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Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Financial Efficiency Inspection of the VA Milwaukee Healthcare System

Financial Inspection	**22-03768-156**	**August 28, 2023**

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Executive Summary

The VA Office of Inspector General (OIG) conducted this inspection to assess the stewardship and oversight of funds by the VA Milwaukee Healthcare System and to identify potential cost efficiencies in carrying out medical center functions.[1] To accomplish this goal, the OIG identified and examined financial activities that are under the healthcare system's control and can be compared to other similar facilities within VA.

This inspection assessed four financial activities and administrative processes to determine whether the healthcare system had appropriate controls and oversight in place from October 2021 through September 2022:

I. **Use of managerial cost accounting information**. The inspection team reviewed healthcare system internal reporting, Financial Management System (FMS) data, and managerial cost accounting information. The inspection focused on the use of managerial cost accounting information to compare planned amounts to actual results, enhance efficiency, help reduce costs, or inform business decisions as described in VA policy. The inspection team also applied federal financial accounting standard practices to determine if cost information was used for performance measurement, budgeting and cost control, and making economic choices for veteran care, such as whether to provide services in-house or use community care.

II. **Accrued expense oversight.** An accrued expense occurs when goods and services that were ordered and for which funds were obligated have been received, but payment has not been made. VA policy states each accrued expense should be reviewed by the finance office monthly against supporting documentation to ensure reports, subsidiary records, and systems reflect proper vendors and correctly calculated accrued balances, the accrual flag is set appropriately, and proper accruals have occurred.[2] The inspection team evaluated whether the healthcare system performed monthly reviews and reconciliations of sampled accrued expenses to ensure they were valid and should remain open. As a matter of context, an accrued expense is considered "valid" if the information found in the system is supported by the documentation reviewed. Failure to properly manage

[1] The healthcare system consists of the Clement J. Zablocki VA Medical Center in Milwaukee, Wisconsin, and community-based outpatient clinics in Appleton, Cleveland, Green Bay, and Union Grove, Wisconsin. For more information about the healthcare system budget, capacity, and daily census, see appendix A.

[2] VA Financial Policy, "Obligations Policy," in vol. 2, *Appropriations, Funds, and Related Information (*September 2021 and April 2022), chap. 5.; An accrual flag is used to automate the accrual process. The automated accrual works well for service orders where about the same amount of service is received each month. However, it is not appropriate to automate all accruals. For example, when projects are paid in advance, if the obligation is accrued it will result in an overstatement of payables and an abnormal balance in certain general ledger accounts. Obligations not set to auto accrue reflect payable amounts upon processing of receiving actions or reports by Logistics.

accrued expenses increases the risk of disbursing funds for goods or services not received.

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

IV. **Inventory and supply management.** Supply chain management is the integration and alignment of people, processes, and systems across the supply chain to manage all product and service planning, sourcing, purchasing, delivering, receiving, and disposal activities. Veterans Health Administration (VHA) policy requires medical facilities to establish, operate, and maintain a supply chain management program that is effective, cost-efficient, transparent, and responsive to customer requirements, and to continually identify ways to ensure high-quality veteran care. The team evaluated whether staff managed the healthcare system's supply chain operations effectively by using the days-of-stock-on-hand performance metric, a nationally set level of inventory for expendable Medical Surgical Prime Vendor (MSPV) program items and non-MSPV items that facilitates efficient purchasing and use of supplies.[3]

The inspection team performed a site visit at the VA Milwaukee Healthcare System during the week of October 17, 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.

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

[3] The MSPV program is a national program providing a customized distribution system to meet or exceed facility requirements through an efficient, cost-effective, just-in-time distribution catalog ordering process.

What the Inspection Found

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

I. **Use of managerial cost accounting information.** The OIG found that the use of cost accounting information could be improved at the healthcare system. Specifically, the healthcare system did not always use cost accounting information to enhance efficiency, help reduce costs, or inform business decisions.

The inspection team used FMS reports to identify that healthcare system obligations grew by almost $143.5 million (18 percent) from about $803 million in fiscal year (FY) 2020 to just over $946.4 million in FY 2022. The team looked at the healthcare system's monthly budget updates for FY 2022. This reporting provided evidence that the healthcare system is using financial information to compare budgeted amounts to actual results as described in VA policy.

The inspection team also compared healthcare system financial management practices against federal financial accounting standard practices. Using document reviews and interviews of healthcare system leaders, the inspection team determined that the healthcare system's managerial cost accounting information is not used for the essential purposes of performance measurement, budgeting and cost control, or making economic choices as described in the federal financial accounting standards.[4] While these federal financial accounting standard practices are not required, healthcare system leaders could consider implementing them as a way to potentially optimize available financial resources. Further, the OIG determined that managerial cost accounting is not a fundamental part of financial management activities at the healthcare system and did not provide evidence that cost accounting information or reports are used consistently to compare planned amounts to actual results, enhance efficiency, help reduce costs, or inform business decisions as described in VA policy.[5]

II. **Accrued expense oversight.** As of July 15, 2022, the healthcare system had 133 outstanding accruals totaling just over $2 million. Of those, 18 valued at more than $283,000 were outstanding for 181 days or more. The inspection team performed data analysis and selected 15 accruals that were outstanding as of July 15, 2022, totaling about $1.2 million. The team reviewed supporting documentation to assess whether the healthcare system determined these accruals were valid and needed to remain open in accordance with VA financial policy.[6] The OIG found the healthcare system personnel

[4] Statement of Federal Financial Accounting Standards 4: *Managerial Cost Accounting Standards and Concepts* (June 2022) FASAB Handbook, Version 21.

[5] VA Financial Policy, "Managerial Cost Accounting (MCA)," in vol. 13, *Cost Accounting* (December 2019), chap. 3.

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

conducted monthly reviews of all 15 sampled accruals. However, six accruals were not valid when the accrued expense occurred. The inspection team identified 19 open obligations with end-date discrepancies between the FMS and the Integrated Funds Distribution, Control Point Activity, Accounting and Procurement System (IFCAP) for three or more months. The team selected and evaluated 10 end-date discrepancies, with variances between systems ranging from one to 399 days, valued at just over $7.9 million. Three of the 10 samples were flagged to auto-accrue the remaining balance of the obligations at the end of the performance period. The team determined that FMS and IFCAP were corrected prior to the inspection and reflected correct end dates for eight obligations, while two of the 10 sampled obligations still had end-date discrepancies. The dates were uncorrectable due to a system limitation that does not allow for end-date changes in IFCAP for Form 1358 obligations.[7] Healthcare system staff reported they occasionally review the FMS and IFCAP reconciliation report throughout the year and rely on monthly reviews to identify end-date discrepancies. Between July and September, they perform a more in-depth review of FMS. The failure to ensure end dates are correct allow for invalid accruals to occur and disbursing funds for goods or services not received.

The healthcare system reported invalid obligations awaiting action by contracting for close-out on the annual certification exceptions lists for FY 2021 and FY 2022. During FY 2021 the healthcare system reported 23 invalid open obligations, valued at about $580,000, awaiting action by contracting. During FY 2022, invalid open obligations increased to 43, valued at about $1.9 million. While healthcare system personnel compiled a monthly listing of contracts not closed by contracting, they did not provide a priority list to the Veterans Integrated Service Network (VISN) chief financial officer or National Contracting Office for action. Because the VISN and contracting office have not worked together, the list of invalid obligations remaining open has continued to grow, leaving about $1.9 million in funds attached to orders that could be used for other purposes to benefit veterans.

III. **Purchase card use.** The inspection team identified a statistical sample of 40 purchase card transactions totaling about $301,000 from October 1, 2021, through July 31, 2022. The inspection team reviewed whether the sampled transactions were processed in compliance with VA policy concerning prior approvals, prompt reconciliations, and segregation of duties throughout the transaction process.[8] Of the 40 sampled transactions,

[7] VA Financial Policy, "1358 Obligations," in vol. 2, *Appropriations, Funds, and Related Information, (*September 2021) chap. 6, app. A, "VA Form 1358 Approved Uses." VA offices may use VA Form 1358 as an obligation control document only for certain uses, including but not limited to, adult day health care, research studies, and home improvement structural alterations.

[8] VA Financial Policy, "Government Purchase Card for Micro-Purchases," in vol. 16, *Charge Card Programs* (May 2022), chap. 1B.

two were not reconciled and approved by the 15th day of the month after the closing of the previous month's billing cycle.

The team selected 20 transactions totaling just over $148,000 to determine if these transactions were modified into smaller parts to avoid exceeding the purchase card limit. The team reviewed transaction documentation and interviewed purchase cardholders and approving officials and determined two sampled transactions, totaling about $10,000 were modified into smaller parts to avoid exceeding the purchase card limit. The team also determined that contracts could have been considered for an at least 6,300 transactions totaling at least $6.7 million. Cardholders and approving officials did not always work together to ensure compliance throughout the transaction process and fulfill roles and responsibilities in accordance with VA policy.[9]

VA Form 0242, which delegates authority to an individual to use a VA purchase card, was maintained by the healthcare system for each cardholder in the inspection sample. The facility's purchase card coordinator conducted purchase card reviews during FY 2022, as required by policy.[10]

The healthcare system provided the requested supporting documentation for all 40 sampled transactions. The healthcare system leaders provided oversight of the purchase card program by having policies in place, maintaining accurate forms, and tracking cardholder training.

IV. **Inventory and supply management.** Oversight could be improved at the healthcare system, as reports and data in the Supply Chain Common Operating Picture (SCCOP) were not being used to monitor stock levels or meet the required accuracy rate for inventory as required by VHA policy.[11] The healthcare system could improve the effectiveness and efficiency of inventory management by ensuring inventory values are recorded correctly in the Generic Inventory Package.[12] Specifically, inventory managers failed to monitor reported conversion factor errors and properly record supplies moving in and out of the contingency inventory point. This led to increased reliance on manual counts, inaccurate inventory values, and use of manual adjustments to correctly record inventory in the Generic Inventory Package.

To avoid overstocking or understocking, VHA requires responsible staff to ensure correct reorder points and inventory levels are maintained.[13] Expendable supplies purchased

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

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

[11] VHA Directive 1761, *Supply Chain Management Operations,* December 30, 2020.

[12] The Generic Inventory Package is the software system authorized to manage the receipt, distribution, and maintenance of expendable supplies used throughout VA.

[13] The reorder point represents the level at which the item is to be replenished.

from MSPV should have 15 days or less of stock on hand, while non-MSPV items should have 30 days or less of stock on hand.[14] From October 2021 through June 2022, the healthcare system had an average of 41 days' stock for MSPV items and did not meet the performance metric for all nine months. The average for non-MSPV items was 74 days' stock and again did not meet the metric for those nine months.[15] As of October 3, 2022, the average days of stock on hand for MSPV items and non-MSPV items was 45.7 and 103, respectively. Because of the COVID-19 pandemic, the healthcare system received a waiver to suspend days-of-stock-on-hand performance measures through September 2022.

Conversion factor errors, if not identified and corrected, can cause the quantity on hand and value of supplies in the Generic Inventory Package to be unreliable. Those errors can lead to the increased reliance on manual inventory counts, manual ordering processes, and incorrect inventory values and quantities in the Generic Inventory Package, which require manual adjustments. Based on analysis of SCCOP reports and testimony received during the inspection, the team completed physical counts of some of the larger dollar items in two of the primary inventory points, as well as the contingency inventory point, to assess the accuracy.

As a result of the OIG inspection, the healthcare system made corrections and adjustments within the inventory points in the Generic Inventory Package to 7,673 items valued at over $502,000. Unreliable inventory data can lead to the purchase of unnecessary supplies. More importantly, errors indicating that supplies are available when they are not could adversely affect the healthcare system's ability to effectively plan and budget for the purchase of supplies to operate and meet patient care needs.

What the OIG Recommended

The OIG made nine recommendations for improvement: eight to the healthcare system director, and one to the VISN 12 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 financial efficiency practices and the strong stewardship of VA resources.

[14] The MSPV program is national and provides a customized distribution system to meet or exceed facility requirements through a just-in-time distribution catalog ordering process.

