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VETERANS HEALTH ADMINISTRATION

Financial Efficiency Inspection of the VA Augusta Health Care System in Georgia

Financial Efficiency Inspection | 23-00821-01 | November 14, 2023

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Executive Summary

The VA Office of Inspector General (OIG) conducts financial efficiency inspections to assess the oversight and stewardship of funds used by VA healthcare systems and to identify opportunities for achieving cost efficiencies. Inspection teams identify and examine 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.[1]

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

I. **Accrued expense oversight.** An accrued expense (referred to as an "accrual" throughout this report) occurs when goods or services that were ordered and obligated have been received but payment has not been made.[2] 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.[3] The inspection team evaluated whether the healthcare system followed VA policy by performing monthly reviews and reconciliations of sampled accrued expenses to ensure they were valid and should remain open. An expense is considered valid if the information found in the system is supported by the documentation reviewed. The team also evaluated whether the healthcare system reconciled end dates between the Financial Management System (FMS) and the Integrated Funds Distribution, Control Point Activity, Accounting and Procurement System (IFCAP) for sampled outstanding obligations.[4] In addition, VA policy requires the healthcare system to establish, in collaboration with the Veterans Integrated Service Network (VISN) chief financial officer and network contracting office, a prioritized list of modifications and canceled

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[1] 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. VA Augusta Health Care System was rated as a level 1b-high-complexity facility.

[2] VA Financial Policy, "Obligations Policy," in vol. 2, *Appropriations, Funds, and Related Information,* (September 2021 and April 2022), chap. 5.

[3] An accrual flag is used to automate the accrual process. The automated accrual works well for service orders under which 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. These reflect payable amounts upon processing of receiving actions or reports by logistics staff. Office of Finance, Accrual Flag National Monitoring Guidance, VA National Monitoring SharePoint Site, rev. December 23, 2021.

[4] Both are accounting systems, with FMS considered the primary accounting system that interfaces with IFCAP. A transaction's end date (which is critical to determining whether an obligation should remain open) may be modified due to delays or scope changes. The modification may not be recorded in both systems because staff can manually change end dates in one system without changing them in the other.

orders for the contracting office to address and adjust as needed.[5] The OIG's assessment included this requirement. Failure to properly manage accrued expenses increases the risk of disbursing funds for goods or services not received.

II. **Purchase card use.** The VA Government Purchase Card Program was established to reduce administrative costs related to the acquisition of goods and services.[6] When used properly, purchase cards can help healthcare systems simplify acquisition procedures and provide an efficient vehicle for obtaining goods and services directly from vendors. Documenting transactions as required helps VA and other oversight authorities identify potential fraud, waste, and abuse. 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.

III. **Inventory and supply chain 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, delivery, 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.[7] The team evaluated whether the healthcare system met the performance metrics for days of stock on hand, conversion factor errors, manual adjustments, and inventory data accuracy.[8]

IV. **Pharmacy operations.** An efficient healthcare system anticipates how much drugs will cost and when inventory needs to be restocked by analyzing available data, such as prime vendor inventory management reports and inventory turnover rates.[9] Doing so helps ensure that the system makes the best use of appropriated funds and has inventory when needed. The team evaluated whether the healthcare system managed its pharmacy operations effectively and provided adequate oversight of inventory management.

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[5] VA Financial Policy, "Obligations Policy." VHA divides the United States into 18 regional networks, known as VISNs, which manage day-to-day functions of medical centers and provide administrative and clinical oversight.

[6] VA Financial Policy, "Government Purchase Card for Micro Purchases," in vol. 16, *Charge Card Programs*, (July 14, 2021), chap. 1B.

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

[8] A conversion factor is required for all supply purchases and connects how a supply item is purchased and how it is issued—for example, cans of soda are purchased by the case but issued individually.

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

The inspection team performed a site visit at the VA Augusta Health Care System during the week of February 27, 2023; 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.

What the Inspection Found

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

I. **Accrued expense oversight.** As of December 15, 2022, the healthcare system had 234 outstanding accruals totaling almost $8.7 million. Of those, 178 totaling close to $8.2 million had been open for 60 days or more, including 26 totaling almost $617,000 that had no activity for at least 181 days. From these, the inspection team developed a statistical sample of 23 outstanding accruals totaling about $4.2 million.[10] The team reviewed supporting documentation to assess whether the healthcare system identified and reviewed the sampled accruals to determine whether they were valid and needed to remain open in accordance with VA financial policy.[11] Although healthcare system financial services staff generally reviewed accruals monthly, the inspection team found 13 accruals totaling over $1.1 million that were not valid and should have been deobligated.[12] Based on the sample review, the team projected that the healthcare system had an estimated $4.6 million that should have been put to better use for 101 of 178 obligations with outstanding accruals (almost 57 percent of the total).

   A separate population of 44 open obligations was identified with end-date discrepancies between FMS and IFCAP for three or more months. From these, the team judgmentally selected and evaluated 10 obligations with end-date discrepancies between the systems ranging from 187 to 1,450 days, valued at about $14.1 million. Five of the 10 samples were flagged to automatically accrue the remaining balance of the obligations at the end of the performance period. Before the inspection, healthcare system financial services

[10] The team statistically selected 22 obligations with 23 outstanding accrual balances. Each obligation may have multiple line items of accrued expenses.

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

[12] Deobligation means a cancelation or downward adjustment of previously incurred obligations. VA Financial Policy, "Obligations Policy."

staff corrected the FMS and IFCAP end dates for nine obligations.[13] The remaining sampled obligation still had an end-date discrepancy due to a data entry error in IFCAP by contracting personnel, which the healthcare system continued to work to correct.

The team also found two of the 10 reviewed obligations had outstanding and accrued balances totaling almost $82,900 that should have been deobligated in a timely manner after the goods were received. They had not been deobligated because of the lack of response and urgency from initiating services and the lack of communication among finance staff and service line staff. The supervisory accountant said that the finance office uses VA's FMS-to-IFCAP reconciliation report to identify end-date discrepancies. However, the healthcare system did not always take prompt actions to ensure end dates were correct and to deobligate excess funds, as outlined in VHA financial policy to protect VHA from financial risk.[14] Had the finance staff properly managed open obligations, they could have reduced the risks of disbursing funds for goods or services that were not received and failing to spend appropriations within the associated fiscal year and repurpose funds to benefit veterans.[15]

The healthcare system reported invalid obligations awaiting action by contracting for closeout on the annual certification exceptions lists for FY 2021 and FY 2022. During FY 2021, the healthcare system reported 15 invalid open obligations, valued at more than $4.2 million, awaiting action by contracting. During FY 2022, the number of invalid open obligations increased to 30, valued at about $1.3 million. Financial officials did not always provide a priority list to the VISN chief financial officer or network contracting office for action. Because the VISN and contracting office did not work together, the number of remaining invalid obligations has continued to grow, leaving about $1.3 million in funds attached to orders that could be used for other purposes to benefit veterans.

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[13] See VA technical comment 1 on page 69/80. VA asked the OIG to consider removing a statement about the analysis of 44 FMS and IFCAP end dates. The comment stated that the 44 items did not have end date discrepancies and that the FMS-to-IFCAP reconciliation report is simply a tool created by the VHA Oversight Team to assist stations in reviewing obligations with potential discrepancies. The OIG team did not make this revision because the FMS-to-IFCAP report data definition states that the main purpose for the creation of such reports is to assist facilities in reconciling FMS obligation data with the source data from IFCAP in accordance with financial policies. Therefore, the OIG used the FMS-to-IFCAP report appropriately to determine the population of 44 open obligations with end-date discrepancies between FMS and IFCAP for three or more months.

[14] VA Financial Policy, "Obligations Policy." See VA technical comment 2 on page 69/80. VA asked the OIG to consider removing the statement from the report that the healthcare system did not always take prompt actions to ensure end dates were correct. The OIG team did not make this revision because the documentation only showed delivery dates that matched with FMS. The OIG maintains its position that the healthcare system did not take prompt actions to ensure compliance because the end dates between systems continued to not reconcile based on the FMS-to-IFCAP report.

[15] Appendix D presents the estimated monetary benefits associated with these obligations.

II. **Purchase card use.** The team reviewed a statistical sample of 85 purchase card transactions from December 1, 2021, through November 30, 2022, totaling approximately $475,000, to determine whether they were processed in compliance with VA policies designed to reduce fraud, waste, and abuse. Specifically, the team assessed whether healthcare system staff obtained prior approvals, reconciled purchase card transactions, maintained segregation of duties throughout the transaction process, followed strategic sourcing guidelines, and maintained supporting documentation for each transaction.[16]

Of the 85 sampled transactions, two did not have documentation indicating prior approval, totaling about $16,500. The team did not use statistical projections for these two transactions.[17] Cardholders also did not perform prompt reconciliations (by the 15th day of the month after the billing cycle ends) for 11 sampled transactions, projected to about 840 transactions resulting in approximately $1.1 million in questioned costs. The lack of prompt reconciliations occurred because approving officials and cardholders did not ensure that cardholders reconciled charges in a timely manner.[18] In addition, the healthcare system reported staffing shortages. An approving official reported many vacancies among logistics staff during the inspection period of December 2021 to November 2022. The healthcare system accreditation specialist corroborated these issues and added that attrition rates continued to increase, making it difficult to fill logistics staff vacancies. In March 2023, the healthcare system reported six of 12 purchase card agent positions were vacant.

According to the team's assessment, the healthcare system largely followed policies related to segregation of duties, split purchases, and strategic sourcing, but it did not always maintain supporting documentation for its transactions.[19] Based on the sample review, the team projected that cardholders did not have sufficient supporting documentation for about 4,400 transactions, which resulted in approximately $4.4 million in questioned costs. This occurred because approving officials and cardholders did not maintain copies of purchase card documentation, and the healthcare system did not obtain supporting documentation from vendors that shipped items directly to patients. The

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

[17] The inspection team reported actual sample results rather than estimates for these transactions because of the low sample size and low error count; the estimate also had poor precision due to the low numbers and high variability in sample weights.

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

[19] A split purchase means modifying a transaction into smaller purchases to avoid exceeding the micropurchase threshold or a cardholder's single-purchase limit.

healthcare system again reported that staffing shortages made it harder to ensure that cardholders retained sufficient documentation to support purchase card transactions.

Based on the results of the sample for all areas reviewed, the team projected that the healthcare system had at least $6.7 million in questioned costs on more than 6,800 of approximately 53,800 purchase card transactions (about 13 percent) due to noncompliance errors during the one-year period ending November 30, 2022.[20]

Regarding purchase card oversight, the inspection team determined that the healthcare system conducted purchase card reviews from December 1, 2021, through November 30, 2022, and generally maintained copies and ensured the accuracy of VA Form 0242—the purchase card certification form—for each cardholder, as required by policy.[21] However, one of 22 cardholders in the inspection team's sample had an incorrect spending limit. This occurred because program coordinators did not adequately ensure that US Bank data were updated when cardholder single-spending limits changed.

III. **Inventory and supply chain management.** The healthcare system could improve oversight of inventory and supply chain management by routinely using Supply Chain Common Operating Picture (SCCOP) data to monitor stock levels and meet the required accuracy rate for inventory required by VHA policy.[22] The effectiveness and efficiency of its inventory management could also be improved by ensuring inventory values are recorded correctly in the Generic Inventory Package, establishing local processes and procedures for routinely monitoring inventory reports, implementing a plan for staff training to increase awareness of internal controls, and taking appropriate steps to ensure all supply chain performance measures are maintained in compliance with VA policy. Specifically, inventory managers failed to routinely monitor reported conversion factor errors and to properly record supplies moving in and out of three inventory points reviewed by the inspection team. This led to increased reliance on manual counts, inaccurate inventory values, and use of manual adjustments to correct inventory records in the Generic Inventory Package. Finally, staffing shortages may have affected the ability of the healthcare system to conduct key supply chain management oversight.

To avoid overstocking or understocking, VHA requires responsible staff to ensure correct reorder points and inventory levels are maintained.[23] SCCOP reports assisted with this requirement by specifying a goal for the number of days of Medical Surgical Prime

[20] When reporting on total errors combined, the OIG used the lower-limit value of the one-sided 90 percent confidence interval as conservative estimates in place of the point estimates due to the low level of precision of the point estimates. Therefore, the individual questioned cost amounts of $4.4 million and $1.1 million do not add up to $6.7 million.

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

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

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

Vendor (MSPV) and non-MSPV stock a healthcare system should have on hand. VA changed this goal in October 2022—during the OIG's period of assessment, which extended 10 months from April 2022 to January 2023—so the inspection team measured the healthcare system's performance in this area in two segments. However, the OIG found that the performance did not meet the goal for the entire 10-month period:

- From April through September 2022, healthcare system staff should have ensured that 15 days or less stock of expendable supplies purchased from the MSPV were on hand, and that 30 days or less stock of non-MSPV items were on hand.[24] The team determined that the healthcare system did not meet that goal and had an average of 109 days of stock on hand for MSPV items and 113 days for non-MSPV items.
- Between October 2022 and January 2023, after the goal changed to 30 days or less for MSPV supplies and 45 days or less for non-MSPV supplies, the healthcare system had an average of 80 days of stock on hand for MSPV items and 133 days for non-MSPV items.

In addition, according to SCCOP, as of February 28, 2023, 5 percent of supply items (1,321 of 25,344) had potential conversion factor errors, which can cause items to be over- or underordered, resulting in under- or overstock.[25] Conversion factor errors, if not identified and corrected, can cause incorrect inventory values and quantities in the Generic Inventory Package to be unreliable, which require manual adjustments. These errors can also lead to increased reliance on manual inventory counts and ordering processes. Based on analysis of SCCOP reports and interviews during the inspection, the team completed physical counts of some of the larger dollar items in two primary inventory points as well as a contingency inventory point to assess the accuracy. Inventory personnel said a contributing factor was that they did not routinely monitor the accuracy of conversion factors due to a staffing shortage. The healthcare system officials also told the review team that there is a lack of local inventory management policies and procedures for training supply chain management staff.

During the physical counts in three inventory storage areas, the inspection team identified additional discrepancies between what was reported in the Generic Inventory Package and what was physically located in the inventory point. For the items reviewed by the team, the Generic Inventory Package records were overstated by almost 38,800 items (about 99 percent of the total) totaling over $2.1 million (almost 64 percent of the total

[24] 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.

[25] VHA Supply Chain Desktop Training, "Conversion Factors," July 5, 2019.

amount). 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.

IV. **Pharmacy operations.** The healthcare system could improve pharmacy efficiency by narrowing the gap between observed and expected drug costs, bringing inventory turnover rates closer to the VHA-recommended level, and completing the B09 reconciliation process, which is how VA medical center pharmacies ensure they make correct payments for the drugs they receive.[26]

According to the Office of Productivity, Efficiency and Staffing (OPES) efficiency opportunity model, the healthcare system's observed drug costs were higher than expected over a three-year period. In FY 2020, the healthcare system's observed drug costs were about $2.8 million more than expected; in FY 2021, the observed drug costs exceeded the expected amount by about $3.8 million; and in FY 2022, the costs were over $5 million higher than expected.[27] The pharmacy chief and staff attributed spending increases to a shortage of drugs that were unavailable from the pharmaceutical prime vendor because the preferred items were unavailable from suppliers. This was a nationwide issue during the COVID-19 surge and was not unique to the healthcare system. Additionally, community prescriptions that come to the pharmacy, often for high cost, and specialized therapies are a negative contributor to the overall efficiency.[28]

As for management of drug quantities on hand, low inventory turnover rates can indicate inefficient use of financial resources. In November 2022, the pharmacy prime vendor reported an inventory turnover rate of 7.5 times for "A" items, 5.5 times for "B" items, and 3.0 times for "C" items.[29] However, when healthcare system staff completed a

[26] VHA Directive 1108.07, *General Pharmacy Service Requirements*, November 28, 2022, the Fiscal B09 report is reviewed and reconciled with VA Form 1358s to ensure the pharmacy is making correct payments for purchases received and with documented evidence (signature and date of review) it has been completed. VHA Office of Finance, Financial Management & Accounting Systems Alert, "Pharmacy Prime Vendors B09 Reconciliation Standard Operating Procedures", October 3, 2012. The Pharmacy Service will prepare a monthly B09 reconciliation package with a memorandum and supporting documentation (i.e., Invoices, B09 Report, McKesson Reports) to provide the reconciliation results to the Finance service.

