



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Financial Efficiency Review of
the VA El Paso Healthcare
System in Texas and New
Mexico



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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 VA El Paso 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 healthcare system had appropriate oversight and controls in place:

- I. **Open obligations oversight.** An open obligation is funding for items or services that are not considered closed or complete and have a balance associated with them. The healthcare system finance office should review open obligations to ensure that beginning and ending dates are accurate; open balances are accurate and agree with source documents, such as contracts and purchase orders, receiving reports, invoices, and payments; and obligations beyond 90 days of the performance end date or without activity in the past 90 days are valid and should remain open. The review team evaluated whether the healthcare system performed monthly reviews and reconciliations of sampled obligations.
- 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. The review team evaluated whether the healthcare system considered establishing contracts when making purchases and properly documented sampled transactions. Documenting transactions as required helps VA and other oversight entities identify potential fraud, waste, and abuse. Using contracts for common purchases has several benefits, such as allowing VA to optimize purchasing power and obtain competitive pricing. The team examined whether the healthcare system's purchase card program ensured compliance with policies and procedures and focused on the consideration of contracts for commonly purchased products, known as strategic sourcing, to provide optimal savings to VA.
- III. **Medical/Surgical Prime Vendor-Next Generation (MSPV-NG) program use.** 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,

¹ The VA El Paso Healthcare System provides primary and specialized ambulatory services to veterans in El Paso and surrounding counties. The healthcare system also operates three community-based outpatient clinics in El Paso and one in Las Cruces, New Mexico.

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 (MSPO) recommends that each medical center purchase at least 90 percent of medical supplies on the formulary from the region's assigned prime vendor.

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

The review team selected these areas based on an analysis of VA data from the Office of Productivity, Efficiency & Staffing (OPES) efficiency opportunity grid, the Supply Chain Common Operating Picture (SCCOP), and reports from the Veterans Health Administration (VHA) Support Service Center (VSSC). The efficiency opportunity grid was used to obtain information on pharmacy operations, SCCOP was used for MSPV-NG information, Financial Management System reports were used for open obligations, and US Bank data were used for purchase cards.

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

What the Review Found

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

- I. **Open obligations oversight.** The healthcare system did not perform required reviews for five of the 10 reviewed inactive obligations, totaling almost \$3 million. According to the chief finance officer, this occurred because the healthcare system was focused solely on deobligating excess or unneeded funds that were 90 days past their period of performance end date and did not review open obligations that had no expenditure activity for more than 90 days. This effort was made in response to prior audits of VA financial statements, which listed open obligations as a material weakness. Failure to review inactive obligations leaves the healthcare system vulnerable to the risk that those funds will not be

² The just-in-time method is an inventory strategy in which materials are only ordered and received as they are needed. The OIG is aware that VA announced its plans to eliminate the MSPV-NG program within VA by September 2023 and instead purchase medical supplies off the Defense Logistics Agency's (DLA) MSPV catalog. As a result of this decision, several contractors who provide medical supplies under VA's MSPV filed civil suits in US federal court. These cases are pending. However, the current pendency of litigation related to the transfer of VA facilities to use the DLA MSPV contract versus the VA MSPV-NG contract does not, at this time, affect either the substance or recommendations in this report.

used in the year they were appropriated, as required. If unspent, these one-year funds cannot be reobligated and used for other goods or services to support veterans.

- II. **Purchase card use.** The healthcare system did not always properly oversee purchase card transactions. Nineteen of the 38 sampled transactions, totaling approximately \$134,000, were not processed in compliance with VA policy. Specifically, prior approval was not obtained for one, reconciliations were not approved in a timely manner for 14, and segregation of duties was not maintained for nine transactions. This occurred because approving officials did not ensure steps in the transaction process were followed and that roles and responsibilities were carried out in accordance with VA policy. The team's review of the sampled transactions also revealed that cardholders did not split purchases to circumvent their authorized single purchase limit.

The healthcare system used strategic sourcing to optimize its purchasing power for the sampled transactions that were reviewed. The team determined cardholders and approving officials were encouraged to use certain vendors and contracts to acquire goods or services before resorting to open market purchases. When used, strategic sourcing helps to ensure VA is obtaining the most competitive prices on goods and services.

Twenty-two of the sampled transactions contained errors that resulted in questioned costs totaling approximately \$159,000.³ Specifically, 10 of these 22, totaling approximately \$79,300, were missing some required documentation, such as a prior approval, a receiving report, or justification for purchases from a third-party payer to verify that purchase card transactions were properly approved and that payments were accurate. This occurred because cardholders did not adhere to VA policy on the retention of purchase card documentation.

Twelve of the 22, totaling approximately \$79,700, did not either maintain a proper segregation of duties or ensure a timely reconciliation of charges, or both.

The review team also determined the healthcare system met these purchase card use requirements: (1) approving officials were assigned no more than 25 purchase card accounts, (2) VA Form 0242, which delegates authority to an individual to use a VA purchase card, was maintained by the healthcare system for each cardholder in the review sample, and (3) the purchase card coordinator conducted quarterly purchase card certification reporting for the scope of the review.

³ 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 cost, at the time of the audit, is not supported by adequate documentation. See appendix D for monetary benefits associated with the questioned costs.

- III. **Use of the MSPV-NG program.** The healthcare system did not meet the formulary utilization goal recommended by the MSPO, which is to purchase 90 percent of formulary items from the MSPV-NG prime vendor. The healthcare system's utilization rate was only 14 percent on average, falling well short of the 90 percent goal. This occurred because of the limitations of the prime vendor's conventional bulk delivery method, the use of national prosthetics contracts instead of the MSPV-NG contract, and the prime vendor's inability to meet the healthcare system's demand when needed. Additionally, the review team found that the healthcare system did not always use the tools available to provide feedback on the prime vendor's performance. As a result of these issues, for 30 sampled purchase records, the healthcare system spent over \$32,000 more for items from vendors other than the prime vendor.⁴ For 21 of these transactions, the review team questioned about \$26,500 because the healthcare system did not submit national contract waiver requests, as required by VA policy.
- IV. **Pharmacy operations.** The healthcare system could improve pharmacy efficiency by narrowing the gap between observed drug costs and expected drug costs, bringing the turnover rates closer to the VHA-recommended level, and meeting requirements for noncontrolled drug line audits. For both FY 2018 and FY 2019, the OPES model showed that the healthcare system had under \$1 million in annual opportunities for savings; however, in FY 2021, the model shows it significantly increased to \$5.8 million.⁵ The gap reportedly resulted from a drastic increase in high-cost prescriptions issued by community care non-VA providers. The healthcare system's rural location increased the veterans' use of non-VA providers in the community, who were prescribing nonformulary drugs at higher costs than VA care providers.

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 2021, the pharmacy prime vendor reported an inventory turnover rate of 6.35 compared to the recommended level of 12. Furthermore, the healthcare system did not run required monthly inventory management reports from the prime vendor software package, use data for inventory management, or adjust stock levels in accordance with VHA policy. Failure to use inventory management reports could result in inaccurate reorder points and inventory levels needed to meet patient needs.

In addition, the healthcare system did not follow line audit requirements for noncontrolled drugs. The team determined that the healthcare system's quarterly review

⁴ A nonstatistical sample of 30 purchasing records, which included 4,313 formulary supply items that were purchased from vendors other than the prime vendor, was selected for facility review and comment.

⁵ The OPES Pharmacy Expenditure model uses the terms "Observed minus Expected" and "Potential Opportunity" to describe the gap between a facility's actual drug costs and expected drug costs. This difference represents the amount associated with potential efficiency improvements.

of noncontrolled drug line items is unreliable and not in compliance with VHA policy. Further, the team determined that the Pharmacy Benefits Management guidance provided to the healthcare system is not aligned with VA policy. In turn, this could have a negative impact on drug inventory management.

The review team was also informed that the healthcare system assigned an acting chief of pharmacy in April 2021 when the chief of pharmacy went on extended leave. The review team determined neither the chief of pharmacy nor managers of the healthcare system adequately transitioned pharmacy responsibilities to the acting chief, which affected inventory management. For example, the acting pharmacy chief was not familiar with pharmacy budget and inventory management practices.

What the OIG Recommended

The OIG made 12 recommendations for improvement to the director of the VA El Paso Healthcare System. 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 the strong stewardship of VA resources.

The OIG recommended the healthcare system director ensure finance office staff are made aware of VA financial policy requirements to conduct reviews on open obligations and review all open obligations as required. To strengthen the oversight of the purchase card program, the OIG made a recommendation to the healthcare system director establish procedures to ensure cardholders comply with record retention and transaction-processing requirements as required by VA financial policy.

The OIG made five recommendations regarding use of the MSPV-NG program. The OIG recommended that the director develop a plan to work with the prime vendor to address having adequate stock to meet the system's needs. The healthcare system director should also ensure staff follow the MSPV-NG ordering hierarchy by purchasing items through the MSPV-NG contract before using nonprime vendors. The healthcare system director should ensure staff elect and are granted a delivery method from the prime vendor that meets just-in-time requirements for MSPV-NG supplies. Additionally, the OIG recommended the director ensure employees obtain approved MSPV-NG waiver requests before purchasing available formulary items from nonprime vendor sources. Finally, the OIG recommended that the director ensure logistics staff and the contracting officer's representative use the tools available to inform the MSPO and Strategic Acquisition Center of prime vendor performance issues.

The OIG made five recommendations regarding pharmacy operations. The healthcare system director should develop formalized processes for achieving identified efficiency targets and use available pharmacy data to make business decisions; develop and implement a plan to increase

inventory turnover closer to the VHA-recommended level; ensure the prime vendor inventory module is used to manage all VA medical facility pharmacy inventories as required by VHA policy; and clarify the disconnect between the Pharmacy Benefits Management inventory reporting tool and VHA policy.

VA Comments and OIG Response

The interim medical center director of the VA El Paso Healthcare System concurred with all recommendations and provided responsive corrective action plans.⁶ The OIG considers all recommendations open. The OIG will monitor the implementation of all planned actions and close the recommendations when the VA El Paso Healthcare System provides sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified. Appendix E includes the interim medical center director's comments.



LARRY M. REINKEMEYER
Assistant Inspector General
for Audits and Evaluations

⁶ Since the position of medical center director of the VA El Paso Healthcare System is currently vacant, the interim medical center director responded to the OIG's recommendations acting in the capacity of director.

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Abbreviations

CBD	conventional bulk distribution
FY	fiscal year
FTE	full-time equivalent
IFCAP	Integrated Funds Distribution, Control Point Activity, Accounting and Procurement system
LUM	low unit of measure
MSPO	Medical Supplies Program Office
MSPV-NG	Medical Surgical Prime Vendor-Next Generation
OIG	Office of Inspector General
OPES	Office of Productivity, Efficiency & Staffing
SCCOP	Supply Chain Common Operating Picture
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VSSC	VHA Support Service Center



Introduction

The VA Office of Inspector General (OIG) conducts financial efficiency reviews to assess the oversight and stewardship of funds used by VA healthcare facilities and to identify opportunities to achieve cost efficiencies. To promote best practices, OIG review teams identify and examine financial activities under the healthcare facility's control and can be compared to VA healthcare facilities that are similar in size and complexity.⁷

This review focused on the VA El Paso Healthcare System. The review team assessed the healthcare system's efficiency in four areas:

- I. **Open obligations oversight.** Open obligations are not considered closed or complete and have a balance associated with them, whether undelivered or unpaid. Open obligations should be reviewed by the healthcare system finance office to ensure that beginning and end dates are accurate; open balances are accurate and agree with source documents, such as contracts and purchase orders, receiving reports, invoices, and payments; and obligations aged beyond 90 days of the period of performance end date or without activity in the past 90 days are valid and should remain open. The review team evaluated whether the healthcare system performed monthly reviews and reconciliations of sampled obligations.
- 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. Documenting transactions as required helps VA and other oversight entities identify potential fraud, waste, and abuse. Using contracts for common purchases has several benefits, such as allowing VA to optimize purchasing power and obtain competitive pricing. The team examined whether the healthcare system's purchase card program ensured compliance with policies and procedures and focused on the consideration of contracts for commonly purchased products, known as strategic sourcing, to provide optimal savings to VA.
- III. **Medical/Surgical Prime Vendor-Next Generation (MSPV-NG) program use.** 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. The program achieves long-term

⁷ 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. El Paso is rated as a 3, low-complexity facility.

savings by using a just-in-time logistics approach.⁸ VA medical facilities are required to use MSPV-NG contracts for products that are available through the program, which appear on a list called a formulary. The Medical Supplies Program Office (MSPO) recommends that each medical center purchase at least 90 percent of the supplies on the formulary from the program's assigned prime vendor.⁹ The review team examined whether the healthcare system met Veterans Health Administration (VHA) goals for using the program.