[15] Data are obtained from the SCCOP intranet, an internal VA website that publishes supply chain management benchmarks and reports.

The OIG recommended the healthcare system director establish a plan to use VA's cost accounting system information and align financial management practices with federal financial accounting standard practices.

The OIG also recommended the healthcare system director ensure initiating services communicate the status of delivered orders in a timely manner so healthcare system finance staff can comply with VA Financial Policy, vol. 2, chap. 5, "Obligations Policy," by ensuring monthly that proper accruals have occurred. The healthcare system director should collaborate with the VISN chief financial officer and the Great Lakes Acquisition Center to establish a monthly prioritized listing of contract medications and canceled orders for goods and services.

To strengthen oversight of purchase card transactions, the OIG recommended the director establish controls to confirm approving officials and cardholders review their purchases and make sure contracting is used when it is in the best interest of the government. The director should also require cardholders to submit ratification requests for any identified unauthorized commitments.

The OIG recommended the Veterans Integrated Service Network 12 director work with the network contracting office to ensure contracts include all needed laboratory tests.

Related to inventory and supply management, the OIG recommended the healthcare system director develop and implement a plan to ensure data accuracy and reliability and ensure contingency inventory space have better access controls.

VA Comments and OIG Response

The director of the Milwaukee VA Healthcare System concurred, or concurred in principle, with all recommendations and provided corrective action plans. Appendix E includes the healthcare system director's comments.

The OIG considers all recommendations open. The director of the healthcare system requested closure of three recommendations. 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 Milwaukee VA 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

Abbreviations

FMS	Financial Management System
FORCE	Forecast of Opportunities and Requirements Center for Excellence
FY	fiscal year
IFCAP	Integrated Funds Distribution, Control Point Activity, Accounting and Procurement System
MSPV	Medical Surgical Prime Vendor
NCO	Network Contracting Office
OIG	Office of Inspector General
SCCOP	Supply Chain Common Operating Picture
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducts financial efficiency inspections to assess stewardship and oversight of funds at VA healthcare systems and to identify opportunities to achieve cost efficiencies. Inspection teams identify and examine financial activities that are under the healthcare system's control and can be compared to healthcare systems similar in size and complexity across VA to promote best practices.[16]

This inspection focused on the VA Milwaukee Healthcare System. The OIG assessed four financial activities and administrative processes to determine whether appropriate controls and oversight were in place from October 2021 through September 2022:

I. **Use of managerial cost accounting information**. The inspection team reviewed healthcare system internal reporting, Financial Management System (FMS) data, and managerial cost accounting information. The inspection focused on the use of managerial cost accounting information to compare planned amounts to actual results, enhance efficiency, help reduce costs, or inform business decisions as described in VA policy.[17] The inspection team also applied federal financial accounting standard practices to determine if cost information was used for performance measurement, budgeting and cost control, and making economic choices for veteran care, such as whether to provide services in-house or use community care.

II. **Accrued expense oversight.** An accrued expense occurs when goods and services that were ordered and for which funds were obligated have been received, but payment has not been made. VA policy states each accrued expense should be reviewed by the finance office monthly against supporting documentation to ensure reports, subsidiary records, and systems reflect proper vendors and correctly calculated accrued balances, the accrual flag is set appropriately, and accruals are proper.[18] The inspection team evaluated whether the healthcare system performed monthly reviews and reconciliations of sampled accrued expenses to ensure they were valid and should remain open. As a matter of context, an accrued expense is considered "valid" if the information found in the system

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

[17] VA Financial Policy, "Managerial Cost Accounting (MCA)," in vol. 13, *Cost Accounting* (December 2019), chap. 3.

[18] VA Financial Policy, "Obligations Policy," in vol. 2, *Appropriations, Funds, and Related Information (*September 2021 and April 2022), chap. 5.; An accrual flag is used to automate the accrual process. The automated accrual works well for service orders where about the same amount of service is received each month. However, it is not appropriate to automate all accruals. For example, when projects are paid in advance, if the obligation is accrued it will result in an overstatement of payables and an abnormal balance in certain general ledger accounts. Obligations not set to auto accrue reflect payable amounts upon processing of receiving actions or reports by Logistics.

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To assess these areas, the inspection team performed a site visit at the healthcare system during the week of October 17, 2022; interviewed healthcare system leaders and staff; and reviewed data, supporting documents, and processes related to the healthcare system's financial efficiency. The team selected data from fiscal year (FY) 2022 for the review. 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. The findings and recommendations in this report should help the healthcare system identify opportunities to improve oversight and ensure the appropriate use of funds.

[19] When approving transactions, an authorizing official must ensure the transaction is legal, proper, mission essential, and the Government purchase cardholder has provided sufficient documentation needed. VA Financial Policy, "Government Purchase Card for Micro-Purchases," in vol. 16, *Charge Card Programs* (July 2021 and May 2022), chap. 1B.

[20] VHA Directive 1761, *Supply Chain Management*, December 30, 2020.

[21] The MSPV program is a national program providing a customized distribution system to meet or exceed facility requirements through an efficient, cost-effective, just-in-time distribution catalog ordering process.

VA Milwaukee Healthcare System

The VA Milwaukee Healthcare System is part of Veterans Integrated Service Network 12 (VISN 12) and provides health care services at six locations in southeastern and east central Wisconsin. Facilities include the Clement J. Zablocki VA Medical Center in Milwaukee and five community-based outpatient clinics in Appleton, Cleveland, Green Bay, Milwaukee, and Union Grove. The Clement J. Zablocki VA Medical Center includes a 245-acre campus on the western edge of Milwaukee. The hospital has acute care beds, domiciliary beds, and nursing home care unit beds. The facility serves a 7,500 square mile region that includes 16 counties.

In FY 2022, the healthcare system operated close to 150 hospital beds among its facilities and provided services to about 62,000 enrolled veterans. The reported FY 2022 medical care budget was about $941.4 million, a $53.8 million increase (6 percent) over the FY 2021 budget of about $887.6 million, and an increase of almost $143 million (18 percent) from the FY 2020 budget of about $798.4 million.

Facility Selection

The inspection team evaluated VA data to identify healthcare systems with the greatest potential for financial efficiency improvements based on data from the VHA Office of Productivity, Efficiency and Staffing efficiency opportunity grid. VHA developed the efficiency opportunity grid, a collection of 12 statistical models, to give facility leaders insight into areas of opportunity for improving efficiency. The grid allows for comparisons between VHA facilities by adjusting data for variations in patient and facility characteristics and in geography. The grid also describes possible inefficiencies and areas of success by showing the difference between a facility's actual and expected costs. The team uses the facility rankings from the stochastic frontier analysis model in the grid to assist in selecting facilities for financial efficiency inspections.[22] The inspections, while limited in scope and not intended to be a comprehensive inspection of all financial operations at the VA Milwaukee Health Care System, set forth a goal to recommend opportunities for process improvement, greater cost efficiencies, and to promote the responsible use of VA's appropriated funds.

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

Results and Recommendations

I. Use of Managerial Cost Accounting Information

The Federal Accounting Standards Advisory Board has developed managerial cost accounting standards for federal agencies and programs.[23] These standards require that each reporting entity accumulate and report the cost of its activities on a regular basis for management information purposes. To help accomplish this, VA implemented the Decision Support System to provide clinical and administrative managers with information about the efficiency and effectiveness of medical programs. The Decision Support System is a managerial cost accounting system that associates costs with the various services that VA medical centers may provide to patients. This cost information is essential for managers to make informed decisions in the areas of performance measurement, budgeting and cost control, and making economic choices for veteran care, such as whether to provide services in-house or use community care.

The team reviewed the following areas:

- **Obligation trends.** The inspection team reviewed obligation amounts originating from the FMS to identify trends and areas of significant obligation growth.
- **Healthcare system internal reporting.** The inspection team reviewed cost and performance reports for planning, budgeting, cost reduction, and efficiency improvement, and comparing planned to actual results. The team used document reviews and interviews to determine whether the healthcare system's use of managerial cost accounting information aligned with federal financial accounting standard practices and VA financial policy.[24]
- **Use of managerial cost accounting information**. The inspection team used a modeling tool created by VHA's Managerial Cost Accounting Office to identify costs associated with veteran care. The team also used analysis and interviews to determine if cost accounting information was used for performance measurement, budgeting and cost control, or making economic choices.

Finding 1: The Healthcare System Did Not Always Use Cost Accounting Information to Enhance Efficiency, Help Reduce Costs, or Inform Business Decisions

The use of cost accounting information could be improved at the healthcare system. The healthcare system created a monthly budget update that compared budgeted amounts to actual

[23] Statement of Federal Financial Accounting Standards 4: *Managerial Cost Accounting Standards and Concepts* (June 2022) FASAB Handbook, Version 21.

[24] VA Financial Policy, "Managerial Cost Accounting (MCA)."

results. However, documentation provided by the healthcare system did not provide sufficient evidence that internal cost accounting information was consistently used to enhance efficiency, help reduce costs, or inform business decisions. Instead, it primarily focused on ensuring the accuracy of the data. In addition, the healthcare system did not always use cost accounting information for performance measurement, budgeting and cost control, or making economic choice decisions.

Obligation Trends

According to FMS reports, healthcare system obligations grew by almost $143.5 million (18 percent) from about $803 million in FY 2020 to just over $946.4 million in FY 2022.

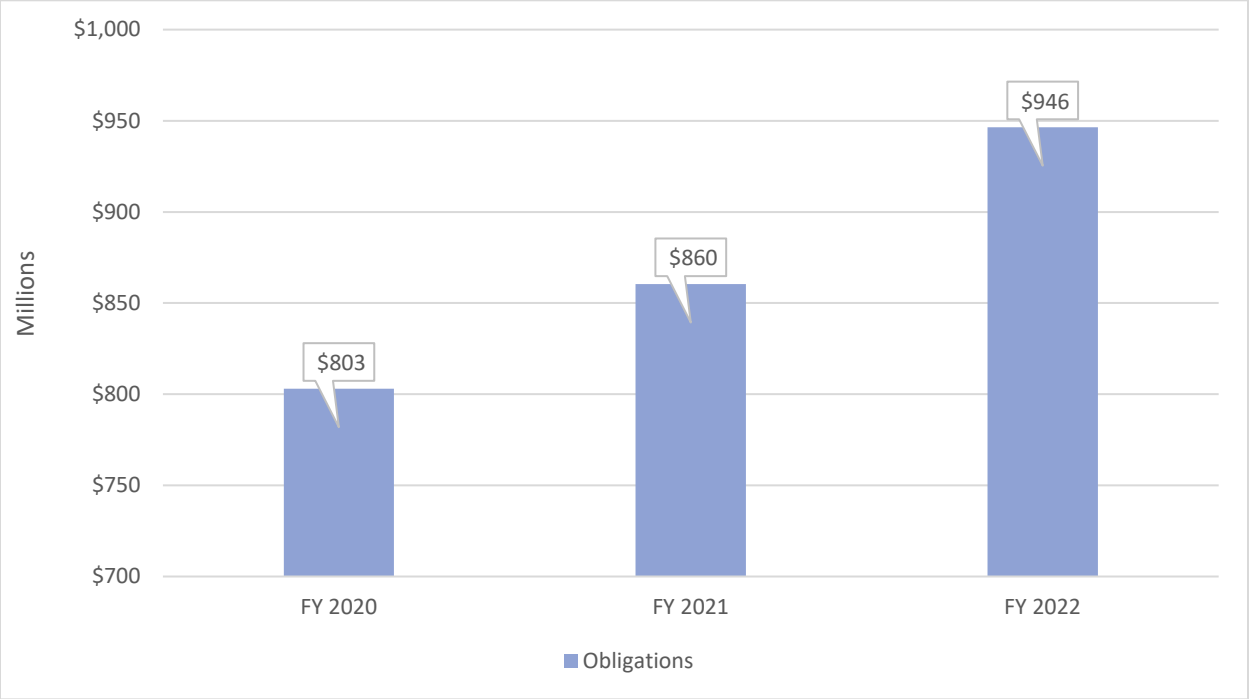

Figure 1. *VA Milwaukee Healthcare System Obligation, FY 2020–FY 2022.*
Source: FMS 887 Obligations report.