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

[28] See VA technical comment 7 on page 71/80.

[29] VHA Directive 1761, app. E. *Supply Chain Management Operations*, December 30, 2020. VHA has adopted ABC classification principles for inventory management. The formula for calculating the annual usage dollars of an item is the annual usage quantity multiplied by the average unit price. Inventory point items with the highest 80 percent of annual usage dollars will be classified as "A." Items with the next highest 10 percent of annual usage dollars will be classified as "B." Lastly, items representing the remaining 10 percent of annual usage dollars will be classified as "C."

wall-to-wall inventory in February 2023, they calculated an inventory turnover rate of 13 times. The pharmacy staff said they did not understand why the prime vendor reported lower rates but were working with the prime vendor to understand and resolve the issue.[30] The healthcare system did not use the prime vendor software package or any other inventory management software to manage inpatient drug inventories or adjust stock levels in accordance with VHA policy.[31] Instead of using the handheld barcode readers, the healthcare system managed the inventory by "walking the shelves" and observing the amount of stock on hand. Pharmacy officials stated that they were unable to use handheld scanners due to issues with wireless connectivity. Specifically, the structure of the building prevents Wi-Fi or hot spot connectivity for the readers to function properly.[32]

The healthcare system's reconciliations of the Pharmacy Prime Vendor Line-Item Report (B09 reconciliations) did not fully comply with VA policy. The OIG found that pharmacy service staff were only sending the required memorandum and reconciliation spreadsheets and did not always provide other supporting documentation, such as invoices, to the finance service. Pharmacy staff said they were not aware of this noncompliance with VA policy. If reconciliations are not completed, there is no assurance that the amount paid to the prime vendor is consistent with the goods received.

What the OIG Recommended

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

Regarding accruals, the OIG recommended the healthcare system director make sure all policy requirements are communicated to finance office staff and collaborate with the VISN chief financial officer and network contracting office to establish a monthly prioritized listing of contract modifications and canceled orders for goods and services. To strengthen oversight of purchase card transactions, the OIG recommended the director ensure cardholders comply with the record retention, prior approval, and purchase card reconciliation requirements in VA financial policy.

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[30] VHA Pharmacy Benefits Management email response to questions from VA OIG Office of Financial Inspections, February 2023. Recommended levels of 12–16 for "A" items, 6–10 for "B" items, and 6–10 for "C" items.

[31] VHA Directive 1761.

[32] A "hot spot" is an area where wireless Internet connection is available. *Merriam-Webster*, "hot spot," accessed February 28, 2023, https://www.merriam-webster.com/dictionary/hot%20spot.

For inventory and supply chain management, all necessary reports should be monitored routinely, all supply chain performance measures should be maintained in compliance with policy, and data in the Generic Inventory Package should be accurate and reliable. Finally, to improve pharmacy operations, the OIG recommended that formal processes be developed for achieving efficiency targets and using available data to make business decisions. The director should also develop and implement a plan to increase inventory turnover closer to the VHA-recommended level, ensure pharmacy staff are trained on the ScriptPro workflow system for pharmacy, and establish processes to ensure compliance with VHA policy to complete B09 reconciliations.

VA Comments and OIG Response

The VA Augusta Healthcare System concurred with all the report’s findings and recommendations and submitted action plans for recommendation 1 through 9. Appendix E provides the full text of the healthcare system’s comments.

The healthcare system requested closure of recommendation 9. However, no evidence or supporting documentation was provided for the OIG to evaluate. The OIG will assess the satisfactory completion of the actions in conjunction with its routine recommendation follow-up. Overall, the proposed corrective measures in the healthcare system’s action plans appear to be responsive to the recommendations and the OIG will monitor their implementation until all stated actions are documented as completed. The OIG considers all recommendations open.

The healthcare system also provided seven technical comments for consideration and the OIG incorporated clarifying information in the report where appropriate. The OIG did not make the revisions requested in technical comments 1 through 6, but instead added text or footnotes within the report to explain why it declined to do so.

For technical comments 1 through 3, the healthcare system requested that the OIG remove, modify, or add wording to clarify and correct reporting about FMS-to-IFCAP end-date discrepancies. The comments stated that the FMS-to-IFCAP reconciliation is simply a tool created by the VHA Oversight Team to assist stations in reviewing obligations with potential discrepancies, and the only true way to ensure accuracy of end dates and delivery dates is to view the obligating documents from FMS and IFCAP. The OIG acknowledged the healthcare system's position; however, VA financial policy requires the finance office to reconcile data from different systems to ensure accuracy, investigate discrepancies, and align end dates. This aligns with the FMS-to-IFCAP report's purpose of assisting facilities in reconciling data each month. Therefore, the OIG affirms that the finding is accurately stated and supported.

For technical comments 4 through 6, the healthcare system stated it complied with VA financial policy because the source documents showed that delivery and end dates matched. The documentation provided to the OIG did not show that the end dates in FMS matched the end dates in IFCAP. When the OIG asked about the differing end dates, financial services staff

explained that they used the obligation-established dates as a workaround to avoid FMS rejection. The OIG maintains that the healthcare system did not take prompt actions to ensure compliance because the end dates between systems continued not to reconcile.[33] The OIG generally agreed with technical comment 7 and incorporated clarifying information in a footnote.

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[33] VA financial policy mandates the finance office to conduct monthly financial reconciliation to ensure accurate financial transactions, and when necessary, perform manual intervention when system rejections occur to resolve inconsistencies across systems. Specifically, under the delivery and end dates review, the policy states the contract is the authoritative document for delivery and end dates.

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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
OIG	Office of Inspector General
OPES	Office of Productivity, Efficiency and Staffing
SCCOP	Supply Chain Common Operating Picture
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VistA	Veterans Health Information Systems and Technology Architecture

Introduction

The VA Office of Inspector General (OIG) conducts financial efficiency inspections to assess the oversight and stewardship of funds used by VA healthcare systems and to identify opportunities for achieving cost efficiencies. Inspection teams identify and examine 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.[34]

This inspection focused on the VA Augusta Health Care System. The inspection team assessed four financial activities and administrative processes to determine whether appropriate oversight and controls were in place. The period of data reviewed by the inspection team varied for each but was no earlier than October 2021 and no later than December 2022. The four activities and processes were the following:

I. **Accrued expense oversight.** An accrued expense (referred to as an "accrual" throughout this report) occurs when goods or services that were ordered and for which funds were obligated have been received but payment has not been made.[35] VA policy states each accrued expense should be reviewed by the finance office monthly against supporting documentation to ensure that reports, subsidiary records, and systems reflect proper vendors and correctly calculated accrued balances; the accrual flag is set appropriately; and proper accruals have occurred.[36] The inspection team evaluated whether the healthcare system followed VA policy by performing monthly reviews and reconciliations of sampled accrued expenses to ensure they were valid and should remain open.[37] As a matter of context, an expense is considered valid if the information found in the system is supported by the documentation reviewed. Failure to properly manage accrued expenses increases the risk of disbursing funds for goods or services not received and may prevent the healthcare system from obtaining the maximum benefit of any unused funds.

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[34] 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. VA Augusta Health Care System was rated as a level 1b-high-complexity facility.

[35] VA Financial Policy, "Obligations Policy," in vol. 2, *Appropriations, Funds, and Related Information,* (September 2021 and April 2022), chap. 5.

[36] An accrual flag is used to automate the accrual process. The automated accrual works well for service orders under which 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. These reflect payable amounts upon processing of receiving actions or reports by logistics staff.

[37] 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 (which is used to automate the accrual process) is set appropriately, and proper accruals have occurred. VA Financial Policy, "Obligations Policy."

II. **Purchase card use.** The VA Government Purchase Card Program was established to reduce administrative costs related to the acquisition of goods and services.[38] When used properly, purchase cards can help healthcare systems simplify acquisition procedures and provide an efficient vehicle for obtaining goods and services directly from vendors. The cards also help document transactions as required and allow VA and other oversight authorities to identify potential fraud, waste, and abuse. The team examined whether the healthcare system's purchase card program ensured compliance with policies and procedures and focused on the consideration of contracts for regularly purchased products to provide optimal savings to VA. Using contracts for regular purchases, known as strategic sourcing, has several benefits, such as optimizing purchasing power by obtaining competitive pricing.

III. **Inventory and supply chain management.** Supply chain management is the integration and alignment of people, processes, and systems to manage planning, sourcing, purchasing, delivering, receiving, and disposal activities.[39] Veterans Health Administration (VHA) policy requires healthcare systems 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.[40] The team evaluated whether the healthcare system managed its supply chain operations effectively using days of stock on hand as a performance metric.

IV. **Pharmacy operations.** An efficient healthcare system anticipates how much drugs will cost and when inventory needs to be restocked by analyzing available data, such as prime vendor inventory management reports and inventory turnover rates.[41] Doing so helps ensure that the system makes the best use of appropriated funds and has inventory when needed. The team evaluated the following areas: whether the healthcare system complied with VA policies, used cost and performance data to track progress toward goals, improved pharmacy program operations, and identified and corrected problems.

To assess these areas, the inspection team performed a site visit at the VA Augusta Health Care System during the week of February 27, 2023; 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

[38] VA Financial Policy, "Government Purchase Card for Micro Purchases," in vol. 16, *Charge Card Programs*, (July 14, 2021), chap. 1B.

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

[40] VHA Directive 1761.

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

more information about the 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.

VA Augusta Health Care System

The VA Augusta Health Care System is a high-complexity (1b) facility reporting to Veterans Integrated Service Network (VISN) 7.[42] The healthcare system provides services at five locations in northeast Georgia and western South Carolina. Facilities include the Charlie Norwood VA Medical Center in downtown Augusta and the Augusta VA Medical Center—Uptown. Its facilities also include three community-based outpatient clinics in Athens and Statesboro, Georgia, and in Aiken, South Carolina.

In fiscal year (FY) 2022, the healthcare system had close to 400 hospital beds with over 2,500 total medical care full-time equivalent staff and provided services to over 49,100 unique patients. The reported FY 2022 medical care budget exceeded $662.2 million, an increase of approximately $17.8 million (3 percent) over the FY 2021 medical care budget of about $644.4 million and an increase of approximately $80.4 million (12 percent) over the FY 2020 medical care budget of about $581.8 million.[43]

Healthcare System 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 (OPES) efficiency opportunity grid. VHA developed the efficiency opportunity grid, a collection of 12 statistical models, to give healthcare system 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 healthcare system characteristics and in geography. The grid also describes possible inefficiencies and areas of success by showing the difference between a healthcare system’s actual and expected costs. The team uses the healthcare system rankings from the stochastic frontier analysis model in the grid to assist in selecting healthcare systems for financial efficiency inspections.[44] The inspection is limited in

[42] VHA divides the United States into 18 regional networks, known as VISNs, which manage day-to-day functions of medical centers and provide administrative and clinical oversight. The VA Augusta Health Care System is station 509 and is in VISN 7, the VA Southeast Network.

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

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

scope and is not intended to be a comprehensive inspection of all financial operations at the healthcare system.

Results and Recommendations

I. 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.[45] Additionally, a 2019 OIG report on undelivered orders recommended VHA ensure staff review and reconcile open orders, identify and deobligate excess funds on those orders, and follow VA policy regarding required reviews of open obligations.[46] If reviews are not conducted, the healthcare system risks not being able to deobligate those funds and use them for other goods or services in that fiscal year to support veterans.

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.
- **Financial Management System (FMS)–to–Integrated Funds Distribution, Control Point Activity, Accounting and Procurement System (IFCAP) reconciliations.** The team identified outstanding obligations with different end dates between FMS and IFCAP

[45] 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 FY 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 in a timely manner. 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.

[46] 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.

to ensure healthcare system staff reconciled end dates between the systems for the sampled obligations.[47]

- **Priority list of 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 list of contract modifications and canceled orders for the contracting office to process closeout actions for goods or services that are no longer needed.[48]

Finding 1: The Healthcare System Does Not Always Ensure Accruals Are Proper and End Dates Are Accurate, or Provide the VISN with 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, including undelivered orders and accrued expenses, are valid.[49] The healthcare system's finance office personnel should verify with the initiating service or contracting officer, if 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.[50]

Figure 1 shows the number and dollar amounts of outstanding accruals for the VA Augusta Health Care System from July 15 through December 15, 2022.

[47] Both are accounting systems, with FMS considered the primary accounting system that interfaces with IFCAP. A transaction's end date (which is critical to determining whether an obligation should remain open) may be modified due to delays or scope changes. The modification may not be recorded in both systems because staff can manually change end dates in one system without changing them in the other. See VA technical comment 3 on pages 69-70. VA requested that the OIG remove the statement that the team identified outstanding obligations with different end dates between FMS and IFCAP to ensure healthcare system staff reconciled end dates between the systems for the sampled obligations. The OIG team did not make this revision because it accurately reflects the FMS-to-IFCAP report data definition. This definition states that the report's primary purpose is to assist facilities in reconciling FMS obligation data with the source data from IFCAP in accordance with financial policies. Therefore, the OIG correctly identified the use of the FMS-to-IFCAP report to ensure healthcare system staff reconciled end dates between the systems for the sampled obligations.

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

[49] VISN 7 Centralized Accounting Office performs monthly reviews and reconciliations for the VA Augusta Health Care System. For the purposes of this report, the OIG uses the terms "financial services" or "finance office" to refer to the Centralized Accounting Office.

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

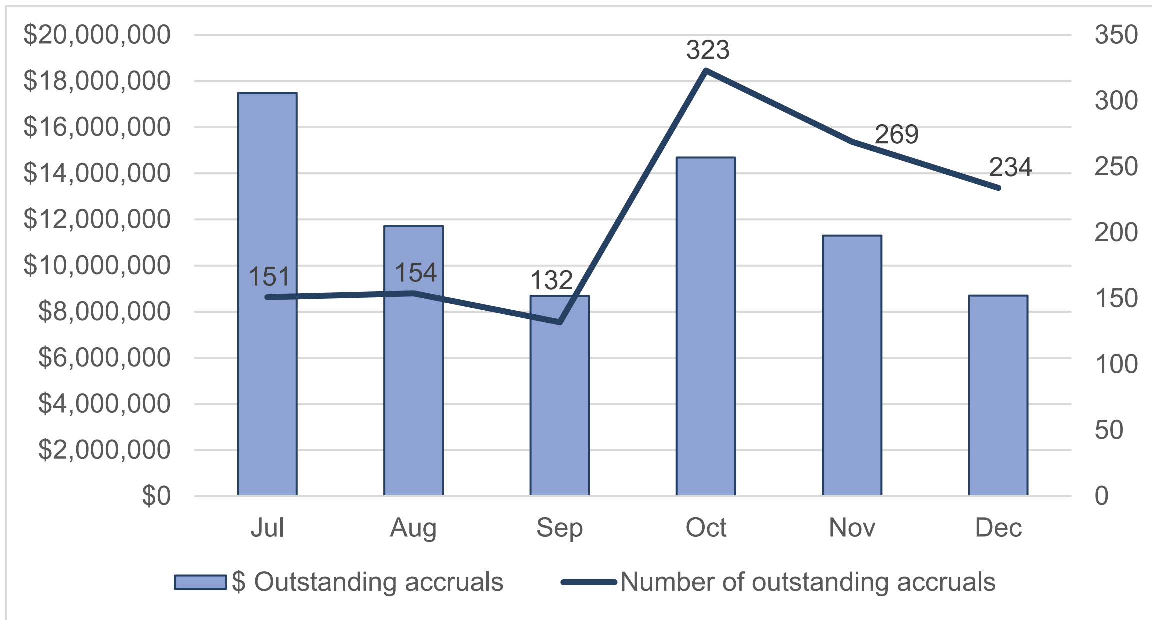

Figure 1. *Number and dollar amounts of outstanding accruals for the VA Augusta Health Care System from July 15 through December 15, 2022.*

Source: VA OIG analysis of VA FMS F851 Report.

As of December 15, 2022, the healthcare system had 234 outstanding accruals totaling almost $8.7 million. From these 234, the team identified 178 obligations with accrual balances that had been open for 60 days or more, totaling close to $8.2 million. Figure 2 shows the age and dollar amounts of these obligations. As shown, 26 obligations with accruals totaling almost $617,000 had been open for 181 days or more.

