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Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Follow-up Financial Efficiency Inspection of the Southeast Louisiana Veterans Health Care System in New Orleans

Financial Inspection | **23-02907-216** | **September 3, 2024**

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Executive Summary

In 2019, the VA Office of Inspector General (OIG) started a financial efficiency inspection program. These inspections assess stewardship and oversight of funds at Veterans Health Administration (VHA) healthcare systems, identify opportunities to achieve cost efficiencies, and promote best practices. Inspection teams identify and examine financial activities controlled by a VHA healthcare system and compare that system's performance to other VHA healthcare systems similar in size and complexity.[1]

The OIG previously inspected the Southeast Louisiana Veterans Health Care System in New Orleans, Louisiana, in 2021 and made six recommendations. This follow-up inspection examined whether the healthcare system made improvements in the oversight of funds and corrected previously identified issues.

During this follow-up inspection, the team found that issues from the 2021 report had not been fully resolved pursuant to plans submitted in response to earlier recommendations.[2] The data reviewed by the inspection team varied for each activity but were from no earlier than May 1, 2022, and no later than April 30, 2023. The team assessed the same four financial activities and administrative processes discussed in the 2021 report:

I. **Medical/Surgical Prime Vendor (MSPV) program use.** VA healthcare systems must use MSPV contracts for medical, surgical, dental, and other products available through the program, with the goal that 90 percent of the healthcare system's spending on MSPV-eligible items be through the MSPV program. The inspection team examined whether the healthcare system met VHA goals for using the program.

II. **Purchase card use.** When used properly, purchase cards can help healthcare systems simplify acquisition procedures and provide an efficient vehicle for obtaining goods and services directly from vendors.[3] Cardholders should obtain approvals before initiating purchases, transactions should be reconciled by the cardholder and approved by an approving official in a timely manner, and segregation of duties should be maintained. Documenting transactions as required by VA policy helps the agency and other oversight

[1] VHA Office of Productivity, Efficiency and Staffing, "VHA Facility Complexity Model Data Definitions," October 1, 2023. The VHA Facility Complexity Model categorizes medical facilities by complexity level based on patient population, clinical services offered, research and educational, and operational cost. Complexity levels include 1a, 1b, 1c, 2, or 3. Level 1a facilities are considered the most complex and level 3 facilities are the least complex. The facility groupings are used for various peer grouping purposes, such as operational reporting, performance measurement, and research studies. The Southeast Louisiana Veterans Health Care System was rated as a level 1b, high-complexity facility.

[2] VA OIG, *Financial Efficiency Review of the Southeast Louisiana Veterans Health Care System in New Orleans*, Report No. 20-00971-235, September 20, 2021.

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

authorities identify potential fraud, waste, and abuse.[4] The inspection team examined whether the healthcare system ensured compliance with purchase card program policies and procedures.

III. **Administrative staffing levels.** Large administrative overhead in health care, which can include high administrative staff levels, is increasingly identified with cost inefficiency.[5] The inspection team determined whether the healthcare system's administrative staffing levels improved since the OIG issued its 2021 financial efficiency report.

IV. **Pharmacy operations.** Pharmacy expenditures, which rely on sound inventory management, account for a substantial percentage of a healthcare system's budget, and healthcare system leaders should analyze this spending to identify opportunities to use pharmacy dollars more efficiently. The inspection team evaluated whether the healthcare system complied with VA policies to use cost and performance reports to review progress, track inventory turnover goals, use scannable barcodes, and follow required B09 reconciliation procedures.[6]

The inspection team performed a site visit at the Southeast Louisiana Veterans Health Care System in August 2023; interviewed healthcare system leaders and staff; and reviewed data, supporting documents, and processes related to the healthcare system's financial efficiency. For more information about the inspection's scope and methodology, see appendix A.

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

What the Inspection Found

The OIG identified issues with MSPV program use, purchase card use, and pharmacy operations. In each area, the healthcare system made limited progress improving issues identified in the OIG's 2021 inspection report. The inspection team found that the healthcare system made

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

[5] VHA Office of Productivity, Efficiency & Staffing, Efficiency Opportunity Grid Model Summaries, https://dvagov.sharepoint.com/:w:/r/sites/VHAOPES/_layouts/15/Doc.aspx?sourcedoc=%7BF01DA872-43D9-482C-9AC0-5A73E121BE4B%7D&file=Efficiency%20Opportunity%20Grid%20Model%20Summaries.docx&action=default&mobileredirect=true&DefaultItemOpen=1. (The website is not publicly accessible.)

[6] VHA Directive 1108.07, *General Pharmacy Service Requirements*, November 28, 2022. The Fiscal B09 report is reviewed and reconciled with 1358 forms to ensure the pharmacy is making correct payments for what is received and there is documented evidence (signature and date of review) that the B09 reconciliation has been completed. VHA Office of Finance, Financial Management & Accounting Systems Alert, "Pharmacy Prime Vendors B09 Reconciliation Standard Operating Procedures," October 3, 2012. The Pharmacy Service will prepare a monthly B09 reconciliation package with a memorandum and supporting documentation (such as invoices, the B09 report, and pharmaceutical prime vendor reports) to provide the reconciliation results to the Finance Service.

improvements in administrative staffing efficiency, but opportunities for improvement continued to exist.

The Healthcare System Did Not Meet the Goal for MSPV Utilization and Did Not Monitor Contract Performance Adequately or Submit Waiver Requests

The healthcare system's MSPV utilization rate, which measures the extent to which healthcare systems use prime vendors for purchases, decreased to about 57 percent for the inspection team's review period from May 2022 through April 2023, compared to the utilization rate of 75 percent noted in the OIG's 2021 report.[7] The monthly average ranged from about 49 percent to about 64 percent. Comparatively, utilization rates for VHA overall averaged 62 percent, and Veterans Integrated Service Network (VISN) 16 averaged 65 percent for the same period. A similar issue was noted during the prior inspection of the healthcare system.

The healthcare system had two different MSPV contracts during the inspection period from May 1, 2022, through April 30, 2023.[8] The contract existing at the start of the team's review period was effective through November 30, 2022. The second contract started on December 1, 2022, and continued past the end of the team's review period. The team found deficiencies in the management and oversight of purchases under both contracts, which resulted in potential improper payments totaling about $1.4 million and about $180,000 in questioned costs. The issues identified stemmed from two factors:

- Healthcare system staff placed orders against the second MSPV contract without delegations of authority.
- The appointed MSPV facility-level contracting officer's representative (COR) under the first contract did not perform monitoring and oversight duties, such as reviewing the accuracy of invoiced distribution fees against contract term.

Healthcare system personnel should alert program leaders and other VA procurement offices if prime vendors do not meet their obligations.[9] The OIG found that the healthcare system did not use three performance reporting tools to monitor the healthcare system's satisfaction with the

[7] These data come from the Supply Chain Common Operating Picture, a dashboard used by Veterans Integrated Service Network (VISN) and facility supply chain staff to manage performance on 14 key metrics and perform deep-dive analysis on supply chain data. The *OB4. Medical Surgical Formulary Utilization* report in the Supply Chain Common Operating Picture is a metric for the MSPV program. The utilization percentage indicates how well a facility used this streamlined supply chain to obtain the everyday-use items purchased through the program.

[8] The first contract was the MSPV-Generation Z Transition (contract 36C10X22D0003), effective December 2021 through November 2022, and the second contract was the MSPV-Generation Z Transition 2 (contract 36C10X23D0003), effective December 2022 through November 2023.

[9] Medical Supplies Program Office, Medical/Surgical Prime Vendor Program, *MSPV Frequently Asked Questions*, p. 23, number 54, April 2019.

MSPV program, product list, and prime vendor performance. The healthcare system did not complete monthly facility execution surveys between May 1, 2022, and April 30, 2023. It also did not report performance issues using the issue reporting tool, which VHA's Procurement and Logistics Office encourages, but does not require. The team also determined that quarterly evaluation reports, which are required to be completed by the MSPV facility-level COR, were not completed during the team's inspection period.

The OIG also found that the healthcare system was not aware of the requirements to submit national contract waiver requests, and as a result, the healthcare system did not submit any waivers. These waivers are required when a healthcare system purchases medical supplies from nonmandatory procurement instruments.[10] Per VHA policy, the waiver is to be used if and when there is a compelling clinical need to deviate from using mandatory procurement instruments, which includes the MSPV contract, to buy medical supplies.[11] Also, each waiver request must provide a valid, justifiable, and appropriate rationale for purchases from nonmandatory procurement instruments.

The Healthcare System Did Not Effectively Ensure Purchases Were Reviewed and Strategic Sourcing Was Used

The inspection team evaluated a statistical sample of 74 purchase card transactions to determine if healthcare system staff considered the use of a contract when it was in the government's best interest.[12] The team analyzed the transactions, which occurred from May 1, 2022, through April 30, 2023, and determined that the healthcare system's expenditures with its top 10 vendors, by dollar amount, were over $10.9 million. The team found that contracts could have been considered for three of those vendors, for just over 3,000 transactions totaling at least $2.7 million. The healthcare system's purchases from these three vendors were made on the open market rather than through contracts that could have resulted in cost savings.

The team evaluated the sample of 74 transactions to assess the purchase card transaction documentation. Based on the sample review, the team projected that cardholders did not obtain prior approval for about 4,200 transactions, resulting in just under $4.1 million in questioned

[10] VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020, p. A-5; Office of Procurement, Acquisition and Logistics, "Medical/Surgical Prime Vendor (MSPV) Program," https://www.va.gov/opal/sac/mspv.asp. (This website is not publicly accessible.); When there is a compelling clinical need to deviate from the requirement to purchase medical supplies from procurement instruments designated as mandatory by VHA policy, healthcare systems must submit a national contract waiver request.

[11] VHA, "Medical/Surgical Prime Vendor (MSPV)" (standard operating procedure), rev. May 2017.

[12] VA Financial Policy, "Government Purchase Card for Micro-Purchases," p. 10. Pursuant to the policy, "strategic sourcing" includes ensuring employees obtain proper contracts when regularly procuring goods and services. Purchases that exceed the cardholder's single purchase threshold cannot be made on purchase cards. Split purchases occur when a cardholder circumvents this requirement by dividing a single purchase or need into two or more smaller purchases.

costs. The team also identified purchase card transactions in which cardholders did not have documentation of approved purchase requests from VA personnel, which included an appropriate justification such as a consult from a doctor supporting the need for the purchase. While on-site, the team learned that pharmaceutical vendor sales representatives contacted healthcare pharmacy cardholders via email and had them create purchase orders for drugs that had been prescribed to a patient. The cardholders made the purchases based solely on the emails, without checking the patient's health records for a doctor's order or prescription. This occurred because the pharmaceutical staff were unaware of the need to substantiate that a legitimate request has been made from VA personnel before making the purchase. As a result, the team projected that at least 940 transactions for at least $909,000 lacked documentation of the request from VA personnel.

The team also identified transactions that were not reconciled or approved by the 15th day of the month after the previous month's billing cycle as required by VA policy.[13] As a result, the team projected that approximately 3,800 transactions for about $3.6 million were not reconciled or approved promptly. The team determined that at least 73 percent of these transactions were reconciled promptly by cardholders but were not approved by approving officials within the required time frame. In addition, the team identified that the healthcare system did not maintain segregation of duties for approximately 5,500 transactions, totaling about $5.3 million in questioned costs. Untimely reconciliations and segregation-of-duty issues increase the risk for data integrity errors and fraud.

The inspection team also reviewed the sample to determine whether the healthcare system maintained required purchase card transaction documentation.[14] The team projected that cardholders may not have had sufficient supporting documentation for at least 2,800 transactions, which resulted in at least $2.8 million in questioned costs.[15]

The Healthcare System Improved Administrative Staffing Efficiency

The VHA Office of Productivity, Efficiency and Staffing's (OPES) model indicated that from fiscal year (FY) 2019 through FY 2023, the healthcare system had a decrease in the difference between expected and actual administrative full-time equivalent positions, but opportunity for improvement continued to exist. The 2021 OIG report found that the healthcare system had almost 252 more administrative full-time equivalent positions than systems of similar size and medical complexity. In FY 2023, these positions decreased by 166, but the healthcare system

[13] VA Financial Policy, "Government Purchase Card for Micro-Purchases," p. 15.

[14] The inspection team reviewed a statistical sample of 74 purchase card transactions from a population of approximately 44,800 totaling about $44.2 million from May 1, 2022, through April 30, 2023.

[15] See appendix A for additional details on the scope and methodology and appendix B for details on sampling. Per 2 C.F.R. § 200.84 (2014), a questioned cost is: (a) an alleged violation of a provision of a law, regulation, contract, grant, cooperative agreement, or other agreement or document governing the expenditure of funds; (b) a finding that, at the time of the audit, such cost is not supported by adequate documentation; or (c) a finding that the expenditure of funds for the intended purpose is unnecessary or unreasonable.

still had 86 more full-time equivalent positions than other systems of similar size and complexity. However, the OIG found that several factors influenced healthcare system staffing, such as the use of activation funding to hire before having a workload history, high vacancy rates, and VHA strategies for growing the workforce.[16]

The Healthcare System Could Improve Pharmacy Efficiency and Strengthen Oversight Controls

The OPES pharmacy expenditure model, which identifies variations in pharmacy costs among VHA facilities, showed that the healthcare system had about $86.9 million in drug costs in FY 2022. According to the OPES model, for FY 2020 through FY 2022, the healthcare system demonstrated decreasing efficiency. In FY 2020 the healthcare system's observed drug costs were almost $7.6 million more than expected. In FY 2021, drug costs were about $13.1 million higher than expected, and in FY 2022 this amount increased to about $18.7 million higher than expected.

The inventory turnover rate is the number of times inventory is used during the year and is the primary measure for monitoring the effectiveness of inventory management per VHA policy.[17] Low inventory turnover rates indicate inefficient use of financial resources. The VHA Pharmacy Benefits Management Office recommended an annual inventory turnover goal of 12 to 16 times for items classified as "A" and six to 10 times for "B" and "C" items.[18] The pharmacy chief said she was aware of these targets, but the healthcare system did not meet them for A and C items. In FY 2022, the pharmacy prime vendor reported that the healthcare system had an inventory turnover rate of 9.6 times for "A" items, 6.4 times for "B" items, and 3.7 times for "C" items.

The OIG found that the healthcare system had a sharp increase in pharmaceutical drug expenditures during the last month of each fiscal year analyzed. The healthcare system averaged just over $2 million in monthly expenditures during the first 11 months of FY 2021, which jumped to almost $5.9 million in the last month. In FY 2022 the healthcare system averaged almost $2.3 million in monthly pharmaceutical drug expenditures during the first 11 months and reported about $5.6 million in expenditures for the last month.

[16] VHA Directive 7516, *VHA Activations Program*, October 24, 2023. Activation is the identification, planning, management, and execution of logistical and operational requirements to bring a new VA medical facility or other space, via construction or lease, into full planned operations. The New Orleans VA Medical Center opened in 2016 to replace the old facility that was destroyed by Hurricane Katrina in 2005.

[17] Pharmacy Informatics Workgroup Training Presentation, "Annual Wall to Wall Physical Inventory," p 11. Inventory turnover rates are based on the previous 12 months of purchases divided by the inventory on hand. VHA Directive 1761, app. H.

[18] VHA Pharmacy Benefits Management Office, email message to the VA OIG Office of Financial Inspections, February 23, 2023.

VHA policy from the Pharmacy Benefits Management Office states that "end of year purchases make pharmaceutical inventories increasingly difficult to manage and need to be avoided."[19] The policy also notes that end-of-year purchases that cause overstocking should be avoided. Overstocking is an inefficient use of resources and increases the risk of damage, contamination, and obsolescence of stock items.

The healthcare system's B09 reconciliation process also did not fully comply with VHA policy.[20] The team determined that the healthcare system did not complete the January 2023 through June 2023 reconciliation packages until after the financial inspection was announced on July 10, 2023. Furthermore, the team reviewed the May 2023 reconciliation package and identified that 37 invoices totaling $280,000 were missing from the B09 report. The facility did not report this discrepancy in its monthly memorandum and had not researched or resolved the issue as of September 2023. Without this documentation, the fiscal service could not complete the full reconciliation as required. If reconciliations are not completed, there is no assurance that the amount paid to the prime vendor is consistent with the goods received.