Inspection team analysis identified obligation growth in off-station fees and medical care contracts and agreements, representing care provided to veterans through community providers. This accounted for a combined growth of just under $67.3 million (47 percent) of the $143.5 million growth. The inspection team confirmed the obligation data with the healthcare system acting assistant finance officer.

To understand financial management practices and growth of obligations at the healthcare system, the inspection team requested internal cost and performance reports and managerial cost accounting reports to compare planned amounts to actual results, enhance efficiency, help reduce costs, or inform business decisions.

Healthcare System Internal Reporting

The inspection team reviewed various monthly budget update reports compiled by the VA Milwaukee Healthcare System finance office during FY 2022. These reports showed estimated revenues and expenses that totaled to either a bottom-line operating surplus or deficit for the healthcare system. While the OIG noted a $3.8 million deficit on the June 2022 budget update report, the August 2022 budget update report reflected a surplus of almost $471,000. The acting assistant finance officer confirmed during interviews that the healthcare system was solvent prior to the end of the fiscal year. The OIG did not test the accuracy or methodology used by the healthcare system to compile these budget projections. However, the OIG did determine that these monthly budget update reports provided evidence that the healthcare system prepared financial information to compare planned amounts to actual results as described in VA policy.[25]

The team also reviewed the healthcare system's managerial cost accounting information. This information included an audit of clinic workload and labor mapping, a labor mapping self-certification, an email showing the annual certification of Managerial Cost Accounting Cost Outlier Reviews, and a spreadsheet showing cost outliers.[26] The team's analysis determined that, collectively, these documents do not provide sufficient evidence that managerial cost accounting data is consistently being used to enhance efficiency, help reduce costs, or inform business decisions. The inspection team interviewed the managerial cost accounting manager and two managerial cost accounting staff dedicated to the healthcare system and asked them to confirm the inspection team's analysis. The manager confirmed the inspection team's analysis that the documentation provided is mainly focused on ensuring the accuracy of the data.

Use of Managerial Cost Accounting Information

VA financial policy describes managerial cost accounting data as a fundamental part of VA's overall financial management activities and states it should be integrated with the financial system for expenses, workload, utilization, performance measurement, and reporting.[27] Federal financial accounting standards state that in managing federal government programs, cost information is essential in performance measurement, budgeting and cost control, and making economic decisions.

The VHA Managerial Cost Accounting Office developed a modeling tool to assist cost accounting staff and managers with analyzing their department cost accounting information. The model displays workload and dollars allocated to departments at the healthcare system.

[25] VA Financial Policy, "Managerial Cost Accounting (MCA)."

[26] Each year, facilities are required to submit an annual certification of cost that affirms the data within the Managerial Cost Accounting system accurately represents the costs of operations. The facility is required to verify the accuracy of, or report corrections for, all stop code and treating specialty costs that exceed 100 percent of their medical center complexity average.

[27] VA Financial Policy, "Managerial Cost Accounting (MCA)."

The model also includes workload volumes, budgeted cost, and the actual costs through the current month processed. The training guide for the model recommends that cost accounting staff analyze cost workload products in various ways. For example, the guide recommends that users can sort by cost to determine if products with high costs seem reasonable. The guide states that high-cost products can be considered outliers. The modeling tool training guide also recommends that users analyze product volumes. The guide recommends that users review various data points and determine if the costs for those high-volume products look appropriate. The inspection team performed these recommended analyses, interviewed healthcare system staff, and determined if cost accounting information was used for performance measurement, budgeting and cost control, and making economic decisions.

Performance Measurement

Federal financial accounting standards also state that measuring cost is an integral part of measuring performance in terms of efficiency and cost-effectiveness. Specifically, cost per unit of output is highlighted as a methodology to evaluate the efforts and accomplishments of a government entity. Additionally, VA financial policy states that the managerial cost accounting system will identify the cost of products and services.[28] Using a national Managerial Cost Accounting Office modeling tool, the inspection team identified and analyzed 10 high-cost products from July 2022.[29] The team determined that six of the 10 products identified were inaccurately costed. The following example describes one of the inaccurately costed products.

Example 1

The inspection team's analysis of high-cost products showed three 15-minute chiropractor appointments with a cost of almost $41,225 per visit. Healthcare system cost accounting personnel responded to this analysis, informing the OIG team the chiropractors had their salaries mapped to one department, but the workload was being captured in a different department. The actual cost of each appointment should have been about $50, leading to a total misstatement of just over $123,500 in reported costs.

Healthcare system cost accounting staff later corrected the error, and the cost of about $50 per appointment was reflected in the August product cost report. The healthcare system also provided evidence that cost accounting staff performed monthly audits of product cost outliers during the period of review. However, when asked if the healthcare system finance department

[28] VA Financial Policy, "Managerial Cost Accounting (MCA)."

[29] The July 2022 product cost report identified 17,248 total products available for review. The 10 products selected for review were judgmentally sampled and represented some of the highest-cost clinical products. A judgmental sample is a nonstatistical sample selected based on auditors' opinion, experience, and knowledge.

looks at high-cost products the acting finance officer was unsure who in the medical center reviewed them.

Using the same national modeling tool, the OIG team also performed a high-level workload analysis, identifying 30-minute primary-care medical doctor visits as a high-volume product. As of July 2022, the healthcare system had reported 23,998 30-minute primary-care appointments with medical doctors. These appointments represented a cost to the healthcare system of just under $12.4 million according to the Managerial Cost Accounting Office modeling tool. Further analysis of the data identified that the healthcare system performed these primary-care visits in eight different clinics with a total cost per visit ranging from $379 to $713 at the various clinics reported in the tool. This analysis was discussed and reviewed with healthcare system managerial cost accounting staff and the acting assistant finance officer. When asked if the healthcare system performs similar program analyses to review the cost and workload of products to enhance efficiency, the managerial cost accounting manager and acting assistant finance officer stated they do not perform this type of analysis.

Budgeting and Cost Control

Federal financial accounting standards state that information on the costs of program activities can be used as a basis to estimate future costs in preparing and reviewing budgets.[30] It also explains that federal managers can use cost information to control and reduce costs and find and avoid waste. While these federal financial accounting standard practices are not required, healthcare system leaders could consider implementing them to potentially help optimize available financial resources. For example, the acting assistant finance officer explained that regardless of costs, budgets are based on historical spending and not managerial cost accounting. He gave the example that salaries are the biggest expense and are fixed regardless of what workload or managerial cost accounting data would show. He also stated that managerial cost accounting data does not correlate to what the budget is going to be and did not understand how using cost accounting data would help to formulate a budget. Nevertheless, with the size of the staffing budget being about $507.2 million (54 percent) of the almost $946.4 million obligated in FY 2022, healthcare system leaders could analyze available cost accounting information and identify opportunities to use available resources as efficiently as possible.

Economic Choices

Agencies and programs face choices among alternative actions, such as whether to do a project in-house or contract it out; to accept or reject a proposal; or to continue or drop a product or service. Making these decisions requires cost comparisons among available alternatives. VA financial policy states the managerial cost accounting system will be used to develop relevant,

[30] Statement of Federal Financial Accounting Standards 4.

detailed information and identify alternatives to reduce costs and enhance efficiency.[31] To gain a better understanding of the use of managerial cost accounting information across VHA, the OIG interviewed leaders from the national Managerial Cost Accounting Office. According to the office's leaders, data is available to determine whether to provide services in-house or contract them out at the individual healthcare system level. However, the methodologies, approach, and completeness of the analysis could vary between individual healthcare systems. When asked if the VA Milwaukee Healthcare System performs any analysis comparing the contracted cost of care in the community to the cost of care provided at the healthcare system, also known as a make-or-buy analysis, the managerial cost accounting manager stated that she does not have any documented analyses. As discussed in the FMS data section of this report, community care obligations accounted for just under $67.3 million (47 percent) of the approximately $143.5 million growth between FYs 2020 and 2022. The use of make-or-buy analyses could have a significant impact on optimizing the resources available to the healthcare system.

Finding 1 Conclusion

The OIG found that the use of cost accounting information could be improved at the healthcare system. The healthcare system's use of managerial cost accounting information does not align with federal financial accounting standard practices. The healthcare system's internal cost and performance reporting did not demonstrate the use of managerial cost accounting information for performance measurement, budgeting and cost control, or making economic choices. While these federal financial accounting standard practices are not required, healthcare system leaders could consider implementing them to potentially help optimize available financial resources. Further, the OIG determined that managerial cost accounting is not a fundamental part of financial management activities at the healthcare system. Healthcare system leaders did not provide evidence that cost accounting information or reports are used consistently to enhance efficiency, help reduce costs, or inform business decisions as described in VA policy.[32]

Recommendations 1–2

The OIG made the following recommendation to the VA Milwaukee Healthcare System director:

1. Establish a plan to use VA's cost accounting system information for the development of relevant, detailed cost information and to identify alternative ways to reduce costs and enhance efficiency as identified by VA financial policy.
2. Consider a plan to align VA Milwaukee Healthcare System financial management practices with federal financial accounting standard practices. This could include using

[31] VA Financial Policy, "Managerial Cost Accounting (MCA)." "VA's cost accounting system will be used to support the development of relevant, detailed cost information; identification of alternatives to reduce cost and enhance efficiency."

[32] VA Financial Policy, "Managerial Cost Accounting (MCA)."

cost information for performance measurement, budgeting and cost control, and making economic choices.

VA Management Comments

The director of the VA Milwaukee 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 a plan will be developed to continue to pursue best practices for incorporating managerial cost accounting data into financial activities. For recommendation 2, the director reported that the managerial cost accounting team will expand the type of data briefed to leaders and work with VISN coordinators to identify best practices and methodologies to incorporate cost accounting data into financial activities.

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.

II. Accrued Expense Oversight

VA's management of accrued expenses has been a longstanding issue and was included as a significant deficiency in VA's FY 2022 and FY 2021 audited financial statements and as a material weakness in VA's FY 2020 audited financial statements.[33] Additionally, a 2019 OIG report on undelivered orders recommended VHA ensure that staff review and reconcile open orders, and follow VA policy regarding required reviews of open obligations.[34] If reviews are not conducted, the healthcare system risks that all activities are not accurately reflected in the financial records, and ultimately, in the financial statements.

The inspection team focused on the following areas of accrual management:

- **Outstanding accruals.** The inspection team assessed whether the healthcare system performed monthly reviews and reconciliations to ensure that the sampled outstanding accrued orders were valid and should remain open.
- **FMS to Integrated Funds Distribution, Control Point Activity, Accounting and Procurement (IFCAP) reconciliations.** The team identified outstanding obligations with different end dates between FMS and IFCAP to ensure the healthcare system reconciled end dates between the systems for the sampled obligations.
- **Priority list of untimely contract modifications.** The team assessed whether the healthcare system complied with policy to collaborate with the VISN chief financial officer and network contracting office to establish a prioritized listing of modifications and canceled orders for the contracting office to accomplish.[35]

Finding 2: The Healthcare System Does Not Always Ensure Accruals are Proper, Verify End Dates are Accurate, or Provide the VISN a Prioritized List of Contracts That Need to Be Closed

VA policy requires finance offices to perform monthly reviews and reconciliations to ensure that their obligations, to include undelivered orders and accrued expenses, are valid. The healthcare system finance office personnel should verify with the initiating service or contracting officer, if

[33] VA OIG, Audit of VA's Financial Statements for Fiscal Years 2022 and 2021, Report No. 22-01155-14, November 15, 2022; 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. In the reports, CliftonLarsonAllen LLP defines a material weakness as 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.

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

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

applicable, to ensure the obligations period of performance dates are correct, open balances are accurate and agree with source documents, the accrual flag is set appropriately, and proper accruals have occurred.[36]

Figure 2 shows the number and dollar amounts of outstanding accruals for the healthcare system from February 15 through July 15, 2022.

