US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Financial Efficiency Inspection of the VA Memphis Healthcare System in Tennessee

Financial Inspection | **23-01198-47** | **February 14, 2024**

BE A
VOICE FOR
VETERANS
REPORT WRONGDOING
vaoig.gov/hotline | 800.488.8244

OUR MISSION

To serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs.

CONNECT WITH US

Subscribe to receive updates on reports, press releases, congressional testimony, and more. Follow us at @VetAffairsOIG.

PRIVACY NOTICE

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

Executive Summary

The VA Office of Inspector General (OIG) conducted this inspection to assess the stewardship and oversight of funds by the VA Memphis Healthcare System in Tennessee and to identify potential cost efficiencies in carrying out healthcare system functions.[1] To determine whether the healthcare system had appropriate controls and oversight in place, the OIG identified four financial activities and administrative processes that draw on considerable VA financial resources and made recommendations to promote the responsible use of VA's appropriated funds—(1) open obligations oversight, (2) purchase card use and oversight, (3) inventory and supply chain management operations, and (4) pharmacy operations.

The inspection team evaluated financial efficiency practices related to these four areas for fiscal year (FY) 2022; the team also assessed the first and second quarters of FY 2023 for the inventory and supply chain management area. The team conducted its inspection from April to November 9, 2023, including a site visit at the VA Memphis Healthcare System during the week of April 3, 2023; interviewed healthcare system leaders and staff; and reviewed data, supporting documents, and processes related to the healthcare system's financial efficiency. The inspection is limited in scope and is not intended to be a comprehensive review of all financial operations at the healthcare system. For more information about the inspection's scope and methodology, see appendixes A and B.

What the Inspection Found

The team identified several opportunities for improvement in the areas inspected. The findings and recommendations in this report should help the healthcare system identify greater financial efficiencies.

Open Obligations Oversight

An obligation is a legally binding commitment of appropriated funds for goods or services. Open obligations are those that are not considered closed or complete and have a balance associated with them, whether undelivered or unpaid. Open obligations should be reviewed by the healthcare system finance office to ensure that beginning and ending dates are accurate; open balances are accurate and agree with source documents such as contracts and purchase orders, receiving reports, invoices, and payments; and obligations beyond 90 days of the period of

[1] The VA Memphis Healthcare System operates community-based outpatient clinics in Dyersburg, Jackson, Memphis, and Savannah, Tennessee; Holly Springs and Tupelo, Mississippi; and Jonesboro and West Helena, Arkansas. The healthcare system is also affiliated with the University of Tennessee Health Science Center.

performance end date or without activity in the past 90 days are valid and should remain open. Any excess funds should be identified promptly and deobligated.[2]

The inspection team analyzed data from August 2022 through January 2023 and judgmentally selected 20 open obligations that had been inactive for more than 90 days, totaling almost $13.4 million. The team assessed whether healthcare system finance office staff reviewed inactive obligations to see if remaining funds associated with each obligation were valid and necessary, as required. The team found 10 obligations were still within the performance period, and the remaining 10 were more than 90 days past the end date. The team was not able to verify that healthcare system staff reviewed 10 of these 20 inactive obligations, totaling approximately $11.5 million. The chief financial officer stated the inability to conduct a complete review of inactive open obligations is attributed to lack of staffing, an ongoing issue for the past three years. Failing to review inactive obligations increases the risk of not spending appropriations within the associated fiscal year or not repurposing the funds if the obligations are no longer valid.

The inspection team did additional sampling to evaluate whether staff reconciled obligations between the Financial Management System (FMS) and the Integrated Funds Distribution, Control Point Activity, Accounting and Procurement System (IFCAP). Using the FMS to IFCAP reconciliation reports, the team identified 22 open obligations with discrepancies that had existed for three or more months.[3] The team selected and evaluated 11 of these open obligations totaling about $957,000. The team determined that the reports reflected accurate order amounts for the 11 sampled obligations; however, four of the 11 obligations had residual funds totaling about $7,200, which should have been deobligated.[4]

Purchase Card Use and Oversight

VA's Government Purchase Card Program was established to reduce administrative costs related to the acquisition of goods and services. When used properly, purchase cards can help facilities simplify acquisition procedures and provide an efficient vehicle for obtaining goods and services directly from vendors. Documenting transactions as required helps VA and other oversight authorities identify potential fraud, waste, and abuse.

However, if goods and services are purchased regularly, facilities should consider putting contracts in place. Using contracts for common purchases—a process known as strategic

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

[3] "FMS to IFCAP Reconciliation Reports" (website), VHA, https://vssc.med.va.gov/VSSCMainApp/products.aspx?PgmArea=59. (This website is not publicly accessible.)

[4] "FMS to IFCAP Reconciliation Report" (website), VHA. See appendix C for more information about better use of funds.

sourcing—has several benefits, such as allowing VA to optimize purchasing power and obtain competitive pricing.

The team reviewed a statistical sample of 40 purchase card transactions from FY 2022 to determine whether they were processed in accordance with VA policy.[5] Based on the results of the review, the team estimated that healthcare system staff may have made noncompliance errors in just over 18,500 purchase card transactions, totaling approximately $19.8 million in questioned costs. Detailed information on the OIG sampling and statistical methodology is available in appendix B.[6]

The OIG found that 13 of the 40 transactions were missing some required supporting documentation and projected that cardholders may not have sufficient supporting documentation for just over 14,800 transactions, which corresponds to approximately $15.9 million in questioned costs. Detailed information on the OIG sampling and statistical methodology is available in appendix B. The OIG determined the healthcare system had not implemented a consistent method for electronically storing purchase card documentation, and approving officials did not ensure cardholders retained sufficient documentation to support purchase card transactions as required by VA policy.[7]

Of the 40 sampled purchase card transactions, 12 were not reconciled in a timely manner. Also, one of the 12 transactions did not meet prior approval and segregation of duties requirements.[8] The team did not identify any split purchases.

The healthcare system maintained a VA Form 0242, which delegates authority to an individual to use a VA purchase card, for 14 of 15 cardholders in the review sample. The team also found

[5] VA Financial Policy, "Government Purchase Card for Micro-Purchases," in vol. 16, *Charge Card Programs* (May 2022), chap. 1B. The inspection team reviewed a statistical sample of 40 purchase card transactions from a population of just over 31,700 purchase card transactions totaling approximately $34.6 million from October 1, 2021, through September 30, 2022. See appendix B for further details.

[6] The team reviewed purchase card transactions for compliance with (1) policy that requires adequate monitoring, approval, and supporting documentation; (2) processes that prevent split purchases and transactions exceeding the cardholder's authorized single-purchase limit; and (3) strategic-sourcing procedures, which VA Financial Policy defines as ensuring employees regularly obtain proper contracts when procuring goods and services on a regular basis. Noncompliance issues were only included once for the purposes of calculating this projection. The team also considered margin of error and median confidence level when projecting questioned costs. For additional information regarding projection totals, see appendix B and tables B.1 and B.2.

A questioned cost is (1) an alleged violation of a provision of a law, regulation, contract, grant, cooperative agreement, or other agreement or document governing the expenditure of funds; (2) a finding that, at the time of the audit, such cost is not supported by adequate documentation; or (3) a finding that the expenditure of funds for the intended purpose is unnecessary or unreasonable. 2 C.F.R. § 200.1 (2021).

[7] VA Financial Policy, "Government Purchase Card for Micro-Purchases." See appendix C for more information about questioned costs.

[8] VA requires that the duties of the cardholder, approving official, requesting official, and receiving official be segregated. An agency or organization program coordinator cannot be a cardholder or an approving official. No one person may order, receive, certify funds, and approve his or her own purchase card purchase.

the agency or organization program coordinator did not conduct an internal purchase card review for the third quarter during FY 2022.[9] Internal reviews help identify purchase card internal control weaknesses and ensure corrective actions are taken by the healthcare system to help mitigate the risk of fraud, waste, and abuse.

The team also assessed whether cardholders adhered to strategic-sourcing guidelines, which ensure VA is obtaining the most competitive prices for goods and services.[10] The OIG found five of the 40 sampled purchase card transactions were open-market purchases from four merchants. During FY 2022, the healthcare system made a little over 70 purchases, totaling approximately $231,000, from these four merchants through the open market instead of establishing contracts that could have resulted in negotiated prices and potential cost savings. Generally, the improper reliance on open-market purchases appeared to persist because contracts were not established for routinely purchased items.

Supply Chain Management Operations

Supply chain management is the integration and alignment of people, processes, and systems to "manage all product and service planning, sourcing, purchasing, delivery, receiving, and disposal activities."[11] Veterans Health Administration (VHA) policy requires medical facilities to establish, operate, and maintain a supply chain management program that is effective, cost-efficient, transparent, and responsive to customer requirements, and to continually identify ways to ensure high-quality veteran care. The inspection team evaluated whether staff managed the healthcare system's supply chain operations effectively by monitoring the days-of-stock-on-hand performance metric, a nationally set level of inventory for expendable Medical Surgical Prime Vendor (MSPV) program items and non-MSPV items that facilitates efficient purchasing and use of supplies.[12]

VHA policy states expendable supplies purchased through the MSPV program should have 30 days or less of stock on hand, whereas non-MSPV items should have 45 days or less of stock on hand.[13] From October 2022 to January 2023, the healthcare system averaged 57 days of stock on hand for MSPV items and 97 days of stock on hand for non-MSPV items. Training issues, inadequate staffing levels, poor oversight, and data validity issues all were found to have affected the stock levels. The healthcare system could improve the efficiency of inventory management

[9] Agency/Organization Program Coordinators (A/OPC) - A VA employee that serves as the primary point of contact for the Government Purchase Card Program for their agency/organization. The A/OPC oversees administration of the Government Purchase Card Program in accordance with law, regulation, and policy.

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

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

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

[13] VHA Directive 1761.

by establishing processes and procedures for ensuring stock levels and inventory values are recorded correctly and routinely monitored. The healthcare system should also train staff and standardize supply chain duties that support accurate data within inventory systems.

Reported leadership vacancies and other staffing shortages may have affected the healthcare system's management of inventory and supplies. The current chief supply chain officer reported having five logistics chiefs from 2017 to June 2023. The lack of consistent leadership may have affected continuity in oversight processes and procedures.

The inspection team also assessed completion of required quarterly physical inventory of "A" classified items—those with the highest 80 percent of annual usage dollars equating to the inventory items that use the majority of budgetary funding.[14] The team found that although the current chief supply chain officer reported physical inventories were conducted, the healthcare system was unable to provide documentation to support this, or that Veterans Integrated Service Network (VISN) personnel were informed upon completion of the physical inventory, as required by VHA policy.[15]

The Generic Inventory Package system, VA's software system that manages the receipt, distribution, and maintenance of expendable supplies, uses an item master file that is created within IFCAP to store and track information for each item. Access to item master files in IFCAP is controlled to ensure data integrity and accuracy. Though the healthcare system maintained an edit access list for the facility item master file, the inspection team was not provided documentation to support that the chief supply chain officer reviewed the list of personnel with access to the inventory system. VHA policy states that the chief supply chain officer must maintain and review the list each calendar year.[16]

Pharmacy Operations

An efficient healthcare system analyzes available reports and data to anticipate how much drugs will cost and when inventory needs to be restocked. Proper inventory management helps ensure that the system makes efficient use of financial resources while ensuring inventory is available when needed. The team evaluated whether the healthcare system complied with VA policies to utilize cost and performance reports to review progress, to track inventory turnover goals

[14] VHA Directive 1761, Appendix E. In the ABC classification method, inventory point items with the highest 80 percent of the inventory annual usage dollars are classified as "A." Items with the next highest 10 percent of inventory annual usage dollars are classified as "B." Lastly, items representing the remaining 10 percent of inventory annual usage dollars are classified as "C." The formula for calculating the annual usage dollars of an item is the annual usage quantity multiplied by the average unit price. Only clinical items (versus nonclinical inventories) were assessed for this inspection.

[15] VHA Directive 1761; VHA divides the United States into 18 regional systems, called VISNs, that work together to meet local healthcare needs and provide greater access to care.

[16] VHA Directive 1761, Appendix B.

developed by Pharmacy Benefits Management office, to use scannable barcodes, and to use the B09 reconciliation process.

The OIG found that the healthcare system had utilized available reports and data for the cost and performance tracking of pharmacy expenditures. According to VHA's Office of Productivity, Efficiency and Staffing (OPES) pharmacy expenditure model (based on FY 2022 data), the healthcare system had actual prescription drug costs of approximately $67 million compared to about $78.9 million in expected drug costs during the inspection period. Over the three-year review period, the healthcare system reported an average of approximately $6.4 million saved through efficiencies.[17] The OIG also found that the healthcare system can further improve pharmacy efficiency by adhering to inventory management best practices, such as increasing inventory turnover rates for "A" and "C" items in accordance with Pharmacy Benefit Management target rates and ensuring compliance with the B09 reconciliation process. The healthcare system's turnover rate for pharmacy inventory did not meet the national inventory turnover target rates, as established by the national Pharmacy Benefits Management office, for "A" and "C" items. In addition, the team found that pharmacy staff were not implementing inventory management practices, such as adding scannable barcodes to shelving when point-of-use equipment was in place. The team also found that healthcare system officials did not always sign and date invoices upon receipt of ordered goods as required during the B09 monthly reconciliation process. Officials reported that efforts are underway to finalize local processes that will offer more uniform compliance with VA policy.

What the OIG Recommended

The OIG made nine recommendations to the healthcare system executive director. The findings and recommendations provide opportunities for healthcare system leaders to improve processes, achieve greater cost efficiencies, and promote the responsible use of VA's appropriated funds.

