DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Financial Efficiency Review of the Miami VA Healthcare System

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Executive Summary

The VA Office of Inspector General (OIG) conducted this review to assess the oversight and stewardship of funds by the Miami VA Healthcare System (the healthcare system) and to identify potential cost efficiencies in carrying out medical center functions.[1] To accomplish this goal, the OIG identified areas that draw on considerable VA financial resources and made recommendations to promote the responsible use of VA's appropriated funds.

This review assessed the following financial activities and administrative processes to determine whether the facility had appropriate oversight and controls in place:

I. **Medical/Surgical Prime Vendor-Next Generation (MSPV-NG) program utilization.** The MSPV-NG program provides a collection of contracts with selected prime vendors that enables VA to streamline purchasing and just-in-time distribution for medical, surgical, dental, and certain prosthetic and laboratory supplies.[2] Supplies that can be purchased through the program appear on a list called a formulary. The VA Medical Supplies Program Office recommends that each medical center purchase at least 90 percent of medical supplies on the formulary from the region's assigned prime vendor.

II. **Purchase card use.** The review team evaluated a sample of 53 purchase card transactions to determine whether the healthcare system used strategic sourcing for commonly purchased products and properly documented transactions.[3] Documenting transactions as required helps VA and other oversight entities identify potential fraud, waste, and abuse. Using contracts for common purchases has benefits, such as allowing VA to leverage purchasing power and obtain competitive pricing.

III. **Administrative staffing levels and accuracy of labor costs.** Administrative staff include positions such as medical support assistants, administrative officers, and human resource specialists. A facility that has more administrative staff than other facilities of similar size and complexity may not be cost efficient and may warrant closer examination. The review team examined whether the healthcare system managed its administrative staffing levels effectively and tracked the related labor costs accurately.

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[1] The healthcare system consists of seven Florida clinics: two major satellite outpatient clinics in Broward County and Key West, and five community-based outpatient clinics in Homestead, Key Largo, Pembroke Pines, Hollywood, and Deerfield Beach.

[2] The "just-in-time" method is an inventory strategy in which materials are ordered and received only as they are needed.

[3] VA Financial Policy, vol. XVI, chap. 1B, "Government Purchase Card for Micro-Purchases," February 27, 2019. This policy defines strategic sourcing as ensuring employees obtain proper contracts when procuring goods and services on a regular basis.

IV. **Pharmacy operations and cost avoidance efforts.** An efficient healthcare system anticipates how much drugs will cost and when inventory needs to be restocked by analyzing available data, such as prime vendor inventory management reports and inventory turnover rates. Doing so helps ensure that the system makes the best use of appropriated funds and has inventory when needed.

The OIG selected these areas for review by using the efficiency opportunity grid, a tool developed by the Office of Productivity, Efficiency & Staffing in the Veterans Health Administration (VHA). The grid helps identify opportunities to improve efficiency by highlighting areas at a given healthcare system with a significantly high volume and/or cost of expenditures. The review is limited in scope and not intended to be a comprehensive review of all financial operations at the facility.

The OIG evaluated financial efficiency practices related to the identified areas for fiscal year (FY) 2019. The team conducted its review from May 2020 to June 2021, including a virtual site visit during the week of May 18, 2020. For more information about the review's scope and methodology, see appendixes B and C.

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

What the Review Found

Although the OIG found the healthcare system has made progress in areas such as pharmacy efficiency, the team identified several opportunities for improvement:

I. **MSPV-NG program utilization.** Because the prime vendor was unable to fill formulary orders consistently, the healthcare system did not meet its MSPV-NG utilization goal in FY 2019. The healthcare system's MSPV-NG formulary utilization rate was about 78 percent on average in FY 2019, falling short of the 90 percent goal.

The review team found that the healthcare system did not always use or have awareness of some of the tools available to provide feedback on prime vendor performance. Although VHA apparently had sufficient information to subsequently terminate the contract with the prime vendor, American Medical Depot, these tools are important for the facility to use going forward to ensure VHA has the information to take corrective action as needed.[4]

Because supplies were not always available from the prime vendor, they were sometimes purchased from other vendors. As a result, the healthcare system was unable to fully

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[4] The American Medical Depot MSPV-NG contract was terminated in August 2020 due to performance issues.

achieve the cost savings associated with the MSPV-NG contract.[5] The review team found that in FY 2019, the healthcare system spent approximately $41,000 more for 324 supply items on the open market because the prime vendor was unable to meet the healthcare system's demand when needed.

II.   **Purchase card use.** The review team determined that strategic sourcing (establishing contracts) could have been appropriate but was not pursued for 28 of the 53 sampled FY 2019 transactions (53 percent), totaling $146,000. Instead of establishing contracts for commonly used goods, staff made purchases on purchase cards. This occurred in part because cardholders and approving officials did not always ensure that cardholders documented a request for contracting staff to consider contracts for commonly ordered goods and services.

In addition, all 53 transactions sampled were missing some supporting documentation to verify that purchase card transactions were properly approved and payments were accurate. Due to inadequate supporting documentation, the healthcare system had $287,000 of questioned costs for these transactions.[6]

Finally, FY 2019 quarterly internal audits for the purchase card program were not completed within the required timeframe. These audits could have prevented split purchases.[7] During the same period, the team identified 25 transactions as potential split purchases, which resulted in approximately $135,000 of potentially unauthorized commitments.[8]

III. **Administrative staffing levels and accuracy of labor costs.** Healthcare system policy requires service chiefs and supervisors to ensure their staffing resources are organized in the most efficient and economical manner.[9] However, the policy does not detail the optimum efficiency goals or how labor efficiency is assessed and measured. The healthcare system had 60 more full-time equivalent (FTE) administrative staff than expected in FY 2019, according to an administrative staffing model developed by the

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[5] Items purchased on the open market sometimes cost less than using the prime vendor, but overall, the healthcare system spent more buying on the open market rather than through the prime vendor.

[6] Per 2 C.F.R. § 200.84, the term "questioned cost" means a cost that is questioned by the auditor because of an audit finding where the costs, at the time of the audit, are not supported by adequate documentation.

[7] VA Financial Policy, vol. XVI, chap. 1B, "Government Purchase Card for Micro-Purchases," February 2019. Purchases that exceed the cardholder's micropurchase 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.

[8] An unauthorized commitment is a purchase made by a government representative who lacks the authority to bind the government or who exceeds his or her delegated authority, or purchases made that are not in accordance with the Federal Acquisition Regulation and the VA Acquisition Regulation.

[9] Healthcare System Policy Memorandum, No. 05-07-18, "Resource Management Board," July 24, 2018.

Office of Productivity, Efficiency & Staffing in VHA.[10] According to healthcare system leaders, this was due to increased community care needs. The difference between the actual and expected number of administrative FTEs signifies the potential opportunity to improve efficiency and should be used as a starting point for deeper examination. More scrutiny is warranted given the high cost of salaries—in this case, about $4.7 million for the 60 administrative FTEs based on the average salary for administrative staff in FY 2019.

Additionally, the healthcare system did not ensure administrative labor costs were recorded accurately. The team determined that some employees' time was charged to incorrect cost centers, and two employees who conducted clinical work were incorrectly classified as administrative employees. This occurred because the healthcare system did not reliably review salary cost data and labor mapping, as required by VA policy, to ensure labor costs were recorded accurately.

The healthcare system's resource management board had identified efficiency and workload as issues of concern in an October 2019 meeting. It determined that the healthcare system could not sustain the number of overall staff on board based on workload and needed to reduce it in FY 2020. The healthcare system began reviewing all administrative positions; however, the review had not been completed due to other priorities during the COVID-19 pandemic. Although the review had not been completed, a separate review resulted in the reduction of 31 administrative positions between August 2020 and March 2021. The OIG findings appear to support the board's concerns.

IV.   **Pharmacy operations and cost avoidance efforts**. The healthcare system improved pharmacy efficiency by narrowing the gap between the facility's actual drug costs and expected drug costs from FY 2017 to FY 2019. Specifically, the healthcare system went from almost $4 million over the expected drug costs to approximately $1.2 million under the expected drug costs.

However, the healthcare system's turnover rate for pharmacy inventory could be improved. The turnover rate is a measure of the number of times inventory is used during the year. In FY 2019, the healthcare system reported an inventory turn of 7.3 compared to the recommended level of 12. This can be partly attributed to the lack of accurate pharmacy inventory reorder points in the facility's demand forecasting methodology. Facility managers stated that several different methodologies have been used to try and correct demand forecasting levels, and a new methodology that appeared to be working was implemented in September 2019.

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[10] The FTE units represent equivalent employees working. One FTE is equivalent to one employee working full time. The number of administrative FTEs is from the OPES administrative staffing model, which includes administrative and clerical personnel, as well as administrative-mapped FTEs.

Furthermore, the healthcare system did not adhere to VA policy to avoid year-end purchases, having made $4 million in pharmaceutical purchases just five days before the close of the fiscal year.[11] The healthcare system had available funding in FY 2019 and was concerned about funding shortfalls at the beginning of FY 2020. However, end-of-year purchases can make pharmaceutical inventories increasingly difficult to manage and need to be avoided when possible. These purchases can reduce the inventory turnover rate, increase the cost to store pharmacy inventory, and potentially lead to overstocking and spoilage.

What the OIG Recommended

The OIG made 12 recommendations for improvement to the healthcare system director. The number of recommendations should not be used, however, as a gauge for the system's overall financial health. The intent is for system leaders to use these recommendations as a road map to improve financial operations. The recommendations address issues that, if left unattended, may eventually interfere with effective financial efficiency practices and stewardship of VA resources.

The OIG recommended the healthcare system director address stock issues with any assigned prime vendor and ensure logistics staff use tools provided by the Medical Supplies Program Office to report prime vendor performance issues.

To strengthen oversight of purchase card transactions, the OIG recommended the healthcare system director

- ensure approving officials and purchase cardholders review their purchases,

- ratify any unauthorized commitments,

- determine when it is in the best interest of the government to use strategic sourcing for goods or services,

- complete quarterly audits so cardholders and approving officials are held accountable for purchases, and

- ensure cardholders maintain an updated Governmentwide Purchase Card Certification Form (VA Form 0242) and comply with record retention requirements as stated in VA financial policy.

For administrative FTEs, the healthcare system director should provide guidance on implementing the healthcare system policy "Resource Management Board," including

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[11] VHA Directive 1108.08(1), "VHA Formulary Management Process," November 2, 2016, amended August 29, 2019.

measurable objectives or clear criteria to determine if a service line is efficient in managing administrative staffing. In addition, the healthcare system director should ensure budget or accounting staff review the labor cost data each pay period and promptly address cost center corrections with human resources staff as needed, and service chiefs and supervisors review labor mapping for accuracy and completeness.

The OIG made two recommendations regarding pharmacy operations. The healthcare system director should continue to develop and implement a plan to increase inventory turnover closer to the recommended level and ensure compliance with VA policy to avoid end-of-year pharmaceutical purchases.

Management Comments

The director of the Miami VA Healthcare System concurred with all 12 recommendations and provided corrective action plans that are responsive to the recommendations. The director requested closure of recommendations 9 and 11.

The OIG considers all recommendations still open. The OIG will close recommendation 9 after receiving evidence that the salary cost data audits are occurring on an ongoing basis. The OIG will close recommendation 11 after receiving a formalized policy or standard operating procedure for managing inventories that aligns with VHA policy used to manage all VA medical facility pharmacy inventories. The OIG will monitor the implementation of all planned actions and will close the recommendations when the Miami VA Healthcare System provides sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified. Appendix E includes the full text of the director's comments.