What the OIG Recommended

The OIG reiterated four recommendations from the 2021 inspection where the plans to address the recommendations were not fully implemented. The OIG also added seven new recommendations, for a total of 11, to the healthcare system director designed to help officials improve performance. The number of recommendations should not be used as a gauge for the system's overall financial health. The intent is for system leaders to use these recommendations as a road map to improve financial operations. The recommendations address issues that, if left unattended, may eventually interfere with effective financial efficiency practices and the strong stewardship of VA resources.

The OIG recommended the healthcare system director ensure the healthcare system establish internal controls to monitor the MSPV product list for updates and complete the item conversion process. The director should also ensure that prime vendor contract performance issues are routinely reported to the Medical Supplies Program Office and Strategic Acquisition Center (SAC) using established VHA reporting tools; submit in coordination with the SAC ratifications for unauthorized commitments following the Federal Acquisition Regulation; and ensure that the MSPV facility-level COR and ordering officers are appointed and delegated appropriately and perform all required duties according to the scope and limitation of the designee's authority. The OIG also recommended that the director ensure the healthcare system submits national contract requests for waiver and justifications prior to purchasing available product list items from nonmandatory procurement instruments.

[19] VHA Directive 1761, p. H-1.

[20] VHA Directive 1108.07, p. 35.

To strengthen oversight of purchase card transactions, the OIG recommended the director ensure cardholders obtain a proper prior approval, maintain segregation of duties, and that both cardholders and approving officials perform prompt purchase card reconciliations as required by VA financial policy. The director should also ensure that approving officials, cardholders, and the agency contracting office review repetitive open market purchases of goods and services and obtain contracts when it is determined to be in the best interest of the government. The OIG recommended the healthcare system, in coordination with the SAC, submit a ratification for an unauthorized commitment following the Federal Acquisition Regulation.

For pharmacy operations, the OIG recommended that the director develop formal processes for achieving identified efficiency targets and use available data to make business decisions. In addition, the director should develop and implement a plan to increase inventory turnover closer to the VHA-recommended level, establish measures that avoid end-of-year purchasing, and complete monthly B09 reconciliations consistently to ensure discrepancies are corrected in a timely manner.

VA Management Comments and OIG Response

The Southeast Louisiana Veterans Health Care System director concurred with all the report's findings and recommendations and submitted action plans for recommendations 1 through 11. Appendix D provides the full text of the healthcare system's comments. The director requested closure of recommendation 2. The director also said that the action plans for recommendations 4 and 6 were completed prior to the publication of this report but did not request closure for these two recommendations. However, no evidence or other documentation supporting closure of recommendations 2, 4, or 6 was provided to the OIG. All recommendations remain open. The OIG will assess the satisfactory completion of the actions during its routine recommendation follow-up. Overall, the proposed corrective measures in the healthcare system's action plans appear responsive to the recommendations, and the OIG will monitor their implementation until all stated actions are documented as completed.

LARRY M. REINKEMEYER
Assistant Inspector General
for Audits and Evaluations

Contents

Abbreviations

COR	contracting officer's representative
FY	fiscal year
IFCAP	Integrated Funds Control, Accounting, and Procurement
MSPO	Medical Supplies Program Office
MSPV	Medical/Surgical Prime Vendor
OIG	Office of Inspector General
OPES	Office of Productivity, Efficiency and Staffing
SAC	Strategic Acquisition Center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

In 2019, the VA Office of Inspector General (OIG) started a financial efficiency inspection program. These inspections assess stewardship and oversight of funds at Veterans Health Administration (VHA) healthcare systems, identify opportunities to achieve cost efficiencies, and promote best practices. Inspection teams identify and examine financial activities controlled by a VHA healthcare system and compare that system's performance to other VHA healthcare systems similar in size and complexity.[21] The OIG conducted this follow-up inspection to determine whether the Southeast Louisiana Veterans Health Care System in New Orleans, Louisiana, made improvements in the oversight of funds and corrected previously identified issues.

The OIG previously inspected the healthcare system in 2021 and made six recommendations to correct identified issues.[22] During this follow-up inspection, the team assessed the same four financial activities and administrative processes discussed in the OIG's 2021 report to determine if the healthcare system had effectively completed appropriate corrective actions:

I. **Medical/Surgical Prime Vendor (MSPV) program use.** VA established the MSPV program to provide an efficient and cost-effective method for ordering and distributing medical, surgical, dental, and select prosthetic and lab supplies across VHA facilities. VA healthcare systems must use MSPV contracts for products that are available through the program. VHA monitors use of the program with a performance metric that recommends 90 percent of the healthcare system's spending on MSPV-eligible items should be through the MSPV program. The inspection team examined whether the healthcare system met VHA goals for using the program.

II. **Purchase card use.** VA established its Government Purchase Card Program to reduce administrative costs related to the acquisition of goods and services.[23] When used properly, purchase cards can help healthcare systems simplify acquisition procedures and provide an efficient vehicle for obtaining goods and services directly from vendors. Cardholders should obtain approvals before initiating purchases, transactions should be

[21] VHA Office of Productivity, Efficiency and Staffing, "VHA Facility Complexity Model Data Definitions," October 1, 2023. The VHA Facility Complexity Model categorizes medical facilities by complexity level based on patient population, clinical services offered, research and educational, and operational cost. Complexity levels include 1a, 1b, 1c, 2, or 3. Level 1a facilities are considered the most complex and level 3 facilities are the least complex. The facility groupings are used for various peer grouping purposes, such as operational reporting, performance measurement, and research studies. The Southeast Louisiana Veterans Health Care System was rated as a level 1b, high-complexity facility.

[22] VA OIG, *Financial Efficiency Review of the Southeast Louisiana Veterans Health Care System in New Orleans*, Report No. 20-00971-235, September 20, 2021.

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

reconciled by the cardholder and approved by an approving official in a timely manner, and segregation of duties should be maintained. Documenting transactions as required by VA policy helps the agency and other oversight authorities identify potential fraud, waste, and abuse.[24] The inspection team examined whether the healthcare system ensured compliance with purchase card program policies and procedures.

III. **Administrative staffing levels.** Large administrative overhead in healthcare, which can include high administrative staff levels, is increasingly identified with cost inefficiency.[25] The inspection team determined whether the healthcare system's administrative staffing levels improved since the OIG issued its 2021 financial efficiency report. The team compared the healthcare system's administrative staffing with 2021 levels and to similar VHA healthcare systems to identify opportunities for efficiency improvements.

IV. **Pharmacy operations.** Pharmacy expenditures account for a substantial percentage of a healthcare system's budget, and healthcare system leaders should analyze this spending to identify opportunities to use pharmacy dollars more efficiently. 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 balances the efficient use of financial resources with ensuring inventory is available when needed. The inspection team evaluated whether the healthcare system complied with VA policies to use cost and performance reports to review progress, track inventory turnover goals, use scannable barcodes, and follow required B09 reconciliation procedures.[26]

During this follow-up inspection, the team identified issues first highlighted in the OIG's September 2021 report that have not been fully resolved pursuant to plans submitted in response to earlier recommendations. To assess these areas, the inspection team performed a site visit at the Southeast Louisiana Veterans Health Care System during the week of August 21, 2023; interviewed healthcare system leaders and staff; and reviewed data, supporting documents, and processes related to the healthcare system's financial efficiency. For more information about the inspection's scope and methodology, see appendixes A and B. The findings and

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

[25] VHA Office of Productivity, Efficiency & Staffing, Efficiency Opportunity Grid Model Summaries, https://dvagov.sharepoint.com/:w:/r/sites/VHAOPES/_layouts/15/Doc.aspx?sourcedoc=%7BF01DA872-43D9-482C-9AC0-5A73E121BE4B%7D&file=Efficiency%20Opportunity%20Grid%20Model%20Summaries.docx&action=default&mobileredirect=true&DefaultItemOpen=1. (The website is not publicly accessible.)

[26] VHA Directive 1108.07, *General Pharmacy Service Requirements*, November 28, 2022. The Fiscal B09 report is reviewed and reconciled with 1358 forms to ensure the pharmacy is making correct payments for what is received and there is documented evidence (signature and date of review) that the B09 reconciliation has been completed. VHA Office of Finance, Financial Management & Accounting Systems Alert, "Pharmacy Prime Vendors B09 Reconciliation Standard Operating Procedures," October 3, 2012. The Pharmacy Service will prepare a monthly B09 reconciliation package with a memorandum and supporting documentation (such as invoices, the B09 report, and pharmaceutical prime vendor reports) to provide the reconciliation results to the Finance Service.

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

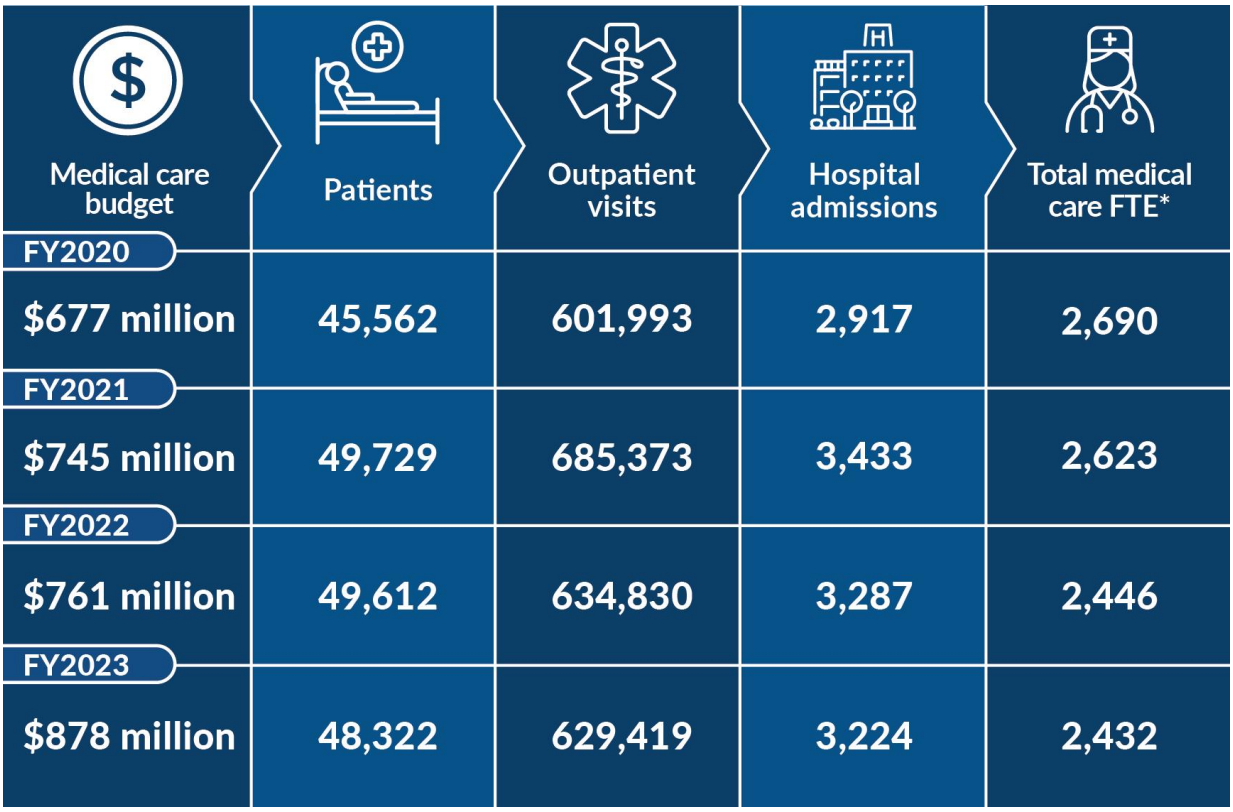
Facility Profile

The Southeast Louisiana Veterans Health Care System is a part of Veterans Integrated Service Network (VISN) 16 and serves veterans at the New Orleans VA Medical Center and throughout 23 parishes in southeast Louisiana.[27] The healthcare system includes eight community-based outpatient clinics in Baton Rouge, Bogalusa, Franklin, Hammond, Houma, Slidell, St. John Parish, and Baton Rouge South. The New Orleans VA Medical Center was destroyed by Hurricane Katrina in 2005, and a new medical center was built and activated when the medical center opened in December 2016. The center saw its first outpatients on December 5, 2016, and its first inpatients on July 14, 2017.

Figure 1 provides background information for this level 1b, high-complexity healthcare system.[28] The data reviewed by the inspection team varied for each activity but originated no earlier than the beginning of May 2022 and no later than the end of April 2023.

[27] VHA divides the United States into 18 Veteran Integrated Service Networks, regional systems that work together to meet local healthcare needs and provide greater access to care.

[28] The Southeast Louisiana Veterans Health Care System is rated as a 1b, high-complexity facility, meaning it has high levels of volume, patient risk, and teaching and research, and also contains a level 4 or 5 ICU unit.



	Medical care budget	Patients	Outpatient visits	Hospital admissions	Total medical care FTE*
FY2020	$677 million	45,562	601,993	2,917	2,690
FY2021	$745 million	49,729	685,373	3,433	2,623
FY2022	$761 million	49,612	634,830	3,287	2,446
FY2023	$878 million	48,322	629,419	3,224	2,432

Figure 1. *Healthcare system profile for the Southeast Louisiana Veterans Health Care System from October 1, 2019, through September 30, 2023.*

Source: VHA Support Service Center, Trip Pack and Operational Statistics report.

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

** FTE is full-time equivalent positions. This category includes both direct medical care FTE positions in budget object codes 1000-1099 (Personal Services) and all cost centers.*

According to the healthcare system's chief financial officer, from October 1, 2019, through September 30, 2022, the system experienced large fluctuations in several spending categories. Figure 2 shows the largest spending fluctuations, with the last column showing both the dollar amount of the change and the percentage change.[29]

[29] FY 2022 total spending of about $781 million is higher than the FY 2022 budget amount of about $761 million because the budget data used by the OIG does not include approximately $19 million of American Rescue Plan funding. The American Rescue Plan funding did not cause differences in FY 2020 and FY 2021.

	FY2020	FY2021	FY2022	FY2022 – FY2020	FY2022 – FY2020 Pct
Salaries	$237,979,058	$262,774,294	$304,777,717	$66,798,659	28.1%
Community care	$170,307,435	$208,720,585	$218,973,730	$48,666,295	28.6%
Equipment	$4,315,671	$4,713,225	$20,841,181	$16,525,510	382.9%
Beneficiary travel	$7,087,824	$9,770,739	$16,266,155	$9,178,331	129.5%
Major activations	$106,271,508	$95,934,410	$54,327,220	$(51,944,288)	-48.9%
Other	$150,909,105	$163,539,407	$165,828,973	$14,919,868	9.9%
Total	**$676,870,601**	**$745,452,660**	**$781,014,976**	**$104,144,375**	15.4%

Figure 2. *Changes in healthcare system spending from FY 2020 through FY 2022.*

Source: VA OIG analysis of data provided by the Southeast Louisiana Veterans Health Care System chief financial officer's office on March 15, 2023.

Other categories not identified separately in figure 1 and with an increase or decrease of over $1 million in spending between FY 2020 and FY 2022 include prosthetics, general patient care, COVID-19, logistics, laboratory, nonrecurring maintenance, and pharmacy.

The chief financial officer explained the relationship between two categories, salaries and major activations. Activation is the identification, planning, management, and execution of logistical and operational requirements to bring a new VA medical facility or other space, via construction or lease, into full planned operations.[30] From October 1, 2019, through September 30, 2022, salaries increased by about $66.8 million, while major activations decreased by about $51.9 million. This occurred because VA policy permitted the newly built New Orleans VA Medical Center—which opened in 2016 to replace the old facility that was destroyed by Hurricane Katrina in 2005—to treat the salaries of new staff as activation costs until the site was serving enough patients to receive funding through one of VA's regular funding processes, known as the Veterans Equitable Resource Allocation.[31]

As the medical center increased its patient population, its spending on salaries transitioned from the major activations category to the salaries category. As a result, the decrease in major activation funding offset some of the corresponding (but not identical) increase in the salary

[30] VHA Directive 7516, *VHA Activations Program*, October 24, 2023.

[31] Government Accountability Office, *VHA Should Improve Activation Cost Estimates and Oversight*, GAO-19-679T, January 2020.

budget. The healthcare system will not receive any activation funding in FY 2024. Also, growth in the care in the community budget represented an increase of almost $48.7 million, or about 46.7 percent of the spending increase described in figure 2. The chief financial officer said this resulted from increases in the healthcare system's consult volume and costs.

