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**OFFICE OF INSPECTOR GENERAL**

*Office of Audits and Evaluations*

VETERANS HEALTH ADMINISTRATION

Financial Efficiency Review of  
the VA Boston Healthcare  
System in Massachusetts



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## Executive Summary

The VA Office of Inspector General (OIG) conducted this review to assess the stewardship and oversight of funds by the VA Boston Healthcare System in Massachusetts and to identify potential cost efficiencies in carrying out medical center functions.<sup>1</sup> 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 four financial activities and administrative processes to determine whether the healthcare system had appropriate controls and oversight 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 and reconcile open obligations to ensure that performance dates are correct (i.e., beginning and ending dates are accurate); open balances are accurate and agree with source documents (e.g., 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 obtain goods and services directly from vendors. The review team evaluated whether the healthcare system (1) adhered to strategic sourcing guidelines and considered establishing contracts when making purchases and (2) properly documented sampled transactions.<sup>2</sup> Using contracts for common purchases has several benefits, such as allowing VA to optimize purchasing power and obtain competitive pricing. Documenting transactions as required helps VA and other oversight entities identify potential fraud, waste, and abuse.
- III. **Inventory and supply management.** Supply chain management is the integration and alignment of people, processes, and systems across the supply chain to manage all product/service planning, sourcing, purchasing, delivering, receiving, and disposal activities. Veterans Health Administration (VHA) policy requires medical facilities to

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<sup>1</sup> The healthcare system consists of three main facilities in Jamaica Plain in Boston, West Roxbury, and Brockton with five community-based outpatient clinics in Boston, Framingham, Lowell, Plymouth, and Quincy. For more information about the healthcare system budget, capacity, and daily census, see appendix A.

<sup>2</sup> VA Financial Policy, vol. XVI, chap. 1B, "Government Purchase Card for Micro-Purchases," October 2019 and July 2021. This policy defines "strategic sourcing" as ensuring employees obtain proper contracts when procuring goods and services on a regular basis.

establish, operate, and maintain supply chain management that is effective, cost efficient, transparent, and responsive to customer requirements and to continually identify ways to deliver high-quality care to veterans.<sup>3</sup> The team evaluated whether the healthcare system managed its supply chain operations effectively by using the performance metric for days of stock on hand.

- IV. **Pharmacy operations.** To anticipate how much drugs will cost and when inventory needs to be restocked, an efficient healthcare system analyzes available data, such as prime vendor inventory management reports and inventory turnover rates.<sup>4</sup> Consistent data review ensures that the healthcare 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 OIG selected the VA Boston Healthcare System and these administrative processes for review based on an analysis of VA data from the VHA Office of Productivity, Efficiency and Staffing (OPES) efficiency opportunity grid. VHA developed the efficiency opportunity grid, a collection of 12 statistical models, to give facility leaders insight into areas of opportunity for improving efficiency. The team obtained the facility rankings from the stochastic frontier analysis model to assist with selecting facilities for financial efficiency reviews. See appendixes B and C for more information about the review's scope and methodology.

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

## What the Review Found

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

- I. **Open obligations oversight.** The review team analyzed data from March 1, 2021, through August 31, 2021, and selected the 20 largest open obligations that had been inactive for more than 90 days, totaling almost \$20.6 million. The team examined whether the healthcare system finance office performed required reviews to assess if the obligations were still valid and necessary. The team found that 10 obligations were still within the performance period, whereas the remaining 10 were more than 90 days past the performance period end date. The team was not able to verify that a review was completed on seven of these 20 inactive obligations. Per the practice of the VA Boston Healthcare System, the review of open obligations is divided among several finance

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<sup>3</sup> VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

<sup>4</sup> The inventory turnover rate is the number of times inventory is used during the year. Low inventory turnover rates indicate inefficient use of financial resources.

personnel based on the nature of the obligation, but not all personnel were aware of the policy requiring review of inactive obligations. Failure to review inactive obligations leaves the healthcare system vulnerable to the risk that those funds will not be used in the year they were appropriated or reobligated and used for other goods or services to support veterans.

