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Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Financial Efficiency Inspection of the VA Northeast Ohio Healthcare System

Financial Inspection	**24-00153-248**	**September 19, 2024**

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Executive Summary

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

What the Inspection Found

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

Use of managerial cost accounting information. Obligations at the healthcare system grew from about $1.25 billion in fiscal year (FY) 2021 to over $1.56 billion in FY 2023, an increase of about $311 million (25 percent). The team reviewed the healthcare system's monthly budget report updates for FY 2023. This reporting showed that the healthcare system is using financial information to compare budgeted amounts to actual results as described in VA policy.

Using document reviews and interviews with healthcare system leaders, the inspection team determined that the healthcare system's use of managerial cost accounting information does not fully align with federal financial accounting standard practices regarding performance measurement, budgeting, cost control, and making economic decisions. For example, the team determined that the healthcare system does not use managerial cost accounting for budget formulation. While these standard practices are not required, healthcare system leaders could consider implementing them to potentially optimize available financial resources. Although the healthcare system focuses on ensuring its cost accounting information is accurate for VA's cost accounting system, the team found inaccurate costs in its managerial cost accounting data. Lastly, the team found the healthcare system does not compare costs of similar products within the healthcare system. Comparing costs of similar products could help identify causes for cost differences, which can help reduce costs and avoid waste.

Open obligations oversight. Open obligations can be either undelivered orders or delivered unpaid orders, known as accruals. The inspection team evaluated whether the healthcare system followed VA policy by performing reviews and reconciliations of sampled open obligations to

[1] The Northeast Ohio Healthcare System serves veterans at the Louis Stokes Cleveland VA Medical Center and 12 community-based outpatient clinics in Akron, Calcutta, Canton, Lorain, Mansfield, New Philadelphia, Parma, Ravenna, Sandusky, Warren, Willoughby, and Youngstown. The system also operates five mobile clinics in the Cleveland area.

ensure they were valid and should remain open and to reconcile end dates and order amounts between the Financial Management System (FMS) and the Integrated Funds Distribution, Control Point Activity, Accounting, and Procurement System (IFCAP).[2] The OIG found that the healthcare system did not always comply with policy to review open obligations and deobligate funds that were no longer needed.[3] Furthermore, the team's review of open obligations identified a contract that was terminated for convenience to the government, yet had not been closed out and thus occupied funds that could be used elsewhere. As a result of the healthcare system's lack of follow-up and reconciliations, the team estimated that at least $5.5 million in open obligations were invalid, should have been deobligated, and could have been put to better use.[4] Lastly, the reconciliation of FMS and IFCAP showed that end dates and order amounts matched.

Purchase card use. VA's Government Purchase Card Program was established to reduce administrative costs related to the acquisition of goods and services. When used properly, purchase cards can help facilities simplify acquisition procedures and provide an efficient vehicle for obtaining goods and services directly from vendors. Documenting transactions as required helps VA and other oversight authorities identify potential fraud, waste, and abuse.[5] Using contracts for common purchases has several benefits, such as allowing VA to optimize purchasing power to obtain competitive pricing. The team examined whether healthcare system staff complied with purchase card program policies and procedures and considered using contracts for frequently purchased goods or services—a process known as strategic sourcing—to provide optimal savings to VA. The OIG found that at least 9,000 transactions did not comply with VA policy, and some contained multiple errors. The violations included a lack of supporting documentation and untimely approvals of reconciliations. The OIG also found all transactions were purchased from a contracted vendor.

After reviewing transaction documentation and interviewing cardholders and approving officials, the team estimated that 100 transactions totaling about $561,000 were modified into smaller

[2] Open obligations include those obligations that are not considered closed or complete and have a balance associated with them, whether undelivered or unpaid. Both of the systems the OIG team used for its evaluation are accounting systems, with FMS considered the primary one that interfaces with IFCAP. A transaction end date (which is critical to determining whether an obligation should remain open) may be modified due to delays or scope changes. The modification might not be recorded in both systems because staff can manually change end dates in one system without changing them in the other. VA Financial Policy, "Obligation Policy," in vol. 2, *Appropriations, Funds and Related Information* (April 2022), chap. 5.

[3] Deobligation means a cancelation or downward adjustment of a previously incurred obligation. VA Financial Policy, "Obligation Policy."

[4] The inspection team considered obligations invalid when the healthcare system confirmed the funds were no longer needed. The better use of funds is related to various open obligation monitoring and administrative deficiencies identified in the sampled obligations. This amount includes $3.3 million from undelivered orders, $1.05 million in contract administration issues related to undelivered orders, and at least $1.1 million from accrual, which brought the total monetary benefits to at least $5.5 million.

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

parts. Interviewees said this was done to avoid contracted vendor pharmacy drug backorders and to obtain the products faster.

Supply chain management operations. Supply chain management is the integration and alignment of people, processes, and systems to "manage all product and service planning, sourcing, purchasing, delivery, receiving, and disposal activities." Veterans Health Administration (VHA) policy requires medical facilities to establish, operate, and maintain a supply chain management program that is effective, cost-efficient, transparent, and responsive to customer requirements and to continually identify ways to ensure high-quality veteran care.[6] The inspection team evaluated the effectiveness of supply chain operations, the accuracy of inventory data, and the system's ability to meet the performance metric for days of stock on hand—a nationally set level of inventory for expendable items, both inside and outside the Medical Surgical Prime Vendor (MSPV) program.[7] The OIG found that the healthcare system could benefit from improving the efficiency of inventory oversight by ensuring inventory values are recorded correctly in the Generic Inventory Package. Establishing local processes and procedures for the timely review of data to detect and correct errors would increase the reliability of inventory data and could help ensure metrics are met. Additionally, the healthcare system and Strategic Acquisition Center failed to have a delegated MSPV facility contracting officer's representative (COR) in place for over a year.

What the OIG Recommended

The OIG made 10 recommendations for improvement: seven to the healthcare system executive director and three to the Network Contracting Office (NCO) 10 director of contracting.[8] The intent is for system leaders to use these recommendations as a road map to improve financial operations. The recommendations address issues that, if left unattended, may eventually interfere with financial efficiency practices and the strong stewardship of VA resources.

In the area of managerial cost accounting information, the OIG recommended that the executive director establish a plan to use VA's cost accounting system information. The healthcare system should also consider requiring a review of the Intermediate Product Cost Outlier report, and it should ensure that healthcare services are completing monthly data validation memos for their managerial cost accounting data. Additionally, healthcare system staff should be made aware of policy requirements to review open obligations and healthcare system contracting staff should follow federal acquisition regulations when terminating contracts.

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

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

[8] Recommendation 10 was addressed to the healthcare system executive director and the Strategic Acquisition Center associate executive director.

To strengthen oversight of purchase card transactions, the OIG recommended that the NCO 10 director of contracting establish controls to ensure cardholders comply with record retention requirements, confirm approving officials and cardholders review purchases for VA policy compliance, and ensure contracting is used when it is in the best interest of the government. The OIG further recommended that the NCO 10 director of contracting require cardholders to submit ratification requests for any identified unauthorized commitments.

For supply chain management operations, the healthcare system executive director should develop and implement a plan to ensure data accuracy and reliability in the Generic Inventory Package and create a standardized training program for inventory staff. The executive director and the Strategic Acquisition Center associate executive director should ensure that facility-level MSPV CORs are appointed and delegated appropriately and perform all required duties according to the scope and limitation of the designee's authority.

VA Management Comments and OIG Response

The executive director of the Northeast Ohio VA Healthcare System concurred with recommendations 1, 2, 3, 4, 8, and 9 and provided corrective action plans for those recommendations. The NCO 10 director of contracting concurred with recommendations 5, 6, and 7 and provided corrective action plans. Lastly, the associate executive director of the Strategic Acquisition Center concurred with recommendation 10 and provided a corrective action plan.[9] The OIG considers all recommendations open. The proposed corrective measures in the action plans appear responsive to the recommendations, and the OIG will monitor their implementation until all stated actions are documented as completed. Comments from the healthcare system director, the NCO 10 director of contracting, and the associate executive director for the Strategic Acquisition Center are presented in Appendixes D, E, and F.

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[9] Through email correspondence with the OIG team, the executive director of the Northeast Ohio Healthcare system provided concurrence of the Strategic Acquisition Center's response for recommendation 10.

Contents

Abbreviations

COR	contracting officer's representative
FAR	Federal Acquisition Regulation
FMS	Financial Management System
FY	fiscal year
IFCAP	Integrated Funds Distribution, Control Point Activity, Accounting and Procurement System
MSPV	Medical Surgical Prime Vendor
NCO	Network Contracting Office
OIG	Office of Inspector General
SCCOP	Supply Chain Common Operating Picture
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducts financial efficiency inspections to assess stewardship and oversight of funds at VA healthcare systems and to identify opportunities to achieve cost efficiencies. Inspection teams identify and examine financial activities that are under the healthcare system's control and can be compared to healthcare systems similar in size and complexity across VA to promote best practices.[10]

This inspection focused on the VA Northeast Ohio Healthcare System. The OIG assessed four financial activities and administrative processes to determine whether appropriate controls and oversight were in place from October 1, 2022, through January 26, 2024:

I. **Use of managerial cost accounting information.** Managerial cost accounting identifies, measures, and analyzes cost information to help managers make informed decisions about allocating federal resources, authorizing and modifying programs, and evaluating program performance. The inspection team evaluated how healthcare system officials used VA's managerial cost accounting system to identify the cost of goods and services, review available workload data, identify alternatives to reduce costs, enhance efficiency, and make effective business decisions. If healthcare system officials are not consistently using reliable and timely cost information for these purposes, they increase the risk that resources are not used efficiently.

II. **Open obligations oversight.** An obligation is a legally binding commitment of appropriated funds for goods or services.[11] Open obligations include those that are not considered closed or complete and have a balance associated with them.[12] They can be either undelivered orders or delivered unpaid orders, known as accruals. VA financial policy requires all finance offices with open obligations to perform reviews to ensure their obligations are valid; beginning and ending dates are accurate; and open and accrued balances are accurate and agree with source documents, such as contracts, purchase orders, receiving reports, invoices, and payments.[13] VA is also required to deobligate stale obligations not established by a contracting officer unless the requesting office can demonstrate those obligations are valid and should remain open.[14] For obligations

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

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

[12] VA Financial Policy, "Obligation Policy."

[13] VA Financial Policy, "Obligation Policy."

[14] A stale obligation is more than 90 days beyond the period of performance end date or has had no activity in the past 90 days.

established by a contracting officer, the requesting office must coordinate necessary actions to deobligate with the logistics and procurement office. The inspection team evaluated whether the healthcare system performed reviews and reconciliations of sampled obligations to ensure the validity of the balance and prompt deobligation of excess funds. When excess funds are not deobligated promptly, the risk increases that unused funds will not be reallocated for other goods and services to benefit veterans. Furthermore, failure to properly manage accruals may lead to misstatements in VA's annual financial statements.

III. **Purchase card use.** VA's Government Purchase Card Program was established to reduce administrative costs related to the acquisition of goods and services. The inspection team examined whether healthcare system staff complied with purchase card program policies and procedures and considered using contracts for frequently purchased goods or services, a process known as strategic sourcing.[15] When used properly, purchase cards can help facilities simplify acquisition procedures and provide an efficient vehicle for obtaining goods and services directly from vendors. Documenting transactions as required helps VA and other oversight authorities identify potential fraud, waste, and abuse. Using contracts for common purchases has several benefits, such as allowing VA to optimize purchasing power to obtain competitive pricing.

IV. **Supply chain management operations.** Supply chain management integrates and aligns people, processes, and systems for the management of product and service planning, sourcing, purchasing, delivery, receiving, and disposal. Veterans Health Administration (VHA) policy requires medical facilities to establish, operate, and maintain a supply chain management program that is effective, cost-efficient, transparent, and responsive to customer requirements, and to continually identify ways to ensure high-quality veteran care.[16] The inspection team evaluated whether the healthcare system met performance metrics for days of stock on hand and complied with policies and procedures for supply chain management. The days-of-stock-on-hand metric is a supply performance measure for expendable items purchased through the Medical Surgical Prime Vendor (MSPV) program, which promotes inventory level efficiency; the metric is also used for non-MSPV inventory items.[17] To evaluate whether the system complied with policies and procedures, the team assessed data validity and identified inventory factors affected by the healthcare system's supply chain management. Unreliable inventory data can lead to the purchase of unnecessary supplies, overstocking, and spoilage. More importantly, errors

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

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

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

indicating that supplies are available when they are not could adversely affect the healthcare system's ability to effectively plan and budget for the purchase of supplies to operate and meet patient care needs.

Facility Profile

The VA Northeast Ohio Healthcare System, part of Veterans Integrated Service Network (VISN) 10, serves veterans at the Louis Stokes Cleveland VA Medical Center.[18] The healthcare system also provides services at 12 community-based outpatient clinics in Akron, Calcutta, Canton, Lorain, Mansfield, New Philadelphia, Parma, Ravenna, Sandusky, Warren, Willoughby, and Youngstown and operates five mobile clinics in the Cleveland area. Figure 1 provides general background information for this 1a healthcare system.

[18] VHA divides the United States into 18 Veteran Integrated Service Networks, regional systems that work together to meet veterans' healthcare needs.

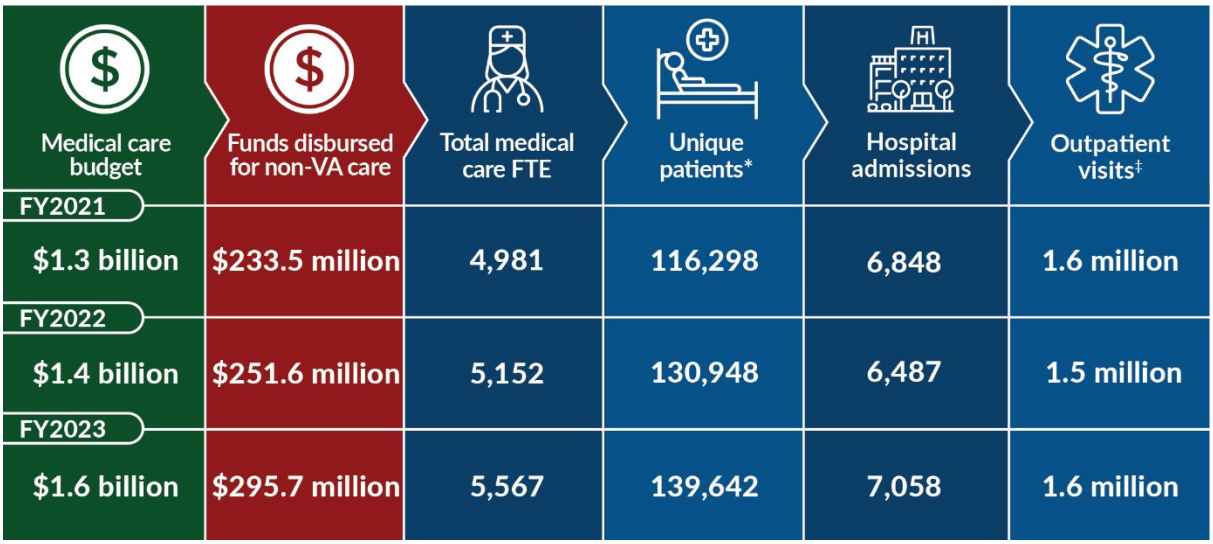

Figure 1. *Facility profile for VA Northeast Ohio Healthcare System, FY 2021–2023.*

Source: VA OIG analysis of the VHA Support Service Center, Trip Pack and Operational Statistics report.