LARRY M. REINKEMEYER
Assistant Inspector General
for Audits and Evaluations

Contents

Abbreviations

FTE	full-time equivalent
FY	fiscal year
GAO	Government Accountability Office
MSPV-NG	Medical/Surgical Prime Vendor-Next Generation
OIG	Office of Inspector General
OPES	VHA Office of Productivity, Efficiency & Staffing
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducts financial efficiency reviews to assess the oversight and stewardship of funds used by VA healthcare systems and to identify opportunities to achieve cost efficiencies. OIG review teams identify and examine areas that draw on considerable VA financial resources and can be compared to similar healthcare systems in size and complexity across VA to promote best practices.[12]

This review focused on the Miami VA Healthcare System (the healthcare system). The OIG team assessed the following financial activities and administrative processes during fiscal year (FY) 2019 to determine whether appropriate oversight and controls were in place for these four areas:

I. **Medical Surgical Prime Vendor-Next Generation (MSPV-NG) program utilization.** The MSPV-NG program provides a collection of contracts with selected prime vendors that enables VA to streamline supply chain management for an array of medical, surgical, dental, and select prosthetic and laboratory supplies. VA medical facilities are required to use MSPV-NG for products that are available through the program, which appear on a list called a formulary. The VA Medical Supplies Program Office recommends that each medical center purchase at least 90 percent of medical supplies on the formulary from the program's assigned prime vendor. The program achieves long-term savings by using a just-in-time logistics approach.[13]

II. **Purchase card usage.** The team examined whether the healthcare system's purchase card program ensured compliance with policies and procedures that reduce the risk of error, fraud, waste, and abuse. The review focused on the use of contracts for commonly purchased products to garner greater savings for VA, which is a process that VA terms "strategic sourcing."

III. **Administrative staffing levels and accuracy of labor costs.** Having a large number of administrative staff in health care is often associated with cost inefficiency.[14] The team identified opportunities to potentially improve administrative full-time equivalent (FTE) efficiency and evaluated whether the healthcare system recorded administrative labor costs accurately.

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[12] The Veterans Health Administration 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. Miami is rated as a 1a–High Complexity facility.

[13] The just-in-time method is an inventory strategy in which materials are only ordered and received as they are needed.

[14] VHA Office of Productivity, Efficiency & Staffing, Administrative Staffing Model, accessed March 24, 2021, http://opes.vssc.med.va.gov/Pages/Administrative-Staffing-Model.aspx. (The website is not accessible by the public.)

IV. **Pharmacy operations and cost avoidance efforts.** The review team assessed whether the healthcare system complied with policies and used cost and performance data to track progress toward cost savings goals, improve pharmacy program operations, and identify and correct problems.

Miami VA Healthcare System

The Miami VA Healthcare System serves veterans in three South Florida counties—Miami-Dade, Broward, and Monroe. In FY 2020, the healthcare system had a medical care budget of approximately $746 million with over 3,000 FTEs and provided services to almost 54,000 veterans.[15] The parent facility that opened in 1968 is the Bruce W. Carter Department of Veterans Affairs Medical Center, which is located on 26.3 acres in downtown Miami. For FY 2020, the healthcare system operated 339 hospital beds, including a four-story community living center attached to the main facility. The healthcare system is also responsible for two major satellite outpatient clinics in Broward County and Key West, and five community-based outpatient clinics in Homestead, Key Largo, Pembroke Pines, Hollywood, and Deerfield Beach.

Efficiency Opportunity Grid

The VHA Office of Productivity, Efficiency & Staffing (OPES) developed the efficiency opportunity grid to give facility leaders insight into areas of opportunity to improve efficiency and optimize resource distribution. The grid highlights areas with significantly high volume and/or cost of expenditures, provides a focus on data quality and validation, and spots areas of success when compared with other VHA facilities. The grid is a collection of 12 statistical models that allows comparisons between VHA facilities and accounts for variations in patient and facility characteristics and geography. OPES adjusts the data in this model for geographic, facility, and patient characteristics to provide more of an "apples to apples" comparison among different VA facilities. It does, however, have a limitation in that OPES is "merely an end-user of data; any data is drawn from the certified financial and workload reports." The data are presented as one way for "facilities to understand where opportunities exist for efficiency improvement" and "when supplemented with local strategies, can optimize resource deployment."[16]

The review team used models from the grid to assess administrative FTE activity and pharmacy drug costs during the review period. These models identify possible inefficiencies by showing the difference between a facility's actual and expected costs. This measurement can also be

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

[16] "Efficiency Opportunity Grid (EOG) Model, Data Definitions," VHA Support Service Center, accessed March 25, 2021. (The website is not accessible by the public.)

expressed as an "observed to expected" ratio so that VA facilities can be ranked on efficiency. Results from prior years can be compared to identify favorable or unfavorable trends.

Results and Recommendations

I. Medical Surgical Prime Vendor-Next Generation Program Utilization

As mentioned previously, VA medical facilities are required to use MSPV-NG for products that are available through the program that appear on a formulary list. The VA Medical Supplies Program Office recommends that each medical center purchase at least 90 percent of medical supplies on the formulary from its region's assigned prime vendor.[17] The Miami healthcare system spent about $6.7 million during FY 2019 on MSPV-NG purchases with the system's prime vendor, American Medical Depot.

The review team focused on two areas of MSPV-NG program use:

- **Formulary utilization rate** is the primary measure for reviewing a facility's MSPV-NG performance.

- **Contract performance monitoring** includes a facility's oversight of the prime vendor, as well as the use of reporting tools that allow the facility to provide information on prime vendor performance and MSPV-NG program feedback. One element of prime vendor performance is the order fulfillment rate, a contractual requirement to fulfill within the specified period at least 95 percent of orders placed by a facility for items on the formulary.

Finding 1: The Miami VA Healthcare System Was Unable to Meet the MSPV-NG Utilization Goal and Did Not Always Use Available Tools to Report Prime Vendor Performance

The healthcare system did not meet the 90 percent formulary utilization goal for purchases made through the MSPV-NG contract in FY 2019. Its formulary utilization rate was about 78 percent on average, according to the MSPV-NG performance metrics dashboard. Generally, this occurred because American Medical Depot did not always have adequate stock on hand to provide supplies when ordered. Although there had been other reports of the vendor's underperformance, as discussed later in this section, the healthcare system did not use Medical Supplies Program Office tools to consistently report the problems with the prime vendor's fulfillment of requested items.[18] The unavailability of supplies from the prime vendor resulted in the need to purchase the unfulfilled supplies from other vendors. The OIG found that the healthcare system spent approximately $41,000 more overall for 324 supply items purchased in

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[17] The Medical Supplies Program Office is a VHA entity in the Procurement and Logistics Supply Chain Program Office that is primarily responsible for supporting VHA's healthcare requirements and overseeing strategic sourcing efforts for supplies ordered through the MSPV-NG program.

[18] The Medical Supplies Program Office was formerly known as the Healthcare Commodities Program Office.

FY 2019 on the open market because the prime vendor was unable to meet the healthcare system's demand for certain supply items.

Formulary Utilization Rate

The utilization rate is not affected if the items ordered were not included on the formulary list, but may result in low utilization of the prime vendor contract.[19] The review team focused only on the utilization rate associated with items actually on the formulary. The team obtained and analyzed MSPV-NG formulary utilization data from the Supply Chain Common Operating Picture for FY 2019 and found the healthcare system was unable to meet the recommended goal of purchasing at least 90 percent of its medical supplies from the formulary list in any month.[20] The review team also interviewed healthcare system leaders, as well as managers and staff from logistics and contracting, and confirmed this was largely due to vendor underperformance.

The healthcare system's utilization rate averaged 78 percent, with a range of 72 to 84 percent. Figure 1 shows the FY 2019 monthly MSPV-NG formulary utilization rates.
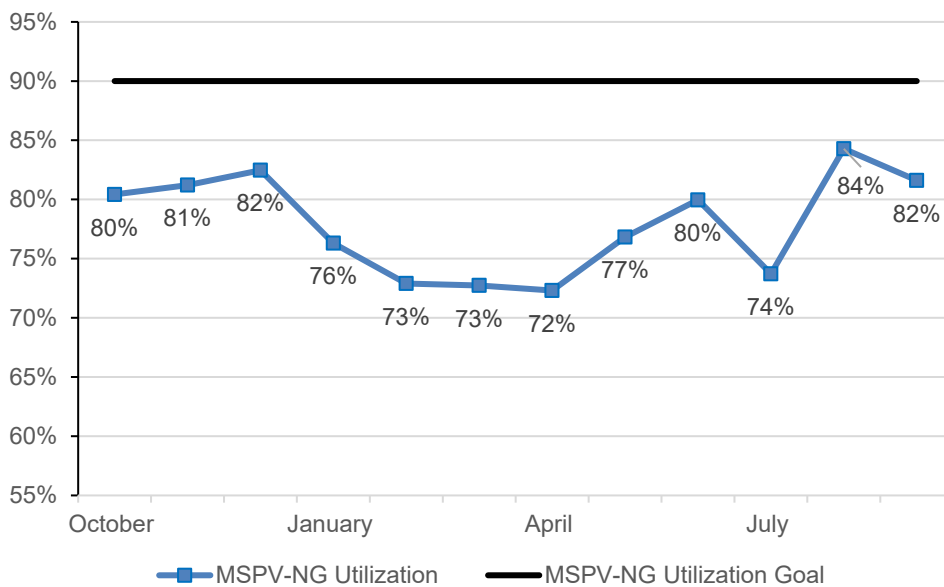
Figure 1. The healthcare system's monthly formulary utilization for FY 2019.
Source: VA OIG analysis of the Supply Chain Common Operating Picture Med/Surg Prime Vendor [MSPV] Formulary Utilization Report.

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[19] GAO, *Veterans Affairs Contracting: Improvements in Buying Medical and Surgical Supplies Could Yield Cost Savings and Efficiency*, GAO-18-34, November 2017. The report concluded that the initial formulary did not meet medical centers' needs, resulting in low utilization of MSPV-NG at some of the sampled medical centers.

[20] The Supply Chain Common Operating Picture is an interactive dashboard that enables supply chain leaders to observe supply chain metrics at the enterprise, Veterans Integrated Service Network, and facility levels. Users can access the Supply Chain Common Operating Picture data through the Supply Chain Data and Informatics Office interface, which contains tools suited for daily monitoring of metrics.

The healthcare system spent over $1.9 million of $8.6 million (22 percent of the total potential MSPV-NG spend) on the open market instead of purchasing from American Medical Depot as the prime vendor for items including medical, surgical, dental, laboratory, and prosthetic supplies. The review team analyzed an FY 2019 MSPV-NG formulary utilization report from the Supply Chain Common Operating Picture to assess the potential difference in prices paid for MSPV-NG items not purchased from the prime vendor that it was required to supply.

The team found that in FY 2019 the healthcare system purchased 324 supply items listed on the formulary from other vendors because the prime vendor was unable to fill the healthcare system's purchase requests. Based on the review team's analysis, the healthcare system spent about $110,000 more for 135 of the items but saved approximately $69,000 on 184 items and paid the same price for five items. Overall, the healthcare system spent approximately $41,000 more because it made purchases on the open market rather than through the prime vendor.