According to the chief financial officer, the increase in equipment amounts reflect nonrecurring supplemental funds provided by the VISN in FY 2022, and these amounts can fluctuate from year to year. The six largest FY 2022 equipment purchases, shown in figure 3, accounted for approximately $11 million of the $16.5 million increase from FY 2020 to FY 2022.

	FY2022
Real time location system	$3,540,025
Ultrasound machine	$1,990,096
CT scanner	$1,679,575
Defibrillators	$1,414,508
Vital sign monitors	$1,262,050
Medication dispensing system	$1,068,769
Total	**$10,955,023**

Figure 3. *Southeast Louisiana Veterans Health Care System's six largest equipment purchases in FY 2022.*

Source: Southeast Louisiana Veterans Health Care System chief financial officer.

Facility Selection

The OIG team selected the Southeast Louisiana Veterans Health Care System because it had a previous financial inspection and because VA data indicated that opportunities for financial efficiency improvements continued to exist at the organization. The team used data from the VHA Office of Productivity, Efficiency and Staffing's (OPES) efficiency opportunity grid. VHA developed the efficiency opportunity grid, a collection of 12 statistical models, to give healthcare system leaders insight into areas for potential efficiency improvement. The grid allows for comparisons between VHA healthcare systems by adjusting data for variations in patient and facility characteristics and geography. The grid also describes possible inefficiencies and areas of success by showing the difference between a healthcare system's actual and expected costs.

After identifying healthcare systems with a previous OIG financial inspection, the team then used the stochastic frontier analysis model ranking of those systems to select a site for a follow-up visit.[32] The inspection was limited in scope and was not intended to be a comprehensive evaluation of all financial operations at the Southeast Louisiana Veterans Health Care System. The inspection set forth a goal to recommend opportunities for process improvement and greater efficiencies and to promote the responsible use of appropriated funds.

The OIG's 2021 Financial Inspection Report

In September 2021, the OIG published a financial efficiency review of the Southeast Louisiana Veterans Health Care System.[33] As a result, the OIG made the following six recommendations for improvement to the healthcare system director:

1. Develop a plan to work with the prime vendor to address having adequate stock from the healthcare system's formulary list [product list] in its warehouse to provide supplies when ordered.
2. Ensure logistics staff and the contracting officer's representative use the tools available to inform the Medical Supplies Program Office and Strategic Acquisition Center of prime vendor performance issues.
3. Ensure approving officials and cardholders review their purchases and make sure strategic sourcing is used when it is in the best interest of the government.

[32] 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.

[33] VA OIG, *Financial Efficiency Review of the Southeast Louisiana Veterans Health Care System in New Orleans*.

4. In coordination with the network purchase card program manager, require purchase cardholders to submit ratification requests to the director of contracting for Network Contracting Office 16 for any unauthorized commitments identified.
5. Ensure quarterly audits of the purchase card program are completed as required by the VHA standard operating procedure, "Internal Audits—Purchase Cards and Convenience Checks."[34]
6. Ensure that the healthcare system meets VHA's recommended inventory turnover rate of 12 times per year, established by the National Pharmacy Benefits Management Program Office.

All six recommendations from the OIG's 2021 inspection report were closed February 3, 2022, after the healthcare system provided a descriptive narrative and documented evidence toward progress in addressing the issues identified.

[34] VHA Government Purchase Card Program, "Internal Audits–Purchase Cards and Convenience Checks" (standard operating procedure), June 20, 2019.

Results and Recommendations

The inspection team reviewed MSPV program usage, purchases cards, administrative staffing levels, and pharmacy operations. The OIG found that the healthcare system made limited progress improving issues identified in the OIG's 2021 inspection report. Although the healthcare system provided acceptable action plans and some evidence toward progress, this inspection showed that subsequent efforts to implement the plans did not improve some previously identified problems.

The healthcare system did not

- increase the MSPV utilization rate,
- ensure the use of strategic sourcing when it is in the best interest of the government, or
- achieve the VHA-recommended level of 12 turns per year for pharmacy inventory.

During this follow-up inspection, the OIG also found additional weaknesses within the MSPV, purchase card, and pharmacy programs.

Figure 4 summarizes the findings and recommendations from the initial inspection and shows whether facility management implemented effective controls to address prior recommendations or if the problems persisted, resulting in repeat findings in FY 2023.

Issue area	Prior finding	Prior recommendation	Problem resolved in FY 2023?
MSPV	The healthcare system was unable to meet the MSPV-NG formulary utilization goal.	Develop a plan to work with the prime vendor to address having adequate stock from the facility's formulary list in its warehouse to provide supplies when ordered.	✗
	The healthcare system did not have a contracting representative assigned to MSPV as required and did not use available tools to report prime vendor performance.	Ensure logistics staff and the contracting officer's representative use the tools available to inform the Medical Supplies Program Office and Strategic Acquisition Center of prime vendor performance issues.	✗
Purchase Card	The healthcare system personnel did not use processes for considering contracting for commonly purchased goods.	Ensure approving officials and cardholders review their purchases and make sure strategic sourcing is used when it is in the best interest of the government.	✗
	The healthcare system cardholders made split purchases to avoid contracting.	In coordination with the network purchase card program manager, require cardholders to submit ratification requests to the director of contracting for Network Contracting Office 16 for any unauthorized commitments identified.	✓
	The healthcare system did not complete the quarterly audits as per the policy requirement.	Ensure quarterly audits of the purchase card program are completed as required by the Veterans Health Administration standard operating procedure, "Internal Audits—Purchase Cards and Convenience Checks."	✓
Pharmacy	The healthcare system did not meet the inventory turnover rate of 12 turns per year.	Ensure that the facility meets the Veterans Health Administration's recommended inventory turnover rate of 12 turns per year, established by the National Pharmacy Benefits Management program office.	✗

Figure 4. *Findings of the OIG's 2021 inspection of the Southeast Louisiana Veterans Health Care System and outcomes of prior recommendations.*

Source: VA OIG analysis.

I. Use of the Medical/Surgical Prime Vendor Program

Each VHA healthcare system is required to use the MSPV program for products that are available on its product list, also referred to as the formulary.[35] According to the Supply Chain Common Operating Picture dashboard, the Southeast Louisiana Veterans Health Care System spent about $3.8 million through the MSPV program from May 2022 through April 2023.[36] The OIG team's inspection focused on three areas of MSPV program use:

- **Product list utilization rate** measures the extent to which healthcare systems use prime vendors for items on the MSPV product list.
- **Contract performance monitoring** includes a healthcare system's oversight of the prime vendor as well as the use of recommended tools to report on prime vendor performance and provide feedback on the MSPV program. One element used to measure prime vendor performance is the order fulfillment rate, a contractual requirement to fulfill at least 95 percent of the healthcare system's monthly orders for MSPV product list items.
- **National contract waiver requests** are required when purchasing available MSPV product list items from nonmandatory procurement instruments. The OIG's 2021 report did not evaluate the healthcare system's performance in this area.

Finding 1: The Healthcare System Did Not Meet the Goal for MSPV Utilization and Did Not Monitor Contract Performance Adequately or Submit Waiver Requests

The healthcare system did not meet the 90 percent product list utilization goal for purchases made through the MSPV program from May 2022 through April 2023, according to MSPV data from the Supply Chain Common Operating Picture.[37] Instead, the formulary utilization rate averaged only about 57 percent as reported by the MSPV performance metrics dashboard.

According to supply chain management personnel, the low utilization rates occurred because the prime vendor could not always supply items at the time they were ordered, items were not set up in the VA system so that they could be ordered, or the healthcare system did not provide demand estimates to help the MSPV maintain the necessary inventory levels. The challenges associated

[35] VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020, p. A-4; Office of Procurement, Acquisition and Logistics, "Medical/Surgical Prime Vendor (MSPV) Program," https://www.va.gov/opal/sac/mspv.asp. (This website is not publicly accessible.)

[36] The OIG team did not assess the accuracy of the summary data in the Supply Chain Common Operating Picture dashboard.

[37] The Supply Chain Common Operating Picture is an interactive dashboard that enables leaders to observe supply chain metrics at the enterprise, VISN, and healthcare system levels.

with staying up to date on frequent price changes in the prime vendor's system were also cited as a factor, as were the loss of key healthcare system supply chain leaders and the loss of an experienced on-site prime vendor representative.

The MSPV Utilization Rate Did Not Improve

The healthcare system's annual average MSPV utilization rate was about 57 percent during the inspection team's review period from May 2022 through April 2023.[38] The monthly average ranged from about 49 percent to about 64 percent. Comparatively, product list utilization rates for VHA overall averaged 62 percent, and VISN 16 averaged 65 percent for the same period.

Figure 5 shows that the healthcare system's monthly MSPV product list utilization rates during the inspection team's 12-month review period.

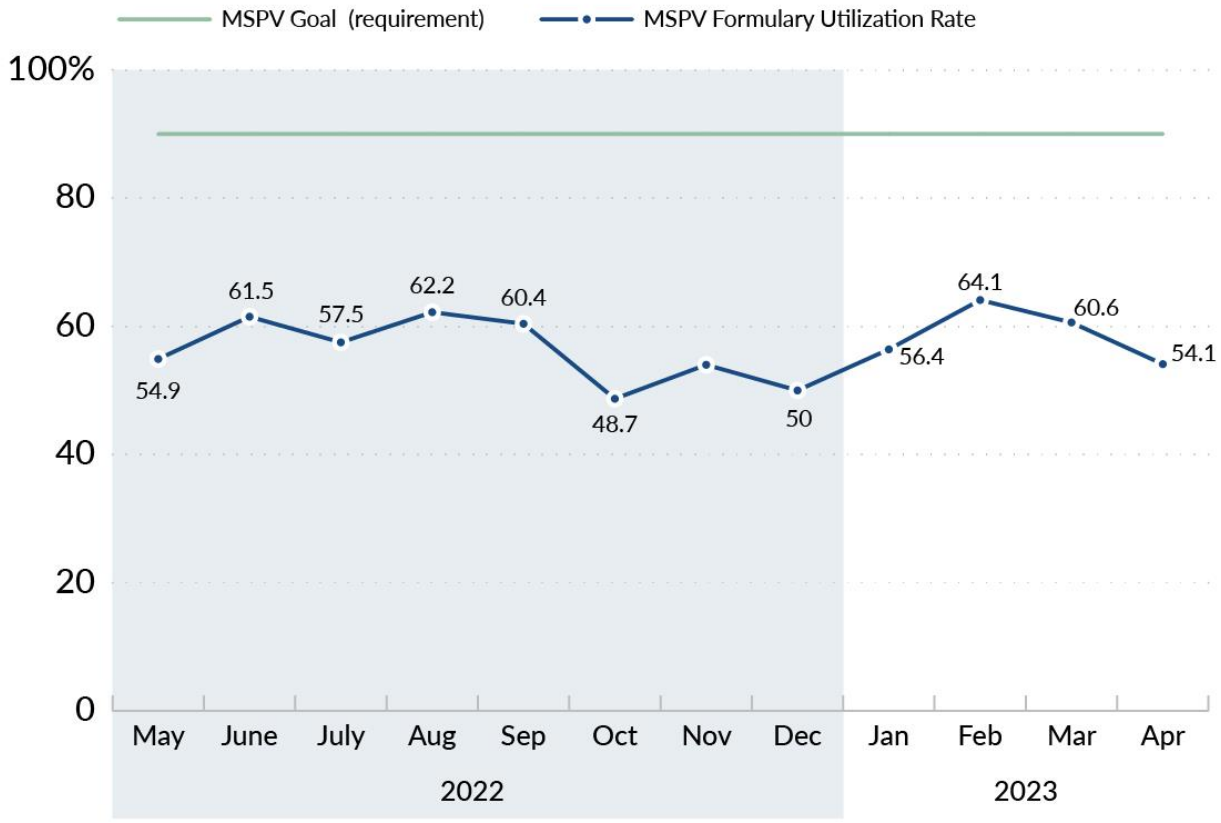


Figure 5. *MSPV product list utilization rates for the Southeast Louisiana Veterans Health Care System.*
Source: VA OIG analysis of the healthcare system's Formulary [product list] Utilization Report.

[38] The Supply Chain Common Operating Picture is used by VISN and facility supply chain staff to manage performance on 14 key metrics and to analyze supply chain data. The *OB4. Medical Surgical Formulary Utilization* report in the Supply Chain Common Operating Picture is a metric for the MSPV program. The utilization percentage indicates how well a facility is using this streamlined supply chain to obtain the everyday-use items purchased through the program.

The inspection team reviewed a judgmental sample of 25 MSPV transactions and interviewed the healthcare system's logistics leaders, managers, and ordering staff to determine why items were not purchased from the prime vendor and why the OIG's 2021 recommendations were not effectively implemented. The healthcare system's MSPV facility-level COR stated that he did not understand his MSPV contract oversight role and responsibilities. The team determined that the MSPV COR did not sufficiently collaborate with the prime vendor or VA inventory management specialists to help ensure the prime vendor maintained an adequate stock of items on the product list to fulfill the healthcare system's orders. This occurred because the healthcare system director and supply chain management service chief did not effectively implement a plan to ensure the COR took action to facilitate prime vendor compliance with the contract. In addition, the healthcare system lost three chief supply chain officers due to a death, an illness and eventual retirement, and acceptance of employment outside of VA, respectively.

VHA guidance states that a healthcare system can improve its product list utilization and help ensure items are stocked in a timely manner by using the prime vendor for all purchases of items on the product list, reviewing inventory needs with its prime vendor, monitoring the product list for updates, and converting supplies to its prime vendor as soon as possible. Item conversion includes updating the local item master file to reflect the new prime vendor, changing the mandatory source in the Generic Inventory Package to the prime vendor, and coordinating with the prime vendor on item usage and timing requirements.[39]

The inspection team determined that low utilization rates occurred because, at times, some MSPV supplies were not available from the prime vendor and could not be supplied when ordered. When inventory managers knew items were on back order with the prime vendor, for example, they sometimes placed orders with nonprime vendors, which lowered utilization rates. Other items had not been set up in the VA system so that they could be ordered. And, as explained by the acting deputy chief supply chain officer, the healthcare system did not provide demand estimates to enable the prime vendor to help maintain sufficient inventory levels to provide required supplies to the healthcare system. The challenges associated with keeping up to date on frequent price changes in the prime vendor's system were also cited as a factor, as was the loss of key healthcare system supply chain leaders, and the loss of an experienced on-site

[39] Medical Supplies Program Office, "The Formulary Utilization Metric: A Deep Dive Explanation," accessed June 30, 2022, https://vaww.va.gov/plo/docs/mspo/mspvFormularyUtilizationMetricOverview.pdf; "Medical/Surgical Prime Vendor (MSPV) Program" (website), Office of Procurement, Acquisition and Logistics, accessed August 8, 2023, https://www.va.gov/opal/sac/mspv.asp. The Generic Inventory Package is the software currently utilized for inventory management of stock. The Generic Inventory Package portion of the Integrated Funds Control, Accounting, and Procurement application (IFCAP) is used to manage the receipt, distribution, and maintenance of supplies utilized throughout VA medical facilities.

prime vendor representative.[40] Since the prior OIG site visit in January 2020, the healthcare system lost three different chief supply chain officers, as mentioned previously.

For the 25 samples reviewed, the healthcare system purchased 462 items on the open market for almost $219,000. This amount was about $656 less than the cost would have been under the MSPV contract. Regardless of the slight savings, it is important for the healthcare system to purchase from the prime vendor to comply with VHA policy and improve product list utilization rates.[41] VHA policy is clear that the appearance of a lower product cost to a specific medical facility is not sufficient justification to deviate from the requirement to use the MSPV contract. This is because one benefit of purchasing products through the MSPV is reducing the risk of product quality and safety issues related to the purchase of items that have not been approved by VA's clinical product review committee.[42] Further, when inventory managers need items that are on back order with the prime vendor—but do not place these orders through the prime vendor—those unavailable items are not reflected on the prime vendor's unadjusted fill rate. As a result, VA cannot accurately determine whether the prime vendor's unadjusted fill rates meet contract requirements. Buying from the prime vendor is also important because of the benefits offered through the MSPV program, which include the use of strategic sourcing, volume buying, expedited shipping, and the availability of core MSPV supplies.[43] In contrast to those benefits, open market purchases create the risk that the healthcare system could acquire supplies that have not been clinically reviewed by a VA medical committee to help ensure adequate product quality and patient safety.[44]

The 2021 OIG report found that the healthcare system did not meet VHA's 90 percent MSPV product list utilization goal, did not have a MSPV facility-level COR to monitor prime vendor

[40] The on-site prime vendor representative is a value-added service that facilities may elect to have under the MSPV program to support VA supply chain performance improvements. The primary goal of the on-site representative is to improve efficiency by reducing open market purchases and enhancing the use of the MSPV program. It is expected that most facilities under the MSPV program will retain the same on-site representative for the duration of the contract barring unforeseen circumstances.