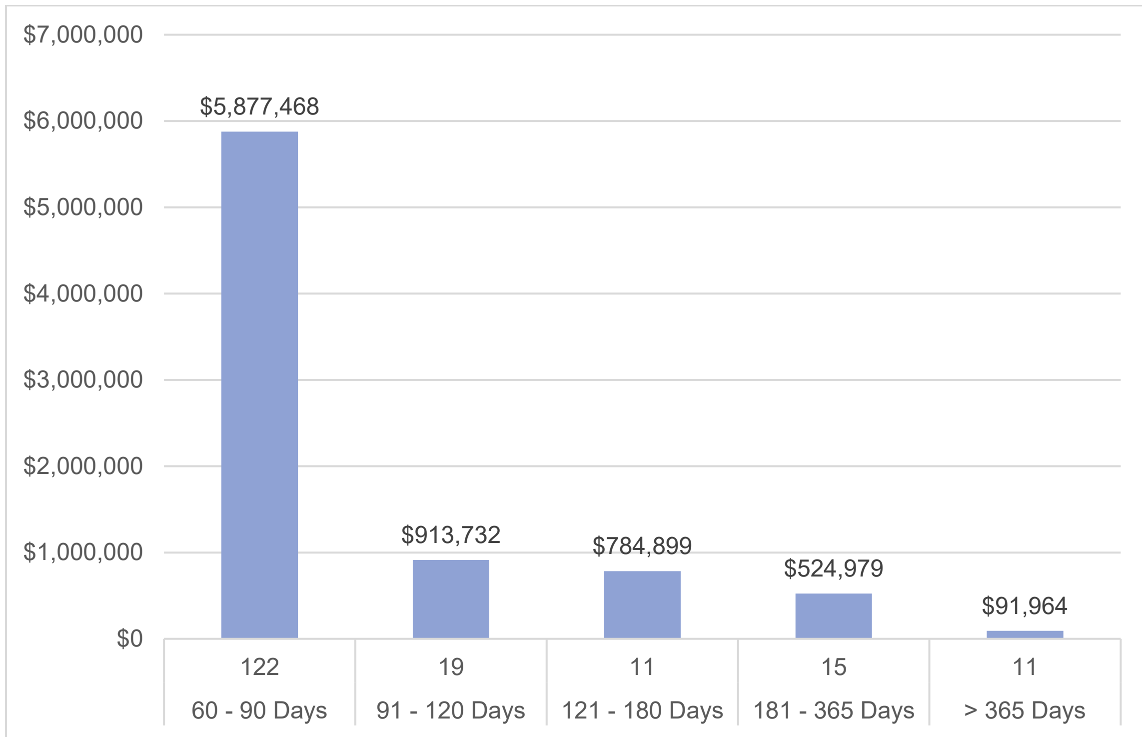

Figure 2. *Outstanding accruals for the VA Augusta Health Care System in December 2022.*
Source: VA OIG analysis of VA FMS F851 Report.

Outstanding Accruals

The inspection team analyzed 178 obligations with accruals outstanding through December 15, 2022, totaling approximately $8.2 million. Of these obligations, the inspection team statistically selected 23 accruals totaling about $4.2 million.[51] The team reviewed supporting documentation to assess whether the healthcare system identified and reviewed the sampled accruals to determine whether they were valid and needed to remain open in accordance with VA financial policy.[52] All 23 accrual balances had been open between 75 and 440 days as of December 15, 2022. Although the healthcare system's finance office generally reviewed accruals monthly, the inspection team determined that 13 accrual balances totaling more than $1.1 million should have been deobligated.[53] The following examples show instances of improper accruals.

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[51] The team reviewed a statistical sample of 22 obligations with 23 outstanding accrual balances. Each obligation may have multiple line items of accrued expenses.

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

[53] The team found 12 obligations with 13 outstanding accruals that should have been deobligated. Deobligation means a cancelation or downward adjustment of previously incurred obligations. VA Financial Policy, "Obligations Policy."

Example 1

One obligation overaccrued $450,565 for about eight months because the initiating service did not follow up with the vendor to ensure all invoices had been received and paid as required by VA financial policy. In its first quarter FY 2023 Quarterly Monitoring Obligation Report, the finance office reported that the service was working with contracting to process an adjustment because the final cost was lower than the original obligation amount. While the finance office escalated the issue to the service chief, the initiating service did not take actions to ensure prompt deobligation.

Example 2

One obligation overaccrued $161,336 for about six months because the initiating service did not submit the deobligation request in a timely manner after the vendor had confirmed that all invoices were paid. While the finance office was aware of the improper accrual, no follow-up actions were taken to ensure prompt deobligation.

Funds were not deobligated as needed due to staff turnover, accounting entry errors, lack of sufficient responses from initiating services, lack of awareness of VA policy, and lack of follow-up by the finance office to ensure initiating services were taking prompt action as required by VA policy.

Based on a review of the 23 outstanding accruals, the team projected an estimated $4.6 million in funds that could be put to better use for the healthcare system for 101 of 178 obligations with outstanding accruals (almost 57 percent). Failure to properly manage accruals increases the risk of disbursing funds for goods or services not received and may prevent the healthcare system from obtaining the maximum benefit of any unused funds.

See appendix B for additional details on the inspection's scope and methodology and appendix C for details on the inspection's statistical sampling methodology and monetary impact.

Reconciliation of FMS and IFCAP End Dates

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.[54] 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. Therefore, open obligations should be reviewed monthly by the healthcare system's

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

finance office, in coordination with the initiating service, to ensure period of performance dates are correct and match in all systems.[55]

The inspection team identified 44 open obligations with end-date discrepancies between FMS and IFCAP for three or more months. The team judgmentally selected and evaluated 10 end-date discrepancies, with variances between systems ranging from 187 to 1,450 days, valued at about $14.1 million. Five of 10 samples were flagged to automatically accrue the remaining balance of the obligations at the end of the performance period.[56] Obligations set to automatically accrue in FMS that have inaccurate end dates could result in invalid accruals. The team determined that FMS end dates and IFCAP delivery dates were corrected by the healthcare system prior to the inspection and reflected correct end dates for nine obligations. However, one of the 10 sampled obligations still had an end-date discrepancy between FMS and IFCAP. This occurred due to a contracting error in entering the delivery date in IFCAP. The healthcare system was working with contracting to correct the IFCAP end-date error.

The supervisory auditor reported that staff only reviewed the delivery date in IFCAP and end-date in FMS because of a Veterans Health Information Systems and Technology Architecture (VistA) system limitation that caused end dates not to reconcile between the two systems. The finance office implemented a workaround process by submitting end-date changes using the date that the obligation was established to avoid FMS rejection. As a result, the end dates will continue to not synchronize because VistA and FMS were not designed to have this functionality. While the finance office submitted documentation showing that FMS end dates match IFCAP delivery dates, the OIG determined that the healthcare system was not in compliance because the end dates between systems continued to not reconcile in accordance with VA financial policy.[57]

The team also found two of 10 reviewed obligations had outstanding and accrued balances totaling almost $82,900 that should have been deobligated in a timely manner after the goods

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

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

[57] VA Financial Policy, "Reconciliations," in vol. 1, *General Accounting* (October 2018), chap. 6. The policy requires manual intervention when there is a system rejection to alleviate inconsistencies between two or more systems. See VA technical comment 4 on page 70/80. VA asked the OIG to consider removing the statement that "the supervisory auditor reported that staff only reviewed the delivery date in IFCAP and end-date in FMS because of a Veterans Health Information Systems and Technology Architecture (VistA) system limitation that caused end dates not to reconcile between the two systems. The finance office implemented a workaround process by submitting end-date changes using the date that the obligation was established to avoid FMS rejection. As a result, the end dates will continue to not sync because VistA and FMS were not designed to have this functionality. While the finance office submitted documentation showing that FMS end dates match IFCAP delivery dates, the OIG determined that the healthcare system was not in compliance because the end dates between systems continued to not reconcile in accordance with VA Financial Policy". The OIG did not make this revision because the documentation only showed delivery dates that matched with FMS. The OIG maintains its position that the healthcare system did not take prompt actions to ensure compliance because the end dates between systems continued to not reconcile based on the FMS-to-IFCAP reconciliation report.

were received. This occurred because of the lack of responses from initiating services and lack of communication among finance staff and service line staff. The supervisory accountant confirmed the finance office does use VA's FMS-to-IFCAP reconciliation report to identify end-date discrepancies.[58] However, the inspection team found that the healthcare system did not always take prompt actions to ensure end dates were correct or deobligate excess funds as outlined in VHA Financial Policy to protect VHA from financial risk.[59] Had the finance office staff properly managed open obligations, they could have reduced the risk of disbursing funds for goods or services that were not received, and also the risk of failing to spend appropriations within the associated fiscal year and repurpose funds to benefit veterans.[60]

Priority List of 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.[61] 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.[62] 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 closeout on the annual certification exceptions lists for FY 2021 and FY 2022. During FY 2021, the healthcare system reported 15 invalid open obligations valued at more than $4.2 million awaiting

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

[59] VA Financial Policy, "Obligations Policy." See VA technical comment 5 on page 70/80. VA asked the OIG to consider removing the statement from the report that the healthcare system did not always take prompt actions to ensure that end dates were correct. The OIG team did not make this revision because the documentation only showed delivery dates that matched with FMS. The OIG maintains its position that the healthcare system did not take prompt actions to ensure compliance because the end dates between systems continued to not reconcile based on the FMS-to-IFCAP reconciliation report.

[60] Appendix D presents the estimated monetary benefits associated with these obligations.

[61] VA FORCE User Guide, July 2020, defines FORCE as "an innovative interface tool that allows Department of Veterans Affairs Program Office and Acquisition Users in the Contracting Office to complete forecasting and planning actions, collaborate to develop a complete and actionable requirement, and submit requirements."

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

action by contracting. During FY 2022, the number of invalid open obligations increased to 30, valued at about $1.3 million.[63]

While the healthcare system generally 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. Finance officials confirmed that only one all-inclusive list of obligations to be closed was provided to the network contracting office. Finance officials also reported that contracting has access to the FORCE system to identify which contracts need action. The healthcare system's finance office, instead of the VISN, conducts monthly follow up actions unless they are having issues with the acquisition office completing the specified actions requested, such as deobligating excess funds. Because the VISN and the contracting office have not worked together, the list of invalid obligations remaining open has continued to grow, leaving about $1.3 million in funds attached to orders that could be used for other purposes to benefit veterans.

Finding 1 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 contract modifications was forwarded for action, resulting in an estimated $5.3 million that could have been put to better use.[64] Failure to properly manage open obligations and accrued expenses increases the risk that appropriated funds will be left attached to orders when they could be used for other purposes to benefit veterans, or erroneously used to pay for goods or services not received.

Recommendations 1–2

The OIG made the following recommendations to the VA Augusta Health Care System director:

1. Ensure that healthcare system finance office staff are made aware of policy requirements and that all accruals are proper and valid, as required by VA Financial Policy, vol. 2, chap. 5, "Obligations Policy."

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[63] Annual accounting records certification is used by VA healthcare systems to certify that the records for accounting periods in each fiscal year accurately reflect the condition of the accounting records for all appropriations and funds maintained. Undelivered orders and accrued expenses exceptions lists are attached to these certifications when VA healthcare systems cannot review and determine that the obligations are valid.

[64] For this inspection, the total of funds that could be put to better use was more than $5.9 million ($4.6 million + $83,000 + $1.3 million). However, the total better use of funds estimate in the report was reduced by close to $590,000 to prevent possibly double counting funds previously identified and reported in the annual exceptions lists for FY 2022. See VA technical comment 6 on pages 71/80. VA asked the OIG to consider changing the statement that the healthcare system did not comply with VA policies to ensure end dates were reconciled between systems. The OIG did not make this revision because the documentation only showed delivery dates that matched with FMS. The OIG maintains its position that the healthcare system did not take prompt actions to ensure compliance because the end dates between systems continued to not reconcile based on the FMS-to-IFCAP reconciliation report.

2. 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 modifications are completed.

VA Management Comments

The director of the VA Augusta Health Care System concurred with recommendations 1 and 2. The responses to all report recommendations are provided in full in appendix E. To address recommendation 1, the director reported that the fiscal chief will collaborate with the Veterans Integrated Service Network (VISN) 7 Centralized Accounting Office to provide training for the initiating services responsible for accrued payables. The healthcare system auditor will assist the office, initiating services, and service chiefs to analyze inactive or expired obligations and will review responses prior to submitting monthly reconciliation reports.

The director noted that recommendation 2 falls under the authority of the VISN Centralized Accounting Office, which will request a monthly list of contract modifications from the contracting office and review, recommend priority, and send to the VISN chief financial officer for review and submission back to the contracting office.

The healthcare system also provided technical comments saying the healthcare system is complying with VA financial policy because the end dates and delivery dates matched for all but one obligation. The comments further stated that the FMS-to-IFCAP reconciliation is simply a tool created by the VHA Oversight Team to assist stations in reviewing obligations with potential discrepancies, and the only true way to ensure accuracy of end dates and delivery dates is to view the obligating documents from FMS and IFCAP. Appendix E contains the full text of VA’s response.

OIG Response

The healthcare system concurred and provided responsive action plans for each of the two recommendations; however, the action plan for recommendation 1 is only partially responsive to the identified issues and intent of the recommendation. While the healthcare system responded that it would develop and provide face-to-face training, its response did not address how the healthcare system will ensure the resolution of FMS-to-IFCAP reconciliation issues identified by the inspection regarding ongoing or future obligations.

The OIG did not make the revisions requested in technical comments 1 through 6 because the healthcare system incorrectly asserted the OIG’s statements were inaccurate or wrong. In technical comments 1 through 3, the healthcare system states that the OIG inappropriately used the FMS-to-IFCAP reconciliation report to identify a separate population of 44 open obligations with end-date discrepancies because the FMS-to-IFCAP is a tool not a report. The healthcare

system further states that the only true way to ensure accuracy of delivery and end dates is to view the dates displayed on the obligating documents.[65]

VHA Financial Policy requires the finance office to perform monthly system reconciliations between FMS and IFCAP to ensure financial data is accurate, and when necessary, investigate and correct discrepancies manually to prevent recurrences. The FMS-to-IFCAP reconciliation report provides obligation data from the FMS and compares them to the related obligation from the IFCAP purchase order. The purpose of this report aligns with the healthcare system's position in ensuring accuracy of end dates and delivery dates is to view the obligating documents from FMS and IFCAP. Therefore, the OIG affirms its position of finding 44 open obligations with end-date discrepancies is accurately stated and supported.

For technical comments 4 through 6, the healthcare system stated it complied with VA financial policy because the source documents showed that delivery and end dates match. However, the documentation provided to the OIG did not show that the end dates in FMS match the end dates in IFCAP. When the OIG asked about the differing end dates, financial services staff explained that they used the obligation-established dates as a workaround to avoid FMS rejection. Consequently, the OIG maintains that the healthcare system did not take prompt actions to ensure compliance because the end dates between systems continued not to reconcile.[66]

The OIG will monitor implementation of planned actions for recommendations 1 and 2 and will close the recommendations when the OIG receives sufficient evidence demonstrating progress in addressing the intent of the recommendations and noncompliance issues identified. See appendix E for the healthcare system's technical comments.

[65] FMS Purchase Order Accounting Line (OBLL) and Orders Header (OBLH) tables provide information on obligating documents and amounts, including outstanding, recently closed, and expended amounts for each line of the obligation. The IFCAP purchase order provides the information, such as order amount and dates on purchase of the goods or services.

[66] VA financial policy mandates monthly financial reconciliation by the finance office to ensure the accuracy of financial transactions, requiring manual intervention when system rejections occur to resolve inconsistencies across systems. Specifically, under the delivery and end dates review, the policy states the contract is one of the authoritative documents for delivery and end dates.

