center using established Veterans Health Administration reporting tools.

VA New York Harbor Health Care System concurs with this finding and recommendation.

Target date for completion: June 30, 2023

Action Plan: The appointed contract COR is responsible for completing the MSPV Monthly Facility Execution Survey and MSPV Quarterly Evaluations forms for SCM. In addition, SCM and the COR will meet with the onsite representative on monthly basis to review MSPV program utilization and areas of focus such as fill rates to ensure MSPV program is utilized as effectively as possible.

Pharmacy Action Plan

Recommendations	Action Plan	Responsible Staff	How will this be Monitored	Status/Target Date
<p>11. Develop formalized process for monitoring and achieving identified efficiency targets and use available pharmacy data to make business decisions</p>	<p>Use PBM 2023 VISN 2 recommended 12 Cost Savings Report and internal medication use reports to identify cost savings opportunities and promote use of preferred agents whenever appropriate</p>	<p>Chief of Pharmacy</p>	<p>Monitor savings trends on the VISN 2 Cost Savings Report (Daily) Monitored by Chief of Pharmacy</p>	<p>5/1/2023 (complete)</p>
<p>12. Develop and implement a plan to achieve an inventory turnover rate closer to the Veterans Health Administration's recommended level</p>	<p>Increase inventory turns by reducing medication inventory, monitored through McKesson Velocity Indicator Report quarterly. Current inventory turns is 10.5, goal to increase to 12</p>	<p>Chief of Pharmacy Pharmacy Inpatient & Outpatient Supervisors Pharmacy Procurement Staff New York Brooklyn St. Albans</p>	<p>Use wholesaler reports, accurately measure inventory using ABC analysis, and minimize inventory based on quarterly min/max method for par levels determined by wholesaler Bar Coding and Ordering System (Daily) Monitored by Responsible Staff</p>	<p>6-1-2023</p>

Recommendations	Action Plan	Responsible Staff	How will this be Monitored	Status/Target Date
<p>12. Implement McKesson barcoding and ordering system</p>	<p>Implement barcode ordering in storage areas to increase efficiency and inventory turns at all three sites. Barcode scanning devices have been ordered for all three sites, to be installed by OIT upon receipt</p>	<p>Chief of Pharmacy Pharmacy Procurement Staff New York Brooklyn St. Albans</p>	<p>Procurement Staff scan product shelf labels to place McKesson orders in lieu of manual entry, import scanned items via McKesson supply manager (Daily) Monitored by Responsible Staff</p>	<p>6-1-2023</p>
<p>13. Develop and implement a plan to report the results of facility-based inventory audits of non-controlled drugs line items, and any follow-up action taken, as required by Veterans Health Administration policy</p>	<p>Report Non-Controlled Substance Inventory results quarterly to P&T committee by Chief of Pharmacy</p>	<p>Chief of Pharmacy Pharmacy Inpatient Supervisors New York Brooklyn St. Albans</p>	<p>Monitor via Control Substance package. Inventory, purchase, dispense, final inventory variance calculated and reconciliation complete (Quarterly) Monitored by Responsible Staff</p>	<p>5/1/2023 (complete)</p>
<p>14. Establish processes to ensure compliance with the Veterans Health Administration directive which requires the BO9 reconciliations are signed by the lead pharmacy technician and include appropriate supporting documentation</p>	<p>Update BO9 memo with a signature line for Pharmacy Procurement Staff at each campus to sign</p>	<p>Chief of Pharmacy Pharmacy Administrative Officer Pharmacy Procurement Staff New York Brooklyn St. Albans</p>	<p>The Procurement Staff reconciling the fiscal BO9 report of each campus must sign and date and Chief of Pharmacy cosigns (Monthly) Monitored by Responsible Staff</p>	<p>4/11/2023 (complete)</p>

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.
----------------	---

Inspection Team	Lance Kramer, Director Angela Billups Steven Flores Nathan Fong Gurpreet Kaur Jimmy Sembiring
------------------------	--

Other Contributors	Dan Blodgett Cliff Stoddard Bill Warhop
---------------------------	---

Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Veterans Health Administration
National Cemetery Administration
Assistant Secretaries
Office of General Counsel
Office of Acquisition, Logistics, and Construction
Board of Veterans' Appeals
Director, VISN 2: New York/New Jersey VA Health Care Network
Director, VA Harbor New York Healthcare System

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs,
and Related Agencies
House Committee on Oversight and Accountability
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs,
and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
US Senate: Kirsten E. Gillibrand, Charles E. Schumer
US House of Representatives: Jamaal Bowman, Yvette Clarke, Anthony D'Esposito,
Adriano Espaillat, Andrew Garbarino, Daniel Goldman, Hakeem Jeffries, Nick LaLota,
Michael Lawler, Nicole Malliotakis, Gregory Meeks, Grace Meng, Jerrold Nadler,
Alexandria Ocasio-Cortez, George Santos, Ritchie Torres, Nydia Velázquez, Brandon
Williams

OIG reports are available at www.va.gov/oig.