** Unique patients include VA and non-VA but exclude pharmacy-only.*

‡ Outpatient visits exclude non-VA care visits.

Note: FTE is full-time equivalent positions. This category includes both direct medical care FTE positions in budget object code 1000–1099 (Personal Services) and all cost centers. The inspection team did not assess VA's data for accuracy or completeness.

Facility Selection

The inspection team evaluated VA data from the VHA Office of Productivity, Efficiency and Staffing's efficiency opportunity grid to identify healthcare systems with the greatest potential for financial efficiency improvements. VHA developed the efficiency opportunity grid, a collection of 12 statistical models, to give facility leaders insight into areas of opportunity for improving efficiency. The grid allows for comparisons between VHA facilities by adjusting data for variations in patient and facility characteristics and in geography. It also describes possible inefficiencies and areas of success by showing the difference between a facility's actual and expected costs. The team uses the facility rankings from the stochastic frontier analysis model in the grid to select facilities for financial efficiency inspections.[19] The inspection, while limited in scope and not intended to be a comprehensive inspection of all financial operations at the VA Northeast Ohio Healthcare System, sets forth a goal to recommend opportunities for process improvement and greater efficiencies and to promote the responsive use of appropriated funds.

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

Results and Recommendations

I. Use of Managerial Cost Accounting Information

VA financial policy says managerial cost accounting should be a fundamental part of the department's overall financial management system and that managerial cost accounting should be integrated with the financial system for expenses, workload, utilization, performance measurement, and reporting.[20] The policy also says VA's cost accounting system will be used to help identify cost reduction alternatives and enhance efficiency, and it requires VA to use managerial cost accounting information to make business decisions.[21]

Managers can measure and analyze cost information to make informed operational decisions while also meeting the objectives of their organizations. The federal managerial cost accounting standards developed by the Federal Accounting Standards Advisory Board require that each reporting entity accumulate and report the cost of its activities on a regular basis for management information purposes. Cost information, according to these standards, is essential for managers to make economic choices and informed decisions in the areas of performance measurement, budgeting, and cost control.[22] For VA, this applies to critical decisions regarding veteran care—such as deciding to expand services at VA facilities, rather than relying on community care. If healthcare system officials fail to consider reliable and timely cost information for these purposes, they increase the risk of waste or inefficient use of resources, along with decreased quality of care for patients.

The team reviewed the following related areas:

- **Obligation trends.** The inspection team reviewed obligation amounts originating from the Financial Management System (FMS) to identify trends and areas of significant obligation.
- **Healthcare system internal reporting.** The inspection team reviewed cost and performance reports for planning, budgeting, cost reduction, efficiency improvement, and comparing budgeted amounts to actual results. The team used document reviews and interviews to determine whether the healthcare system's use of managerial cost accounting information aligned with federal financial accounting standard practices and VA financial policy.[23]

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

[21] VA Financial Policy, "Managerial Cost Accounting."

[22] Federal Accounting Standards Advisory Board (FASAB), "Statement of Federal Financial Accounting Standards 4: Managerial Cost Accounting Standards and Concepts."

[23] VA Financial Policy, "Managerial Cost Accounting."

Finding 1: The Healthcare System Needs to Improve Its Use of Managerial Cost Accounting Information

The OIG determined that the healthcare system could use managerial cost accounting information more effectively to help make financial decisions. The healthcare system's fiscal chief stated that the fiscal office does not use managerial cost accounting data in its day-to-day operations, but the managerial cost accounting data labor mapping report is used to assist with position management for clinical staff. The healthcare system is primarily focused on ensuring information in the managerial cost accounting system is accurate. Even so, the healthcare system can improve its performance measurement process to identify and correct cost inaccuracies.

Obligation Trends

According to FMS reports, the healthcare system's obligations increased from about $1.25 billion in fiscal year (FY) 2021 to almost $1.56 billion in FY 2023, an increase of about $311.4 million (25 percent) (figure 2).

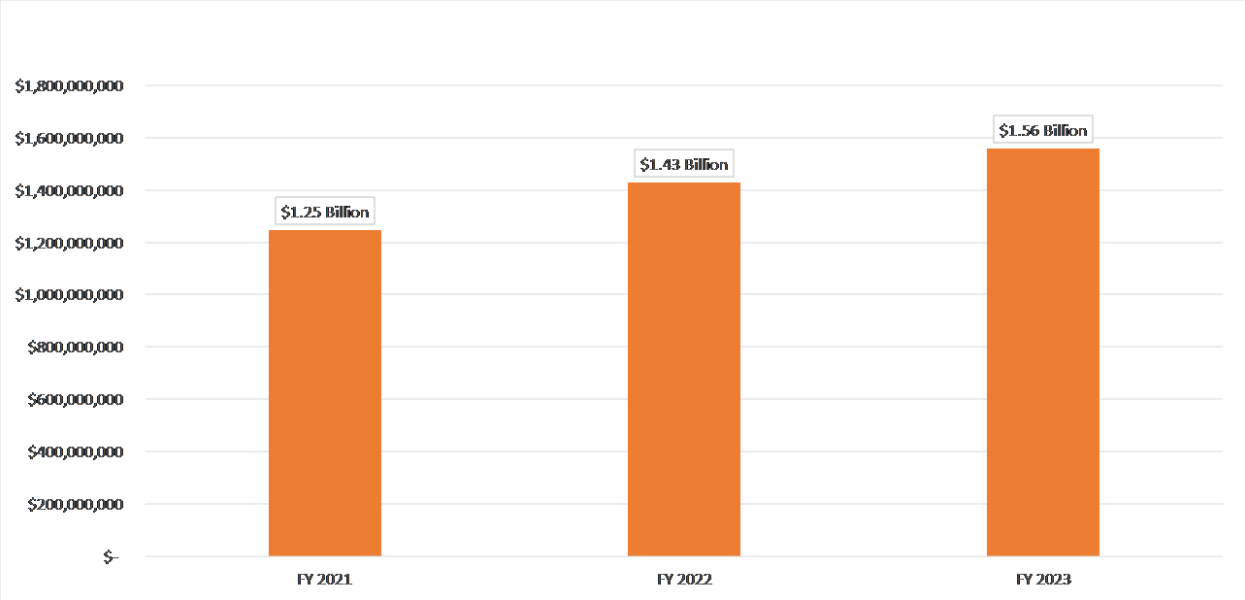

Figure 2. *VA Northeast Ohio Healthcare System obligations, FY 2021–FY 2023.*

Source: VA OIG analysis of Mainframe FMS and VHA Allocation Resource Center Cube.

Note: Numbers do not always sum due to rounding.

The inspection team identified obligation growth for personnel, community care, and supplies and materials. These areas accounted for approximately $298 million (96 percent) of the almost $311.4 million growth in obligations. From FY 2021 through FY 2023, personnel such as physicians, physician assistants, nurses, pharmacists, social workers, and administrative personnel accounted for almost $201 million, or about 64 percent, of the growth. Of the almost $201 million in personnel growth, nurses reflected the largest portion, representing almost $82 million.

The inspection team confirmed the obligation data with reports from the healthcare system's fiscal chief. To understand financial management practices and growth of obligations at the healthcare system, the inspection team requested internal managerial cost accounting reports, analyzed performance measurement data, and conducted interviews with the healthcare system's leaders.

Healthcare System Internal Reporting

The OIG determined that the healthcare system prepared financial information to compare budgeted amounts to actual results as described in VA policy. The inspection team reviewed quarterly budget reports compiled by the healthcare system finance office during FY 2023. The healthcare system reported a surplus at the end of each quarter in FY 2023 and ended the year with a surplus of about $105,000. The team did not test the accuracy or methodology used by the healthcare system to compile these budget projections.

Additionally, the OIG determined that the healthcare system did not have a consistent process in place to use managerial cost accounting information to identify opportunities to reduce costs and enhance efficiency.

To gain an understanding of how the healthcare system used managerial cost accounting data, the inspection team reviewed managerial cost accounting documentation, interviewed healthcare system leaders and four members of the VISN 10 managerial cost accounting team. During its review of the available reports, the team found that the healthcare system reports included the national managerial cost accounting dashboard, data validation memorandums, the medical center director's annual certification of managerial cost accounting data in the managerial cost accounting system, a stop code average cost report, and a labor mapping report.[24]

The healthcare system's fiscal chief stated that the fiscal office does not use managerial cost accounting data in its day-to-day operations, but managerial cost accounting data are used to assist with position management for clinical staff, which could help maintain appropriate staffing levels. The fiscal chief stated that the facility has a position management team that reviews managerial cost accounting workload and labor mapping information when a service makes a request for additional clinical staff. The fiscal chief also said the position management team considers hiring additional clinical staff if they can see a service's workload increasing month to month and that the service's current staff are efficiently managing their time.

The OIG found that managerial cost accounting reports are primarily used to ensure the healthcare system's information is complete and accurate for VA's managerial cost accounting system. The medical center director's annual certification of managerial cost accounting data requires the director to certify to VHA's Office of Finance that the healthcare system's information is accurate in the VA system. A VISN 10 supervisor stated that the managerial cost accounting team uses the stop code average cost report to help identify potential cost outliers that may need additional review. Furthermore, a VISN 10 analyst stated that their day-to-day operations involve performing various audits of managerial cost accounting data.

According to a VISN 10 analyst, the managerial cost accounting team requests clinical and administrative services to conduct a monthly self-certification of their managerial cost accounting information in the national dashboard. Each service must complete a service data validation memorandum to certify that their information is accurate and that any needed corrective actions have been made. However, for FY 2023, all healthcare system services did not complete the data validation memorandum every month. Of the 40 services, the managerial cost accounting team reported that only 16 services, or 40 percent, completed the data validation

[24] VA Financial Policy, "Managerial Cost Accounting." Medical center directors are required to submit an annual certification of their managerial cost accounting records. In addition, VA assigns certain costs to stop codes, which assist VA medical facilities in defining patient workload and serve as a stable identification method that can be used to compare costs between facilities. They are the single and critical designation by which VHA defines outpatient clinical work units for costing purposes.

memorandum for every month in FY 2023. Healthcare system leaders did not follow up with services to ensure the memorandums were completed monthly. The fiscal chief said the system will work on improving this process.

Performance Measurement

Federal financial accounting standards state that measuring cost is an integral part of measuring performance in terms of efficiency and cost-effectiveness.[25] Specifically, the standards highlight cost per unit of output as a methodology to evaluate the efforts and accomplishments of a government entity. Additionally, VA financial policy states that the managerial cost accounting system will identify the cost of products and services.[26] Although the healthcare system does identify the costs of products and services, the OIG determined that the healthcare system had inaccuracies in its managerial cost accounting data. Also, the OIG determined that the healthcare system does not compare the costs of similar products throughout the system.

The VHA Managerial Cost Accounting Office developed a modeling tool to assist cost accounting staff and managers with analyzing their department cost accounting information.[27] The training guide for the model recommends that cost accounting staff analyze cost workload products in various ways.[28] For example, the guide recommends that users sort by highest cost then determine whether the cost is reasonable or an outlier. The guide states that high-cost products can be considered outliers.

High-Cost Products

The inspection team used the modeling tool to identify the 10 highest-cost-per-unit products for September 2023 and asked the managerial cost accounting team to verify whether the costing was accurate. Examples of high-cost products include pacemakers and emergency mental health encounters. The managerial cost accounting team reported accurate costs for all 10 highest-cost-per-unit products identified for September 2023.

[25] FASAB, "Statement of Federal Financial Accounting Standards 4: Managerial Cost Accounting Standards and Concepts."

[26] VA Financial Policy, "Managerial Cost Accounting."

[27] VHA Managerial Cost Accounting Office, "MCA RVU Modeling Tool Training Guide" (June 2022).

[28] VA administrations identify workload as the volume of work performed (outputs of products and services resulting from the input of supplies, labor, and equipment). Examples of workload products include laboratory tests, drugs, and patient days.

The inspection team also identified nine intermediate product cost outliers for September 2023 and requested the managerial cost accounting team verify whether the costing was accurate.[29] The Intermediate Product Cost Outlier report identifies potential costing errors based on site-specific costs per product that appear too extreme to be attributed to normal cost variations in the delivery of products and services. The managerial cost accounting team reported inaccurate costs for six of the nine high-cost products identified on the Intermediate Product Cost Outlier report. These errors were corrected in the December 2023 through February 2024 product cost reports from the modeling tool. Example 1 describes one of the intermediate product cost outliers with inaccurate costs.

Example 1

The inspection team's analysis of the September 2023 Intermediate Product Cost Outlier report showed 726 rheumatology-related encounters with an inaccurate cost of $998.29 each, while the actual product cost for each encounter should have been $107.08. The resulting misstatement of reported costs totaled $647,017.84. A VISN 10 analyst said the managerial cost accounting team determined in October 2023 that labor costs for all medicine clinics in a primary care department, including rheumatology, should be reallocated to a newly created medicine department. This reflects a more accurate cost for the products in each department.

The inaccurate costs were not identified in prior cost outlier reviews because the healthcare system's managerial cost accounting team does not review the Intermediate Product Cost Outlier report. A VISN 10 analyst said they review the modeling tool and outpatient stop code average cost report to help identify cost outliers. However, the analyst said that although the Intermediate Product Cost Outlier report was not familiar, analysts do eventually review these same products on other reports. While the modeling tool can be used to identify products that may or may not be cost outliers with inaccurate costs, the Intermediate Product Cost Outlier report is a national report that is preloaded with products identified as having potential costing errors. Further, the Outpatient Stop Codes Average Cost report can be used to identify cost outliers by division and stop code, but it does not always help with identifying all potential cost outliers that need immediate attention. By reviewing the Intermediate Product Cost Outlier report on a monthly basis, the managerial cost accounting team may be able to identify cost inaccuracies in a timelier manner.

[29] "Guidebook for the Decision Support System (DSS) Intermediate Product Department" (website), Health Economics Resource Center (HERC), https://www.herc.research.va.gov/files/BOOK_688.pdf. Intermediate products are the procedures and services used in treating a patient in an episode of care. These intermediate products represent work performed in each department and are bundled to make up the end product—the encounter—which is either an inpatient stay or an outpatient visit. Some examples are bed day in the surgical ward, 15-minute health risk assessment, single drug dispensed, or MRI brain scan.

Additionally, the inaccurate costs may have occurred because the healthcare system services did not always complete a thorough review of their managerial cost accounting data. As previously noted, only 40 percent of healthcare system services completed a data validation memo for their managerial cost accounting data. If products with inaccurate costs remain unidentified, the healthcare system increases the risk of making important business decisions with inaccurate cost information. Further, these inaccurate costs may be input into VA's managerial cost accounting system, which VA uses to help formulate its overall budget.