II. Purchase Card Use

VA established its Government Purchase Card Program to reduce administrative costs related to acquiring goods and services. When used properly, purchase cards can help healthcare systems simplify acquisition procedures and provide an efficient vehicle for obtaining goods and services directly from vendors. From December 1, 2021, through November 30, 2022, the healthcare system had approximately 55,000 purchase card transactions that totaled just under $50.6 million. The inspection team removed negative purchase card transaction amounts from the total population of transactions and obtained a population of almost 53,800 transactions that totaled over $51.3 million.[67] The amount and volume of spending through the Government Purchase Card Program make it important to have strong controls over purchase card use to safeguard government resources and ensure compliance with policies and procedures that reduce the risk of error, fraud, waste, and abuse.[68]

The team reviewed the following areas for the sampled transactions:

- **Purchase card transactions.** The inspection team examined whether the healthcare system processed purchase card transactions in accordance with VA policy, including whether cardholders obtained prior approvals before initiating a purchase, transactions were reconciled by the cardholder and approved by the designated official in a timely manner, and segregation of duties was maintained.[69] Additionally, the team inquired as to whether the healthcare system considered obtaining contracts for regularly procuring particular goods and services, which VA refers to as strategic sourcing. The use of contracts lowers the risk of split purchases and duplicate payments on purchase cards by reducing open market or individual purchases and enables VA to leverage its purchasing power.[70]
- **Purchase card oversight.** The inspection team assessed whether the healthcare system tracked purchase card training, had purchase card policies in place, assigned no more than 25 purchase card accounts to an approving official, and maintained accurate

[67] Examples of negative purchase card transaction amounts include refunds for disputed transactions and other corrections.

[68] VA Financial Policy, "Government Purchase Card for Micro-Purchases," in vol. 16, *Charge Card Programs* (July 14, 2021), chap. 1B.

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

[70] VA Financial Policy, "Government Purchase Card for Micro-Purchases," in vol. 16, *Charge Card Programs* (July 14, 2021), 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.

Governmentwide Purchase Card Certification forms (VA Form 0242).[71] The team also assessed whether the healthcare system's purchase card coordinator provided oversight of the purchase card program by conducting periodic internal reviews.[72] These activities are examples of systematic controls that help reduce errors and ensure a healthcare system complies with VA policy.

- **Supporting documentation.** Maintaining documentation is required for purchases to provide assurance of payment accuracy and to justify the need to purchase a good or service. The inspection team examined whether the healthcare system maintained supporting documentation as required. This includes approved purchase requests, purchase orders, receiving reports, vendor invoices, and, when necessary, written justification for purchases from a third-party payer.[73] Supporting documentation enables program oversight and helps prevent fraud, waste, and abuse.

Finding 2: Purchase Card Transaction Processing Needs Improvement

The inspection team obtained a population of almost 53,800 purchase card transactions from December 1, 2021, through November 30, 2022, which totaled over $51.3 million.[74] Of these transactions, the team reviewed a statistical sample of 85 transactions totaling approximately $475,000 to determine whether the healthcare system maintained purchase card documentation and whether transactions were processed in accordance with VA policy. See appendix B for a full description of the inspection's scope and methodology and appendix C for details on its sampling. An analysis of the sample led the team to project noncompliance errors for at least 6,800 purchase card transactions (about 13 percent of transactions), totaling at least $6.7 million in questioned costs.[75]

The inspection team observed that cardholders and approving officials were using government purchase cards in support of the agency's mission and were aware of VA policy requirements for purchase card training, split purchases, and single transaction limits. Also, the purchase card coordinator consistently performed periodic audits of the purchase card program. Although the healthcare system leaders provided program oversight, the OIG found that improvements could

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[71] VA Financial Policy, "Administrative Actions for Government Purchase Cards". An approved VA Form 0242, Governmentwide Purchase Card Certification, is used to delegate authority to an individual to use the purchase card to procure and pay for goods and services.

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

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

[74] The inspection team pulled a statistical sample from positive dollar amount transactions (negative transactions such as refunds were excluded).

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

be made to ensure that prior approvals are obtained; monthly reconciliations are performed in a timely manner; and approving officials, purchase card coordinators, and cardholders review purchases and maintain supporting documentation consistently. Reviewing transactions helps ensure that approving officials and cardholders are following policy; reduces the risk of error, fraud, waste, and abuse; and promotes the good stewardship of government funds.

Purchase Card Transactions

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

- **Prior approval** was obtained to ensure a valid business need before initiating a purchase.[76]
- **Reconciliation** of a purchase was approved in a timely manner to help identify fraudulent or erroneous charges and unauthorized commitments.[77]
- **Segregation of duties** was maintained to ensure roles and responsibilities did not overlap.[78]

In its assessment of purchase card transaction documentation to determine whether these requirements were met, the team identified two transactions, totaling about $16,500, that did not have documentation indicating prior approval. A statistical projection using just two transactions would have lacked precision and was therefore not conducted.[79] The team also determined that cardholders did not perform prompt reconciliations (by the 15th day of the month after the previous billing cycle) for 11 transactions. Based on the sample review, the team projected those cardholders did not perform prompt reconciliations for at least 840 transactions, resulting in at least $1.1 million in questioned costs. Untimely reconciliation increases the risk for data integrity errors and fraud. The lack of prompt reconciliations occurred because approving officials and cardholders did not ensure that cardholders reconciled charges in a timely manner.[80]

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[76] 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.

[77] VA Financial Policy, “Government Purchase Card for Micro-Purchases.”

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

[79] The inspection team reported actual sample results rather than estimates for these transactions because of the low sample size and low error count; the estimate also had poor precision due to the low numbers and high variability in sample weights.

[80] VA Financial Policy, “Government Purchase Card for Micro-Purchases.”

Table 1 shows the results of the sample review.

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

Requirement	Number of noncompliant transactions
Prior approval	2
Reconciliation approved by the 15th day of the month after the closing of the previous month's billing cycle	11
Segregation of duties	0

Source: VA OIG inspection team assessment of 85 sampled transactions.

Also contributing to problems with approvals and reconciliations were staffing shortages reported by the healthcare system. An approving official reported many vacancies among logistics staff during the past year. The healthcare system accreditation specialist corroborated these issues and added that attrition rates continue to increase, making it difficult to maintain logistics staffing levels. As of March 2023, the healthcare system's prosthetics purchasing agent reported six of 12 purchase card agent positions were vacant.

The inspection team also assessed whether cardholders split purchases into two or more transactions to avoid exceeding the micropurchase threshold and whether they modified purchases to stay within the authorized single-purchase limit. Contracts must be used when the total value of the requirement exceeds the micropurchase threshold. Cardholders are instructed not to modify or split a requirement 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.[81] The team selected a statistical sample of 65 transactions totaling approximately $389,000 to determine whether cardholders split purchases. The team reviewed transaction documentation and interviewed purchase cardholders and approving officials and determined that none of the transactions were split purchases.

Last, the inspection team inquired whether the healthcare system considered obtaining contracts for procuring goods and services on a regular basis. In accordance with policy, VA cardholders are instructed to pursue strategic sourcing—establishing contracts that generally provide greater savings to VA rather than using purchase cards for open market acquisitions without a negotiated price—for goods that are purchased on a recurring or ongoing basis.[82] By leveraging VA's

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

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

purchasing power, strategic sourcing may offer the most competitive prices. The OIG found overall that the healthcare system had procedures and controls in place that sufficiently considered strategic sourcing.

Purchase Card Oversight

Responsible officials are accountable for compliance with the Government Purchase Card Program and for implementing internal controls to protect and conserve federal funds. Oversight activities include periodic and continuous monitoring; checks and balances; and policies, procedures, and segregation of duties implemented to reduce the risk of error, fraud, waste, and abuse in the purchase card program.[83]

To assess oversight of the program and compliance with VA policy, the inspection team determined whether the healthcare system monitored purchase card training, implemented purchase card policies, assigned no more than 25 purchase card accounts to an approving official, maintained an approved VA Form 0242 for each cardholder in the inspection sample, maintained segregation of duties, and conducted reviews of cardholder transactions.[84] 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 official changes, cardholders change their legal names, or the single-purchase limit is changed from the originally requested amount.[85]

The inspection team determined that the healthcare system generally maintained copies and ensured the accuracy of these forms. However, one of the 22 cardholders in the inspection team's sample had an incorrect spending limit. This occurred because program coordinators did not adequately ensure US Bank data were updated when cardholder single-spending limits changed. The inspection team determined that the healthcare facility maintained segregation of duties in purchase card transactions and performed periodic reviews of the purchase card program.

Supporting Documentation

VA policy requires cardholders to upload and electronically store supporting documents for purchase card transactions to a VA-approved document-imaging system.[86] When healthcare system staff buy goods and services using a purchase card, they must maintain supporting documentation including approved purchase requests, vendor invoices, complete and accurate

[83] VA Financial Policy, "Government Purchase Card for Micro-Purchases."
[84] VA Financial Policy, "Government Purchase Card for Micro-Purchases."
[85] VA Financial Policy, "Administrative Actions for Government Purchase Cards."
[86] VA Financial Policy, "Government Purchase Card for Micro-Purchase."

purchase orders, and receiving reports for six years. This documentation verifies that purchase card transactions were properly approved and that payments were accurate. The inspection team identified transactions that were missing some required supporting documentation. Also, the team identified one sampled transaction that had incomplete supporting documentation: the purchase order did not include information such as the type of product and quantity ordered. Based on these results, the team projected those cardholders did not have sufficient supporting documentation for at least 4,400 transactions, which resulted in at least $4.4 million in questioned costs. These issues occurred because the healthcare system did not have controls designed to obtain packing slips, receiving reports, or proof of delivery from vendors that shipped items directly to patients. In addition, according to the prosthetics purchasing agent, increased workloads due to staffing shortages meant approving officials could not fully ensure cardholders retained sufficient documentation to support purchase card transactions.

Finding 2 Conclusion

Some of the sampled purchase card transactions were not supported by evidence of prior approvals and prompt reconciliations. Also, the healthcare system lacked proper supporting documentation for some of the sampled purchase card transactions. Based on the results of all areas reviewed, the team projected that the healthcare system had noncompliance errors in at least 6,800 purchase card transactions, totaling at least $6.7 million in questioned costs.[87] These issues could have been identified with more effective reviews by approving officials and with controls designed to obtain documentation from vendors.

Recommendation 3

The OIG made the following recommendation to the VA Augusta Health Care System director:

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

VA Management Comments

The director of the VA Augusta Health Care System concurred with recommendation 3. To address recommendation 3, the director reported that the healthcare system's fiscal service will provide training to all purchase cardholders by November 15, 2023, and annually thereafter, and

[87] When reporting on total errors combined, the OIG uses the lower-limit value of the one-sided 90 percent confidence interval as conservative estimates in place of the point estimates due to the low level of precision of the point estimates. Therefore, the individual questioned cost amounts of $4.4 million and $1.1 million do not add to $6.7 million.

on an as needed basis for new employees. The facility auditor will work with individual cardholders and will conduct monthly audits to ensure compliance of 90 percent or greater.

In August 2023, the acting chief of supply chain management authorized the use of micropurchases to maintain inventory levels required by VHA Directive 1761. Also, cardholders were required to follow the IFCAP Purchase Card Reconciliation User Manual to reconcile transactions. An approving official started reviewing weekly VISN 7 reports and working with cardholders to complete reconciliations. The approving official will perform monthly audits that the chief of supply chain management will review. The audits will continue until compliance is 90 percent or greater for six consecutive months. Additionally, approving officials will review transactions to ensure cardholders reconcile transactions within 14 days.

OIG Response

The healthcare system director’s action plan is responsive to the recommendation. The OIG will close the recommendation when it receives sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified.

III. Inventory and Supply Chain 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, delivery, 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.[88]

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 stores item information such as the description, vendor, unit price, and packaging for tracking. Inventory data, if properly recorded in the Generic Inventory Package, identify the quantity and dollar values of supply items in stock. Supplies are received at the warehouse and 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 Medical Surgical Prime Vendor (MSPV) and non-MSPV items that facilitates efficient purchasing and use of supplies. A conversion factor is required for all supply purchases and connects how a supply item is purchased and how it is issued—for example, cans of soda are purchased by the case but issued individually. A conversion factor is a number used to change the unit of receipt to the unit of issue. An incorrect conversion factor will cause an item to be over- or underordered and result in under- or overstock.[89] 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

[88] VHA Directive 1761, p. 11.

[89] VHA Supply Chain Desktop Training, "Conversion Factors," July 5, 2019.

larger dollar items in two primary inventory points and the contingency inventory point to assess accuracy.[90]

Finding 3: The Healthcare System Needs to Improve Oversight of Inventory and Accuracy of Inventory Data

The OIG found that the healthcare system could improve oversight by routinely using SCCOP data to help monitor stock levels and meet the inventory accuracy rate required by VHA policy.[91] In addition, the healthcare system could improve the effectiveness and efficiency of inventory management by ensuring inventory values are recorded correctly in the Generic Inventory Package. Specifically, healthcare system inventory managers failed to routinely monitor reported conversion factor errors and properly record supplies moving in and out of the three inventory points the team reviewed. 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. In addition, staffing shortages may have affected the ability of the healthcare system to conduct key supply chain management oversight, establish and follow internal controls, and achieve or maintain efficiency.

The inspection team also determined that a lack of local processes and procedures hindered the monitoring efforts needed to manage and reduce data integrity issues and to perform oversight of stock levels. These issues affected the healthcare system's ability to meet days-of-stock-on-hand performance metrics. The healthcare system could establish local processes and procedures for routinely monitoring inventory reports and implement a plan for staff training to increase awareness of internal controls to ensure all supply chain performance measures are maintained in compliance with VA policy. The 2022–2023 Workforce Plan reported that the primary drivers of the staffing shortage are the slow pace of hiring, the complicated onboarding process, noncompetitive salaries, limited supply of candidates, lack of qualified applicants, and competition from other healthcare systems and employers.[92] Failure to properly align systems, personnel, and processes across the supply chain can threaten the healthcare system's ability to effectively plan, mitigate issues, and budget for the purchase of supplies that meet patient care needs. The following topics are discussed: supply management oversight, conversion factors, and inventory adjustments.

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[90] VHA Directive 1761, pp. 38–71. The VA Pandemic Influenza Plan (March 2006) permits VA medical facilities to have medical supplies available/stored for future use in the case of a pandemic influenza outbreak, disaster, or emergency. Pandemic medical supplies must be maintained in a Generic Inventory Package primary inventory point designated by the naming standard ##CONTINGENCY or other VHA-approved inventory management system.

[91] VHA Directive 1761.

[92] The VHA annual workforce planning cycle uses submissions from VHA's 139 healthcare systems to identify staffing shortage occupations, current and future workforce challenges, and other workforce planning needs. "Overview of VHA Workforce Planning Cycle" (website), VHA Workforce Management & Consulting, accessed May 12, 2023, https://vssc.med.va.gov/VSSCMainApp. (This website is not publicly accessible.)

Supply Management Oversight

To avoid overstocking or understocking, VHA requires responsible staff to ensure correct reorder points and inventory levels are maintained.[93] VHA also requires the VISN chief logistics officer and healthcare system's chief supply chain officer to set up local processes and procedures to make sure all necessary reports are monitored routinely and all supply chain performance measures are maintained in compliance with performance criteria.[94] For VHA supply chain management, benchmarks and reports were published and tracked on SCCOP.[95] SCCOP reports assisted with this requirement by specifying a goal for the number of days of Medical Surgical Prime Vendor (MSPV) and non-MSPV stock a healthcare system should have on hand. From April through September 2022, the days-of-stock-on-hand goal for expendable items purchased through the MSPV program was to have 15 days or less stock on hand, and for non-MSPV items to have 30 days or less stock on hand.[96] The healthcare system did not meet this goal, and instead had an average of 109 days of stock on hand for MSPV items and 113 days for non-MSPV items.

In October 2022, VA changed this goal to 30 days of stock on hand for MSPV items and 45 days for non-MSPV items. From October 2022 through January 2023, the healthcare system again did not meet this goal and had an average of 80 days for MSPV items and 133 days for non-MSPV items.[97]

Table 2. Days of Stock on Hand

Purchase category	April through September 2022		October 2022 through January 2023	
	Benchmark (in days)	Monthly average (in days)	Benchmark (in days)	Monthly average (in days)
MSPV items	15	109	30	80
Non-MSPV items	30	113	45	133

Source: OIG analysis of MSPV and non-MSPV days of stock on hand cost information extracted from the Power BI Production SCCOP dashboard.