The chief supply chain officer attributed the low utilization rate to American Medical Depot not having contractually required stock in its warehouse to provide supplies when ordered, leading to canceled orders. American Medical Depot's contractual requirements included maintaining the necessary inventory levels to provide the required products to participating facilities and distributing an extensive list of authorized medical and surgical supplies on the formulary at an unadjusted fill rate of 95 percent. The unadjusted fill rate is the calculation of orders filled against orders requested (that is, any medical/surgical supply item not completely filled at the time of request for any reason counts against this measure). Figure 2 shows American Medical Depot's self-reported fill rates for FY 2019.
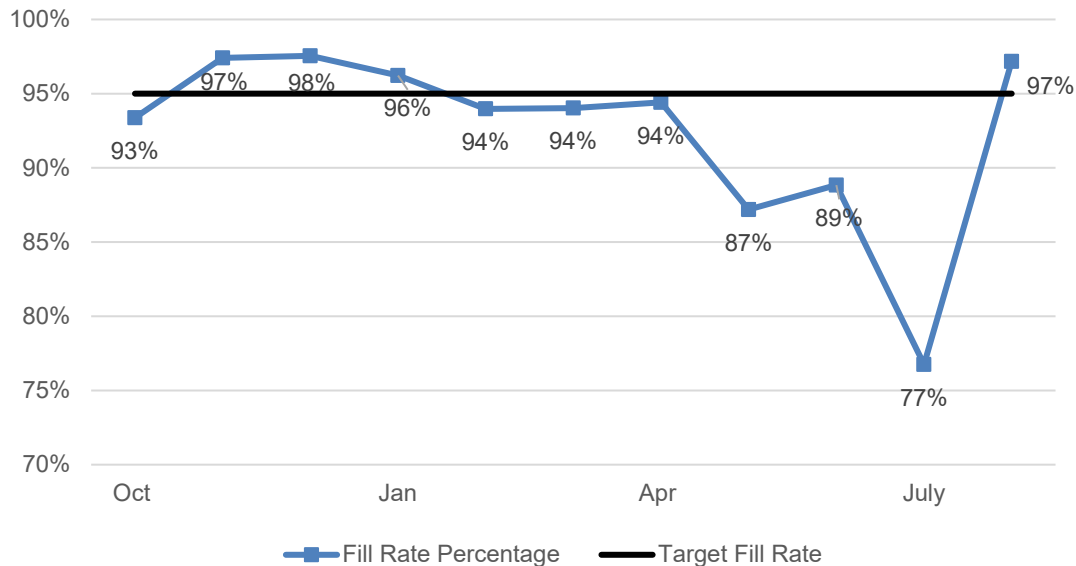
Figure 2. *American Medical Depot fill rates, October 2018–August 2019.*
Source: American Medical Depot MSPV-NG Customer Performance Dashboard obtained from the healthcare system.

However, neither the chief supply chain officer nor the assistant supply chain officer thought the self-reported fill rates were accurate or reliable. According to the chief supply chain officer, American Medical Depot's self-reported fill rates did not include orders that were canceled by the prime vendor prior to the healthcare system receiving an order confirmation. For example, the healthcare system places an order for 10 boxes of gloves. It sends the order to the prime vendor for confirmation, but the prime vendor sends an order confirmation for six boxes of gloves and cancels four boxes. The four canceled boxes would not figure into the prime vendor's fill rate. If the prime vendor then sends five of the six boxes from the confirmed order, its reported fill rate would be 83 percent when in fact it was actually 50 percent (five out of 10). A previous OIG report found that American Medical Depot incorrectly calculated unadjusted fill rates by using a methodology not prescribed by the MSPV-NG contract and by identifying core items—medical or surgical products requested at least once per month—inconsistently.[21]

During interviews, logistics management and staff expressed concern with American Medical Depot's ability to provide needed supplies. These concerns were also reflected in contemporaneous documents. For example, in an evaluation for the fourth quarter of FY 2019, the contracting officer's representative stated, "[The] Prime vendor fill rate drop [*sic*] tremendously during this quarter. They have made improvements; however[,] they are still not meeting their obligated accuracy rate."

Contract Performance Monitoring

If prime vendors do not meet their obligations, it is important that facility personnel alert program leaders and other VHA staff. One tool for doing so is the monthly facility execution survey, which informs the Medical Supplies Program Office of the facility's satisfaction with the MSPV-NG program, its prime vendors, and the formulary. Survey submissions are restricted to the first five days of each month and should be completed by the facility chief supply chain officer. The review team determined Miami logistics staff completed one monthly facility execution survey during FY 2019. The chief supply chain officer and the contracting officer's representative were both unaware of this tool.[22]

Another method for reporting concerns with the prime vendor's performance is the issue management tool, which is intended to help facilitate issue resolution and improve communication between contracting officer's representatives, supply chain staff, and the prime vendor. Throughout VHA, 1,026 matters were reported in the issue management tool in FY 2019. Of the 1,026 issues, 810 (79 percent) were complaints about American Medical Depot,

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[21] VA OIG, *Inadequate Oversight of the Medical/Surgical Prime Vendor Program's Order Fulfillment and Performance Reporting for Eastern Area Medical Centers*, Report No. 17-03718-240, December 17, 2019.

[22] The contracting officer's representative interviewed was not in that position during FY 2019. The logistics staff who completed the one monthly facility execution survey during FY 2019 had retired.

which was one of four prime vendors used by VHA.[23] Of the 810 identified American Medical Depot issues, 610 were related to order and delivery (75 percent), including orders that were incorrectly billed and facilities not receiving ordered items. The review team identified six issues reported in the tool by the Miami healthcare system. Three were for delivery issues, two were for order issues, and one was described as "other."

Because the healthcare system did not effectively use the available tools to report issues with the prime vendor, the facility could not be assured that VHA had all information needed to evaluate the effectiveness of the prime vendor and the MSPV-NG program or to help ensure American Medical Depot was held accountable at the earliest opportunity for meeting contractual obligations.

Finding 1 Conclusion

Because of American Medical Depot's inability to consistently fill formulary orders, the healthcare system was hindered in meeting its MSPV-NG utilization goal in FY 2019. Healthcare system personnel did not appear to fully utilize, or even have awareness of, some of the available reporting tools to provide feedback on the prime vendor's poor performance. Although VHA apparently had sufficient information to subsequently terminate the contract with American Medical Depot, these tools are important for the facility to use going forward to ensure VHA has the information needed to take corrective action as appropriate. As a result of these problems, medical supplies were sometimes purchased from other vendors and the healthcare system did not achieve the full cost savings associated with purchasing medical supplies through the MSPV-NG contract.

Recommendations 1–2

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

1. Develop a plan to work with the assigned prime vendor to address having adequate stock from the facility's formulary list in its warehouse to provide supplies when ordered.

2. Ensure logistics staff use the tools available to inform the Medical Supplies Program Office of prime vendor performance issues.

Management Comments

The director of the Miami VA Healthcare System concurred with recommendations 1 and 2. The responses to all report recommendations are provided in full in appendix E.

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[23] The American Medical Depot MSPV-NG contract was terminated in August 2020 due to performance issues.

To address recommendation 1, the Miami VA Healthcare System director reported the facility is championing efforts with the supply chain management service chief to develop a plan for the contracting officer's representative to work with the prime vendor to complete the monthly Prime Vendor Performance Report to help identify trends with stock issues. The contracting officer's representative will also collaborate with the supervisory inventory management specialists to monitor stock levels to assure adequate supplies are available from the prime vendor when ordered. For recommendation 2, the director reported that the facility is ensuring supply chain staff have been trained and are using available tools. Staff also meet weekly with the prime vendor to discuss fill rates, issues, and concerns.

OIG Response

The Miami VA Healthcare System director's action plan is responsive to the recommendations. The OIG will monitor implementation of the planned actions and will close the recommendations when the OIG receives sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified.

II. Purchase Card Use

The VA Government Purchase Card program was established to reduce administrative costs related to the acquisition of goods and services. When used properly, purchase cards can help facilities simplify acquisition procedures and provide an efficient vehicle for obtaining goods and services directly from vendors. In FY 2019, the Miami healthcare system spent approximately $48 million through purchase cards, representing about 48,000 transactions. The amount and volume of spending through the VA Government Purchase Card program makes it important to have strong controls over purchase card use to safeguard government resources and ensure compliance with policies and procedures that reduce the risk of error, fraud, waste, and abuse.

The OIG team reviewed the following areas:

- **Purchase card transactions.** The review team examined whether the healthcare system ensured employees obtained proper contracts when procuring goods and services on a regular basis, which VA refers to as "strategic sourcing." This enables VA to leverage its purchasing power and reduce the risk of split purchases and duplicate payments on purchase cards.[24]

- **Supporting documentation** is required for purchases to provide assurance of payment accuracy and the need to purchase a good or service. This includes approved purchase requests, purchase orders, receiving reports, and vendor invoices. Supporting documentation enables program oversight and helps prevent fraud, waste, and abuse.

Finding 2: The Healthcare System Did Not Always Pursue Strategic Sourcing and Maintain Supporting Documentation

The review team evaluated a judgmental sample of 53 purchase card transactions from FY 2019 to determine whether the healthcare system's purchase card program personnel considered contracting in lieu of using purchase cards and properly documented transactions.[25] (See appendix B for more on scope and methodology and appendix C for details on the review's sampling.) The team determined that contracts could have been considered in 28 of the 53 transactions (53 percent), totaling almost $146,000. In addition, all 53 transactions sampled were missing some required supporting documentation needed to verify accuracy and approval for the purchase card transactions. The team also identified 25 transactions as potential split purchases that resulted in approximately $135,000 of potentially unauthorized commitments.

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[24] VA Financial Policy, vol. XVI, chap. 1B, "Government Purchase Card for Micro-Purchases," February 27, 2019. According to this policy, purchases that exceed the cardholder's micropurchase 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.

[25] A judgmental sample is a nonstatistical sample that is selected based on auditors' opinion, experience, and knowledge.

These issues occurred in part because approving officials did not comply with policy that requires a review to ensure that cardholders document communication with the contracting office. This documentation would show that staff considered whether contracts were warranted when purchasing commonly ordered goods and services.[26] Additionally, a purchase card program coordinator did not submit quarterly internal audits to the medical center director and approving officials within the required timeframe.[27] Quarterly audits of the purchase card program, as well as more effective reviews by approving officials, could have detected and mitigated the lack of strategic sourcing and documentation issues identified, which resulted in just over $287,000 in questioned costs.[28]

Purchase Card Transactions

Pursuant to VA financial policy, VA should enhance its purchasing authority by utilizing strategic sourcing. Properly using contracts generally results in greater savings to VA than open market acquisitions through the use of purchase cards without a negotiated price.[29] Cardholders are instructed to reduce individual purchases made with the purchase cards and leverage VA's purchasing power. Approving officials, the agency/organization program coordinator, and cardholders must review purchases to determine when it is in the best interest of the government to use strategic sourcing to consider contracts and ensure purchasers are obtaining the most competitive prices. Generally, VA should use contracts if the purchase is for ongoing repetitive orders of goods or services and the total value of the requirement exceeds the micropurchase threshold of the purchase card. Cardholders must not modify a requirement or order into smaller parts to avoid exceeding the purchase card threshold, which requires using more formal contracting procedures. The requirement for the goods or services should be communicated to the contracting office for procurement.[30]

The review team also interviewed the purchase cardholders to determine if the purchase requirements were split into two or more purchases to circumvent the micropurchase threshold. The team identified 25 potential split purchase transactions totaling approximately $135,000. Any split purchases represent unauthorized commitments.[31] The following example represents a confirmed split purchase.

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[26] VA Financial Policy, vol. XVI, chap 1B, "Government Purchase Card for Micro-Purchases," February 27, 2019.

[27] VHA Government Purchase Card Program, standard operating procedure, "Internal Audits-Purchase Cards and Convenience Checks," June 20, 2019.

[28] Per 2 C.F.R. § 200.84, the term "questioned cost" means a cost that is questioned by the auditor because of an audit finding where the costs, at the time of the audit, are not supported by adequate documentation.

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

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

[31] Unauthorized commitments occur when a purchase is made by a government representative who lacks the authority to bind the government or who exceeds his or her delegated authority, or purchases are made that are not in accordance with the Federal Acquisition Regulation and the VA Acquisition Regulation.