[41] VHA Directive 1761, pp. A-4 and A-5; Medical Supplies Program Office, "The Formulary Utilization Metric."

[42] Medical Supplies Program Office, Medical/Surgical Prime Vendor, *MSPV Frequently Asked Questions*, p. 14, number 25, April 2019. Clinical product review committees evaluate medical/surgical supplies for quality and safety before they are available on the MSPV product list. VHA, "Waiver Process and Procedure," rev. June 2017, in *Medical/Surgical Prime Vendor (MSPV) Standard Operating Procedure (SOP)*, p. 5.

[43] "Medical/Surgical Prime Vendor (MSPV) Program" (website), Office of Procurement, Acquisition and Logistics. Based on routine usage data provided by the VA medical centers, prime vendors are able to stock core items, which expedite the ordering, shipping, and receipt process. "MSPV Product List and Category Management" (website), Medical Supplies Program Office, accessed on December 12, 2023, https://vaww.va.gov/plo/mspo/index.asp. Category management is a strategic sourcing approach and commercial best practice of buying common goods and services to increase efficiency, reduce costs, minimize redundancies, and deliver more value to the federal government.

[44] "MSPV Product List and Category Management" (website). The MSPV Product List includes approximately 61,000 low-complexity, frequently purchased items that have been clinically reviewed to increase product quality and patient safety.

performance, and did not always use or have awareness of tools available to provide feedback on prime vendor performance. In 2021, the OIG made two recommendations to improve the healthcare system's use of the MSPV program.[45] The follow-up inspection found the healthcare system did not effectively implement these recommendations.

The MSPV product list utilization rate was reported as 75 percent in the 2021 OIG report. The OIG recommended the healthcare system develop a plan to work with the prime vendor to address having adequate stock from the product list in its warehouse to provide supplies when ordered. The OIG closed that recommendation after confirming that inventory managers completed MSPV training for ordering officers. The OIG also considered the healthcare system's testimonial evidence that the COVID-19 pandemic had disrupted supply chains and made it difficult for the prime vendor to meet demand.

Contract Performance Monitoring Was Inadequate

The healthcare system had two different MSPV contracts during the inspection period from May 1, 2022, through April 30, 2023.[46] The contract existing at the start of the team's review period was effective through November 30, 2022. The second contract started on December 1, 2022, and continued past the end of the team's review period.

The team found deficiencies in the management and oversight of purchases under both contracts, which resulted in more than $1.4 million in potential improper payments and about $180,000 in questioned costs. The issues identified stemmed from two factors:

- Healthcare system staff placed orders against the second MSPV contract without delegations of authority.
- The appointed MSPV facility-level COR under the first contract did not perform monitoring and oversight duties, such as reviewing the accuracy of invoiced distribution fees against contract terms.

[45] The OIG's 2021 MSPV recommendations were: 1) to develop a plan to work with the prime vendor to address having adequate stock from the facility's formulary list [product list] in its warehouse to provide supplies when ordered; and 2) ensure logistics staff and the contracting officer's representative use the tools available to inform the MSPO and SAC of prime vendor performance issues. VA OIG, *Financial Efficiency Review of the Southeast Louisiana Veterans Health Care System in New Orleans*.

[46] The first contract was the MSPV-Generation Z Transition (contract 36C10X22D0003), effective December 2021 through November 2022, and the second contract was the MSPV-Generation Z Transition 2 (contract 36C10X23D0003), effective December 2022 through November 2023.

MSPV ordering officers are required to be nominated by logistics leaders and appointed by the MSPV contracting officer.[47] The inspection team found that the MSPV ordering officers at the healthcare system were properly nominated and delegated for the contract in place during May 1 through November 30, 2022, and were thus authorized to place MSPV orders. However, for the contract effective from December 1, 2022, through April 30, 2023, MSPV ordering officers placed orders without being nominated by logistics leadership and delegated by the MSPV contracting officer, which means they were not authorized to place those orders. This occurred because the healthcare system failed to submit delegation of authority nominations, which the acting deputy chief supply chain officer attributed to turnover in logistics leadership. As a result, healthcare system staff made potentially improper payments resulting in unauthorized commitments totaling more than $1.4 million. The healthcare system should work with the Strategic Acquisition Center (SAC) to submit ratifications for any MSPV unauthorized commitments.[48] Ratification is the process of approving an unauthorized commitment by an official who has the authority to do so.[49]

The MSPV facility-level COR plays a crucial role in ensuring that prime vendors meet their contractual obligations within the MSPV program.[50] The COR acts as a liaison between the facility and the prime vendor and provides vital feedback, which assists the Medical Supplies Program Office (MSPO) and SAC in monitoring prime vendor performance, identifying program risks, and addressing issues that arise. The healthcare system must have at least one certified MSPV facility-level COR, who is to be nominated by logistics leaders and appointed by the MSPV contracting officer.[51]

The inspection team found that a facility-level COR was appointed for the MSPV contract that was effective through November 30, 2022. However, the COR did not perform many delegated duties and was ostensibly serving in the position in title only. The COR did not monitor and provide oversight of the contract utilization at the healthcare system, did not review the prime

[47] Associate deputy assistant secretary for procurement policy, systems and oversight and deputy senior procurement executive, "VA Procurement Policy Memorandum (2016-02) – VA Wide Procedures Regarding the Use of Ordering Officers (VAIQ 7696245)," memorandum to under secretaries for health, benefits, and memorial affairs, et al., April 28, 2016; Procurement and Logistics Office, *MSPV (Medical/Surgical Prime Vendor) Field Guide*, "Ordering Officer Nominations," May 3, 2023. Pursuant to VA policy, ordering officers must be nominated by their supervisor. For the MSPV transactions reviewed, the ordering officers' supervisor was a member of logistics leadership.

[48] FAR 1.602-3 (2024). Unauthorized commitments are not binding because the government representative who made them lacked the authority to enter into that agreement. VA Directive 7401.7, *Unauthorized Commitments and Ratification*, October 7, 2004. The directive defines ratification as the process by which an authorized official converts an unauthorized commitment to a legal contract.

[49] FAR 1.602-3(a) (2024).

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

[51] VHA Supply Chain Program Office, Procurement and Logistics Office*, One Book*; Procurement and Logistics Office, Enterprise Acquisition System, "Medical Surgical Prime Vendor (MSPV) Contracting Officer Representative (COR) Chapter," April 2023.

vendor's invoices and vouchers for accuracy, and did not ensure they were placed in accordance with contract requirements.[52] The COR informed the inspection team that he did not have MSPV-specific training and did not understand his MSPV contract oversight role and responsibilities. Additionally, he also served as the COR on 17 other contracts for the healthcare system, which prevented him from giving adequate time and attention to the MSPV contract. As a result, about $180,000 of invoiced distribution fees were not reviewed for accuracy and compliance with contract requirements. The COR's MSPV appointment letter requires the COR to review these invoiced fees and ensure they accurately reflect the orders placed in accordance with the requirements of the contract.[53] Because the COR did not do that, the inspection team considers these payments as questioned costs.

The person designated as the facility-level COR for the contract ending on November 30, 2022, who did not perform many delegated duties, was also assumed to be the COR for the follow-on MSPV contract. This contract started on December 1, 2022. A COR must be nominated and delegated duties to perform them on the contract; however, this person's nomination was not submitted, and therefore he was not formally designated as COR. According to the healthcare system's acting deputy chief supply chain officer, the facility failed to submit the COR nomination due to turnover in logistics leadership. As a result, the risk of not meeting MSPV program objectives increased. Specifically, the COR did not monitor the MSPV contract, did not serve as the official liaison between the healthcare system and the prime vendor, and did not provide feedback about the prime vendor to the MSPO and SAC. This prevented the MSPO and SAC from monitoring overall performance and addressing risks and issues. As a result of the OIG's inspection, in September 2023, the healthcare system and MSPV contracting officer nominated and delegated the previous facility-level COR, two new CORs, and previous ordering officers.

The prime vendor's contract requires it to meet an unadjusted fill rate of 95 percent for recurring medical/surgical supplies.[54] This fill rate represents the percentage of orders requested that were filled at the time of request.[55] According to VHA's electronic data interchange dashboard, the prime vendor's fill rate was less than 95 percent for 10 of 12 months from May 2022 through

[52] Veterans Affairs Acquisition Regulations 852.232-72(d) (2018) states, "Invoices shall comply with FAR 32.905." FAR 32.905 (2024) states, "Payment will be based on receipt of a proper invoice and satisfactory contract performance."

[53] Contracting officer's representative appointment letter, December 9, 2021 (not publicly accessible); 2 C.F.R. § 200.84 (2014).

[54] Recurring medical/surgical supplies are supplies ordered by individual medical facilities at least once per month.

[55] The healthcare system was covered by two MSPV contracts during the OIG's review period. The MSPV-Generation Z Transition (contract 36C10X22D0003), effective December 2021 through November 2022, and MSPV-Generation Z Transition 2 (contract 36C10X23D0003), effective December 2022 through November 2023.

April 2023.[56] Monthly fill rates ranged from a low of 82 percent to a high of 96 percent during this period.[57] These fill rates demonstrated that the prime vendor could not always supply items when ordered.[58] Figure 6 shows the prime vendor's unadjusted fill rate percentages from May 1, 2022, through April 30, 2023.

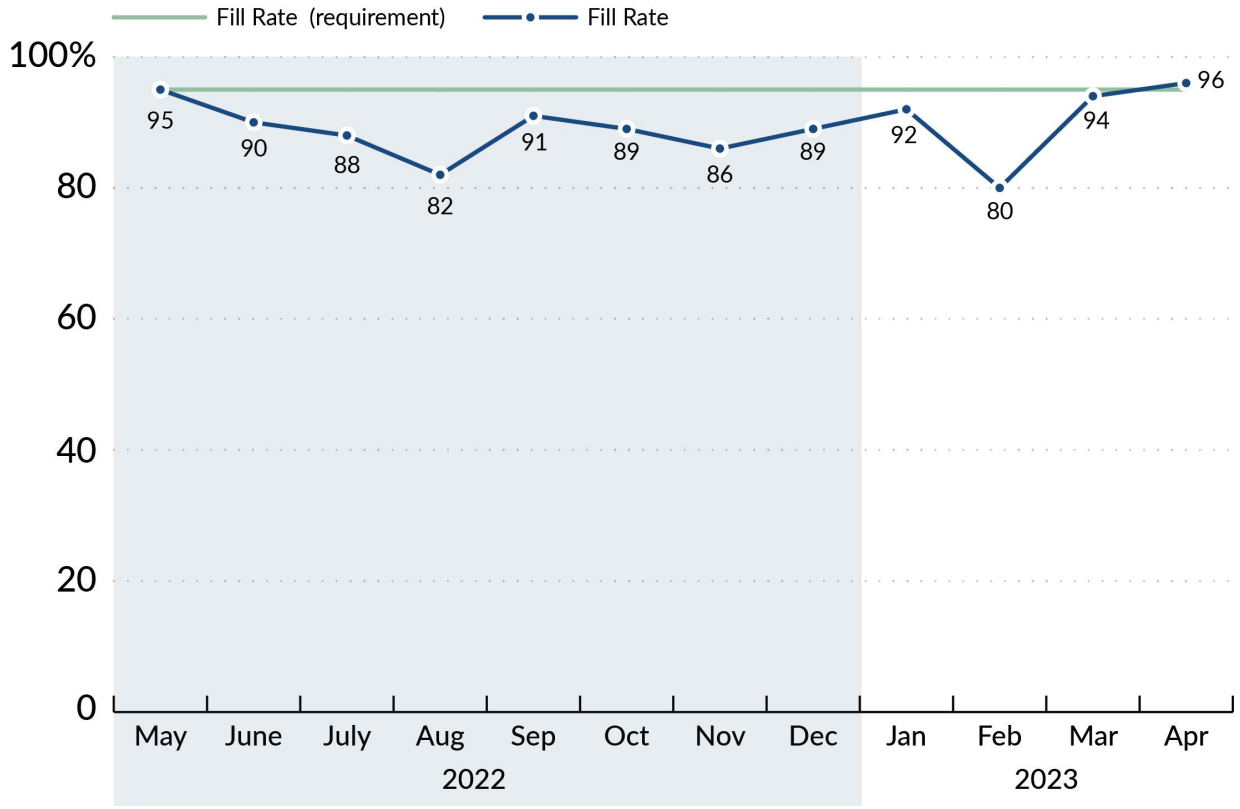


Figure 6. *The prime vendor's unadjusted fill rate percentages, May 1, 2022, through April 30, 2023.*
Source: VA OIG analysis of VHA's electronic data interchange dashboard fill rate report.

Healthcare system staff said they used other vendors because the prime vendor was unable to fill the purchase requests. The healthcare system logistics team and the prime vendor's on-site representative told the inspection team that he worked with inventory managers daily to help

[56] "Electronic Data Interchange," Financial Services Center, accessed March 26, 2024, https://dvagov.sharepoint.com/sites/VHAPLO/Logistics/MSPO/EDIDashboard. (This source is not publicly accessible.) The electronic data interchange dashboard provides a centralized tracking system to enhance VA's ability to track vendor performance for orders placed using the electronic data interchange. The dashboard will allow facilities to see metrics and underlying data such as a site's unadjusted and adjusted fill rates along with other key data points.

[57] Per the MSPO, the electronic data interchange dashboard does not include two transactions for the fill rate calculations, which are not required in the current MSPV contract.

[58] The unadjusted fill rate calculates the percentage of orders fulfilled against orders requested and is the raw fill rate at the line-item level for recurring medical/surgical supplies only. Manufacturer back orders and usage spikes are not to be excluded from the calculation.

ensure items were available when needed. Starting in April 2023, the healthcare system's logistics team began providing the prime vendor's on-site representative with the Supply Chain Data Informatics Office's monthly Prime Vendor Conversion and Recommendation Tool report. The prime vendor on-site representative used this report to make monthly recommendations to the healthcare system on MSPV supply needs. If the facility chose to accept those recommendations, the on-site representative would make adjustments to help ensure item availability.[59] Specifically, the report's order history data was used by the on-site representative to begin or update medical/surgical procurement needs and help ensure item availability.[60]

If prime vendors do not meet their obligations, healthcare system personnel should alert program leaders and other VA procurement offices.[61] There are three performance reporting tools used to monitor the healthcare system's satisfaction with the MSPV program, product list, and prime vendor performance: (1) a monthly facility execution survey, (2) an issue reporting tool, and (3) quarterly evaluation reports.

The healthcare system did not complete any monthly facility execution surveys between May 1, 2022, and April 30, 2023. VHA encourages that the monthly facility execution survey, which provides the MSPO with feedback on the MSPV program and the MSPV prime vendor, be completed by the chief of logistics.[62] Healthcare system officials said they did not complete the facility execution surveys because they were not aware of them. As discussed later, using reporting tools was addressed as a recommendation to the healthcare system in the 2021 OIG report.

VHA's Procurement and Logistics Office encourages, but does not require, employees to use another tool—the issue reporting tool—to report any prime vendor performance issues, including incorrect performance data, incorrect or missing reports, an inability to acquire eligible MSPV items, and inaccurate product information for procurements.[63] For issues that cannot be resolved by the facility-level COR, the issue reporting tool has the capability to escalate issues to the MSPO and SAC. The inspection team was told performance issues had not been reported. The prime vendor was unable to provide certain items when ordered, since they were on allocation and back order. In another example, the team was told the healthcare system received damaged items from the prime vendor. Neither issue was reported using the reporting tools.

[59] The Supply Chain Data Informatics Office Toolbox provides reports to be used for supply chain operations to improve Supply Chain Common Operating Picture metrics and policy compliance and gain efficiencies in supply chain management.

[60] The Supply Chain Data Informatics Office Toolbox, Prime Vendor Conversion and Recommendation Tool.

[61] Medical Supplies Program Office, Medical/Surgical Prime Vendor Program, *MSPV Frequently Asked Questions*, p. 23, number 54, April 2019.