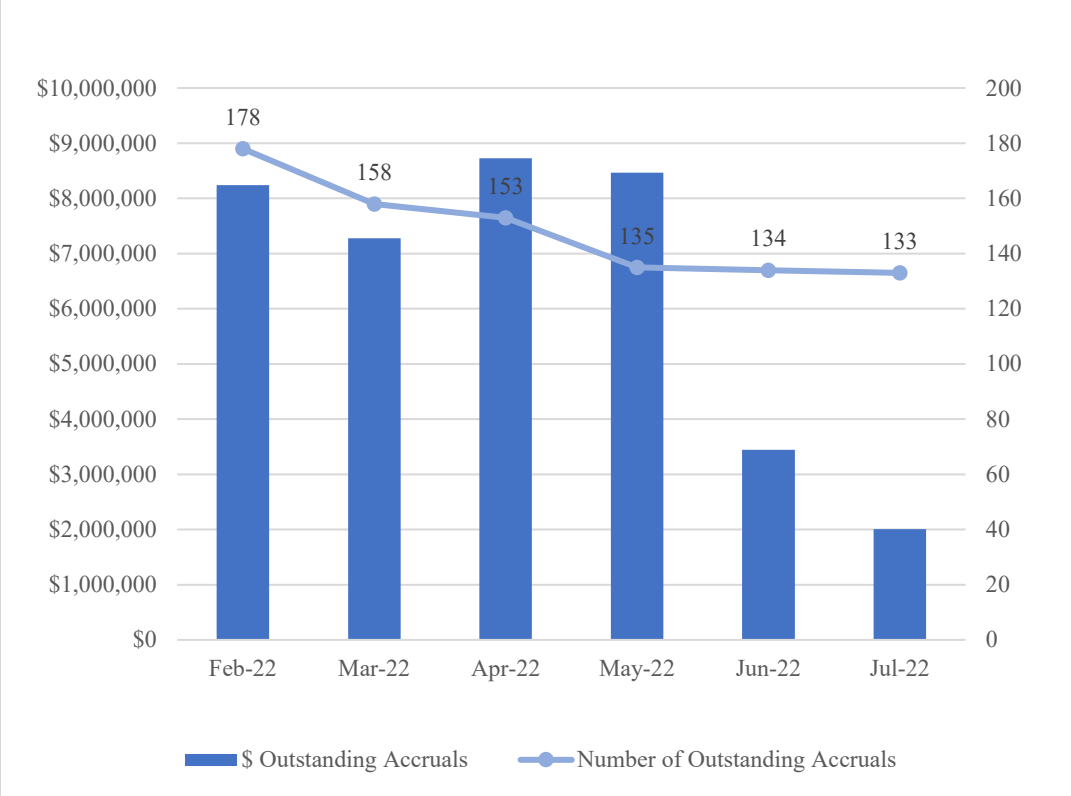

Figure 2. *VA OIG analysis of outstanding accruals for the VA Milwaukee Healthcare System, February 15 through July 15, 2022.*
Source: VA FMS F851 Report.

As of July 15, 2022, the healthcare system had 133 outstanding accruals totaling just over $2 million. Figure 3 shows the age and dollar amounts of these obligations. As shown, 18 accruals totaling more than $283,000 were outstanding for 181 days or more.

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

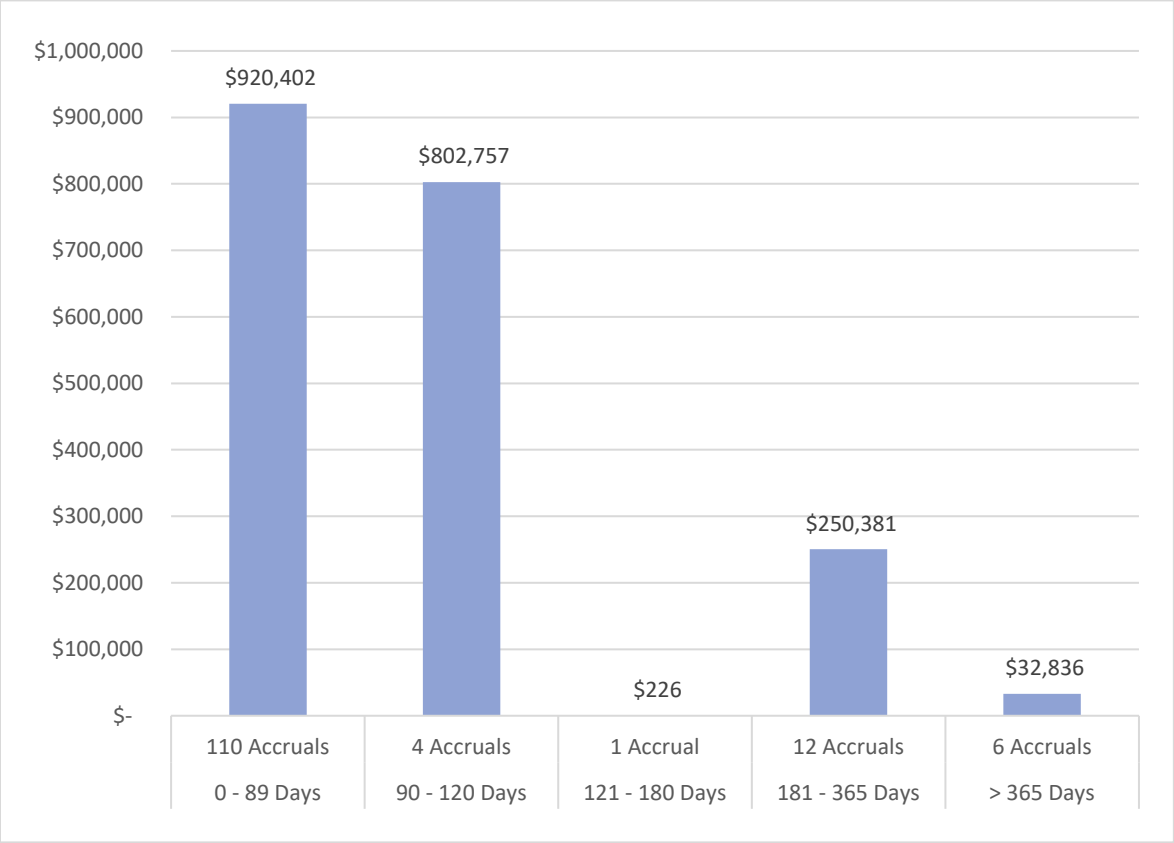

Figure 3. *VA OIG analysis of outstanding accruals for the VA Milwaukee Healthcare System as of July 2022.*

Source: VA FMS F851 Report.

Outstanding Accruals

The inspection team performed data analysis and selected 15 accruals outstanding as of July 2022 totaling about $1.2 million. The team reviewed supporting documentation to assess whether the healthcare system identified and reviewed the sampled accruals to determine if they were valid and needed to remain open in accordance with VA financial policy.[37] All 15 accrual balances were open between 73 and 866 days as of July 15, 2022. See appendix B for additional details on the inspection's scope and methodology and appendix C for details on the inspection's sampling.

The OIG found the healthcare system personnel conducted monthly reviews of all 15 sampled accruals. However, six accruals were not valid when the accrued expense occurred. The following examples show instances of improper accruals.

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

Example 1

An obligation was over-accrued $397,185 for four months. This occurred because a contract modification to decrease the amount of the obligation was not entered in FMS.

Example 2

An entire obligation was accrued for $20,000 prior to full receipt of goods. This occurred because the obligation was not entered correctly in FMS. While finance was aware of the improper accrual, no action was taken to correct it. Goods were received and disbursements were paid out over a six-month period.

Failure to properly manage accruals increases the risk of disbursing funds for goods or services not received.

End-Date Discrepancies between FMS and IFCAP Reconciliations

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.[38] The end dates in both systems should be the same. However, staff can manually change end dates in one system without changing them in the other. Open obligations should be reviewed monthly by the healthcare system's finance office, in coordination with the initiating service, to ensure period of performance dates are correct and match in all systems.[39]

The inspection team identified 19 open obligations with end-date discrepancies between FMS and IFCAP for three or more months. The team selected and evaluated 10 end-date discrepancies, with variances between systems ranging from one to 399 days, valued at just over $7.9 million. Three of the 10 samples were flagged to auto-accrue the remaining balance of the obligations at the end of the performance period.[40] Obligations set to auto accrue in FMS that have inaccurate end dates result in potential invalid accruals. The team determined that FMS and IFCAP were corrected prior to the inspection and reflected correct end dates for eight obligations, while two of the 10 sampled obligations still had end-date discrepancies between

[38] 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.

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

[40] Auto-accrue is when an accrual is processed automatically in FMS for the remaining unpaid balance.

FMS and IFCAP. The dates were uncorrectable due to a system limitation that does not allow for end-date changes in IFCAP for Form 1358 obligations.[41]

Healthcare system staff reported they occasionally review the FMS and IFCAP reconciliation report throughout the year and rely on monthly reviews to identify end-date discrepancies. Between July and September, they perform a more in-depth review of FMS. The failure to ensure end dates are correct allows for invalid accruals to occur and the potential that funds are disbursed for goods or services that were not received.

Priority List of Untimely Contract Modifications

When goods or services are no longer needed, contracting officers are notified through a request by the initiating service in the Forecast of Opportunities and Requirements Center for Excellence (FORCE) system that the remaining balance of the contract needs to be modified for closeout. If workload does not permit the contracting office to accomplish the modification within five calendar days of being notified by the initiating service, the healthcare system will collaborate with the VISN chief financial officer to establish a prioritized listing of modifications.[42] Furthermore, if the prioritized listing has not been accomplished within five calendar days, the VISN chief financial officer will work with the network contracting office to develop a plan to reduce outstanding obligations.

The healthcare system reported invalid obligations awaiting action by contracting for close-out on the annual certification exceptions lists for FYs 2021 and 2022. During FY 2021, the healthcare system reported 23 invalid open obligations, valued at about $580,000 awaiting action by contracting. During FY 2022, the numbers increased to 43 invalid open obligations, valued at about $1.9 million.

While the healthcare system compiled a monthly listing of contracts not closed by contracting, a priority list was not provided to the VISN chief financial officer or network contracting office for action. Officials confirmed only one all-inclusive list of obligations identified to be closed was provided to the VISN chief financial officer and network contracting office. Furthermore, officials reported contracting has access to the FORCE system to identify which contracts need action and the finance office conducts follow-up instead of the VISN to avoid contracting being inundated with email requests. Because the VISN and the contracting office have not worked together, the list of invalid obligations remaining open has continued to grow, leaving about $1.9 million in funds attached to orders that could be used for other purposes to benefit veterans.

[41] VA Financial Policy, "1358 Obligations," in vol. 2, *Appropriations, Funds, and Related Information, (*September 2021) chap. 6, app. A, "VA Form 1358 Approved Uses," VA offices may use VA Form 1358 as an obligation control document only for certain uses including but not limited to adult day health care, research studies, and home improvement structural alterations.

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

Finding 2 Conclusion

Healthcare system personnel did not comply with VA policies to ensure accruals were proper, end dates were reconciled between systems, and a prioritized list of untimely contract modifications was forwarded for action.[43] Failure to properly manage open obligations and accrued expenses increases the risk that appropriated funds would be left attached to orders when they could otherwise be used for other purposes to benefit veterans or used to pay for goods or services not received.

Recommendations 3–4

The OIG made the following recommendation to the VA Milwaukee Healthcare System director:

3. Ensure initiating services communicate status of delivered orders in a timely manner so healthcare system finance staff can comply with VA Financial Policy, vol. 2, chap. 5, "Obligations Policy," by ensuring monthly that proper accruals have occurred.
4. Collaborate with the Veterans Integrated Service Network chief financial officer and network contracting office to establish a monthly prioritized listing of contract modifications and canceled orders for goods or services that have not been addressed by contracting officers to ensure modification actions are completed.

VA Management Comments

The director concurred with recommendation 3 and concurred in principle with recommendation 4. For recommendation 3, the director reported that the system's internal procedures require daily orders to be processed within 24 hours and for initiating services to inform VISN 12 of undelivered orders. The director requested closure of this recommendation.