Example 1

> *An inventory management specialist requested replacement surgical equipment in preparation for an upcoming surgery totaling $10,900. The cardholder placed the orders with the vendor using two purchase orders, totaling $9,000 and $1,900. The single requirement, as evidenced in the request memorandum provided as supporting documentation for this transaction, was known to the cardholder at the time when the two purchases were made. Since the total need and cost were known at the time of purchase to exceed the cardholder's micropurchase threshold for goods of $10,000, these transactions make up a split purchase.*

The proper way to purchase commonly needed or high-cost goods, particularly those over the purchase card limit, would have been to send the service request to the contracting office for purchase. This requires planning to ensure there is sufficient time for a contract to be expanded or established, if none exists, to purchase the products in time for scheduled use. Any VA purchase cardholder who makes an unauthorized commitment, including a split purchase, exceeding his or her level of authority has made an improper payment and must submit a request for ratification to the chief of the contracting office that provides contracting support to the organization involved.[32]

Generally, the improper reliance on purchase cards and any related unauthorized commitments appeared to persist because approving officials did not adequately review those purchases to determine if alternative contracting options were warranted or available.

Moreover, quarterly internal purchase card audits that could identify such issues were not completed within the required time period by the purchase card coordinator. Quarterly purchase card audits are intended to evaluate and improve the effectiveness of internal controls and compliance with regulations and policies. VHA procedures require a formal memo of the audit results to be sent to the medical center director, with copies to the approving official and/or supervisor, no later than the end of the calendar month after the close of the quarter.[33] However, the review team found one memo that was issued over a year late. The agency/organization program coordinator acknowledged that the audits were not conducted in compliance with policy due to competing priorities and confusion about how the audits were to be conducted.[34] The coordinator recalled being instructed to conduct audits for multiple quarters at once, then to return to completing them quarterly.

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[32] VA Directive 7401.7, *Unauthorized Commitments and Ratification*, October 7, 2004. This directive defines ratification as the process whereby designated officials convert an unauthorized commitment to a legal contract.

[33] VHA Government Purchase Card Program, standard operating procedure, "Internal Audits-Purchase Cards and Convenience Checks," June 20, 2019.

[34] The agency/organization program coordinator is a position title explained in VA Financial Policy, vol. XVI, chap. 1A, "Administrative Actions for Government Purchase Cards," June 14, 2018.

This resulted in a missed opportunity by the healthcare system to evaluate the purchase card program and its compliance with regulations and policies, as well as to improve the effectiveness of internal controls.

Supporting Documentation

When the healthcare system buys goods and services using a purchase card, it must maintain supporting documentation, such as approved purchase requests, vendor invoices, purchase orders, and receiving reports, for six years. Charge card documents that must be retained include the Governmentwide Purchase Card Certification Form (VA Form 0242). 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. A revised form is required when there is a change in the approving officer, cardholders change their name legally, or the single purchase limit is increased above the originally requested amount.[35]

All 53 transactions sampled were missing some required supporting documentation to verify that purchase card transactions were properly approved and payments were accurate. The review team considered supporting documentation to include approved purchase requests, vendor invoices, receipts, purchase orders, and packing slips or receiving reports.

The healthcare system provided guidance to cardholders outlining the minimum supporting documentation requirements for purchase card transactions. However, purchase cardholders could not provide all the required supporting documentation for the sampled transactions, which resulted in $287,000 in questioned costs.

Additionally, the team determined that 15 of 23 cardholders responsible for the 53 transactions had an inaccurate VA Form 0242 with missing signatures from approving officials, incorrectly stated spending limits, or listed approvers who no longer worked for VA. The VA Form 0242 must be signed by an approving official and updated when there is a change in the approving official or an increase in the purchase limit. The VA Form 0242 is an important control that helps ensure compliance with purchase limits and responsibilities. The accuracy of the VA Form 0242 is essential for holding cardholders and approving officials accountable.

Finding 2 Conclusion

The healthcare system did not always use strategic sourcing. As a result, contracts for commonly used goods were not fully utilized and proper documentation was missing for purchase card transactions in FY 2019. These issues, which resulted in $287,000 of questioned costs, could have been detected by quarterly audits of the purchase card program and more effective reviews by approving officials.

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

Recommendations 3–7

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

3. Establish controls to confirm approving officials and purchase cardholders review their proposed purchases and make sure contracting is used when it is in the best interest of the government.

4. Require purchase cardholders to submit a request for ratification for any unauthorized commitments identified.

5. Develop checks on the successful completion of quarterly audits of the purchase card program as required by the Veterans Health Administration's standard operating procedure, "Internal Audits—Purchase Cards and Convenience Checks."

6. Ensure cardholders comply with record retention requirements as stated in VA's Financial Policy, vol. XVI, "Charge Card Program."

7. Develop measures to confirm completed VA Form 0242 submissions are accurate and updated for all cardholders.

Management Comments

The director of the Miami VA Healthcare System concurred with recommendations 3–7. To address recommendation 3, the Miami VA Healthcare System director reported that the Network Contracting Office Government Purchase Card Team will provide quarterly reports on strategic sourcing opportunities to the facility leadership team. Appropriate recommendations to consolidate requirements and submit to contracting in support of strategic sourcing will be discussed during the quarterly report overview. For recommendation 4, the director reported that the purchase card team will reeducate and reissue the unauthorized-commitment standard operating procedure, which outlines the ratification process to cardholders and approving officials yearly. Additionally, the purchase card team will identify and submit potential unauthorized commitments to Miami VA leaders for review during a monthly contracting meeting. To address recommendation 5, the director reported that the purchase card team will review the quarterly audits to ensure the purchase card coordinators complete purchase card audits timely. For recommendation 6, a SharePoint site has been created where electronic files are retained. The purchase card team will validate, on an ongoing basis, that records are being uploaded and retained as required. For recommendation 7, the purchase card team will conduct quarterly reviews on all VA Form 0242s and maintain verification documentation on the SharePoint site.

OIG Response

The Miami VA Healthcare System director's action plan is responsive to the recommendations. The OIG will monitor implementation of the planned actions and will close the recommendations when the OIG receives sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified.

III. Administrative Staffing Levels and Accuracy of Labor Costs

Large administrative overhead in health care is often associated with cost inefficiency.[36] Medical centers can help ensure funds are put to the best use by identifying potential indicators of inefficiencies, such as higher administrative staff levels than VHA facilities that are similar in size and complexity. Variances in numbers of personnel should be a starting point for deeper examination and are in themselves not determining factors. Administrative personnel such as medical support assistants, administrative officers, and human resource specialists help clinicians with administrative duties and support core functions such as hiring and training. Administrative personnel may also facilitate care in the community when those services cannot be adequately provided for veterans, particularly those living far from the facility. Accordingly, staffing efficiency numbers should be a starting point for leaders to determine if a problem exists and develop improvement strategies considering the effect on veterans' access to quality care. Oversight and controls on labor cost help ensure that accurate data are used for efficiency analysis and improvement.

The OIG team reviewed the following administrative staffing areas:

- **Administrative staffing efficiency** involves comparing the facility's administrative FTE levels with those at comparable facilities.

- **Facility resource management** includes how facilities oversee administrative staffing and address identified problems.

- **Labor cost and mapping reviews** determine whether staff hours and salaries were assigned the correct codes in VA's Financial Management System and Decision Support System based on the duties performed. These reviews help ensure that correct information is available for budget decisions and forecasting and allow facilities to compare data from one period to another.

Finding 3: The Healthcare System Had Higher Administrative Staff Levels Than Similar Facilities and Did Not Ensure All Administrative Labor Costs Were Recorded Correctly

The healthcare system's policy requires service chiefs and supervisors to ensure their staffing resources are organized in the most efficient and economical manner. However, the policy does not provide guidance on what optimum efficiency is or how it will be assessed and measured.[37]

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[36] VHA OPES, Administrative Staffing Model, accessed March 24, 2021, http://opes.vssc.med.va.gov/Pages/Administrative-Staffing-Model.aspx. (The website is not accessible by the public.)

[37] Healthcare System Policy Memorandum, No. 05-07-18, "Resource Management Board," July 24, 2018.

The healthcare system had 60 more administrative FTEs (8 percent) than the expected number of administrative FTEs in FY 2019, based on the OPES administrative staffing model.[38] The difference between the actual and expected number of administrative FTEs signifies a potential opportunity to improve efficiency and should be used as a starting point for deeper discussion.[39] The healthcare system leaders attributed the increased number of administrative staff to the facilitation of care in the community.

The healthcare system began reviewing all administrative positions in FY 2020 after its resource management board determined in an October 2019 meeting that the workload could not sustain the total number of FTEs. However, the review had not been completed due to other priorities during the COVID-19 pandemic. Although this review had not been completed, a separate review resulted in the reduction of 31 administrative positions between August 2020 and March 2021.

Additionally, the healthcare system did not ensure administrative labor costs were recorded accurately. The review team found that some employees' hours were erroneously charged to other cost centers, and two employees who conducted clinical work were incorrectly classified as administrative employees. This occurred because the healthcare system did not review salary cost data and labor mapping as required by VA policy.[40] Labor mapping is the assignment of labor costs to their functional work areas.

The accuracy of administrative labor cost data depends on personnel selecting the correct cost center, as well as accurately mapping the work to related service lines. If fiscal personnel do not review salary cost data and supervisors do not review labor mapping, the accuracy of labor cost information cannot be ensured. As a result, reported administrative staff numbers may be inaccurate for service lines. Additionally, productivity analyses may not be reliable if clinicians had time improperly mapped to an administrative area. For clinician productivity analyses, only the clinical portion of the hours worked is considered; hours associated with administration, research, and education are excluded. Furthermore, inaccurate labor cost information can affect budget development and forecasting and inhibit management's ability to appropriately staff the facility.

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[38] The FTE units represent equivalent employees working. One FTE is equivalent to one employee working full time. The number of administrative FTEs is from the OPES administrative staffing model, which includes administrative and clerical personnel as well as administrative-mapped FTEs.

[39] Additional scrutiny is warranted given the high cost of salaries, in this case about $4.7 million for the 60 administrative FTEs based on the average salary for administrative staff in FY 2019.

[40] VA Financial Policy, vol. XIII, chap. 3, "Managerial Cost Accounting," February 27, 2019.

Administrative Staffing Efficiency and Facility Resource Management

In 2018, a healthcare system memorandum stated that the system's facilities should use available human and financial resources in the most efficient and effective manner.[41] To accomplish this goal, a resource management board reviews all requests and justifications for staffing and budget changes, as well as workload data. The policy also lists several general requirements for service chiefs and supervisors, such as

- ensuring their staffing resources do not exceed what is required for the performance of their mission and that such resources are organized in the most efficient and economical manner,

- reviewing and documenting the design of their respective services and work units in an organizational and functional chart,

- analyzing expenditures and establishing projections based on the efficient use of available resources, and

- providing data-based assessments and detailed analyses of all issues to the resource management board when expenditures are expected to exceed budget allocations.