[62] MSPV Facility Execution Survey Reference Guide, September 2022.

[63] VHA Procurement and Logistics Office, Medical Supplies Program Office, *Medical Surgical Prime Vendor Issue Reporting Tool,* June 2023.

Quarterly evaluation reports, required to be completed by the MSPV facility-level COR, are another method for reporting concerns with prime vendor performance.[64] These reports assess a prime vendor's performance in areas such as the quality of logistical performance, adherence to required delivery schedules, and coordination of all activity needed to execute the contract. The team was told the healthcare system did not complete quarterly evaluations during the inspection period. The COR told the inspection team he did not complete the quarterly evaluation reports because he did not understand his role and responsibilities with respect to the MSPV contract. However, the COR had signed nomination and delegation letters that clearly defined the extent of his duties. The COR also told the review team he was not aware of contractor performance reporting tools and had never completed a prime vendor performance-based report. The acting deputy chief supply chain officer also said she was not aware of these tools. The quarterly reviews and documentation of performance serve as the basis for the MSPV contracting officer's formal annual performance evaluations of the prime vendor, are used in procurement source selections, and allow VA to make informed business decisions when awarding contracts.

In the OIG's 2021 report, the OIG recommended the healthcare system use reporting tools to inform the MSPO and SAC of prime vendor performance issues. The OIG team interviewed healthcare system staff, did not find reports of performance issues with the MSPV contract, and closed the recommendation. During the follow-up inspection, however, the OIG was told performance issues had not been reported to the MSPO and SAC. Those issues included damaged items received by the healthcare system as well as the prime vendor's inability to provide certain items when ordered because they were on allocation and back order. The inspection team determined that the healthcare system had not implemented the OIG's 2021 recommendations on a sustained basis and did not use the recommended issue reporting tools in 2023.

The Healthcare System Did Not Submit National Contract Requests for Waiver

In addition to the product list utilization rate and contract performance monitoring, the inspection team looked at the healthcare system's use of national contract requests for waiver. The acting chief supply chain officer and acting assistant chief supply chain officer told the team that the healthcare system was not aware of the requirements to submit national contract waiver requests and therefore did not submit any. Waivers are required when a healthcare system purchases items that are available on the MSPV product list from nonmandatory procurement

[64] VA Procurement and Logistics Office, *Medical Surgical Prime Vendor (MSPV) Roles and Responsibilities*, April 2023.

instruments.[65] Per VHA policy, the waiver is to be used if and when there is a compelling clinical need to deviate from using mandatory procurement instruments, including the MSPV contract, to buy medical supplies.[66] Also, each waiver request must provide a valid, justifiable, and appropriate rationale for purchases that do not use mandatory procurement instruments.

The healthcare system's acting chief supply chain officer and acting deputy chief supply chain officer said these waivers were not used because the logistics team was unaware of the requirement. VHA headquarters directs that, to the extent permitted by law, VA healthcare systems must use the MSPV distribution contracts or other national contracts designated as mandatory in VHA policy to purchase medical supplies. When an item is simultaneously available through an MSPV distribution contract and another mandatory procurement instrument, the MSPV contract must be used.[67]

Finding 1 Conclusion

The OIG found that the healthcare system did not meet VHA's 90 percent MSPV formulary utilization goal, did not use available reporting tools to inform the MSPO and SAC about prime vendor contract performance issues, and did not submit national contract requests for waiver. The OIG also found the appointed MSPV COR under the first contract ending November 30, 2022, did not review the accuracy of invoiced distribution fees against contract terms, resulting in questioned costs totaling about $180,000. In addition, MSPV ordering officers were not properly delegated when a new MSPV contract became effective on December 1, 2022, leading to about $1.4 million in potential improper payments resulting from unauthorized commitments.

Recommendations 1–5

The OIG made five recommendations to the director of the Southeast Louisiana Veterans Health Care System:

1. Establish internal controls to help ensure the healthcare system monitors the Medical/Surgical Prime Vendor product list for updates and completes the item conversion process.

[65] VHA Directive 1761, p. A-5; Office of Procurement, Acquisition and Logistics, "Medical/Surgical Prime Vendor (MSPV) Program," https://www.va.gov/opal/sac/mspv.asp. (This website is not publicly accessible.). When there is a compelling clinical need to deviate from the requirement to purchase medical supplies from procurement instruments designated as mandatory by VHA policy, healthcare systems must submit a national contract waiver request.

[66] VHA, "Medical/Surgical Prime Vendor (MSPV)" (standard operating procedure).

[67] VHA Directive 1761, p. A-5.

2. Ensure that prime vendor contract performance issues are routinely reported to the Medical Supplies Program Office and the Strategic Acquisition Center using established Veterans Health Administration reporting tools.
3. In coordination with the Strategic Acquisition Center, submit ratifications for any unauthorized commitments following the Federal Acquisition Regulation.
4. Ensure that the facility-level contracting officer's representative and ordering officers are appointed and delegated properly and perform all required duties according to the scope and limitation of the designee's authority.
5. Establish internal controls to help ensure the healthcare system submits national contract requests for waiver and justifications prior to purchasing available product list items from nonmandatory procurement instruments.

VA Management Comments

The director of the Southeast Louisiana Veterans Health Care System concurred with recommendations 1 through 5. The responses to all report recommendations are provided in full in appendix D.

To address recommendation 1, the director reported that the healthcare system established weekly meetings with facility management, inventory managers, contracting officer's representatives, and prime vendor on-site representatives to discuss the MSPV list and said these meetings had resulted in an increase of the MSPV purchase rate to 70.6 percent in April 2024. The director said the facility will continue to monitor progress until the 90 percent goal is achieved.

The director requested closure for recommendation 2 and reported that as of September 2023, the healthcare system effectively implemented the use of the MSPV quarterly evaluation form so CORs can submit routine reports on time.

To address recommendation 3, the director said that the healthcare system will collaborate with the contracting office to ensure the submission of the ratification packets.

For recommendation 4, the director reported that all required memoranda to appoint CORs and "purchasing agents" had been signed and issued as of October 2023, and processes have been established to effectively update documentation as new contracts or new employees are added. The director also said that the action plan for this recommendation was completed prior to publication of the report but did not request closure or provide supporting documentation for the OIG to evaluate that claim.

To address recommendation 5, the director stated that the chief of logistics is creating a new standard operating procedure to address the submission of national contract requests for waiver and justifications.

OIG Response

The healthcare system director's action plans are responsive to recommendations 1 through 5. The OIG will monitor implementation of the planned actions and will close the recommendations when it receives sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified.

While the director requested closure of recommendation 2 and stated that the targeted completion date for the recommendation 4 action plan was October 2023, the OIG did not receive any related evidence or supporting documentation, and the recommendations remain open.

II. Purchase Card Use

VA established its Government Purchase Card Program to reduce administrative costs related to acquiring goods and services. When used properly, purchase cards can help healthcare systems simplify acquisition procedures and provide an efficient vehicle for obtaining goods and services directly from vendors. From May 1, 2022, through April 30, 2023, the healthcare system had approximately 45,300 purchase card transactions that totaled just under $43.6 million. The amount and volume of spending through the Government Purchase Card Program make it important to have strong controls over purchase card use to safeguard government resources and ensure compliance with policies and procedures that reduce the risk of error, fraud, waste, and abuse.[68]

The inspection team reviewed a sample of purchases for compliance in the following areas:

- **Purchase card transactions.** The inspection team determined whether the healthcare system processed purchase card transactions in accordance with VA policy, such as if cardholders obtained prior approvals before initiating a purchase, transactions were reconciled by the cardholder and approved by the approving official in a timely manner, and segregation of duties was maintained.[69] The team also assessed if cardholders split purchases by intentionally dividing a single purchase into two or more to avoid exceeding the micropurchase threshold. Additionally, the team inquired whether the healthcare system considered obtaining contracts when regularly procuring goods and services, which VA refers to as "strategic sourcing." The use of contracts in place of open market or individual purchases lowers the potential risk for split purchases on purchase cards. VA is also able to leverage its purchasing power through using competitively priced contracts.[70]
- **Purchase card oversight**. The team assessed whether the healthcare system's purchase card coordinator provided oversight by conducting periodic internal reviews.[71] These activities are examples of systematic controls that help reduce errors and ensure a healthcare system complies with VA policy. The team also assessed whether the healthcare system tracked purchase card training, had purchase card policies in place,

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

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

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

[71] VA Financial Policy, "Government Purchase Card for Micro-Purchases," p. 4.

assigned no more than 25 purchase card accounts to a single approving official, and maintained accurate Governmentwide Purchase Card Certification forms (VA Form 0242).[72]

- **Supporting documentation.** The team examined whether the healthcare system maintained supporting documentation for purchases, as required by VA policy, to provide assurance of payment accuracy and to justify the need to purchase a good or service. This included approved purchase requests, purchase orders, receiving reports, and vendor invoices.[73] Supporting documentation enables program oversight and helps prevent fraud, waste, and abuse.[74]

Finding 2: The Healthcare System Did Not Effectively Ensure Purchases Were Reviewed and Strategic Sourcing Was Used

The inspection team obtained a population of approximately 45,300 purchase card transactions from May 1, 2022, through April 30, 2023, which totaled just under $43.6 million. Of these transactions, the team reviewed a statistical sample of 74 transactions totaling approximately $223,000 to determine whether the healthcare system maintained purchase card documentation and whether transactions were processed in accordance with VA policy.[75] See appendix A for a full description of the inspection's scope and methodology and appendix B for details on its sampling. An analysis of the sample led the team to project noncompliance errors for almost 13,900 purchase card transactions (about 31 percent of transactions), totaling at least $13.4 million in questioned costs.[76]

Purchase Card Transactions

VA policy has specific requirements for using a government purchase card to acquire goods and services.[77]

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

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

[74] VA Financial Policy, "Government Purchase Card for Micro-Purchases," p. 20.

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

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

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

- Prior approval must be obtained to ensure a valid business need before initiating a purchase. Approval may vary in form and content but must be retained as supporting documentation.[78]
- Transactions must be reconciled and approved no later than the 15th calendar day of the month (for example, July 15), after the closing of the previous month's billing cycle.[79]
- Segregation of duties should be maintained to ensure roles and responsibilities do not overlap among the cardholder, approving official, or purchase card coordinator in order to reduce the risk of fraud, waste, and abuse.[80]

The team used the sample of 74 transactions to evaluate purchase card transaction documentation to determine if these requirements were met. Based on the sample review, the team projected that cardholders did not obtain prior approval for about 4,200 transactions, resulting in just under $4.1 million in questioned costs.

The team also identified transactions that were not reconciled or approved by the 15th day of the month after the previous month's billing cycle as required by VA policy.[81] As a result, the team projected that approximately 3,800 transactions for about $3.6 million were not reconciled or approved promptly. The team determined that at least 73 percent of these transactions were reconciled promptly by cardholders but were not approved by approving officials within the required time frame. In addition, the team identified that the healthcare system did not maintain segregation of duties, which resulted in projected questioned costs for approximately 5,500 transactions totaling about $5.3 million. Untimely reconciliations and segregation-of-duty issues increase the risk for data integrity errors and fraud.

Table 1 shows the results of the sample review.

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

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

[80] VA Financial Policy, "Government Purchase Card for Micro-Purchases." VA requires that the duties of the cardholder, approving official, requesting official, and receiving official be segregated. An agency or organization program coordinator cannot be a cardholder or an approving official. No one person may order, receive, certify funds, and approve his or her own card purchases.

[81] VA Financial Policy, "Government Purchase Card for Micro-Purchases," p. 15.

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

Requirement	Projected dollar amount of noncompliant transactions
Prior approval	$4,100,000
Reconciliation approved by the 15th day of the month after the closing of the previous month's billing cycle	$3,600,000
Segregation of duties	$5,300,000

Source: VA OIG inspection team assessment of 74 sampled transactions.

These issues occurred because approving officials did not provide sufficient oversight of the transaction process to ensure cardholders obtained documented approvals before making purchases. Approving officials also did not ensure that cardholders maintained all required supporting documentation—such as written requests, vendor invoices, and proof of delivery receipts. Also, cardholders did not always reconcile charges promptly, and approving officials did not always ensure that cardholders' reconciliations were approved within the time frame established in VA policy.[82] Approving officials must ensure transactions are legal, proper, and mission essential. Untimely reconciliation and approval increases the risk for data integrity errors and fraud. This includes ensuring that proper approvals are obtained and documented before the purchase and that segregation of duties is maintained throughout the transaction process.[83]

The healthcare system supervisor of facility operations reported that staffing shortages also contributed to problems with approvals and reconciliations. The supervisor reported that he had to cover for another work group because that group's supervisor had left, and that position was still vacant during FY 2022. The healthcare system agency organization program coordinator corroborated this issue and added that attrition rates continue to increase, making it difficult to maintain logistics staffing levels.

The team assessed whether cardholders split purchases into two or more transactions to avoid exceeding the micropurchase threshold and whether they modified purchases to stay within the authorized single purchase limit from May 1, 2022, through April 30, 2023. Contracts must be used when the total value of the requirement exceeds the micropurchase threshold. Cardholders are instructed not to modify or split a requirement into smaller parts to avoid exceeding their purchase card limit or the micropurchase threshold as a means to circumvent the use of formal contracting procedures. Instead, cardholders should refer this type of purchase to the contracting office for procurement.[84] The team selected a statistical sample of 49 transactions totaling approximately $164,000 to determine if cardholders split purchases. After reviewing

[82] VA Financial Policy, "Government Purchase Card for Micro Purchases," p. 7.
[83] VA Financial Policy, "Government Purchase Card for Micro-Purchases."
[84] VA Financial Policy, "Government Purchase Card for Micro-Purchases."

documentation and interviewing cardholders to discuss the transactions, the team determined two transactions totaling about $3,700 were split purchases. The split purchases also represented unauthorized commitments for about $3,700 in questioned costs.[85] A statistical projection using just two transactions would have lacked precision and was therefore not conducted.[86]

Example 1 describes a sampled transaction identified as a split purchase and unauthorized commitment.

Example 1

On March 9, 2023, healthcare system staff used a purchase card to pay for charges for tele-town hall virtual meeting services that were not covered under a contract. The healthcare system staff intentionally created two separate purchase orders to pay for charges totaling approximately $3,700, which could have been avoided by combining the charges into a single payment. The total charge exceeded the staff member's purchase card limit of $3,500.

The split purchases occurred because approving officials did not always provide sufficient oversight to ensure cardholders communicated with the contracting office to determine if contracting options were warranted or available as an alternative. The proper way to purchase frequently needed or high-cost goods above the purchase card limit is to send the service request to the contracting office for purchase. This requires planning to ensure there is sufficient time for a contract to be expanded—or established if none exists—to purchase the products in time for planned use. The unauthorized commitments resulting from these split purchases is considered an improper payment, and the VA cardholder must submit a request for ratification to the chief of the contracting office that provides contracting support to the organization involved.[87]

In the 2021 report, the OIG recommended that the healthcare system submit ratification requests for the unauthorized commitments the OIG team had identified. During the follow-up visit in 2023, the team assessed whether the healthcare system had submitted ratification requests and correctly processed those unauthorized commitments. The team reviewed the ratification documents and determined that ratifications had been processed correctly.

During the review period from May 1, 2022, through April 30, 2023, the team also identified purchase card transactions for which cardholders did not have documentation of the request from VA personnel, with justification such as a consult from a doctor that supports the need for a prescription. While on-site, the team learned that pharmaceutical vendor sales representatives

[85] Unauthorized commitments can occur when a purchase, including a split order, is made by a cardholder or contractor who lacks the authority to bind the government or who exceeds his or her delegated authority.

[86] The inspection team reported actual sample results rather than estimates for these transactions because of the low sample size, and low error count prevented a precise projection.

[87] FAR 1.602-3 (2024). This section establishes the process by which an authorized official converts an unauthorized commitment to a legal contract.

contacted healthcare pharmacy cardholders via email and directed the agents to create purchase orders for drugs that had been prescribed to a patient. The sales representative would specify the requested drug and the total order amount and would also provide minimal patient information in the email. The cardholders made the purchase based solely on the email, without checking the patient's health record for an existing doctor's order or prescription.