- IV. **Pharmacy operations.** The review team assessed whether the healthcare system complied with applicable policies and used drug cost and performance data to track progress toward goals developed by the national Pharmacy Benefits Management office, improve pharmacy program operations, and identify and correct problems.

VA El Paso Healthcare System

The VA El Paso Healthcare System opened its main facility in October 1995, which initially consisted of nearly 250,000 square feet housed within a four-story building. A 29,000 square foot addition opened in June 2008. The healthcare system provides primary and specialized ambulatory services to veterans in El Paso and surrounding counties. The healthcare system, which is part of Veterans Integrated Service Network (VISN) 17, also operates three community-based outpatient clinics in El Paso and one community-based outpatient clinic in Las Cruces, New Mexico. Inpatient care for acute medical and surgical emergencies is provided through an extensive VA-Department of Defense sharing agreement with the William Beaumont Army Medical Center. The facility also provides administrative support to a veterans outreach center and to the Fort Bliss and Fort Bayard national cemeteries.

In fiscal year (FY) 2021, VA El Paso Healthcare System had a medical care budget of approximately \$443 million with over 1,100 full-time equivalent (FTE) employees and provided services to about 35,000 veterans. For more information about the healthcare system, see appendix A.

⁸ The just-in-time method is an inventory strategy in which materials are only ordered and received as they are needed. The OIG is aware that VA announced its plans to eliminate the MSPV program within VA by September 2023 and to purchase medical supplies from the Defense Logistics Agency's (DLA) MSPV catalog. As a result of this decision, several contractors who provide medical supplies under VA's MSPV filed civil suits in US federal court. These cases are pending. However, the pendency of litigation related to the transfer of VA facilities to use the DLA MSPV contract versus the VA MSPV contract does not, at this time, affect either the substance or recommendations in this report.

⁹ 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. It was formerly known as the Healthcare Commodities Program Office. Medical Supplies Program Office, "The Formulary Utilization Metric: A Deep Dive Explanation," accessed May 6, 2021, <https://vaww.va.gov/plo/docs/mspo/mspvFormularyUtilizationMetricOverview.pdf>. (This is an internal website not publicly accessible.)

Facility and Efficiency Selection

The review team evaluated VA data to identify those facilities with the greatest potential for financial efficiency improvements. The review team obtained this data from the Office of Productivity, Efficiency & Staffing (OPES) efficiency opportunity grid, the Supply Chain Common Operating Picture (SCCOP), and reports from the VHA Support Service Center (VSSC). The efficiency opportunity grid was used to obtain information on pharmacy operations; SCCOP was used for MSPV-NG information; Financial Management System reports were used for open obligations; and US Bank data were used for purchase cards.

VHA developed the efficiency opportunity grid to give facility leaders insight into areas of opportunity for improving efficiency when compared with other VHA facilities. The grid is a collection of 12 statistical models, which allows for comparisons between VHA facilities by adjusting data for variations in patient, facility, and geographic characteristics. It describes possible inefficiencies and areas of success by showing the difference between a facility's actual and expected costs. The team obtained the facility rankings from three statistical models in the grid to assist in selecting facilities for financial efficiency reviews: the Stochastic Frontier Analysis model, the administrative FTE model, and the pharmacy expenditure model. The team then used a SCCOP report to gather MSPV-NG data for all VA medical centers and rank them by utilization percentages.

Results and Recommendations

I. Open Obligations Oversight

VA's management of open obligations has been a longstanding problem and was included as a significant deficiency in VA's FY 2021 audited financial statements and as a material weakness in VA's FY 2020 and FY 2019 audited financial statements.¹⁰ Additionally, a 2019 report on undelivered orders recommended VHA ensure staff review and reconcile open orders, identify and deobligate excess funds on those orders, and ensure staff follow VA policy regarding required reviews of open obligations.¹¹ If reviews are not conducted, the facility is vulnerable to the risk that those funds cannot be reobligated and used for other goods or services in that fiscal year to support veterans.

As stated earlier, obligations not considered closed or complete that have a balance associated with them, whether undelivered or unpaid, should be reviewed by the healthcare system finance office to ensure that performance beginning and end dates are accurate; open balances are accurate and agree with source documents, such as receiving reports, invoices, and payments; and obligations without recent activity are still valid and should remain open. Failure to properly manage open obligations leaves funds attached to orders that could be closed and used for other purposes to benefit veterans.

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

- **Inactive obligations.** The team assessed whether the healthcare system performed monthly reviews and reconciliations to ensure that the reviewed inactive obligations were valid and should remain open. Inactive obligations have had no activity for more than 90 days.
- **End-date modifications.** The team identified open obligations with changes to the end date for the period of performance and reviewed evidence from the healthcare system that supported those changes. The period of performance is the time during which the goods or services are to be provided.

¹⁰ VA OIG, *Audit of VA's Financial Statements for Fiscal Years 2021 and 2020*, Report No. 21-01052-33, November 15, 2021; VA OIG, *Audit of VA's Financial Statements for Fiscal Years 2020 and 2019*, Report No. 20-01408-19, November 24, 2020; VA OIG, *Audit of VA's Financial Statements for Fiscal Years 2019 and 2018*, Report No. 19-06453-12, November 19, 2019. A material weakness is a deficiency, or combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented or detected and corrected on time. A significant deficiency is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

¹¹ VA OIG, *Insufficient Oversight of VA's Undelivered Orders*, Report No. 17-04859-196, December 16, 2019. All recommendations in this report have been closed and implemented.

Finding 1: Inactive Obligations Were Not Being Reviewed

VA policy requires finance offices to perform monthly reviews and reconciliations of open obligations that have aged beyond 90 days of the period of performance end date or that have been inactive for more than 90 days to ensure the obligation is still valid and funds are not underused.¹² For these obligations, finance office personnel should verify with the initiating service or contracting officer, if applicable, that the goods or services have not been received and are still needed. The responsible finance office should review data from VA’s Financial Management System against supporting documentation monthly to ensure reports, subsidiary records, and systems reflect proper costing, accurate delivery dates and end dates, and a correctly calculated unliquidated balance.¹³

Figure 1 shows the healthcare system’s inactive obligations from October 2020 through March 2021.

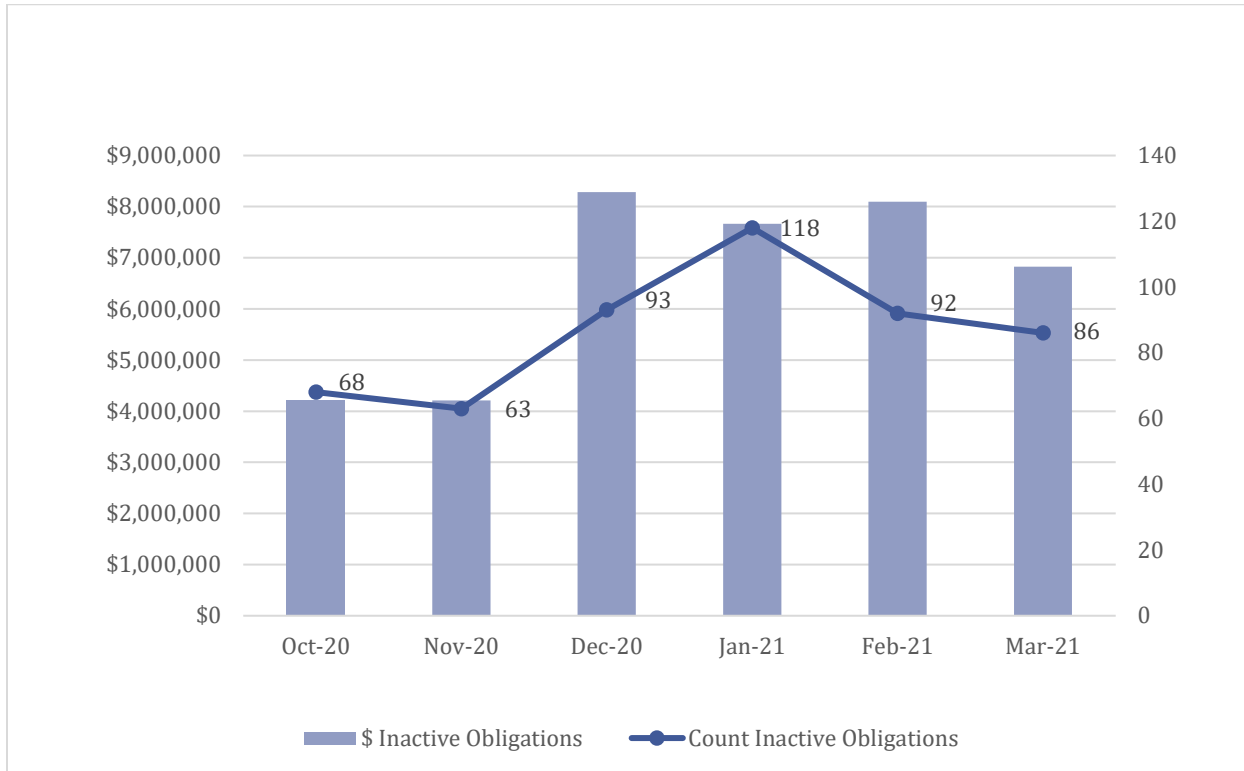


Figure 1. Analysis of inactive obligations for the VA El Paso Healthcare System, October 2020 through March 2021.

Source: VA Financial Management System F850 Report.

¹² VA Financial Policies and Procedures, vol. II, chap. 5, “Obligations Policy,” October 2020.

¹³ Per 2 C.F.R. § 200.97, the term *unliquidated balance* means an obligation incurred by a nonfederal entity that has not been paid (liquidated) or for which the expenditure has not been recorded.

As of March 31, 2021, the healthcare system had 86 inactive obligations totaling about \$6.8 million, as detailed in figure 2. As shown, 44 of the 86 obligations totaling almost \$5.1 million had no activity for over 180 days.

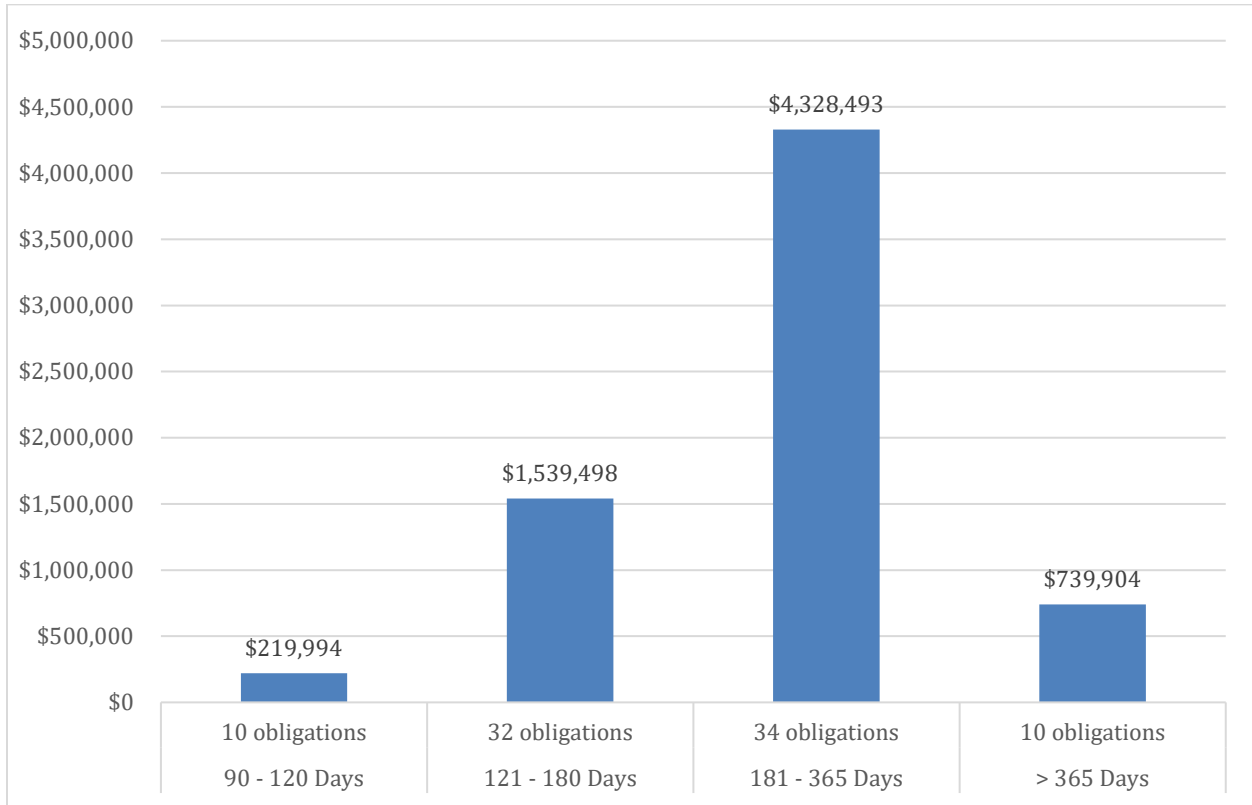


Figure 2. Inactive obligations for March 2021.