For recommendation 4, the director reported that to ensure modification actions are completed, the healthcare system's supporting finance team from the VISN 12 Consolidated Finance Service will hold a monthly call with Network Contracting Office (NCO) 12 leaders to review and discuss the prioritized listing of contract modifications and canceled orders for goods or services that have not been addressed by contracting officers.

OIG Response

The healthcare system director's action plans are partly responsive to the recommendations. Although the director requested closure of recommendation 3, the OIG considers both recommendations open. For recommendation 3, while the response addresses how undelivered orders are reviewed, it is not specific on how the services or finance office ensure delivered orders or accruals are proper. Additionally, the OIG reported that healthcare system personnel

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

conducted monthly reviews of the sampled accruals; however, the team found instances where the recorded accruals (of *delivered orders*) were improper for three months or more.

For recommendation 4, the response states that a monthly call is held between the healthcare system's supporting finance team from the VISN 12 Consolidated Finance Service and NCO 12 to discuss contract modifications. However, the response does not address how the healthcare system will work with the VISN and NCO to create a monthly prioritized listing of contract modifications and canceled orders for goods or services.

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. Purchase Card Use

VA established its Government Purchase Card Program to reduce the administrative costs related to acquiring goods and services. When used properly, purchase cards can help facilities simplify acquisition procedures and provide an efficient vehicle for obtaining goods and services directly from vendors. From October 1, 2021, through July 31, 2022, the healthcare system spent about $46.5 million through purchase cards, representing about 52,800 transactions. The amount and volume of the healthcare system's spending through the program makes it important to have strong controls over purchase card use to safeguard government resources and ensure compliance with policies and procedures that reduce the risk of error, fraud, waste, and abuse.

The team reviewed the following areas:

- **Purchase card transactions.** The inspection team determined whether the healthcare system processed purchase card transactions in accordance with VA policy, such as if 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 maintained segregation of duties.[44] The team also assessed if cardholders split purchases, intentionally dividing a single purchase into two or more to avoid exceeding the single purchase limit or micropurchase threshold. Additionally, the team inquired whether the healthcare system considered obtaining contracts when regularly procuring goods and services, which VA refers to as "strategic sourcing." The use of contracts in place of open market or individual purchases lowers the potential risk for split purchases on purchase cards. VA is also able to leverage its purchasing power through using competitively priced contracts.[45]
- **Purchase card oversight.** The inspection team assessed whether the healthcare system tracked purchase card training, had purchase card policies in place, maintained accurate VA Form 0242s, and whether approving officials were assigned no more than 25 purchase card accounts.[46] The team also assessed whether the healthcare system's purchase card coordinator provided oversight of the purchase card program by completing purchase card reviews. These activities are

[44] VA Financial Policy, "Administrative Actions for Government Purchase Cards," in vol. 16, *Charge Card Program* (June 2018), chap. 1A.

[45] VA Financial Policy, "Government Purchase Card for Micro-Purchases," in vol. 16, *Charge Card Programs* (May 2022), chap. 1B. 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.

[46] 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.

examples of systematic controls that help reduce errors and ensure a facility complies with VA policy.[47]

- **Supporting documentation.** The team examined whether the healthcare system maintained supporting documentation, as required, for purchases to provide assurance of payment accuracy and to justify the need to purchase a good or service. This includes approved purchase requests, purchase orders, receiving reports, and vendor invoices.[48] Supporting documentation enables program oversight and helps prevent fraud, waste, and abuse.

Finding 3: The Healthcare System Did Not Always Consider Using Contracts, but Maintained Supporting Documentation

The inspection team identified a sample population of about 51,900 purchase card transactions totaling about $47.1 million from October 1, 2021, through July 31, 2022.[49] Of these transactions, the team reviewed a statistical sample of 40 transactions, totaling about $301,000, to determine whether the healthcare system's personnel processed transactions in accordance with policy, including considering using contracts; provided oversight; and maintained required supporting documentation.[50] Twenty of the 40 sampled transactions, totaling just over $148,000, were also reviewed to determine if cardholders split purchases to circumvent their authorized single purchase limit.[51] See appendix B for a full description of the inspection's scope and methodology and appendix C for details on its sampling. Based on the results of the sample, the team projected errors could exist in at least 6,300 of 51,900, or 12 percent, of purchase card transactions, totaling at least $6.9 million in questioned costs. The team also found that two of 20 sampled transactions, totaling about $10,000, were split purchases.

Healthcare system leaders provided oversight of the purchase card program by having policies in place, maintaining accurate copies of VA Form 0242, and tracking cardholder training. The facility's purchase card coordinator conducted purchase card reviews during FY 2022, as required by policy.[52] However, the OIG found that improvements could be made to ensure approving officials, purchase card coordinators, and cardholders review purchases as they are processed. Reviewing transactions helps ensure that approving officials and cardholders are

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

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

[49] The inspection team pulled a statistical sample from positive transactions (the sample population varies from the total spending due to negative transactions) with purchase dates between October 1, 2021, and July 31, 2022. During this time, purchase card data was not available for August 1 through September 30, 2022.

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

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

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

following policy; reduces the risk of error, fraud, waste, and abuse; and promotes the good stewardship of taxpayer dollars.

Purchase Card Transactions

When using a government purchase card to acquire goods and services, VA policy requires cardholders to do the following:[53]

- Cardholders should obtain prior approval to ensure a valid business need before initiating a purchase. Approval may vary in form and content but must be retained as supporting documentation.[54]
- Purchases should be reconciled and approved in a timely manner, no later than the 15th calendar day of the month after the closing of the previous month's billing cycle.[55]
- Segregation of duties should be applied to ensure roles and responsibilities do not overlap among the cardholder, approval official, or purchase card coordinator and reduce the risk of fraud, waste, and abuse.[56]

The inspection team assessed the documentation of purchase card transactions provided by healthcare system personnel to determine if these requirements were met. Of the 40 sample transactions reviewed, the OIG found that only two did not comply with VA policy as it relates to the areas reviewed above. Specifically, the two were not reconciled and approved by the 15th day of the month after the closing of the previous month's billing cycle. Untimely reconciliations create opportunity for data integrity errors and fraud. Table 1 shows the results of the sample review.

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

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

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

[56] VA Financial Policy, "Government Purchase Card for Micro-Purchases." VA requires that the duties of the cardholder, approving official, requesting official, and receiving official be segregated. An agency or 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.

Table 1. Purchase Card Sample Transactions Not Complying with VA Policy

Requirement	Number of noncompliant transactions
Retained supporting documentation	0
Obtain prior approval	0
Have reconciliation approved by the approving official no later than the 15th day of the month after the closing of the previous month's billing cycle	2
Maintain segregation of duties over the transaction	0

Source: VA OIG team assessment results of 40 sampled transactions.

The inspection team also assessed if cardholders split purchases into two or more acquisitions to circumvent their authorized single purchase limit. Contracts must be used when the requirement is for an ongoing repetitive order of goods or services and the total value of the requirement exceeds the micropurchase threshold or the cardholder's authorized single purchase limit.[57] Cardholders are instructed not to modify a requirement or split purchases into smaller parts to avoid exceeding their purchase card limit or the use of formal contracting procedures; instead, cardholders should communicate the need for the order of goods or services to the contracting office for procurement.[58]

The team selected 20 transactions totaling just over $148,000 to determine if cardholders split purchases. The team reviewed documentation and consulted purchase cardholders and an approving official to discuss the transactions. After reviewing transaction documentation and interviewing purchase cardholders and an approving official, the team determined that two sampled transactions, totaling about $10,000, were modified into smaller parts to avoid exceeding the purchase card limit. The following example describes a split purchase transaction.

Example 3

On June 11, 2022, healthcare system staff used a purchase card to split purchases for laboratory tests not covered under a contract. Healthcare system staff intentionally ordered and paid for laboratory tests in $5,000 increments to avoid exceeding their purchase card limit or use of formal contracting procedures.

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

The purchase cardholder said she split purchases for the tests because they were needed but not covered under an existing contract. She also told the team the contracting personnel at the Great Lakes Acquisition Center, the network contracting office for VISN 12, said the current contract could not be amended because that would change the scope. The inspection team asked the supervisor and an approving official if they had documentation of the discussions with the network contracting office, both replied that they did not, adding that the former approving official who retired was likely the one who had it. According to the acting medical center director, laboratory purchases fall under the VISN.

The proper way to purchase frequently needed or high-cost goods above the purchase card limit is to send the service request to the contracting office for purchase. This requires planning to ensure there is sufficient time for a contract to be expanded or established, if none exists, to purchase the products in time for scheduled use. Any VA purchase cardholder or approving official who makes or certifies a purchase exceeding the micropurchase threshold has created an unauthorized commitment that must be ratified.[59]

Use of Contracts

The inspection team also assessed the sampled transactions for evidence that healthcare system staff had considered the most appropriate purchasing mechanism. In accordance with policy, VA cardholders should pursue strategic sourcing—establishing contracts that generally provide greater savings to VA rather than using purchase cards for open market acquisitions without a negotiated price—for goods that are purchased on a recurring or ongoing basis.[60] Approving officials, the agency or organization program coordinator, and cardholders must review purchases to determine when establishing contracts is in the best interest of the government and must communicate accordingly with the procurement office. Generally, VA should use contracts if the purchase is for an ongoing order of goods or services.

During the review, the OIG found that contracts could have been considered for an estimated 6,300 transactions totaling at least $6.7 million. The healthcare system made purchases from six merchants through the open market instead of leveraging established contracts that could have resulted in cost savings. Also, the team reviewed the healthcare system's purchase card transactions from October 1, 2021, through July 31, 2022, to determine the number of transactions and spend amounts for the six merchants. Five of the six merchants had multiple transactions with the healthcare system. Table 2 shows the six merchants with total transactions and spend amounts for the healthcare system from October 1, 2021, through July 31, 2022.

[59] FAR 1.602-3 (August 2022) "Ratification of unauthorized commitments" defines ratification as the act of approving an unauthorized commitment by an official who has the authority to do so.

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

Table 2. Six Merchants with Open Market Purchases from the Milwaukee Healthcare System

Merchants	Spend amount	Transaction count
Merchant 1	$1,172,066	328
Merchant 2	$573,359	1,308
Merchant 3	$422,009	136
Merchant 4	$237,038	162
Merchant 5	$155,087	43
Merchant 6	$15,973	1
Total	**$2,575,532**	**1,978**

Source: VA OIG team assessment of VA Milwaukee Healthcare System purchase card data from October 1, 2021, through July 31, 2022.

Generally, the improper reliance on purchase cards instead of communicating with the procurement office appeared to persist because the approving officials and cardholders did not work together to comply with the transaction process or to ensure that roles and responsibilities were carried out in accordance with VA policy. Such prior reviews of purchases ensure that every effort is made to consider whether alternative contracts were warranted or available when purchasing goods and services on a regular basis. To meet the intent of VA policy, cardholders and approving officials should work with the contracting office to determine if alternative contracting options are warranted or available.

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.[61] Oversight activities such as periodic and continuous monitoring; checks and balances; policies, procedures, and segregation of duties reduce the risk of error, fraud, waste, and abuse in the purchase card program.

To assess oversight of the program and compliance with VA policy, the inspection team determined whether the healthcare system tracked purchase card training, had purchase card policies in place, assigned approving officials no more than 25 purchase card accounts, maintained a VA Form 0242 for each cardholder in the inspection sample, and conducted reviews of cardholder transactions. To ensure approving officials can perform an adequate review and verification of cardholder transactions, approving officials are limited to no more than 25 purchase card accounts under their purview. VHA prosthetic purchase card accounts are

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

exempt from this limit and may have a ratio as high as 40 purchase card accounts to one approving official.[62] An approved VA Form 0242 is used to delegate authority to an individual to use the purchase card to procure and pay for goods and services. This form also establishes purchase limits and responsibilities and certifies that cardholders and approving officials understand the policies and regulations governing the purchase card program. A revised form is required when the approving officer changes, cardholders legally change their names, or the single purchase limit is changed from the originally requested amount.