VA policy requires that agency personnel requesting purchases of goods or services must provide written and electronic requests for the items.[88] Documentation must clearly indicate a valid business need for the requested goods or services. In these cases, agency personnel did not make the request as required by policy. This occurred because the pharmaceutical staff was unaware of the need to substantiate that a legitimate request has been made from VA personnel before making the purchase. As a result, the team projected that at least 940 transactions for at least $909,000 lacked documentation of the request from VA personnel. The chief of pharmacy became aware of these issues before the inspection started, took steps to halt the use of this practice by third-party representatives, and concurred with the team that orders should not have been made in this manner. The chief of pharmacy also began implementing existing VA-developed guidance for processing these types of pharmaceutical purchases.[89]

Use of Contracts

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

The team analyzed the transactions, which occurred from May 1, 2022, through April 30, 2023, and determined that the healthcare system's expenditures with its top 10 vendors, by dollar amount, were over $10.9 million. The team found that contracts could have been considered for three of those vendors, for just over 3,000 transactions totaling at least $2.7 million. The healthcare system's purchases from these three vendors were made on the open market rather than through contracts that could have resulted in cost savings. Table 2 shows the total number

[88] VA Financial Policy, "Government Purchase Card for Micro-Purchases," p. 11.

[89] VA Pharmacy Benefits Management Services, "VA Ordering Summary" (standard operating procedure), September 2023.

of transactions and amounts spent with the three vendors with no contracts in place during the review period.

Table 2. Three Vendors with Open Market Purchases from the Southeast Louisiana Veterans Health Care System

Merchants	Amount spent	Transaction count
Vendor 1	$1,189,628	12
Vendor 2	$784,018	2,712
Vendor 3	$734,886	282
Total	**$2,708,532**	**3,006**

Source: VA OIG analysis of Southeast Louisiana Veterans Health Care System purchase card data from May 1, 2022, to April 1, 2023.

The team interviewed the cardholders and learned that they were not being instructed to review their purchases and determine when it is in the best interest of the government to utilize strategic sourcing. Strategic sourcing is the process of obtaining contracts for goods and services that are frequently purchased.

In the 2021 report, the OIG recommended the healthcare system and contracting officials ensure approving officials and cardholders review their purchases and make sure strategic sourcing is used when it is in the best interest of the government. The director concurred with the recommendation and provided an action plan specifying that the chief logistics officer would ensure approving officials and cardholders review their purchases and use strategic sourcing when necessary. The action plan further stated that the chief logistics officer and the medical supply distribution chief had retrained all logistics cardholders on the use of the software that enables users to determine the availability of items through various vendors to secure the best pricing, and that all medical center cardholders would receive this training.

The OIG closed the recommendation based on the director's action plan and evidence that logistics cardholders had received Power BI training.[90] The OIG understood that all cardholders would receive this training. Instead, non-logistics cardholders only received mandatory computer-based training. The director confirmed that all cardholders received this computer-based training, and that 95 percent of current cardholders were current on training requirements. However, because the computer-based training did not address strategic sourcing, it was

[90] "VA Enterprise Architecture, Power BI" (website), https://vaww.vear.ea.oit.va.gov/#system_and_application_domain_defs_system_252383.htm. (This website is not publicly accessible.) Power BI (Business Intelligence) is a business analytics service that delivers insights for analyzing data.

ineffective to meet the intent of the OIG's recommendation. Therefore, the OIG is reiterating its recommendation from the 2021 report as a result of this inspection.

Supporting Documentation Was Not Always Sufficient

VA policy requires cardholders to upload and electronically store supporting documents for purchase card transactions to a VA-approved document-imaging system.[91] When healthcare system staff buy goods and services using a purchase card, they must maintain supporting documentation such as approved purchase requests, vendor invoices, purchase orders, and receiving reports for six years. This documentation verifies that purchase card transactions were properly approved and that payments were accurate.

The inspection team reviewed a statistical sample of 74 transactions to determine whether the healthcare system maintained required documentation of purchase card transactions.[92] The team projected that cardholders may not have had sufficient supporting documentation for at least 2,800 transactions, which resulted in at least $2.8 million in questioned costs.[93] This occurred because approving officials did not always ensure cardholders retained sufficient documentation to support purchase card transactions.

Finding 2 Conclusion

The OIG found that some purchase card transactions lacked proper approvals, reconciliations, and supporting documentation. Healthcare system personnel should be aware of and comply with VA policies on purchase card record retention requirements and split purchases. Managers should ensure that cardholders review their purchases and consider obtaining contracts to strategically source facility needs when procuring goods and services. The purchase card reviews projected noncompliance errors in almost 13,900 transactions, totaling approximately $13.4 million.

Recommendations 6–8

The OIG made the following recommendations to the director of the Southeast Louisiana Veterans Health Care System:

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

[92] The inspection team reviewed a statistical sample of 74 purchase card transactions from a population of approximately 44,800 totaling about $44.2 million from May 1, 2022, through April 30, 2023.

[93] See appendix A for additional details on the scope and methodology and appendix B for details on sampling. Per 2 C.F.R. § 200.84 (2014), a questioned cost is: (a) an alleged violation of a provision of a law, regulation, contract, grant, cooperative agreement, or other agreement or document governing the expenditure of funds; (b) a finding that, at the time of the audit, such cost is not supported by adequate documentation; or (c) a finding that the expenditure of funds for the intended purpose is unnecessary or unreasonable.

6. Ensure cardholders obtain a proper prior approval and maintain segregation of duties, and ensure that cardholders and approving officials perform prompt purchase card reconciliations as required by VA financial policy.
7. Develop formalized processes and controls to ensure approving officials, cardholders, and the agency contracting office review repetitive open market purchases of goods and services and obtain contracts when it is determined to be in the best interest of the government.
8. In coordination with the Strategic Acquisition Center, submit a ratification for an unauthorized commitment following the Federal Acquisition Regulation.

VA Management Comments

The director concurred with recommendations 6 through 8. To address recommendation 6, the director said measures have been implemented to ensure ongoing compliance, including training and processes to monitor for violations, notify cardholders, and inform them of corrective actions needed. As of October 2023, the healthcare system has run monthly reports and performed quarterly purchase order reviews to ensure the prior approval of purchase card transactions, timely reconciliations, and segregation of duties. To address recommendation 7, the director said the healthcare system will complete required training and implement use of the Strategic Sourcing Tool from the Supply Chain Data Informatics Office. For recommendation 8, the director stated that the healthcare system will submit a ratification packet by September 30, 2024.

OIG Response

The healthcare system director's action plans are responsive to recommendations 6 through 8. The OIG will monitor implementation of the planned actions and will close the recommendations when it receives sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified. While the director reported that the targeted completion date for its recommendation 6 action plan was October 2023 (prior to the publication of this report), the OIG did not receive any related evidence or supporting documentation and considers all these recommendations open.

III. Administrative Staffing Levels

Large administrative overhead in health care is increasingly identified with cost inefficiency.[94] Healthcare systems can help ensure funds are put to the best use by identifying potential indicators of inefficiencies, such as higher administrative staff levels than those found at VHA facilities similar in size and complexity.

The 2021 OIG report found that the healthcare system had almost 252 more administrative full-time equivalent positions than systems of similar size and medical complexity. Based on this metric, the OPES model ranked the healthcare system last among 21 peer facilities in the 1b, high-complexity cohort.[95]

The team reviewed the following administrative staffing areas:

- **Administrative staffing efficiency** by comparing the number of the healthcare system's administrative full-time equivalent positions against those reported in the OIG's September 2021 report, and also against the FY 2022 numbers reported among the healthcare system's cohort of 20 peers in the 1b, high-complexity group.
- **Facility resource management** including how healthcare systems oversee administrative staffing and address identified problems.

Finding 3: The Healthcare System Improved Administrative Staffing Efficiency

The healthcare system did not have any administrative staffing recommendations from the 2021 OIG report to address. In that report, the OPES administrative staffing model ranked the healthcare system last in the 1b-high-complexity cohort. However, the OIG did not make any recommendations at that time because the healthcare system had implemented strategies to improve staffing efficiency and management. The 2021 report also noted that the healthcare system was continuing to activate the New Orleans VA Medical Center, which opened in 2016, and it intentionally hired employees before having a history of actual workload. The healthcare system director said the facility would achieve more efficient administrative full-time equivalent staffing metrics as more medical services were activated, more workload was recorded, and the misalignment of workload and staff improved.

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[94] "Administrative Staffing Model Overview" (website), OPES,; https://dvagov.sharepoint.com/sites/VHAOPES/SitePages/Staffing-Resources.aspx#administrative-staffing-model-overview. (This website is not publicly accessible.); "VHA Facility Complexity Model Data Definitions," accessed March 19, 2024, http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=3757. (This website is not publicly accessible.)

[95] Due to rounding, the number of employed full-time equivalent workers (780) minus the expected full-time equivalent workers (529) does not match 252.

In the 2021 report, the human resource staff for the healthcare system stated that administrative personnel, such as medical support assistants, administrative officers, and logistics specialists, help clinicians with administrative duties and support core functions with patient care needs. Administrative personnel may also facilitate community care when appropriate, particularly for veterans who live far from the New Orleans VA Medical Center. Accordingly, staffing efficiency numbers should be a starting point for leaders to determine if a problem exists and develop improvement strategies with considerations of the impact on veterans' access to quality care.

During the August 2023 site visit, OPES model results indicated that the healthcare system had improved administrative staffing efficiency since the 2021 OIG report, but opportunity for improvement continued to exist. As noted previously, the FY 2019 OPES model reported 252 more administrative full-time equivalent positions than expected. This measure is known as the "observed minus expected" value, and it decreased to 86 positions in FY 2023.

Figure 7 compares the healthcare system's OPES administrative staffing model results to comparable facilities from FY 2019 through FY 2023.

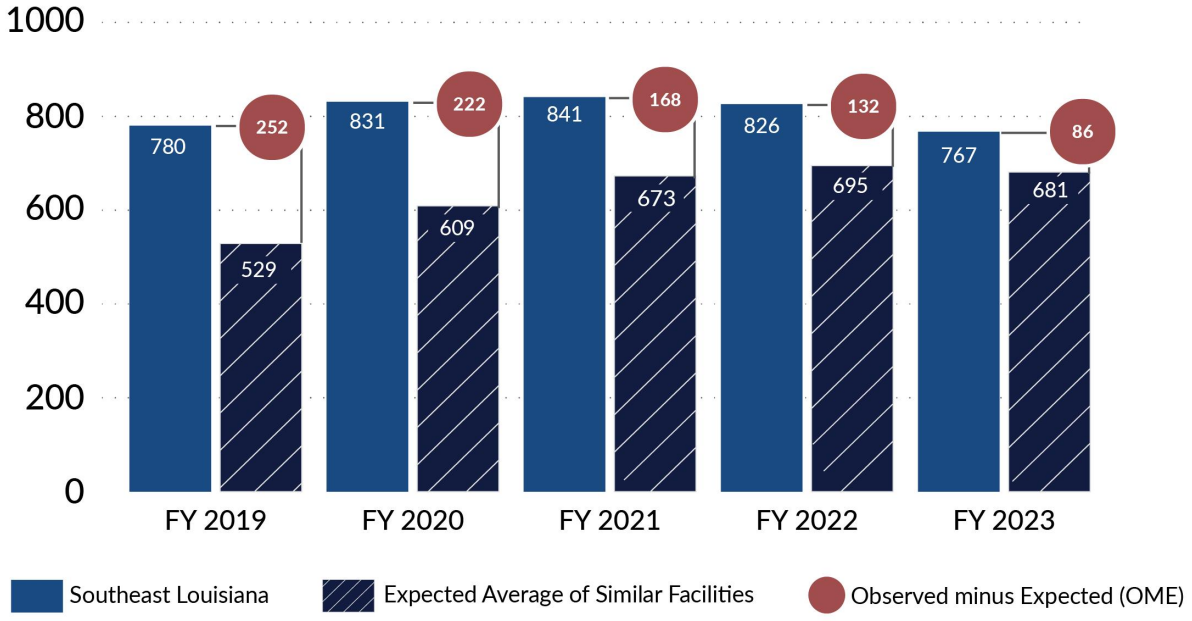

Figure 7. *Total administrative full-time equivalent positions at Southeast Louisiana Veterans Health Care System compared with similar 1b, high-complexity facilities nationwide, FY 2019–FY 2023.*

Source: VA OIG analysis of OPES administrative staffing model data.

Even though the healthcare system utilized 86 more administrative full-time equivalent positions than expected, the healthcare system does not plan to reduce its full-time equivalent positions because the existing ones are needed and there are vacant ones that needed to be filled. The chief financial officer said the healthcare system was not able to reduce them further because the medical center was extremely understaffed and had vacancies in critical positions such as the

chief of logistics and assistant chief of logistics. The healthcare system director also explained that further full-time equivalent position reductions would be inconsistent with the VHA priority to promote strategies for a growing workforce and achieve a growth rate that is 5 percent higher than the five-year average growth rate.[96] In a follow-up message in March 2024, the director stated that growth rate was related to FY 2023; however, he did not explain whether the VHA priority to grow the workforce was still in effect for FY 2024.

Finding 3 Conclusion

In regard to administrative staffing, the healthcare system had more administrative full-time equivalent positions than other healthcare systems of similar size and complexity. The OIG found that several factors influenced healthcare system staffing, such as the use of activation funding to hire staff before having a workload history, high vacancy rates, and VHA strategies for growing the workforce. The OIG made no recommendations related to administrative staffing levels for the follow-up inspection.

[96] The FY 2023 Senior Executive Service Executive Performance Plan incorporates VA's goal to promote innovative strategies for a growing workforce, with a focus on recruitment, retention, training, and development. An outstanding performance in this area requires medical center directors to achieve a growth rate that is 5 percent higher than the five-year average growth rate.

IV. Pharmacy Operations

In FY 2022, prescription drug spending at the healthcare system was almost $86.9 million, which represented just over 11 percent of the healthcare system's budget of about $761 million.[97] Because pharmacy accounts for a substantial percentage of any healthcare system's budget, healthcare system leaders need to analyze spending and identify opportunities to use pharmacy dollars efficiently. The OIG team's inspection focused on these areas:

- **OPES pharmacy expenditure data** help VHA facilities track cost performance and identify potential opportunities for improvement.
- **Inventory turnover rate** is the number of times inventory is used during the year and is the primary measure for monitoring the effectiveness of inventory management per VHA policy.[98] Low inventory turnover rates indicate inefficient use of financial resources.
- **End-of-year purchases of pharmacy drugs** can lower the inventory turnover rate and increase the total replenishment cost of pharmacy inventories. These purchases complicate pharmaceutical inventory management and should be avoided, according to VHA policy and Pharmacy Benefits Management Office guidance.[99]
- **B09 reconciliation** helps ensure the facility is making correct payments for the drugs it receives.[100] This is necessary because healthcare systems make payments to the prime vendor before receiving the pharmaceuticals. Without this reconciliation process there is no assurance that the amount paid to the prime vendor is consistent with the amount of goods received.

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

The OIG found that the healthcare system could improve pharmacy efficiency by narrowing the gap between expected and observed pharmacy drug costs, achieve an inventory turnover rate closer to the VHA-recommended level, and avoid end of-year-purchases. In addition, the healthcare system did not fully complete B09 monthly reconciliations. Failure to properly

[97] Office of Productivity, Efficiency and Staffing, "FY 2023 Pharmacy Expenditure Model (based on FY 2022 data)," accessed May 18, 2023, https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?/MgmtReports/OPES/EOG_Model&rs:Command=Render&rc:Parameters=true&Model=pharm1&VISN=0. (This website is not publicly accessible.)

[98] Pharmacy Informatics Workgroup Training Presentation, "Annual Wall to Wall Physical Inventory," p 11. Inventory turnover rates are based on the previous 12 months of purchases divided by the inventory on hand. VHA Directive 1761, app. H.

[99] VHA Directive 1108.07; Pharmacy Informatics Workgroup Training Presentation, "Annual Wall to Wall Physical Inventory," p. 11.

[100] VHA Directive 1108.07, p. 8.

manage pharmacy operations can lead to increased replenishment costs, overstocking, spoilage, and diversion of drugs, as well as decrease the funding available to meet other healthcare system and patient care needs.[101]

OPES Pharmacy Expenditure Data

The OPES pharmacy expenditure model, which identifies variations in pharmacy drug costs among VHA facilities, showed that the healthcare system had about $86.9 million in drug costs in FY 2022. According to the model, this amount was about $18.7 million higher than expected costs of about $68.2 million. On that basis, the healthcare system's observed minus expected ratio was about 1.27, which ranked it 137th out of 139 VHA facilities for pharmacy drug cost efficiency.[102]

According to the OPES model, for FY 2020 through FY 2022, the healthcare system demonstrated decreasing efficiency. In FY 2020 the healthcare system's observed drug costs were almost $7.6 million more than expected. In FY 2021, drug costs were about $13.1 million higher than expected, and in FY 2022 this amount increased to about $18.7 million.