Primary Care Products

Using the Managerial Cost Accounting Office Modeling tool, the inspection team conducted a product comparison of 30-minute primary care visits. From the September 2023 product cost report, the inspection team reviewed all 13 clinics that provide 30-minute primary care visits with a physician. For September 2023, the healthcare system reported almost 73,000 visits among the 13 clinics with a total cost per visit ranging from $321.24 to $857.92. The team further noted that indirect, direct, and variable cost inputs varied significantly among the clinics. Table 1 shows the costs associated with 30-minute primary care appointments at each of the 13 clinics.[30]

[30] The VA Northeast Ohio Healthcare System has a main healthcare facility in Cleveland and 12 community-based outpatient clinics in various cities across northeast Ohio: Akron, Calcutta, Canton, Lorain, Mansfield, New Philadelphia, Parma, Ravenna, Sandusky, Warren, Willoughby, and Youngstown.

Table 1. 30-Minute Primary Care Visits

Clinic type	Number of visits	Actual cost per visit	Fixed indirect cost*	Fixed direct cost‡	Variable cost‡‡
Primary Care #1	6,009	$857.92	$421.34	$45.15	$391.42
Primary Care #2	1,817	$737.80	$356.78	$6.34	$374.68
Primary Care #3	5,239	$614.78	$304.75	$0.00	$310.02
Primary Care #4	116	$559.23	$284.73	$10.83	$263.67
Primary Care #5	10,240	$493.41	$230.87	$0.53	$262.01
Primary Care #6	6,183	$492.95	$234.00	$12.56	$246.38
Primary Care #7	6,934	$473.51	$230.55	$9.97	$233.00
Primary Care #8	3,252	$466.34	$222.26	$5.73	$238.35
Primary Care #9	2,740	$394.79	$208.10	$5.38	$181.31
Primary Care #10	9,666	$355.02	$178.37	$1.80	$174.85
Primary Care #11	4,099	$354.63	$184.51	$11.62	$158.50
Primary Care #12	11,100	$334.30	$157.79	$9.03	$167.47
Primary Care #13	5,471	$321.24	$161.04	$1.29	$158.90

Source: VA OIG analysis of cost associated with 30-minute primary care visit data from VHA's Managerial Cost Accounting Office RVU Modeling Tool and Managerial Cost Accounting Dashboard.

Note: The inspection team did not test the accuracy of the costs reported by the healthcare system.

** Fixed indirect cost: The costs not directly related to patient care, and therefore not specifically identified with an individual patient or group of patients. These costs are allocated to direct departments through the indirect cost allocation process. Examples include utilities, maintenance, and administration costs. All indirect costs are classified as fixed.*

‡ Fixed direct cost: The costs of direct patient care that do not vary in direct proportion to the volume of patient activity. The word "fixed" does not mean that the costs do not fluctuate, but rather that they do not fluctuate in direct response to workload changes. Examples include depreciation of medical equipment and salaries of administrative positions in clinical areas.

‡‡ Variable cost: The costs of direct patient care that vary directly and proportionately with fluctuations in workload. Examples include salaries of providers and the cost of medical supplies. Variable direct cost equals variable supply cost plus variable labor cost.

The team provided the above data to the healthcare system to determine whether it reviews and compares detailed costs of similar products within the healthcare system. In response, the healthcare system's fiscal chief said the fiscal office does not review product cost information as shown in table 1. A VISN 10 analyst stated that the managerial cost accounting team does not compare similar products across clinics within the healthcare system due to overhead costs that vary at each of the clinics and other costs that are calculated at the program office level. A VISN 10 coordinator alluded that staff do not have the resources to do a deep dive into cost information as shown in table 1 and would perform this level of review only if there were issues with cost outliers.

The managerial cost accounting team reviewed and reported accurate costs per unit for the 30-minute primary care products in table 1. However, the primary care service completed a data validation memorandum for their managerial cost accounting data for only two out of 12 months in FY 2023. This lends to the possibility that other primary care products may have inaccurate costs that have not yet been identified.

Although product costs can vary among different clinics within the healthcare system, not comparing costs of similar products could lead to missed opportunities to correct inaccurate costs and improve cost efficiency. Federal financial accounting standards assert that federal managers can compare costs of similar activities and find causes for cost differences with appropriate cost information, which can help reduce costs and avoid waste.

Budgeting and Cost Control

Federal financial accounting standards state that information on the costs of program activities can be used as a basis to estimate future costs in preparing and reviewing budgets.[31] The standards also say federal managers can use cost information to control and reduce costs and avoid waste. As previously noted, the healthcare system does not compare costs of similar products, which could lead to missed opportunities to reduce costs and avoid waste. Additionally, the OIG found that the healthcare system's budget formulation is based on historical spending, not managerial cost accounting information. The VISN 10 chief financial officer reported that managerial cost accounting data are used in budget formulation at the national level and are used for reviewing position management at the local facility level. While the federal financial accounting standards are not required, healthcare system leaders should consider implementing these standards to potentially optimize available financial resources.

Economic Choices

Agency and program decisions—such as whether to complete a project in-house or contract it out, to accept or reject a proposal, or to continue or drop a product or service—require cost comparisons among available alternatives. The OIG determined that the healthcare system has an Informatics and Analytics group that compares the cost of some services at the healthcare system to the cost of similar contracted services in the community. However, this analysis is only performed when a gap has been identified in areas such as healthcare access or productivity.

A managerial cost accounting analyst reported that there is no standard make-or-buy model. Several VHA program offices are collaborating to develop a tool that will provide use of managerial cost accounting data for make-or-buy analysis. From FY 2021 through FY 2023, community care obligations accounted for almost $73.4 million, or about 24 percent, of the

[31] FASAB, "Statement of Federal Financial Accounting Standards 4: Managerial Cost Accounting Standards and Concepts."

$311-million growth. The use of make-or-buy analyses could help optimize the resources available to the healthcare system in these areas.

Considering VHA's current budget constraints, it is important for the healthcare system to maintain accurate managerial cost accounting data for decision-makers. Federal financial accounting standards state that cost information can be used by Congress and federal executives in making decisions about allocating federal resources, authorizing and modifying programs, and evaluating program performance. The cost information can also be used by program managers in making managerial decisions to improve operating economy and efficiency.

Finding 1 Conclusion

VA expects its healthcare systems to use managerial cost accounting information to enhance efficiency, help reduce costs, and make business decisions as described in VA financial policy.[32] The OIG found that leaders of the VA Northeast Ohio Healthcare System did not consistently use managerial cost accounting information for those purposes. Additionally, the healthcare system's use of managerial cost accounting information does not fully align with federal financial accounting standard practices regarding performance measurement, budgeting, cost control, and making economic decisions. Given the significant growth of obligations at the healthcare system, consistent use of managerial cost accounting information could promote more efficient use of taxpayer resources.

Recommendations 1-3

The OIG made the following recommendations to the VA Northeast Ohio Healthcare System executive director:

1. Establish a plan to use VA's cost accounting system information to identify alternative ways to reduce costs, enhance efficiency, and inform business decisions as identified by VA financial policy. This could include implementing federal financial accounting standard practices to use cost information for performance measurement, budgeting, cost control, and making economic choices.
2. Consider requiring that the managerial cost accounting team review the Intermediate Product Cost Outlier report to identify cost outliers that may occur at the healthcare system.
3. Ensure healthcare services are completing monthly data validation memos for their managerial cost accounting data.

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

VA Management Comments

The healthcare system executive director concurred with recommendations 1 through 3. The responses are provided in full in appendix D. To address recommendation 1, the executive director reported that the facility will continue to integrate managerial cost accounting dashboards and other data elements in formal decision-making processes. To address recommendation 2, the executive director reported that the Managerial Cost Accounting Office had been phasing out the Intermediate Product Cost Outlier report but has since determined to modify it to reduce duplicative auditing. To address recommendation 3, the executive director noted that service leaders and administrative staff have been trained on the managerial cost accounting dashboard data validation process and will complete the data validation monthly. Furthermore, VISN managerial cost accounting staff provided training to service leadership and administrative staff.

OIG Response

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

II. Open Obligations Oversight

VA policy requires finance offices to perform reviews and reconciliations to ensure that their obligations, including undelivered orders and delivered unpaid orders, known as accruals, are valid.[33] The healthcare system's finance office personnel should verify with the requesting office to ensure the obligations' period-of-performance dates are correct, open balances are accurate and agree with source documents, obligations aged beyond 90 days of the period-of-performance end date or without activity in the past 90 days are valid and should remain open, and proper accruals have occurred. The requesting office is supposed to research these transactions—or any other transactions requiring adjustments—and respond to the finance office within 10 calendar days.[34]

VA's management of open obligations has been a long-standing issue and was included as a significant deficiency in the department's FY 2023, FY 2022, and FY 2021 audited financial statements and as a material weakness in its FY 2020 audited financial statements.[35] Additionally, a 2019 OIG report on undelivered orders recommended VHA ensure that staff review and reconcile open orders, identify and deobligate excess funds on those orders, and follow VA policy regarding required reviews of open obligations.[36] If reviews are not conducted, the healthcare system risks not being able to deobligate those funds and repurpose them for other goods or services in that fiscal year to support veterans. Fiscal officers should review obligations to confirm they are necessary and financially valid to ensure prudent use of funds.[37] Furthermore, the healthcare system risks not being able to accurately budget for goods or services potentially needed in the future. Lastly, the healthcare system risks all activities not being accurately reflected in the financial records and, ultimately, in the financial statements.

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

[33] An accrual is a delivered order that is unpaid. Undelivered orders are supplies and services that have been approved and awarded on an obligation but have not been delivered to or accepted by the government. This includes any orders for which advance payment has been made, but delivery or performance has not yet occurred.

[34] VA Financial Policy, "Obligation Policy."

[35] VA OIG, *Audit of VA's Financial Statements for Fiscal Years 2023 and 2022*, Report No. 23-00940-18, November 15, 2023; VA OIG, *Audit of VA's Financial Statements for Fiscal Years 2022 and 2021*, Report No. 22-01155-14, November 15, 2022; VA OIG, *Audit of VA's Financial Statements for FY 2021 and 2020*, Report No. 21-01052-33, November 15, 2021. In these reports, CliftonLarsonAllen LLP defines a material weakness as a deficiency, or combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented or detected and corrected in a timely manner. A significant deficiency is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

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

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

- **Undelivered orders.** The team assessed whether healthcare system staff performed reviews and reconciliations to ensure that the sampled undelivered orders with no activity for more than 90 days were valid and should remain open.
- **Outstanding accruals.** The team assessed whether the healthcare system performed reviews and reconciliations to ensure that the sampled outstanding accrued orders were valid and should remain open.
- **FMS–to–Integrated Funds Distribution, Control Point Activity, Accounting and Procurement System (IFCAP) reconciliations.** The team identified outstanding obligations with different end dates or order amounts between FMS and IFCAP to ensure healthcare system staff reconciled end dates between the systems for the sampled obligations.[38]

Finding 2: The Healthcare System Did Not Always Review Inactive Obligations and Ensure Accruals Were Valid

The OIG found that healthcare system staff could improve management of open obligations by reviewing inactive open obligations with the requesting office and by creating an escalation process to notify leaders when services are not providing open orders status. Failure to properly manage open obligations increases the risk that appropriations are not spent within the correct fiscal year and, potentially, that funds will remain attached to orders when they could be used for other purposes.

Undelivered Orders

VA financial policy states that open obligations should be reviewed by the finance office, in coordination with the requesting office, to ensure obligations without activity in the past 90 days are valid and should remain open.[39] Furthermore, requesting offices will research these obligations and provide a response to the finance office within 10 calendar days. If funds remain on the obligation after delivery, the requesting office has confirmed acceptance of all goods or services, and invoices have been received and paid, the acquisition office is supposed to modify the contract or order to reflect the final cost and quantity and decrease the remaining funds on the obligation.

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

[39] VA Financial Policy, "Obligation Policy." The requesting office is the term used to encompass the individual or program office that initiated the request for the obligation, such as the contracting officer's representative, initiating service, customer, requirement submitter or program office representative.

Figure 3 shows the number and dollar amounts of inactive obligations for the VA Northeast Ohio Healthcare System from June 15 through November 15, 2023. As of November 15, 2023, the healthcare system had 128 undelivered orders valued at more than $27.7 million that had been inactive for more than 90 days.[40]

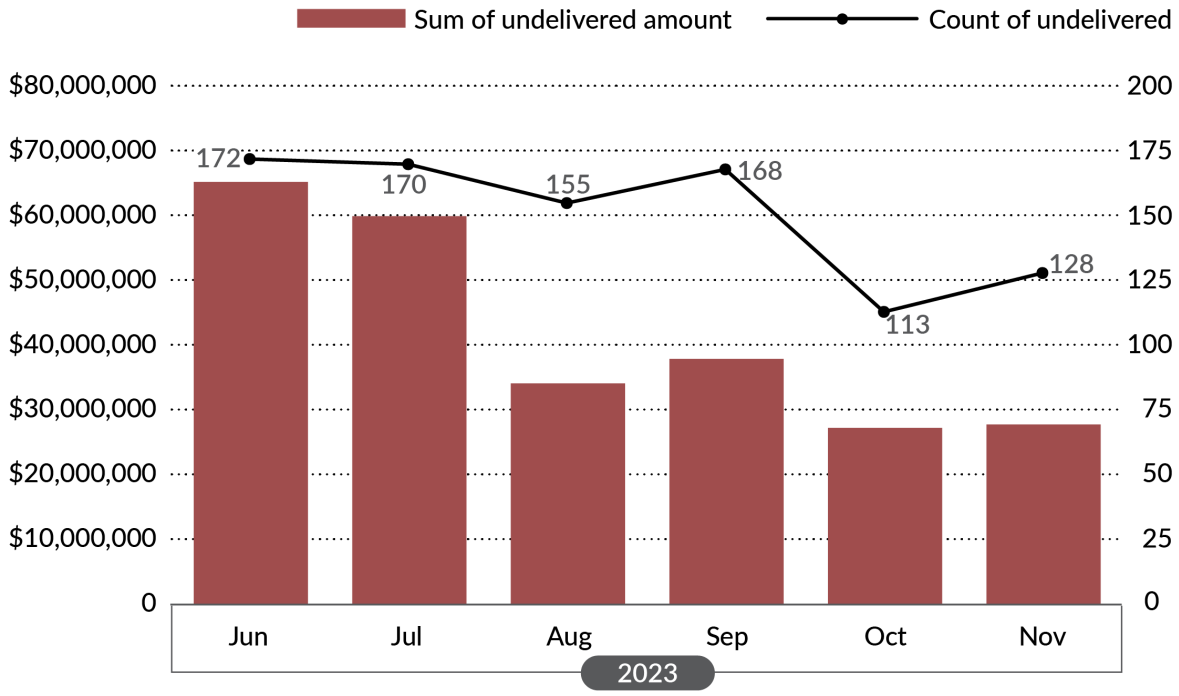

Figure 3. *Number and dollar amount of inactive undelivered orders for VA Northeast Ohio Healthcare System from June 15 through November 15, 2023.*

Source: VA OIG analysis of VA FMS F850 Report.

Figure 4 shows the age and dollar amount of the 128 obligations. From the 128 obligations, 70 totaling just over $21.1 million had no activity for at least 181 days.