The OIG recommended that the healthcare system executive director (1) ensure finance office staff are made aware of policy requirements, conduct reviews on all inactive open obligations, and deobligate any identified excess funds.[18]

To strengthen purchase card transactions, the executive director should (2) ensure cardholders comply with record retention policy requirements and (3) establish controls to confirm approving

[17] "VHA Office of Productivity, Efficiency, and Staffing (OPES) Pharmacy Expenditure Model" (based on FY 2022 data) (website), OPES, http://opes.vssc.med.va.gov/Pages/Pharmacy-Model.aspx. (This website is not publicly accessible.) The OPES pharmacy expenditure model uses the terms "observed minus expected" and "potential opportunity" to describe the gap between a facility's actual drug costs and expected drug costs. This difference represents the amount associated with potential efficiency improvements. An observed-minus-expected ratio above 1.0 indicates that a facility may have opportunities to reduce its pharmacy costs.

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

officials and that purchase cardholders review purchases properly and make sure contracting is used when it is in the best interest of the government.

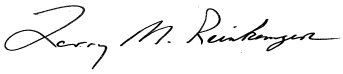
Related to supply chain management operations, the OIG recommended the executive director (4) establish local processes and procedures to ensure routine scanning of inventory items and monitoring of data to ensure performance measures are maintained; (5) initiate and provide training on local supply chain procedures and processes to correct data validity issues within inventory systems; (6) ensure compliance with the physical inventory of "A" classified items, and (7) ensure compliance with the annual review of the edit access list for the facility item master file.

The OIG made two recommendations regarding pharmacy operations, including to (8) develop a plan to align inventory management practices with VHA policy to (9) establish processes to ensure compliance with VHA's directive for the B09 reconciliation process.

VA Management Comments and OIG Response

The VA Memphis Healthcare System executive director concurred with recommendations 1–7 and recommendation 9, and provided responsive corrective action plans for those recommendations. The healthcare system executive director did not concur with recommendation 8 to develop a plan to align inventory management practices with VHA policy. Instead, the executive director suggested the system is maintaining compliance with all VHA directives and handbooks by using electronic inventory management software in both the inpatient and outpatient pharmacies for continuous monitoring, setting inventory levels, and suggested ordering based upon utilization and local restock levels. However, the OIG received no relevant evidence or supporting documentation by which to evaluate these actions.

The OIG considers all recommendations open. The OIG will monitor the implementation of all planned actions and will close the recommendations when the VA Memphis Healthcare System provides sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified. Appendix D includes the healthcare system executive director's comments.



LARRY M. REINKEMEYER
Assistant Inspector General
for Audits and Evaluations

Contents

Executive Summary i

Abbreviations x

Introduction 1

Results and Recommendations 5

Finding 1: Inactive Obligations Were Not Always Being Reviewed, and Some Obligations Were Not Deobligated Timely 5

Recommendation 1 9

Finding 2: Healthcare System Staff Did Not Always Maintain Supporting Documentation or Consider Using Contracts 12

Recommendations 2–3 17

Finding 3: The Healthcare System Should Ensure Supply Chain Operations Comply with VHA Policy and Inventory Data Are Accurate 20

Recommendations 4–7 26

Finding 4: The Healthcare System Could Improve Oversight Controls 29

Recommendations 8–9 35

Appendix A: Scope and Methodology 37

Appendix B: Sampling Methodology 39

Appendix C: Monetary Benefits in Accordance with Inspector General Act Amendments 44

Appendix D: VA Management Comments 45

OIG Contact and Staff Acknowledgments 49

Report Distribution 50

Abbreviations

FMS	Financial Management System
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	VHA Office of Productivity, Efficiency and Staffing
SCCOP	Supply Chain Common Operating Picture
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducts financial efficiency inspections to assess stewardship and oversight of funds at VA healthcare systems and to identify opportunities to achieve cost efficiencies. Inspection teams identify and examine financial activities that are under the healthcare system's control and can be compared to healthcare systems similar in size and complexity across VA to promote best practices.[19]

This inspection focused on the VA Memphis Healthcare System in Tennessee. The OIG assessed the following financial activities and administrative processes to determine whether appropriate controls and oversight were in place during fiscal year (FY) 2022. The first four months of FY 2023 were also part of the inspection scope for the review of open obligations and days of stock on hand for expendable supplies.

I. **Open obligations oversight.** An obligation is a legally binding commitment of appropriated funds for goods or services.[20] Open obligations include those obligations that are not considered closed or complete and have a balance associated with them, whether undelivered or unpaid. The inspection team evaluated whether healthcare system staff performed monthly reviews, reconciled sampled obligations, and identified excess funds for the timely closing of obligations. Open obligations should be reviewed by healthcare system finance office staff to ensure that beginning and ending dates are accurate; open balances are accurate and agree with source documents, such as contracts and purchase orders, receiving reports, invoices, and payments; and obligations beyond 90 days of the period of performance end date or without activity in the past 90 days are determined by the finance office to be valid and should remain open.[21] Any excess funds should be identified and deobligated so that they may be used elsewhere.

II. **Purchase card use and oversight.** The VA Government Purchase Card Program was established to reduce administrative costs related to the acquisition of goods and services. When used properly, purchase cards can help facilities simplify acquisition procedures and provide an efficient vehicle for obtaining goods and services directly from vendors. Documenting transactions helps VA and other oversight authorities identify potential fraud, waste, and abuse. The team assessed whether the healthcare system's purchase card program ensured compliance with policies and procedures. Also, the team reviewed whether the healthcare system properly used contracts for commonly purchased products.

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

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

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

Known as strategic sourcing, using contracts for common purchases allows VA to optimize purchasing power and obtain competitive pricing.[22]

III. **Supply chain management operations.** Supply chain management is the integration and alignment of people, processes, and systems to manage all product and service planning, sourcing, purchasing, delivering, receiving, and disposal activities. Veterans Health Administration (VHA) policy requires medical facilities to establish, operate, and maintain a supply chain management program that is effective, cost-efficient, transparent, and responsive to customer requirements and to continually identify ways to deliver high-quality care to veterans.[23] The inspection team evaluated whether the healthcare system met performance metrics for days of stock on hand and complied with policies and procedures for supply chain management. The days-of-stock-on-hand metric is a supply performance measure for items purchased through the Medical Surgical Prime Vendor (MSPV) program, which promotes inventory level efficiency and other means. To evaluate whether the system complied with policies and procedures, the team assessed data validity, identified factors that affected the healthcare system's supply chain management, and reviewed quarterly physical inventories.

IV. **Pharmacy operations.** An efficient healthcare system analyzes available reports and data to anticipate how much drugs will cost and when inventory needs to be restocked. Proper inventory management helps ensure that the system makes efficient use of financial resources while ensuring inventory is available when needed. The team evaluated whether the healthcare system complied with VA policies to utilize cost performance reports to review progress, tracked inventory turnover goals developed by Pharmacy Benefits Management office, used scannable barcodes, and conducted the B09 reconciliation process.[24]

To assess these areas, the inspection team visited the VA Memphis Healthcare System during the week of April 3, 2023; interviewed healthcare system leaders and staff; and reviewed data, supporting documents, and processes related to the healthcare system's financial activities. For more information about the inspection's scope and methodology, see appendixes A and B.

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

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

[24] VHA Directive 1761, *Supply Chain Management Operations,* December 30, 2020., VHA Directive 1108.08(1), *VHA Formulary Management Process*, November 2, 2016, was amended August 29, 2019; subsequently, it was rescinded and the requirement to monitor noncontrolled drugs on a quarterly basis was incorporated into VHA Directive 1108.07, *General Pharmacy Service Requirements*, November 28, 2022.

VA Memphis Healthcare System

The VA Memphis Healthcare System, part of Veterans Integrated Service Network (VISN) 9, serves veterans in Memphis at the Lt. Col. Luke Weathers, Jr. VA Medical Center.[25] The healthcare system also provides services at 10 community-based outpatient clinics in western Tennessee, northern Mississippi, and northwestern Arkansas.[26] In FY 2022, the medical center operated just over 190 hospital beds among its facilities and provided services to 68,739 patients. The reported FY 2022 medical care budget was approximately $736 million, about an $8 million increase (1 percent) over the FY 2021 budget of approximately $728 million. The budget increase during FY 2021 was almost $73.2 million (11 percent) from the FY 2020 budget of approximately $655 million (see figure 1). The medical center is primarily affiliated with the University of Tennessee Health Science Center and offers a wide range of health, support, and facility services.

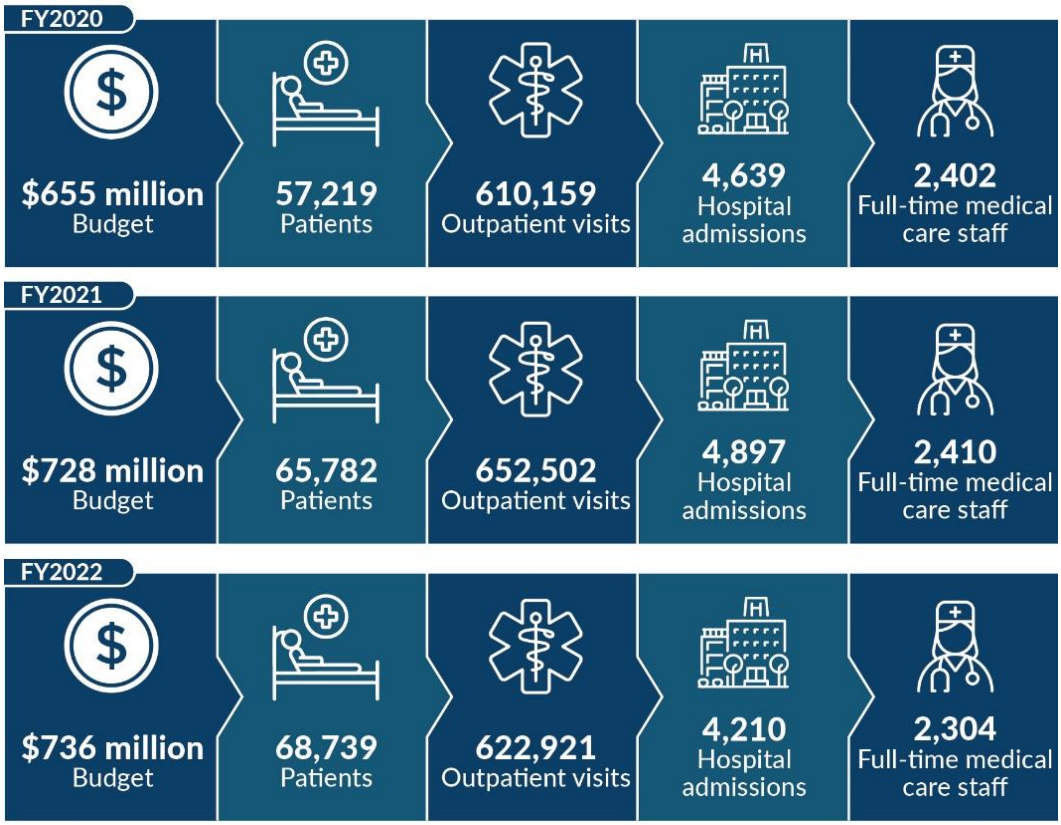


Figure 1. *Facility profile for the VA Memphis Healthcare System, FY 2020–FY 2022.*
Source: VHA Support Service Center, Trip Pack - Operational Statistics Report.

[25] VHA divides the United States into 18 regional systems, called VISNs, that work together to meet local healthcare needs and provide greater access to care.

[26] The VA Memphis Healthcare System operates community-based outpatient clinics at several locations in Dyersburg, Jackson, Memphis, and Savannah, Tennessee; Holly Springs and Tupelo, Mississippi; and Jonesboro and West Helena, Arkansas.

Facility Selection

The inspection team evaluated data from the VHA Office of Productivity, Efficiency and Staffing's (OPES) efficiency opportunity grid to identify healthcare systems with the greatest potential for financial efficiency improvements. VHA developed the efficiency opportunity grid, a collection of 12 statistical models, to give facility leaders insight into areas of opportunity for improving efficiency. The grid allows for comparisons between VHA facilities by adjusting data for variations in patient and facility characteristics and in geography. The grid also describes possible inefficiencies and areas of success by showing the difference between a facility's actual and expected costs.[27] The team uses the facility rankings from the stochastic frontier analysis model in the grid to select facilities for financial efficiency inspections.[28] The inspection, while limited in scope and not intended to be a comprehensive inspection of all financial operations at the VA Memphis Healthcare System, sets forth a goal to recommend opportunities for process improvement, greater efficiencies, and promotion of the responsible use of appropriated funds.

[27] "VHA OPES Efficiency Opportunity Grid FY 2023 (based on 2022 data)" (website), OPES, https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx. (This website is not publicly accessible.)

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

Results and Recommendations

I. Open Obligations Oversight

VA's management of open obligations has been a long-standing issue. It was included as a significant deficiency in VA's FY 2020 and FY 2021 audited financial statements and as a material weakness in VA's FY 2022 audited financial statements.[29] Additionally, a 2019 OIG report on undelivered orders recommended VHA ensure that staff review and reconcile open orders, identify and deobligate excess funds on those orders, and follow VA policy regarding required reviews of open obligations.[30] If required reviews are not conducted, the facility is vulnerable to the risk that those funds cannot be used for other goods or services in that fiscal year.

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

- **Inactive obligations.** The inspection team assessed whether healthcare system staff performed monthly reviews and reconciliations to ensure that the sampled inactive obligations were valid and should remain open. Inactive obligations are those that have had no activity for more than 90 days.
- **Financial Management System (FMS) to Integrated Funds Distribution, Control Point Activity, Accounting and Procurement System (IFCAP) reconciliations.** The team identified open obligations with different end dates or order amounts between FMS and IFCAP to assess whether healthcare system staff reconciled end dates and order amounts between the systems for the sampled obligations.