Source: OIG analysis of VA Financial Management System F850 Report.

The review team selected 10 inactive open obligations as of March 31, 2021, totaling almost \$3.4 million. The team reviewed supporting documentation to determine if the healthcare system assessed the inactive obligations to see if they were still valid and necessary, in accordance with VA financial policy.¹⁴ Five obligations were still within the performance period, while the remaining five were more than 90 days past the performance period end date.¹⁵ The review team found that the healthcare system did not assess five of the 10 inactive obligations totaling almost \$3 million. According to the chief financial officer, the healthcare system was focused solely on deobligating excess or unneeded funds that were 90 days past their period of performance end dates and did not review open obligations that had no expenditure activity for more than 90 days.

¹⁴ VA Financial Policies and Procedures, vol. II, chap. 5, “Obligations Policy,” October 2020.

¹⁵ See appendix B for additional details on scope and methodology and appendix C for details on the review’s sampling.

This focus was based on two prior audits of VA financial statements, which first listed open obligations as a material weakness and then a significant deficiency.

The five obligations the healthcare system did not review were funded by single-year appropriations. Single-year appropriated funds are available for obligation only during the fiscal year in which the appropriation is made.¹⁶ If appropriated funds are not obligated in that fiscal year, they expire and are no longer available for new obligations for goods and services. Here, the unused funds associated with the five unreviewed obligations would therefore expire at the end of the fiscal year, potentially having almost \$3 million in funds that cannot be reobligated or available for other uses to benefit veterans.

Obligation End-Date Modifications Were Supported

The review team evaluated the sample of 10 open obligations to determine if there were any end-date modifications and, if so, whether they were supported, accurate, and reconciled between the Integrated Funds Distribution, Control Point Activity, Accounting and Procurement system (IFCAP) and VA's Financial Management System. IFCAP handles the processing of certified invoices and receiving documents to the VA Financial Management System. In addition, IFCAP transfers obligation information back to the control point and updates the control point balance automatically.¹⁷ The end dates in both systems should be the same. The team determined that VA's Financial Management System and IFCAP reflected accurate end dates for all 10 obligations, and the healthcare system had support for the modifications.

Finding 1 Conclusion

Healthcare system personnel did not comply with VA policies requiring routine follow-up and could improve management and oversight of open obligations. The OIG found that open obligations with no activity for more than 90 days were not reviewed for validity. Failure to properly manage open obligations increases the risk of failing to spend appropriations within the associated fiscal year and leaving funds attached to orders that could be closed and used for other purposes to benefit veterans. For obligation end-date modifications, the healthcare system had properly documented evidence to support the changes for the obligations identified in the review team's sample.

¹⁶ United States House of Representatives, Glossary of Terms, accessed February 2, 2022, <https://www.house.gov/the-house-explained/open-government/statement-of-disbursements/glossary-of-terms>. Annual appropriations (also called one-year appropriations) are made for a specified fiscal year and are available for obligation only during the fiscal year for which made. Funds expire after one year and are no longer available to incur new obligations.

¹⁷ A control point is a financial element used to permit the tracking of monies to a specified service, activity, or purpose from an appropriation or fund.

Recommendation 1

The OIG made the following recommendation to the director of the VA El Paso Healthcare System:

1. Ensure healthcare system finance office staff are made aware of policy requirements for open obligations and the responsible healthcare system finance office conducts reviews on all open obligations as required by VA Financial Policies and Procedures, Volume II, Chapter 5, “Obligations Policy,” October 2020.

VA Management Comments

The interim medical center director of the VA El Paso Healthcare System concurred with recommendation 1.¹⁸ The responses to all report recommendations are provided in full in appendix E.

The interim medical center director reported that a standard operating procedure addressing open obligations and escalation processes was drafted and implemented on June 15, 2021. The standard operating procedure was shared with all healthcare system finance staff. VA financial policy updates are disseminated to the finance staff via email immediately upon receipt and a copy is maintained in a shared folder.

OIG Response

The interim medical center director’s action plan is responsive to the recommendation. While the director reported that actions have been completed on recommendation 1, the OIG considers the recommendation open and will close it once sufficient evidence has been provided demonstrating progress in addressing the intent of the recommendations and the issues identified.

¹⁸ Since the position of medical center director of the VA El Paso Healthcare System is currently vacant, the interim medical center director responded to the OIG’s recommendations acting in the capacity of director.

II. Purchase Card Use

VA established its government purchase card program to reduce the 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. From April 2020 through March 2021, the healthcare system spent over \$16 million through purchase cards, representing 25,796 transactions. The amount and volume of spending through the 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 review team focused on three areas related to purchase cards:

- **Purchase card transactions.** The review team examined whether the healthcare system processed purchase card transactions in accordance with VA policy. Additionally, the team inquired whether the healthcare system considered obtaining contracts when procuring goods and services on a regular basis, referred to as “strategic sourcing.” The use of contracts lowers the risk of split purchases and duplicate payments on purchase cards by reducing open market or individual purchases and enables VA to leverage its purchasing power.¹⁹
- **Supporting documentation.** The review team examined whether the healthcare system maintained supporting documentation. Supporting documentation is required for purchases to provide assurance of payment accuracy and the mission-essential need to purchase a good or service. This includes approved purchase requests, purchase orders, vendor invoices, receiving reports, and, when necessary, written justification for purchases from a third-party payer.²⁰ Supporting documentation enables diligent program oversight and helps prevent fraud, waste, and abuse.
- **Purchase card oversight.** The review team assessed whether approving officials were assigned no more than 25 purchase card accounts, and if the healthcare system ensured that approving officials conducted reviews of cardholder transactions and quarterly purchase card certifications were conducted. These activities are examples

¹⁹ Per VA Financial Policy, vol. XVI, chap. 1B, “Government Purchase Card for Micro-Purchases,” October 2019, purchases over \$10,000—the 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.

²⁰ VA Financial Policy, vol. XVI, chap. 1B, “Government Purchase Card for Micro Purchases,” October 2019. Cardholders will not use third-party payers unless there are no other available vendors. Cardholders will justify in writing if a third-party payer is used and keep documentation identifying the actual vendor providing the item. Examples of third-party payers include PayPal, E-Money, E-Account, Amazon Marketplace, Google Checkout, and Venmo.

of systematic controls that help reduce errors and ensure the healthcare system complies with VA policy.

Finding 2: The VA El Paso Healthcare System Did Not Always Maintain Supporting Documentation or Meet Requirements for Processing Purchase Card Transactions

The review team evaluated a judgmental sample of 38 purchase card transactions totaling about \$346,000 from April 2020 through March 2021 to determine whether the healthcare system processed transactions in accordance with VA policy and maintained required purchase card transaction documentation. Though healthcare system leaders did oversee the program, the OIG found employees did not consistently process card transactions and maintain all documentation as required.

These issues occurred because approving officials did not closely review purchases as they were processed, and policy was not followed. Compliance with policies and procedures reduces the risk of fraud, waste, and abuse and enhances the stewardship of government money.

Purchase Card Transactions

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

- *Prior approval* was obtained to ensure a valid business need before the cardholder initiated a purchase.
- *Reconciliation* of a purchase was approved in a timely manner to aid in identifying fraudulent or erroneous charges and unauthorized commitments.
- *Segregation of duties* was maintained to ensure roles and responsibilities did not overlap.

The OIG determined that 19 of 38 purchase card transactions, or 50 percent of those sampled, did not meet those requirements. The healthcare system's approving officials did not provide sufficient oversight of purchase card transactions, which resulted in a total of 24 individual noncompliant issues, listed in the table below. These transactions totaled approximately \$134,000.

Table 1 summarizes the results of the team's review of transactions.

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

VA purchase card policy requirement	Sample number of transactions reviewed*	Sample number of noncompliant issues	Sample percent of noncompliant issues
Cardholders must obtain prior approval before making any purchase*	38	1	3%
Transactions must be reconciled and approved by an approving official no later than the 15th calendar day of the month after the closing of the previous month's billing cycle*	38	14	37%
Stations must maintain appropriate segregation of duties for each transaction to ensure roles and responsibilities do not overlap*/**	38	9	24%
Cardholders must not split a purchase requirement into smaller parts to avoid exceeding the micropurchase threshold*	10	0	0%

Source: VA OIG analysis of sample transactions.

*All 38 transactions were assessed for each policy requirement except for split purchases. The review team assessed 10 potential split purchase bundles comprised of 28 samples.

**The review team determined seven of the 13 cardholders in the review team's sample did not maintain segregation of duties for nine sample transactions.

Purchase card officials for the healthcare system did not provide mitigating circumstances to explain why the transactions were processed incorrectly. For example, transactions were not approved and reconciled in a timely manner, or the ordering and approving roles were performed by the same person. These issues occurred because approving officials did not provide sufficient oversight over the transaction process to ensure roles and responsibilities were adhered to in accordance with VA policy.

The review team also assessed if cardholders split purchases into two or more acquisitions to circumvent their authorized single purchase limit. The review team selected 10 potential split purchase bundles (comprising 28 sample transactions) totaling approximately \$145,000 to determine if cardholders split purchases. Per the team's analysis of the 10 bundles, the team did not find any split purchases.

Lastly, the review team inquired whether the healthcare system considered obtaining contracts when procuring goods and services on a regular basis, referred to as "strategic sourcing." The program coordinator, approving officials, and cardholders must review purchases and determine when it is in the best interest of the government to utilize strategic sourcing, which generally provides greater savings to VA than the use of purchase cards.

VA financial policy states that VA must attempt to reduce individual purchases made with the purchase cards and pursue strategic sourcing. By leveraging VA's purchasing power, strategic

sourcing may offer the most competitive prices. The review team learned from the program coordinator that cardholders and approving officials are told which vendors they should use before making open market purchases. A cardholder also conveyed to the review team that their purchase card lead emphasizes the use of contracts.

Supporting Documentation

VA requires each healthcare system to maintain supporting documentation for purchases of goods and services using a purchase card for six years. Required documents include preapprovals, purchase orders, vendor invoices, receiving reports, and written justifications for purchases from a third-party payer.

The review team determined that 10 of the 38 sampled transactions (26 percent) were missing documentation. Table 2 summarizes the results of the team’s review of supporting documents.

Table 2. Evaluation of Sample Supporting Transaction Documentation Provided by the Healthcare System

Purchase card supporting document	Number of samples supporting documents <u>not</u> provided	Percent of sample supporting documentation <u>not</u> provided
Prior approval/purchase request	1 of 38	3%
Purchase order	0 of 38	0%
Vendor invoice	0 of 38	0%
Receiving reports	4 of 38	11%
Justification for purchase from a third-party payer	5 of 5	100%

Source: VA OIG assessment of the 38 sampled transactions.

While purchase cardholders generally maintained prior approval, purchase request, purchase order, and vendor invoice documentation, they did not consistently maintain receiving reports or justifications when purchasing from third-party payers. The healthcare system did not provide mitigating circumstances to explain the lack of supporting documentation.

The 10 transactions with missing documentation resulted in about \$79,300 in questioned costs. Missing documentation included receiving reports for four of these transactions totaling \$16,100. Given there was no evidence that the goods had been received, the review team could not

determine if these were proper or improper payments. These payments are considered unknown payments per Office of Management and Budget guidance.²¹

In addition, the review team found that for 12 purchase card transactions that did have supporting documentation, the cardholders either did not maintain a proper segregation of duties or ensure a timely reconciliation of charges, or both. These transactions resulted in additional questioned costs of about \$79,700, for a total of about \$159,000 questioned costs for 22 of 38 sampled transactions.

Oversight of the Purchase Card Program

Responsible officials are accountable for compliance with the government purchase card program and for implementing internal controls to protect and conserve federal funds. Oversight activities reduce the risk of error, fraud, waste, and abuse within the purchase card program.

To assess oversight of the program and compliance with VA policy, the review team determined whether the healthcare system's approving officials were assigned no more than 25 purchase card accounts; whether a VA Form 0242, which delegates authority to an individual to use a VA purchase card, was maintained for each cardholder in the review sample; and if reviews of cardholder transactions and quarterly purchase card certifications were conducted. The review team found that approving officials did not exceed the threshold for purchase card accounts, VA Form 0242s were maintained for cardholders, and that reviews and purchase card certifications were conducted.

Finding 2 Conclusion

The healthcare system did not always process transactions according to VA policy. Transactions lacked prior approval, were not reconciled timely by an approving official, or were transacted without an appropriate segregation of duties. Some transactions were not properly documented. These issues, which resulted in at least \$159,000 of questioned costs, could have been detected with effective reviews by purchase card program officials.