[40] For these 128 obligations, the largest dollar amounts were obligated for equipment purchases, other contractual services, supplies and materials, and land and structures.

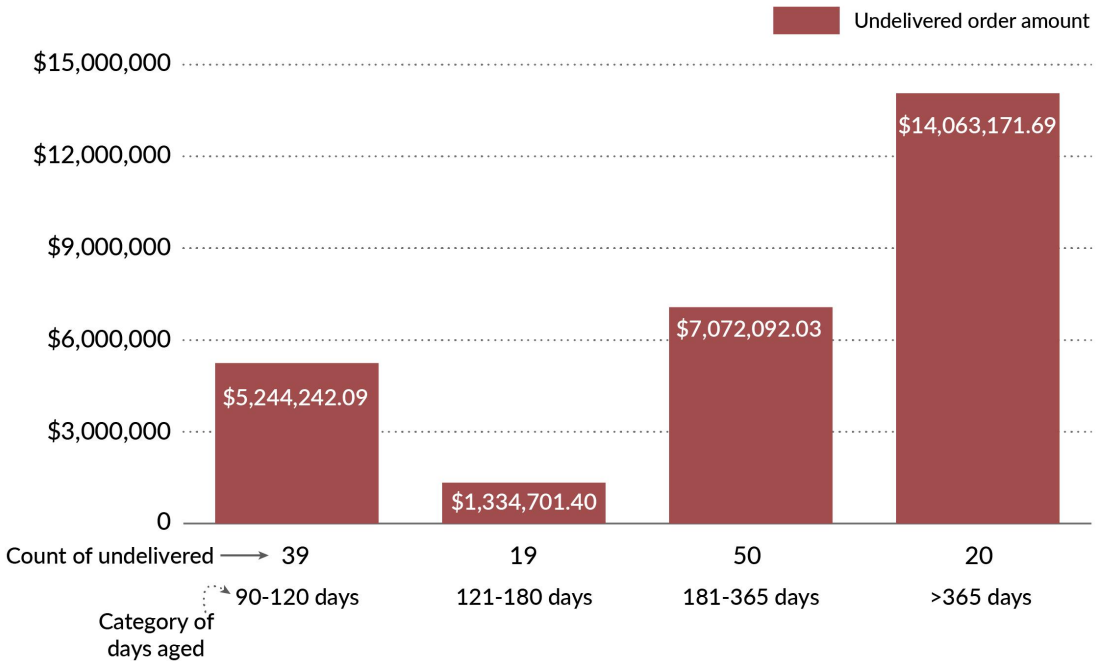

Figure 4. *Number and dollar amount of inactive obligations for the VA Northeast Ohio Healthcare System as of November 2023.*

Source: VA OIG analysis of VA FMS F850 Report.

The inspection team analyzed obligation data and statistically selected 25 inactive obligations open as of November 15, 2023, totaling close to $21.3 million.[41] The team reviewed supporting documentation to assess whether the healthcare system staff identified and reviewed the sampled obligations to determine whether they were still valid and needed to remain open in accordance with VA financial policy.[42] Based on the result of this review, the OIG estimated that the healthcare system did not comply with VA policy and did not always perform a review on about 120 obligations (89 percent) still within the performance period, totaling approximately $24.8 million. Additionally, two sampled inactive obligations had close to $3.3 million of outstanding funds that were invalid and should have been deobligated.[43] The OIG considered these obligations invalid because the healthcare system confirmed the funds were no longer needed. Example 2 describes an invalid obligation.

[41] See appendix A for additional details on the inspection's scope and methodology, and appendix B for details on the inspection's sampling.

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

[43] The F850 sample results had two samples that should have been deobligated. This is not sufficiently precise for use in the projections included in this OIG report.

Example 2

On August 31, 2022, the healthcare system placed an order for high-tech medical equipment, obligating funds just over $1.9 million, with an expected delivery date of September 30, 2023. On September 22, 2023, the finance office followed up with the requesting office and the assistant service chief stated the order's end date was updated to September 22, 2024. As of November 15, 2023, there was no activity on the order. At the inspection team's request, the finance office requested a status update from the service. The assistant service chief informed the finance office that the order was canceled and the balance of $1.9 million was subsequently deobligated.

According to the supervisory accountant and a staff accountant, instead of reviewing all inactive obligations, financial services staff focused on deobligating excess or unneeded funds that were 90 days past their end date, not obligations inactive for 90 days. This focus was based on the healthcare system's "Aging of Orders–Count" financial indicator, which emphasizes the need for the healthcare system to follow up on open orders greater than 90 days past their period-of-performance end date. As a result of the incomplete review by the healthcare system, the OIG found that two of the 25 obligations—totaling at just over $3.3 million—were invalid, should have been deobligated, and could have been put to better use.[44] Failure to properly manage undelivered orders could increase the risk of failing to spend appropriations within the associated fiscal year and may prevent the healthcare system from obtaining the maximum benefit of any unused funds.

Additionally, one of the 25 inactive obligations, considered stale, had a balance of $1.05 million that has been outstanding for more than six years.[45] According to the contracting officer, the balance has remained open for so long because the funds are still needed to pay the contractor for potentially lost expenses and profits resulting from a "termination for convenience" contract modification issued on July 25, 2016. VA policy states that when obligations established by a contracting officer are stale, one of the potential actions to take if goods and services are no longer needed is to have the contracting officer complete a termination for convenience or modify the contract and adjust the obligation accordingly.[46] The Federal Acquisition Regulation (FAR) states that when a contract is terminated for convenience, contractors are eligible to recover expenses and lost profits by submitting a termination settlement proposal payment within one year of the termination unless extended in writing.[47] If a contractor does not provide a

[44] Due to the small number of errors, the OIG reported actual results and no estimates.

[45] VA policy states that obligations established by a contracting officer aged beyond 90 days of the period-of-performance end date or without activity in the past 90 days are considered stale obligations.

[46] VA Financial Policy, "Obligation Policy."

[47] FAR 52.249-2(e) details the process for when a contract is terminated for convenience of the government.

proposal within the specified period, the contracting officer may determine, based on the information available, any amount due the contractor because of the termination and pay that amount. However, the contracting officer was not able to provide documentation of any communication with the contractor about potentially lost expenses and profits. When asked why the contract has not been settled and closed out, the contracting officer responded that he is working on a termination for convenience with the contractor but has had trouble obtaining responses from them. Additionally, in his current role as VISN branch chief, he has been trying to manage staff shortages along with emergencies at other facilities and thus has not been able to make time to close out the contract. Therefore, the contracting officer has repeatedly requested extensions of the end date to keep the obligation open instead of closing out the contract as required. As a result of the end-date extensions, the obligation remains open, and the funds cannot be deobligated and used for any other purpose.

As of April 30, 2024, the contracting officer had not determined any amount due to the contractor as a result of this termination and the contract had not been closed out. Furthermore, the contractor did not submit a termination settlement proposal to the contracting officer within the allowed time and the contracting officer could not provide documentation to support the validity of the outstanding balance. As a result, the OIG determined the full $1.05 million could have been put to better use.[48]

Outstanding Accruals

As of November 15, 2023, the healthcare system had 425 outstanding accruals totaling close to $23 million. Figure 5 shows the number and dollar amount of outstanding accruals for the VA Northeast Ohio Healthcare System from June 15 through November 15, 2023.

[48] Although the team considers the $1.05 million as better use of funds, the team did not consider this amount for deobligation because a settlement amount could still be paid to the contractor.

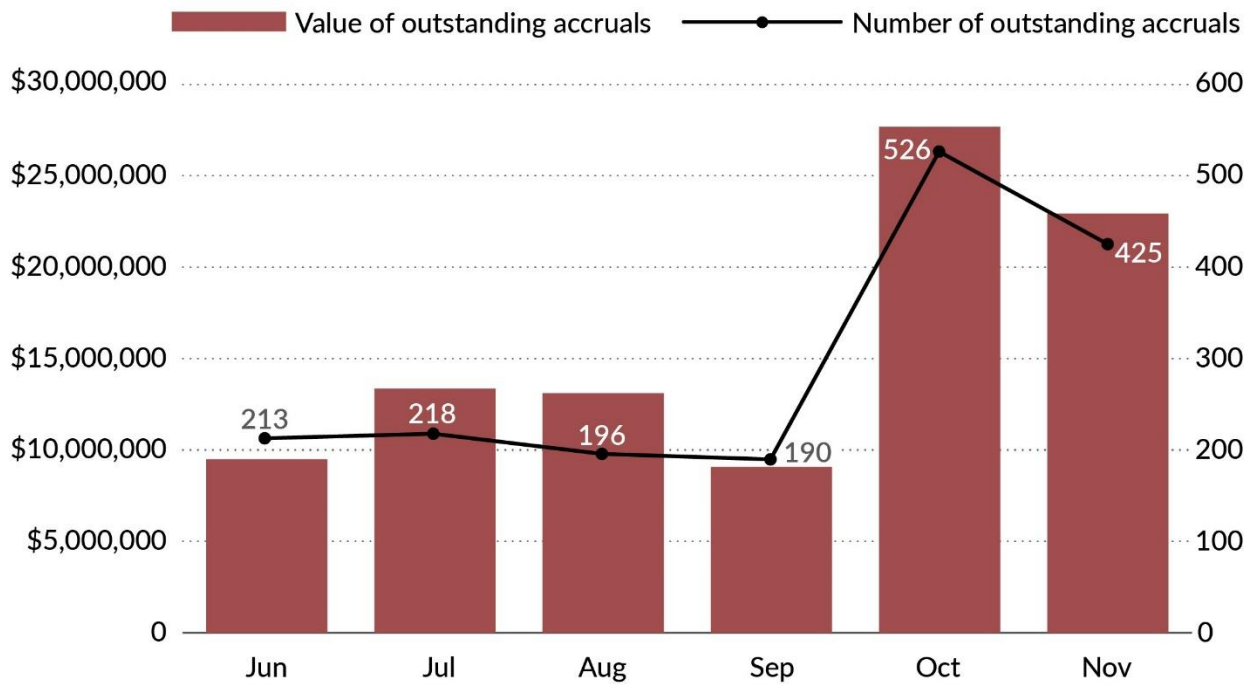

Figure 5. *Age and dollar amount of outstanding accruals.*

Source: VA OIG analysis of VA FMS F851 reports, outstanding accruals for the VA Northeast Ohio Healthcare System from June 15 through November 15, 2023.

Of the 425 outstanding accruals, 180 totaling just under $5.6 million had been open for more than 90 days.[49] Figure 6 shows the age and dollar amount of the 180 obligations. The OIG found that, of the 180 obligations, 109 with accruals totaling just over $2.8 million had been open for 181 days or more.

[49] For these 180 outstanding accruals, the largest dollar amounts were obligated for other contractual services and materials and rents, communications, and utilities.

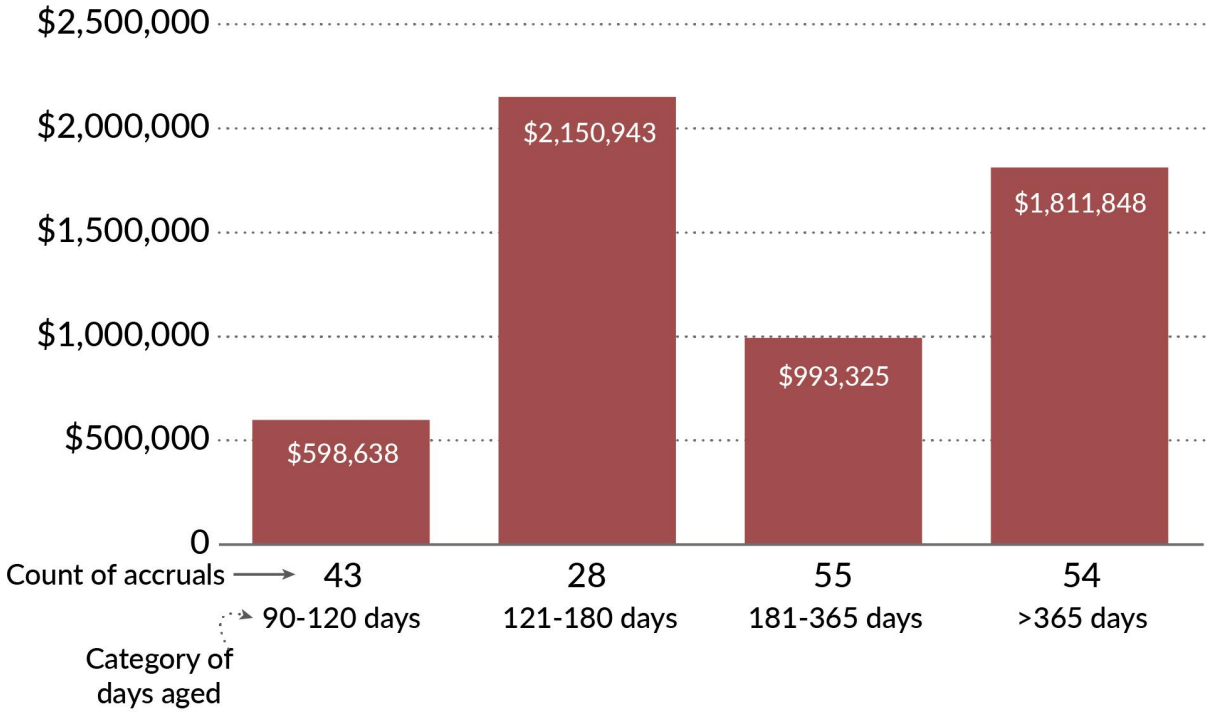

Figure 6. *Outstanding accruals for the VA Northeast Ohio Healthcare System as of November 2023. Source: VA OIG analysis of VA FMS F851 Report.*

The inspection team analyzed and statistically selected 25 accruals outstanding through November 15, 2023, totaling more than $1.25 million. These accrual balances had been open between 138 and 782 days. The team reviewed supporting documentation to assess whether the healthcare system identified and reviewed the sampled accruals to determine whether they were valid and needed to remain open in accordance with VA financial policy.[50] Based on the results of the review, the OIG estimates the healthcare system's finance office was not compliant with VA policy and did not always review accruals for about 160 accrual balances (87 percent) totaling approximately $8.3 million. The OIG also estimates that approximately 96 accrual balances totaling at least $1.1 million were invalid and needed to be reversed and deobligated.[51] The following is an example of an improper accrual.

Example 3

One obligation with an outstanding accrual balance of almost $322,000 auto-accrued at the end of the performance period. This balance was invalid because the period-of-performance end date of September 30, 2022, had passed and there

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

[51] Deobligation means a cancelation or downward adjustment of a previously incurred obligation. VA Financial Policy, "Obligation Policy."

was no activity indicating the accrual balance was still needed. Further, the requesting office was not always responsive to requests for status updates from the finance office. After the team informed the healthcare facility of the inspection, the remaining balance was deobligated on December 8, 2023, 14 months after the period of performance ended. Lastly, the finance office did not have an escalation process in place, as required by VA policy, to notify the healthcare system's associate director about the lack of responsiveness.

Timely responses and escalation are necessary to ensure prompt deobligation of the accrual, and to ensure that funds can be repurposed for other goods and services to benefit veterans.