Finding 1: Inactive Obligations Were Not Always Being Reviewed, and Some Obligations Were Not Deobligated Timely

The OIG found healthcare system staff could improve management of open obligations by reviewing all inactive obligations and closing purchase orders and obligations after the initiating service has confirmed acceptance of all goods or services and all invoices have been received

[29] VA OIG, *Audit of VA's Financial Statements for Fiscal Years 2022 and 2021*, Report No. 22-01155-14, November 15, 2022; VA OIG, *Audit of VA's Financial Statements for Fiscal Years 2021 and 2020*, Report No. 21-01052-33, November 15, 2021; VA OIG, *Audit of VA's Financial Statements for Fiscal Years 2020 and 2019*, Report No. 20-01408-19, November 24, 2020. CliftonLarsonAllen LLP defines a material weakness as "a deficiency, or combination of deficiencies, in internal control over financial reporting such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented or detected and corrected on a timely basis." According to CliftonLarsonAllen LLP, "a significant deficiency is a deficiency, or a combination of deficiencies, in internal control over financial reporting that is less severe than a material weakness, yet important enough to merit attention by those charged with governance."

[30] 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.

and paid. Failure to properly manage open obligations increases the risk of not spending appropriations within the correct fiscal year and potentially leaving funds attached to orders when they could be used for other purposes.

To ensure obligations are still valid and funds are expended appropriately, VA policy requires finance offices to perform monthly reviews and reconcile obligations that are open more than 90 days past the period of performance end date or have been inactive for more than 90 days.[31] Healthcare system finance office personnel should verify with the initiating service or contracting officer that the goods or services have not been received and are still needed. The responsible finance office should also review data from VA's FMS against supporting documentation on a monthly basis to ensure reports, subsidiary records, and systems reflect proper costing, an accurate delivery date and end date, and a correctly calculated unliquidated balance.[32] If funds remain obligated after the goods or services have been delivered, the initiating service has confirmed acceptance, and invoices have been received and paid, the acquisition office will modify the contract or order to reflect the final cost and decrease the remaining funds on the obligation. Figure 2 shows the number and dollar amounts of inactive obligations for the VA Memphis Healthcare System from August 2022 through January 2023.

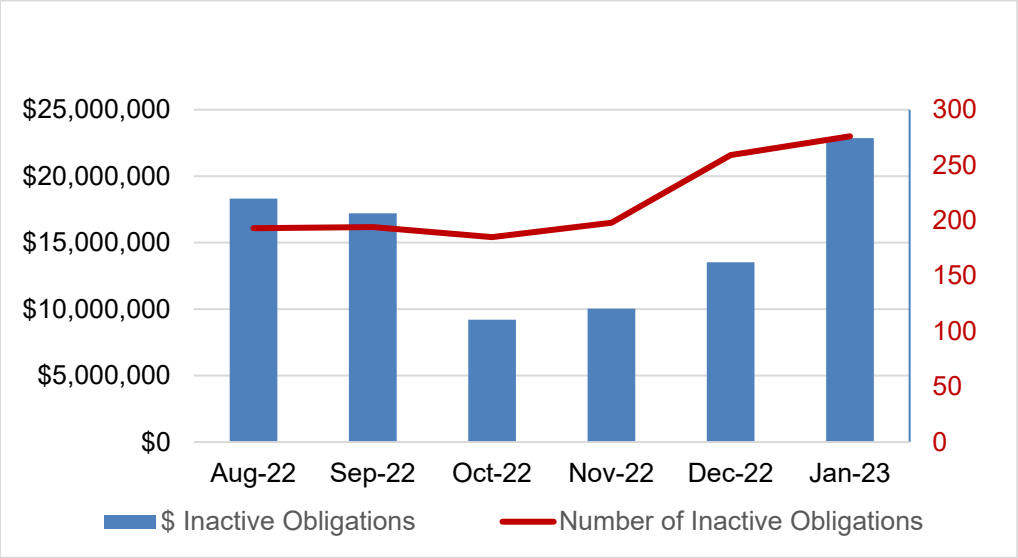


Figure 2. *VA OIG analysis of inactive obligations for the VA Memphis Healthcare System, August 2022–January 2023.*

Source: VA FMS F850 Report.

As of January 31, 2023, the healthcare system had 276 inactive obligations totaling approximately $22.9 million. Figure 3 shows the age and dollar amounts of the 276 obligations.

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

[32] 2 C.F.R. § 200.1 (2022). The term "unliquidated financial obligations" means obligations incurred by a nonfederal entity that has not been paid (liquidated) or for which the expenditure has not been recorded.

As shown, 133 obligations totaling approximately $4.7 million had no activity for at least 181 days.

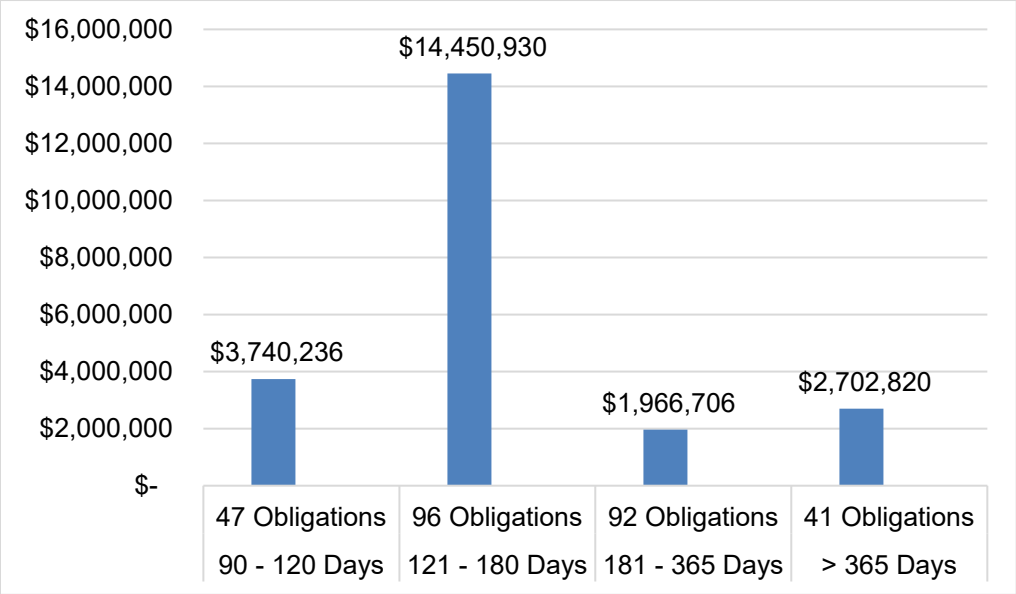


Figure 3. *VA OIG analysis of inactive obligations for the VA Memphis Healthcare System in January 2023.*

Source: VA FMS F850 Report.

Inactive Obligations

The inspection team analyzed obligation data and selected 20 inactive obligations open as of January 31, 2023, totaling almost $13.4 million. The team reviewed supporting documentation to assess whether the healthcare system staff identified and reviewed the sampled obligations to determine whether they were still valid and needed to remain open in accordance with VA financial policy.[33] Ten obligations were still within the performance period, and the remaining 10 were more than 90 days past the performance period end date. The team was not able to verify that a monthly review was completed on the 10 obligations still within the performance period, totaling approximately $11.5 million. See appendix A for additional details on the inspection's scope and methodology and appendix B for details on the inspection's sampling.

When presented with this finding by the OIG team, the medical center chief financial officer stated that the fiscal department has only three positions filled out of 10. As a result, the fiscal staff focused only on obligations that were beyond 90 days of the period of performance end date and were unable to conduct the required review of obligations with more than 90 days of

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

inactivity. The chief financial officer stated this has been an ongoing issue for three years and attributed it to the lack of employees.

Reconciliation of IFCAP and FMS End Dates and Amounts

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.[34] The end dates in both IFCAP and FMS should be the same. Open obligations should be reviewed monthly by the healthcare facility's finance office, in coordination with the initiating service, to ensure period of performance dates are correct and match in all systems.[35]

End-Date and Order Amount Discrepancies

The inspection team reviewed FMS to IFCAP reconciliation reports for the period of August 2022 through January 2023 for end-date and order amount discrepancies. The team identified 16 open obligations with end-date discrepancies of three or more months. Healthcare system officials reported that because of the staff shortages over the past three years, they prioritized order amount differences between FMS and IFCAP instead of end-date differences. As a result of the inspection, the assistant chief financial officer said finance office staff began using the FMS to IFCAP reconciliation report to compare end dates and work on reconciling them.

The inspection team identified 22 additional open obligations with order amount discrepancies of three or more months. To determine whether order amounts were accurate and reconciled between the two systems, the team selected and evaluated 11 of these open obligations with order amount discrepancies totaling about $957,000.[36] The team reviewed and validated that the FMS and IFCAP order amount discrepancies were corrected by healthcare system staff before the inspection and took no exception to this issue.

During the review of order amounts, the team identified four obligations that had residual funds totaling approximately $7,200 that should have been deobligated in a timely manner after the goods were received. For these four obligations, healthcare system staff did not deobligate the residual funds after the initiating service had confirmed acceptance of all goods or services and all invoices had been received and paid. The procurement office should modify the contract or order to reflect the final cost and quantity of the goods or services and decrease the remaining

[34] 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.

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

[36] "FMS to IFCAP Reconciliation Reports" (website), VHA, https://vssc.med.va.gov/VSSCMainApp/products.aspx?PgmArea=59. (This website is not publicly accessible.)

funds on the obligation.[37] Contracting staff and service line staff should complete the deobligation in FMS in a timely manner. If the end date has passed and the obligation is no longer valid, those funds should also be deobligated and made available for use elsewhere.[38]

Finding 1 Conclusion

Healthcare system personnel should be aware of and comply with VA policy on open obligations. The inspection team found that, specifically for open obligations with no activity for more than 90 days, monthly reviews were not always conducted. Also, the inspection team found that for four obligations with residual balances totaling approximately $7,200, healthcare system staff did not deobligate funds after the goods were received. Failure to properly manage open obligations increases the risk of failing to spend appropriations within the associated fiscal year and leaving funds attached to orders when they could be used for other purposes to benefit veterans.

Recommendation 1

The OIG made one recommendation to the executive director of the VA Memphis Healthcare System:

1. Ensure that healthcare system finance office staff are made aware of all VA financial policy requirements in the review and management of inactive open obligations and deobligate any identified excess funds.

VA Management Comments

The VA Memphis Healthcare System executive director concurred with recommendation 1. The responses to all report recommendations are provided in full in appendix D.

To address recommendation 1, the executive director reported finance staff will be assigned updated training and will continue to work with initiating services regarding proper acceptance of goods and services as well as payment of invoices. The executive director also detailed efforts to work with human resources to address staffing vacancies regarding the recruitment and hiring of six accountants, including a vacancy for the supervisor.

OIG Response

The healthcare system executive director's action plans are responsive to the recommendation. The OIG will monitor implementation of the planned actions and will close the recommendation

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

when the OIG receives sufficient evidence demonstrating progress in addressing the intent of the recommendation and the issues identified.

II. Purchase Card Use and Oversight

VA established its Government Purchase Card Program to reduce the administrative costs of acquiring goods and services. When used properly, purchase cards can help facilities simplify acquisition procedures and provide an efficient vehicle for obtaining goods and services directly from vendors. During FY 2022, the VA Memphis Healthcare System spent approximately $34.2 million through purchase cards, representing approximately 32,100 transactions. The amount and volume of the healthcare facility's spending through the 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. Failure to properly manage the purchase card program increases the risk of insufficient documentation, improper payments, and missed opportunities to optimize cost savings.

The team reviewed the following areas:

- **Supporting documentation.** The team assessed whether healthcare system staff maintained supporting documentation as required for purchases to provide assurance of payment accuracy and to justify the need to purchase a good or service. This includes approved purchase requests, purchase orders, receiving reports, vendor invoices, and written justification for purchases from a third-party payer when necessary.[39] Supporting documentation enables program oversight and helps prevent fraud, waste, and abuse.
- **Purchase card transactions.** The team assessed whether approving officials ensured cardholders obtained prior approvals, conducted prompt reconciliation of transactions, and maintained segregation of duties.[40] Also, the team reviewed whether healthcare system staff processed purchase card transactions in accordance with VA policy, such as whether approving officials prevented split purchases designed to avoid exceeding the single-purchase limit or micropurchase threshold.[41]
- **Use of contracts.** The team assessed whether healthcare system staff considered obtaining contracts when procuring goods and services regularly, which VA refers

[39] VA Financial Policy, "Government Purchase Card for Micro-Purchases," in vol. 16, *Charge Card Programs* (May 2022), chap. 1B. Per this policy, cardholders should not use third-party payers unless there are no other available vendors and should justify in writing if a third-party payer is used and keep documentation identifying the actual vendor providing the item. Examples of third-party payers include PayPal, EMoney, E-Account, Amazon Marketplace, Google Checkout, and Venmo.

[40] VA requires that the duties of the cardholder, approving official, requesting official, and receiving official be separated. An agency or organization program coordinator cannot be a cardholder or an approving official. No one person may order, receive, certify funds, and approve a purchase card purchase.

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

to as strategic sourcing.[42] Using contracts reduces open-market or individual purchases and enables VA to leverage its purchasing power.