[93] VHA Directive 1761, p. D-2. The reorder point represents the level at which the item is to be replenished.

[94] VHA Directive 1761, p. A-3.

[95] VHA Directive 1761, p. A-3.

[96] Power Business Intelligence Supply Chain Common Operating Picture metrics and reports. 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. VHA Strategic Acquisition Center PowerPoint, MSPV-NG Program Overview, April 20, 2017.

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

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. Inventory managers said they were unaware of the updated days-of-stock-on-hand metrics, which became effective in October 2022. They explained that, ideally, Generic Inventory Package data should correctly reflect what is in the storerooms. However, it is hard to manage and maintain accurate records for medical surgical inventory points because they track large inventory point locations with too many hands involved, pulling and stocking items around the clock, without the ability to adjust what is in the system in real time. According to inventory personnel, they did not have time to routinely monitor performance metrics due to staffing shortages. This practice is inconsistent with VHA's requirement to monitor and review inventory points to ensure correct items and levels are maintained at least quarterly.

In addition, the chief and deputy supply chain officers stated that their healthcare system does not have local policies, procedures, or standard operating procedures for the management of inventory stock levels and inventory system data accuracy, including conversion factors and Generic Inventory Package adjustments, as required by VHA policy.[98] They also said that they rely on VHA Directive 1761 and VISN quality control reviews to guide their work.

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 inventory.[99] Any calculation error in the conversion factor causes inaccurate quantities and values in the system. Those errors can lead to increased reliance on manual inventory counts and ordering processes. Errors can also cause incorrect inventory values and quantities in the Generic Inventory Package, which require manual adjustments. 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, 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

[98] VHA Directive 1761, p. A-3.

[99] A conversion factor is a number used to convert a measured quantity to a different unit of measure without changing the relative amount. In the Generic Inventory Package, a conversion factor is a number used to change the unit of receipt to the unit of issue.

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 dashboard to review the healthcare system's conversion factor report 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.[100] According to SCCOP data, as of February 28, 2023, 1,321 of 25,344 supply items, or 5 percent, had potential conversion factor errors. Inventory personnel said a contributing factor was that they did not routinely monitor the accuracy of conversion factors due to a staffing shortage. The healthcare system also reported a lack of local inventory management policies and procedures for training supply chain management staff. Inventory managers said they received only on-the-job-training. While there were mandatory training classes on a VA website, the healthcare system lacked a structured training program and written policy for specific inventory tasks, such as the process for calculating conversion factors and for dealing with expired or spoiled items.[101]

Inventory Adjustments

The team analyzed the SCCOP adjustments report for the 90 days prior to February 13, 2023, to determine the number of adjustments for all inventory points made at the healthcare system, and the associated value for those adjustments.[102] The report shows positive and negative adjustments in the Generic Inventory Package to correct inventory points. Adjustments are made for a variety of reasons, such as items not needed, incorrect supply levels, or costing errors. According to the report, healthcare system staff made almost 118 adjustments affecting over 5,812 items totaling about $601,317. There was one adjustment affecting 600 items totaling over $493,000 in the medical surgical inventory point. According to a continuous readiness coordinator at the healthcare system, this adjustment was made for catheter needles that were received and brought into the medical surgical primary inventory point. The catheters were then moved to a secondary location, but this movement was not recorded in the Generic Inventory Package. Therefore, the healthcare system made a manual adjustment. The inspection team also determined that, since its on-site visit, healthcare system staff made an additional manual adjustment totaling about $2.1 million due to a cost error.

Conversion factor errors can lead to adjustments in the Generic Inventory Package. Of the 10,705 supply items in the medical surgical inventory point, 690 items, or 6 percent, had a "false" conversion factor. The team asked the supply chain management team questions about

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[100] The Conversion Factor Primary Inventory Point report was accessed by the inspection team on February 28, 2023, from the SCCOP dashboard; this report details point-in-time conversion factor data at the healthcare system.

[101] VA's Talent Management System is a web-based training site where VHA staff access various job-related training courses.

[102] The full name is the SCCOP GIP [Generic Inventory Package] Adjustments Report.

the accuracy of the value and quantities as shown on the days-of-stock-on-hand report. Based on interview responses and analysis of SCCOP reports 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.

Warehouse Conditions

Storeroom inventory points are designed to promote cleanliness, visibility, safety, and efficiency of distribution. The inventory in these areas needs to be monitored routinely for proper storage conditions, accuracy of inventory balances, and items that are expired, outdated, damaged, or obsolete.VA policy addresses these requirements, which include the cleanliness of VA warehouses, barcode use on stored items, and proper temperature and other environmental conditions to prevent damage to items.[103] The inspection team toured three warehouses and observed improper warehouse conditions, including clutter, lack of barcodes, items stored directly on the floor instead of the requirement to be at least eight inches off the floor, items stored in shipping containers without temperature controls, and items stored close to lighting fixtures that could melt the plastic wrap around the items. These warehouse conditions increase the risk of items being lost, damaged, or degraded while in storage. Further, these conditions impeded the inspection team's tour of the warehouses and ability to locate and count a large number of items related to the contingency inventory point.

Inventory Data Accuracy

During the physical counts in three inventory storage areas, the inspection team found additional discrepancies between what was reported in the Generic Inventory Package and what was physically located at the inventory point. The team counted some larger dollar items at the medical surgical primary inventory point, the operating room primary inventory point, and the contingency inventory point. For the items reviewed by the team, the Generic Inventory Package records were overstated for 38,791 items (about 99 percent) totaling over $2.1 million (almost 64 percent). According to VHA policy, at least quarterly, inventory managers and functional area employees must review inventory points to ensure correct items and levels are maintained in the Generic Inventory Package.[104]

Table 3 shows the discrepancies between what was reported in the Generic Inventory Package and what was counted in the warehouses and storerooms, as of February 28, 2023.

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[103] VHA Directive 1761, p. F-3.

[104] VHA Directive 1761.

Table 3. Discrepancies between Generic Inventory Package Records and the OIG Team's Physical Counts

Inventory Point	Generic Inventory Package		Physical Count		Difference	
	Quantity	Amount	Quantity*	Amount	Quantity	Amount
Medical surgical	3,729	$2,462,746	332	$209,108	-3,397	$-2,253,638
Operating room	59	$815,795	75	$998,441	16	$182,646
Contingency	35,457	$75,330	47	$3,614	-35,410	$-71,717
Total	**39,245**	**$3,353,872**	**454**	**$1,211,163**	**-38,791**	**$-2,142,709**

Source: VA OIG analysis of SCCOP and physical count data.

Note: The total does not sum due to rounding.

Medical Surgical Primary Inventory Point

The OIG team found that the on-hand quantity of selected items in the medical surgical primary inventory point was overstated in the Generic Inventory Package by about 3,400 items, totaling almost $2.3 million. The team selected six inventory items in this location and found that on-hand quantities for two stock items were higher than the quantities reported in the Generic Inventory Package, two other items were lower than the inventory numbers reported in the Generic Inventory Package, and another two were "pass-through" items that were taken to secondary inventory points, and they could not be counted. An inventory manager told the team he forgot to adjust the Generic Inventory Package records to reflect that the "pass-through" items had been taken to secondary inventory points.

Operating Room Inventory Point

The team's count of six selected inventory items in the operating room inventory point determined that the Generic Inventory Package understated inventory by about 20 boxes of items, totaling almost $183,000. The team found that the physical counts matched the Generic Inventory Package records for three inventory items. Two of the six items were higher than the Generic Inventory Package amounts, and one item was under the Generic Inventory Package amount. The team also determined that the Generic Inventory Package reported that no unilateral dissecting balloons were in stock but a supply of them was incorrectly valued at about $90,000. As stated previously, healthcare system inventory managers failed to routinely record supplies moving in and out of the inventory points reviewed by the inspection team. Therefore, it is possible that the unilateral dissecting balloons were recorded in the Generic Inventory Package

when received, but not removed from the Generic Inventory Package when they were used, excessed, or expired. The inventory manager could not tell the inspection team why this occurred.

Contingency Inventory Point

The team's count of six selected inventory items in the contingency inventory point determined that the Generic Inventory Package overstated inventory by about 35,400 items, totaling almost $71,700. For one of the six inventory items, the team determined that 159 cases of gloves were missing, totaling about $14,000.[105] According to the team's count, the correct quantity should have been 41 cases of gloves for a total of $3,600. The inventory manager could not tell the inspection team when the gloves were removed, where they went, or who took them out of the warehouse.

For one of the six inventory items (surgical masks), the Generic Inventory Package data showed about 9,400 cases of masks. However, the team counted about six cases of masks on hand.[106] After searching through multiple storage areas, the team found some of the masks in a cluttered warehouse space, spread across multiple boxes, and without any barcodes. A supervisory supply technician explained that she believed the missing 9,354 cases were stored in one of the many containers located outside of the warehouse. The team tried to access the containers but could not because boxes stored in the front of the container blocked access to boxes in the back of the container. Also, the containers were situated on a sloping hill that prevented a forklift from entering them to aid the team's search. The team did not determine the quantity of items in the containers but did observe boxes of expired goods in the front row of one container, and rows of boxes that were stacked several columns deep in another container.

According to supply chain management personnel, there was no recent order history for four of six inventory items, and these items could not be found in the contingency inventory point. The chief supply chain officer explained that at the start of the COVID-19 pandemic, the VA Augusta Health Care System was chosen as the central storage and distribution site for VISN 7 personal protective equipment. Some orders made by VHA and the VISN were shipped to the Augusta warehouse, which lacked records for them. The healthcare system's role as a central distribution point for personal protective equipment, along with the volume of items received, caused storage space to fill up quickly. This condition reduced the space available to store regularly stocked items necessary for the continued replenishment and sustainment of operations.

[105] According to SCCOP data, each of these cases contained 2,000 pairs of gloves. Power BI Production SCCOP Dashboard, "*Primary Conversion Factor Generic Inventory Item Details,*" accessed February 28, 2023.

[106] Power BI Production SCCOP Dashboard.

Finding 3 Conclusion

The healthcare system has generally provided oversight of the expendable supplies to avoid shortages and ensure that patient needs are met. However, the healthcare system could improve efficiency by creating and documenting local processes and improving the accuracy of inventory quantities and values in the Generic Inventory Package. VHA policy states that it is essential that Generic Inventory Package information be complete and accurate.[107] 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.

Recommendations 4–5

The OIG made the following recommendations to the VA Augusta Health Care System director:

4. Develop and implement processes to ensure all necessary reports are monitored routinely and appropriate steps are taken to ensure all supply chain performance measures are maintained in compliance with policy.
5. Develop and implement a plan to ensure data accuracy and reliability in the Generic Inventory Package in accordance with Veterans Health Administration policy.

VA Management Comments

The director of the VA Augusta Health Care System concurred with recommendations 4 and 5. To address recommendation 4, the director reported that the chief of supply chain management will develop a local standard operating procedure to ensure compliance with VHA Directive 1761 and local procedures for reviewing all Power BI Supply Chain Common Operating Picture (SCCOP) performance metrics. These metrics are reviewed at weekly supply chain management operations meetings, where each section chief reports on their metrics and the actions taken to meet established goals. Additionally, the inventory management specialist will be trained to review for inaccuracies. The supervisor and supply and distribution section chief will monitor compliance and meet with the inventory management specialist to discuss and ensure they are complying.

For recommendation 5, a training plan aligned with VHA Directive 1761 will be developed for each supply chain management expendable employee. The training will provide employees with VA, VISN and local policies directives, handbooks, and standard operating procedures on logistics management. The training will also provide instruction on the item master file, the Generic Inventory Package, maintaining stock levels, and generating reports for better oversight

[107] VHA Directive 1761, p. B-1.

of days of stock on hand. Each supervisor will be responsible for reviewing Power BI SCCOP data for their areas and the logistics management specialist will conduct reviews for data inaccuracies and ensure reconciliation as warranted.

OIG Response

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

IV. Pharmacy Operations

In FY 2022, prescription drug spending at the VA Augusta Health Care System was almost $64 million, which represented just under 10 percent of the healthcare system's budget of about $662 million.[108] Because pharmacy accounts for a substantial percentage of any medical center's budget, medical center leaders need to analyze spending and identify opportunities to use pharmacy dollars more efficiently. The inspection team used the pharmacy expenditure model in the OPES efficiency opportunity grid to identify such opportunities.

The team reviewed the following pharmacy areas:

- **OPES pharmacy expenditure data** help VHA facilities track cost performance and identify potential opportunities for improvement.
- **Inventory turnover rate** is the number of times inventory is used during the year and is the primary measure to monitor the effectiveness of inventory management per VHA policy.[109] Low inventory turnover rates indicate inefficient use of financial resources.
- **The B09 reconciliation process** can help VA medical center pharmacies ensure they are making correct payments for the drugs they receive.[110] It is necessary because medical centers make payments to the prime vendor before receiving the pharmaceuticals. Without this reconciliation process there is no assurance that the amount paid to the prime vendor is consistent with the amount of goods received. These reports are prepared monthly to reconcile pharmaceuticals purchased and ordered with pharmaceuticals that are invoiced and received at the facility. A memorandum and supporting documentation are provided to the finance service for review and concurrence. The results of the reviewed reconciliation are to be returned and retained with the pharmacy service, and any identified discrepancies are to be corrected in a timely manner.

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[108] Office of Productivity, Efficiency & Staffing, "FY 2023 Pharmacy Expenditure Model (based on FY 2022 data)," accessed March 16, 2023. Office of Productivity, Efficiency, and Staffing, https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?/MgmtReports/OPES/EOG_Model&rs:Command=Render&rc:Parameters=true&Model=pharm1&VISN=0 (This website is not publicly accessible.)

[109] Pharmacy Informatics Workgroup Training Presentation, "Annual Wall to Wall Physical Inventory," p 11. Inventory turnover rates are based on the previous 12 months of purchases divided by the inventory on hand.

[110] VHA Directive 1108.07, November 28, 2022. The Fiscal B09 report is reviewed and reconciled with VA Form 1358s to ensure that the pharmacy is making correct payments for what is received and there is documented evidence (signature and date of review) that the B09 reconciliation has been completed. VHA Office of Finance, Financial Management & Accounting Systems Alert, "Pharmacy Prime Vendors B09 Reconciliation Standard Operating Procedures", October 3, 2012. The Pharmacy Service will prepare a monthly B09 reconciliation package with a memorandum and supporting documentation (i.e., Invoices, B09 Report, McKesson Reports) to provide the reconciliation results to Finance service.

Finding 4: The Healthcare System Could Improve Pharmacy Efficiency and Strengthen Oversight Controls

The OIG found the healthcare system could improve pharmacy efficiency by reducing the difference between observed and expected drug costs, increasing inventory turnover closer to the VHA-recommended level, and ensuring completion of the B09 reconciliation process in accordance with policy. Failure to properly manage pharmacy operations can lead to increased replenishment costs, overstocking, spoilage, and diversion of drugs and decrease the funding available to meet other healthcare system and patient care needs.

OPES Pharmacy Expenditure Data

The OPES pharmacy expenditure model, which identifies variations in pharmacy costs among VHA facilities, showed that the healthcare system had about $64 million in drug costs in FY 2022. According to the model, this amount was almost $5 million higher than the expected costs of about $59 million. On that basis, the healthcare system's observed-minus-expected ratio was about 1.08, which ranked it 107th out of 139 VHA facilities for pharmacy drug cost efficiency.[111]

According to the OPES model, for FY 2020 through FY 2022, the healthcare system demonstrated decreasing efficiency. In FY 2020 the healthcare system's observed drug costs were almost $2.8 million more than expected, in FY 2021, the observed drug costs exceeded the expected amount by about $3.8 million and in FY 2022 were over $5 million higher than expected.

Figure 3 shows the increase in the observed-minus-expected costs for the healthcare system.

[111] The OPES pharmacy expenditure model uses the terms "observed minus expected" and "potential opportunity" to describe the gap between a healthcare system's actual drug costs and expected drug costs. This difference represents the amount associated with potential efficiency improvements. An observed-minus-expected ratio above 1.0 indicates that a facility may have opportunities to reduce its pharmacy costs.