According to fiscal staff, instead of reviewing all inactive obligations, including undelivered orders and accruals, they were focused on the Analysis of Open Documents (889B) reports to identify obligations inactive for over 90 days past their end date, not obligations inactive for 90 days. This focus was based on the healthcare system's "Aging of Orders–Count" financial indicator, which emphasizes the need for the healthcare system to follow up on open orders greater than 90 days past their period-of-performance end date. However, as of January 22, 2024, there were no financial indicators to measure obligations inactive for 90 days, regardless of the performance end date.[52]

Furthermore, when fiscal staff did follow up with the service to determine the status of specific obligations, the service did not always respond. VA financial policy outlines specific ways to resolve unresponsiveness such as escalating to the associate director.[53] However, fiscal staff stated they did not have an escalation policy in place at the time of the inspection. Without proper monitoring for all obligations and an escalation process, the healthcare system runs the risk that it will not be able to:

- determine whether funds can be deobligated and repurposed for other needs to benefit veterans,
- accurately forecast future budget needs for goods and services, and
- determine whether future budget requests are potentially overestimated.

The inspection team estimated that 96 of the 180 outstanding accruals (53 percent), totaling at least $1.1 million, were invalid and needed to be reversed and deobligated because the funds

[52] The team conducted its site visit to the VA Northeast Ohio Healthcare System during the week of January 22, 2024.

[53] VA Financial Policy, "Obligation Policy."

were no longer needed.[54] Failure to properly manage accruals may prevent the healthcare system from obtaining the maximum benefit of any unused funds.

Although the inspection identified inconsistent monitoring of open obligations, fiscal staff explained they had begun working on a process to monitor open obligations prior to the inspection team's engagement. The process involves creating a central location for all obligations to efficiently track and manage open obligations. The system will be designed to send automated messages to a service line point of contact on a schedule that aligns with VA financial policy. If the point of contact does not respond, a tiered escalation is then implemented. The first tier of escalation would be to include the point of contact's supervisor. The second tier would be to the next-level supervisor and service chief. The last tier of escalation would be to the associate director.

FMS-to-IFCAP Reconciliations

IFCAP handles the processing of certified invoices and electronic transmission of receiving documents to FMS. In addition, IFCAP transfers obligation information back to the control point and updates the control point balance automatically.[55] The end dates in both systems should be the same. However, staff can manually change end dates in one system without changing them in the other. Therefore, open obligations should be reviewed by the healthcare system's finance office, in coordination with the requesting office, to ensure period-of-performance dates are correct and match in all systems.[56] The inspection team analyzed FMS-to-IFCAP reconciliation reports for the period of June 15 through November 15, 2023, to identify obligations with end-date and order amount discrepancies that remained between FMS and IFCAP for three or more months.

End-Date Discrepancies

The inspection team identified and evaluated four open obligations with end-date discrepancies of three months or more between FMS and IFCAP, totaling just over $2.9 million, to determine whether the end dates had been accurately reconciled.[57] The OIG determined that the four FMS and IFCAP discrepancies had been corrected prior to the inspection, and fiscal staff provided documentation that reflected correct end dates for the obligations.

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[54] The OIG used the one-tail lower limit as a conservative estimate in place of point estimate for this projection due to the low level of precision of the point estimate. Appendix B provides additional information on the statistical projections.

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

[56] VA Financial Policy, "Obligation Policy."

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

Order Amount Discrepancies

The inspection team identified one open obligation with an order amount discrepancy that remained between FMS and IFCAP for three or more months. To determine whether the order amount had been accurately reconciled between the two systems, the team evaluated this open obligation, which had a discrepancy of almost $2.1 million. The OIG determined the discrepancy had been corrected prior to the inspection, and fiscal staff provided documentation that reflected the correct order amount for this obligation.

The healthcare system has had a process in place since at least 2018 to reconcile differences between FMS and IFCAP end dates and order amounts. Twice a month, fiscal staff use a VA macro to individually pull data from both systems. This macro combines the data from the two systems and compiles a list of discrepancies between end dates and order amounts. Once the list is complete, fiscal staff determine why any differences exist and then reconcile those differences.

Finding 2 Conclusion

Healthcare system personnel did not always comply with VA policies requiring routine follow-up to improve management and oversight of open obligations. Although the healthcare system reviewed and corrected discrepancies between the FMS and IFCAP systems, the OIG found that open obligations were not always reviewed for validity—resulting in at least $5.5 million that could have been put to better use.[58] Prudent use of funds relies on management of open obligations to determine whether they are still needed. Failure in this area increases the risk of misstated financial statements or improper use of appropriated funds.

Recommendations 4–5

The OIG made the following recommendation to the VA Northeast Ohio Healthcare System executive director:

4. Ensure that healthcare system staff follow policy requirements; and that fiscal staff conduct reviews on all open obligations as required by VA Financial Policy, vol. 2, chap. 5, "Obligations" (2020), updated May 2023.

The OIG made the following recommendation to the Network Contracting Office 10 director of contracting:

5. Ensure that healthcare contracting staff follow federal acquisition regulations when terminating contracts for convenience to the government.

[58] The better use of funds is related to various open obligation monitoring and administrative deficiencies identified in the sampled obligations. This amount includes $3.3 million from undelivered orders, $1.05 million in contract administration issues related to undelivered orders, and an estimated $1.1 million from accrual, which brought the total monetary benefits to at least $5.5 million.

VA Management Comments

The executive director concurred with recommendation 4, and the NCO 10 director of contracting concurred with recommendation 5. The response to recommendation 4 is provided in full in appendix D, and the response to recommendation 5 is provided in full in appendix E.

To address recommendation 4, the executive director reported that the supervisor of accounting will implement an automated SharePoint to enable the accounting team to review all open obligations monthly to ensure validity and proper documentation. If services within the healthcare system do not respond to the inquiries from the system, the inquiries will be escalated to the assistant financial officer, the chief financial officer, then the deputy director. Inquiries to contracting that are not responded to will be escalated to the VISN 10 chief financial officer on a monthly basis for action with the network contracting officer.

To address recommendation 5, the NCO 10 director of contracting is developing training on proper contract termination for next year's schedule. NCO 10 management staff will conduct internal reviews to ensure that acquisition regulations are followed and terminations for convenience are coordinated with the Office of General Counsel.

OIG Response

The healthcare system and NCO 10's action plans are responsive to the recommendations. The OIG will monitor implementation of the planned actions and will close the recommendations upon receipt of sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified.

III. Purchase Card Use

During FY 2023, the healthcare system spent about $101 million through purchase cards, representing 96,457 transactions. The amount and volume of the healthcare system's spending through the program make it important to have strong controls over purchase card use to safeguard government resources and ensure compliance with policies and procedures that reduce the risk of error, fraud, waste, and abuse.

The team reviewed the following areas through sampled transactions:

- **Purchase card transactions.** The inspection team determined whether the healthcare system processed purchase card transactions in accordance with VA policy, including whether cardholders obtained prior approvals before initiating a purchase and reconciled transactions in a timely manner with prompt action from approving officials, and whether segregation of duties was maintained.[59] The team also assessed whether cardholders split purchases—intentionally dividing a single purchase into two or more purchases to avoid exceeding the micropurchase threshold.[60]
- **Supporting documentation.** The team assessed whether the healthcare system maintained supporting documentation, as required, for purchases to provide assurance of payment accuracy and to justify the need to purchase a good or service. Such documentation includes approved purchase requests, purchase orders, receiving reports, and vendor invoices.[61]
- **Use of contracts.** Additionally, the team inquired whether the healthcare system considered obtaining contracts when regularly procuring goods and services, which VA refers to as strategic sourcing. Using 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 by using competitively priced contracts.[62]
- **Purchase card oversight.** The inspection team assessed whether the healthcare system had purchase card policies in place, maintained accurate VA Form 0242s,

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

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

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

[62] VA Financial Policy, "Government Purchase Card for Micro-Purchases." According to this 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.

and approving officials were assigned no more than 25 purchase card accounts (40 purchase card accounts for prosthetics) each.[63] These are examples of systematic controls that help reduce errors and ensure a facility complies with VA policy.[64]

Finding 3: Healthcare System Staff Did Not Always Process Transactions Properly

The OIG found that healthcare system leaders could ensure transactions are processed in compliance with VA policy and improve efficiency by consistently ensuring approving officials and cardholders properly review transactions to validate purchases and avoid split purchases. Based on the results of all areas reviewed, the team projected that the healthcare system had noncompliance errors in at least 9,000 purchase card transactions, totaling at least $9.9 million in questioned costs.

Purchase Card Transactions

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

- **Prior approval.** Before initiating a purchase, the cardholder must obtain prior approval for the purchase and ensure the purchase is for a valid business need. The approval may vary in form and content but must be retained as supporting documentation.[65]
- **Reconciliation.** Reconciliation of a purchase should be completed by the cardholder and approved by the approving official no later than the 15th calendar day of the month after the closing of the previous month's billing cycle. Accounts not reconciled within 30 days of the due date will have their single-purchase limit lowered.[66]
- **Segregation of duties.** To reduce the risk of fraud, waste, and abuse, healthcare system staff must maintain appropriate segregation of duties to ensure roles and

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

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

[65] 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.

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

responsibilities do not overlap among the cardholder, approving official, receiver of purchased items or services, or requesting official.[67]

To determine whether these requirements were met, the inspection team assessed the documentation for sampled purchase card transactions provided by healthcare system personnel. Of the 95,483 transactions, the OIG estimated that at least 9,000 did not comply with VA policy for one of the areas reviewed above. Some transactions had multiple errors.

The violations included untimely approval of transaction reconciliations. Specifically, the OIG determined that approving officials did not approve reconciliations by the 15th day of the month after the previous billing cycle for at least 8,900 transactions totaling at least $9.3 million. The purchase card coordinator stated that this occurred because cardholders and approving officials were on leave and did not reconcile charges in a timely manner. Untimely approval of reconciliations creates the possibility of data integrity errors and fraud.

According to healthcare system personnel, staffing shortages also contributed to problems with approvals and reconciliations. An approving official reported that, during the inspection period of FY 2023, he was assigned too many cardholder accounts because another approving official had left the facility. The healthcare system purchase card coordinator corroborated these issues and added that attrition rates continued to increase, making it difficult to fill staff vacancies.

The inspection team assessed sampled transactions for evidence that healthcare system staff had considered the most appropriate purchasing mechanism. In accordance with policy, VA cardholders should pursue establishing contracts for goods that are purchased on a recurring or ongoing basis. Known as strategic sourcing, this generally provides greater savings than using purchase cards for open-market acquisitions.[68] Approving officials, the agency or organization program coordinator, and cardholders must review purchases to determine when establishing contracts is in the best interest of the government. Generally, VA should use contracts if the purchase is for an ongoing order of goods or services, or when the total value of the requirement exceeds the micropurchase threshold or the cardholder's authorized single-purchase limit. The OIG determined that all sampled purchase card transactions were purchases from established vendors who already had contracts with VHA.

Additionally, a cardholder must not modify a requirement or order into smaller parts to avoid exceeding their micropurchase threshold or purchase card limit or to circumvent the use of formal contracting procedures.[69] The inspection team assessed additional sampled transactions and based on the results, the OIG projected an estimated 100 transactions, totaling

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

about $561,000 were potential split purchases.[70] Any VA cardholder or approving official who makes or certifies a purchase exceeding the micropurchase threshold has created an unauthorized commitment that must be ratified.[71] Example 4 describes a split purchase.

Example 4

In November 2022, healthcare system staff used a purchase card to purchase items via open market. Healthcare system staff ordered and paid for pharmaceutical drugs in increments of just over $5,000 and $9,900, which—when combined—exceeded their purchase card limit. The cardholder said there were stock issues due to back orders that forced them to procure items as they became available throughout the day. As a result, there were multiple invoices processed on a single day for the same vendor and same items. When added up, these separate orders exceeded the purchase card limit.

Supporting Documentation

VA financial policy requires cardholders to upload and electronically store supporting documents for purchase card transactions to a VA-approved document-imaging system. When healthcare system staff buy goods and services, they must maintain supporting documentation, such as approved purchase requests, vendor invoices, purchase orders, and receiving reports, for six years.[72] This documentation verifies that purchase card transactions were properly approved and that payments were accurate.

The inspection team assessed supporting documentation for 52 statistically sampled purchase card transactions provided by healthcare system staff to determine whether the medical center maintained required supporting documentation.[73] Based on this assessment, the team projected those cardholders did not have sufficient supporting documentation for at least eight transactions, which resulted in at least $15,200 in questioned costs. This occurred because the healthcare system did not have controls designed to ensure cardholders maintained all required documentation including packing slips and receiving reports.

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

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

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

[73] The inspection team reviewed a statistical sample of purchase card transactions from a population of just over 95,483 purchase card transactions for FY 2023, totaling approximately $102 million.

Purchase Card Oversight

Responsible officials are accountable for compliance with the Government Purchase Card Program and for implementing internal controls to protect and conserve federal funds. Purchase card coordinators should identify and report any issues and ensure remediation actions are effective.[74] Internal controls include periodic and continuous monitoring; checks and balances; and policies, procedures, and segregation of duties implemented to reduce the risk of error, fraud, waste, and abuse in the purchase card program.

An approved VA Form 0242 is used to delegate authority to an individual to use a purchase card to procure and pay for goods and services. This form also establishes purchase limits and responsibilities and certifies that cardholders and approving officials understand the policies and regulations governing the purchase card program. A revised form is required when the approving official changes, cardholders change their legal names, or the single-purchase limit is changed.

The OIG found that the healthcare system provided oversight of the purchase card program, all 24 cardholders responsible for the sampled purchase card transactions had an approved VA Form 0242, and the healthcare system had purchase card policies in place.

Finding 3 Conclusion

Healthcare system personnel made potential split purchases, indicating they were not as familiar with VA policies and procedures as they should have been. Additionally, healthcare system leaders should ensure that staff both comply with VA policies and identify internal control weaknesses to mitigate the risk of fraud, waste, and abuse. Based on the results of all areas reviewed, the team projected that the healthcare system had noncompliance errors in at least 9,000 purchase card transactions, totaling at least $9.9 million in questioned costs.

Recommendations 6–7

The OIG made the following recommendations to the Network Contracting Office 10 director of contracting:

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

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

VA Management Comments

The NCO 10 director of contracting concurred with recommendations 6 and 7. The responses are provided in full in appendix E. To address recommendation 6, VISN 10 leaders will require all cardholders and approving officials to attend at least one purchase card training per year and will mandate attendance at a refresher training for high-volume and high-risk purchasing areas. Additionally, VISN 10 leaders will prioritize review of supporting documentation when reconciling and approving purchases. Furthermore, approving officials will be required to spot check records of at least 25 percent of their cardholders each quarter and provide confirmation of completion to the purchase card coordinator by the last day of the quarter. Lastly, department leaders will establish an internal process ensuring cardholder preapproval prior to a cardholder making a purchase.