Recommendation 2

The OIG made the following recommendation to the director of the VA El Paso Healthcare System:

²¹ OMB Memo M-21-19, "Transmittal of Appendix C to OMB Circular A-123, Requirements for Payment Integrity Improvement," March 5, 2021; GAO, *Payment Integrity: Federal Agencies' Estimates of FY 2019 Improper Payments*, GAO-20-344, March 2020, accessed January 25, 2021. "Unknown" is the estimated amount within the agency's improper payment estimate that could be either proper or improper, but the agency is unable to discern whether the payment was proper or improper as a result of insufficient or lack of documentation.

2. Establish procedures to ensure cardholders comply with record retention and transaction-processing requirements as stated in VA's Financial Policy, vol. XVI, "Charge Card Program."

VA Management Comments

The healthcare system interim medical center director concurred with recommendation 2. The interim medical center director reported the healthcare system provided remedial training for all purchase card holders in the first quarter of fiscal year 2022, with a focus on preapproval requirements, timely reconciliation, and segregation of duties. The interim medical center director also reported program coordinators will complete quarterly audits of transactions, to include documentation of preapproval, record retention, and segregation of duties.

Appendix E contains the full text of the interim medical center director's comments.

OIG Response

The interim medical center director's action plan is responsive to the recommendation. The OIG will monitor implementation of the planned actions and will close the recommendation upon receiving sufficient evidence demonstrating progress in addressing the intent of the recommendation and the issues identified.

III. Medical Surgical Prime Vendor-Next Generation Program Use

VHA medical facilities are required to use MSPV-NG for products that are available through the program, which appear on a list called a formulary.²² As previously mentioned, the VA MSPO recommends that each medical center purchase at least 90 percent of its medical supplies on the formulary from its assigned regional prime vendor.

During the COVID-19 pandemic, VA recognized that there was increased stress on its supply chain. In March and May of 2020, VA issued memos suspending certain performance measures related to medical supply purchases to maintain operations. The 90 percent metric was not one of the suspended performance measures.

According to the MSPV-NG formulary utilization dashboard, the healthcare system spent about \$120,800 from March 1, 2020, through February 28, 2021, on MSPV-NG purchases from its prime vendor, Medline Industries.²³ In contrast, the healthcare system spent about \$731,900 purchasing supplies from sources other than the prime vendor.

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

- **Formulary utilization rate** measures the extent to which facilities use prime vendors for formulary item purchases.
- **National contract waiver requests** are required when purchasing available formulary items from nonprime vendor sources.
- **Contract performance monitoring** includes a healthcare system's oversight of the prime vendor, as well as the use of reporting tools that allow the healthcare system to report on prime vendor performance to provide MSPV-NG program feedback. One element of prime vendor performance is the order fulfillment rate, a contractual requirement to fulfill at least 95 percent of monthly orders placed by a facility for items on the formulary.

Finding 3: The VA El Paso Healthcare System Did Not Meet the MSPV-NG Utilization Goal, Did Not Request National Contract Waivers, and Did Not Routinely Use All Reporting Mechanisms on Prime Vendor Performance

The healthcare system did not meet the 90 percent formulary utilization goal for purchases made through the MSPV-NG program from March 1, 2020, through February 28, 2021, according to

²² VHA memorandum, "Use of Medical/Surgical Prime Vendor (MSPV) Contracts is Mandatory," June 22, 2015.

²³ The review team did not assess the accuracy of the summary data in the MSPV-NG formulary utilization dashboard.

MSPV-NG data from SCCOP.²⁴ Its formulary utilization rate averaged about 14 percent according to the MSPV-NG performance metrics dashboard. The review team did not assess the impact that the COVID-19 pandemic may have had on the healthcare system's MSPV-NG utilization rates. However, the team did determine that utilization rates have been consistently below the goal, both before and after the onset of the COVID-19 pandemic and its associated supply chain disruptions. For the 12 months before the COVID-19 pandemic, March 2019 through February 2020, the healthcare system's formulary utilization averaged about 21 percent.

Generally, this occurred when Medline, the MSPV-NG prime vendor, did not have adequate stock on hand to provide supplies when ordered due to supply chain shortages, and because the agreed-upon delivery method did not consistently support the healthcare system's need for timely delivery.²⁵ The healthcare system's requests to switch delivery methods were not granted by the prime vendor. Medline's contract requirements include maintaining the necessary inventory levels to provide the required supplies to participating facilities and distributing supplies at the required unadjusted fill rates.²⁶ The unavailability of supplies and delivery method limitations from the prime vendor resulted in the need to purchase formulary supplies from other vendors. Nonetheless, the healthcare system reported in quarterly evaluations that Medline provided satisfactory or higher service and did not make use of another issue-reporting tool. The OIG also found that the healthcare system paid approximately \$32,049 more for 4,313 supply items purchased from nonprime vendor sources because of these issues.²⁷ Additionally, the review team found that the healthcare system did not submit contract waiver requests for approval for 3,417 of these purchased supply items totaling approximately \$26,533 as required by VA policy.²⁸

Formulary Utilization Rate Challenges

The healthcare system's annual average MSPV-NG utilization rate was about 14 percent, and the monthly average ranged from 8 percent to 22 percent during the 12-month OIG review period. In response to the urgent need and medical supply shortages that medical centers experienced

²⁴ 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.

²⁵ *COVID-19: Federal Efforts Could Be Strengthened by Timely and Concerted Actions*, GAO, September 2020, accessed January 17, 2021, <https://www.gao.gov/assets/gao-20-701.pdf>. Shortages of certain types of personal protective equipment and testing supplies remain due to a supply chain with limited domestic production and high global demand.

²⁶ The unadjusted fill rate is the calculation of orders fulfilled 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).

²⁷ A judgmental sample of 30 purchasing records, which covers 17 frequently acquired formulary supply items purchased 4,313 times in total from vendors other than the prime vendor, was selected for facility review and comment.

²⁸ VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

during the pandemic, VA adjusted expectations for medical center inventory and purchasing. For example, a VA memo dated March 15, 2020, provides purchasing flexibilities that included increasing the emergency acquisition threshold for government purchase cards and contracts to expedite the delivery of goods and services.²⁹ While VA did not specifically suspend the 90 percent formulary utilization goal, the review team determined that the healthcare system’s annual average formulary utilization rate decreased from 21 percent for the 12 months before the review period to 14 percent during the review period. Figure 3 shows the healthcare system’s monthly MSPV-NG formulary utilization rates.

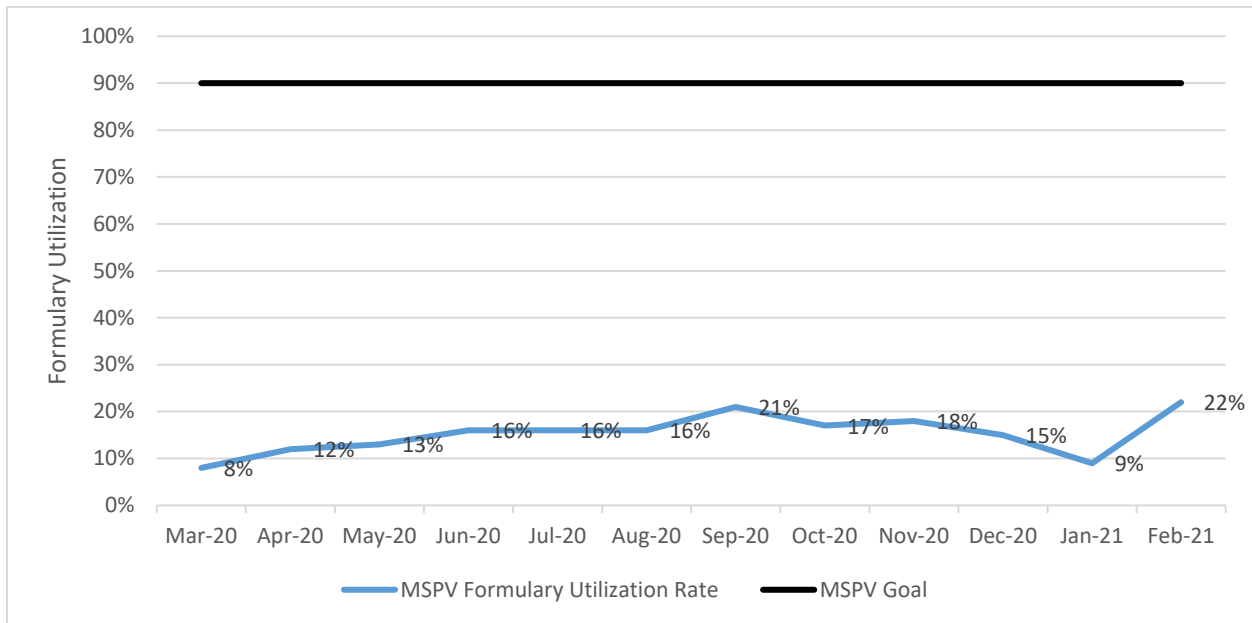


Figure 3. MSPV-NG Utilization Rates for the VA El Paso Healthcare System.

Source: VA OIG analysis of the VA El Paso Healthcare System’s MSPV-NG Utilization Report.

The healthcare system spent about \$731,900 on formulary supply items from nonprime vendor sources (just under 86 percent of the total potential MSPV-NG expenditure), versus purchasing from Medline as the prime vendor for supply items. Using the MSPV-NG formulary utilization report from the SCCOP dashboard, the review team judgmentally sampled 30 purchase records of formulary items acquired from nonprime vendor sources to assess why these items were purchased using these sources. The team provided these records to facility staff and requested comments from them to understand why these items were not purchased through the prime vendor and to assess the potential cost differences. These 30 records cover 17 frequently acquired formulary supply items, purchased 4,313 purchased times in total at a cost of about \$387,116.

²⁹ VA memo, “Emergency Acquisition Flexibilities – Emergency Assistance Activities in support of Global Pandemic for Coronavirus Disease 2019 (COVID-19),” March 15, 2020.

The review team interviewed the healthcare system’s logistics leaders, managers, and ordering staff to determine what challenges the staff faced when purchasing supplies from the MSPV-NG prime vendor. Table 3 shows the reasons staff gave for not purchasing these items from the prime vendor.

**Table 3. Reason Categories for Sample of Nonprime Vendor Purchases
March 1, 2020, through February 28, 2021**

Reason category	Number of reviewed transactions	Number of items in records (quantity)	Prices paid to nonprime vendor sources according to recorded amount	Difference between prices paid to nonprime vendor sources and MSPV-NG formulary prices (Overpayment or underpayment)	OIG questioned costs due to not submitting national contract waiver requests (difference between prices paid and MSPV-NG prices)
Allocation limitation	8	796	\$58,726	\$6,508	\$0
Prosthetics items purchased through national prosthetics contracts instead of the MSPV-NG program	14	3,230	\$155,755	\$1,379	\$1,379
Specialty items staff believed were not available from the prime vendor	5	37	\$37,017	\$23,970	\$23,970
Use of the Defense Logistics Agency’s Medical Electronic Catalog (ECAT) system	2	150	\$130,616	\$1,184	\$1,184
Items purchased through a local contract instead of the	1	100	\$5,002	(\$992)	\$0

Reason category	Number of reviewed transactions	Number of items in records (quantity)	Prices paid to nonprime vendor sources according to recorded amount	Difference between prices paid to nonprime vendor sources and MSPV-NG formulary prices (Overpayment or underpayment)	OIG questioned costs due to not submitting national contract waiver requests (difference between prices paid and MSPV-NG prices)
MSPV-NG program					
Total	30	4,313	\$387,116*	\$32,049*	\$26,533*

Source: VA OIG analysis of the VA El Paso Healthcare System sample responses.

* Values are rounded.

The healthcare system’s prosthetics and logistics staff explained that 14 of the 30 records reviewed, or 3,230 formulary items, were purchased from nonprime vendor sources because they incorrectly believed the use of national prosthetics contracts were required over the MSPV-NG contract. Also, logistics staff explained that eight of the purchases reviewed, or 796 formulary items, were purchased from nonprime vendor sources because the good or service could not be filled at the time due to allocation-related issues. When items are on allocation, it means the prime vendor limits the amount that a single customer can purchase of the item. In addition to masks and other personal protective equipment, items such as disinfecting wipes and cloths and disinfecting solution were placed on allocation during the review time frame.

Due to the short supply and high demand for personal protective equipment and other supplies during the pandemic, the prime vendor maintained these allocations. Consequently, the healthcare system attempted to purchase items from other sources. Given the increased use during the pandemic, Medline’s allocated quantities were not sufficient to meet VA’s needs, which added to the need to go to other vendors for supplies.