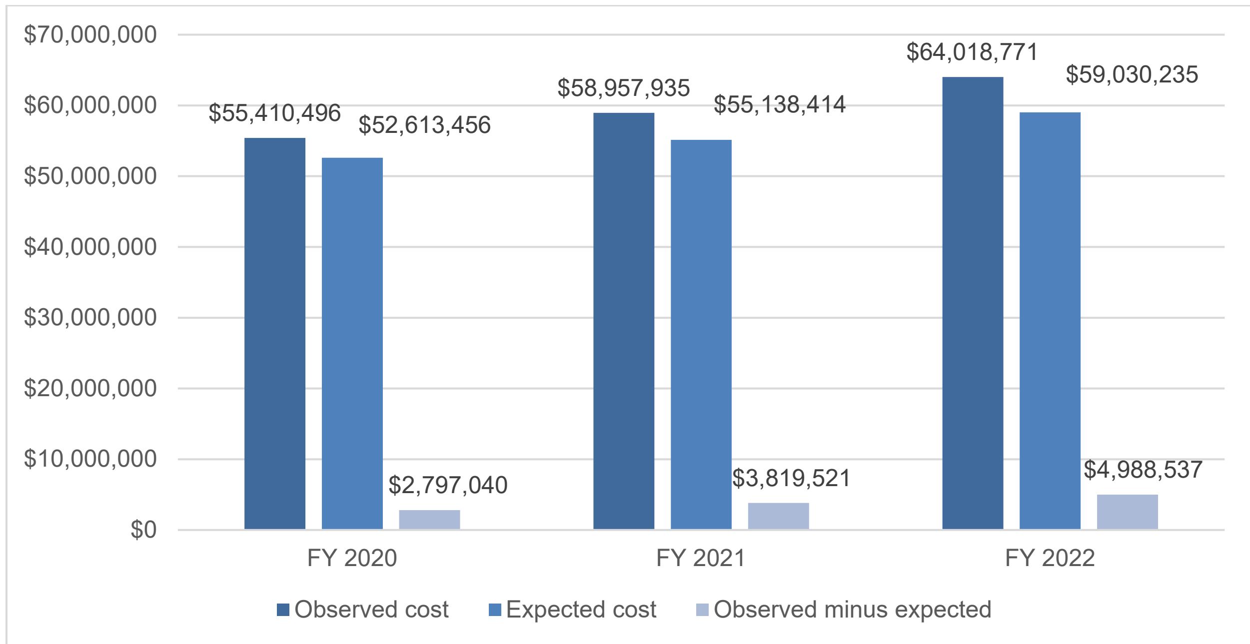

Figure 3. *Observed-minus-expected drug costs, FY 2020 through FY 2022.*
Source: OPES pharmacy expenditure model.
Note: The OPES data models are based on the previous fiscal year data (i.e., the FY 2022 data model was based on FY 2021 data).

According to the pharmacy chief, the pharmacy service did not routinely monitor the OPES pharmacy model and use that information to identify and act on potential savings opportunities. The pharmacy chief said she had become familiar with OPES but did not find it user-friendly. Another pharmacy staff member spoke of not being able to access the OPES model and related reports to review the pharmacy model.

The chief of pharmacy and staff attributed spending increases to a shortage of drugs that were unavailable from the pharmaceutical prime vendor because the preferred items were unavailable from suppliers. This was a nationwide issue during the COVID-19 surge and was not unique to the healthcare system. Additionally, community prescriptions that come to pharmacy, often for high cost, and specialized therapies are a negative contributor to the overall efficiency. Pharmacy leaders at the healthcare system also said that spending increased because of the high cost of specialty drugs prescribed by community care providers to treat specific conditions. According to OPES, the healthcare system potentially missed opportunities to reduce spending on drugs from FY 2020 through FY 2022.[112]

[112] See VA technical comment 7 on page 71/80.

Inventory Turnover Rate

VHA policy states that inventory turnover is the primary measure of the effectiveness of inventory management.[113] Furthermore, VHA adopted ABC classification principles to increase accountability for inventory management and establish more rigorous requirements for managing high-dollar-usage inventory items. This method is based on annual inventory usage, in dollars, of all items at a specific inventory point. To establish ABC categories, items are ranked from highest dollar amount of usage to lowest. Items with the highest 80 percent of annual usage are classified as "A" items; the next highest 10 percent are classified as "B" items; and the remaining 10 percent are classified as "C" items.[114]

The VA Pharmacy Benefits Management office recommended an annual inventory turnover goal of 12 to 16 times for items classified as "A" and six to 10 times for "B" and "C" items.[115] Higher inventory turnover rates are associated with decreased inventory carrying cost, the cost associated with holding inventory in storage. On the other hand, low inventory turnover could indicate the inefficient use of financial resources and the inability to properly forecast the amount of pharmacy drugs needed to meet patient care needs.

The healthcare system did not meet all the established Pharmacy Benefits Management program office targets. In November 2022, the pharmacy prime vendor reported an inventory turnover rate of 7.53 times for "A" items, 5.52 times for "B" items, and 3.0 times for "C" items. However, when healthcare system staff completed a wall-to-wall inventory in February 2023, they calculated an inventory turnover rate of 13 times. The pharmacy staff said they did not understand why the prime vendor reported lower rates, but they are working with the prime vendor to understand and resolve the issue.

VHA policy also mandates the use of prime vendor inventory management reports for all VA pharmacy inventories.[116] However, the inspection team determined that the healthcare system did not use the prime vendor's software or any other inventory management software to manage inpatient pharmacy drug inventories in accordance with VHA policy.[117] Instead of using handheld barcode readers, the healthcare system managed the inventory by "walking the shelves" and observing the amount of stock on hand. Pharmacy officials stated that they were unable to use handheld scanners due to issues with wireless connectivity. Specifically, the

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[113] VHA Directive 1761, app. H.

[114] VHA Directive 1761, app. E. *Supply Chain Management Operations,* December 30, 2020. VHA has adopted ABC classification principles for inventory management. The formula for calculating the annual usage dollars of an item is the annual usage quantity multiplied by the average unit price.

[115] VHA Pharmacy Benefits Management office, email message to the VA OIG Office of Financial Inspection, February 2023; VHA Directive 1761, app. E.

[116] VHA Directive 1761.

[117] VHA Directive 1761.

structure of the building prevents Wi-Fi or hot spot connectivity for the readers to function properly.[118]

Additional challenges were reported by a procurement technician in outpatient pharmacy regarding the use of the ScriptPro information management system.[119] The healthcare system implemented the system about two years ago for outpatient pharmacy services. Due to a lack of training, pharmacy staff did not know how to use the system. Instead, pharmacy staff reported that they have had to manually count the pharmaceuticals to determine the quantity of drugs on hand.

B09 Reconciliation Process

VHA policy requires a review of the B09 report and reconciliation of that report with VA Form 1358 and other supporting documentation. This is to ensure that the pharmacy is making correct payments for received items and that there is documented evidence, such as signature and date of review, that the transaction has been completed. The report is generated weekly and is a summary of multiple invoices. VHA policy requires reconciliation of billing statements; verification that items ordered were received; and certification of accuracy including maintaining supporting documentation such as receipts, invoices, and packing slips. The pharmacy service must provide a monthly report, with adequate documentation, to the chief of the finance service stating the 1358 forms and B09 reports were reconciled and noting any unresolved discrepancies. VHA policy also states that the pharmacy must maintain separation of duties so that a pharmacy staff member who places an order (creates the VA Form 1358) cannot also receive that order or any others placed using that form.[120]

The team found that the healthcare system's B09 reconciliation process did not fully comply with VHA policy. The OIG found that pharmacy service staff were only sending the required memorandum and reconciliation spreadsheets and did not always supply other supporting documentation, such as invoices, to the finance service. Pharmacy staff said they were not aware of this noncompliance with VA policy. B09 reconciliations are necessary because payments are made to the prime vendor before the pharmaceuticals are received. Without this documentation, the finance service could not complete the full reconciliation as required. The healthcare system reported that pharmacy leaders will familiarize themselves with and disseminate the necessary policy requirements to ensure reconciliations are completed.

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[118] A "hot spot" is an area where wireless Internet connection is available. *Merriam-Webster*, "hot spot," accessed February 28, 2023, https://www.merriam-webster.com/dictionary/hot%20spot.

[119] VA, "ScriptPro" (web page), VA Enterprise Architecture Repository, accessed June 8, 2023, https://vaww.vear.ea.oit.va.gov/#system_and_application_domain_defs_system_23537.htm. The "ScriptPro workflow system provides real-time inventory tracking, order generation, electronic transmission, and inventory receiving for outpatient pharmacies."

[120] VHA Directive 1108.07.

Finding 4 Conclusion

The healthcare system could improve pharmacy efficiency by narrowing the gap between observed and expected drug costs and by increasing its inventory turnover to meet the VHA-recommended level. The healthcare system could further improve efficiency by submitting monthly B09 reconciliation supporting documents to the finance service and correcting any discrepancies appropriately. An efficient healthcare system anticipates drug costs, knows when inventory needs to be restocked, makes the best use of appropriated funds, and has inventory when needed.

Recommendations 6–9

The OIG made the following recommendations to the VA Augusta Health Care System director:

6. Develop formalized processes for monitoring and achieving efficiency targets and using available pharmacy data to make business decisions.
7. Develop and implement a plan to achieve an inventory turnover rate closer to the Veterans Health Administration's recommended level.
8. Ensure that pharmacy staff are trained on the ScriptPro workflow system for pharmacy.
9. Establish processes to ensure compliance with the Veterans Health Administration directive to complete the B09 reconciliation process.

VA Management Comments

The director concurred with recommendations 6 through 9. In response to recommendation 6, the director noted that the COVID-19 pandemic affected the variables used by the OPES model, which contributed to the observed reduced efficiency targets. The director said that the pharmacy service is committed to safe and effective medication use and would improve cost and efficiency through a focused effort on reducing the use of partial fills at the outpatient window and will also use less branded medications when generics are available.

For recommendation 7, the director said that the OIG noted concerns about the accuracy of the McKesson inventory turn rates from its experience in prior financial inspections, and he said that this concern was also evident in this inspection. Due to concerns with accuracy, the facility does not consider the McKesson report above the annual wall-to-wall inventory report, which is required and validated. Pharmacy leaders and procurement staff will review quarterly reports in depth and work with the McKesson representative to reconcile the differences.

For recommendation 8, the director said that all operations staff were trained on the workflow system approximately two years ago and that the healthcare system will also conduct a training for all operations staff before December 25, 2023, to ensure 100 percent compliance with training. Operations section supervisors will be asked to verify that this is a part of the

orientation process and included in the position check list. Annual refresher training will be offered during a departmental staff meeting, starting in March 2024.

The director requested closure for recommendation 9, and reported that since September 2023, reconciliation memos included a link to all supporting documents which the procurement staff has uploaded. This electronic access will help the centralized accounting staff complete the reconciliation process and help ensure compliance with the B09 reconciliation process.

The healthcare system provided technical comments that the OPES model statement, which says that community care patients are a positive independent variable which decrease a facility's expected cost, has not been proven accurate. The technical comments also stated that because OPES model results are based on prior fiscal year data, the 80 back-ordered items discussed in the report are not reflected in the current year's OPES results, which diminishes the value of the expected pharmacy costs in the model.

OIG Response

The healthcare system director's action plans are responsive to recommendations 6 through 8. The OIG will monitor implementation of the planned actions and will close the recommendations when it receives sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified.

While the director requested closure of recommendation 9, the OIG did not receive any evidence or supporting documentation of the agreement or other actions to evaluate and considers the recommendation open.

The OIG agreed with technical comment 7 and incorporated requested clarifying information in the report text and footnote where appropriate.[121]

[121] VA's technical comments are in appendix E.

Appendix A: Healthcare System Profile

Healthcare System Profile

Table A.1 provides general background information for the VA Augusta Health Care System, a level 1b-high-complexity facility reporting to Veterans Integrated Service Network (VISN) 7.[122]

Table A.1. Profile for the VA Augusta Health Care System, October 1, 2020, through September 30, 2022

Profile element	FY 2020	FY 2021	FY 2022
Total medical care budget in dollars	$ 581,830,488	$644,436,119	$662,236,864
Number of: • Unique patients	46,021	48,578	49,102
• Outpatient visits	546,835	629,896	623,468
• Total medical care full-time equivalent staff	2,467.3	2,591.7	2,548.5
Type and number of operating beds: • Hospital	215	204	204
• Domiciliary	60	60	60
• Community living center	132	132	132
Average daily census: • Hospital	113	107	104
• Domiciliary	35	25	39
• Community living center	78	51	50

Source: VA, "Trip Pack Operational Statistics Table" (web page), VHA Support Service Center, accessed January 2, 2023, https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?%2fMgmtReports%2fPocketCard%2fTripPack_OperationalStatisticsTable&rs:Command=Render. (This is an internal VA website not publicly accessible.)

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

According to VHA Support Service Center data, the healthcare system's medical care budget increased by about $80.4 million (about 13.8 percent) between fiscal year (FY) 2020 and FY 2022. At the same time, the number of unique patients increased by approximately 3,100 (about 6.7 percent). According to the chief financial officer, during this period the healthcare system experienced large fluctuations in several budget categories. The chief financial

[122] The Facility Complexity Model classifies VHA facilities at levels 1a, 1b, 1c, 2, or 3, with level 1a being the most complex and level 3 being the least complex.

officer provided the team with a breakdown of the budget changes in 14 categories. The document showed that the categories with the largest increases included care in the community (almost $39.9 million), salaries (over $39.8 million), nonrecurring maintenance (almost $25.5 million), prosthetics (over $9.9 million), and equipment (over $11.2 million). There was also a reduction in the COVID-19 budget (over $48.2 million) and miscellaneous general purpose funds for general patient care (almost $11.8 million). Various other categories with smaller dollar amount changes represented about $14.1. million in budget decreases.

The chief financial officer explained that care in the community costs increased significantly due to increased referrals for pain management, gastroenterology, and complementary and integrative health. Also, a major increase in the number of veterans serviced at the nursing home led to higher per diem and medication costs. The budget increase for salaries, which was about 14.2 percent over the two-year period, was due to staffing increases, promotions, within-grade increases, relocation, retention and recruitment incentives, and lump sum retirement leave payouts. According to the chief, the budget amounts for nonrecurring maintenance and equipment are approved by the VISN, not the healthcare system, and these amounts can fluctuate from year to year.

Appendix B: Scope and Methodology

Scope

The team conducted its inspection of the VA Augusta Health Care System from January 2023 to September 2023, including a site visit during the week of February 27, 2023. The inspection was limited in scope and is not intended to be a comprehensive inspection of all financial operations at the VA Augusta Health Care System.

Methodology

The inspection team evaluated financial efficiency practices for July through December 2022 for accrued expense oversight, December 2021 through November 2022 for purchase card use, and April 2022 through January 2023 for supply and inventory management. The team also analyzed financial efficiency practices related to the healthcare system's pharmacy costs using the FY 2023 Office of Productivity, Efficiency and Staffing (OPES) efficiency opportunity grid model; however, the FY 2023 data model was based on FY 2022 data from the Financial Management System (FMS).

To conduct the review, the team

- interviewed healthcare system leaders and staff,
- identified and reviewed applicable laws, regulations, VA policies, operating procedures, and guidelines related to managing open obligations, overseeing purchase card transactions, calculating days of stock on hand, and addressing inefficiencies in pharmacy costs,
- evaluated a judgmental sample of 10 open obligations to determine whether the healthcare system reconciled end dates between FMS and IFCAP for sampled obligations, and
- statistically sampled
    - 22 obligations with 23 outstanding accrual balances to assess whether the healthcare system identified and reviewed the accruals to determine whether they were still valid and needed to remain open in accordance with VA financial policy, and
    - 85 purchase card transactions to determine whether 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 Augusta Health Care System significant to the inspection objective. This assessment considered the five internal control components in the Government Accountability Office's *Standards for Internal Control in the Federal Government*, along with the related principles contained in each component. The five internal control components are control environment, risk assessment, control activities, information and communication, and monitoring.[123] The team identified internal control weaknesses in all four protocols assessed—accrued expense oversight, purchase card use, inventory and supply chain management, and pharmacy operations—and made recommendations to address the control deficiencies.