- **Purchase card oversight.** The team assessed whether the agency or organization program coordinator completed periodic purchase card reviews throughout FY 2022.[43] These reviews ensure systematic controls are in place to help reduce errors and ensure a facility complies with VA policy. In addition, the team reviewed VA 0242 forms to determine if each cardholder has a complete and accurate form.[44] An approved VA Form 0242 is used to delegate authority to an individual to use the purchase card to pay for goods and services. This form also establishes purchase limits and responsibilities and is essential for accountability for cardholders and approving officials. A revised form is required when the approving officer changes, cardholders legally change their names, or the single-purchase limit is increased above the originally requested amount.[45]

Finding 2: Healthcare System Staff Did Not Always Maintain Supporting Documentation or Consider Using Contracts

The team found that healthcare system leaders did oversee the purchase card program but could improve efficiency by consistently maintaining supporting documentation for purchase card transactions. In addition, healthcare system staff did not ensure approving officials and cardholders properly reviewed transactions to validate purchases and support strategic sourcing. Based on the results of the review, the team estimated healthcare system staff may have made noncompliance errors in just over 18,500 purchase card transactions, totaling approximately $19.8 million in questioned costs.[46] The healthcare system should continue to ensure internal reviews are conducted to mitigate the risk of fraud, waste, and abuse.

[42] VA Financial Policy, "Government Purchase Card for Micro-Purchases." Strategic sourcing is the practice of ensuring employees obtain proper contracts when procuring goods and services regularly.

[43] Agency/Organization Program Coordinators (A/OPC) - A VA employee that serves as the primary point of contact for the Government Purchase Card Program for their agency/organization. The A/OPC oversees administration of the Government Purchase Card Program in accordance with law, regulation, and policy.

[44] 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.

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

[46] 2 C.F.R. § 405 (2022). A questioned cost is (1) an alleged violation of a provision of a law, regulation, contract, grant, cooperative agreement, or other agreement or document governing the expenditure of funds; (2) a finding that, at the time of the audit, such cost is not supported by adequate documentation; or (3) a finding that the expenditure of funds for the intended purpose is unnecessary or unreasonable. Noncompliance issues were only included once for the purposes of calculating this projection. The team also considered margin of error and median confidence level when projecting questioned costs. For additional information regarding projection totals, see appendix B and tables B.1 and B.2.

Supporting Documentation

VA financial policy requires cardholders to upload and electronically store supporting documents for purchase card transactions to a VA-approved document-imaging system. When healthcare system staff buy goods and services, they must maintain supporting documentation, such as approved purchase requests, vendor invoices, purchase orders, and receiving reports, for six years.[47] This documentation verifies that purchase card transactions were properly approved and that payments were accurate.

The inspection team reviewed a statistical sample of 40 transactions to determine whether the medical center maintained required purchase card transaction documentation.[48] The team found that 13 sampled purchase card transactions were missing some required supporting documentation. For example, supporting documentation for three transactions did not contain vendor invoices. Based on these results, the team estimated cardholders may not have sufficient supporting documentation for just over 14,800 of 31,700 purchase card transactions (about 47 percent), which resulted in approximately $15.9 million in questioned costs. See appendix A for additional details on the scope and methodology and appendix B for details on sampling. This occurred because approving officials did not always ensure cardholders retained sufficient documentation to support purchase card transactions. In addition, the healthcare system has not implemented a consistent method for electronically storing documentation on the charge card portal or another VA-approved document-imaging system.

Purchase Card Transactions

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

- **Prior approval.** Before initiating a purchase, the cardholder must obtain prior approval for the purchase to ensure a valid business need; the approval may vary in form and content but must be retained as supporting documentation.[49]
- **Reconciliation.** Reconciliation of a purchase should be completed by the cardholder and approved by the approving official no later than the 15th calendar day of the month after the closing of the previous month's billing cycle (accounts not

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

[48] The inspection team reviewed a statistical sample of 40 purchase card transactions from a population of just over 31,700 purchase card transactions, totaling approximately $34.6 million from October 1, 2021, through September 30, 2022.

[49] 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.

reconciled within 30 days of the due date will have their single-purchase limit lowered).[50]

- **Segregation of duties.** Healthcare facility staff must maintain appropriate segregation of duties to ensure roles and responsibilities do not overlap among the cardholder, approving official, receiver of purchased items or services, or requesting official to reduce the risk of fraud, waste, and abuse.[51]

The inspection team assessed documentation for the 40 sampled purchase card transactions provided by healthcare system personnel to determine whether these requirements were met. The team found errors in 12 transactions regarding timely reconciliation. Based on these results, the team estimated cardholders may not have reconciled just over 14,800 transactions timely, resulting in approximately $15.8 million in questioned costs. Untimely reconciliation increases the risk for data integrity errors and fraud. These issues occurred because the facility was unable to provide evidence that showed cardholders and their approving officials performed reconciliations in a timely manner. Also, for one of the 12 transactions, the team was unable to determine whether prior approval and segregation of duties requirements were met due to the facility not providing any supporting documentation for a former employee of the healthcare system.[52] Table 1 shows the results of the sample review.

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

Requirement	Number of noncompliant transactions
Prior approval	1
Reconciliation approved by the 15th day of the month after the closing of the previous month's billing cycle	12
Segregation of duties	1

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

Approving officials must ensure transactions are legal, proper, and mission-essential. This includes ensuring that proper approvals are obtained and documented before the purchase and that segregation of duties is maintained throughout the transaction process.[53]

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

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

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

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

The inspection team also assessed if cardholders split purchases into two or more acquisitions to circumvent their authorized single-purchase limit. Contracting should be used when the total value of the requirement exceeds the micropurchase threshold or the cardholder's authorized single-purchase limit. Cardholders must not modify a requirement or order into smaller parts to avoid exceeding their micropurchase threshold, purchase card limit, or the use of formal contracting procedures. The requirement for the goods or services should be communicated to the contracting office for procurement.[54]

The team assessed 23 sampled purchase card transactions to determine whether cardholders split purchases.[55] After reviewing documentation and interviewing a purchase cardholder, approving official, and purchase card coordinator, the team determined none of the sampled transactions were split purchases. As a result, the team did not estimate cardholder transactions that may have been split purchases.

Use of Contracts

The inspection team also assessed the 40 sampled transactions for evidence that healthcare system staff had considered the most appropriate purchasing mechanism. In accordance with policy, VA cardholders should pursue establishing contracts for goods that are purchased on a recurring or ongoing basis. Known as strategic sourcing, this generally provides greater savings to VA rather than using purchase cards for open-market acquisitions without a negotiated price.[56] Approving officials, the agency or organization program coordinator, and cardholders must review purchases to determine when establishing contracts is in the best interest of the government. Generally, VA should use contracts if the purchase is for an ongoing order of goods or services.

During the review, the team determined five sampled purchase card transactions were open-market purchases from four merchants. Further analysis of FY 2022 purchase card data showed that healthcare system staff made just over 70 purchases, totaling approximately $231,000, from these four merchants. Healthcare system staff made these purchases through the open market instead of establishing contracts that could have resulted in negotiated prices and potential cost savings. Table 2 shows the four merchants with the total number of transactions and amounts spent for the healthcare system in FY 2022.

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

[55] VA Financial Policy, "Government Purchase Card for Micro-Purchases." A split purchase occurs when a cardholder intentionally modifies a known single requirement into two or more purchases or payments to avoid exceeding the single purchase limit or the micropurchase threshold.

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

Table 2. Four Merchants with Open-Market Purchases from the VA Memphis Healthcare System

Merchants	Amount spent	Transaction count
Merchant 1	$123,468	25
Merchant 2	$81,968	27
Merchant 3	$21,133	7
Merchant 4	$4,060	14
Total	**$230,630**	**73**

Source: VA OIG team's assessment of FY 2022 purchase card data from the VA Memphis Healthcare System. Numbers may not sum due to rounding.

Generally, the improper reliance on open-market purchases appeared to persist at the healthcare system because contracts were not established for routinely purchased items. Throughout the transaction process, approving officials and cardholders should communicate with the contracting office to establish contracts and minimize open-market purchases. To meet the intent of VA policy, approving officials and cardholders should work with the contracting office to determine whether alternative contracting options are warranted or available.[57]

Purchase Card Oversight

Periodic purchase card reviews are intended to evaluate and improve the effectiveness of internal controls and compliance with regulations and policies. VA policy requires the purchase card coordinator and the Financial Services Center to conduct reviews to ensure purchases are properly documented and identify potential split purchases, unauthorized commitments, fraud, waste, and abuse.[58] The purchase card coordinators should also analyze spending patterns and determine whether cardholders are optimizing purchasing power and cost savings by using strategic sourcing techniques. Last, reviewers should identify and report any issues and ensure remediation actions are effective.[59]

During the inspection period, the team found that the purchase card coordinator only conducted internal purchase card reviews for the first, second, and fourth quarters of FY 2022. The Network Contracting Office 9 purchase card manager stated that he suspended the internal review for the third quarter of FY 2022 to revise the review process and to standardize the format for reporting the review information to station directors. It is imperative that these internal reviews are

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

[58] VA Financial Policy, "Government Purchase Card for Micro-Purchases." The Financial Services Center provides a wide range of financial and accounting products and services to both the VA and Other Government Agencies (OGA).

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

consistently completed to help identify purchase card internal control weaknesses and ensure corrective actions are taken by healthcare system staff to help mitigate the risk of fraud, waste, and abuse.

Additionally, the team found that 14 of 15 cardholders responsible for the sampled purchase card transactions had a VA Form 0242. An approved VA Form 0242 is used to delegate authority to an individual to use the purchase card to pay for goods and services. Healthcare system staff were unable to provide a VA Form 0242 for one former employee. Also, three cardholders had inaccurate spending limits compared to the cardholder's US Bank data.

Finding 2 Conclusion

Healthcare system personnel should be aware of and comply with VA policies on purchase card record retention requirements and use of contracts to strategically source goods to meet facility needs. Failure to properly manage the purchase card program increases the risk of insufficient documentation, improper purchases, and missed opportunities to optimize cost savings. The healthcare system should continue to ensure reviews are conducted to identify internal control weaknesses to mitigate the risk of fraud, waste, and abuse.

Recommendations 2–3

The OIG made the following recommendations to the executive director of the VA Memphis Healthcare System:

2. Ensure cardholders comply with VA financial policy record retention requirements.
3. Establish controls to confirm approving officials and purchase cardholders review purchases for VA policy compliance and ensure contracting is used when it is in the best interest of the government.

VA Management Comments

The VA Memphis Healthcare System executive director concurred with recommendations 2–3.

To address recommendation 2, the executive director reported that local processes are being refined to archive purchase card transaction documentation on a common shared drive. The purchase card coordinator stated that a new guidebook will soon be published with additional required documents for all purchase card transactions. The executive director also reported that purchasing agents will be made aware of the new requirements, and spot checks will be conducted periodically on the folders to ensure compliance by the acquisition utilization specialist supervisor.

For recommendation 3, the executive director reported that the purchase card coordinator has provided a pre-approval memo template to be used going forward. The acquisition utilization specialist supervisor will ensure a memo is completed for FY 2024. The executive director also

reported that efforts are being made to ensure contracting is used when it is in the best interest of the government and that transactions are periodically checked to determine if establishing a contract is appropriate.

OIG Response

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

III. Supply Chain Management Operations

Supply chain management is the integration and alignment of people, processes, and systems across the supply chain to manage all product and service planning, sourcing, purchasing, delivering, receiving, and disposal activities. 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 veterans receive high-quality care.[60] Supplies are received at the warehouse and distributed to a primary inventory point and then to a secondary inventory storeroom at a medical facility if established by a healthcare system.[61] Secondary inventory storerooms are maintained by the clinical staff who use these supplies.

The Generic Inventory Package is the software system authorized to manage the receipt, distribution, and maintenance of expendable supplies used throughout VA. This system uses an item master file, created within IFCAP, to store and track information, such as the description, mandatory source or vendor details, unit price, packaging, and manufacturing information for each item. Per VHA policy, it is essential that this information be entered into the IFCAP system completely and correctly. Access to item master files in IFCAP is controlled to ensure data integrity and accuracy. The VA medical facility chief supply chain officer is responsible for maintaining the access list and reviewing it each calendar year.[62]

The team reviewed the following areas:

- **Days of stock on hand performance metrics.** The team assessed whether the healthcare system met the performance metric for days of stock on hand—a supply performance measure for items purchased through the MSPV program and for non-MSPV items, which promotes inventory level efficiency.
- **Inventory data accuracy.** Using analysis of Supply Chain Data Informatics Office Toolbox reports and interviews conducted during the inspection, the team completed a physical count of some of the high-value items in two of the primary inventory points.
- **Supply chain management oversight.** The team also assessed processes that affected the healthcare system's supply chain management, reviewed required quarterly physical

[60] VHA Directive 1761.

[61] A primary inventory point contains all expendable items for an inventory account and are replenished by placing orders outside of the VA medical facility. When established, secondaries serve as points of distribution related to, and replenished from, a primary inventory. A primary with no secondary is referred to as a stand-alone primary inventory.

[62] VHA Directive 1761.

inventory for "A" classified items, and assessed whether healthcare system staff properly maintained and reviewed edit access to the item master file.[63]

Finding 3: The Healthcare System Should Ensure Supply Chain Operations Comply with VHA Policy and Inventory Data Are Accurate

The team found that the healthcare system could improve the efficiency of inventory management by establishing processes and procedures to ensure stock levels and their associated expendable inventory data values are recorded correctly and routinely monitored in the Generic Inventory Package. The team found that the healthcare system was unable to provide evidence that staff conducted physical inventory reviews of "A" classified items in the first or second quarters of FY 2023 or that the chief supply chain officer reviewed the edit access list for the item master file according to policy. In addition, the healthcare system did not meet performance metrics that measure days of stock on hand. 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. Leadership vacancies and staffing shortages may have affected the ability of the healthcare system to establish local processes and procedures, develop training plans, and conduct supply chain oversight.