The review team compared the purchase prices for the eight samples identified as nonprime vendor purchases due to allocation-related issues, to the prices listed in the MSPV-NG formulary. This analysis determined that the healthcare system paid over \$58,726 for the items from nonprime vendor sources, which was about \$6,508 more when compared to prices listed in the formulary. Using the prices stated in the formulary, these items would have totaled about \$52,217.

Prime Vendor Supply Chain Shortages

The healthcare system’s prime vendor, Medline, described the COVID-19 global pandemic as a crisis, and reported continued disruptions in production as demand grew to 300 percent higher than traditional manufacturing and distribution volumes. As a result, Medline put inventory management policies into effect. One such policy was to ration personal protective equipment

supplies, including face masks, isolation gowns and coveralls, surgical drapes and gowns, standard and custom packs, hand sanitizer, and exam gloves. Medline representatives explained that Medline was also experiencing issues with getting items from its suppliers who could not get the raw materials to manufacture items. For example, the availability of materials for disinfectant wipes intermittently disrupted production and the market-wide shortage of isopropyl alcohol, a key ingredient in many products, challenged Medline. During this time, the healthcare system's logistics staff said Medline did not have adequate stock on hand to provide ordered supplies. The review team determined that the prime vendor's allocation reports showed that Medline could not always supply items when ordered.

Use of Other Procurement Vehicles over the MSPV-NG Program

VHA policy stipulates that VA medical facilities must use MSPV-NG distribution contracts to the extent provided by law, in addition to other national contracts designated as mandatory in VHA policy, to purchase medical supplies. When an item is simultaneously available through an MSPV-NG distribution contract and another mandatory procurement instrument, the MSPV-NG contract must be used.³⁰

The OIG found that the healthcare system used other procurement vehicles to purchase items that were available on the MSPV-NG formulary. Other procurement vehicles used include national prosthetics contracts, specialty vendors, the Defense Logistic Agency's Medical Equipment Catalog (ECAT), and a local contract.³¹ VHA ordering hierarchy guidance says facilities should procure items from sources according to the order below:

1. AbilityOne Procurement List³²
2. MSPV-NG formulary
3. Existing mandatory and regional blanket purchase agreement and indefinite delivery indefinite quantity contracts
4. Medical Electronic Catalog (ECAT)

As mentioned previously, the review team learned from the healthcare system's prosthetics and logistics chiefs that 14 of the 30 records reviewed, or 3,230 prosthetic items, were purchased

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

³¹ The Defense Logistics Agency (DLA) MSPV-NG program is available to non-Department of Defense customers through a process known as Medical Electronic Catalog Prime Vendor Web Ordering. This process uses DLA's ECAT platform to allow registered non-Department of Defense customers to access MSPV-NG items. ECAT is an internet solution that uses the latest technology for ordering, distribution, and payment, providing Department of Defense and other Federal agencies access to multiple manufacturers and distributors' commercial catalogs at discounted prices.

³² The U.S. Ability One Commission is the operating name for the Committee for Purchase from People Who Are Blind or Severely Disabled.

from nonprime vendor sources because the logistics team and the chief of prosthetics believed use of national prosthetics contracts were required, instead of purchasing the items through the MSPV-NG contract. The review team compared the purchase prices for the 14 records the healthcare system purchased through national prosthetics contracts, to prices listed in the MSPV-NG formulary. This analysis determined that the healthcare system paid over \$155,755 for the items from nonprime vendor sources, about \$1,379 more when compared to prices listed in the formulary. Using the prices stated in the formulary, these items would have totaled about \$154,376.

The review team also learned from the healthcare system's logistics team that five of the 30 purchase records reviewed, or 37 specialty items, were purchased from nonprime vendor sources because the logistics team believed the specialty items were not available from the prime vendor. The review team compared the purchase prices for the five samples the healthcare system purchased utilizing specialty vendors, to prices listed in the MSPV-NG formulary. This analysis determined that the healthcare system paid over \$37,017 for the items from nonprime vendor sources, which is about \$23,970 more when compared to prices listed in the formulary. Using the prices stated in the formulary, these items would have totaled about \$13,047.

The review team learned from the logistics team that two of the 30 samples, or 150 equipment items totaling approximately \$130,616, were purchased through ECAT. This occurred because the healthcare system's logistics team believed these equipment purchases should have been purchased using ECAT, rather than the MSPV-NG contract. The chief of logistics said that the VISN was pushing the use of ECAT to purchase equipment. As stated above, VA policy stipulates that when supply items are simultaneously available through an MSPV-NG contract and another procurement vehicle, the MSPV-NG contract must be used.

To identify the financial impact of using ECAT instead of the MSPV-NG formulary, the review team compared ECAT costs against MSPV-NG formulary pricing for the same items. The analysis determined that the cost of an equivalent order using formulary prices would be \$129,433, about \$1,184 less than the actual price paid by VA using ECAT.

The logistics team also told the review team that one of the 30 samples reviewed, or 100 items totaling approximately \$5,002, were purchased from a nonprime vendor source because the logistics team used a local vendor it had used for years, rather than purchasing the items from the MSPV-NG contract. The review team compared prices paid to MSPV-NG formulary prices for the same item and found that the healthcare system paid \$992 less when purchasing the item from another source.

Limitations with Conventional Bulk Distribution and Low Unit of Measure Delivery Methods

The distribution methods offered by vendors participating in the program vary based upon the needs of medical facilities. The spectrum ranges from conventional bulk distribution (CBD) to

unit of use or low unit of measure (LUM) delivery programs in a just-in-time environment. The intent is to provide maximum benefit and flexibility to all VA medical facilities that participate in the program. Although distribution fees are higher with LUM than with CBD because of the cost of more frequent item delivery and package breakdown by the prime vendor, the LUM ordering option allows facilities to order items in quantities different than the formulary's unit of issue and helps facilities save space, reduce inventory, and minimize supply expirations.

According to the chief of logistics and his staff, Medline's CBD delivery method was not conducive with timely and efficient order fulfillment. Medline imposed a 250-pound minimum weight requirement on the healthcare system's orders for them to qualify for "next day" delivery. Logistics personnel told the review team that it was difficult for the healthcare system to meet this weight requirement due to its relatively small size and small order quantities. According to the chief of logistics, since the conventional/bulk delivery method contained a weight requirement the healthcare system was limited to one or two deliveries per week, at most. The review team did not quantify the magnitude of the impact, but the healthcare system said that it affected the decision as to whether to use the prime vendor. Per the chief logistics officer, this limitation led the healthcare system to purchase supplies from nonprime vendor sources to obtain supplies when needed.

Although the LUM delivery method would be more expensive than the CBD delivery method, the healthcare system's logistics team said they believe it would better meet needs and support just-in-time operations as described by VA policy. LUM ordering offers next day deliveries and allows the healthcare system to place orders five days per week. Requests to switch to LUM delivery were not granted by the prime vendor, which said that the reason was primarily due to COVID-19 pandemic priorities. Over five months after the initial request, the prime vendor offered a hybrid CBD and LUM delivery method; however, the healthcare system declined the offer because the logistics team believed they would still encounter the "weight-break" issue with the hybrid delivery method. To support this assertion, the healthcare system's logistics personnel provided documentary and testimonial evidence, including email messages demonstrating that the terms of the conventional bulk delivery method were not conducive with timely and efficient order fulfillment.

Contract Waiver Requests

Additionally, the review team found that the healthcare system did not submit waiver requests required by VA policy for 22 of these purchases, which totaled approximately \$328,390. If the healthcare system had used the formulary pricing for 21 of these 22 purchases, it would have paid \$301,857. The OIG identified the additional approximately \$26,533 paid as questioned

costs because the system should have purchased the items with formulary pricing.³³ For one of the 22 records, the review team did not identify the price difference as a questioned cost because the healthcare system paid approximately \$992 less by purchasing from a nonprime vendor source. For eight records reviewed, or 796 items totaling approximately \$58,726, the supply items were unavailable from the prime vendor due to rationing. As a result, waiver requests were not required, and the review team did not question these costs.

The healthcare system's chief of logistics told the review team that staff do not use national waiver requests when purchasing formulary items from nonprime vendor sources because the logistics team was not aware of the waiver request requirement. This is not consistent with VHA policy, which stipulates that facilities must submit a national contract waiver request when there is a compelling clinical need to not use the MSPV-NG contract to buy medical supplies. Each waiver request must provide a valid, justifiable, and appropriate clinical rationale for purchases from a nonprime vendor source. VHA's headquarters directs that, to the extent permitted by law, VA medical facilities must utilize the MSPV-NG distribution contracts, in addition to other national contracts designated as mandatory in VHA policy, to purchase medical supplies. When an item is simultaneously available through an MSPV-NG distribution contract and another mandatory procurement instrument, the MSPV-NG contract must be used.

Contract Performance Monitoring

If prime vendors do not meet their obligations, healthcare system personnel should alert program leaders and other VA procurement offices. One tool for doing so is the monthly facility execution survey, which informs the MSPO of the healthcare system's feedback on the MSPV-NG program and the MSPV-NG prime vendor. The review team determined the contracting officer's representative was unaware of the monthly facility execution survey and therefore never used it.

Another method for reporting concerns with the prime vendor's performance is the issue management tool, which is used by contracting officer's representatives and supply chain staff. The review team determined that the healthcare system did not always use the issue management tool, as there were only three issues reported in the tool from March 1, 2020, through February 28, 2021.

The team also obtained four quarterly evaluations reports for FY 2020 from the MSPV-NG contracting officer's representative. The evaluations are completed by the contracting officer's representative and assess a prime vendor's performance in areas such as quality, schedule, management, and regulatory compliance. The evaluations the review team assessed did not

³³ 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 cost, at the time of the audit, is not supported by adequate documentation. See appendix D for monetary benefits associated with the questioned costs.

reflect the significant delivery or fulfillment rate issues experienced at the healthcare system. On four evaluations, the contracting officer's representative rated Medline as "satisfactory" to "very good" in all areas.³⁴ A satisfactory rating indicates only minor problems exist, or a major problem that the contractor corrected and did not affect contract performance. These ratings are contrary to the major delivery and fulfillment issues experienced by the healthcare system.

The lack of facility execution surveys and the contracting officer representative's satisfactory or higher ratings on vendor evaluations limited the ability of the MSPO and Strategic Acquisition Center to hold Medline accountable for meeting its contractual obligations. Facility personnel should use all available tools to report issues with the prime vendor and provide accurate evaluations and feedback to the MSPO and Strategic Acquisition Center so that officials have the information needed to evaluate the effectiveness of the prime vendor and the MSPV-NG program, and to remind the prime vendor of its contractual obligations.

Prime Vendor Fill Rates

Medline's contractual requirements included maintaining the necessary inventory levels to provide the required supplies to participating facilities and distributing supplies at an unadjusted fill rate of 95 percent. Medline provided the team with a monthly summary fill rate report for March 1, 2020, through February 28, 2021. According to this report, the prime vendor's unadjusted fill rate averaged 85 percent, demonstrating on average that the prime vendor did not meet the required 95 percent fill rate requirement.

The team reviewed this report and found that Medline's monthly fill rates ranged from a low of approximately 62 percent to a high of 100 percent, with a 12-month average of 85 percent during the team's review period and Medline's unadjusted fill rates only met or exceeded the 95 percent fill rate requirement for two of the 12 months. Figure 4 depicts Medline's monthly unadjusted fill rates for March 1, 2020, through February 28, 2021.

³⁴ The contracting officer's representative evaluation form assesses prime vendor performance using a five-level evaluation scale, which includes five rating categories: exceptional, very good, satisfactory, marginal, and unsatisfactory.