To address recommendation 7, NCO 10's purchase card program managers will ensure that the training provided to the cardholders once a year clearly delineates the process by which unauthorized commitments are ratified. Once an unauthorized commitment has been identified, the director of contracting will assign a contracting officer to the request for ratification from the individual office or cardholder. The ratification package and supporting documentation should be prepared and returned to NCO 10 within 20 calendar days of notification, and the director of contracting will provide ratification information to healthcare system leaders and the VISN 10 deputy network director.

OIG Response

NCO 10's action plans are responsive to the recommendations. The OIG will monitor implementation of the planned actions and will close the recommendations when sufficient evidence is received demonstrating progress in addressing the intent of the recommendations and the issues identified.

IV. Supply Chain Management Operations

The Generic Inventory Package is the software system authorized to manage the receipt, distribution, and maintenance of expendable supplies throughout VA. Inventory data, if properly recorded in this system, should reflect the actual quantity and dollar values of supply items in stock. Supplies are received at the warehouse and stored at a primary inventory point. These supplies are distributed as needed to secondary inventory points such as storage rooms within the clinical areas that use those items. The team reviewed the following areas:

- **Inventory performance metrics.** The team assessed whether the healthcare system met the performance metrics for days of stock on hand for both MSPV and non-MSPV expendable items.
- **Inventory data accuracy.** Based on analysis of Supply Chain Data Informatics Office reports and interviews, the team completed a physical count of some of the larger-dollar items in two of the primary inventory points to assess accuracy.
- **Supply chain management oversight.** The team assessed processes that affected the healthcare system's supply chain management.

Finding 4: The Healthcare System Should Ensure that Supply Chain Operations Comply with VHA Policy and Inventory Data Are Accurate

The OIG found that the healthcare system could improve the efficiency of inventory management by establishing processes and procedures to ensure stock levels and their associated expendable inventory data values are recorded correctly and routinely monitored in the Generic Inventory Package. Specifically, supply chain managers failed to properly record distribution of supplies for inventory areas reviewed by the inspection team. In addition, the healthcare system did not fully meet performance metrics that measure days of stock on hand. The days-of-stock-on-hand metric measures the efficiency of inventory management for expendable items. Maintaining the appropriate level of inventory—neither overstocking nor understocking—helps avoid interruptions to patient care. Understocking could increase the risk of unavailability of supplies where overstocking could increase the risk of items becoming damaged, contaminated, or outdated before they can be used. The healthcare system also failed to have a delegated facility contracting officer's representative (COR) in place for over a year. Failure to properly align systems, personnel, and processes across the supply chain can threaten the healthcare system's ability to effectively plan, mitigate issues, and budget for the purchase of supplies that meet patient care needs. Finally, staffing shortages may have affected the ability of the healthcare system to establish local processes and procedures, develop training plans, and conduct supply chain oversight.

Inventory Performance Metrics

Supplies are received at the warehouse and distributed to inventory points throughout the healthcare system.[75] The Supply Chain Common Operating Picture (SCCOP) dashboard tracks the use of these supplies. The dashboard, which receives part of its data from the Generic Inventory Package, lists the performance measure for expendable supplies purchased both inside and outside the MSPV program. Expendable supplies purchased through the MSPV program should have 30 days or less of stock on hand, while non-MSPV items should have 45 days or less of stock on hand.[76] To avoid overstocking or understocking, VHA requires staff to ensure correct reorder points and inventory levels are maintained.[77] The team accessed the SCCOP dashboard and downloaded a six-month days-of-stock-on-hand summary report for the healthcare system, from May through October 2023 for both MSPV and non-MSPV stock. These reports showed the healthcare system had an average of 22 days of stock for MSPV items and met the performance metric for all six months. However, for non-MSPV items in the same period, the healthcare system had an average of 79 days of stock, which did not meet the performance metric.[78] The average days-of-stock-on-hand metric does not give the full picture, as it divides the current value on hand by the average value daily used. Because of this, the team analyzed additional reports.

While the healthcare system met the MSPV days-of-stock-on-hand performance metrics on average, not all individual primary inventory points met metrics. This was found when the team downloaded the standard clinical days-of-stock-on-hand summary reports, for both MSPV and non-MSPV items. Those reports show all the clinical primary inventory points for the healthcare system. These reports gave insight to which inventory points met the days-of-stock-on-hand metrics for the last 90 days as of January 8, 2024. These reports showed 10 clinical primary inventory points with MSPV items and 15 with non-MSPV items. Six of the 10 (60 percent) with MSPV items did not meet the performance metric for days of stock on hand, and 10 of 15 clinical primary inventory points (67 percent) with non-MSPV items did not meet the metrics.

The healthcare system's inability to meet the days-of-stock-on-hand performance metric at the inventory point levels was due to multiple factors—which included supply chain demands, physical count adjustments, and inventory staff who were unfamiliar with the metrics or lacked

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

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

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

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

time to analyze reports. The OIG determined that a lack of local processes and procedures hindered the monitoring efforts needed to manage and reduce data integrity issues and oversee stock levels. The healthcare system should establish and implement local processes and procedures to routinely monitor inventory reports, increase awareness of internal controls through training, and ensure supply chain performance measures comply with VA policy.

Inventory Data Accuracy

The inspection team downloaded the "All Days-of-Stock-on-Hand Summary by Inventory Point" report, from the SCCOP dashboard on January 8, 2024. This SCCOP report identified surgery and prosthetics as two of the top inventory points measured by value on hand. The inspection team conducted interviews and walkthroughs in these inventory points during the week of January 22, 2024.

To identify and count stock of items for data accuracy, the team accessed the Supply Chain Data Informatics Office Toolbox and downloaded an expendables report for two of the top inventories identified. The team then looked at six items in each inventory and physically counted the stock of the items to assess data accuracy.[79] For these two inventory storage areas, the inspection team found discrepancies between what was reported in the Generic Inventory Package and what was physically located in the inventory points. The team identified counts and values for the items selected that did not agree with what was reported in the Generic Inventory Package. Tables 2 and 3 show counts and discrepancies for the items selected that did not agree with what was reported in the Generic Inventory Package for surgery and prosthetics.

Table 2. Discrepancies between Generic Inventory Package Data and the Physical Count in Surgery Inventory

Item description	Generic Inventory Package data		Physical inventory count		Decrease in value on hand
	Number of items	Value on hand	Number of items	Value on hand	
Shockwave catheter	23	$79,350	2	$6,900	-$72,450
Sepra adhesion barrier	15	$54,782	15	$5,478	-$49,304
Viscoat solution	210	$37,769	42	$7,554	-$30,215
SF curved 45 stapler	18	$36,948	0	$0.00	-$36,948

Source: VA OIG analysis of surgery inventory data versus a physical inventory count.

[79] Two of the top inventories were selected from a point-in-time determination based on accessing the "All Days-of-Stock-on-Hand Summary by Inventory Point" report from the SCCOP dashboard on January 8, 2024.

Table 3. Discrepancies between Generic Inventory Package Data and the Physical Count in Prosthetics Inventory

Item description	Generic Inventory Package data		Physical inventory count		Decrease in value on hand
	Number of items	Value on hand	Number of items	Value on hand	
Guardian, alert plus	1,275	$343,421	115	$30,975	-$312,446
OrCam MyEye	22	$76,298	8	$29,192	-$47,106
Oximeter, pulse, finger	2,814	$70,322	2,661	$66,498	-$3,824
Patriot viewpoint	11	$38,545	9	$33,255	-$5,290
Device, dual cefaly	55	$35,445	0	$0.00	-$35,445
Auto reader lyric	17	$33,320	9	$17,640	-$15,680

Source: VA OIG analysis of prosthetics inventory data versus a physical inventory count.

The inventory management specialist acknowledged the physical inventory count errors the inspection team found during the walk-through and agreed the counts for the numbers of items in stock needed to be corrected in the inventory management system. Inventory items are constantly being pulled from the shelves, and the counts were not being changed in the inventory system accurately or promptly. The lack of internal controls over inventory increases the risk that goods can be misappropriated.

According to VHA policy, inventory managers and functional area employees must review inventory points at least quarterly to ensure correct items and levels are maintained in the Generic Inventory Package. To enhance efficiency and ensure reliable data, inventory managers are required to use scanning and the auto-generation tool to create orders to replenish inventories unless point-of-use equipment is used.[80] The tool is designed to generate reports indicating when inventory should be reordered. However, inventory staff mentioned that the scanners did not always work and they were not using the auto-generation tool for inventory management due to time constraints and a lack of confidence in its accuracy.

The team assessed the SCCOP dashboard and downloaded the healthcare system's "conversion factor primary inventory report." Conversion factor data errors can affect the accuracy of days-of-stock-on-hand metrics and lead to incorrect inventory values and quantities in the Generic Inventory Package, which require manual adjustments. A unit conversion factor is computed by dividing the quantity purchased by the quantity issued.[81] This factor connects how

[80] VHA Directive 1761.

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

a supply item is purchased and issued. For example, a vendor may sell an item in cases of 24 cans, but the end user—such as hospital staff—receives individual cans from that case. A "false" conversion factor showing in the SCCOP dashboard may be the result of a conversion being entered into the Generic Inventory Package system incorrectly. The team accessed the SCCOP dashboard to review the healthcare system's conversion factor primary inventory report.[82] At the time the report was accessed, 1,424 of 15,045 conversion factors (9 percent) had false results, and two of 15,045 conversion factors were blank for clinical primary inventory points.[83] Supply vendors are not consistent in how they sell stock, such as by the case, box, or package. Therefore, supply chain management staff should ensure that purchased items are converted correctly, although supply chain management acknowledged a lack of time to pull reports and review false factors contributed to errors in the inventory system. Example 5 describes a conversion factor error resulting in overstatement of the value on hand.

Example 5

The Supply Chain Data Informatics Office report showed the healthcare system had 15 boxes of Seprafilm Adhesion Barriers in the inventory, valued at a cost of $3,652.10 per barrier for a total value on hand of $54,781.50. However, the price was entered in the Generic Inventory Package at the cost for a box (10 barriers per box) instead of at a single price of $365.21 each. This conversion factor error caused the total value on hand to be overstated by $49,303.35.

To determine the number and associated value of adjustments for the clinical inventory points made at the healthcare system, the team analyzed the SCCOP "Generic Inventory Package Adjustments" report for the 90 days prior to January 8, 2024. The report showed positive and negative adjustments in the Generic Inventory Package to correct inventory points. Adjustments are made for a variety of reasons, such as items not needed, incorrect supply levels, or costing errors. According to the SCCOP report, there were over 530 adjustments made, affecting over 16,100 items and totaling more than $471,000. Supply chain managers explained that these adjustments occur when hospital staff pull more stock off the shelves than needed and return it later after inventory checks.

Supply Chain Management Oversight

The inspection team interviewed inventory staff to evaluate the factors impacting oversight controls and efficiency of the healthcare system's supply chain management. The chief supply chain officer stated that supply tech positions are difficult to retain as employees often seek

[82] The inspection team accessed the "Conversion Factor Primary Inventory Point" report—which details point-in-time conversion factor data at the healthcare system—from the SCCOP dashboard on January 8, 2024.

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

higher grade positions within the healthcare system. Additionally, attendance issues among logistics staff were noted as a challenge, when employees frequently calling out of work or always being on leave have led to logistics management staff having to fill in and take on additional work. The interviews revealed that increased workloads further strained the resources and capacity of the supply chain management team, which left insufficient time to effectively monitor performance metrics. Instead, staff members were often engaged in physical counts, replenishing inventory, and reconciling accounts, which decreased the time they had available for formal training or dedicated efforts toward monitoring and improving performance.

Overall, the findings from the interviews highlighted the critical need to address staffing challenges, improve attendance, and provide adequate training and resources to enable effective oversight and efficiency in supply chain management.

Contracting Officer's Representatives

The healthcare system must have at least one facility-level MSPV COR, who is nominated by logistics leaders and appointed by the MSPV contracting officer.[84]

The facility-level MSPV COR plays a crucial role in ensuring that prime vendors meet their contractual obligations within the MSPV program. The COR acts as a liaison between the facility and the prime vendor's on-site representative to ensure compliance with contract terms, monitor prime vendor performance, identify program risks, and address issues that arise.

One MSPV contract was effective during the OIG inspection period from May 1, 2023, through January 26, 2024. However, the facility-level COR designated on the previous MSPV contract, which ended in November 2022, performed the duties on the new contract for over a year without proper authorization from the contracting officer. These duties included reviewing invoices for monthly distribution fees to ensure they were accurate and in accordance with contract requirements. This individual created the monthly purchase orders for vendor distribution fees amounting to just under $518,000, that were certified and approved for payment during the inspection period.[85] Because these actions were performed by an individual who was not formally designated a COR as required, the OIG considers these payments to be questioned costs.

The facility chief supply chain officer did not ensure that a facility-level MSPV COR was nominated for appointment by the MSPV contracting officer. The chief supply chain officer attributed this failure to an administrative oversight within the supply chain management responsibilities.

[84] Department of Veterans Affairs, Procurement and Logistics Office, Medical Supply Program Office, "Medical Surgical Prime Vendor Field Guide-Roles and Responsibilities," April 2023.

[85] Distribution fees are what the prime vendor charges as a percentage of the total amount medical facilities spend on medical and surgical supplies.

In January 2024, as a result of the OIG inspection, the facility's chief logistics officer nominated three CORs for the MSPV contract, who were subsequently appointed by the Strategic Acquisition Center MSPV contracting officer.[86] It is important for the facility to ensure proper authorization and oversight are in place to prevent similar occurrences in the future.

Finding 4 Conclusion

The healthcare system's oversight of supply chain management can be improved to ensure performance metrics for days of stock on hand are met for all clinical inventory points and inventory data are accurate in the Generic Inventory Package. VHA policy states that Generic Inventory Package information should be complete and accurate.[87] Unreliable inventory data can lead to the purchase of unnecessary supplies, overstocking, and spoilage. Additionally, increased reliance on manual inventory counts, ordering processes, and incorrect inventory values and quantities in the Generic Inventory Package could lead to manual adjustments and can affect the healthcare system's performance metrics. More importantly, errors indicating that supplies are available when they are not could adversely affect the healthcare system's ability to effectively plan and budget for the purchase of supplies to operate and meet patient care needs.

In addition, the healthcare system's oversight could be improved by ensuring that MSPV CORs are properly appointed and delegated, reducing the risk of questioned costs.

Recommendations 8–10

The OIG made the following recommendations to the VA Northeast Ohio Healthcare System executive director:

8. Develop and implement a plan to ensure data accuracy and reliability in the Generic Inventory Package.
9. Develop and maintain a standardized training program for logistics and clinical staff on the proper recording of items as they are removed from primary and secondary inventory points.

The OIG made the following recommendation to the VA Northeast Ohio Healthcare System executive director and the Strategic Acquisition Center associate executive director:

10. Ensure that MSPV facility-level contracting officer's representatives are appointed and designated properly and perform all required duties according to the scope and limitation of the designee's authority.

[86] Department of Veterans Affairs, Procurement and Logistics Office, Medical Supply Program Office, "Medical Surgical Prime Vendor Filed Guide-Roles and Responsibilities," April 2023.

[87] VHA Directive 1761.

VA Management Comments

The healthcare system executive director concurred with recommendations 8 and 9. The responses are provided in full in appendix D. The Strategic Acquisition Center associate executive director concurred with recommendation 10. That response is provided in full in appendix F.