The OIG found that the healthcare system provided oversight of the purchase card program. Specifically, healthcare system staff tracked cardholder training, had purchase card policies in place, and conducted required reviews of cardholder transactions. A listing from the VA's purchase card reporting disclosed that 10 of 196 cardholders were not compliant with mandatory training prior to participation in the purchase card program; however, the 18 cardholders who made the 40 sampled transactions were compliant. Purchase card reviews are intended to evaluate the effectiveness of internal controls and compliance with regulations and policies. Additionally, only one of the 18 cardholders responsible for the 40 sampled transactions had an inaccurate VA Form 0242. The VA Form 0242 for this cardholder was corrected prior to the OIG's site visit.

Supporting Documentation

Cardholders are required to electronically upload and store supporting documents for purchase card transactions to a VA-approved document-imaging system.[63] When using a purchase card to buy goods and services, healthcare system staff must maintain supporting documentation, such as approved purchase requests, vendor invoices, purchase orders, and receiving reports, for six years. This documentation can be used to verify that purchase card transactions were properly approved and that payments were accurate. The inspection team determined that none of the 40 sampled transactions were missing required supporting documentation.

Finding 3 Conclusion

The healthcare system generally processed purchase card transactions in compliance with VA policy and maintained proper supporting documentation. However, some transactions were made that led to split purchases and potentially missed cost savings for frequently used goods. Based on the results of all areas of review for the sample, the team projected that the healthcare system may have made noncompliance errors in at least 6,300 of 51,900 purchase card transactions,

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

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

totaling at least $6.9 million in questioned costs.[64] Internal reviews of the purchase card program should continue to be performed and corrective actions should be taken to ensure approving officials and cardholders consistently comply with VA policy.

Recommendations 5–7

The OIG made the following recommendation to the Veterans Integrated Service Network 12 director:

5. Work with the network contracting office to amend the current contract or establish a new contract to include all needed laboratory tests.

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

6. Establish controls to confirm approving officials and purchase cardholders review purchases for VA policy compliance and ensure contracting is used when it is in the best interest of the government.
7. Require purchase cardholders to submit a request for ratification for any unauthorized commitments identified.

VA Management Comments

The director of the VA Milwaukee Healthcare System responded on behalf of the VISN director and concurred with recommendation 5.

The director also concurred with recommendations 6 and 7.

For recommendation 5, the director reported the healthcare system's laboratory leaders will review the types and volume of completed testing to ensure they have appropriate contracts in place. Additionally, to prevent split purchases, laboratory leaders and NCO 12 will (1) establish a recurring meeting to review open market purchases and (2) identify changes in test type and frequency and modify current contracts or add new vendors, if necessary.

For recommendation 6, the director reported that NCO 12 has scheduled required quarterly training for cardholders and approving officials. The training, provided by the General Services

[64] 2 C.F.R. § 200.1 Questioned cost means a cost that is questioned by the auditor because of an audit finding: (1) Which resulted from a violation or possible violation of a statute, regulation, or the terms and conditions of a Federal award, including for funds used to match Federal funds; (2) Where the costs, at the time of the audit, are not supported by adequate documentation; or (3) Where the costs incurred appear unreasonable and do not reflect the actions a prudent person would take in the circumstances. (4) Questioned costs are not an improper payment until reviewed and confirmed to be improper as defined in OMB Circular A–123 appendix C. Purchase card transactions with multiple types of noncompliance issues were only included once for the purposes of calculating this projection. Consideration was also given for margin of error and median confidence level when projecting questioned costs. For additional information regarding projection totals, see appendix B and tables C.1 and C.2.

Administration, will ensure cardholders and approving officials are better aware of how to find items on contract and mandatory source requirements. The director requested closure of this recommendation.

For recommendation 7, the director reported that when NCO 12 identifies unauthorized commitments, cardholders are required to submit all documentation to the purchase card program coordinator for submission to contracting for ratification. The split laboratory purchase referenced in this report is being ratified. He further advised that NCO 12 established processes and procedures for ongoing audits of all purchase cardholders, and they complete ratifications based on any findings.

OIG Response

The director's action plans are responsive to the recommendations. Although the director requested closure of recommendation 6, the OIG did not receive any evidence or supporting documentation to evaluate actions taken. 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.

IV. Inventory and Supply Management

Supply chain management is the integration and alignment of people, processes, and systems across the supply chain for product and service planning, sourcing, purchasing, delivering, receiving, and disposal. VHA policy requires medical facilities to establish, operate, and maintain a supply chain management program that is effective, cost-efficient, transparent, and responsive to customer requirements and to continually identify ways to support high-quality veteran care.[65] The Generic Inventory Package is the software system authorized to manage the receipt, distribution, and maintenance of expendable supplies used throughout VA. This system features an item master file, which uses a number for the storage of item information such as the description, vendor, unit price, and packaging for tracking. Inventory data, if properly recorded in the Generic Inventory Package, identifies the quantity and dollar values of supply items in stock. Supplies are received at the warehouse, distributed to a primary inventory point, and from there to secondary inventory points in the healthcare system. Secondary locations are generally storage rooms within the clinical areas that use those items. The team reviewed the following areas:

- **Supply chain management oversight.** The team assessed how the healthcare system ensured whether stock levels and inventory values were accurate for expendable items by analyzing Supply Chain Common Operating Picture (SCCOP) reports for performance metrics for days of stock on hand, conversion factor errors, and the number of manual adjustments needed to be made to inventory records. Days of stock on hand is a nationally set level of inventory for MSPV and non-MSPV items that facilitates efficient purchasing and use of supplies. The conversion factor is required for all supply purchases and connects how a supply item is purchased and how it is issued—for example, purchased by the case but issued individually. Manual adjustments are used to make corrections to the quantity or value of supplies recorded in the Generic Inventory Package.
- **Inventory data accuracy.** Based on analysis of SCCOP reports and interviews conducted during the inspection, the team completed a physical count of some of the larger dollar items in two of the primary inventory points as well as the contingency inventory point to assess accuracy.

Finding 4: The Healthcare System Needs to Improve Oversight of Inventory and the Accuracy of Inventory Data

Oversight could be improved at the healthcare system, as stock levels were not monitored as required by VHA policy.[66] The healthcare system could improve the effectiveness and efficiency

[65] VHA Directive 1761, *Supply Chain Management Operations,* December 30, 2020.
[66] VHA Directive 1761.

of inventory management by ensuring inventory values are recorded correctly in the Generic Inventory Package. Specifically, healthcare system inventory managers failed to monitor reported conversion factor errors and properly record supplies moving in and out of the contingency inventory point. This led to increased reliance on manual counts, inaccurate inventory values, and use of manual adjustments to correctly record inventory in the Generic Inventory Package.

Supply Management Oversight

To avoid overstocking or understocking, VHA requires responsible staff to ensure correct reorder points and inventory levels are maintained.[67] Expendable supplies purchased through the MSPV program should have 15 days or less stock on hand, while non-MSPV items should have 30 days or less stock on hand.[68] From October 2021 through June 2022, the healthcare system had an average of 41 days' stock for MSPV items and did not meet the performance metric for all nine months. The average for non-MSPV items was 74 days' stock and again did not meet the metric for those nine months.[69] As of October 3, 2022, the average days of stock on hand for MSPV items and non-MSPV items was 45.7 and 103, respectively. Because of the COVID-19 pandemic, the healthcare system received a waiver to suspend days-of-stock-on-hand performance measures through September 2022.

The inspection team analyzed SCCOP reports and interviewed supply chain management leaders and staff to determine how they ensured stock levels and inventory values were accurate and what challenges they faced managing stock levels. According to one of the inventory managers, since the COVID-19 pandemic, she manages the incoming and outgoing inventory on a day-to-day basis. Some inventory points are based on par levels from 2019 due to the uncertainty of vendors. According to this inventory manager, there was not time to monitor performance metrics in SCCOP as she barely has time to do one task before another one arises. Other issues of concern were not being able to rely on the prime vendor for anything as half the items ordered are not available from the prime vendor. Since COVID the supply chain management have had supply chain shortages. During the pandemic, it is understandable that there was an increased need to have extra supplies on hand, and the healthcare system stored as much as possible to avoid potential shortfalls. The OIG made no recommendations related to the days of stock on hand at the healthcare system as officials are working to improve their inventory management system after more than two years of pandemic conditions.

[67] VHA Directive 1761. The reorder point represents the level at which the item is to be replenished.

[68] Power Business Intelligence Supply Chain Common Operating Picture Metrics and Reports.

[69] Data are obtained from the SCCOP intranet, an internal VA website that publishes supply chain management benchmarks and reports.

Conversion Factors

In the Generic Inventory Package, an accurate conversion factor for individual supply items is necessary to determine both the cost and the value of the inventory. The unit conversion factor connects how a supply item is purchased and distributed or used.[70] Any calculation error in the conversion factor causes inaccurate quantities and values in the system. For example, if the healthcare system purchased a case of 24 cans of soda for $24 and issued one can at a time, the correct conversion factor is 24 (quantity purchased of 24 divided by quantity issued of one), and, after issuing one can, the inventory quantity and value should be 23 cans and $23. However, if the conversion factor was incorrectly set at one, the Generic Inventory Package will remove all 24 cans (one case) after the first issuance of one can, and the inventory value will be $0 with zero quantity in the system. In this scenario, the difference is $23 and 23 cans, requiring the supply chain management staff to manually adjust the quantity and the value of inventory on hand. To reconcile the unit cost when purchased and the unit cost when issued, the supply chain management staff therefore would have to divide the cost of the case by 24 to reach the cost of each unit.

The team analyzed the SCCOP conversion factor error report for all inventory points at the healthcare system and identified conversion factor errors that, if not identified and corrected, can cause the quantity on hand and value of supplies in the Generic Inventory Package to be unreliable. According to SCCOP, 2,741 of 29,779 supply items (9 percent) had potential conversion factor errors as of October 3, 2022. One inventory manager said that there is no time to look at anything in SCCOP and conversion factor reports are only reviewed when problems arise, which is about twice a week. This manager reported that most of these discrepancies are due to differences in packaging when ordered from non-MSVP vendors versus the MSPV vendor and the conversion factor is not updated in the Generic Inventory Package. For example, the healthcare system may have to order by the case from the MSPV vendor but by the box from the non-MSPV vendor. Additionally, two other inventory managers admitted that they do not look at the conversion factor reports.

To illustrate the effect of conversion factor errors, the inspection team asked about a large adjustment located on the manual adjustments transactions report. The adjustment had to be made when 800 pairs of gloves were entered and valued incorrectly at $120 per pair, for a total of $96,000. The inventory manager overseeing the contingency inventory confirmed this occurred due to an incorrect calculation of the conversion factor and led an inventory manager to incorrectly enter the per pair price as the case price of $120. The correct price was $2.40 per pair. Therefore, the total value on hand for 800 pairs of gloves should have been $1,920. Conversion factor errors can lead to the increased reliance on manual inventory counts, manual ordering

[70] The unit conversion factor is computed by dividing the unit of purchase by the unit of issue and equals one when the unit of purchase and the unit of issue are the same.

processes, and incorrect inventory values and quantities in the Generic Inventory Package, which require manual adjustments.

Inventory Adjustments

The team analyzed the SCCOP Generic Inventory Package Adjustments report for the 90 days prior to October 3, 2022, to determine the number of adjustments for all inventory points made at the healthcare system, and the associated value for those adjustments. The report shows positive and negative adjustments in the Generic Inventory Package to correct inventory points. The healthcare system made over 440 adjustments affecting over 227,000 items totaling about $895,000 for the 90 days prior to October 3, 2022. There were 56 adjustments affecting almost 83,300 items totaling just over $571,000 in the contingency inventory point alone. The report showed that the adjustments occurred due to a variety of reasons; physical counts, outdated or expired inventory, and conversion factor errors. The chief of supply chain management and one of the inventory managers stated the healthcare system had been doing a lot of cleanups within the inventory points since the pandemic, which included disposing of expired inventory items. The manager for the contingency inventory point stated that carts had been placed within the hospital for staff to place expired items, and then a tech would oversee inventorying the expired items to prepare for an inventory manager to adjust those items out of inventory.