Additional guidance that provides objective measurements to evaluate labor efficiency is necessary so that the healthcare system can ensure staffing resources do not exceed what is required for the performance of the mission and resources are organized in the most efficient and economical manner.
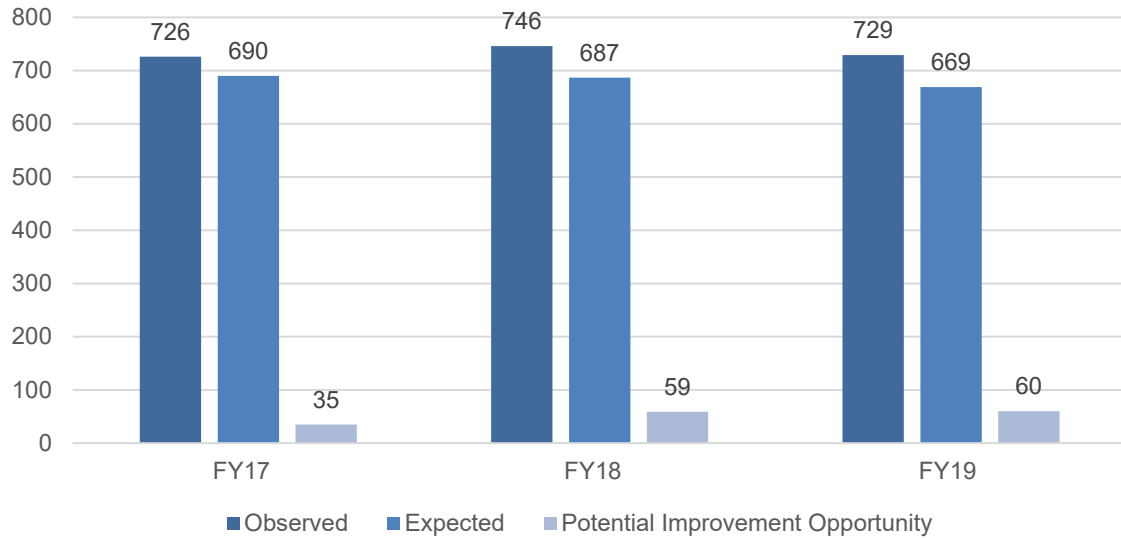
Using the OPES administrative staffing model, the review team compared the healthcare system's actual administrative staffing to the expected staffing, as well as individual service lines' administrative FTEs to those of similar VA facilities.[42] According to the administrative staffing model, the difference between the facility's actual administrative FTE level and expected administrative FTE level increased from FY 2017 to FY 2019. Specifically, the healthcare system went from 35 FTEs over the expected administrative FTE level in FY 2017 to 60 FTEs over the expected administrative FTE level in FY 2019. The difference between the actual and expected numbers of administrative FTEs represents the potential opportunity for

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[41] Healthcare System Policy Memorandum, No. 05-07-18.

[42] The staffing model compares a facility's actual number of administrative FTEs to an expected number and the number of administrative FTEs in a cost center to the average of the same cost center in similar facilities. The expected number of administrative FTEs is a predicted value for a facility after accounting for differences in facility, patient, and geographic characteristics. The difference between the actual and expected values equals potential improvement opportunities.

efficiency improvement.[43] Figure 3 shows the observed-to-expected administrative FTE levels for the healthcare system.

Figure 3. *Observed versus expected administrative FTEs at the healthcare system between FY 2017 and FY 2019.*
Source: OPES Efficiency Opportunity Grid Administrative Staffing Model.
Note: Numbers may not add up due to rounding.

In FY 2019, three cost centers—Care Coordination Management (8286), Chief of Staff (8409), and Human Resource Management (8431)—had the largest administrative staffing variances when compared to the medical center group averages of similar VA medical facilities.[44] These variances were 64, 45, and 20 more administrative FTEs, respectively. Figure 4 shows the variances for the cost centers.

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[43] "Efficiency Opportunity Grid Fact Sheet," OPES, accessed March 15, 2021, http://raft.vssc.med.va.gov/ SelfPacedDocuments/Efficiency%20Opportunity%20Grid%20Fact%20Sheet.pdf. (The website is not accessible by the public.)

[44] The medical center group consists of VA hospitals that are similar in size and complexity as determined by OPES. The Miami healthcare system was a 1a–High Complexity facility in FY 2019.

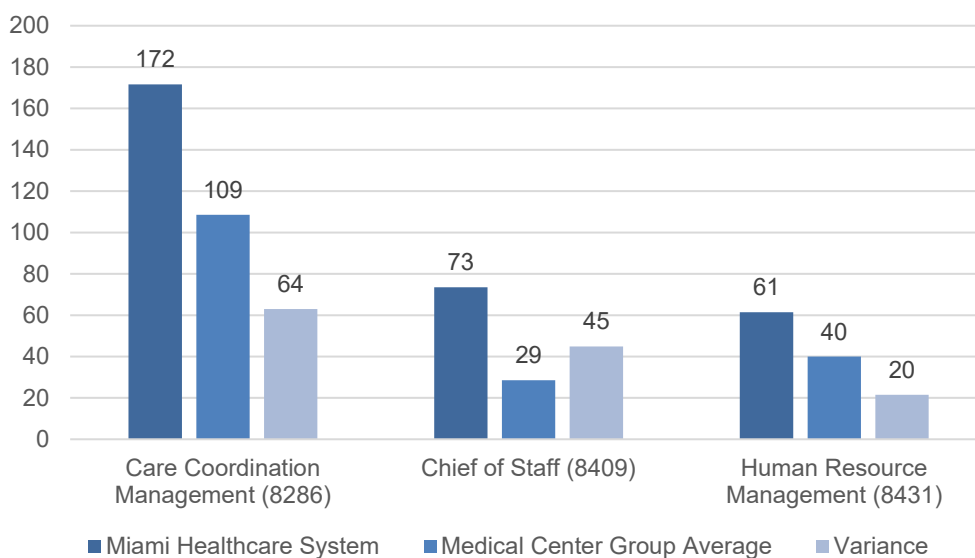***Figure 4.*** *Variances between the healthcare system and medical center group average for FY 2019. Source: OPES Efficiency Opportunity Grid Administrative Staffing Model. Note: Numbers may not add up due to rounding.*

The healthcare system staff attributed the increase of administrative FTEs to the VA MISSION Act of 2018, which expanded access to community care for veterans. In FY 2019, the healthcare system approved 18 positions to facilitate care in the community.

The review team interviewed service chiefs and supervisors regarding how they monitored administrative staffing efficiency. They used measures including service workload, ratio of administrative to clinical FTEs, and guidance about the ratio of administrative FTEs to the number of patients enrolled. Although the service lines did not identify staffing overages, variances of administrative FTE when compared to similar facilities should be used to prompt further evaluation of labor efficiency.

Salary Cost and Labor Mapping Reviews

VA financial policy requires two types of labor cost data reviews:

1. **Salary cost reviews.** VA financial policy requires that employees' hours and salaries be assigned to the correct cost center using an accurate budget object code.[45]

    - A **cost center** helps VA correctly identify and record costs. Cost centers identify the office and function as part of the accounting record for financial transactions. The accuracy of labor costs in VA's Financial Management System depends on human resources staff selecting the correct cost center.

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[45] VA Financial Policy, vol. XIII, chap. 2, July 2019, and chap. 3, February 2019. Budget object codes correspond to financial obligations according to the nature of the services or items purchased by the federal government.

- **Budget object codes** reflect the nature of financial transactions. Administrative employees should be assigned to budget object code 1001 or 1002, in accordance with VA financial policy. VA financial policy requires that fiscal personnel record financial obligations and expenditures in accordance with appropriate budget object codes.[46]

Budget or accounting staff at each facility are required to review the salary cost data each pay period and promptly address cost center corrections with human resources as needed.[47] This review ensures cost data are recorded accurately in VA's Financial Management System.

2. **Labor mapping reviews.** VA policy requires service chiefs and organizational leaders to review labor mapping periodically for accuracy and completeness.[48] To ensure that VA cost information is accurate, employees must have their hours and salary correctly mapped to the functional cost centers, known as "account level budgeter cost centers," where they perform their duties.

The review team assessed five cost centers to determine if the labor costs were applied to the correct cost center and whether labor mapping reviews were conducted:

- Care Coordination Management (8286)

- Chief of Staff (8409)

- Human Resources Management (8431)

- Telehealth (8250)

- Psychiatry (8203)

The five cost centers were selected based on the largest administrative staffing variance when compared with the medical center group average from VHA's OPES administrative staffing model.

Care Coordination Management (8286), Chief of Staff (8409), and Human Resources Management (8431) were the three cost centers in FY 2019 that had the largest administrative staffing variance compared with the medical center group average of similarly sized facilities at

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[46] VA Financial Policy, vol. XIII, chap. 2, "Budget object codes," July 23, 2019.

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

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

the 1a–High Complexity level.[49] Because two of three cost centers with the largest variances only had administrative budget object codes, the team included two additional cost centers that had both administrative and clinical budget object codes for review.

The review team evaluated labor mapping data from VHA's National Mapping Tool for all employees under the five cost centers for the last three pay periods in FY 2019. The team identified some discrepancies where employees under Human Resources Management were erroneously charged to other cost centers. Also, 36 administrative staff under Care Coordination Management were incorrectly assigned to another cost center. The healthcare system personnel did not correct these cost center errors until the OIG review team brought the issue to their attention. It is imperative the responsible healthcare system staff review salary cost data to identify and correct cost center errors in a timely manner.

During the review, the team identified one physician whose time was mapped to administrative work every pay period; however, there was no review to ensure the labor mapping was correct. VA financial policy requires individual physician labor mapping to be accurate and current within three working days after the close of the calendar month in order to determine productivity.[50] The review team also identified two administrative employees who mapped over 90 percent of their time to clinical work. These employees were health technicians but were incorrectly classified as administrative employees. Although a managerial cost accounting coordinator sends reminders every pay period requesting supervisors review and certify labor mapping, oversight was inadequate to make sure reviews were consistently conducted.

Finding 3 Conclusion

The healthcare system had higher administrative staffing than the medical center group average of similarly sized facilities, some of which can be attributed to the increased need for community care and some to incorrectly assigning personnel to cost centers. The labor costs for these personnel variances are in the millions of dollars, and therefore the issue warrants closer scrutiny to ensure the optimization of administrative positions. It is imperative, however, that labor efficiency is not at the expense of patient care.

The healthcare system's cost center assignment and labor mapping appeared adequate overall. However, some errors such as those detailed above could have been identified had more consistent reviews been conducted. Labor cost data affect budget formulation, forecasting, and

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[49] "Facility Complexity Model"; VHA Office of Productivity, Efficiency, and Staffing; accessed February 3, 2021; http://opes.vssc.med.va.gov/Pages/Facility-Complexity-Model.aspx. Facilities are categorized into one of five groups: 1a (most complex), 1b, 1c, 2, and 3 (least complex). The highest-complexity facilities, group 1a, have a high volume of patients, high-risk patients (based on severity of illnesses/diagnoses), the most complex clinical programs, and large research and teaching programs.

[50] VA Financial Policy, vol. XIII, chap. 3, "Managerial Cost Accounting," February 2019.

staffing decisions. Without measurable objectives and accurate labor cost data, the healthcare system's ability to improve its efficiency is limited.

Recommendations 8–10

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

8. Provide guidance on implementing the healthcare system policy "Resource Management Board," including measurable objectives or clear criteria to determine if a service line is efficiently managing administrative staffing.[51]

9. Establish controls to make certain that budget or accounting staff review the salary cost data each pay period and promptly address cost center corrections with human resources staff as needed.

10. Ensure service chiefs and supervisors review labor mapping for accuracy and completeness.

Management Comments

The director of the Miami VA Healthcare System concurred with recommendations 8–10 and requested closure of recommendation 9. To address recommendation 8, the Miami VA Healthcare System director reported that the Resource Management Board's charter will be redesigned to include measurable objectives/criteria to determine administrative staffing efficiency. For recommendation 9, the director reported that a team has been set up to establish controls through fiscal service salary cost data audits being performed each pay period. The director stated any corrections are addressed promptly. To address recommendation 10, the director reported that service leader training will be provided in the fourth quarter of FY 2021 to ensure labor mapping for accuracy and completeness.

OIG Response

The Miami VA Healthcare System director's action plan is responsive to the recommendations. While the director requested the closure of recommendation 9, the OIG considers the recommendation to be open. To close recommendation 9, the OIG needs to see evidence that the salary cost data audits are occurring on an ongoing basis. 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.

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[51] Healthcare System Policy Memorandum, No. 05-07-18.

IV. Pharmacy Operations and Cost Avoidance Efforts

In FY 2019, prescription drug spending at the Miami VA Healthcare System exceeded $62 million, which represented over 10 percent of the healthcare system's budget of approximately $598 million. Because pharmacy expenditures account for a substantial percentage of any medical center's budget, it is important for facility leaders to analyze spending and identify opportunities to use pharmacy dollars more efficiently. The review team used the pharmacy cost model in the OPES efficiency grid to identify opportunities for improvement in the healthcare system.