Days-of-Stock-On-Hand Performance Metrics

The Supply Chain Common Operating Picture (SCCOP) dashboard tracks the use of expendable and nonexpendable items. The dashboard, which receives part of its data from the Generic Inventory Package, lists the performance measure for expendable supplies purchased through the MSPV program as 30 days or fewer of stock on hand, whereas non-MSPV items should have 45 days or fewer of stock on hand.[64] Before the inspection site visit, the team accessed the SCCOP dashboard and downloaded the healthcare system's "MSPV Days of Stock on Hand" and "Non-Prime Vendor Days of Stock on Hand" reports from October 2022 to January 2023. To determine whether MSPV and non-MSPV items met the days-of-stock-on-hand metrics, the team reviewed the healthcare system's monthly performance and clinical primary inventory

[63] "A" classified items, which garner the highest 80 percent of annual usage dollars for a given year, are reviewed quarterly. Only clinical item (versus nonclinical) inventories were assessed for this inspection. VHA defines clinical items as nondurable, disposable healthcare materials ordered or prescribed, which are primarily and customarily used to serve a medical purpose. Physical inventories of "A" classified items are to be conducted each quarter.

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

points.[65] The team determined that the healthcare system averaged 57 days of stock on hand for MSPV items and 97 days of stock on hand for non-MSPV items during the review period.

The team also evaluated a sample of clinical primary inventory points within the supply chain management service line that were subject to days-of-stock-on-hand metrics. However, the days-of-stock-on-hand metrics were missing from the report, so the team could not fully determine the number of inventories that met the MSPV or non-MSPV metrics. Instead, the team determined that seven of 21 clinical inventory points (33 percent) did not have metric data in the report, and eight of 25 clinical primary inventory points (32 percent) with non-MSPV items did not include metric data—one of the top two inventory points by dollar value was missing data for both the MSPV and non-MSPV item categories. One staff member reported not scanning assigned inventories due to workload and a lack of time. The chief of supply chain management during the OIG's site visit expressed concerns about the staff's ability to complete duties due to insufficient leadership and a lack of training. In addition, staff reported a lack of training at the local level.

Using available data pertaining to days of stock on hand, the team found none of the clinical primary inventories with MSPV items met the 30-day metric, and 15 of 17 clinical primary inventories with non-MSPV items (88 percent) did not meet the 45-day metric. The inability to meet the days-of-stock-on-hand metric was primarily due to a lack of staff to conduct required inventory management procedures. Noncompliance with inventory management hinders the healthcare system's ability to obtain accurate and current information about stock levels and values when ordering supplies, which increases the risk of overstocking or understocking inventory items. Efforts are underway by healthcare system leaders and staff to identify strategies to overcome these challenges.

Inventory Data Accuracy

After analyzing SCCOP reports, the team identified the top two inventories by value on hand. A physical count of selected items was assessed for data accuracy.[66] During the physical counts, the team found discrepancies between stock levels reported in the inventory management system and those in storage for both the C-CARDIO and C-SURG inventory points.[67] For instance, the team counted intravenous infusion pumps and electrocardiogram electrode patches at the C-CARDIO primary clinical inventory space. There were eight intravenous infusion pumps, valued at

[65] The inspection team only considered clinical primary inventory points for analysis. Inventory Point Identifier. The Inventory Point Identifier (IE) is an internal system identifier for the inventory point that is automatically assigned when the inventory point is created.

[66] The top two inventories by value on hand and items were selected from a point-in-time determination based on accessing the "All Days of Stock on Hand Summary by Inventory Point" report from the SCCOP dashboard on March 23, 2023.

[67] C-CARDIO represents a clinical inventory point with inventory items for the cardiology service line. C-SURG represents a clinical inventory point with inventory items for the surgical service line.

approximately $201,000, counted at the inventory space versus three items, valued at approximately $75,400, reported in the system. This discrepancy amounted to an increase in value on hand of about $126,000. In addition, the team counted 44 electrocardiogram electrode patches, valued at approximately $13,200, at the C-CARDIO primary clinical inventory space, versus 250 items, valued at approximately $75,000, that were reported in the system. This discrepancy amounted to a decrease in value on hand of approximately $61,800 (see table 3). The C-CARDIO inventory management specialist acknowledged that inventory barcodes had not been scanned in some time, which affected the accuracy of inventory data.

Table 3. C-CARDIO Clinical Primary Inventory Point Physical Count of Selected Items

Item	System data		Physical inventory count		Increase/decrease in value
	Number of items	Value on hand	Number of items	Value on hand	
Intravenous infusion pumps	3	$75,400	8	$201,000	+$126,000
Electrocardiogram electrode patches	250	$75,000	44	$13,200	-$61,800

Source: VA OIG team assessment of C-CARDIO inventory data versus a physical inventory count.
Note: Numbers do not always sum due to rounding.

The team counted custom heart pumps and specialized surgical gloves at the C-SURG primary clinical inventory space. Counts for these items were also different from data pulled from the inventory management system. Specifically, the team counted six custom heart pumps at the inventory space, valued at approximately $7,200, versus a count of 32 reported in the system, with a value of $38,600. This discrepancy amounted to a decrease in value on hand of approximately $31,400. For specialized surgical gloves, the team identified three boxes in stock, with a value of approximately $640, while the system reported 308 boxes with a value of approximately $66,100. This discrepancy amounted to a decrease in value on hand of approximately $65,500 (see table 4). The C-SURG inventory management specialist acknowledged that inventory barcodes had not been scanned in some time, which affected the accuracy of inventory data.

Table 4. C-SURG Clinical Primary Inventory Point Physical Count of Selected Items

Item	System data		Physical inventory count		Increase/decrease in value
	Number of items	Value	Number of items	Value	
Custom heart pumps	32	$38,600	6	$7,200	-$31,400
Specialized surgical gloves	308	$66,100	3	$640	-$65,500

Source: VA OIG team assessment of C-SURG inventory data versus a physical inventory count.
Note: Numbers do not always sum due to rounding.

Staff attributed noncompliance with counts of inventories to a lack of staff, as well as the lack of time due to the overwhelming quantity of inventory points assigned. Both the current chief supply chain officer and staff members acknowledged inventory data were not accurate but stated that plans to correct the issue had been initiated. The current chief supply chain officer also told the team that he has emphasized scanning inventories since assuming this role.[68]

The team also assessed conversion factor data, which can affect the accuracy of days-of-stock-on-hand metrics. A unit conversion factor is computed by dividing the quantity purchased by the quantity issued.[69] This factor connects how a supply item is purchased and issued. For example, a vendor may sell an item in cases of 24 cans, but the end user (hospital staff) receives individual cans from that case. A "false" conversion factor showing in the SCCOP dashboard may be the result of a conversion being entered into the Generic Inventory Package system incorrectly. The team accessed the SCCOP dashboard to review the healthcare system's conversion factor primary inventory report.[70] At the time the report was accessed, six of 9,501 conversion factors (0.06 percent) for clinical primary inventory points had false results.[71] The OIG considered this result immaterial and did not take exception in this review area.

Data inaccuracies can impact stock levels and the ability of the healthcare system to automate ordering. Automated ordering reduces separate purchases to the same vendor within short

[68] The assistant chief supply chain officer during the inspection team's site visit was promoted to chief supply chain officer at the healthcare system on June 5, 2023.

[69] Department of VA Office of Information and Technology Product Development, Integrated Funds Distribution, Control Point Activity, Accounting and Procurement (IFCAP) Version 5.1 Generic Inventory User's Guide, October 2000, rev. October 2019. A conversion factor expresses the ratio between the vendor's unit of measure and the unit of issue and is used to translate the order quantities into supply station amounts.

[70] The inspection team accessed the Conversion Factor Primary Inventory Point report from the SCCOP dashboard on March 23, 2023; this report details point-in-time conversion factor data at the healthcare system.

[71] When a conversion factor does not equal an item's unit of receipt (i.e., bought by the case) divided by the unit of issue (distributed by the case), it is flagged as a "false" result.

periods of time. During the week of the inspection site visit, VISN staff were on site providing auto-generation tool training to inventory staff. Supply chain personnel reported that the facility was not currently using the auto-generation tool due to inaccurate data. The current chief supply chain officer informed that use of this tool would be incremental as inventory data are corrected. As processes and data become more reliable, the healthcare system can become more efficient through the consistent use of the automated ordering of stock.

Supply Chain Management Oversight

During the site visit, the team interviewed supply chain service leaders and staff to assess factors that affected the healthcare system's oversight controls and efficiency. The former chief supply chain officer reported inconsistent leadership and inadequate staffing levels at the facility. Staff members also reported challenges related to inconsistent leadership, inadequate local training and staffing levels, as well as unbalanced workloads at the healthcare system. During the past five years, the chief supply chain officer role has been held by five different individuals. As of the beginning of June 2023, the facility reported 14 vacancies among 79 positions within the supply chain management service. Specifically for the expendable supply distribution section, the vacancies include six supply technicians. These issues may have hindered efforts necessary to manage inventory supplies, detect and reduce data validity issues, and to meet the days-of-stock-on-hand performance metrics.

In March 2023, the VISN 9 chief logistics officer and staff conducted a quality control review. This review yielded 59 supply chain management areas at risk requiring the development of a corrective action plan. As detailed within the memorandum of results following the quality control review, the VISN 9 chief supply chain officer will liaise with the medical center in all matters regarding supply chain management and action plans associated with the findings of the quality control review. As local staff work to address issues, the VISN 9 Supply Chain Management Office will serve as a collaborative partner and sounding board as needed.

The team assessed oversight related to the required quarterly physical inventory of "A" classified items and for the edit access list for the facility item master file. "A" classified items comprise the highest 80 percent of annual usage dollars.[72] VHA policy designates the chief supply chain officer as responsible for signing and sending physical inventory memoranda to the VISN chief logistics officer and deputy network director.[73] The current chief supply chain officer reported physical inventories were conducted; however, the healthcare system was unable to provide any

[72] In the ABC classification method, inventory point items with the highest 80 percent of annual usage dollars are classified as "A." Items with the next highest 10 percent of annual usage dollars are classified as "B." Finally, items representing the remaining 10 percent of annual usage dollars are classified as "C." The formula for calculating the annual usage dollars of an item is the annual usage quantity multiplied by the average unit price. Only clinical item (versus nonclinical) inventories were assessed for this inspection.

[73] VHA Directive 1761.

documentation to support this statement. A recent quality control review conducted by the VISN also reported the facility was considered noncompliant in conducting physical inventory reviews. By monitoring completion and routing of the physical inventory memoranda, leaders can acknowledge inaccuracies and demonstrate efforts that aim to correct or mitigate potential issues.

The inspection team also assessed if healthcare system staff maintained and reviewed the edit access list for the facility item master file. The edit access list documents all individuals at a VA medical facility who have permission to enter or modify data within the item master file, which holds pertinent supply item details.[74] Although the inspection team received documentation that the edit access list was maintained, the current chief supply chain officer was unable to provide the team with documentation to demonstrate when, or if, the former chief supply chain officer reviewed the access list for FY 2022 or FY 2023. The current chief supply chain officer told the team that, although the access list is periodically reviewed, there is no formal, written process in place to conduct the review. Proper oversight of the access list helps to ensure unauthorized staff do not access the inventory system and input erroneous data. Accurate data for inventory supplies is necessary for the continuity of healthcare services for veterans.

Finding 3 Conclusion

Supply chain management at the VA Memphis Healthcare System was not sufficient to ensure the proper oversight of expendable supplies. Establishing local processes and procedures for the timely scanning of inventories and developing a plan for the standardization of staff training would increase the reliability of inventory data. Ensuring that quarterly physical inventory memoranda of "A" classified items is completed and that the chief supply chain officer documents the annual review of the edit access list for the facility item master file could improve the healthcare system's management and controls over inventory supplies.[75] Lack of local policies and procedures, as well as unreliable inventory data, can lead to purchasing unnecessary supplies and can adversely affect patient care. By addressing the OIG's recommendations, the healthcare system can more effectively plan and budget for supplies to operate and meet patient care needs.

[74] The item master file is a file within the IFCAP software program that captures storage information for items, including item description, mandatory source, vendor, unit price and packaging, and product and manufacturer information. This file links with the request and procurement files and provides for the extraction of item procurement history.

[75] VHA Directive 1761.

Recommendations 4–7

The OIG made the following recommendations to the executive director of the VA Memphis Healthcare System:

4. Establish local processes and procedures to ensure the routine scanning of inventory items, as well as monitoring of all inventory data, so that performance measures are maintained.
5. Ensure supply chain managers implement a plan to train staff to promote the standardization of supply chain duties and to correct data validity issues within inventory systems.
6. Ensure the chief of supply chain services conducts and documents quarterly physical inventory memoranda of "A" classified items in accordance with Veterans Health Administration's Directive 1761, *Supply Chain Management Operations*.
7. Ensure the chief supply chain officer reviews the edit access list for the facility item master file, and a process is put in place to document this review, as required in the Veterans Health Administration's Directive 1761, *Supply Chain Management Operations*.

VA Management Comments

The VA Memphis Healthcare System executive director concurred with recommendations 4–7.

To address recommendation 4, the executive director reported stand-alone primary inventory scanning is being monitored on a monthly basis at the local level. Staffing shortages and imbalanced workload for current staff have been challenges for the healthcare system; however, the healthcare system hired six new employees in the past six months, so inventory management is anticipated to improve.

For recommendation 5, the executive director said the healthcare system is continuing to work on training staff and correcting data validity issues. Conversion factor errors, along with other metrics contained in the SCCOP portal, are monitored on a weekly basis, and the logistics management specialist or the chief supply chain officer sends reminders to the assigned inventory management specialist to correct identified errors. Continued efforts, training, and ownership have been reported as contributing to the decline in data errors and the ability to continue to meet performance metrics.