As stated previously, conversion factor errors can lead to adjustments in the Generic Inventory Package. The team identified that 104 of 297 supply items in the contingency inventory point, or 35 percent, had a "false" conversion factor. Based on analysis of SCCOP reports and testimony received during the inspection, the team completed physical counts of some of the larger dollar items in two of the primary inventory points as well as the contingency inventory point to assess the accuracy.

Inventory Data Accuracy

During the physical counts within the inventory points, the inspection team identified discrepancies between what was reported in SCCOP and what was physically located in the warehouse storage areas. The team counted laryngoscope blades, surgical gloves, isolation gowns, and disinfectant wipes within the contingency space. The inspection team discovered that counts of these items, apart from the isolation gowns, were different than what was reported in SCCOP. For example, the team discovered 950 pairs of gloves were missing and valued incorrectly at $106.75 a pair, for a total of $101,412.50. The correct value should have been $2.39 a pair, or $2,270.50. An adjustment had to be made to remove those missing gloves out of the contingency inventory space, which reduced value on hand that was overstated. The inventory manager could not tell the inspection team when the gloves were removed, where they went, or who took them out of the contingency space.

The inspection team's physical counts within the distribution inventory storage area resulted in similar issues. When comparing the data found in SCCOP to what was in the storage area, the team found:

- 217 fewer personal property bags,
- 1,478 fewer 12-ounce bottles of hand sanitizer,
- 1,138 more pairs of gloves, and
- 1,074 fewer 10-milliliter syringes.

The inventory manager stated that people are constantly coming in and out of the inventory space and the data cannot be relied on because "there are too many hands in the pot."

The team also selected six items in the catheter laboratory space to physically count, but only took exception to one stock item (an inflation device) being under the inventory number reported in SCCOP. The Generic Inventory Package data showed 65 devices, each costing $126.86, for a total of $8,245.60. However, the inspection team only found 50, meaning 15 were missing. The team also found the price in the Generic Inventory Package was incorrect and should have been $74.96. The missing devices and the error in cost resulted in an on-hand value that was overstated by $4,497.60.

As a result of the OIG inspection, the healthcare system made corrections and adjustments within the inventory points and created adjustment vouchers. The inspection team analyzed the vouchers and determined that after combining both positive and negative adjustments made by inventory management staff, the extent of the adjustments totaled 7,673 items valued at just over $502,000.

Finding 4 Conclusion

The healthcare system provided oversight of the expendable supplies to avoid stock shortages and ensure that patient needs were met during the pandemic. However, the healthcare system could improve efficiency by improving the accuracy of inventory quantities and values in the Generic Inventory Package. VHA policy states that Generic Inventory Package information should be complete and accurate.[71] Unreliable inventory data can lead to the purchase of unnecessary supplies, overstocking, and spoilage. More importantly, errors indicating that supplies are available when they are not could adversely affect the healthcare system's ability to effectively plan and budget for the purchase of supplies to operate and meet patient care needs.

[71] VHA Directive 1761.

Recommendations 8–9

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

8. Develop and implement a plan to ensure data accuracy and reliability in the Generic Inventory Package per Veterans Health Administration policy.

9. Develop better access controls over the contingency space, to ensure less accessibility to reduce missing inventory.

VA Management Comments

The healthcare system director concurred with recommendation 8 and said the healthcare system would develop and implement a plan to ensure data accuracy and reliability in the Generic Inventory Package.

The director concurred in principle with recommendation 9 and requested closure, saying the healthcare system has appropriate access controls established, the contingency inventory space is always locked, keys are only available to supervisors or under direct surveillance, and only specific individuals are permitted to access the contingency space unescorted.

OIG Response

The healthcare system director's action plan is responsive to recommendation 8. The OIG will monitor implementation of the planned actions and will close the recommendation when the OIG receives sufficient evidence demonstrating progress in addressing the intent of the recommendation and the issues identified.

The healthcare system director's action plan is partly responsive to recommendation 9. While the director requested closure of the recommendation, the OIG considers the recommendation open. The OIG acknowledges that the contingency inventory space was locked as observed during the inspection team's walkthrough. However, the OIG believes the healthcare system needs to implement stronger access controls because the inspection team discovered that inventory was missing and there was no record of who had removed the items or where they were moved. More effective access controls would help ensure this does not occur.

Appendix A: Healthcare System Profile

Table A.1 provides general background information for the VA Milwaukee Healthcare System, a level 1a, high-complexity facility reporting to VISN 12.[72]

Table A.1. Facility Data for VA Milwaukee Healthcare System from October 1, 2020, through September 30, 2022

Item	FY 2020	FY 2021	FY 2022
Total medical care budget	$798,441,617	$887,591,623	$941,398,228
Number of patients	61,042	61,521	61,999
Outpatient visits	707,468	809,881	796,784
Total medical care FTEs*	3,699	3,841	3,829
Number of operating beds: Hospital	196	158	143
Community living center	111	111	111
Domiciliary	125	125	125
Average daily census: Hospital	114	122	107
Community living center	107	95	92
Domiciliary	53	43	46

Source: *VHA Support Service Center, Trip Pack and Operational Statistics report.*
Note: *The OIG did not assess VA's data for accuracy or completeness.*
******* *FTE is full-time equivalent positions. This category includes both direct medical care FTEs in budget object code 1000–1099 (Personal Services) and all cost centers.*

According to VHA Support Service Center data, the healthcare system medical care budget was about $941.4 million, about a $53.8 million increase (6 percent) over the FY 2021 budget, and an increase of almost $143 million (about 18 percent) from the FY 2020 budget.[73] The number of unique patients increased by less than 1,000 from FY 2020 to FY 2022, which is only about a 1.6 percent change. OIG analysis of healthcare system obligation data determined that off-station fees and medical care contracts and agreements represented care provided to veterans through community providers. This accounted for just under $67.3 million (47 percent) of the reported growth. The inspection team confirmed the obligation data with the healthcare system acting assistant finance officer.

[72] The facility 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.

[73] Medical care budget was reported by the VHA Support Services Center using the AACS—Automated Allotment Control System—as the data source. The data definitions section of the report contains a link for a report that can be used to validate the budget data on Trip Pack-Operational Statistics Table.

Appendix B: Scope and Methodology

Scope

The team conducted its inspection of the VA Milwaukee Healthcare System from September 2022 to June 2023, including a site visit during the week of October 17, 2022. The inspection is limited in scope and is not intended to be a comprehensive inspection of all financial operations at the VA Milwaukee Healthcare System.

Methodology

The inspection team evaluated financial efficiency practices for FY 2022, as well as first quarter of FY 2023 if available, related to accrued expenses, use of managerial cost accounting information, days of stock on hand for expendable supplies, and purchase card transactions.

To conduct the inspection, the team

- interviewed healthcare system leaders and staff;
- identified and reviewed applicable laws, regulations, VA policies, operating procedures, and guidelines related to accrued expenses, use of managerial cost accounting information, overseeing purchase card transactions, calculating days of stock on hand metrics;
- judgmentally sampled
    - 15 outstanding accruals to assess whether the healthcare system identified and reviewed the accruals to determine if they were valid and needed to remain open in accordance with VA financial policy;
    - 10 obligations with different end dates from VA's FMS to IFCAP Reconciliation reports to determine if end dates reconciled between VA's FMS and IFCAP; and
- statistically sampled
    - 40 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.

Internal Controls

The inspection team assessed the internal controls of the VA Milwaukee Healthcare System significant to the inspection objective. This included an assessment of the five internal control components to include control environment, risk assessment, control activities, information and

communication, and monitoring.[74] In addition, the team reviewed the principles of internal controls as associated with this objective. The team identified internal control weaknesses during this inspection in all four sub-objectives assessed—use of managerial cost accounting information, accrued expense oversight, purchase cards, and inventory and supply management—and proposed recommendations to address the weaknesses.

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 team 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, a central repository of US bank data that is updated monthly, SCCOP reports, FMS reports, and cost accounting data from the RVU modeling tool. 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 identification numbers, purchase dates, cardholder names, payment amounts, and vendor and merchant names as provided in the data received for the samples reviewed. Testing of the data disclosed that they were sufficiently reliable for the inspection objectives.

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

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*.

[74] GAO, Standards for Internal Control in the Federal Government, GAO-14-704G, September 2014.

Appendix C: Sampling Methodology

Accrued Expense Oversight

The team evaluated a judgmental sample of outstanding accruals as of July 15, 2022, to determine whether the VA Milwaukee Healthcare System performed monthly reviews and reconciliations of the reviewed accrued expenses to ensure the accruals were valid and should remain open. The team also evaluated a judgmental sample of open obligations from February through July 2022 to determine whether the healthcare system reconciled end dates between FMS and IFCAP.

Population

As of July 15, 2022, the healthcare system had 133 outstanding accruals, totaling about $2 million. Of those accruals, 23, totaling about $1.1 million, were older than 90 days. From February through July 2022, there were 19 obligations with end-date discrepancies between FMS and IFCAP for three or more months.

Sampling Design

The inspection team selected two judgmental samples:

Outstanding Accruals. The team selected 15 outstanding accrued expenses from the July 15, 2022, FMS F851 report. This report lists each accrual and its remaining balance. Our sample included seven accrued expenses for miscellaneous orders and eight accrued expenses for service orders.

FMS to IFCAP reconciliations. The team selected 10 obligations with different end dates between FMS and IFCAP from the VA's FMS to IFCAP reconciliation reports for February through July 2022.

The samples included 25 total open obligations: 15 outstanding aged accruals, totaling about $1.2 million; and 10 open obligations with different end dates between FMS and IFCAP, totaling about $7.9 million.

The team requested supporting documentation for each of the 25 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 identified a statistical sample of purchase card transactions from October 1, 2021, through July 31, 2022, to determine if the VA Milwaukee Healthcare System (1) reviewed purchase card payments to ensure they were adequately monitored, approved, and supported by documentation; and (2) 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 period of October 1, 2021, through July 31, 2022, purchase cardholders at the facility made about 52,800 purchase card transactions totaling about $46.5 million. A statistical sample was selected from about 51,900 non-negative transactions during the same period totaling about $47.1 million. The sampling frame was developed inclusive of two strata: potential split transactions and nonpotential split transactions. About 900 transactions were potential split transactions and the other strata for nonpotential split purchase transactions comprised about 51,000 transactions.

Sampling Design

For both strata, samples were selected using probability proportional to size, by bundle (for potential split purchases) or individual transaction (for other nonpotential split purchases):

> **Potential split purchases.** 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 procurement limit. The team identified 207 bundles of potential split purchases and selected 10 of those bundles for review.
>
> **Other purchases.** Transactions in this stratum are the remaining transactions after potential split purchase transactions were identified.

The statistical sample included 40 total individual transactions: 20 potential split purchase transactions, totaling just over $148,000, and 20 other transactions, totaling more than $152,000.

To review the sampled transactions, the team requested supporting documentation for each of the 40 sampled transactions, VA Form 0242, 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

inspection 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.