To address recommendation 8, the chief and assistant chief of logistics will review key performance indicators with section chiefs monthly and develop corrective actions as necessary. If any metric is below the standard, meetings will increase to every other week until the standard is met or an approved deviation from the standard is issued.

To address recommendation 9, logistics staff will develop and communicate a standard operating procedure for access to the main distribution primary inventory by non-logistics personnel, restrict access, and include requirements for logging items being removed. Additionally, logistics staff will work with personnel security staff to review access information to the inventory point and remove individuals who should not have access. Lastly, all inventory management specialists and their backups have received training on proper inventory file maintenance, as well as program classification and utilization on the handheld scanners. This training will be required for new hires and will also be given as a refresher training.

To address recommendation 10, the associate executive director of the Strategic Acquisition Center advised that appointments were completed for three facility-level MSPV CORs.[88] The healthcare system's chief of logistics, VISN 10 leaders, and the expendable supply team will use monthly MSPV call attendance and monthly review of appointment letters to ensure the system always has an up-to-date, appointed facility-level MSPV COR.

OIG Response

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

[88] Through email correspondence with the OIG team, the executive director of the Northeast Ohio Healthcare system provided concurrence of the Strategic Acquisition Center's response for recommendation 10.

Appendix A: Scope and Methodology

Scope

The team conducted its inspection of the VA Northeast Ohio Healthcare System from January 2024 through July 2024, including a site visit during the week of January 22, 2024. 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 for FY 2023 related to the use of managerial cost accounting information, open obligations, days-of-stock-on-hand measures for expendable supplies, and purchase card transactions. To conduct the inspection, the team interviewed healthcare system leaders and staff and identified and reviewed applicable laws, regulations, VA policies, operating procedures, and guidelines.

The team statistically selected

- 50 outstanding obligations (25 undelivered orders and 25 accrued expenses) to assess whether the healthcare system identified and reviewed the obligations to determine whether they were valid and needed to remain open in accordance with VA financial policy, and
- 52 purchase card transactions to determine whether there was proper oversight and governance of the purchase card program, as well as to assess the risk for illegal, improper, or erroneous purchases.

The team judgmentally selected

- five obligations with differences (four end-date differences and one order amount difference) from VA's Financial Management System (FMS) to Integrated Funds Distribution, Control Point Activity, Accounting and Procurement System (IFCAP) Reconciliation reports to determine which system reflected accurate order amounts and whether further reconciliation efforts were needed in either VA's FMS or IFCAP.

Internal Controls

The team assessed the internal controls of the VA Northeast Ohio Healthcare System that were significant to the inspection objective. This included an assessment of the five internal control components known as control environment, risk assessment, control activities, information and

communication, and monitoring.[89] In addition, the team reviewed the principles of internal controls as associated with this objective. The team identified internal control weaknesses during this inspection in all four subobjectives assessed—use of managerial cost accounting information, open obligation oversight, purchase cards, and inventory and supply management—and proposed recommendations to address the weaknesses.

Fraud Assessment

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

Data Reliability

The inspection team used computer-processed data obtained from US Bank files through a corporate data warehouse, SCCOP reports, FMS reports, and cost accounting data from the relative value unit modeling tool. To test for reliability, the team determined whether any data were missing from key fields, including any calculation errors, or were outside the time frame requested. The team also assessed whether the data contained obvious duplication of records, alphabetic or numeric characters in incorrect fields, or illogical relationships among data elements. Furthermore, the team compared purchase identification numbers, purchase dates, cardholder names, payment amounts, and vendor and merchant names as provided in the data received for the samples reviewed. Testing of the data showed that they were sufficiently reliable for the inspection objectives.

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

Government Standards

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

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

Appendix B: Sampling Methodology

Open Obligations

The inspection team evaluated a statistical sample of outstanding accruals and a statistical sample of undelivered orders and accruals as of November 15, 2023, to determine whether the VA Northeast Ohio Healthcare System performed required reviews and reconciliations to ensure that its obligations were valid and should remain open. The team also evaluated a judgmental sample of open obligations as of November 15, 2023, to determine whether the end dates and amounts were accurate and reconciled between the Financial Management System (FMS) and Integrated Funds Distribution, Control Point Activity, Accounting and Procurement (IFCAP).

Population

As of November 15, 2023, the healthcare system had 308 open obligations totaling about $33.3 million that had been open for more than 90 days. Of those obligations, 128 were undelivered orders valued at more than $27.7 million and 180 were outstanding accruals valued at just under $5.6 million. The inspection team also analyzed FMS-to-IFCAP reconciliation reports for the period of June 15, 2023, through November 15, 2023, for end-date and order-amount discrepancies. The team identified four open obligations totaling almost $3 million with end-date discrepancies and one open obligation totaling close to $2.1 million with order amount discrepancies between FMS and IFCAP; in all of these instances, the discrepancies existed for three or more months.

Sampling Design

The inspection team reviewed the following from FMS reports to design its sample:

Undelivered Orders. The team used a method of probability proportionate to size selection where the probability of selection was based on the number of days open greater than or equal to 90 days and the associated undelivered amount. The sampling design resulted in the review of 25 outstanding undelivered orders from the November 2023 FMS F850 report, which lists each outstanding undelivered order, and allowed the inspection team to project its findings from the sample to the population.

Outstanding Accruals. The team used a method of probability proportionate to size selection where the probability of selection was based on the number of days open greater than or equal to 90 days and the associated outstanding balance. The sampling design resulted in the review of 25 outstanding accrued expenses from the November 2023 FMS F851 report, which lists each accrual and its outstanding balance, and allowed the inspection team to project its findings from the sample to the population.

FMS-to-IFCAP reconciliations. The team judgmentally selected four obligations with different end dates and one with a different order amount between FMS and IFCAP from VA's FMS-to-IFCAP reconciliation reports for November 2023.

The samples included 55 total open obligations: 25 outstanding undelivered orders totaling close to $21.3 million; 25 outstanding accruals, totaling more than $1.25 million aged 90 days or more; four open obligations with different end dates between FMS and IFCAP, totaling more than $2.9 million; and one open obligation with a different order amount between FMS and IFCAP, totaling almost $2.1 million.

The team requested supporting documentation for each of the 55 sampled transactions, including reviews and reconciliations, financial system screen prints and reports, and emails related to the obligations.

Purchase Cards

The inspection team evaluated a statistical sample of purchase card transactions that occurred for FY 2023 to determine whether the VA Northeast Ohio Healthcare System reviewed transactions to (1) ensure they were adequately monitored, approved, and supported by documentation; (2) prevent split purchases; and (3) ensure goods or services were procured using strategic sourcing.

Population

During FY 2023, the healthcare system had 96,457 purchase card transactions, which totaled just under $101 million. The inspection team removed negative purchase card transaction amounts from the total population of transactions and obtained a population of 95,483 transactions totaling over $102 million.[90] From this population, the team developed two 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; this stratum included a total of 225 bundles of transactions comprised of 830 individual transactions, which totaled approximately $3.4 million. The second stratum included the remaining purchase transactions, 94,653 transactions totaling about $98.7 million that were greater than or equal to $0 and were not included in the prior stratum.

[90] The statistical sample was selected from positive dollar amount transactions (negative transactions such as refunds for disputed transactions and other corrections were excluded).

Sampling Design

For the two strata, 52 sample transactions were selected using probability proportional to size of purchase amount by bundle (for potential split purchases) or by individual transaction (for other purchases).

- **Potential split purchases exceeded the 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 eight bundles of potential split purchases that included 27 transactions totaling approximately $126,900.
- **Other purchases.** The team selected 25 transactions totaling about $282,900 greater than or equal to $0 after excluding previously identified potential split purchases.

Weights

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

Projections and Margins of Error

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

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

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

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

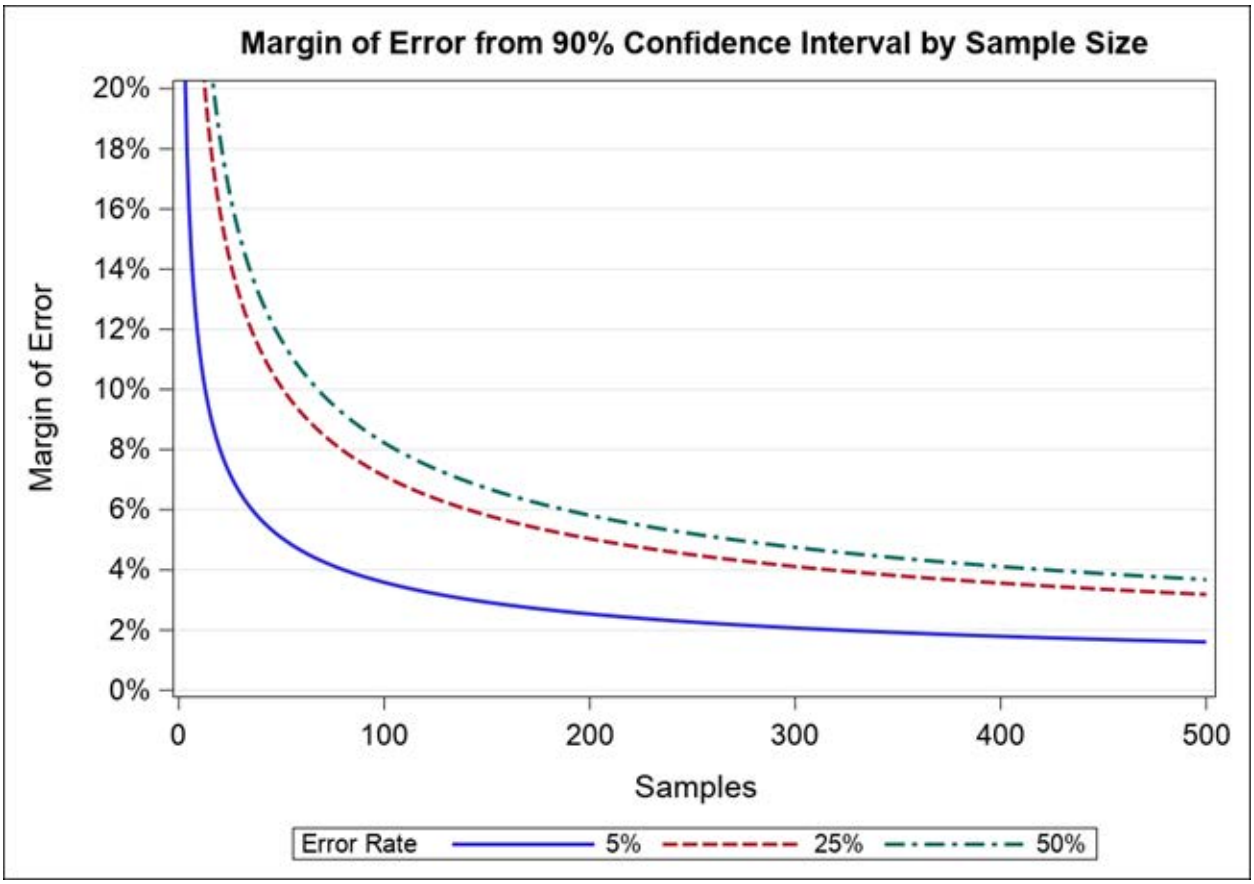

Figure B.1. *Effect of sample size on margin of error.*
Source: OIG statistician's analysis.

Open Obligations Oversight

Tables B.1 and B.2 show statistical projections of noncompliant undelivered orders and the associated dollar amounts. Tables B.3 and B.4 show the statistical projections of noncompliant accruals and the associated dollar amounts. Tables B.5. and B.6. show the statistical projection of invalid accruals and the associated dollar amounts.

Table B.1. Statistical Projections Summary for Noncompliant Undelivered Orders: Count

Estimate name	Estimate number	90 percent confidence interval			Sample	
		Margin of error	Lower limit	Upper limit	Error	Size
Overall undelivered orders errors (count)	115	24	91	128	24	25
Overall undelivered orders errors (percent)	89	18	71	100	24	25

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

Table B.2. Statistical Projections Summary for Noncompliant Undelivered Orders: Dollar Amounts

Estimate name	Estimate number	90 percent confidence interval			Sample size
		Margin of error	Lower limit	Upper limit	
Undelivered Orders	$24,799,004	$5,099,055	$19,699,949	$27,714,207	25

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

Note: Due to the small number of deobligation undelivered order errors, the OIG reported no estimates.

Table B.3. Statistical Projections Summary for Noncompliant Accruals: Count

Estimate name	Estimate number	90 percent confidence interval			Sample	
		Margin of error	Lower limit	Upper limit	Error	Size
Overall accrual errors (count)	156	25	131	180	21	25
Overall undelivered orders errors (percent)	87	14	73	100	21	25

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

Table B.4. Statistical Projections Summary for Noncompliant Accruals: Dollar Amounts

Estimate name	Estimate number	90 percent confidence interval			Sample size
		Margin of error	Lower limit	Upper limit	
Accruals	$8,293,576	$2,330,904	$5,642,718	$10,624,480	25

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

Table B.5. Statistical Projections Summary for Invalid Accruals: Count

Estimate name	Estimate number	90 percent confidence interval			Sample	
		Margin of error	Lower limit	Upper limit	Error	Size
Overall invalid accrual errors (count)	96	35	61	131	15	25
Overall invalid accrual errors (percent)	53	20	34	73	15	25

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

Table B.6. Statistical Projections Summary for Invalid Accruals: Dollar Amounts

Estimate name	Estimate number	90 percent confidence interval				Sample size
		Margin of error	Lower limit	Upper limit	One-tailed lower limit	
Invalid accruals	$2,906,107	$2,377,561	$528,547	$5,283,668	$1,074,751	15

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

Note: Due to poor precision, the one-tailed lower limit for the 90 percent confidence interval is reported.

Purchase Cards

Table B.7 shows purchase card transaction sample errors, and tables B.8 and B.9 show statistical projections of purchase card transaction errors and their dollar amounts.

Table B.7. Purchase Card Transaction Sample Errors

Estimate name	Number of errors	Sample size
Overall errors	18	52
Prompt reconciliation approval	7	52
Supporting documentation	3	52
Potential split purchase	12	27

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

Table B.8. Statistical Projections for Purchase Card Transaction Errors

Estimate name	Estimate number		90 percent confidence interval		
		Margin of error	Lower limit	Upper limit	One-tailed lower limit
Overall errors	19,043	12,952	6,091	31,995	9,006
Prompt reconciliation approval	18,945	12,952	5,993	31,897	8,908
Supporting documentation	28	26	2	54	8
Potential split purchase	103	43	60	146	N/A

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 because five transactions had multiple errors.

Table B.9. Statistical Projections for Purchase Card Transaction Error Dollar Amounts

Estimate name	Estimate number		90 percent confidence interval		
		Margin of error	Lower limit	Upper limit	One-tailed lower limit
Overall errors	$20,340,153	$13,508,587	$6,831,566	$33,848,740	$9,871,906
Prompt reconciliation approval	$19,793,349	$13,505,222	$6,288,128	$33,298,571	$9,327,711
Supporting documentation	$143,065	$173,870	$15,164	$316,935	$15,164
Potential split purchase	$561,306	$315,696	$245,610	$877,003	$317,915

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 because five transactions had multiple errors.