Fraud Assessment

The inspection team exercised due diligence in staying alert for the risk that fraud and noncompliance with provisions of laws, regulations, contracts, and grant agreements, significant in 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, the OPES efficiency opportunity grid, and the Supply Chain Common Operating Picture (SCCOP) dashboard. To test for reliability, the team determined whether any data were missing from key fields, included any calculation errors, or were outside the time frame requested. The 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/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 team found that summary data were sufficiently reliable for reporting on the healthcare system's open obligations.

[123] Government Accountability Office, *Standards for Internal Control in the Federal Government*, GAO-14-704G, September 2014.

Government Standards

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

Appendix C: Statistical Sampling Methodology

Accrued Expense Oversight

The team evaluated a statistical sample of outstanding accruals as of December 15, 2022, to determine whether the VA Augusta Health Care System performed monthly reviews and reconciliations to ensure the accruals were valid and should remain open. The team also evaluated a judgmental sample of open obligations as of December 6, 2022, to determine whether the healthcare system reconciled end dates between the Financial Management System (FMS) and Integrated Funds Distribution, Control Point Activity, Accounting and Procurement (IFCAP) for sampled obligations.

Population

During December 2022, the healthcare system had 234 outstanding accruals, totaling almost $8.7 million. Of the 234 accruals, 178, totaling close to $8.2 million, were more than 60 days old. From July through December 2022, there were 44 open obligations with end-date discrepancies between FMS and IFCAP for three or more months.

Sampling Design

The inspection team selected:

- **Outstanding accruals.** The team used a method of unequal probability selection where the probability of selection was based on the number of days open greater than or equal to 60 days and the associated outstanding balance. The sampling design resulted in the review of 22 obligations with 23 outstanding accrued expenses from the December 2022 FMS F851 report and allowed the inspection team to project its findings from the sample to the population. This report lists each accrual and its remaining balance. The sample included 19 obligations with accrued expenses for services and three obligations with four accrued expenses for goods.
- **FMS–to–Integrated Funds Distribution, Control Point Activity, Accounting and Procurement (IFCAP) reconciliations.** The team judgmentally selected 10 obligations with different end dates between FMS and IFCAP from VA's FMS-to-IFCAP reconciliation reports for December 2022.

The samples included 33 sampled transactions: 22 obligations with 23 outstanding accruals, totaling about $4.2 million; and 10 open obligations with different end dates between FMS and IFCAP, totaling about $14.1 million.

The team requested supporting documentation for each of the 33 sampled transactions, including monthly reviews and reconciliations, financial system screen prints and reports, and emails related to the obligations.

Purchase Cards

The inspection team evaluated a statistical sample of purchase card transactions that occurred from December 1, 2021, through November 30, 2022, to determine whether the VA Augusta Health Care System reviewed transactions to (1) ensure they were adequately monitored, approved, and supported by documentation, (2) prevent split purchases and transactions exceeding the cardholder's authorized single-purchase limit, and (3) ensure goods or services were procured using strategic sourcing.

Population

From December 1, 2021, through November 30, 2022, the healthcare system had approximately 55,000 purchase card transactions which totaled just under $50.6 million. The inspection team removed negative purchase card transaction amounts from the total population of transactions and obtained a population of almost 53,800 transactions totaling over $51.3 million.[124] From this population, the team developed three strata from which to draw statistical samples. The first stratum included potential split transactions that exceeded the micropurchase threshold in the aggregate but not individually. The stratum included a total of 77 bundles of transactions comprised of about 710 individual transactions. The second stratum included potential split transactions that exceeded a cardholder's single-purchase limit and were less than the micropurchase threshold. This stratum included about 230 bundles consisting of approximately 1,500 transactions. The third stratum included the remaining purchase transactions, approximately 51,500 transactions greater than or equal to $0 that were not included in the prior two strata.

Sampling Design

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

- **Potential split purchases exceeded micropurchase threshold.** The team identified potential split purchases as transactions with the same purchase date, purchase card number, and merchant and a sum greater than the micropurchase threshold. The statistical

[124] The inspection team pulled a statistical sample from positive dollar amount transactions (negative transactions such as refunds were excluded).

sample consisted of 12 bundles of potential split purchases that included 75 transactions. The team selected 34 transactions for review.

- **Potential splits exceeded single-purchase limit.** The team identified potential split purchases as transactions with the same purchase date, purchase card number, and merchant and an aggregate sum greater than the cardholder's authorized single-purchase limit but less than the micropurchase threshold. The statistical sample consisted of 12 bundles of potential split purchases that included 57 transactions. The team selected 31 transactions for review.
- **Other purchases.** The team selected 20 transactions greater than or equal to $0 after all potential split purchases were identified.

The statistical samples included 85 total individual transactions: 65 potential split purchase transactions, totaling approximately $389,000 and 20 other purchase transactions, totaling approximately $85,400.

To review the transactions selected in the sample, the team requested supporting documentation for each of the 85 transactions, VA Forms 0242 for all 22 cardholders associated with the selected transactions, and documentation to support the completion of purchase card reviews.

Weights

Samples were weighted to represent the population from which they were drawn, and the weights were used in the estimate calculations. For example, the team calculated the error rate estimates by first summing the sampling weights for all sample records that contained the given error, then dividing that value by the sum of the weights for all sample records.

Projections and Margins of Error

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

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

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

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

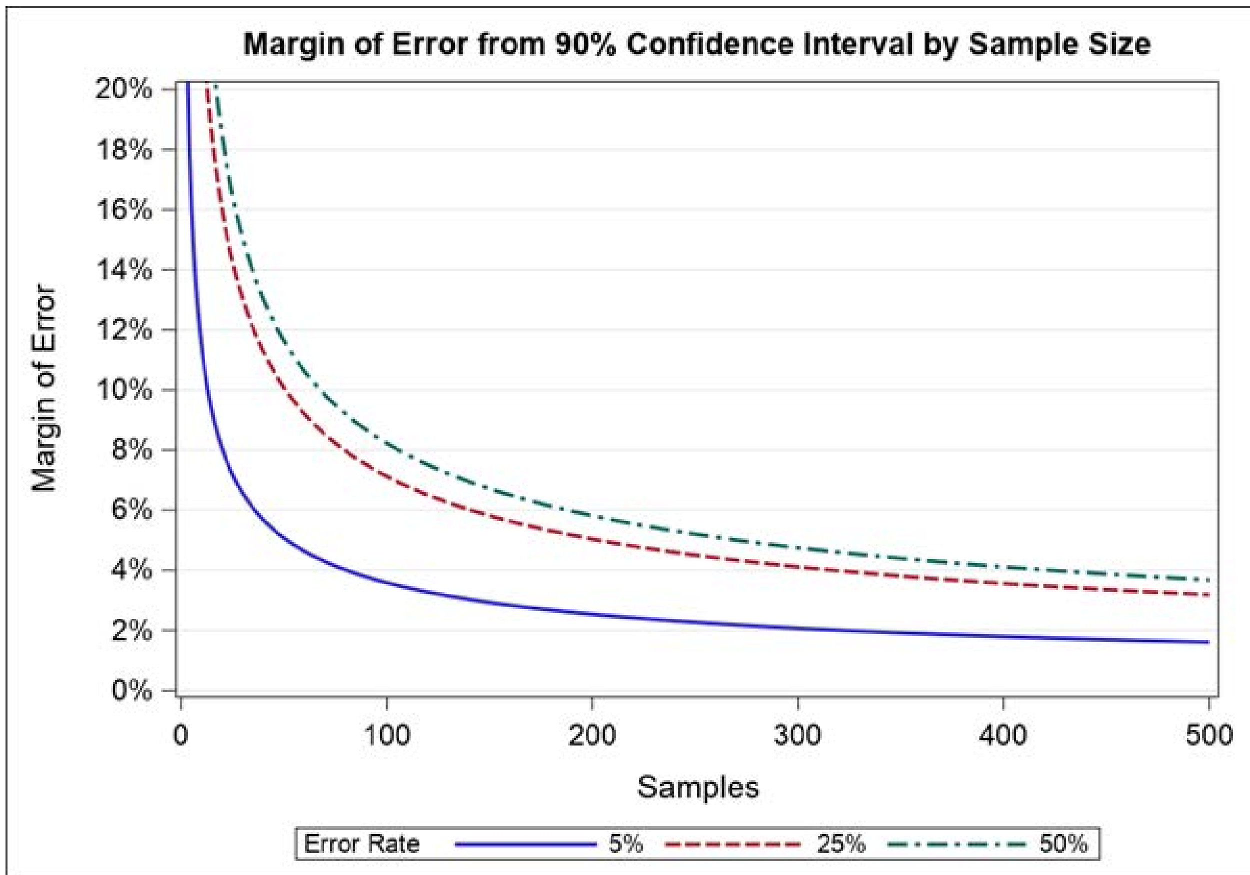

Figure C.1. *Effect of sample size on margin of error.*
Source: OIG statistician's analysis.

Projections

Accrued Expense Oversight

The team reviewed a statistical sample from a population of about 178 obligations with accrual balances totaling close to $8.2 million. Based on the results, the team projected that 101 obligations totaling an estimated $4.6 million were not deobligated in accordance with VA policy.

Tables C.1 and C.2 show statistical projections of accrual errors and the associated dollar amounts.

Table C.1. Statistical Projections for Accrual Errors

Estimate name	Estimate	90 percent confidence interval			Sample size
		Margin of error	Lower limit	Upper limit	
Overall errors (count)	101	32	68	133	13
Overall errors (percent)	57%	18%	38%	75%	13

Source: VA OIG statistician's analysis and team's review of obligations with accrual balances.

Table C.2. Statistical Projections for Accrual Errors: Dollar Amounts

Estimate name	Estimate	90 percent confidence interval			Sample size
		Margin of error	Lower limit	Upper limit	
Better use of funds	$4,588,967	$1,475,154	$3,113,813	$6,064,121	13

Source: VA OIG statistician's analysis and team's review of obligations with accrual balances.

Purchase Cards

The team reviewed a statistical sample from a population of approximately 53,800 purchase card transactions totaling approximately $51.3 million. Based on the results, the team projected that at least 6,800 transactions totaling at least $6.7 million were not processed in accordance with VA policy. The team further projected that the VA Augusta Health Care System

- did not have supporting documentation for at least 4,400 transactions totaling at least $4.4 million, and[125]
- did not have reconciliations for at least 840 transactions totaling at least $1.1 million.

Tables C.3 and C.4 show statistical projections of purchase card transactions errors and their dollar amounts.

[125] Results of lack of supporting documentation are conservative estimates based on the lower bound of the projections due to the larger margin of error.

Table C.3. Statistical Projections for Purchase Card Transaction Errors

Estimate name	Estimate	90 percent confidence interval				Sample size
		Margin of error	Lower limit	Upper limit	One-tailed lower limit	
Overall errors (count)	13,384	8,518	4,866	21,903	6,769	21
Overall errors (percent)	25%	16%	9%	14%	13%	21
Supporting documentation errors	10,557	7,868	2,689	18,425	4,446	12
Reconciliation errors	5,425	5,902	NA	11,327	841	11

Source: VA OIG statistician's analysis and team's review of purchase card transactions.
Note: For estimates with poor precision, the one-tailed lower limit for the 90 percent confidence interval is reported. This is a more conservative value than the estimate. When reporting on total errors combined, a projected "overall errors" estimate is used to avoid double counting transaction amounts. The use of this estimate causes the overall errors count to be different from the sum of the supporting documentation errors and reconciliation errors.

Table C.4. Statistical Projections for Purchase Card Transaction Errors: Dollar Amounts

Estimate name	Estimate	90 percent confidence interval				Sample size
		Margin of error	Lower limit	Upper limit	One-tailed lower limit	
Overall errors	$12,565,669	$7,592,559	$4,973,109	$20,158,228	$6,669,419	21
Supporting documentation errors	$9,815,742	$7,012,130	$2,803,611	$16,827,872	$4,370,243	12
Reconciliation errors	$5,146,590	$5,261,260	$46,767	$10,407,851	$1,060,787	11

Source: VA OIG statistician's analysis and team's review of purchase card transactions.
Note: For estimates with poor precision, the one-tailed lower limit for the 90 percent confidence interval is reported. This is a more conservative value than the estimate. When reporting on total errors combined, a projected "overall errors" estimate is used to avoid double counting transaction amounts. The use of this estimate causes the overall errors count to be different from the sum of the supporting documentation errors and reconciliation errors.

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

Recommendation	Explanation of Benefits	Better Use of Funds	Questioned Costs*
1	Ensure that healthcare system finance office staff are made aware of policy requirements and that all accruals are proper and valid as required by VA Financial Policy, vol. 2, chap. 5, “Obligations Policy.”	$4,671,854†	$0
2	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.	$673,696‡	$0
3	Ensure cardholders comply with record retention, prior approval, and purchase card reconciliation requirements as required by VA Financial Policy, vol. 16, chap. 1B, “Government Purchase Card for Micro-Purchases.”	$0	$6,685,919§
	Total	**$5,345,550****	**$6,685,919***

** 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; when costs are not supported by adequate documentation; or when they are expended for purposes that are unnecessary or unreasonable under governing authorities. Within questioned costs, the OIG must, as required by section 405 of the IG Act, report unsupported costs. Unsupported costs are those determined by the OIG to lack adequate documentation at the time of the audit. Of the $6,685,919 in questioned costs, approximately $4,400,000 were unsupported costs.*

† The team added the projected amount of almost $4.6 million from outstanding accruals and $82,900 from FMS-to-IFCAP reconciliations.

‡ The team identified almost $1.3 million of funds in the annual exceptions lists for FY 2022 that could be put to better use. However, this amount was reduced by close to $590,000 to prevent the possibility of double counting funds identified in this inspection report.

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

*** The total may not sum due to rounding.*

Appendix E: VA Management Comments, Director, VA Southeast Network (10N7)

Department of Veterans Affairs Memorandum

Date: October 6, 2023

From: Director, VA Southeast Network (10N7)

Subj: Financial Efficiency Inspection of the VA Augusta Health Care System in Augusta, Georgia (Project Number 2023-00821-AE-0029)

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

1. I have completed a full review of the Financial Efficiency Inspection of the VA Augusta Health Care System in Augusta, Georgia (Project Number 2023-00821-AE-0029).

2. I concur with the responses and the nine implementation plans submitted by the Charlie Norwood VA Medical Center in Augusta, Georgia.

3. I appreciate the opportunity for this review as part of a continuing process to improve our responsible use of VA's appropriated funds.

4. If you have questions or require further information, please contact the VISN 7 Quality Management Officer.

The OIG removed point of contact information prior to publication.

(Original signed by)

David M. Walker, MD, MBA, FACHE

Network Director

VA Southeast Network (VISN 7) (10N7)

Appendix E: VA Management Comments, Director, VA Augusta Health Care System in Augusta, Georgia

Department of Veterans Affairs Memorandum

Date: September 29, 2023

From: Director, VA Augusta Health Care System (509/00)

Subj: Financial Efficiency Inspection of the VA Augusta Health Care System in Augusta, Georgia (Project Number 2023 00821 AE 0029)

To: Director, VA Southeast Network (10N7)

1. We at VA Augusta Health Care System, thank the Office of Inspector General for evaluating and providing recommendations to strengthen our processes as it relates to management of accruals, purchase card usage and oversight, inventory and supply management and pharmacy operations.

2. I hereby submit the attached nine implementation plans for each recommendation with target completion dates. I have reviewed and concur with our nine implementation plans.

3. I appreciate the opportunity for this review as part of a continuing process to improve our responsible use of VA's appropriated funds.

The OIG removed point of contact information prior to publication.

(Original signed by)

Robin E. Jackson, PhD

Medical Center Director

Attachment

Attachment

Technical Comments

Comment 1

Draft location: page vi, paragraph 2, lines 75-81

Current language: A separate population of 44 open obligations was identified with end-date discrepancies between FMS and IFCAP for three or more months. From these, the team judgmentally selected and evaluated 10 obligations with end-date discrepancies between the systems ranging from 187 to 1,450 days, valued at about $14.1 million. Five of the 10 samples were flagged to automatically accrue the remaining balance of the obligations at the end of the performance period. Before the inspection, healthcare system financial services staff corrected the FMS and IFCAP end dates for nine obligations.