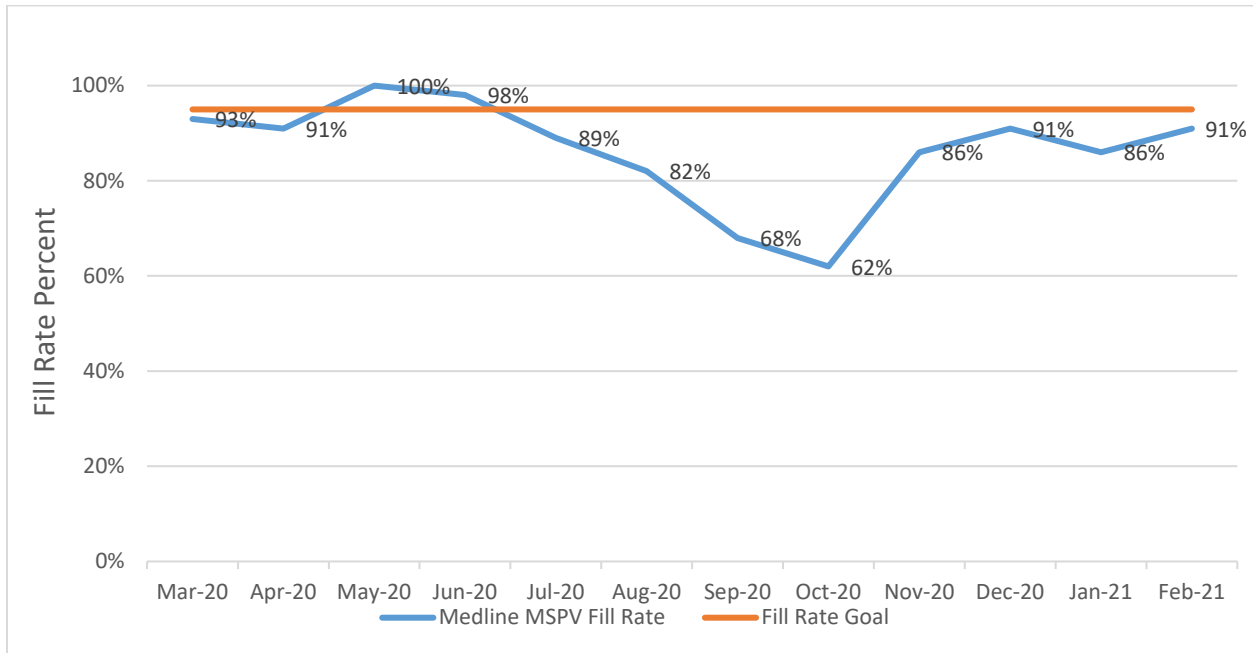


Figure 4. Medline’s Unadjusted Fill Rate Percentages, March 2020 through February 2021.

Source: Monthly summary of fill rate percentages provided by Medline Industries, Inc.

Finding 3 Conclusion

The healthcare system did not meet the MSPV-NG utilization goal from March 1, 2020, through February 28, 2021, because (1) Medline did not always have adequate stock on hand to provide supplies when ordered, (2) the healthcare system used other procurement vehicles instead of the MSPV-NG program, and (3) the conventional bulk delivery method was subject to weight requirements. As a result, for the sample of purchases reviewed, the healthcare system spent approximately \$32,049 more on supply items from nonprime vendor sources than it would otherwise have spent. Also, because the healthcare system was unaware of waiver request requirements, it did not submit MSPV-NG waiver requests for approval when purchasing available formulary items from nonprime vendor sources, as required by VHA policy resulting in about \$26,533 in questioned costs. Lastly, healthcare system personnel did not fully use the available reporting tools to provide feedback on the prime vendor’s performance to assist with solving identified issues. These tools are important because they ensure VHA has the information needed to take corrective action as needed.

Recommendations 3–7

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

3. Develop a plan to work with the prime vendor to address having adequate stock to meet orders, reducing the need for the healthcare system to use nonprime vendors.

4. Ensure the healthcare system follows the Medical Surgical Prime Vendor-Next Generation ordering hierarchy and purchases items from the Medical Surgical Prime Vendor-Next Generation contract before using other sources.
5. Ensure the healthcare system elects and is granted a delivery method that meets just-in-time requirements.
6. Ensure the healthcare system submits Medical Surgical Prime Vendor-Next Generation waiver requests and obtains approval before purchasing available formulary items from nonprime vendor sources.
7. Ensure logistics staff and contracting officer's representatives use all the tools available to inform the Medical Supplies Program Office and Strategic Acquisition Center of prime vendor performance issues.

VA Management Comments

The healthcare system interim medical center director concurred with recommendations 3–7. To address recommendation 3, the interim medical center director reported the healthcare system stationed a representative from Medline locally on December 6, 2021, to help facilitate purchases and improve the MSPV-NG utilization rate to 35 percent. The response also noted that the Medline representative has been instrumental in identifying substitution options for items that would otherwise be purchased from nonprime vendors on the open market.

For recommendation 4, the interim medical center director reported that the Medline representative would assist in transitioning more items through MSPV-NG, and that training with purchasing and inventory staff has been conducted that identifies conditions to be met prior to purchasing through nonprime vendor sources. The interim medical center director also stated that certain prosthetic devices can only be ordered through specific vendors, and that contracted purchase card purchases are allowed but may affect MSPV-NG utilization rates.

To address recommendation 5, the interim medical center director reported the healthcare system submitted a new service election form to Medline that requires lowest unit of measure deliveries along with four delivery days per week. Additionally, Medline is following a two-day shipping schedule from the time they receive orders from the facility.

For recommendation 6, the interim medical center director reported the healthcare system's logistics staff will conduct and document training on waiver submission processes and provide staff with a written reference to the process.

To address recommendation 7, the interim medical center director reported that the healthcare system meets weekly with VISN logistics staff to identify and rectify MSPV-NG performance issues. A quality control review is scheduled for the fourth quarter of FY 2022 to review implementation of procedure updates, MSPV utilization, and any continuing issues with prime vendor performance.

Appendix E contains the full text of the interim medical center director's comments.

OIG Response

The interim medical center director's action plans are responsive to the recommendations. The OIG will monitor implementation of the planned actions. While the interim medical center director reported that actions have been completed on recommendations 3, 4, and 5, the OIG considers all the recommendations open and will close them once sufficient evidence has been provided demonstrating progress in addressing the intent of the recommendations and the issues identified.

IV. Pharmacy Operations

The FY 2020 OPES pharmacy model, based on FY 2019 VA data, reported that prescription drug spending at the healthcare system about \$33.8 million. This spending represented almost 9 percent of the healthcare system's budget of approximately \$399 million. It is important for medical center 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 opportunity grid to identify opportunities for improvement in the healthcare system.

The team reviewed the following pharmacy areas:

- **OPES pharmacy expenditure** data that helps VHA facilities track cost performance and identify potential opportunities for improvement.
- **Inventory turnover rate** (the number of times inventory is used during the year) as the primary measure to monitor the effectiveness of inventory management per VHA policy.³⁵ Low inventory turnover rates indicate inefficient use of financial resources.
- **Noncontrolled drug line audits**, which are to be performed quarterly for specific drugs identified as potentially high risk for diversion and are required by VHA policy.³⁶

Finding 4: The VA El Paso Healthcare System Could Improve Pharmacy Efficiency, Increase Inventory Turnover Rate, and Strengthen Oversight Controls

The OIG found the healthcare system could improve pharmacy efficiency by reducing the difference between actual drug costs and expected drug costs, increasing inventory turnover closer to the VHA-recommended level, and meeting noncontrolled drug line audit requirements. Failure to properly manage pharmacy operations can lead to increased replenishment costs, overstocking, spoilage, diversion of drugs, and decreases the funding available to meet other healthcare system and patient care needs.

OPES Pharmacy Expenditure Data

The OPES pharmacy expenditure model, which identifies variations in pharmacy costs among VHA facilities, showed that the VA El Paso Healthcare System spent about \$33.8 million on drugs in FY 2020. According to the model, this amount was about \$5.8 million higher than the expected costs of about \$28 million. Based on these numbers, the healthcare system's observed-

³⁵ VHA Directive 1761(2), *Supply Chain Inventory Management*, app. I, October 24, 2016, amended October 26, 2018. Inventory turnover rates are based on total dollar value purchased for the year divided by the dollar values of items on the shelf.

³⁶ VHA Directive 1108.08 (1), *VHA Formulary Management Process*, November 2, 2016, amended August 29, 2019.

to-expected ratio was 1.205, which ranked it 136 out of 139 VHA facilities for pharmacy drug cost efficiency. An observed-minus-expected ratio above 1.0 indicates that a facility may have opportunities to reduce its pharmacy costs.³⁷

For both FY 2018 and FY 2019, the model showed that the healthcare system had under \$1 million in annual opportunities for savings, which significantly increased to about \$5.8 million for FY 2020. The OIG team attributed this to the healthcare system not having dedicated efforts such as action plans, benchmarking, workgroups, or actions taken to address the inefficiencies. In addition, pharmacy leaders stated that due to community care, the healthcare system experienced high-cost prescriptions issued by community care non-VA providers. The healthcare system’s rural location increased the veterans’ use of non-VA providers who were prescribing nonformulary drugs at higher costs than VA providers. Figure 5 shows the observed cost, expected cost, and observed-minus-expected drug costs for FY 2018 through FY 2020.

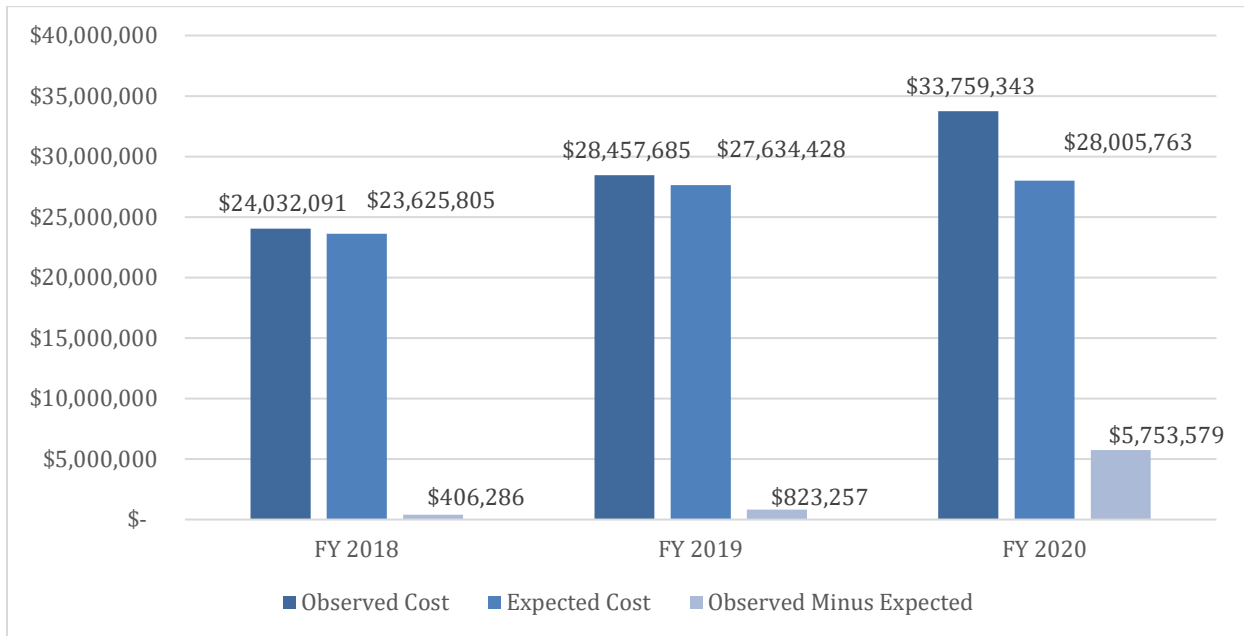


Figure 5. Observed versus expected drug cost, FY 2018–FY 2020.

Source: VA OIG analysis of OPES pharmacy expenditure model.

Note: The OPES data models are based on the previous fiscal year data (e.g., FY 2020 data model was based on FY 2019 data.) Values are rounded.

³⁷ The OPES Pharmacy Expenditure model uses the terms “Observed minus Expected” and “Potential Opportunity” to describe the gap between a facility’s actual drug costs and expected drug costs. This difference represents the amount associated with potential efficiency improvements.

Inventory Turnover Rate

The OIG determined that the healthcare system did not run required monthly inventory management reports from the prime vendor software package, use data for inventory management, or adjust stock levels in accordance with VHA policy. According to pharmacy personnel, inventories were being “managed by demand” instead of using demand forecasting as directed by policy.³⁸ Demand forecasting, in which weighting factors are applied to past purchases, must be used in the calculation of both the reorder points and reorder quantities for more accurate inventory management.

VHA policy states that monitoring inventory turnover is the primary measure of the effectiveness of inventory management.³⁹ The turnover rate is a measure of the number of times inventory is used during the year. In FY 2021, the pharmacy prime vendor reported an inventory turnover rate of 6.35, lower than VHA’s recommended level of 12 as established by the Office of Pharmacy Benefits Management Services. 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. VHA policy also mandates the use of prime vendor inventory management reports to manage all VA medical facility pharmacy inventories.⁴⁰

The review team was told the healthcare system assigned an acting chief of pharmacy in April 2021 when the chief of pharmacy went on extended leave. According to the acting pharmacy chief, the healthcare system was below the recommended inventory turnover level because the chief of pharmacy did not transition pharmacy responsibilities adequately and did not establish inventory management practices before going on leave. In addition, the acting pharmacy chief was not familiar with inventory management, pharmacy budget, and VHA policy requirements before taking the position.

Noncontrolled Drug Line Audit

VHA policy requires regular facility-based inventory audits for specific drugs identified as potentially at high risk for diversion. A manual count of each drug item selected must be completed and compared to reports and other tools selected by local pharmacy management. The variance between the observed and predicted amount on hand for the reporting period must be calculated. Variances greater than 5 percent require the healthcare system to perform an in-depth review and analysis.⁴¹

³⁸ VHA Directive 1108.08 (1), *VHA Formulary Management Process*, November 2, 2016, amended August 29, 2019.