The team reviewed pharmacy data, cost avoidance plan progress, inventory rate changes, and end-of-year drug purchases:

- **OPES pharmacy expenditure data** help VHA facilities track cost performance and identify potential opportunities for improvement.

- **Cost avoidance initiatives** are VA medical center action plans to reduce the cost of pharmacy operations and increase efficiency. VA medical centers monitor progress on these initiatives and report their effect on pharmacy operations and efficiency.

- **Inventory turnover rate** is used as the primary measure to monitor the effectiveness of inventory management per VHA policy.[52] It reflects the number of times inventory is used during the year.[53] Low inventory turnover rates generally indicate inefficient use of financial resources.

- **End-of-year purchases of pharmacy drugs** can negatively affect the inventory turnover rate and the total replenishment cost of pharmacy inventories. These purchases complicate pharmaceutical inventory management and are to be avoided, according to VHA policies and Pharmacy Benefits Management program office guidance.[54]

Finding 4: The Healthcare System Improved Pharmacy Inefficiencies but Could Increase Inventory Turnover Rate and Avoid End-of-Year Purchases

The healthcare system significantly improved pharmacy efficiency by taking steps to reduce the difference between actual drug costs and expected drug costs from FY 2017 through FY 2019.

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[52] VHA Directive 1761(2), "Supply Chain Inventory Management," app. I, October 24, 2016, amended October 26, 2018.

[53] Inventory turnover rates are based on the total dollar value purchased for the year divided by the dollar value of items on the shelf.

[54] VHA Directive 1108.08(1), "VHA Formulary Management Process," November 2, 2016, amended August 29, 2019; VHA Directive 1761(2); Pharmacy Benefits Management, "Physical Inventory Training 2019," December 2019.

Specifically, the healthcare system went from almost $4 million over the expected drug cost to approximately $1.2 million under the expected drug cost. To further this success, the healthcare system's pharmacy inventory turnover rate could be improved.

In FY 2019, the healthcare system reported an inventory turnover rate of 7.3 compared to VHA's recommended level of 12. According to a pharmacy supervisor, this occurred because the facility's demand forecasting methodology for pharmacy inventories did not establish accurate reorder points. The supervisor also stated that several different methodologies have been used at the Miami facility to try and correct demand forecasting levels, and a new methodology was implemented in September 2019 that appeared to be working. Furthermore, contrary to VHA policy, the healthcare system did not avoid year-end purchases and made $4 million in pharmaceutical purchases just five days before the end the fiscal year. According to the chief financial officer, this occurred because the healthcare system had available funding in FY 2019 and was concerned about funding shortfalls at the beginning of FY 2020. While the healthcare system has greatly improved efficiencies associated with pharmacy operations, it could realize additional improvements by developing a plan to increase the inventory turnover rate and avoiding end-of-year purchases.

OPES Pharmacy Expenditure Data

The healthcare system improved pharmacy efficiency by narrowing the gap between actual drug costs and expected drug costs from FY 2017 through FY 2019, according to the OPES pharmacy expenditure model. As mentioned above, the healthcare system went from almost $4 million over the expected drug cost to approximately $1.2 million under the expected drug cost. This is attributed to pharmacy leaders holding weekly cost containment meetings that focused on gaining efficiencies in all aspects of pharmacy operations. Figure 5 shows the observed and expected drug costs for the healthcare system, and the gap between them.
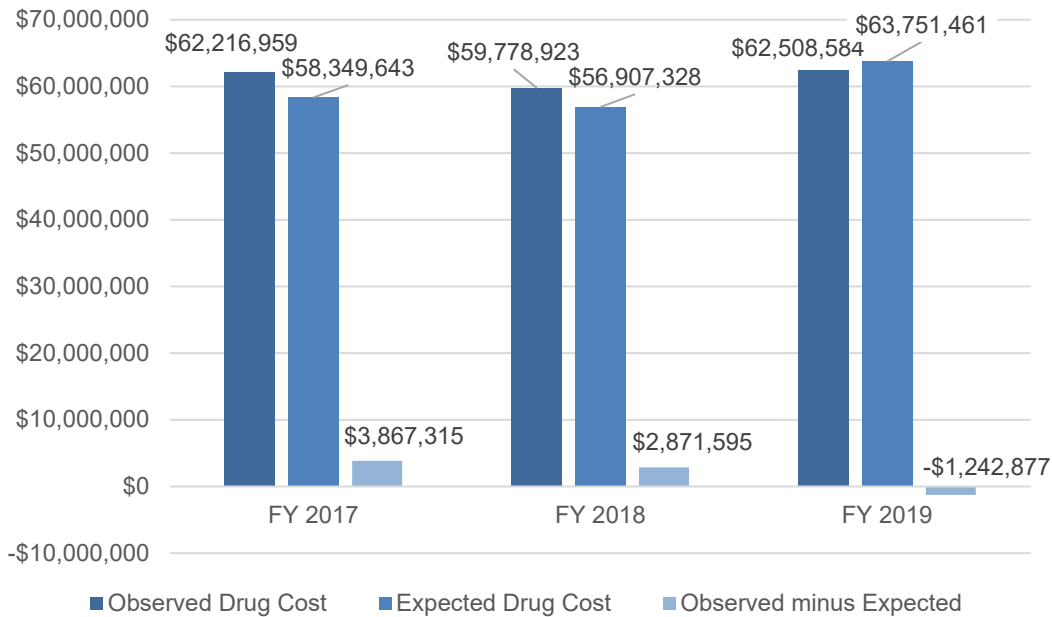
Figure 5. Observed versus Expected Drug Cost, FYs 2017–2019.
Source: OPES pharmacy expenditure model.

Cost Avoidance Initiatives

The review team also analyzed the cost avoidance goals for the healthcare system for FY 2019. According to the end-of-year cost savings report provided by Veterans Integrated Service Network (VISN) 8 leaders, the healthcare system exceeded its $1 million goal by 361 percent, avoiding nearly $4 million of costs.[55]

The healthcare system's pharmacy leaders and key staff attributed their results to the weekly cost containment and avoidance meetings mentioned above. The acting pharmacy chief led the meetings with support from the procurement supervisor and supervisors in the clinical, inpatient, and outpatient areas, as well as other pharmacy staff. In these meetings, topics such as inventory management, drug utilization data, and special initiative projects were discussed to try and meet National Pharmacy Benefits Management, VISN 8, and locally developed cost containment goals. The work group's actions were shared at monthly staff meetings where attendees discussed initiatives that had started or would be initiated. For example, after determining clinical appropriateness for each patient, the cost avoidance gained by converting a prescription from one brand of phosphate binder to another was almost $268,000.

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[55] National Pharmacy Benefits Management cost avoidance spreadsheet.

Inventory Turnover Rate

VHA policy states that monitoring inventory turnover is the primary measure of the effectiveness of inventory management.[56] Increasing the turnover rate decreases inventory carrying cost associated with holding items in storage. VHA policy also mandates the use of prime vendor inventory management reports to administer all VA medical facility pharmacy inventories.[57]

As previously mentioned, in FY 2019, the healthcare system reported an inventory turnover rate of 7.3 compared to the VHA average of 10 and VHA's recommended level of 12 as established by the National Pharmacy Benefits Management program office. Low inventory turnover could indicate the inefficient use of financial resources and the inability to properly forecast needed inventories of pharmacy drugs to meet patient care needs. Additionally, VISN 8 pharmacy leaders confirmed that low inventory turnover could indicate overbuying, high volumes of expired drugs, and other inventory management issues.

The turnover rates were adversely affected by deficits in the demand forecasting methodology. Demand forecasting uses weighted factors applied to past purchases to help calculate the reorder points and quantities for more accurate inventory management. Previously, inventory reorder points were set by using prime vendor reports, according to the pharmacy procurement supervisor. However, these reports did not include purchases from other sources and did not account for how drugs were dispensed to patients.

At the time of the OIG's review in May 2020, the facility was creating separate reports showing all drug purchases and drug-dispensing data. This information was then analyzed and compared to the prime vendor inventory reports as an additional resource for demand forecasting, according to the pharmacy procurement supervisor. The pharmacy procurement supervisor responsible for drug procurements stated that the healthcare system has tried several different methodologies to correct deficiencies in demand forecasting of drug inventories. A manual approach implemented in September 2019, using dispensing data, is very time intensive but seems to work best for establishing reorder points, according to the pharmacy procurement supervisor. He also stated that he cannot quantify results for spoilage or out-of-stock items yet but can safely assume there are improvements for both by having the right reorder point. However, as of January 2021, the facility had not yet finalized a policy or procedure for completing demand forecasting using the approach implemented in September 2019.

End-of-Year Purchases of Pharmacy Drugs

VHA policy and guidance from the Pharmacy Benefits Management program office state that "[e]nd-of-year purchases make pharmaceutical inventories increasingly difficult to manage and

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[56] VHA Directive 1761(2).

[57] VHA Directive 1761(2).

need to be avoided."[58] Furthermore, Pharmacy Benefits Management program office guidance, along with interviews with senior VISN 8 pharmacy staff, confirmed that end-of-year purchases can skew the reported inventory turnover rate, affecting the validity of that measure, and potentially lead to overstocking and spoilage.

To validate observed drug cost expenditures reported by the OPES pharmacy cost model, the review team pulled and analyzed monthly pharmaceutical drug expenditure data from VA's Financial Management System for FY 2019. While monthly expenditure data matched the total reported in the OPES model for FY 2019, the team identified that the healthcare system had a sharp increase in expenditures for the month of September. The healthcare system averaged $4.75 million in monthly pharmaceutical drug expenditures during the first 11 months of FY 2019. In the last month of FY 2019, the healthcare system reported about $10.2 million in pharmaceutical drug expenditures. Figure 6 shows the FY 2019 monthly reported pharmacy drug expenditures.
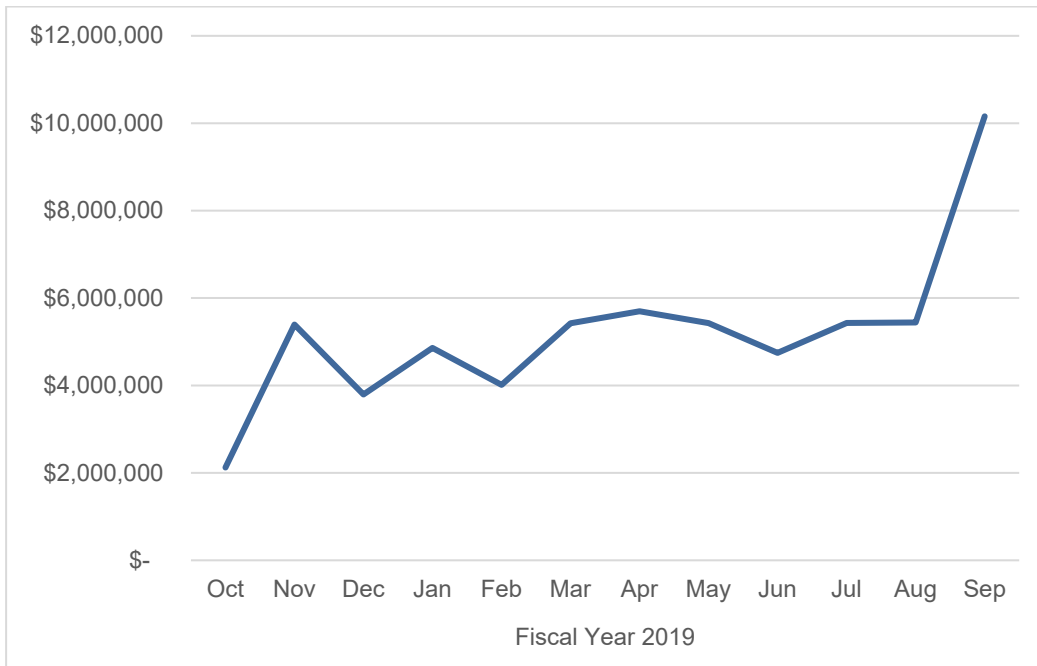
Figure 6. Healthcare system monthly drug expenditure data for FY 2019 (October 2018–September 2019). Source: OIG analysis of VA Financial Management System (FMS 830/887 report).