Figure 8 shows the healthcare system's trend of increasing observed minus expected drug costs from FY 2020 through FY 2022.

[101] VHA Directive 1108.07(1), *Pharmacy General Requirements*, March 10, 2017, amended January 26, 2021.

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

Figure 8. *Observed minus expected drug costs, FY 2020 through FY 2022.*

Source: OPES pharmacy expenditure model.

Note: The OPES data models are based on the previous fiscal year data (for example, the FY 2022 data model was based on FY 2021 data).

According to the healthcare system's pharmacy chief, the Pharmacy Service did not routinely monitor the OPES pharmacy model to identify and act on potential savings opportunities. The pharmacy chief explained that the cost increases can be attributed to several factors, including an increase in Central Mail Order Pharmacy orders and rising medication costs. The pharmacy chief also said that spending increased because of an increase in the volume of high-cost specialty drugs prescribed by community care providers to treat specific conditions and diseases. According to OPES, the healthcare system may have missed opportunities to reduce spending on drugs from FY 2020 through FY 2022.

Inventory Turnover Rate

VHA policy states that inventory turnover is the primary measure of the effectiveness of inventory management.[103] Furthermore, VHA adopted ABC classification principles to increase accountability for inventory management and establish more rigorous requirements for managing high-dollar-usage inventory items.[104] This method is based on annual usage, in dollars, of all items at a specific inventory point. To establish ABC categories, items are ranked from highest

[103] VHA Directive 1761, app. H. In 2021, the OIG team reviewed the wall-to-wall inventory report. However, in August 2023, the team replaced its source of data to prime vendor 12-month summary inventory reports.

[104] VHA Directive 1761, app. E. VHA adopted ABC classification principles for inventory management. The formula for calculating the annual usage dollars of an item is the annual usage quantity multiplied by the average unit price.

dollar amount of usage to lowest. Items with the highest 80 percent of annual usage are classified as "A" items; the next highest 10 percent are classified as "B" items; and the remaining 10 percent are classified as "C" items.

The VHA Pharmacy Benefits Management Office recommended an annual inventory turnover goal of 12 to 16 times for items classified as "A" and six to 10 times for "B" and "C" items.[105] The pharmacy chief said she was aware of these targets, but the healthcare system did not meet these targets for A and C items in FY 2022, as shown in table 3.

Table 3: FY 2022 Recommended and Actual Inventory Turnover Rates

Item classification	Recommended annual inventory turnover rate	Actual FY 2022 annual turnover rate
A items	12 to 16	9.6
B items	6 to 10	6.4
C items	6 to 10	3.7

Source: VA OIG analysis of the pharmaceutical prime vendor's 12-month Inventory Turns Forecast Report/Summary Report.

VHA policy also mandates that pharmacy services use the pharmaceutical prime vendor's inventory management software or another inventory management system to manage all VA medical facility pharmacy inventories.[106] However, the inspection team determined that the healthcare system did not use the prime vendor's software or any other inventory management software to manage pharmacy drug inventories in accordance with VHA policy.[107] These inventories were managed by walking through the aisles rather than more accurate inventory management practices. The team also found pharmacy staff did not consistently use handheld barcode readers.[108] Pharmacy officials stated that they were unable to use handheld scanners due to issues with wireless connectivity. Specifically, staff mentioned that the structure of the building prevented Wi-Fi or hot spot connectivity for the readers to function properly.[109]

Higher inventory turnover rates are associated with decreased inventory carrying cost, which is the cost of holding inventory in storage. On the other hand, low inventory turnover could indicate the inefficient use of financial resources and the inability to properly forecast the amount

[105] VHA Pharmacy Benefits Management Office, email message to the VA OIG Office of Financial Inspections, February 23, 2023.

[106] VHA Directive 1761, p H-1.

[107] VHA Directive 1761.

[108] VHA Directive 1761, app. D.

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

of pharmacy drugs needed for patient care. By not meeting recommended inventory turnover rates, the healthcare system increases its risk of being inefficient with VA resources.

In the 2021 report, the OIG recommended that the healthcare system ensure it meets VHA's recommended inventory turnover rate of 12 times per year. The healthcare system responded in December 2021 and said its action plans resulted in steady improvement. The OIG closed the recommendation based on a review of documented evidence that showed the healthcare system, during weekly procurement meetings, was reeducating its staff to review returns and inventory levels. However, in a June 2022 inventory report, the healthcare system did not achieve 12 turns per year or make significant progress toward that goal. According to the pharmaceutical prime vendor's inventory data, the healthcare system's inventory turnover rate trended downward from 9.92 turns in January 2022 to 7.92 in June 2022.[110] The pharmacy chief said she educated her staff and held weekly procurement meetings; however, staffing shortages and large year-end drug purchases prevented the facility from continuing to improve the process and meet the target.

End-of-Year Purchases of Pharmacy Drugs

The OIG found that the healthcare system had a sharp increase in pharmaceutical drug expenditures during the last month of each fiscal year analyzed. The healthcare system averaged just over $2 million in monthly expenditures during the first 11 months of FY 2021, which jumped to almost $5.9 million in the last month. In FY 2022 the healthcare system averaged almost $2.3 million in monthly pharmaceutical drug expenditures during the first 11 months and reported $5.6 million in expenditures for the last month. Figure 9 shows the spike in pharmacy drug expenditures during the last month of FY 2021 and FY 2022.

[110] In 2021, the team reviewed the wall-to-wall inventory report. However, during the 2023 financial inspection, the team extended its review to include wall-to-wall and prime vendor 12-month summary inventory reports.

Figure 9. *Southeast Louisiana Veterans Health Care System's monthly drug expenditure data for FY 2021 and FY 2022.*

Source: OIG analysis of VA Financial Management System (FMS 830/887 report).

VHA policy from the Pharmacy Benefits Management Office states that "end-of-year purchases make pharmaceutical inventories increasingly difficult to manage and need to be avoided."[111] The policy also notes that end-of-year purchases that cause overstocking are to be avoided. Overstocking is an inefficient use of resources and increases the risk of damage, contamination, and obsolescence of stock items.

Pharmacy leaders said the healthcare system's fiscal office initiates the request for this spending and gives the Pharmacy Service only a few days' notice near the end of the fiscal year to spend the remainder of appropriated funds. Interviews further confirmed that these end-of-year purchases included orders for high-cost drugs.

B09 Reconciliation Process

VHA policy requires a review of the B09 report and reconciliation of that report with VA Form 1358 and other supporting documentation.[112] These reports are generated weekly to reconcile pharmaceuticals that are purchased and ordered to pharmaceuticals that are invoiced and received at the facility. A monthly memorandum and supporting documentation are provided to the Finance Service for review and concurrence. The results of the reconciliation are to be returned and retained with the Pharmacy Service, and any identified discrepancies are to be

[111] VHA Directive 1761, p. H-1.

[112] VHA Directive 1108.07(1), p. B-1.

corrected in a timely manner. VA offices may use VA Form 1358 as an obligation control document only for certain approved uses.[113] The use of this form helps ensure that the pharmacy is making correct payments for what is received and that there is evidence, such as a signature and date of review, that documents the completion of the order. The B09 report summarizes multiple invoices and is generated weekly. VHA policy requires reconciliation of billing statements, verification that items ordered are received, certification of accuracy, and the maintenance of supporting documentation such as receipts, invoices, and packing slips. The Pharmacy Service must provide a monthly report, with adequate documentation, to the fiscal service stating that the 1358 forms and B09 reports were reconciled and noting any unresolved discrepancies. VHA policy also states that the pharmacy staff must maintain a segregation of duties during the Form 1358 ordering process, which requires different staff members to establish, approve, obligate, and receive the goods ordered.[114]

The healthcare system's B09 reconciliation process did not fully comply with VHA policy. When an order is delivered, Pharmacy Service staff should input a daily activity entry on the Form 1358 in the Integrated Funds Control, Accounting, and Procurement application (IFCAP) for each invoice received from the prime vendor. The Pharmacy Service should also reference the pharmaceutical prime vendor invoice number in the daily activity entry. According to pharmacy staff, the healthcare system did not record daily activity on the Form 1358 in IFCAP for each invoice received from the prime vendor.

The team determined that the healthcare system did not complete six months of reconciliation packages, from the beginning of January 2023 through June 2023, until after the financial inspection was announced on July 10, 2023. Further, the team reviewed the May 2023 reconciliation package and identified that 36 invoices totaling almost $284,000 were missing from the B09 report. The facility did not report this discrepancy in its monthly memorandum and did not appropriately research or resolve the issue as of September 2023. The healthcare system attributed noncompliance with timeliness of the B09 reconciliations to staffing shortages, hurdles to hire additional staff, and prioritization of tasks. Without this documentation, the fiscal service could not complete the full reconciliation as required. If reconciliations are not completed, there is no assurance that the amount paid to the prime vendor is consistent with the goods received.

Finding 4 Conclusion

The healthcare system could improve pharmacy efficiency by narrowing the gap between observed and expected drug costs, increasing inventory turnover to meet the VHA-recommended level, and decreasing end-of-year purchases. The healthcare system could further improve

[113] VA Financial Policy, "1358 Obligations," in vol. 2, *Appropriations, Funds and Related Information* (May 2021, and September 2021), chap. 6, app. A; VHA Office of Finance, Financial Management & Accounting Systems Alert, "Pharmacy Prime Vendors B09 Reconciliation Standard Operating Procedures," October 3, 2012.

[114] VHA Directive 1108.07(1).

pharmacy efficiency by submitting monthly B09 reconciliation reports to the fiscal office and correcting discrepancies appropriately.

Recommendations 9–11

The OIG made the following recommendations to the director of the Southeast Louisiana Veterans Health Care System:

9. Develop formalized processes for monitoring and achieving efficiency targets and using available pharmacy data to make business decisions.
10. Develop and implement a plan to increase inventory turnover to meet or exceed the VHA-recommended level, and complete monthly B09 reconciliations consistently to ensure discrepancies are corrected in a timely manner.
11. Establish measures to improve compliance with the VA directive to avoid end-of-year pharmaceutical purchases.

VA Management Comments

The director concurred with recommendations 9 through 11. To address recommendation 9, the director said that as of March 2023, the healthcare system pharmacy targeted an inventory turnover rate of 12 turns or higher and was tracking and reporting inventory data, managing high-cost medications, reducing automatic medication refills, streamlining purchases, and ensuring a 30-day return policy for excess or unnecessary items.

For recommendation 10, the director said the healthcare system introduced a new plan that showed progress towards the goal of 12 turns per year and improved the turnover rate from 7.91 turns to 10.31. The director also said that the B09 reconciliations are now current and there is an agreement to minimize VA revenue loss and ensure accurate obligation tracking and recording. A change in the B09 reconciliation process has expedited B09 reconciliations and enabled the fiscal and pharmacy services to make real-time corrections.

For recommendation 11, the director said that the pharmacy transitioned away from end-of-year purchases as of January 2023, and there were no end-of-year purchases for FY 2023 and no projected end-of-the-year purchases for FY 2024.

OIG Response

The healthcare system director's action plans are responsive to recommendations 9 through 11. The OIG will monitor implementation of the planned actions and will close the recommendations when it receives sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified.

Appendix A: Scope and Methodology

Scope

The team conducted its inspection of the Southeast Louisiana Veterans Health Care System from July 2023 to June 2024, including a site visit during the week of August 21, 2023. The inspection was limited in scope and is not intended to be a comprehensive inspection of all financial operations at the healthcare system.

Methodology

The inspection team evaluated financial efficiency practices from May 2022 through April 2023 for purchase card use and MSPV utilization. The team also analyzed financial efficiency practices related to the healthcare system's administrative staffing levels and pharmacy costs using the fiscal year (FY) 2023 Office of Productivity, Efficiency and Staffing (OPES) efficiency opportunity grid model. The FY 2023 data model was based on FY 2022 data from the Financial Management System.

To conduct the inspection, the team

- interviewed healthcare system leaders and staff;
- identified and reviewed applicable laws, regulations, VA policies, operating procedures, and guidelines related to managing open obligations, overseeing purchase card transactions, calculating days of stock on hand, and addressing inefficiencies in pharmacy costs;
- judgmentally sampled 25 purchase records for Medical/Surgical Prime Vendor (MSPV) product list items to determine why those items were purchased using nonprime-vendor sources; and
- statistically sampled 74 purchase card transactions to determine if there was proper oversight and governance of the purchase card program, as well as to assess the risk for illegal, improper, or erroneous purchases.

Internal Controls

The inspection team assessed the internal controls of the Southeast Louisiana Veterans Health Care System significant to the inspection objective. This assessment considered the five internal control components in the Government Accountability Office's *Standards for Internal Control in the Federal Government*, along with the related principles contained in each component.[115] The

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

five internal control components are control environment, risk assessment, control activities, information and communication, and monitoring. The team identified internal control weaknesses in three of the four protocols assessed—MSPV, purchase cards, and pharmacy operations—and made recommendations to address the control deficiencies.

Fraud Assessment

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

Data Reliability

The inspection team used computer-processed data obtained from US Bank files through a corporate data warehouse, a central repository of US Bank data that is updated monthly, the OPES efficiency opportunity grid, and the Supply Chain Common Operating Picture dashboard. To test for reliability, the team determined whether any data were missing from key fields, included any calculation errors, or were outside the time frame requested. The team also assessed whether the data contained obvious duplication of records, alphabetic or numeric characters in incorrect fields, or illogical relationships among data elements. Furthermore, the team compared purchase identification numbers, purchase dates, cardholder names, payment amounts, and vendor/merchant names as provided in the data received for the samples reviewed. Testing of the data disclosed that they were sufficiently reliable for the inspection objectives.

Government Standards

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

Appendix B: Statistical Sampling Methodology

Approach

The inspection team evaluated a statistical sample of purchase card transactions that occurred from May 1, 2022, through April 30, 2023, to determine if the Southeast Louisiana Veterans Health Care System reviewed transactions to (1) ensure they were adequately monitored, approved, and supported by documentation, (2) prevent split purchases and transactions exceeding the cardholder's authorized single purchase limit, and (3) ensure goods or services were procured using strategic sourcing.

Population

From May 1, 2022, through April 30, 2023, the healthcare system had 45,291 purchase card transactions which totaled $43,581,110. After the inspection team removed transactions with negative purchase amounts, 44,751 transactions totaling $44,242,564 remained.[116] From this population, the team developed three strata from which to draw statistical samples. The first stratum included potential split transactions that exceeded the micropurchase threshold in the aggregate but not individually. The sample from this stratum included a total of 10 bundles of transactions composed of 33 individual transactions that totaled approximately $155,221. The second stratum included potential split transactions that exceeded a cardholder's single purchase limit and were less than the micropurchase threshold. The sample from this stratum included 10 bundles consisting of 27 transactions that totaled approximately $37,943. The third stratum included transactions greater than $0 that were not included in the prior two strata. The sample from this stratum included 25 purchase card transactions, which totaled approximately $58,506.

Sampling Design

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

- **Potential split purchases exceeded micropurchase threshold.** The team identified potential split purchases as transactions with the same purchase date, purchase card number, and merchant, as well as a sum greater than the micropurchase threshold. The statistical sample consisted of 10 bundles of potential split purchases that included 33 transactions. The team selected 27 transactions for review.

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

- **Potential splits exceeded single purchase limit.** The team identified potential split purchases as transactions with the same purchase date, purchase card number, and merchant, as well as an aggregate sum greater than the cardholder's authorized single purchase limit but less than the micropurchase threshold. The statistical sample consisted of 10 bundles of potential split purchases that included 27 transactions. The team selected 22 transactions for review.
- **Other purchases.** The team developed a statistical sample of 25 transactions greater than $0 from the remaining population after all potential split purchases were identified.

The statistical samples included 85 individual transactions: 60 potential split purchase transactions, totaling approximately $193,000; and 25 other purchase card transactions, totaling approximately $58,500. The team selected 49 transactions totaling approximately $164,200 from the potential split purchase samples for review. This yielded a final sample group of 74 transactions that were reviewed by the team.