³⁹ VHA Directive 1761(2), *Supply Chain Inventory Management*, October 24, 2016, amended October 26, 2018.

⁴⁰ VHA Directive 1761(2), *Supply Chain Inventory Management*, October 24, 2016, amended October 26, 2018.

⁴¹ VHA Directive 1108.08 (1), *VHA Formulary Management Process*, November 2, 2016, amended August 29, 2019.

The team's review of the healthcare system's quarterly noncontrolled drug line audits for FY 2020 determined that these audits did not meet the requirements of VHA policy. The OIG team re-calculated the facility's reported quarterly variances and found that 18 of the 61 were inaccurate. Further, the team determined that the Pharmacy Benefits Management inventory reporting tool, which is used by the healthcare system, incorrectly states that an in-depth review was required if the variance is greater than 10 percent. According to VHA policy, a facility must complete an in-depth review if variance is greater than 5 percent. Therefore, the Pharmacy Benefits Management inventory reporting tool did not align with VHA policy. The pharmacy specialist stated that he was unaware of the disconnect between the Pharmacy Benefits Management tool and VHA policy.

In addition, VHA policy requires the results of these audits to be reported to facility management through the quality assurance process on a quarterly basis. Also, quarterly, and annual summaries are to be reported to the VISN Pharmacy Executive Committee and should indicate the results of the reviews and any follow-up actions taken. During interviews conducted with pharmacy staff, the review team learned these requirements were not met, and that pharmacy leaders and staff were not made aware of the review results. Failure to fully complete regular inventory audits can lead to an increased risk of drug diversion, inadequate inventory levels to meet patient care needs, and the likelihood of unnecessary spending within the pharmacy program.

Finding 4 Conclusion

The healthcare system needs to improve pharmacy efficiency by taking a more proactive approach in reducing the gap between actual drug costs and expected drug costs, increasing the inventory turnover, ensuring the use of the prime vendor inventory management reports to manage drug inventory, and in meeting noncontrolled drug line audit requirements. An efficient healthcare system anticipates how much drugs will cost and when inventory needs to be restocked to help ensure that the system makes the best use of appropriated funds and has inventory when needed.

Recommendations 8–12

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

8. Develop formalized processes for achieving identified efficiency targets and use available pharmacy data to make business decisions.
9. Educate non-VA providers on prescribing lower-cost drugs.
10. Develop and implement a plan to increase inventory turnover to the Veterans Health Administration-recommended level.

11. Develop and implement a plan to complete facility-based inventory audits of noncontrolled drug line items in compliance with Veterans Health Administration policy.
12. Develop a plan to ensure that appropriate metrics for monitoring compliance with Veterans Health Administration policy are calculated correctly in the Pharmacy Benefits Management inventory reporting tool.

VA Management Comments

The healthcare system interim medical center director concurred with recommendations 8–12. To address recommendation 8, the interim medical center director reported the pharmacy will provide data and plans of action for various metrics either monthly or quarterly to the chief of pharmacy for review and implementation.

For recommendation 9, the interim medical center director reported that during onboarding webinars, the healthcare system educates non-VA providers on the VA medication process guide, the VA formulary, and the need to follow the formulary. The healthcare system will provide Community Care Services with a VISN 17 common formulary medication list twice every fiscal year for dissemination to non-VA providers through TriWest. The healthcare system pharmacy will also review and recommend prescriptions to community care providers based on the VA Pharmacy Benefits Management formulary. Pharmacy staff also routinely communicate medication change requests with non-VA providers to improve formulary usage.

For recommendation 10, the interim medical center director reported that the FY 2021 overall pharmacy inventory turn rate was 13.1 times, about double the prior year's rate of 6.35 times. The interim medical center director stated the pharmacy changed the ordering process after our review and that ordering on demand helped the pharmacy to achieve higher inventory turn rate numbers for the current year's wall-to-wall inventory.

To address recommendation 11, the interim medical center director reported the healthcare system will create a standard operating procedure to guide noncontrolled drug line items. The standard operating procedure will include steps to guide the monthly process of noncontrolled drug inventory audit.

To address recommendation 12, the interim medical center director reported the pharmacoeconomics pharmacist will enter data into a noncontrolled substance database and the associate chief of pharmacy and procurement program manager will verify the data to ensure accuracy.

Appendix E contains the full text of the interim medical center director's comments.

OIG Response

The healthcare system interim medical center director's action plans are responsive to the recommendations. The OIG will monitor implementation of the planned actions. While the interim medical center director reported that actions have been completed on recommendation 11, the OIG considers all the recommendations open and will close them once sufficient evidence has been provided 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 healthcare system reporting to VISN 17. The VHA Facility Complexity Model categorized the VA El Paso Healthcare System as a level 2, medium complexity facility until September 30, 2020.⁴² The model is reviewed and updated every three years by the VHA Facility Complexity Model Workgroup and effective on October 1, 2020, the facility's level was changed to level 3, low complexity.

Table A.1. Healthcare System Profile for the VA El Paso Healthcare System (FY 2018–FY 2021)

Profile element	Facility data FY 2018	Facility data FY 2019	Facility data FY 2020	Facility data FY 2021
Total medical care budget in dollars	\$286,653,460	\$250,090,940	\$398,736,066	\$443,228,404
Number of:				
Unique patients	34,890	35,759	34,794	35,432
Outpatient visits	372,957	380,203	316,599	357,818
Total medical care FTE ⁴³	1,016	1,030	1,118	1,150
Type and number of operating beds*:				
Hospital	0	0	0	0
Domiciliary	0	0	0	0
Community living center	0	0	0	0
Average daily census:				
Hospital	0	0	0	0
Domiciliary	0	0	0	0
Community living center	0	0	0	0

Source: VSSC, Trip Pack and Operational Statistics report.

* There are no operating beds because inpatient care is provided through a VA/Department of Defense sharing agreement with the William Beaumont Army Medical Center.

Note: Values are rounded.

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

⁴² 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.

⁴³ Total Medical Care FTE includes both direct medical care FTEs in budget object code 1000–1099 (Personal Services) and all cost centers.

According to VSSC data, the healthcare system's medical care budget increased by over \$156 million, or about 55 percent between FY 2018 and FY 2021, while the number of unique patients increased by about 542, which is only a 2 percent change. The chief financial officer told the review team that the budget increased for the following reasons: there was a spike in community care costs due to the COVID pandemic; in 2020, \$77 million in community care funding was moved into the medical care budget that previously was reported separately; and finally, the healthcare system opened three new community-based outpatient clinics during FY 2020 and FY 2021 that required a budget increase for staffing needs, buildout costs, and equipment for the new facilities.

Appendix B: Scope and Methodology

Scope

The team conducted its review of the VA El Paso Healthcare System from May 2021, through April 2022, including a virtual site visit during the week of May 17, 2021. The review team evaluated financial efficiency practices for March 1, 2020, through February 28, 2021, for MSPV-NG utilization, October 1, 2020, through March 31, 2021, for open obligations, and April 1, 2020, through March 31, 2021, for purchase card transactions. The team also analyzed financial efficiency practices related to the healthcare system's pharmacy costs using the FY 2021 OPES data model—the FY 2021 OPES data model results are calculated based on FY 2020 data.

To conduct the review, the team

- interviewed healthcare system leaders and staff;
- identified and reviewed applicable laws, regulations, VA policies, operating procedures, and guidelines related to financial efficiency practices for MSPV-NG utilization, overseeing purchase card transactions, monitoring open obligations, and addressing inefficiencies in pharmacy costs;
- judgmentally sampled 10 obligations with no activity for more than 90 days from the March 31, 2021, FMS F850 report. This report lists each open obligation and its remaining balance. Five obligations were still within the performance period, and the remaining five were more than 90 days past the performance period end date and judgmentally sampled an additional 10 obligations to review end-date modifications; and
- judgmentally sampled 38 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

Computer-processed data used included reports from VA's Financial Management System to determine open obligation amounts. The team found that summary-level data were sufficiently reliable for reporting on the healthcare system's open obligations.

The review team used computer-processed data obtained from US Bank files 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 SCCOP dashboard to determine MSPV-NG utilization rates. The dashboard summary-level data were sufficiently reliable for reporting on the healthcare system's MSPV-NG utilization rate.

Government Standards

The OIG review team 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: Statistical Sampling Methodology

Open Obligations Oversight

The review team evaluated a judgmental sample of open obligation transactions from October 1, 2020, through March 31, 2021, to determine if (1) the healthcare system performed monthly reviews and reconciliations of the reviewed obligations with no activity for more than 90 days to ensure they were valid and should remain open, and (2) the healthcare system identified and supported open obligations from the sample with end-date modifications to the period of performance.

Population

From October 1, 2020, through March 31, 2021, open obligations with inactivity dates greater than 90 days at the healthcare system consisted of 86 records totaling approximately \$6.8 million. From October 1, 2020, through March 31, 2021, there were 19 obligations with end-date modifications.

Sampling Design

The review team selected two judgmental samples:

- **Inactive obligations.** The team selected 10 obligations with no activity for more than 90 days from the March 2021 FMS F850 report. This report lists each open obligation and its remaining balance.
- **End-date modifications.** The team selected 10 obligations with modified end dates to the period of performance for all open obligations from FMS F850 reports for March 2021 through August 2021.

The samples included 20 total open obligations: 10 with no activity for more than 90 days, totaling approximately \$3.4 million, and 10 with end-date modifications, totaling approximately \$3.9 million.

To review the sampled obligations, the team requested supporting documentation for each of the 20 sampled transactions, including monthly reviews and reconciliations, financial system screen prints and reports, and emails related to the obligations.

Projections and Margins of Error

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

Purchase Card Use

The review team evaluated a judgmental sample of 38 purchase card transactions from April 1, 2020, through March 31, 2021, to determine if for the reviewed transactions the healthcare system (1) processed purchase card transactions in accordance with VA policy and considered obtaining contracts for goods and services obtained on a regular basis; (2) maintained required supporting documentation; and if (3) oversight was maintained for the purchase card program.

The team defined potential split purchases as transactions with the same purchase date, purchase card number, and merchant, and an aggregate sum of greater than the cardholder's micropurchase limit. Within the 38 samples overall, the team identified a subset of 28 individual transactions, grouped into 10 bundles, as potential split purchases. This subset totaled approximately \$144,977.

Population

During April 2020 through March 2021, the healthcare system spent over \$16 million, representing 25,796 transactions through purchase cards.

Sampling Design

The review team developed a judgmental sample of high-risk transactional areas that identified potential split purchases. The team defined potential split purchases as transactions with the same purchase date, purchase card number, and merchant, and an aggregate sum of greater than the cardholder's micropurchase limit.

To review the sampled transactions, the team requested supporting documentation for each of the 38 sampled transactions. For the cardholders for these samples, the team also requested their VA Form 0242s.

Projections and Margins of Error

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

MSPV-NG Program Use

The review team evaluated a judgmental sample of purchase records of formulary items acquired by the healthcare system during the period of March 1, 2020, through February 28, 2021, to determine why these items were purchased using nonprime vendor sources.

Population

From March 1, 2020, through February 28, 2021, the healthcare system spent about \$731,900 on formulary supply items from nonprime vendor sources.

Sampling Design

The review team selected a judgmental sample of 30 records, totaling approximately \$387,116 of purchases from vendors other than the prime vendor.

To review the sampled purchase records, the team requested supporting documentation from the healthcare system for each of the 30 sampled transactions, including purchase orders, invoices, receiving reports and explanations as to why it purchased these items using a source other than the MSPV-NG prime vendor.

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
2	Establish procedures to ensure cardholders comply with record retention and transaction-processing requirements as stated in VA's Financial Policy, vol. XVI, "Charge Card Program."	\$0	\$159,000
6	The VA El Paso Healthcare System needs to ensure that national contract waiver requests are submitted before purchasing available formulary supply items from nonprime vendor sources.	\$0	\$26,533
	Total	\$0	\$185,533

Appendix E: Management Comments

Department of Veterans Affairs Memorandum

Date: May 12, 2022

From: Mark R. Rielo, Interim Medical Center Director, El Paso VA Health Care System

Subj: Draft Report, Financial Efficiency Review of the VA El Paso Healthcare System (Project Number 2021-02197-AE-0098)

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

Finding 1: Inactive Obligations Were Not Being Reviewed

Recommendation: Ensure all health care system finance office staff are aware of policy requirements for open obligations and the responsible health care system finance office conducts reviews on all open obligations as required per policy.

Concur.

Completed: June 15, 2021.