To address recommendation 6, the executive director reported "A" inventories were attempted but not completed to standard during the inspection review period. VISN-provided training material on ABC inventories and "A" and "B" inventories were implemented during the first quarter of FY 2024.

For recommendation 7, the executive director said the logistics management specialist maintains the item master file list, and a policy will be established to routinely review the list.

OIG Response

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

IV. Pharmacy Operations

The FY 2023 OPES pharmacy expenditure model, based on FY 2022 VA data, reported that the VA Memphis Healthcare System spent almost $67 million on prescription drugs. This spending represented just over 9 percent of the healthcare system's medical care budget.[76] Healthcare system leaders should analyze spending and identify opportunities for efficient use of pharmacy dollars. 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.** These data are designed to allow VHA facilities to track costs and identify potential opportunities for improvement.
- **Inventory turnover rate.** This rate is the number of times inventory is replaced during the year and is the primary measure to monitor the effectiveness of inventory management per VHA policy.[77] Low inventory turnover rates could indicate inefficient use of financial resources.
- **Noncontrolled drug line monitoring.** VHA policy requires monitoring to be performed quarterly for specific drugs identified.[78]
- **The B09 reconciliation process.** VA medical center pharmacies ensure they make correct payments for the drugs they receive through B09 reconciliation. This process is necessary because payments are made to the prime vendor before the drugs are received from the pharmacy prime vendor. Without reconciliation, there is no assurance that the amount paid to the prime vendor is consistent with the amount of goods received.
- **End-of-year purchases of pharmacy drugs.** Purchasing drugs at the end of the year can lower the inventory turnover rate and increase the total replenishment cost of pharmacy inventories. These purchases complicate pharmaceutical inventory management and are to be avoided, according to Pharmacy Benefits Management program office guidance and VHA policy.[79]

[76] "Office of Productivity, Efficiency and Staffing (OPES) Pharmacy Expenditure Model" (based on FY 2022 data) (website), OPES, http://opes.vssc.med.va.gov/Pages/Pharmacy-Model.aspx. (This website is not publicly accessible.)

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

[78] VHA Directive 1108.08(1), *VHA Formulary Management Process*, November 2, 2016, was amended August 29, 2019; subsequently, it was rescinded and the requirement to monitor noncontrolled drugs on a quarterly basis was incorporated into VHA Directive 1108.07, *General Pharmacy Service Requirements*, November 28, 2022.

[79] VHA Directive 1108.07, *General Pharmacy Service Requirements*, November 28, 2022.

Finding 4: The Healthcare System Could Improve Oversight Controls

The team found the healthcare system could improve pharmacy efficiency by aligning processes with inventory management best practices, such as achieving an inventory turnover rate closer to the VHA-recommended level and using barcode labeling for shelving when point-of-use equipment is in place. In addition, healthcare system staff did not consistently complete some B09 monthly reconciliations.[80] Failure to properly manage pharmacy operations can lead to increased replenishment costs, overstocking, spoilage, and diversion of drugs, and can decrease the funding available to meet other healthcare system and patient care needs.

OPES Pharmacy Expenditure Data

The OPES pharmacy expenditure model, which identifies variations in pharmacy costs among VHA facilities, showed that the healthcare system's observed-minus-expected ratio was 0.85 during FY 2022, also resulting in a top ranking of 14 out of 139 among VHA facilities for pharmacy drug cost efficiency. An observed-minus-expected ratio above 1.0 indicates that a facility may have opportunities to reduce its pharmacy costs.[81] From FY 2020 through FY 2022, the healthcare system averaged approximately $6.4 million in annual cost savings, which reflects that the system spent less than expected for similar facilities as outlined within the model. In FY 2020, the healthcare system reported almost $2.8 million lower-than-expected costs. This increased to about $4.5 million in FY 2021 and then increased significantly in FY 2022, to about $11.9 million lower than expected. Figure 4 describes the healthcare system's year-over-year increases in observed-minus-expected costs.

[80] VHA Directive 1108.07. The Fiscal B09 report is reviewed and reconciled with the VA Form 1358 to ensure that the pharmacy makes correct payments for what is received and documents (signature and date of review) that a purchase has been completed.

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

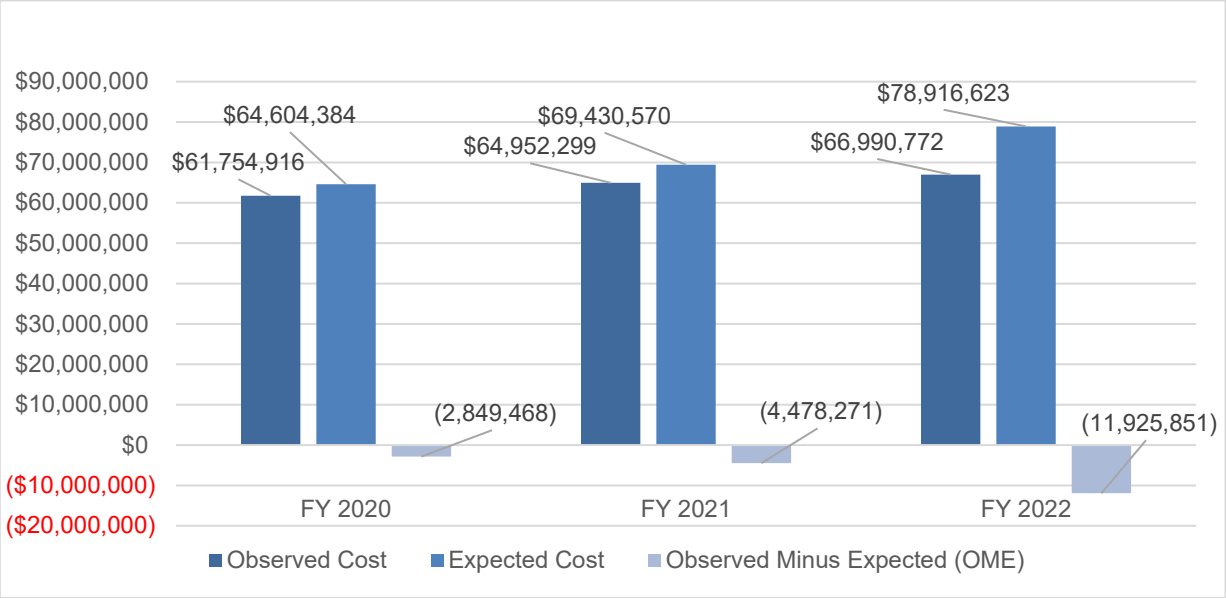


Figure 4. *Observed versus expected drug cost, FY 2020–FY 2022.*
Source: OPES pharmacy expenditure model.
Note: The OPES data models are based on the previous fiscal year data (i.e., the FY 2023 data model was based on FY 2022 data).

Pharmacy personnel were familiar with the OPES models and reported use of them for business decisions. The chief pharmacy service also attributed cost savings to several other areas. During FY 2022, the healthcare system achieved 124 percent of its savings opportunity goal identified by the VA Pharmacy Benefits Management office's savings opportunities report. The chief pharmacy service reported that reviews of expenditures, demand, and costs per unique veteran are conducted frequently to determine proper pricing and efficient ordering. In addition, the pharmacist for research and pharmacoeconomics reviews the cost savings monitoring website to determine which initiatives are to be implemented and how current efforts compare to other facilities. Through efforts to evaluate cost savings, the facility recognized $2.6 million in savings. Additionally, the facility reported that the VISN pharmacist executive site visit was conducted annually, and the Pharmacy and Therapeutics Committee met at least four times each calendar year to discuss issues or cost-saving opportunities with facility stakeholders. Last, the facility reported that due to the changing nature of drug prices, processes are in place to review pricing on a daily basis to ensure proper ordering and receipt of pharmaceuticals.

Inventory Turnover Rate

VHA adopted the "ABC" classification principles to increase accountability for inventory management and to establish more rigorous requirements for highest-dollar usage inventory items. This classification 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 the highest-dollar amount of usage to the lowest. Items with the highest 80 percent of annual usage dollars are

classified as "A" items, with the next highest 10 percent classified as "B," and the remaining classified as "C".[82]

Based on VHA policy, inventory turnover is the primary measure of the effectiveness of inventory management, and the VA Pharmacy Benefits Management office is responsible for guidance on turnover rates. The Pharmacy Benefits Management office recommends 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.[83] Higher inventory turnover rates are associated with decreased inventory carrying cost (that is, the cost associated with holding inventory storage). On the other hand, low inventory turnover could indicate inefficient use of financial resources and the inability to properly forecast the number of pharmaceuticals needed to meet patient care needs. The team found that in February 2023, the turnover rate for pharmacy inventory was consistent with meeting the Pharmacy Benefits Management inventory turnover rates for "B" items but did not meet the target rates for "A" and "C" items. Reports reflected an inventory turnover rate of 11 times for "A" items, six times for "B" items, and four times for "C" items.

VHA policy requires that the Pharmacy Service use the pharmaceutical prime vendor's inventory management software to manage inventory turnover rates for facility inventories.[84] However, according to the chief pharmacy service at the VA Memphis Healthcare System, pharmacy drug inventories are maintained in a manner that differs from the Pharmacy Benefits Management inventory turnover target rates. Therefore, the facility considers its current process for reviewing turnover rates as more encompassing than those provided in the prime vendor's inventory management software reports. Because the Pharmacy Benefits Management office guidance is the only established policy that outlines turnover rate targets, the OIG team used these turnover rates to assess the healthcare system's inventory management. Efforts to assess facility reconciliation among Pharmacy Benefits Management inventory turnover target rates, prime vendor reporting tools, and results of annual wall-to-wall inventory are ongoing.

The team also found pharmacy staff were not using required barcodes. VHA policy requires its medical facilities to use computerized barcode labels to identify all expendable items within a primary and secondary inventory point, including point-of-use equipment. Barcode labels should be affixed to shelving in point-of-use cabinets so that in the event of a system failure, staff can continue operations and manually scan barcodes for restocking purposes. The team found that the facility did not consistently have barcode labels on its shelves, or in some instances if labels were present, they were outdated and did not correctly represent the drug that was stored there. For example, there were missing labels on the shelving where excess pharmaceuticals from the

[82] VHA policy mandates the ABC inventory analysis method. VHA Directive 1761, app. E.

[83] VHA Pharmacy Benefits Management office, email message to the VHA Pharmacy Executives, February 2023; VHA Directive 1761, app. E.

[84] VHA Directive 1761, app. H.

point-of-use cabinets are stored. Following the visit by the inspection team, pharmacy staff began correcting barcode labels; therefore, the OIG is not making any recommendations related to this issue.

Noncontrolled Drug Line Audits

VHA policy requires regular facility-based inventory audits for specific drugs identified as high cost or at high risk for diversion. A manual count of each drug item selected must be completed and compared to reports and other tools chosen by local pharmacy managers. The variance between the observed and predicted amount on hand for the reporting period must be calculated. Variances greater than 5 percent require the healthcare system to perform an in-depth review and analysis.[85]

The OIG team reviewed the healthcare system's quarterly noncontrolled drug line audits for FY 2022 and determined that they met VHA policy requirements. The team found that the results of the audits were reported to healthcare system managers through the quality assurance process on a quarterly basis. Quarterly summaries were also reported to VISN pharmacy executives. Interviews with pharmacy staff and supporting documentation indicated these reviews assisted in determining potential variance issues with the automated dispensing equipment used in the pharmacy. Other variances identified would require further investigation because the source of the issue was unknown.

B09 Reconciliation Process

VHA policy requires pharmacy service staff to review B09 reports and to reconcile those reports with VA Form 1358 and other supporting documentation.[86] VA Form 1358 is an obligation control document.[87] The reconciliation is necessary to ensure pharmacy is making correct payments for purchases received and with documented evidence (signature and date of review) it has been completed. The report is generated weekly and summarizes multiple invoices. The pharmacy service must provide a monthly report with adequate documentation to the fiscal service stating the VA 1358 forms and B09 reports were reconciled, and any unresolved discrepancies were noted. VHA policy also states that pharmacy staff must maintain segregation of duties during the VA Form 1358 ordering process. This requires different staff members to establish, approve, obligate, and receive the goods ordered.[88] B09 reconciliations are necessary because payments are made to the prime vendor before the facility receives ordered

[85] VHA Directive 1108.08(1).

[86] VHA Directive 1108.07. The B09 reconciliation process is how VA medical center pharmacies review what is ordered against what is received to ensure they are making correct payments for the drugs they receive.

[87] VA Financial Policy, "1358 Obligations," in vol. 2, *Appropriations, Funds and Related Information* (September 2021), chap. 6, app. A.

[88] VHA Directive 1108.08(1).

pharmaceuticals. Without a consistent process for reconciliation, there is increased risk that the amount paid to the prime vendor is inconsistent with the goods received.

The OIG team found the healthcare system's B09 reconciliation process was not fully compliant with VHA policy. Officials did not consistently sign and date invoices to document receipt of ordered goods. The inspection team reviewed invoices from B09 weekly reconciliations for December 26–30, 2022, and February 13–17, 2023. Of the 131 invoices reviewed, valued at just over $752,000, the inspection team found 40 invoices (about 31 percent) were not signed and dated to document receipt of goods for which the healthcare system paid. This resulted in approximately $264,000 of unsupported questioned costs. Staff reported that several personnel can receive ordered goods, and the healthcare system faces challenges ensuring process consistency among all staff. Healthcare system staff reported they will disseminate the necessary policy requirements and local policies to ensure reconciliations are conducted consistently going forward.