Comment and justification: VAAHCS asks OIG to consider removing: A separate population of 44 open obligations was identified with end-date discrepancies between FMS and IFCAP for three or more months. From these, the team judgmentally selected and evaluated 10 obligations with end-date discrepancies between the systems ranging from 187 to 1,450 days, valued at about $14.1 million. Five of the 10 samples were flagged to automatically accrue the remaining balance of the obligations at the end of the performance period. Before the inspection, healthcare system financial services staff corrected the FMS and IFCAP end dates for nine obligations.

Justification: The report OIG pulled data from was a tool, not an accurate report to use for true end date discrepancies. The population of 44 obligations did not have end date discrepancies.

Comment 2

Draft location: pages vi-vii, paragraph 2, lines 88-90?

Current language: The supervisory accountant said that the finance office uses VA's FMS-to-IFCAP reconciliation report to identify end-date discrepancies. However, the healthcare system did not always take prompt actions to ensure end dates were correct.

Comment and justification: VAAHCS asks OIG to consider stating: The supervisory accountant said that the finance office uses VA's FMS-to-IFCAP reconciliation report as a tool to review and identify FMS end-date and IFCAP delivery date discrepancies. VAAHCS asks OIG to consider removing: However, the healthcare system did not always take prompt actions to ensure end dates were correct.

Justification: The finance staff was able to show the reviewers that all the end-dates and delivery dates from the samples matched, except for 1 obligation, which finance was aware of, and already working with contracting prior to the review. The FMS-to-IFCAP reconciliation is simply a tool created by the VHA Oversight Team to assist stations in reviewing obligations with potential discrepancies. The only true way to ensure accuracy of end date and delivery dates is to view the dates displayed on the obligating documents (FMS OBLH, OBLL, and IFCAP Purchase Order).

Comment 3

Draft location: page 7, paragraph 1, lines 366-370

Current language: Financial Management System (FMS)–to–Integrated Funds Distribution, Control Point Activity, Accounting and Procurement System (IFCAP) reconciliations. The team identified outstanding obligations with different end dates between FMS and IFCAP to ensure healthcare system staff reconciled end dates between the systems for the sampled obligations.

Comment and justification: VAAHCS asks OIG to consider removing: The team identified outstanding obligations with different end dates between FMS and IFCAP to ensure healthcare system reconciled and dates between the systems for sampled obligations.

Justification: The sampled obligations were pulled from a tool that did not have true end date discrepancies. All the documentation provided to the reviewers showed the end date/delivery dates matched on the source documents. For the 1 discrepancy that the facility concurred with, the staff was already aware of this discrepancy.

Comment 4

Draft location: page 12, paragraph 2, lines 447-456

Current language: The supervisory accountant reported that staff only reviewed the delivery date in IFCAP and end-date in FMS because of a Veterans Health Information Systems and Technology Architecture (VistA) system limitation that caused end dates not to reconcile between the two systems. The finance office implemented a workaround process by submitting end-date changes using the date that the obligation was established to avoid FMS rejection. As a result, the end dates will continue to not sync because VistA and FMS were not designed to have this functionality. While the finance office submitted documentation showing that FMS end dates match IFCAP delivery dates, the OIG determined that the healthcare system was not in compliance because the end dates between systems continued to not reconcile in accordance with VA Financial Policy.

Comment and justification: VAAHCS asks OIG to consider removing: The supervisory accountant reported that staff only reviewed the delivery date in IFCAP and end-date in FMS because of a Veterans Health Information Systems and Technology Architecture (VistA) system limitation that caused end dates not to reconcile between the two systems. The finance office implemented a workaround process by submitting end-date changes using the date that the obligation was established to avoid FMS rejection. As a result, the end dates will continue to not sync because VistA and FMS were not designed to have this functionality. While the finance office submitted documentation showing that FMS end dates match IFCAP delivery dates, the OIG determined that the healthcare system was not in compliance because the end dates between systems continued to not reconcile in accordance with VA Financial Policy.

Justification: The healthcare system is in compliance with VA Financial Policy in reviewing source documents for end date/delivery dates to ensure they match. Documentation provided showed the dates matched, except for 1 known discrepancy.

Comment 5

Draft location: page 13, paragraph 1, lines 460-463

Current language: The supervisory accountant confirmed the finance office does use VA's FMS-to-IFCAP reconciliation report to identify end-date discrepancies. However, the inspection team found that the healthcare system did not always take prompt actions to ensure end dates were correct…

Comment and justification: VAAHCS asks OIG to consider stating: The supervisory accountant confirmed the finance office does use VA's FMS-to-IFCAP reconciliation report to identify end-date discrepancies. However, the inspection team found that the healthcare system did not always take prompt actions to deobligate excess funds…

Justification: The station does take prompt actions to ensure end dates are correct, as indicated in the review of all the supporting documentation provided.

Comment 6

Draft location: page 15, paragraph1, line 495-496z

Current language: Healthcare system personnel did not comply with VA policies to ensure accruals were proper, end dates were reconciled between systems…

Comment and justification: VHA asks OIG to consider stating: Healthcare system personnel did not comply with VA policies to ensure accruals were proper and a prioritized list of contract modifications was forwarded for action, …

Justification: The station does take prompt actions to ensure end dates are correct, as indicated in the review of all the supporting documentation provided.

Comment 7

Draft location: page LX, paragraph 2, lines 965-972

Current language: The chief of pharmacy and staff attributed spending increases to a shortage of drugs that were unavailable from the pharmaceutical prime vendor because the preferred items were unavailable from suppliers, and the healthcare system had to buy more expensive alternatives. The team reviewed the prime vendor's March 8, 2023, report and determined that 80 items were back-ordered. Pharmacy leaders at the healthcare system also said that spending increased because of the high cost of specialty drugs prescribed by community care providers to treat specific conditions and diseases. According to OPES, the healthcare system potentially missed opportunities to reduce spending on drugs from FY 2020 through FY 2022.

Comment and justification: VAAHCS asks OIG to consider changing page LX, paragraph 2, lines 965-972 to state: The chief of pharmacy and pharmacy staff attributed spending increases to a shortage of drugs that were unavailable from the pharmaceutical prime vendor because the preferred items were unavailable as this was not unique to healthcare facilities across the nation during the COVID surge. Additionally, community prescriptions that come to pharmacy, often for high cost, specialized therapies are a negative contributor to the overall efficiency.

Justification: The impact of the back-order situation was validated with the March 8, 2023, report with 80 items listed as on back-order would not be accounted for in the OPES model, which is based on the previous fiscal years data, diminishing the value of the "expected" pharmacy costs in the model.

The OPES model currently lists care in the community patients as a positive independent variable, decreasing facilities expected costs, but that had not proven to be accurate. The OIG did evaluate care in the community volume as part of the visit, but it was noted that it was absent from the report and has been launched as a sperate OIG audit.

Recommendation 1:

Ensure that healthcare system finance office staff are made aware of policy requirements and that all accruals are proper and valid, as required by VA Financial Policy, Vol. 2, Chapter 5, “Obligations Policy.”

Concur

Target date for completion: November 13, 2023

Director’s Comments:

The Chief of Fiscal will collaborate with the VISN 7 Centralized Accounting Office (CAO) to develop and provide face-to-face training to initiating services responsible for accrued payables. Training will be conducted on the proper review and management of undelivered orders and accrued payables in accordance with guidance in Financial Policy Volume II, Chapter 5, Obligations Policy. Agenda items and training materials will be disseminated to all in attendance. The Auditor will continue to assist the CAO, initiating services, and service chiefs in the analyzation of inactive or expired obligations so that the responses accurately reflect the condition of the obligation/accrual. The auditor will review responses to obligations prior to submission of the reconciliation reports monthly.

Training will be conducted annually after the initial training, and on an as needed basis for new employees. Record of attendance will be maintained to ensure all identified individuals receive required training. Auditor will continue to monitor open obligations reports of expired obligations. VSSC reports of expired obligations will be reviewed to ensure there is a reduction in expired accruals with corrective actions as warranted.

Recommendation 2:

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 modifications are completed.

Concur

Target date for completion: October 5, 2023

Director’s Comment:

This recommendation falls under the authority of the VISN Centralized Accounting Office, not VA Augusta Healthcare System.

The Centralized Accounting Office (CAO) will request a list of contract modifications from the contracting office monthly, beginning October 5, 2023. CAO will review, recommend priority, and send to the VISN Chief Financial Officer (CFO) for review and submission back to the contracting office.

Sustainment: The list will be maintained at the CAO and referred to each subsequent month to ensure priority actions were worked.

Recommendation 3:

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

Concur

Target date for completion: March 2024

<u>Director Comments:</u>

The following actions will be completed by VA Augusta Healthcare System Fiscal Service:

VA Augusta healthcare system finance service will provide formal training by November 15, 2023, to all purchase cardholders on policy requirements as they relate to supporting documentation retention, purchase approval, and timely reconciliation requirements. The facility auditor will work with cardholders on an individual basis on these requirements through facility audits, correspondence, and monitoring of financial indicators. Agenda items and training materials will be disseminated to all in attendees.

Training will be conducted annually after the initial training, and on an as needed basis for new employees. Facility Auditor will conduct monthly audits to ensure compliance of 90% or greater.

The following actions will be completed by VA Augusta Healthcare System Supply Chain Management Service:

To ensure compliance with VA Financial Policy, Vol. 16, Chap. 1B "Government Purchase Card for Micro-Purchases," a memorandum was issued on August 18, 2023, by the Acting Chief Supply Chain Management (SCM) authorizing Government Purchase Card (GPC) Cardholders in SCM to make micro-purchases to replenish stock levels and maintain inventory par levels as required by VHA Directive 1761. In addition, each GPC Cardholder in SCM is required to follow IFCAP Purchase Card Reconciliation User Manual (dated April 2008) for the step-by-step process to reconcile transactions timely and appropriately.

GPC Cardholders in SCM will have prior approval from their Approving Official before placing any micro-purchase order. All GPC Cardholders in SCM will follow VHA GPC Program SOP Minimum Supporting Documentation which outlines all documents required to be maintained for micro-purchases made using the GPC.

Weekly reports sent from VISN 7 GPC Purchase Card Coordinator are reviewed by the responsible Approving Official for each GPC Cardholder. Since April 25, 2023, the Approving Official has been working directly with the GPC Cardholder to complete pending reconciliations. This report is reviewed by the Approving Official who works directly with the SCM GPC Cardholder to timely close the reconciliations.

The Approving Official will review micro-purchases by auditing 10 orders, monthly. Results of audits will be reviewed by the Chief SCM with corrective action as warranted. Audits will continue until compliance of 90% or greater is reached for six consecutive months.

Approving Officials will review aged open orders and unreconciled transactions to ensure GPC Cardholder is maintaining compliance with reconciling transactions within 14 days. This process is on-going.

Recommendation 4:

Develop and implement processes to ensure all necessary reports are monitored routinely and appropriate steps are taken to ensure all supply chain performance measures are maintained in compliance with policy.

Concur

Target date for completion: October 31, 2023

<u>Director Comments:</u>

The Chief SCM will develop local SOP to ensure compliance as outlined in VHA Directive 1761 and focus on local procedures for review of all Power BI SCCOP performance metrics. Currently SCM metrics are

reviewed weekly at the standing Wednesday SCM Operations Meeting and each Section Chief reports on their respective metrics, current performance, changes from previous report, and actions taken to improve to meet established metric goals. Additionally, a training plan will be developed focusing on reports that Inventory Management Specialist need to generate and review for inaccuracies. These key reports will include Days of Stock On Hand, Emergency Stock, Inactive Items, Stock Status, Transaction Register, Usage Demand Analysis and Usage Demand Item Report. The Supervisor and S&D Section Chief will monitor compliance through generated reports for review of outliers needing corrective and meet with the Inventory Management Specialist to discuss and ensure they are complying.

Supply Chain Management performance metrics will be added as an agenda item to review and discuss at the weekly meeting. Minutes will be maintained.

Recommendation 5:

Develop and implement a plan to ensure data accuracy and reliability in the Generic

Inventory Package in accordance with Veterans Health Administration policy.

Concur

Target date for completion: December 31, 2023

Director Comments:

A training plan will be developed to support the training requirements for each SCM Expendable employee. This training will align with requirements specified in VHA Directive 1761. The training plan will cover general duties described in the position description, attendees will be provided a copy of all required VHA Directives, VA Handbooks, VISN and local policies or SOPs related to Logistics Management Procedures; the plan will include specific “how to” instruction related to item master file entry/edit/maintenance, vendor file data management, GIP utilization (including actions required to bring supplies into the inventory and to issue them out through a picking ticket) and data management for primary inventory points, requirements for establishing and maintaining appropriate stock levels, procedure for and a focus on generating reports for better oversight of days of stock on hand, conversion factors, and performing inventory adjustments.

The PowerBI SCCOP reports are pulled and reviewed weekly during the SCM Operations meeting for data accuracy. Each Supervisor is responsible for reviewing the data for their respective areas. The Logistics Management Specialist will conduct drill down reviews for data inaccuracies and ensure reconciliation as warranted.

Recommendation 6:

Develop formalized processes for monitoring and achieving efficiency targets and using

available pharmacy data to make business decisions.

Concur

Target date for completion: October 31, 2023

Director Comments:

The OPES model for efficiency is a complex tool that takes into consideration pharmacy expenses (dependent variable) against characteristics of the facility that can impact the dependent variable (independent variable), including items like pro-rated patients, case-mix, rural penetration, CITC use, and many other factors. The time frame reviewed by the OIG report reflect the prime COVID years, which

dramatically impacted both the dependent and independent variables, contributing to the observed reduced efficiency targets. Pharmacy service is committed to safe and effective medication use for the Veterans, including cost efficiency. The number of variables impacting efficiency are too numerous to list, but the following actions are an area of focus for the pharmacy service to continue to improve costs and positively impact efficiency targets.

1. Focused effort on reducing the use of partial fills at the outpatient window. The partial process and expectations for staff was discussed during the August 23, 2023, staff meeting. The partial fill report will be monitored monthly by Associate Chief Operations or their designee, with feedback and follow up to the outpatient staff when partials are dispensed that do not meet expectations.
2. Decrease the utilization of branded medications when generics are available. The Pharmacoeconomics program manager is working on a comprehensive drug file review to find opportunities for cost savings and will be reporting quarterly to P&T committee. The proposal for automatic conversions to the generic medications will be presented for approval during the October 19th, 2023, P&T committee meeting and quarterly reports will begin after approval.

Recommendation 7:

Develop and implement a plan to achieve an inventory turnover rate closer to the

Veterans' Health Administration's recommended level.

Concur

Target date for completion: September 30th, 2023

Director's Comments:

It was noted by the OIG that there have been documented concerns about the accuracy of the McKesson inventory turn rates from other sites, which was evident in this review. VHA directive 1761recommends a quarterly review of the McKesson 12-Month Turns Forecast Report, which has been completed in the past, but due to concerns with accuracy, not considered above the annual wall to wall inventory report, which is required and validated. Pharmacy leadership and procurement staff will ensure the quarterly reports are reviewed in depth quarterly and work with the McKesson representative to reconcile the differences between the quarterly and annual report. This first meeting quarterly review occurred during the August 31, 2023, meeting with the McKesson representative.

Recommendation 8:

Ensure that pharmacy staff are trained on the ScriptPro workflow system for pharmacy.

Concur

Target date for completion: December 25, 2023

Director's Comments:

Operations staff were all initially trained on the workflow system during the roll out approximately 2 years ago but will conduct a training for all operations staff before December 25, 2023, to ensure 100% compliance with training. Operations section supervisors will be asked to verify that this is a part of the orientation process and included in the position check list by October 31, 2023. An annual refresher training will be offered during a departmental staff meeting, starting with the March 2024 meeting.

Recommendation 9:

Establish processes to ensure compliance with the Veterans Health Administration

directive to complete the B09 reconciliation process.

Concur

Target date for completion: September 25, 2023

Director's Comments:

To ensure compliance with the B09 reconciliation process, the reconciliation memos starting with the September 2023 memo will include a link to the site where all the supporting documents have been uploaded by the procurement staff. This will allow the centralized accounting staff electronic access to all the documentation needed to complete the reconciliation process. Request this item be closed since the process has been established and agreed upon by the Chief Financial Officer, Centralized Accounting Office.

We are requesting closure of this recommendation.

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

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