Director Comments

The El Paso VA Health Care System concurs with Finding 1 and concurs with the recommendation, as stated immediately above, with reference to policy VA Financial Policies and Procedures, Volume II, Chapter 5, "Obligations Policy," October 2020. EPVAHCS Standard Operating Procedure (SOP 04-10) addressing open obligations and escalation processes was drafted and implemented on June 15, 2021. The SOP was shared with all health care system finance staff. VA financial policy updates are disseminated to the finance staff via email immediately upon receipt and a copy is maintained in the Service's Shared Folder (S: drive).

Finding 2: El Paso VA Health Care System Did Not Always Maintain Supporting Documentation or Meet Requirements for Processing Purchase Card Transactions

Recommendation: Establish procedures to ensure cardholders comply with record retention and transaction processing requirements as stated in VA policy.

Concur.

Target date for completion: June 30, 2022

Director Comments

The El Paso VA Health Care System concurs with Finding 2 and concurs with the recommendation, as stated immediately above, with reference to policy VA Financial Policy, Vol XVI, Chapter 1B, "Government Purchase Card for Micro-Purchases," October 2019. The EPVAHCS provided remedial training for all purchase card (PC) holders in Quarter 1 Fiscal Year 2022 (Q1FY22), with a focus on preapproval requirements, timely reconciliation, and segregation of duties. Approving Official, Purchase Cards (A/O PC) for facility PC will continue to provide training for new holders with focus on reconciliation timeframes and backup documentation requirements. A/O PC will complete quarterly audits of transactions, to include documentation of preapproval, record retention, and separation of duties.

Finding 3: The El Paso VA Healthcare System Did Not Meet the MSPV-NG Utilization Goal, Did Not Request National Contract Waivers, and Did Not Routinely Use All Reporting Mechanisms on Prime Vendor Performance

Concur.

Recommendation: Develop a plan to work with prime vendor to address having adequate stock to meet orders, reducing the need for the health care system to use non-prime vendors.

Concur.

Completed: December 6, 2021

Director Comments

The El Paso VA Health Care System concurs with the recommendation, as stated immediately above, with reference to policy VHA Memorandum, "Use of Medical/Surgical Prime Vendor (MSPV) Contracts is Mandatory", June 22, 2015. The EPVAHCS stationed a representative from Medline (MSPV vendor) locally to help facilitate purchases and improve utilization to 35% on 6 December 2021. The Medline representative has been instrumental in identifying substitution options for items that would otherwise be purchased open market (Non-Prime Vendor).

Recommendation: Ensure the health care system follows the MSPV-NG ordering hierarchy and purchases items from the MSPV-NG contract before using other sources.

Concur.

Completed: May 4, 2022

Director Comments

The EPVAHCS concurs with the recommendation, as stated immediately above, with reference to policy VHA Memorandum, "Use of Medical/Surgical Prime Vendor (MSPV) Contracts is Mandatory", June 22, 2015. The El Paso VA Health Care System stationed a representative from Medline locally on 6 December 2021 to assist in transitioning more items through MSPV. Training with purchasing and inventory staff has been conducted that identifies the conditions to be met prior to purchasing through Non-Prime Vendor sources. ** It is important to note that certain Prosthetic devices can only be ordered through specific vendors. Contracted PC purchase are allowed but may impact the MSPV-NG utilization rates.

Recommendation: Ensure the health care system elects and is granted a delivery method that meets just-in-time requirements.

Concur.

Completed: July 15, 2021

Director Comments

The EPVAHCS concurs with the recommendation, as stated immediately above, with reference to policy VHA Memorandum, "Use of Medical/Surgical Prime Vendor (MSPV) Contracts is Mandatory," June 22, 2015. The El Paso VA Health Care System submitted new service election form to Medline (MSPV) that requires Lowest Unit of Measure (LUM) deliveries along with 4 delivery days per week. In addition to 4 delivery days per week Medline is following a 2 day shipping schedule from the time they receive our orders.

Recommendation: Ensure the health care system submits the MSPV-NG waiver requests and obtains approval before purchasing available formulary items from non-prime vendor sources.

Concur.

Target date for completion: June 30, 2022

Director Comments

The EPVAHCS concurs with the recommendation, as stated immediately above, with reference to policy VHA Memorandum, "Use of Medical/Surgical Prime Vendor (MSPV) Contracts is Mandatory," June 22, 2015. The El Paso VA Health Care System stationed a representative from Medline locally to help facilitate purchases and improve utilization to 35%. Training on waiver submission processes will be conducted and documented by Logistics, providing staff with a written reference to the process.

Recommendation: Ensure Logistics staff and contracting officer's representatives use all the tools available to inform the Medical Supplies Program Office and Strategic Acquisition Center of prime vendor performance issues.

Concur.

Target date for completion: September 30, 2022

Director Comments

The EPVAHCS concurs with the recommendation, as stated immediately above, with reference to policy VHA Memorandum, "Use of Medical/Surgical Prime Vendor (MSPV) Contracts is Mandatory," June 22, 2015. The El Paso VA Health Care System meets weekly with VISN Logistics staff to identify and rectify MSPV-NG performance issues. A Quality Control Review (QCR) is scheduled for FY22 Q4 by VISN 17 Logistics leadership to review implementation of procedure updates, MSPV utilization, and review any continuing issues with prime vendor performance. The action is targeted for completion on September 30, 2022.

Finding 4: The El Paso VA Healthcare System Could Improve Pharmacy Efficiency, Increase Inventory Turnover Rate, and Strengthen Oversight Controls

Concur.

Recommendation: Develop finalized processes for achieving identified efficiency targets and use available pharmacy data to make business decisions.

Concur.

Target date for completion: September 30, 2022.

Director Comments

The EPVAHCS concurs with the recommendation, as stated immediately above. The El Paso VA Health Care System Pharmacy Informatics/Pharmacoeconomics Pharmacist will provide data and plans of action for various metrics either monthly or quarterly (based on the availability of the data) to the Chief of Pharmacy for review and implementation. The metrics include:

- a. Progress on the National cost savings initiative.
- b. Consolidated Mail Outpatient Pharmacy (CMOP) Utilization report with a goal of greater than 90% utilization. This report will compare percentage of prescriptions filled locally (mail/window) versus percentage of prescriptions filled at CMOP.

- c. Report that allows review of items that can potentially be marked for CMOP.
- d. Report that shows local mail cost trend.
- e. Multi-Month report will show the percentage of total prescriptions filled for less than 60 days and allow the opportunity to convert clinically appropriate prescriptions to 60 or 90 days' supplies to reduce cost per fill of prescriptions.
- f. The Pharmacoeconomics Pharmacist will review and promptly report any increases identified on Prime Vendor quarterly purchase report quarterly to the Chief of Pharmacy along with a plan of action.
- g. Increased communication with Staff prior to rolling out any initiative to improve awareness/understanding of the initiative. Information will also be presented during the biweekly procurement meeting.
- h. Monthly updates will be provided to the Service Chief for all local cost savings initiatives.

Recommendation: Educate non-VA providers on prescribing lower-cost drugs.

Concur.

Target date for completion: September 30, 2022.

Director Comments

The EPVAHCS concurs with the recommendation, as stated immediately above. The El Paso VA Health Care System provides education to non-VA providers during onboarding webinars on the VA medication process guide, VA formulary and the need to follow the VA formulary. The education is provided by TriWest.

El Paso VA Health Care System Community Care Services (CCS) hosts Vendors Fair twice every fiscal year in which Pharmacy is invited to speak on Pharmacy related topics to include VA formulary updates.

The El Paso VA Health Care System Pharmacy will provide CCS with a digital VISN 17 Common Formulary Medication LIST twice every fiscal year to disseminate to Non-VA Providers through TriWest. This list has commonly used medications for most common disease states. The El Paso VA Health Care System Pharmacy also utilizes the Prior authorization process to review and make recommendations to Community care providers based on the VA Pharmacy Benefit Management Formulary. Ongoing in-services are provided to Pharmacy Staff on Prior Authorization Review (PADR). PADR peer reviews were added unto the performance standards for our pharmacist this grading year. This will help standardize the approval process we currently have in place.

Pharmacy routinely communicate medication change request with non VA-Providers to improve formulary usage.

Recommendation: Develop and implement a plan to increase inventory turnover to the Veterans Health Administration (VHA) recommended level.

Concur.

Target date for completion: September 30, 2022.

Director Comments

The EPVAHCS concurs with the recommendation, as stated immediately above, with reference to policies: VHA Directive 1108.08(1), VHA Formulary Management Process, November 2, 2016, amended

August 29, 2019; and VHA Directive 1761(2), Supply Chain Management, app. I, October 24, 2016, amended October 26, 2018. The El Paso VA Health Care System overall inventory Turns rate for the Pharmacy this fiscal year 2021 was 13.1. This number is approximately a 100% increase over last year's Turns of 6.35.

After the audit, the pharmacy changed ordering process especially for the Category A inventory drugs. Ordering on demand helped the ELP VA Pharmacy to achieve higher Turns number at this year's wall to wall inventory.

Pharmacy continues to utilize Pharmacy Prime vendor by balancing Veteran's needs, customer satisfaction and product availability (due to supply chain issues) prior to determining ordering quantities.

A position was approved for Pharmacy Procurement Manager (currently in the hiring process). The incumbent will be tasked with managing procurement, creating par levels for all products within the pharmacy, and ensuring the Team is ordering on demand.

Training was provided to the procurement Team on Turns rate which greatly improved their understanding of the inventory process.

The VISN 17 Procurement committee provides a monthly procurement meeting open to all procurement Staff to standardize procurement within the VISN 17.

Recommendation: Develop and implement a plan to complete facility-based inventory audits of noncontrolled drug line items in compliance with VHA policy.

Concur.

Completed: May 6, 2022

Director Comments

The EPVAHCS concurs with the recommendation, as stated immediately above, with reference to policy VHA Directive 1108.08(1), VHA Formulary Management Process, November 2, 2016, amended August 29, 2019. The ELP VA healthcare system, will create a Standard Operating Procedure (SOP) to guide noncontrolled drug line items. The Procurement Team and the Pharmacoeconomics Pharmacist will ensure the data is reported on the PBM dashboard by the 10th of each month or by the date specified by the PBM if earlier than the 10th of each month. The following steps will be included in the SOP to guide the monthly process of noncontrolled drug inventory audit:

- a. By close of Business on the last day of each month, Procurement/Supply Technicians will count and report inventory and record current inventory in the designated spreadsheet.
- b. The Procurement/Supply technicians will also verify Prime Vendor purchases for the month and record accurately in the spreadsheet.
- c. The Procurement Technician will send a digital copy of the completed spreadsheet to the Pharmacy Procurement Manager (Pharmacy Pharmacoeconomics Pharmacist will perform this duty until Pharmacy Procurement Manager is hired).
- d. The Pharmacoeconomics Pharmacist will review the dispensing history for each listed medication for the previous months.
- e. Pharmacoeconomics Pharmacist will evaluate usage against current on hand quantity to determine the presence of any discrepancy.

- f. Pharmacoeconomics Pharmacist will investigate each discrepancy by verifying all patient prescriptions dispensed for the specific medication in an effort to determine the cause of the discrepancy. All reasons for discrepancies will be logged into the dashboard and on the spreadsheet for record. National dashboard required only discrepancies greater than 5% should be recorded. El Paso will record any discrepancy less than 5% in the spreadsheet for record keeping. Any discrepancies greater 5% will be recorded both on the dashboard and on the spreadsheet.
- g. If unable to determine the cause of the discrepancy or if there are frequent discrepancies to that specific drug, the medication will be transferred to the vault where access will be controlled for the medication.

Recommendation: Develop a plan to ensure that appropriate metrics for monitoring compliance with VHA policy are calculated correctly in the Pharmacy Benefits Management inventory reporting tool.

Concur.

Target date for completion: July 30, 2022

Director Comments

The EPVAHCS concurs with the recommendation, as stated immediately above, with reference to policy VHA Directive 1108.08(1), VHA Formulary Management Process, November 2, 2016, amended August 29, 2019. The El Paso VA Health Care System Pharmacoeconomics Pharmacist will enter the data into the OIG Non-Control substance database and Procurement Program Manager/Associate Chief of Pharmacy will verify the entry to ensure accuracy.

(Original signed by)

Mark R. Rielo

Interim Medical Center Director

Attachments:

1. Standard Operating Procedure (SOP) 04-10, Open and Undelivered Orders Management, effective date June 7, 2021
2. Memorandum, Subject: Use of Medical/Surgical Prime Vendor (MSPV) Contracts is Mandatory, dated June 22, 2015
3. Standard Operating Procedure (SOP) 119-37, PBM Mandated Monthly Non-Control Drug Inventory, effective date May 6, 0222

The OIG did not include attachments as part of this appendix. For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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Inspection/Audit/Review Team	Anthony Leigh, Director Zachary Beres Angela Billups Nicole Brehon Jennifer Casteline Nathan Fong Melissa Garcia Gurpreet Kaur Athenia Rosolowski
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Other Contributors	Charles Hoskinson Cliff Stoddard
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