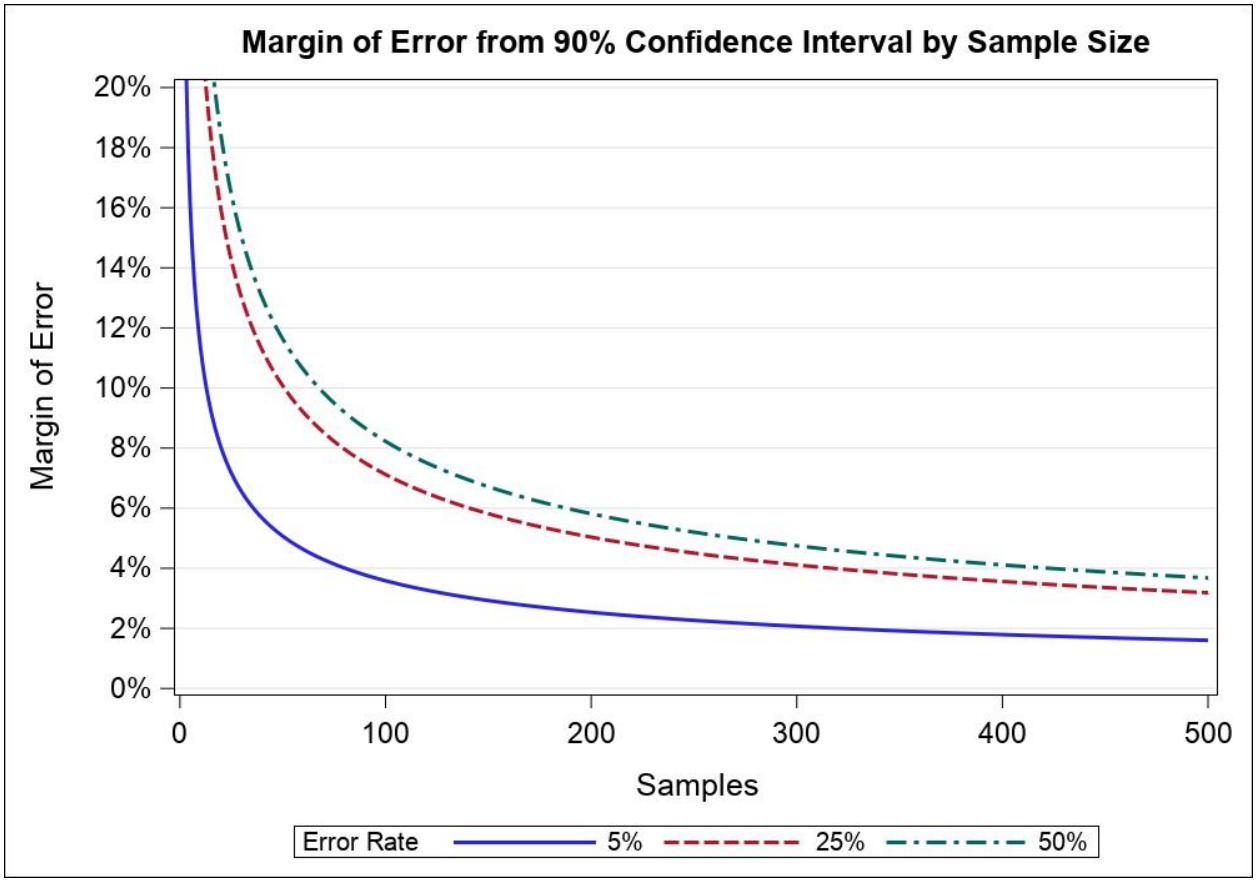

Figure C.1 *Effect of sample size on margin of error.*

Source: OIG statistician's analysis.

Projections

The team reviewed a statistical sample from a population of about 51,900 purchase card transactions, totaling an estimated $47.1 million. Based on the results from the sample, the team

projected that at least 6,300 transactions, totaling at least $6.9 million, were not processed in accordance with VA policy.[75]

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

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

Estimate name	Estimate number	90 percent confidence interval			Number of errors	Sample size
		Margin of error	Lower limit	Upper limit		
Overall errors	12,941	NA	6,322	NA	9	40
Strategic sourcing errors	12,899	NA	6,280	NA	8	40

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

Note 1: *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 transactions. These projections have "NA" for the margin of error and the upper limit.*

Note 2: *Nine overall transactions had multiple errors including strategic sourcing (8), prompt reconciliation (2) and potential split (2); however, the errors for prompt reconciliation and potential split were not precise enough for projections.*

[75] Strategic sourcing errors are included in the overall errors.

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

Estimate name	Estimate amount	90 percent confidence interval			Number of errors	Sample size
		Margin of error	Lower limit	Upper limit		
Overall errors	$13,550,438	NA	$6,861,672	NA	9	40
Strategic sourcing errors	$13,383,700	NA	$6,697,353	NA	8	40

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

Note 1: *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.*

Note 2: *Nine overall transactions had multiple errors including strategic sourcing (8), prompt reconciliation (2) and potential split (2); however, the errors for prompt reconciliation and potential split were not precise enough for projections.*

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

Recommendation	Explanation of Benefits	Better Use of Funds	Questioned Costs[76]
4	Collaborate with the Veterans Integrated Service Network chief financial officer and network contracting office to establish a monthly prioritized listing of contract modifications and canceled orders for goods or services that have not been addressed by contracting officers to ensure modification actions are completed.	$1,900,000	
6	Establish controls to confirm approving officials and purchase cardholders review purchases for VA policy compliance and ensure contracting is used when it is in the best interest of the government.		$6,900,000
	Total	**$1,900,000**	**$6,900,000**

[76] The OIG questions costs when VA action or inaction (such as spending or failure to fully compensate eligible beneficiaries) is determined by the OIG to violate a provision of law, regulation, contract, grant, cooperative agreement, or other agreement; are not supported by adequate documentation; or are expended for purposes that are unnecessary or unreasonable under governing authorities. Of the estimated $6.9 million in questioned costs, none were unsupported.

Appendix E: VA Management Comments

Department of Veterans Affairs Memorandum

Date: July 12, 2023

From: James D. McLain

Subj: VA Management Comments - Draft Report: Financial Efficiency Inspection of the VA Milwaukee Healthcare System

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

Finding 1: The Healthcare System Did Not Always Use Cost Accounting Information to Enhance Efficiency, Help Reduce Costs, or Inform Business Decisions.

Recommendation 1: Establish a plan to use VA's cost accounting system information for the development of relevant, detailed cost information and to identify alternative ways to reduce costs and enhance efficiency as identified by VA financial policy.

Concur or Non-Concur: Concur

Target Date for Completion: September 1, 2023

Director's Comments: A plan will be developed by September 1, 2023. Medical Center leadership meets monthly with MCA staff and will determine what additional data would be beneficial to review. New data / reports will be kept in the administrative drive and shared with Divisional leaders as necessary. The Milwaukee MCA team will continue to pursue best practices for incorporating MCA data into financial activities and share those practices with the Milwaukee leadership team.

Recommendation 2: Consider a plan to align VA Milwaukee Healthcare System financial management practices with federal financial accounting standard practices. This could include using cost information for performance measurement, budgeting and cost control, and making economic choices.

Concur or Non-Concur: Concur

Target Date for Completion: September 1, 2023

Director's Comments: The Milwaukee MCA team will expand the type of MCA data briefed to leadership to go beyond the current focus of ensuring data accuracy. The VISN 12 MCA Coordinator has reached out to the MCA VISN Coordinators inquiring on best practices and methodologies to incorporate cost accounting data into financial activities within their health care facilities. Medical Center leadership meets monthly with MCA staff and will determine what additional data would be beneficial to review. New data / reports will be kept in the administrative drive and shared with Divisional leaders as necessary.

Finding 2: The Healthcare System Does Not Always Ensure Accruals are Proper, Verify End Dates are Accurate, or Provide the VISN a Prioritized List of Contracts That Need to Be Closed

Recommendation 3: Ensure initiating services communicate status of delivered orders in a timely manner so healthcare system finance staff can comply with VA Financial Policy, vol. 2, chap. 5, "Obligations Policy," by ensuring proper accruals have occurred on a monthly basis.

Concur or Non-Concur: Concur

Target Date for Completion: September 1, 2023

Director's Comments: Our internal procedures require us to receive and process daily orders within 24 hours of arrival, unless there are issues with the PO/delivery, which would require further investigation. In addition, in order to ensure proper accruals have occurred on a monthly basis, the VISN 12 Finance Service requires initiating services to inform them of undelivered orders. The Finance team then holds a monthly call with NCO12 Contracting to review aged / undelivered orders. This allows us to elevate any closeout issues as they arise. We are requesting closure of this Recommendation.

Recommendation 4: Collaborate with the Veterans Integrated Service Network chief financial officer and network contracting office to establish a monthly prioritized listing of contract modifications and canceled orders for goods or services that have not been addressed by contracting officers to ensure modification actions are completed.

Concur or Non-Concur: Concur in principle

Target Date for Completion: September 1, 2023

Director's Comments: In order to ensure modification actions are completed, the Medical Center's supporting finance team from the VISN 12 Consolidated Finance Service will hold a monthly call with NCO 12 Contracting leadership to review and discuss the prioritized listing of contract modifications and canceled orders for goods or services that have not been addressed by contracting officers.

Finding 3: The Healthcare System Did Not Always Consider Using Contracts but Maintained Supporting Documentation.

Recommendation 5: Work with the network contracting office to amend the current contract or establish a new contract to include all needed laboratory tests.

Concur or Non-Concur: Concur

Target Date for Completion: January 1, 2024

Director's Comments: The Medical Center's Laboratory leadership will review the types and volume of completed testing to ensure we have appropriate contracts in place. To prevent split orders on the purchase cards due to high dollar purchases, Laboratory leadership and NCO 12 Contracting will establish a recurring meeting to review open market purchases and to identify changes in test type and frequency and then either modify current contracts or add new vendors, if necessary. These meetings will begin in October 2023.

Recommendation 6: Establish controls to confirm approving officials and purchase cardholders review purchases for VA policy compliance and ensure contracting is used when it is in the best interest of the government.

Concur or Non-Concur: Concur

Target Date for Completion: October 1, 2023

Director's Comments: NCO 12 Contracting has scheduled quarterly VISN-wide GSA Advantage and E-Library training with our new GSA contact. This will ensure cardholders and approving officials are more aware of how to find items on contract and mandatory source requirements. All cardholders and approving officials are required to attend GSA training offered by the purchase card program coordinators, ensuring they are knowledgeable in the use of contract sources using GSA Advantage, GSA E-Library, and GSA Global Supply. By using the online resources provided by the NCO 12 purchase card program coordinators, users can familiarize themselves with how to ensure proper contract information is in the IFCAP vendor file and referenced on the IFCAP purchase card order. Oversight for

the purchase card program is conducted by NCO 12 Contracting, including training, audits and approvals. We are requesting closure of this Recommendation.

Recommendation 7: Require purchase cardholders to submit a request for ratification for any unauthorized commitments identified.

Concur or Non-Concur: Concur

Target Date for Completion: September 1, 2023

Director's Comments: When NCO 12 Contracting identifies unauthorized commitments, cardholders are required to submit all documentation to the purchase card program coordinator for submission to Contracting for ratification. The split laboratory purchase referenced in the draft report is being ratified. NCO 12 establishes processes and procedures for ongoing audits of all purchase card holders and they complete ratifications based on any findings.

Finding 4: The Healthcare System Needs to Improve Oversight of Inventory and the Accuracy of Inventory Data

Recommendation 8: Develop and implement a plan to ensure data accuracy and reliability in the Generic Inventory Package per Veterans Health Administration policy.

Concur or Non-Concur: Concur

Target Date for Completion: January 1, 2024

Director's Comments: We will develop and implement a plan to ensure data accuracy and reliability in the Generic Inventory Package (GIP) per Veterans Health Administration policy. Pandemic related supply chain issues, unprecedented supply chain disruptions and inflation have continued to marginally improve since the sampled period. The cost of goods and availability of goods is becoming more consistent, allowing us to keep better track of not only what we have on hand, but what the system dually reflects as a result of improved cyclical inventories. Across the board, inventory accuracy levels have continued to rise since we reinstituted ABC inventorying in October 2022. This accuracy, which in turn influences the accuracy of our GIP operating system, which in turn influences the accuracy of IFCAP and our financial indicators. We will continue to focus on lower levels of product. Having one consistent product has contributed to improved data accuracy, via controlled inventory management and oversight.

Recommendation 9: Develop better access controls over the contingency space, to ensure less accessibility to reduce missing inventory.

Concur or Non-Concur: Concur in principle

Target Date for Completion: October 1, 2023

Director's Comments: We believe we have appropriate access controls established. The contingency inventory space is locked at all times and the only available key that is not under direct supervisory control is under surveillance at all times. In addition, nobody other than Inventory Management team 6 is permitted to access the contingency space unescorted unless they are expressly authorized by Supply Chain Management leadership. We are requesting closure of this Recommendation.

(Original signed by)

James D. McLain, FACHE
Clement J. Zablocki VA Medical Center
Executive Director
Attachment: Draft Milwaukee Financial Efficiency Inspection Report

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 Melissa Garcia Jamie Kelly Steven King Athenia Rosolowski Jill Talbot
Other Contributors	Daniel Blodgett Charles Hoskinson Clifford Stoddard

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