The team then reviewed daily obligation activity in VA's Financial Management System and found that three obligations totaling $4 million were placed on September 25, 2019, just five days prior to the close of the fiscal year. During FY 2019, the healthcare system made large

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[58] VHA Directive 1108.08(1). The directive does not define the number of days prior to the end of the year after which purchases should not be made.

obligations at the beginning of each quarter for pharmaceutical drugs, making the $4 million end-of-year obligations inconsistent with previous obligation patterns for pharmaceuticals.

The review team interviewed healthcare system leaders, pharmacy management and staff, and the facility's chief financial officer, and confirmed that the $4 million in September obligation activity was for end-of-year purchases of pharmaceutical drugs. The chief financial officer stated that the facility had available funding in FY 2019 and was concerned about potential funding shortfalls at the beginning of FY 2020. These purchases can reduce the inventory turnover rate and increase the carrying cost of pharmacy inventories.

Finding 4 Conclusion

An efficient healthcare system anticipates how much drugs will cost and when inventory needs to be restocked by analyzing available data, such as prime vendor inventory management reports and inventory turnover rates. Doing so helps ensure that the system makes the best use of appropriated funds and has inventory when needed. The healthcare system significantly improved pharmacy efficiency by convening a diverse group of stakeholders to focus on achieving efficiency goals, thereby reducing the difference between the facility's actual drug costs and expected drug costs by millions of dollars from FY 2017 to FY 2019. To build on those successes, the healthcare system continues to look for ways to improve the accuracy of its reorder inventory points to increase the turnover rate for pharmacy inventory. End-of-year purchases for FY 2019 should be examined to determine if better advance planning could distribute purchases over the year. The healthcare system appears committed to helping ensure that the system makes the best use of appropriated funds and has inventory when needed.

Recommendations 11–12

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

11. Continue to develop and implement a plan to increase inventory turnover closer to the VHA-recommended level.

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

Management Comments

The director of the Miami VA Healthcare System concurred with recommendations 11 and 12 and requested closure of recommendation 11. To address recommendation 11, the director reported that pharmacy staff will continue to use an internal dispensing data model to set reorder points and quantities. The Broward pharmacy was one of the initial sites in VA that implemented a perpetual inventory management system in conjunction with VHA Pharmacy Benefits

Management to improve inventory management and subsequently increase inventory turns. Implementation was completed on May 23, 2021. For recommendation 12, the director reported that the facility's chief of staff will work with pharmacy service to improve compliance with the VA directive to avoid end-of-year pharmaceutical purchases by ensuring that inventory management is consistent with the ABC inventory classification method outlined in VHA Directive 1761, while mitigating potential for damage, outdating, contamination, and obsolescence.

OIG Response

The Miami VA Healthcare System director's action plan is responsive to the recommendations. While the director requested the closure of recommendation 11, the OIG considers the recommendation to be open. To close recommendation 11, the OIG needs to see a formalized policy or standard operating procedure for managing Miami VA Healthcare System Pharmacy inventories that aligns with VHA policy requiring the Prime Vendor Inventory module or another inventory management system to be used to manage all VA medical facility pharmacy inventories. 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.

Appendix A: Healthcare System Profile

Facility Profile

The table below provides general background information for this 1a-High Complexity healthcare system reporting to VISN 8.[59]

Table A.1. Facility Profile for Miami VA Healthcare System
(October 1, 2016, through September 30, 2020)

Profile element	Facility data FY 2017	Facility data FY 2018	Facility data FY 2019	Facility data FY 2020
Total medical care budget in dollars	$590,174,542	$558,878,523	$597,888,934	$745,632,802
Number of:				
• Unique patients	56,915	56,832	57,199	53,906
• Outpatient visits	759,621	768,770	796,848	758,339
• Total Medical Care FTEs[60]	2,784	2,813	2,948	3,051
Type and number of operating beds:	176	176	176	176
• Hospital				
• Domiciliary	53	53	53	53
• Community Living Center	110	110	110	110
Average daily census:				
• Hospital	108	109	103	86
• Domiciliary	30	30	27	20
• Community Living Center	74	67	78	74

Source: VHA Support Service Center, Trip Pack and Operational Statistics report.
Note: The OIG did not assess VA's data for accuracy or completeness.

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

[60] Total Medical Care FTEs includes both direct medical care FTEs in budget object code 1000–1099 (Personal Services) and all cost centers.

Appendix B: Scope and Methodology

The OIG conducted its review of the Miami Veterans Healthcare System from May 2020 to June 2021, including a virtual site visit during the week of May 18, 2020. The review team evaluated financial efficiency practices for FY 2019 related to MSPV-NG utilization and purchase card transactions. The team also analyzed financial efficiency practices related to the facility's administrative FTE labor costs and pharmacy costs using the FY 2019 OPES data model; however, the FY 2019 data model was based on FY 2018 data.

To conduct the review, the team

- interviewed facility leaders and staff;

- identified and reviewed applicable laws, regulations, VA policies, operating procedures, and guidelines related to using financial efficiency practices for MSPV-NG utilization, overseeing purchase card transactions, and addressing inefficiencies in administrative FTE and pharmacy costs; and

- judgmentally sampled 53 purchase card transactions to determine if there was proper oversight and governance of the purchase card program, as well as to assess the risk for illegal, improper, or erroneous purchases.

Data Reliability

The review team obtained U.S. Bank data files through the corporate data warehouse, a central repository for such bank information that is updated monthly, as well as the OPES efficiency opportunity grid. To test for reliability, the team determined whether any data were missing from key fields, included any calculation errors, or were outside the timeframe requested. The review 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 ID numbers, purchase dates, payee names, payment amounts, cardholder names, and credit card numbers as provided in the data received in the samples reviewed. Testing of the data disclosed that they were sufficiently reliable for the review objectives.

In addition, computer-processed data included reports from the Supply Chain Common Operating Picture dashboard to determine MSPV-NG utilization rates. The review team found that detailed data were missing for three months during the fiscal year. However, the dashboard summary level data were sufficiently reliable for reporting on the facility's MSPV-NG utilization rate.

Government Standards

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

Appendix C: Sampling Methodology

Purchase Cards

The review team evaluated a judgmental sample of FY 2019 purchase card transactions to determine if (1) the Miami VA Healthcare System's purchase card payments were adequately monitored and approved to prevent duplicate payments and split purchases, and (2) ongoing repetitive orders with the same merchant that exceeded the micropurchase limit in aggregate were procured after using strategic sourcing procedures.

Population

During FY 2019, purchase cardholders at the facility made about 48,000 purchase card transactions totaling approximately $48 million.

Sampling Design

The review team developed a judgmental sample of high-risk transactional areas that identified potential duplicate, split, and repetitive purchases. The team identified indicators for each high-risk transaction:

- **Potential duplicate payments**—Transactions with the same purchase date, merchant, credit card number, and purchase amount

- **Potential split purchases**—Transactions with the same purchase date, purchase card number, and merchant, and an aggregate sum of greater than the $10,000 micropurchase limit

- **Potential repetitive purchases**—Individual purchase card transactions with the same merchant for anticipated, recurring, and ongoing needs

The sample included 53 individual transactions totaling approximately $287,000 in spending.[61]

To review the sampled transactions, the team requested supporting documentation for each of the 53 sampled transactions, VA Form 0242s, completion certificates for purchase card training for the sampled cardholders, and quarterly purchase card audits.

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[61] The 53 transactions were made up of the following: seven potential duplicates that included 19 separate transactions, six potential split purchases totaling 16 transactions, and eight repetitive purchases with 18 transactions.

Projections and Margins of Error

The review team did not use projections and margins of error because it did not use a statistical sample.

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

Recommendation	Explanation of Benefits	Better Use of Funds	Questioned Costs[62]
1	Develop a plan to work with the prime vendor to address having adequate stock in its warehouse to provide supplies when ordered.	$41,000	
3–7	Establish controls to confirm approving officials and purchase cardholders review their proposed purchases and make sure contracting is used when it is in the best interest of the government. Require purchase cardholders to submit a request for ratification for any unauthorized commitments identified. Also, ensure cardholders comply with record retention requirements as stated in VA's Financial Policy, Volume XVI, "Charge Card Program" and develop measures to confirm completed VA Form 0242 submissions are accurate and updated for all cardholders.		$287,000
	Total	**$41,000**	**$287,000**

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[62] As stated earlier, per 2 C.F.R. § 200.84, the term "questioned cost" includes a cost that is questioned by the auditor because of an audit finding where the costs, at the time of the audit, are not supported by adequate documentation.

Appendix E: Management Comments, Director for Miami VA Medical Center

Department of Veterans Affairs Memorandum

Date: July 19, 2021

From: Director, Miami VA Medical Center (546/00)

Subj: Draft Report, Financial Efficiency Review of the Miami VA Healthcare System

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

1. I have reviewed and concur with the findings and recommendations from the VA Office of the Inspector General (OIG) Draft Report Financial Efficiency Review of the Miami VA Healthcare System.

2. Attached is the Miami VA Healthcare System's comments for each recommendation. The Miami VA Healthcare System is requesting closure of Recommendations #9, and #11. Recommendations #1 through #8 and #10 and #12 will remain open and still in progress.

3. Please express my gratitude to the VA Office of Inspector General Survey team for their professionalism and assistance to us.

The OIG removed point of contact information prior to publication.

(Original signed by)

Kalautie S. JangDhari

Director, Miami VA Healthcare System

Attachments

OIG Recommendations

The OIG made 12 recommendations for improvement to the healthcare system director. The number of recommendations should not be used, however, as a gauge for the system's overall financial health. The intent is for system leaders to use these recommendations as a road map to improve financial operations. The recommendations address issues that, if left unattended, may eventually interfere with effective financial efficiency practices and stewardship of VA resources. The OIG recommended the healthcare system director address stock issues with any assigned prime vendor and ensure logistics staff use tools provided by the Medical Supplies Program Office to report prime vendor performance issues. To strengthen oversight of purchase card transactions, the OIG recommended the healthcare system director:

- ensure approving officials and purchase cardholders review their purchases

- ratify any unauthorized commitments

- determine when it is in the best interest of the government to use strategic sourcing for goods or services

- complete quarterly audits so cardholders and approving officials are held accountable for purchases

- ensure cardholders maintain an updated Governmentwide Purchase Card Certification Form (VA Form 0242) and comply with record retention requirements as stated in VA financial policy.

For administrative FTEs, the healthcare system director should provide guidance on implementing the healthcare system policy "Resource Management Board" including measurable objectives and clear criteria to determine if a service line is efficient in managing administrative staffing. In addition, the healthcare system director should ensure budget or accounting staff review the labor cost data each pay period and promptly address cost center corrections with human resources staff as needed, and service chiefs and supervisors review labor mapping for accuracy and completeness. The OIG made two recommendations regarding pharmacy operations. The healthcare system director should continue to develop and implement a plan to increase inventory turnover closer to the recommended level and ensure compliance with VA policy to avoid end-of-year pharmaceutical purchases.

Management Comments

Concur.

The Miami VA Healthcare System has reviewed and concurs with the findings and recommendations of the VA Office of Inspector General (OIG) Draft Report: Financial Efficiency Review of the Miami VA Healthcare System. The Miami VA Healthcare System is requesting closure of Recommendations #9 and 11 per supporting documents.

Recommendations #1 through #8 and #10 and #12 will remain open and are still in progress.