End-of-Year Purchases of Pharmacy Drugs

The inspection team found that the healthcare system had what appeared to be an increase in pharmaceutical drug expenditures during the last month of the fiscal year in one of the three years analyzed. The healthcare system averaged approximately $4.6 million in monthly expenditures during the 11 months of FY 2020, which jumped to about $11.4 million in the last month. In FY 2021, the healthcare system averaged approximately $5.4 million in monthly pharmaceutical drug expenditures for 11 months and reported about $5.6 million in expenditures for the last month. In FY 2022, pharmacy drug expenditures averaged just over $5.5 million in monthly expenditures for 11 months and just under $6.3 million in the last month.

Figure 5 shows the monthly pharmacy drug expenditures during FY 2020, FY 2021, and FY 2022.

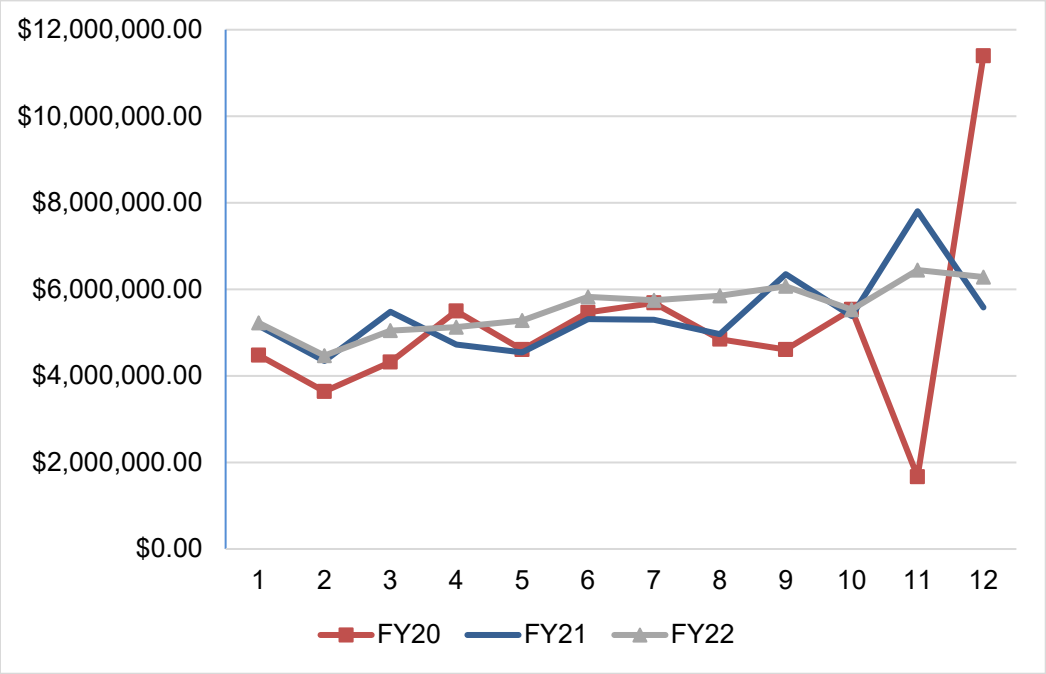


Figure 5. *Monthly drug expenditure data at the VA Memphis Healthcare System for FY 2020 through FY 2022 (October 2019–September 2022).*
Source: VA OIG analysis of VA FMS (FMS 830/887 report).

The chief of pharmacy service reported the healthcare system does not make end-of-year purchases. In FY 2020 there appears to be a spike in the last month of the year; however, this spike was caused by a calculation error in the pharmacy expenditure model. VHA policy and guidance from the Pharmacy Benefits Management office recommend that end-of-year purchases make pharmaceutical inventories increasingly difficult to manage and need to be avoided.[89] Additionally, stock levels should be kept at a minimum for efficient use of financial resources.

Finding 4 Conclusion

The healthcare system can improve pharmacy efficiency by increasing its inventory turnover rate to meet the VHA-recommended level for "A" and "C" items; the healthcare system met the national inventory turnover target rate for "B" items. The healthcare system could further improve efficiency and policy compliance by completing the B09 reconciliation process to ensure that the amount paid to the prime vendor agrees with the amount of actual goods.

[89] VHA Directive 1761.

Recommendations 8–9

The OIG made the following recommendations to the executive director of the VA Memphis Healthcare System:

8. Develop a plan to align inventory management practices, such as ABC inventory analysis methodology, with Veterans Health Administration policy.
9. Establish processes to ensure compliance with the Veterans Health Administration directive to complete the B09 reconciliation process.

VA Management Comments

The VA Memphis Healthcare System executive director did not concur with recommendation 8 but did concur with recommendation 9.

To address recommendation 8, the executive director reported the ABC inventory analysis methodology was removed from VHA Directive 1761. The executive director agrees that inventory turnover is one method for determining efficiencies within the Pharmacy Service but reported the Pharmacy Benefits Management office provided quarterly pharmaceutical prime vendor inventory turnover report as a reference. The executive director reported that the healthcare system considers the annual wall-to-wall inventory completed every January as a more comprehensive approach for oversight of pharmaceutical inventory turnover management. The healthcare system uses electronic inventory management software in both the inpatient and outpatient pharmacies, allowing continuous monitoring of on-hand inventory, the ability to set maximum and minimum inventory, and suggested ordering based upon utilization and locally established restock levels in accordance with policy. The executive director also reported that a full-time inventory management pharmacist oversees these efforts to ensure appropriate medications and supplies are available for patient care.

For recommendation 9, the executive director said due to significant turnover among pharmacy technician and procurement staff during the timeframe of invoice review, several invoices did not have appropriate signatures and dates. Staffing has stabilized and a new inventory program manager pharmacist is in place to oversee all aspects of the B09 reconciliation process. Monthly audits will be completed by the pharmacy quality assurance program manager to confirm compliance going forward. Outcomes from the audits will be reported to the facility quality manager through the chief of pharmacy on a quarterly basis. Following two sustained quarters of compliance, the local quarterly audit process will include only a sampling of invoices for compliance.

OIG Response

Regarding the executive director's response to recommendation 8, the OIG agrees that the annual wall-to-wall inventory is an important part of inventory management but disagrees that the

Pharmacy Benefits Management-provided quarterly pharmaceutical prime vendor inventory turnover report is just a reference. VA policy requires the prime vendor inventory turnover report to be reviewed to efficiently manage inventory turnover rates. During the OIG inspection, the healthcare system staff stated reviewing the prime vendor inventory turnover report was not part of the current local process. To maintain compliance with all VHA directives and handbooks, the executive director reported the healthcare system uses electronic inventory management software in both the inpatient and outpatient pharmacies for continuous monitoring, setting inventory levels and suggested ordering based upon utilization and local restock levels. However, the OIG received no relevant evidence or supporting documentation by which to evaluate these actions.

The healthcare system executive director's action plan for recommendation 9 is responsive to the recommendation. The OIG will monitor implementation of the reported and planned actions and considers these recommendations open until sufficient evidence is provided demonstrating progress in addressing the intent of the recommendations and the issues identified.

Appendix A: Scope and Methodology

Scope

The team conducted its inspection of the VA Memphis Healthcare System from April 2023 to November 9, 2023, including a site visit during the week of April 3, 2023. The inspection is limited in scope and is not intended to be a comprehensive inspection of all financial operations at the healthcare system.

Methodology

The team evaluated financial efficiency practices for fiscal year (FY) 2022 and for the first four months of FY 2023 related to open obligations and days of stock on hand for expendable supplies. The team also analyzed financial efficiency practices related to the healthcare system's pharmacy costs using the Veterans Health Administration (VHA) FY 2023 Office of Productivity, Efficiency and Staffing (OPES) data model; however, the FY 2023 data model was based on FY 2022 data.

To conduct the inspection, the team

- interviewed facility leaders and staff,
- identified and reviewed applicable laws, regulations, VA policies, operating procedures, and guidelines related to managing open obligations, overseeing purchase card transactions, calculating days-of-stock-on-hand metrics, and addressing inefficiencies in pharmacy costs, and
- judgmentally sampled
    - 20 inactive obligations to assess whether healthcare system staff identified and reviewed the obligations to determine whether they were still valid and needed to remain open in accordance with VA financial policy,
    - 11 obligations with different order amounts from VA's Financial Management System (FMS) to Integrated Funds Distribution, Control Point Activity, Accounting and Procurement System (IFCAP) Reconciliation reports were selected to determine which system reflected accurate order amounts and if further reconciliation efforts were needed in either VA's FMS or IFCAP, and
- statistically sampled
    - 40 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 Memphis Healthcare System significant to the inspection objective. This included an assessment of the five internal control components: control environment, risk assessment, control activities, information and communication, and monitoring.[90] In addition, the team reviewed the principles of internal controls as associated with this objective. The team identified internal control weaknesses during this inspection in all four subobjectives assessed—open obligations, purchase cards, and supply chain management, and pharmacy—and proposed recommendations to address the control deficiencies.

Fraud Assessment

The inspection team exercised due diligence in staying alert for the risk that fraud and noncompliance with provisions of laws, regulations, contracts, and grant agreements, significant within the context of the inspection objectives, could occur during this inspection. The 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, and the OPES efficiency opportunity grid. To test for reliability, the team determined whether any data were missing from key fields, including any calculation errors, or were outside the time frame requested. The team also assessed whether the data contained obvious duplication of records, alphabetic or numeric characters in incorrect fields, or illogical relationships among data elements. 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-level data were sufficiently reliable for reporting on the healthcare system's open obligations.

Government Standards

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

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

Appendix B: Sampling Methodology

Open Obligations

The team evaluated a judgmental sample of open obligation transactions from August 2022 through January 2023 to determine whether (1) VA Memphis Healthcare System staff performed monthly reviews and reconciliations of the reviewed obligations with no activity for more than 90 days to ensure the obligations were valid and should remain open and (2) healthcare system staff reconciled order amounts between VA's Financial Management System (FMS) and Integrated Funds Distribution, Control Point Activity, Accounting and Procurement System (IFCAP) for sampled obligations.

Population

During January 2023, the healthcare system had 752 open obligations, totaling approximately $111.3 million. Of those open obligations, 276 obligations, totaling approximately $22.9 million, had no activity for more than 90 days. From August 2022 through January 2023, there were 22 obligations with order amount discrepancies between FMS and IFCAP for three or more months.

Sampling Design

The inspection team selected two judgmental samples:

- **Inactive obligations.** The team selected 20 obligations with no activity for more than 90 days from the January 2023 FMS F850 report. This report lists each open obligation and its remaining balance. Ten obligations were still within the performance period, and the remaining 10 were more than 90 days past the performance period end date.
- **FMS to IFCAP reconciliations.** The team selected 11 obligations with different order amounts between FMS and IFCAP from VA's FMS to IFCAP Reconciliation reports for August 2022 through January 2023.

The samples included 31 total open obligations: 20 with no activity for more than 90 days, totaling approximately $13.4 million, and 11 obligations with different order amounts between FMS and IFCAP totaling approximately $445,000.

The team requested supporting documentation for each of the 31 sampled transactions, including monthly reviews and reconciliations, financial system screen prints and reports, and emails related to the obligations.

Projections and Margins of Error

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

Purchase Cards

The inspection team evaluated a statistical sample of FY 2022 purchase card transactions to determine whether VA Memphis Healthcare System staff (1) reviewed purchase card payments to ensure they were adequately monitored, approved, and supported by documentation and (2) reviewed transactions for compliance with processes to prevent split purchases and transactions exceeding the cardholder's authorized single-purchase limit and to ensure goods or services were procured using strategic-sourcing procedures.

Population

During FY 2022 (October 1, 2021–September 30, 2022,) purchase cardholders at the facility made about 32,100 purchase card transactions totaling approximately $34.2 million. This sampling frame was developed inclusive of two strata: potential split transactions and nonpotential split transactions. Just over 500 transactions were potential split transactions, whereas about 31,600 were nonpotential split purchase transactions. However, for sampling purposes, the team removed an estimated 400 transactions with negative amounts, resulting in a total of just over 31,700 transactions as the sample projection population.

Sampling Design

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

- **Potential split purchases.** The team identified potential split purchases as transactions with the same purchase date, purchase card number, and merchant and an aggregate sum greater than the cardholder's authorized single procurement limit.
- **Nonpotential split purchases.** Transactions in this stratum were the remaining transactions after potential split purchase transactions were identified.

The statistical sample included 40 total individual transactions: 23 potential split purchase transactions, totaling approximately $103,000, and 17 nonpotential split purchase transactions totaling approximately $122,000.

To review the 40 sampled transactions, the team requested supporting documentation for each transaction, VA Form 0242, and documentation to support the completion of purchase card reviews.

Projections and Margins of Error

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

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

The sample size was determined after reviewing the expected precision of the projections based on the sample size, potential error rate, and logistical concerns of the sample review. While precision improves with larger samples, the rate of improvement decreases significantly as more records are added to the sample review (figure B.1).