To review the transactions selected from the samples, the team requested supporting documentation for each of the 74 transactions, the VA Form 0242 for each of the 20 cardholders associated with the selected transactions, and documentation to support the completion of purchase card reviews.

Weights

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

Projections and Margins of Error

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

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

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

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

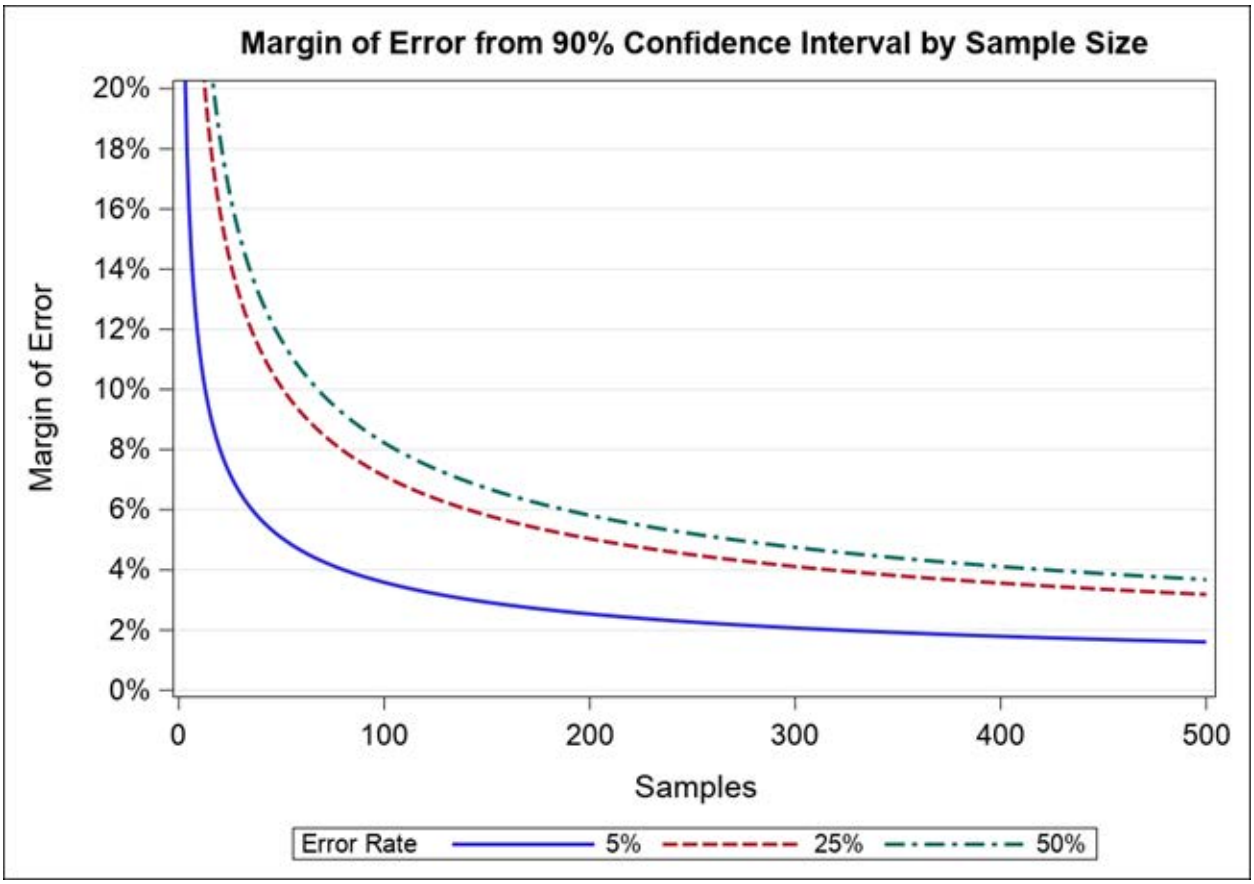

Figure B.1. *Effect of sample size on margin of error.*
Source: OIG statistician's analysis.

Projections

The team reviewed a statistical sample from a population of approximately 44,800 purchase card transactions totaling approximately $44.2 million. Based on the results, the team projected that almost 13,900 transactions with a projected total of approximately $13.4 million were not processed in accordance with VA policy. The team further projected that the Southeast Louisiana Veterans Health Care System

- did not have supporting documentation for at least 2,800 transactions with a projected total of at least $2.8 million;[117]
- did not have documented prior approval for about 4,200 transactions with a projected total of just under $4.1 million;

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

- had improper authorization from merchants for at least 940 transactions that lacked documentation of the request from VA personnel with a projected total of at least $909,000;
- did not have compliant reconciliations for approximately 3,800 transactions with a projected total of about $3.6 million; and
- did not maintain segregation of duties for approximately 5,500 transactions, resulting in about $5.3 million in projected questioned costs.

The team also observed split purchases for two transactions resulting in approximately $3,700 in unauthorized commitments. There were not enough split purchases found in the sample review to project to the population.

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

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

Estimate name	Estimate number	90 percent confidence interval				Sample
		Margin of error	Lower limit	Upper limit	One-tailed lower limit	
Overall errors	13,868	7,446	6,422	21,314	N/A	44
Overall errors (percent)	31%	17%	14%	48%	N/A	44
Supporting documentation errors	7,781	6,359	1,422	14,139	2,845	17
Prior approval errors	4,207	2,064	2,143	6,271	N/A	19
Improper authorization from merchants	1,974	1,334	640	3,308	939	7
Reconciliation errors in total	3,765	2,345	1,420	6,110	N/A	21
Segregation of duties errors	5,522	2,619	2,902	8,141	N/A	25

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

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

this estimate causes the overall errors count to be different than the sum of the supporting documentation errors and reconciliation errors.

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

Estimate name	Estimate number	90 percent confidence interval				Sample
		Margin of error	Lower limit	Upper limit	One-tailed lower limit	
Overall errors	$13,432,140	$7,212,320	$6,219,820	$20,644,459	N/A	44
Supporting documentation errors	$7,536,126	$6,158,801	$1,377,326	$13,694,927	2,755,759	17
Prior approval errors	$4,074,896	$1,999,216	$2,075,681	$6,074,112	N/A	19
Improper authorization from merchants	$1,911,966	$1,291,671	$620,295	$3,203,637	$909,391	7
Reconciliation errors in total	$3,646,516	$2,271,397	$1,375,119	$5,917,912	N/A	21
Segregation of duties errors	$5,348,095	$2,537,135	$2,810,960	$7,885,230	N/A	25

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

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

Table B.3 shows statistical projections for the percent of transactions that approving officials did not promptly reconcile.

Table B.3 Statistical Projection for Percent of Transactions Not Promptly Reconciled Due to Approving Official

Estimate Name	90 percent confidence interval	
	Weighted Percent	Lower One-Tailed Limit
Not Promptly Reconciled (no prompt reconciliation or no prompt approval)	85%	73%

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

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

Recommendation	Explanation of Benefits	Better Use of Funds	Questioned Costs[118]
3	In coordination with the Strategic Acquisition Center, submit ratifications for any MSPV unauthorized commitments.	$0	$1,400,000
4	Ensure a medical/surgical prime facility-level contracting officer's representative is appointed and delegated appropriately and perform all required duties according to the scope and limitation of the designee's authority.	$0	$180,000
8	In coordination with the Strategic Acquisition Center, submit a ratification for an unauthorized commitments following the Federal Acquisition Regulation.	$0	$13,400,000
	Total	**$0**	**$14,980,000**

[118] The OIG questions costs when VA action or inaction (such as spending or failure to fully compensate eligible beneficiaries) is determined by the OIG to violate a provision of law, regulation, contract, grant, cooperative agreement, or other agreement; when costs are not supported by adequate documentation; or when they are expended for purposes that are unnecessary or unreasonable under governing authorities. Within questioned costs, the OIG must, as required by section 405 of the IG Act of 1978, report unsupported costs. Unsupported costs are those determined by the OIG to lack adequate documentation at the time of the audit. Of the estimated $15 million in questioned costs, approximately $2.8 million were unsupported costs.

Appendix D: VA Management Comments

Department of Veterans Affairs Memorandum

Date: July 26, 2024

From: Medical Center Director (629/00)

Subj: Draft Report - Follow-up Financial Efficiency Inspection of the VA Southeast Louisiana Veterans Health Care System (SLVHCS)

To: Director, Financial Inspections Division (52C05)

1. I have reviewed the draft report and concur with the recommendations identified in the Office of Inspector General Draft Report – Follow-up Financial Efficiency Inspection of the VA Southeast Louisiana Healthcare System.

2. I would like to thank the Office of Inspector General for a thorough review and recommendations. SLVHCS is diligently working on action plans to improve our processes as we remain committed to identifying opportunities for cost efficiency and promotion of best practices.

(Original signed by)

Fernando O. Rivera, FACHE

CEO/Medical Center Director

Attachment

Attachment

VHA RESPONSE TO
Office of Inspector General
Facility Comments on Follow-up Financial Efficiency Inspection
Southeast Louisiana Veteran's Health Care System
New Orleans, LA
DATE: 07/10/2024

Recommendation 1: Establish internal controls to help ensure the healthcare system monitors the medical/surgical prime vendor product list for updates and completes the item conversion process.

Concur.

Target Date for Completion: October 1, 2024.

Response: As of October 2023, the Southeast Louisiana Veterans Health Care System established weekly meetings with Facility management, Inventory Managers, Contracting Officer's Representatives (COR) and On-Site Prime Vendor Representatives to discuss the Medical Surgical Prime Vendor (MSPV) List. This process has proven to be effective as the facility has increased the MSPV purchase rate from 54.9% in 2022 and 54.1% in 2023 to 70.6% in April 2024. Will continue to monitor progress until utilization goal of 90% is achieved.

Recommendation 2: Ensure that prime vendor contract performance issues are routinely reported to the Medical Supplies Program Office and Strategic Acquisition Center using established Veterans Health Administration reporting tools.

Concur.

Target Date for Completion: September 30, 2023.

Response: As of September 2023, the Southeast Louisiana Veterans Health Care System effectively implemented the use of MSPV GenZ T2 COR Quarterly Evaluation Form to submit routine reports timely. Closure requested.

Recommendation 3: In coordination with the Strategic Acquisition Center, submit ratifications for any unauthorized commitments following the Federal Acquisition Regulation.

Concur.

Target Date for Completion: September 30, 2024.

Response: The Southeast Louisiana Veterans Health Care System will collaborate with the Contracting Office to ensure submission of the ratification packet(s).

Recommendation 4: Ensure that the facility-level contracting officer's representative and ordering officers are appointed and delegated properly and perform all required duties according to the scope and limitation of the designee's authority.

Concur.

Target Date for Completion: October 31, 2023.

Response: As of October 2023, all required memos have been issued with appropriate signatures, appointing contracting officer's representatives, and purchasing agents from the National Contracting Officer. Additionally, processes have been established to effectively update documentation as new contracts or new employees are added.

Recommendation 5: Establish internal controls to help ensure healthcare system submits national contract requests for waiver and justifications prior to purchasing available product list items from non-mandatory procurement instruments.

Concur.

Target Date for Completion: December 31, 2024

Response: The Chief of Logistics is in the process of developing a new standard operating procedure (SOP) to address the submission of national contract requests for waiver and justifications. The SOP will be effectively implemented to ensure compliance with VA policy.

Recommendation 6: Ensure cardholders obtain a proper prior approval and maintain segregation of duties and ensure that cardholders and approving officials perform prompt purchase card reconciliations as required by VA financial policy.

Concur.

Target Date for Completion: October 31, 2023

Response: The corrective measures listed below are in force to ensure sustained compliance:

1. A process was implemented to monitor compliance and notify cardholders and approving officials of violations prior to approval.
2. A list was sent to all cardholders and approving officials that encompasses what they need to keep for proper purchase order documentation.
3. A purchase card checklist is provided to cardholders and approving officials, which includes all the steps that should be taken prior to using a government purchase card.
4. The Fiscal Services Center (FSC) Purchase Card Handbook was distributed to all cardholders and approving officials that explains policy.
5. Individual and service group purchase card training was provided for all levels of leadership, cardholders, and approving officials.

As of October 2023, the Southeast Louisiana Veterans Health Care System runs monthly reports to ensure that cardholders and approving officials are performing prompt purchase card reconciliations, reconciling, and approving bank transactions no later than the 15th calendar day of the month, as required by VA Financial Policy. The results of these reports are emailed to the cardholders and approving officials to alert them of actions that need to be taken. In addition, a quarterly purchase order review is conducted to verify proper prior approval and ensure segregation of duties is being maintained.

Recommendation 7: Develop formalized processes and controls to ensure approving officials, purchase cardholders, and the agency contracting office review repetitive open market purchases of goods and services, and obtain contracts when it is determined to be in the best interest of the government.

Concur.

Target Date for Completion: September 30, 2024

Response: The Southeast Louisiana Veterans Health Care System will complete required training and implement utilization of the Strategic Sourcing Tool process from Supply Chain Data Informatics Office (SCDIO) by September 30, 2024.

Recommendation 8: In coordination with the Strategic Acquisition Center, submit a ratification for an unauthorized commitment following the Federal Acquisition Regulation.

Concur.

Target Date for Completion: September 30, 2024.

Response: The Southeast Louisiana Veterans Health Care System will submit a ratification packet by September 30, 2024.

Recommendation 9: Develop formalized processes for monitoring and achieving efficiency targets and using available pharmacy data to make business decisions.

Concur.

Target Date for Completion: September 30, 2024.

Response: As of March 2023, the Southeast Louisiana Veterans Health Care System Pharmacy initiated target Inventory turn rate of 12 or more with monthly tracking, trending, reporting, and making data-driven changes. Specifically, the formalized process below is in place.

1. Managing high costs medications by ordering when needed and not keeping on the shelf.

2. Decreasing overall number of PARS on medications by using the Prime Vendor's Pharmacy Management reports.

3. Identifying multiple therapeutic classes to streamline the purchases down to the least expensive and contract compliant.

4. Ensuring a 30 day return for items ordered in excess or not needed.

Recommendation 10: Develop and implement a plan to increase inventory turnover to meet or exceed the VHA-recommended level, and complete monthly B09 reconciliations consistently to ensure discrepancies are corrected in a timely manner.

Concur.

Target Date for Completion: September 30, 2024.

Response: The Southeast Louisiana Veterans Health Care System has implemented a new turnover rate plan. The Procurement Team is actively managing pars and inventory controls daily, to reduce ordering amounts, increasing return items to wholesaler, and optimizing consolidated mail order pharmacy (CMOP) penetration. To date, the inventory turn-over rate has improved from 7.91 to 10.31, which demonstrates progress towards the goal of 12 turns per year.

B09 Reconciliations are up to date. A B09 Reconciliation Agreement was signed between Pharmacy and Fiscal to mitigate revenue loss for the VA as well as ensure accurate obligation tracking and recording. In the process, Pharmacy receives the B09 Prime Vendor Report on a weekly basis. Then, verifies each amount listed on the B09 Report and reconciles to source documents (e.g., McKesson Invoices, McKesson reports) and the daily activity entry on the 1358 in Integrated Funds Distribution, Control Point Activity, and Accounting and Procurement. Discrepancies are notated, researched, and resolved appropriately. Pharmacy notifies Fiscal of any incorrectly referenced obligations on the B09 Report so that appropriate action can be taken to move the payment to the correct obligation in the Financial Management System (FMS). Then, prepares a monthly B09 reconciliation package with a memorandum and supporting documentation (i.e., Invoices, B09 Report, McKesson Reports) to provide the reconciliation results to Fiscal by the 15th day of the following month end. Fiscal reviews the reconciliation

package for accuracy to ensure that discrepancies are identified and corrected. Fiscal returns the B09 reconciliation package to Pharmacy Service for retention. The change in process has expedited the B09 reconciliation process and enabled both services to make corrections in real time.

Recommendation 11: Establish measures to improve compliance with the VA directive to avoid end-of-year pharmaceutical purchases.

Concur.

Target Date for Completion: September 30, 2024.

Response: As of January 2023, Pharmacy transitioned away from end of year purchases. There were zero end of year (EOY) purchases for fiscal year (FY) 2023 and zero projected EOY purchases for FY2024.

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

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Lance Kramer, Director Angela Billups Steve Flores Nathan Fong Gurpreet Kaur Jimmy Sembiring
Other Contributors	Dan Blodgett Dyanne Griffith Chuck Hoskinson Cliff Stoddard Rachel Stroup Bill Warhop

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