Finding 1 Conclusion

Because of American Medical Depot's inability to consistently fill formulary orders, the healthcare system was hindered in meeting its MSPV-NG utilization goal in FY 2019. Healthcare system personnel did not

appear to fully utilize or even have awareness of some of the available reporting tools to provide feedback on the prime vendor's poor performance. Although VHA apparently had sufficient information to subsequently terminate the contract with American Medical Depot, these tools are important for the facility to use going forward to ensure VHA has the information needed to take corrective action as appropriate. As a result of these problems, the healthcare system did not achieve the full cost savings associated with purchasing medical supplies through the MSPV-NG contract.

Recommendations 1-2

The VA Office of Inspector General made two recommendations to the Miami VA Healthcare System Director regarding Finding #1:

1. Develop a plan to work with the assigned prime vendor to address having adequate stock from the facility's formulary list in its warehouse to provide supplies when ordered.

2. Ensure logistics staff use the tools available to inform the Medical Supplies Program.

Management Comments

Recommendation #1: Develop a plan to work with the assigned prime vendor to address having adequate stock from the facility's formulary list in its warehouse to provide supplies when ordered.

Concur

Target date for completion: 12/01/2021   **Status:** Open

The Facility's Assistant Medical Center Director is championing efforts with Supply Chain Management Service Chief to develop a plan for the COR to work with Prime Vendor to complete the monthly Prime Vendor Performance Report to help identify trends with stock issues. The COR will also work collaboratively with the Supervisory Inventory Management Specialists to monitor stock levels to assure adequate supplies are available from the Prime Vendor when ordered.

Recommendation #2: Ensure logistics staff use the tools available to inform the Medical Supplies Program.

Concur

Target date for completion: 12/01/2021   **Status:** Open

The Facility's Assistant Medical Center Director is championing efforts to ensure Supply Chain Management Staff has been trained and they are using available tools. SCM reviews the Supply Chain Common Operating Picture (SCCOP) data monthly to ascertain improvements and address issues. The OB4 Report (MSPV Available Formulary Items Purchased from Prime Vendor) from SCCOP tool is being used weekly to meet with our current provider to help identify gaps in items being purchased through the open market. SCM staff meets weekly with the current MSPV to discuss utilization, fill rates, updates, gaps, issues, and concerns. A copy of data metrics showing improvement or declination which is used for weekly discussions with the Prime Vendor will be maintained to document compliance.

Finding 2 Conclusion

The healthcare system did not always use strategic sourcing. As a result, contracts for commonly used goods were not fully utilized and there was missing proper documentation for purchase card transactions in FY 2019. These issues, which resulted in $287,000 of questioned costs, could have been detected by quarterly audits of the purchase card program and more effective reviews by approving officials.

Recommendations 3-7

The VA Office of Inspector General made five recommendations to the Miami VA Healthcare System Director regarding Finding #2:

3. Establish controls to confirm approving officials and purchase cardholders review their proposed purchases and make sure contracting is used when it is in the best interest of the government.

4. Require purchase cardholders to submit a request for ratification for any unauthorized commitments identified.

5. Develop checks on the successful completion of quarterly audits of the purchase card program as required by the Veterans Health Administration's standard operating procedure, "Internal Audits—Purchase Cards and Convenience Checks."

6. Ensure cardholders comply with record retention requirements as stated in VA's Financial Policy, Vol. XVI, "Charge Card Program."

7. Develop measures to confirm completed VA form 0242 submissions are accurate and updated for all cardholders.

Management Comments

Recommendation #3: Establish controls to confirm approving officials and purchase cardholders review their proposed purchases and make sure contracting is used when it is in the best interest of the government

Concur

Target date for completion: 12/01/2021   **Status:** Open

The Network Contracting Office (NCO-8) Government Purchase Card (GPC) Team will provide quarterly reports on Strategic Sourcing Opportunities with the Facility Leadership team. Appropriate recommendations to consolidate requirements and submit to Contracting in support of Strategic Sourcing will be discussed during the quarterly report overview.

During the monthly VISN8 Contracting meeting with MVAHS Leadership the Contracting team will review and discuss outliers with the MVAHS Leadership Team for further facility review. All outliers are addressed by the MVAHS Leadership team.

Recommendation #4: Require purchase cardholders to submit a request for ratification for any unauthorized commitments identified.

Concur

Target date for completion: 12/01/2021   **Status:** Open

Purchase Cardholders and Approving Officials must complete Unauthorized Commitment (UAC) training every two years. Quarterly certification reports are sent to both the VISN and local CFOs acknowledging the supporting documentation which validates and monitors the required UAC training. NCO-8 GPC will re-educate and re-issue the UAC standard Operating Procedure, which outlines the ratification process to cardholders and approving official yearly.

Monthly, via the VISN 8 Contracting meeting with MVAHS Leadership, NCO-8 identifies potential UAC which is tracked and submitted to MVAHS Leadership for review and UAC SOP adherence. All ratifications are submitted to the MCD or designee for review and approval.

Recommendation # 5. Develop checks on the successful completion of quarterly audits of the purchase card program as required by the Veterans Health Administration's standard operating procedure, "Internal Audits—Purchase Cards and Convenience Checks."

Concur

Target date for completion: 12/01/2021   **Status:** Open

The NCO-8 GPC will review the quarterly audits to ensure the Purchase Card Coordinators PCC) complete the purchase card audits timely following the VHA's Standard Operating Procedures, "Internal Audits—Purchase Cards and Convenience Checks." The Purchase Card Coordinators will document and reinforce submission of the Convenience Checks by the Approving Officials. Quarterly reports will be submitted to the MCD or designee for review.

Recommendation #6: Ensure cardholders comply with record retention requirements as stated in VA's Financial Policy, Vol. XVI, "Charge Card Program."

Concur

Target date for completion: 12/01/2021   **Status:** Open

The NCO-8 GPC has created a SharePoint site and shared drive where electronic files are retained according to VHA's Financial Policy, Vol. XVI, "Charge Card Program."; They are then stored according to the VA record storage policy. The NCO-8 GPC will validate on an ongoing basis that SharePoint and shared drive records are being uploaded and retained as required.

Recommendation #7: Develop measures to confirm completed VA form 0242 submissions are accurate and updated for all cardholders.

Concur

Target date for completion: 12/01/2021   **Status:** Open

The NCO-8 GPC team will conduct quarterly reviews on 100% of all 0242s. The Purchase Card Coordinators will maintain verification documentation on the SharePoint site.

Finding 3 Conclusion

The healthcare system had higher administrative staffing than the medical center group average of similarly sized facilities, some of which can be attributed to the increased need in community care and

some to incorrectly assigning personnel to cost centers. The labor costs for these personnel variances are in the millions of dollars, and therefore the issue warrants closer scrutiny to ensure the optimization of administrative positions. It is imperative, however, that labor efficiency is not at the expense of patient care. The healthcare system's cost center assignment and labor mapping appeared adequate overall. However, some errors such as those detailed above could have been identified had more consistent reviews been conducted. Labor cost data affect budget formulation, forecasting, and staffing decisions. Without measurable objectives and accurate labor cost data, the healthcare system's ability to improve its efficiency is limited.

Recommendations 8–10

The VA Office of Inspector General made three recommendations to the Miami VA Healthcare System Director regarding Finding #3:

8. Provide guidance on implementing the healthcare system policy "Resource Management Board," including measurable objectives or clear criteria to determine if a service line is efficiently managing administrative staffing.

9. Establish controls to make certain that budget or accounting staff review the salary cost data each pay period and promptly address cost center corrections with human resources staff as needed.

10. Ensure service chiefs and supervisors review labor mapping for accuracy and completeness.

Management Comments

Recommendation #8: Provide guidance on implementing the healthcare system policy "Resource Management Board," including measurable objectives or clear criteria to determine if a service line is efficiently managing administrative staffing.

Concur

Target date for completion: 10/01/2021   **Status:** Open

The Facility's Associate Medical Center Director will champion plans to provide guidance by redesigning the RMB charter/policy to include measurable objectives/criteria to determine administrative staffing efficiency.

Recommendation #9: Establish controls to make certain that budget or accounting staff review the salary cost data each pay period and promptly address cost center corrections with human resources staff as needed.

Concur

Target date for completion: 12/31/2020   **Status:** Requesting Closure

The Facility's Associate Medical Center Director championed a team to establish controls through Fiscal Service salary cost data audits being performed each pay period. Any corrections are communicated to HRMS promptly / as needed.

Supporting Documentation

New Employee Cost Audit

Salary Costing Audit

[…]

Recommendation #10. Ensure service chiefs and supervisors review labor mapping for accuracy and completeness.

Concur

Target date for completion: 12/01/2021   **Status:** Open

Service leader training will be provided by DSS in FY21Q4 to ensure labor mapping for accuracy and completeness.

Finding 4 Conclusion

An efficient healthcare system anticipates how much drugs will cost and when inventory needs to be restocked by analyzing available data, such as prime vendor inventory management reports and inventory turnover rates. Doing so helps ensure that the system makes the best use of appropriated funds and has inventory when needed. The healthcare system significantly improved pharmacy efficiency by convening a diverse group of stakeholders to focus on achieving efficiency goals, thereby reducing the difference between the facility's actual drug costs and expected drug costs by millions of dollars from FY 2017 to FY 2019. To build on those successes, the healthcare system continues to look for ways to improve the accuracy of its reorder inventory points to improve the turnover rate for pharmacy inventory. Given VHA policy to the contrary, end-of-year purchases should be examined for FY 2019 to determine if better advance planning could distribute purchases over the year. The healthcare system appears committed to helping ensure that the system makes the best use of appropriated funds and has inventory when needed.

Recommendations 11–12

The VA Office of Inspector General made two recommendations to the Miami VA Healthcare System Director regarding Finding #4:

11. Continue to develop and implement a plan to increase inventory turnover closer to the VHA-recommended level.

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

Recommendation #11: Continue to develop and implement a plan to increase inventory turnover closer to the VHA-recommended level.

Concur

Target date for completion: 12/31/2020   **Status:** Requesting Closure

The Facility's Chief of Staff will continue to champion development of plans to increase inventory turnover. Pharmacy will continue to manage pharmacy inventory using ABC Inventory Classification Method outlined in VHA Directive 1761. As outlined in OIG report, pharmacy has moved from prime vendor purchase history reorder point (ROP) / reorder quantity (ROQ) generated data and moved to a more accurate internal dispensing data model to set ROP and ROQs since September 2019. The Broward Pharmacy was one of the initial sites in VA that implemented a perpetual inventory management

(PIM) system in conjunction with VHA PBM to improve inventory management and subsequently increase inventory turns. Implementation was completed on 5/23/2021.

Supporting Documentation

1. 546-Miami Outpatient Inventory data 2020

2. 546BZ- Broward Mckesson Purchase data 2020

3. 546BZ- Broward VA OPC Inventory 2020

4. 546- Miami and Broward 2020 calculations

5. 546- Miami Inpatient Inventory 2020

6. 546- Miami Mckesson Purchase data 2020

7. Inventory Turns for 2020 and 2021

8. Broward Mckesson Purchase data 2021

9. Miami Mckesson Purchase data 2021

10. Miami VAMC INP 2-21

11. Miami VAMC OUT 2-21

12. 2021 calculations

13. Broward County VA OPC 2-21

[…]

Recommendation #12. Establish measures to improve compliance with the VA directive to avoid end-of-year pharmaceutical purchases.

Concur

Target date for completion: 09/30/2021   **Status:** Open

The Facility's Chief of Staff will work with Pharmacy Service to improve compliance with the VA Directive to avoid end-of-year pharmaceutical purchases by ensuring that inventory management is consistent with the ABC Inventory Classification Method outlined in VHA Directive 1761 while mitigating potential for damage, outdating, contamination, and obsolescence.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Review Team	Anthony Leigh, Director Tesia Basso Zachary Beres Nicole Brehon Jennifer Casteline Melissa Garcia Steven King Lance Kramer Melanie Tsai
Other Contributors	Rasmi Simhan Clifford Stoddard

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