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

Recommendation	Explanation of Benefits	Better Use of Funds	Questioned Costs[91]
4	Ensure that healthcare system staff follow policy requirements, and that the responsible fiscal office conducts reviews on all open obligations and establishes an escalation process.	$4,400,000	$0
5	Ensure that healthcare contracting staff follow federal acquisition regulations when terminating contracts for convenience to the government.	$1,050,000	$0
7	Ensure cardholders comply with record retention and purchase card reconciliation requirements as required by VA Financial Policy, vol. 16, chap. 1B, "Government Purchase Card for Micro Purchases."	$0	$9,900,000
10	Ensure a medical/surgical prime facility-level contracting officer's representative is appointed and delegated appropriately and performs all required duties according to the scope and limitation of the designee's authority.	$0	$518,000
	Total	**$5,500,000**	**$10,400,000***

Note: The better use of funds for recommendations 4-5 is related to various open obligation monitoring and administrative deficiencies identified in the sampled obligations. This amount includes $3.3 million from undelivered orders, $1.05 million in undelivered orders contract administration issues and an estimated $1.1 million from accruals, bringing the total monetary benefits to at least $5.5 million.
**Numbers may not sum due to rounding.*

[91] 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 funds are expended for purposes that are unnecessary or unreasonable under governing authorities. Within questioned costs, the OIG must, as required by section 405 of the IG Act, report unsupported costs. Unsupported costs are those determined by the OIG to lack adequate documentation at the time of the audit. Of the $10,400,000 in questioned costs, $15,164 were unsupported costs.

Appendix D: VA Management Comments, Northeast Ohio Healthcare System Director

Department of Veterans Affairs Memorandum

Date: August 20, 2024

From: Executive Medical Center Director (00)

Subj: Financial Efficiency Inspection of the VA Northeast Ohio Healthcare System Management Comments

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

Thru: MCA Operations Manager/VISN Coordinator

Chief Financial Officer, Fiscal Services

Chief of Logistics

Chief Informatics and Analytics

CC VISN 10 Chief Financial Officer

The VA Northeast Ohio Healthcare System (VANEOHS) would like to thank the OIG for taking the time to complete the Financial Efficiency Inspection. The finding and recommendations provided in the report along with the corrective action plans will strengthen our processes as it pertains to the use of Managerial Cost Accounting (MCA) Information, open obligation oversight, Purchase Card use and Supply Chain Management Operations.

Finding 1:

Recommendation 1: Establish a plan to use VA's cost accounting system information to identify alternative ways to reduce costs, enhance efficiency, and inform business decisions as identified by VA financial policy. This could include implementing federal financial accounting standard practices to use cost information for performance measurement, budgeting, cost control, and making economic choices.

Concur

Target Date for Completion: January 2, 2025

Action Plan: VANEOHS will continue to integrate MCA Dashboards and other data elements in formal decision-making processes. MCA has been added to the VANEOHS Healthcare Operations Committee (HOC) as a standing agenda item/slot. MCA liaisons and fiscal staff are on the 8/24 HOC agenda with a standard report elements format as follows:

-MCA Liaison and Service Collaboration: Overview, schedule, and major opportunities discussed with services

-Proactive engagement: Engagement with core groups like profile managers and HIMS in early issue identification and resolution

-Summary of Actions and Opportunities: Summary list of specific action plans to address service level opportunities

-Leadership Support Needs: MCA Liaison and Cost Accounting Staff needs from VANEOHS Leadership

Structured reporting to HOC is a major opportunity and engagement point for VANEOHS Leaders to drive MCA data into service level planning efforts. The monthly report will offer MCA Liaisons the opportunity to provide visibility of their work with the services, highlight current actions being taken, bring forward prioritized opportunities for proactive engagement, and ensure leadership visibility and support for cost reduction initiatives across the medical center.

Recommendation 2: Consider requiring that the managerial cost accounting team review the Intermediate Product Cost Outlier report to identify cost outliers that may occur at the healthcare system.

Concur

Target Date for Completion: FY25 Q1

Action Plan: The Managerial Cost Accounting Office (MCAO) was originally sunsetting the Intermediate Product Cost Outlier report but have since determined to modify to reduce duplicative auditing, see memo "IP Cost Outlier Report Memo" attached. Most of the outliers that appear on this report are already reviewed in other monthly audits, but the VISN 10 MCA Team will institute a quarterly review beginning FY25 when first quarter data is published.

Recommendation 3: Ensure healthcare services are completing monthly data validation memos for their managerial cost accounting data.

Concur

Target Date for Completion: Continuous and ongoing to ensure monthly memos are completed.

Action Plan: Service leadership and administrative staff have been trained on the MCAD data validation process and need to complete the data validation monthly. Trainings were provided by our VISN MCAD staff and recorded to allow staff to go back in case of any questions. Training dates were Thursday, October 19 and Monday October 23, 2023. Chief of Staff (COS) office will continue with monthly monitoring of service completion. Refresher will be provided by COS office to all service level AO's at next monthly AO meetings to ensure understanding and progress will be continued to be reported out at subsequent meetings.

MCAD will send monthly report to COS office regarding compliance with submission and COS office and HSS Support team will provide follow-up to services that are not in compliance monthly. The goal is 100% compliance with submission and has been added to Service Chiefs performance standards to ensure completion.

Finding 2:

Recommendation 4: Ensure that healthcare system staff follow policy requirements; and that fiscal staff conduct reviews on all open obligations as required by VA Financial Policy, vol. 2, chap. 5, "Obligations" (2020), updated May 2023.

Concur

Target Date for Completion: 1/02/2025

Action Plan: Supervisor of Accounting will implement an automated SharePoint that will enable the accounting team to review all open obligations monthly to ensure validity and proper documentation. The

automated SharePoint site will distribute emails to Services with open obligations over 90 days past the end date and stale obligations without activity over 90 days within the first five calendar days of the month and require staff who receive the emails to provide updates to the open obligations. Accounting staff will review to ensure that notes and documentation are updated properly with this feedback. Open orders and stale obligations will be tracked separately within this system and stale obligations will be deobligated or the period of performance will be updated using feedback from the requesting service.

If services within the healthcare system do not respond to the inquiries from the system are received, they will be escalated to the AFO, CFO, then Deputy Director. Inquiries to contracting that are not responded to will be escalated to VISN 10 CFO on a monthly basis for action with Network Contracting Officer. Fiscal will also initiate monthly meetings with Contracting to discuss open obligations that require Contracting action.

This automated system will go through a test and training phase from July to December. This will give time to Services and Fiscal staff for training and implantation of procedures that follow policy. Fiscal will also initiate monthly meetings with Contracting to discuss open obligations that require Contracting action.

Finding 4

Recommendation 8: Develop and implement a plan to ensure data accuracy and reliability in the Generic Inventory Package (GIP).

Concur

Target Date for Completion: 9/30/2024

Action Plan: The Logistics Service utilizes Key Performance Indicators (KPI) for the GIP within both expendable supply management sections, Total Supply Support (TSS) and Distribution. KPIs are an effective tool for monitoring and ensuring data accuracy and reliability. The KPI's are broken down into two elements, Individual and Section.

a. Individual KPIs
    i. Items Below Emergency Stock Level
    ii. Items Above Normal Stock level
    iii. Orders Placed
    iv. Transaction History (Total number of Inventory Corrections)
    v. Transaction History (Total Number of Days Inventory Maintenance was performed).
b. Section KPIs
    i. Long Supply
    ii. Turnover Rate
    iii. MSPV Days of Stock On-Hand
    iv. Non- MSPV Days of Stock On-Hand

Distribution Section

The Chief and Assistant Chief of Logistics will review KPI performance with the Distribution Section Chief monthly and develop corrective actions as necessary. NOTE: Distribution will be the model for TSS KPI monitoring and corrective action development as they were compliant with all national performance metric standards both during the inspection and to this date. If any metric is below the standard, meetings will increase to bi-weekly until standard is met or an approved deviation from standard is issued from ELT, VISN, or VACO.

TSS Section

The Chief and Assistant Chief of Logistics will review KPI performance with the TSS Section Chief monthly and develop corrective actions as necessary. If any metric is below the standard, meetings will increase to bi-weekly until standard is met or an approved deviation from standard is issued from ELT, VISN, or VACO.

Recommendation 9: Develop and maintain a standardized training program for logistics and clinical staff on the proper recording of items as they are removed from primary and secondary inventory points.

Concur

Target Date for Completion: 8/31/2024

Action Plan: NLT August 31, 2024, Logistics will effectively communicate and train a locally developed Standard Operating Procedure (SOP) with all Nurse Managers and Assistant Nurse Managers, and conduct refresher training on an annual basis. The SOP establishes the procedure for access into the main Distribution Primary Inventory by non-Logistics personnel. The SOP outlines the mandate for restricted access to the primary inventory, dress attire, how to locate the supply being sought, as well as the requirement for logging anything being removed so it may be properly decremented once proper personnel arrive on tour. Additionally, Logistics will work with personnel security to review access information to the Inventory point and remove individuals who should not have access to the area per the SOP.

Multiple occurrences pertaining to GIP (Generic Inventory Package) Primary stand-alone inventories were also identified. With these inventories being stand-alone (no affiliated secondary inventory points for distribution), they are entirely dependent upon obtaining their accuracy via physical inventory counts and scanning. Additionally, the applications on the scanners must be utilized appropriately to account for true inventory utilization. The stand-alone primary inventories are just-in-time inventories, meaning clinical staff will take product as needed and from time to time some product which was removed is returned to the inventory. Meaning if an item were counted and decremented as usage then the product was returned, it would need to be re-entered into the inventory count to appropriately account for the new on-hand balance. All Inventory Management Specialists for these stand-alone GIP inventories, as well as their back-ups, have received training on proper inventory file maintenance, as well as program classification and utilization on the hand-held scanners. Additionally, a workforce development committee formed earlier this year by the VISN10 SCM Team, has revised the Individual Training Plan (ITP) for Inventory Management Specialists and addresses this as a new hire training requirement and refresher training.

The Blind Rehabilitation (BR) section of the Prosthetics Primary Inventory was another area of concern during the OIG inspection of the Cleveland VAMC. Upon review, it appeared that numerous items were ordered outside of GIP, as well as without proper approval via the Clinical Product Review Committee (CPRC) via VHA Directive 1761 (Dated 30 December 2020). Per the directive, the requirement for clinical

product reviews is applicable to all VHA clinical programs, except Non-Human Research and Pharmacy, who are responsible for tracking and managing the expendable clinical items of their respective programs. In the second and third quarters of FY24, Logistics worked with BR to identify items which were not accounted for within GIP as well as items that did not have IMF numbers created for them. These items and their associated new IMF numbers, have been physically counted and adjustments were performed to account for them within GIP. Additionally, all BR GIP supply rooms are now properly labeled and barcoded. For all new items being requested, the BR staff have been trained on the CPRC process and are now utilizing CPRC. This will not only allow for approval for use within VANEOHS but will also establish an IMF number to maintain a proper record, as well as assist in determining tracking and notifications in the event of a product recall.

(Original signed by)

Jill Dietrich Mellon

Executive Director

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

Appendix E: VA Management Comments, NCO 10 Director of Contracting

Department of Veterans Affairs Memorandum

Date: August 22, 2024

From: NCO 10 Director of Contracting

Subj: Financial Efficiency Inspection of the VA Northeast Ohio Healthcare System Management Comments

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

Finding 2:

Recommendation 5: Ensure that healthcare contracting staff follow federal acquisition regulations when terminating contracts for convenience to the government.

Concur

Target Date for Completion: Spring 2025

Action Plan: NCO 10 contracting conducts routine internal training for all purchasing staff. The FY25 training plan is currently in the process of being developed. Training on proper contract termination will be included in next year's training schedule. NCO 10 management staff will provide oversight through internal reviews to ensure that acquisitions regulations are followed and terminations for convenience are coordinated with the Office of General Counsel.

Finding 3

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

Concur

Target Date for Completion: Spring 2025

Action Plan: Continual training of various types is provided by the AOPC to medical center cardholder staff throughout the year. Attendance at these trainings fluctuates. Additional controls will be put into place to ensure compliance moving forward. VISN 10 leadership shall:

- require all cardholders and approving officials to attend at least one purchase card training per year.
- mandate attendance at refresher training for high volume/high risk purchasing areas including but not limited to Supply Chain Management and Prosthetics.
- prioritize the transaction approval process, to include review of supporting documentation when reconciling and approving, and ensure the documentation is available to approving officials upon cardholder departure.

- require approving officials to spot check records of at least 25% of their cardholders each quarter and provide confirmation of completion to the AOPC by the last day of the quarter.
- devise a process for findings and missing spot checks to be returned to the AOPC by the medical center director within two weeks of receiving the memo.
- coordinate with the VISN office to suspense the completion of pending delinquent bank approvals identified in the monthly memo provided by VHA Purchase Card Operations.
- department leadership establish an internal process that ensures cardholder(s) obtain a pre-approval prior to initiating a purchase using their purchase card.

The Director of Contracting will coordinate with the local medical center leadership to ensure any internal findings from the spot checks are reviewed and the appropriate corrective actions are in place.

Recommendation 7: NCO 10 Director of Contracting require cardholders to submit a request for ratification for any unauthorized commitments identified.

Concur

Target Date for Completion: In accordance with policies and procedures currently in place, this recommendation is implemented immediately.

Action Plan: NCO 10's Purchase Card Program Manager(s) will ensure that the training the AOPCs provide to the card holders annually clearly delineates the process by which unauthorized commitments are ratified. Once an unauthorized commitment has been identified, the Director of Contracting will assign a contracting officer to the request for ratification from the individual office/cardholder. The ratification package and supporting documentation should be prepared and returned to NCO 10 within 20 calendar days of notification. The Director of Contracting will provide ratification information to the local medical center leadership as well as to the VISN 10 Deputy Network Director for awareness.

(Original signed by)

Marie L. Smith

Director of Contracting

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

Appendix F: VA Management Comments, Strategic Acquisition Center

Department of Veterans Affairs Memorandum

Date: August 20, 2024

From: Associate Executive Director, Strategic Acquisition Center

Subj: Financial Efficiency Inspection of the VA Northeast Ohio Healthcare System Management Comments

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

Finding 4

Recommendation 10: Ensure that MSPV facility-level contracting officer's representatives are appointed and designated properly and perform all required duties according to the scope and limitation of the designee's authority.

Concur

Target Date for Completion: Completed on 1/16/2024 and ongoing.

Action Plan: Upon discovering that VHACLE did not have an active, approved, and appointed facility-level MSPV COR, nominations letters were immediately submitted. Appointment letters were received on 1/16/2024 for (3) separate facility-level MSPV CORs, one as the primary, the other two as backups. The appointment letters do not have an expiration date and terminate on completion of the contract or when the CO rescinds their appointment. The VHACLE Chief of Logistics will work in tandem with VISN 10 Leadership and EX Supply Team to ensure VHACLE always has an up-to-date appointed facility-level MSPV COR through emails, monthly MSPV call attendance, and monthly review of appointment letters.

(Original signed by)

Christopher D. Parker, SES

Associate Executive Director

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

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