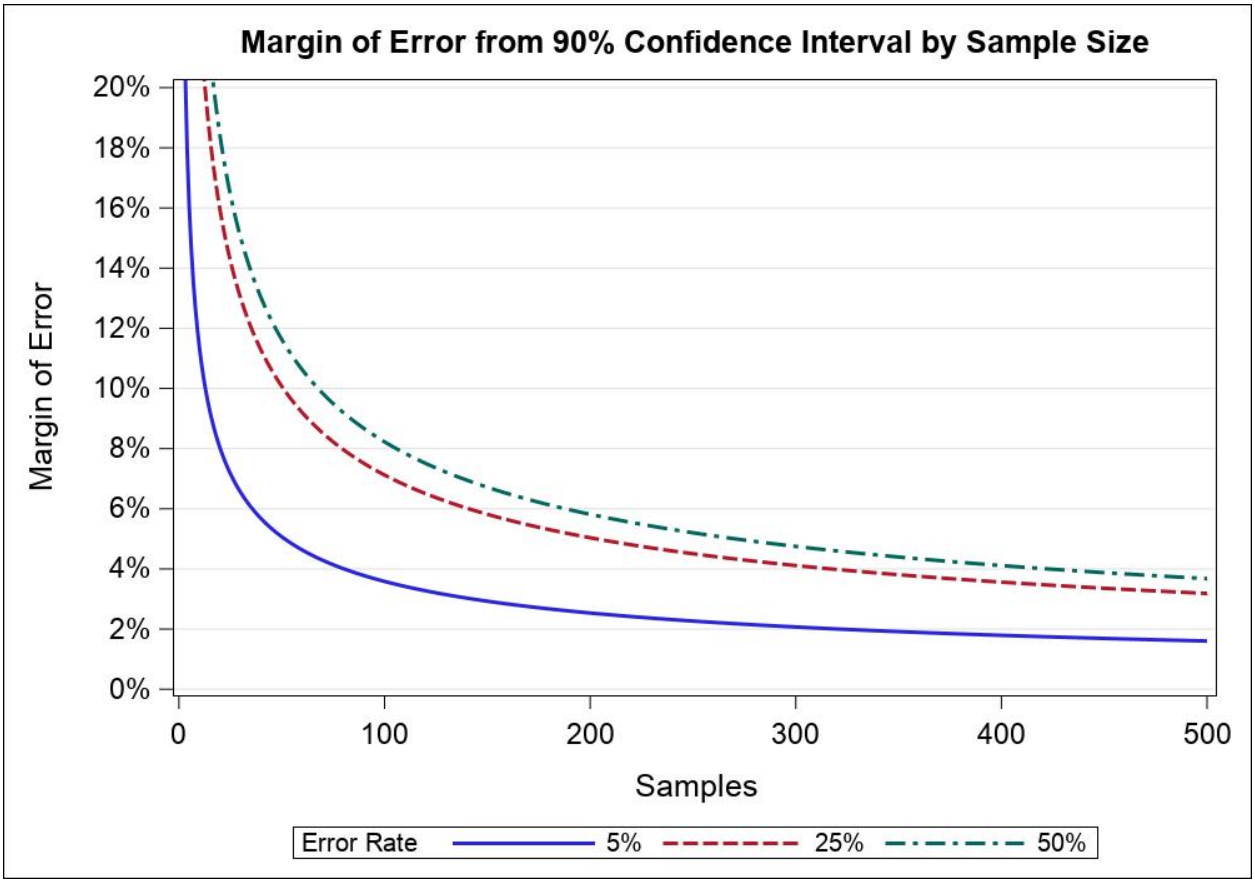


Figure B.1. *Effect of sample size on margin of error.*
Source: OIG statistician's analysis.

Projections

The team reviewed a statistical sample from a population of about 31,700 purchase card transactions, totaling approximately $34.6 million. Using the results from the sample, the team

estimated that just over 18,500 transactions, totaling approximately $19.8 million, were not processed in accordance with VA policy. [91] Further analysis of the sampled transactions indicated that the VA Memphis Healthcare System

- may not have supporting documentation for just over 14,800 transactions, totaling approximately $15,900,000; and
- may not have made prompt reconciliations for just over 14,800 transactions, totaling approximately $15,800,000.

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

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

Estimate name	Estimate number	90 percent confidence interval			Number of errors	Sample size
		Margin of error	Lower limit	Upper limit		
Overall errors (percent)	18,501 (58)	6,493 (20)	12,008 (38)	24,995 (79)	15	40
Supporting documentation	14,819	6,586	8,233	21,404	13	40
Prompt reconciliation	14,801	6,586	8,216	21,387	12	40

Source: VA OIG statistician's analysis and team's review of purchase card transactions.
Note: When reporting on total errors combined, a projected overall errors estimate is used to avoid double-counting transactions.

[91] Note that some transactions were in both categories, so the dollar amount does not sum to $19.8 million.

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

Estimate name	Estimate number	90 percent confidence interval			Number of errors	Sample size
		Margin of error	Lower limit	Upper limit		
Overall errors	$19,824,842	$6,905,416	$12,919,426	$26,730,258	15	40
Supporting documentation errors	$15,909,821	$7,003,303	$8,906,519	$22,913,124	13	40
Prompt reconciliation	$15,826,575	$7,002,152	$8,824,423	$22,828,727	12	40

Source: VA OIG statistician's analysis and team's review of purchase card transactions.
Note: When reporting on total errors combined, a projected overall errors estimate is used to avoid double-counting transaction amounts.

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

Recommendation	Explanation of Benefits	Better Use of Funds	Questioned Costs[92]
1	Ensure healthcare system finance office staff are made aware of policy requirements and reviews are conducted on all inactive open obligations as required by VA financial policy.	$7,200	$0
2–3	Ensure cardholders comply with VA financial policy record retention requirements. Establish controls to confirm approving officials and purchase cardholders review purchases for VA policy compliance and ensure contracting is used when it is in the best interest of the government.	$0	$19,800,000
9	Establish processes to ensure compliance with the Veterans Health Administration directive to complete the B09 reconciliation process.	$0	$264,000
	Total	**$7,200**	**$20,100,000**

[92] 2 C.F.R. § 405 (2022). A questioned cost is (1) an alleged violation of a provision of a law, regulation, contract, grant, cooperative agreement, or other agreement or document governing the expenditure of funds; (2) a finding that, at the time of the audit, such cost is not supported by adequate documentation; or (3) a finding that the expenditure of funds for the intended purpose is unnecessary or unreasonable. The OIG questions costs when VA action or inaction (such as spending or failure to fully compensate eligible beneficiaries) is determined by the OIG to violate a provision of law, regulation, contract, grant, cooperative agreement, or other agreement; are not supported by adequate documentation; or are expended for purposes that are unnecessary or unreasonable under governing authorities. 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 estimated $20,100,000 in questioned costs, approximately $16,200,000 were unsupported costs.

Note: Numbers do not always sum due to rounding.

Appendix D: VA Management Comments

Department of Veterans Affairs Memorandum

Date: December 18, 2023

From: Joseph P. Vaughn, MBA, FACHE, Executive Director

Subj: V09-24-354-OSV: Financial Efficiency Inspection of VA Memphis HCS – Draft Report 16Nov2023

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

Attached is the management at VA Medical Center at Memphis, Tennessee's response to the Draft Report for the Financial Efficiency Inspection of the VA Memphis Healthcare System. Responsible official(s) for each recommendation have prepared a written response. In instances where a consolidated response was needed to a recommendation involving multiple offices, the highest – ranking officials provided response.

(Original signed by)

Joseph P. Vaughn, MBA, FACHE

Executive Director

Attachment

Attachment

Finding 1: Inactive Obligations Were Not Always Being Reviewed, and Some Obligations Were Not Deobligated Timely.

Recommendation 1:

1. Ensure the finance office staff are aware of all VA financial policy requirements in the review and management of inactive open obligations and deobligate any identified excess funds.

Concur. We will ensure assigned finance staff receive updated training and continue to work with initiating services regarding acceptance of the goods and services and the receipt and payment of invoices. Additionally, we continue to work with HR regarding the recruitment and hiring of six accountants, including our vacancy for the supervisor, in spite of the nationwide shortage for this specific skill set.

Target Completion Date: March 30, 2024

Finding 2: Healthcare System Staff Did Not Always Maintain Supporting Documentation or Consider Using Contracts.

Recommendation 2-3

2. Ensure cardholders comply with VA financial policy record retention requirements.

Concur: We will refine our process for using the S: drive to archive GPC transactions. Some purchasing agents in logistics used it to archive transactions. However, they did not archive with all the required documents per the purchase card coordinator. The purchase card coordinator stated that a new guidebook coming out from Purchase Card Operations will require an 0242, 2237, Purchase Order, Receipt/Invoice, Pre-Approval Memo, and third-party verification (if applicable). The AUS Supervisor will ensure all purchasing agents are aware of this requirement and periodically conduct spot checks on the folders to ensure compliance.

Target Completion Date: March 30, 2024

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

Concur: The purchase card coordinator provided a template for a pre-approval memo. This template will be utilized going forward. The AUS supervisor will ensure one is completed for FY24. We strive to always ensure contracting is utilized when it is the best interest of the government. We will conduct period spot check on transactions to determine if setting up a contract is appropriate.

Target Completion Date: March 30, 2024

Finding 3: The Healthcare System Should Ensure Supply Chain Operations Comply with VHA Policy and Inventory Data are Accurate.

Recommendation 4 - 7

4. Establish local processes and procedures to ensure the routine scanning of inventory items, as well as monitoring of all inventory data, so that performance measures are maintained.

Concur: Stand-alone primary inventory scanning is monitored monthly at the local level. Although not 100% monthly as required per VHA Directive 1761, there have been improvements on scanning. Inventory Management Specialist (EX - expendable) staffing shortages were a contributing factor to this

finding. At points, Supply Chain Management (SCM) was 60% filled on authorized Inventory Management Specialist (IMS) (EX) which resulted in people having to cover multiple inventory points. Additionally, the IMS (EX) were not familiar with the additionally assigned inventory points. During the past six months, six new IMS(EX) have been hired. As they are trained and become more familiar with their assigned inventories, inventory management will improve.

Target Completion Date: March 30, 2024

5. Ensure supply chain managers implement a plan to train staff to promote the standardization of supply chain duties and to correct data validity issues within inventory systems.

Concur: Training and correcting data validity issues are ongoing. Specific to conversion factor errors discussed in the report, we currently have 16. Conversion factor errors, along with other metrics contained in the Supply Chain Common Operating Picture portal (SCCOP), are monitored weekly and reminders are sent by Logistics Management Specialist (EX) or the Chief Supply Chain Officer to the assigned IMS (EX) to correct the errors. The number of conversion factor errors fluctuates. For perspective, in February 2022, we had over 1600 conversion factor errors. A lot of hard work and effort contributed to this decline. The key to sustainability of all SCCOP performance metrics is training and IMS(EX) taking ownership of their assigned inventory.

Target Completion Date: March 30, 2024

6. Ensure the chief of supply chain services conducts and documents quarterly physical inventory memoranda of "A" classified items in accordance with Veterans Health Administration's Directive 1761, *Supply Chain Management Operations*.

Concur: "A" inventories were not conducted as required by VHA Directive 1761. The inventories were attempted but not completed to standard. VISN conducted and provided training material on ABC inventories. Both "A", and "B" inventories were conducted Q1, FY24.

Target Completion Date: March 30, 2024

7. Ensure the chief supply chain officer reviews the edit access list for the facility item master file, and a process is put in place to document this review, as required in the Veterans Health Administration's Directive 1761, *Supply Chain Management Operation*

Concur: The logistics management specialist maintains the item master file list. We will establish a policy to review the Item Master File (IMF) list on a routine basis. Currently, we have been editing it when someone new arrives or someone departs.

Target Completion Date: March 30, 2024

Finding 4: The Healthcare System Could Improve Oversight Controls.

Recommendation 8 - 9

8. Develop a plan to align inventory management practices, such as ABC inventory analysis methodology, with Veterans Health Administration policy.

Non-Concur. The ABC inventory analysis methodology was removed from VHA Directive 1761 when it was published in December 2020, and its use is not required by any VHA Guidance, Policy, Handbook, or Directive. We agree that inventory turns are one method for determining efficiencies within the Pharmacy Service. However, there is not a suggested inventory turn rate established by Pharmacy Benefits Management (PBM). (Please see email from the Assistant Deputy Chief Consultant, PBM Clinical Informatics) **(See attachment).** PBM provides a quarterly report from the Pharmaceutical Prime Vendor

which includes inventory turns for reference, but report does not consider the actual inventory on the shelf and excludes products which are ordered from sources other than the Pharmaceutical Prime Vendor. For this reason, VA Pharmacies conduct an annual Wall-to-Wall Inventory every January to have more comprehensive oversight of our inventory management. The Memphis VA utilizes electronic inventory management software in both the inpatient and outpatient pharmacies. This software allows continuous monitoring of on-hand inventory, the ability to set maximum and minimum inventory, and suggests ordering based upon utilization and locally established restock levels. With this information, we have the ability to maintain compliance with all VHA Directives and Handbooks. Pharmacy procurement balances the local utilization pattern with the knowledge of recent pharmaceutical and supply recalls and manufacturer back orders to ensure appropriate medications and supplies are available for patient care. In compliance with VHA Directive 1108.07, a full-time Inventory Management Pharmacist oversees these efforts.

Target Completion Date: March 30, 2024

9. Establish processes to ensure compliance with the Veterans Health Administration directive to complete the B09 reconciliation process.

Concur. Significant turnover of pharmacy technician staff to include procurement technician staff during the timeframe of invoice review contributed to the number of invoices without appropriate signatures and dates. Staffing has stabilized and a new inventory program manager pharmacist is in place to oversee all aspects of the B09 reconciliation process. Monthly audits will be completed by the Pharmacy Quality Assurance Program Manager to confirm compliance. Outcomes from these audits will be reported to the Facility Quality Manager through the Chief of Pharmacy on a quarterly basis. After two sustained quarters of compliance, audits of a representative sample of invoices will be done quarterly.

Target Completion Date: March 30, 2024

Attachment

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

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Lance Kramer, Director Tesia Basso Zachary Beres Curtis Boston Jennifer Casteline Melissa Garcia Jill Talbot
Other Contributors	Daniel Blodgett Jill Russell Clifford Stoddard

Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Veterans Health Administration
National Cemetery Administration
Assistant Secretaries
Office of General Counsel
Office of Acquisition, Logistics, and Construction
Board of Veterans' Appeals
Director, VISN 9: MidSouth Healthcare Network
Director, VA Memphis Healthcare System

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Accountability
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
US Senate: Marsha Blackburn, Bill Hagerty
US House of Representatives: Steve Cohen

OIG reports are available at www.vaoig.gov.