The team reviewed VA's reconciliation reports between the Financial Management System (FMS) and the Integrated Funds Distribution, Control Point Activity, Accounting and Procurement System (IFCAP) and determined that FMS and IFCAP reflected accurate end dates and order amounts for the 20 sampled obligations; however, two of the 20 obligations had residual funds totaling approximately \$4,439 that should have been deobligated.<sup>5</sup> For the two obligations with residual funds, the healthcare system did not deobligate purchase orders and obligations when the initiating service had confirmed acceptance of all goods or services and that all invoices had been received and paid. If the end date has passed and the obligation is no longer valid, those funds could be deobligated and used elsewhere.

- II. **Purchase card use and oversight.** The review team analyzed a sample of 36 transactions from October 1, 2020, through September 30, 2021, totaling \$441,000. The team found that the healthcare system did not always properly maintain supporting documentation for the sampled transactions. The review determined 28 of 36 sampled transactions, totaling approximately \$375,000, were missing some required documentation—for example, a prior approval, a purchase order, or a vendor invoice to verify that purchase card transactions were properly approved and that payments were accurate. This lack of documentation occurred because approving officials and cardholders did not properly adhere to VA policy.<sup>6</sup>

The review team also assessed whether the sampled transactions were processed in compliance with VA policy, to include segregation of duties throughout the transaction process and prompt reconciliations.<sup>7</sup> Of the 36 sampled transactions, five had delayed reconciliations, and 25 showed that cardholders and approving officials did not adhere to the separation of duties designed by policy to reduce fraud, waste, and abuse.

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<sup>5</sup> "FMS to IFCAP Reconciliation Report," VHA, accessed October 1, 2021, <https://vssc.med.va.gov/VSSCMainApp/products.aspx?PgmArea=59>. (This is an internal VA website not publicly accessible). See appendix D for more information about better use of funds.

<sup>6</sup> VA Financial Policy, "Government Purchase Card for Micro-Purchases." See appendix D for more information about questioned costs.

<sup>7</sup> VA requires that the duties of the cardholder, approving official, requesting official, and receiving official be segregated. An agency or organization program coordinator cannot be a cardholder or an approving official. No one person may order, receive, certify funds, and approve his or her own purchase card purchase.

The team further assessed potential split purchases and whether cardholders adhered to strategic sourcing guidelines. Strategic sourcing ensures VA is obtaining the most competitive prices for goods and services. The team identified potential split purchases for 10 of the 36 sampled transactions, totaling approximately \$122,000. Procuring these items by contract could lower the risk of split purchases and potentially garner additional savings for VA. These issues occurred because cardholders and approving officials did not work together to ensure compliance throughout the transaction process and that roles and responsibilities were carried out in accordance with VA policy. Also, they did not communicate with the procurement office to determine if alternative contracting options were warranted or available.

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. The healthcare system's purchase card coordinator conducted quarterly purchase card internal audits during fiscal year (FY) 2021, but confirmation was not available to support that the memorandum of results was sent to or acknowledged by the medical center director. Quarterly purchase card audits are intended to evaluate and improve the effectiveness of internal controls and compliance with regulations and policies.

- III. **Inventory and supply management.** The team found, overall, the healthcare system provided oversight to maintain stock levels for expendable clinical Medical Surgical Prime Vendor (MSPV) and non-MSPV items from October 2020 to August 2021. However, the healthcare system could improve the effectiveness and efficiency of inventory management by ensuring stock levels and inventory values are recorded correctly in the Generic Inventory Package system.

To avoid overstocking or understocking, VHA requires responsible staff to ensure correct reorder points and inventory levels are maintained. Expendable supplies purchased from an MSPV should have 15 days or less stock on hand, whereas non-MSPV items should have 30 days or less stock on hand. The healthcare system averaged 30 days of stock on hand for MSPV items and 52 days of stock on hand for non-MSPV items during the review period. During the pandemic, the healthcare system received a waiver to suspend the corresponding days-of-stock-on-hand performance oversight measures and order accordingly to avoid potential shortfalls. The memorandum was first issued May 7, 2020, and was extended through March 31, 2022.

To determine if the healthcare system had excess inventory, the team evaluated the inventory points under the purview of supply chain management. Seven of nine MSPV inventory points (78 percent) and seven of 10 non-MSPV inventory points (70 percent), including two top-dollar inventory points in the supply chain management service line, did not meet the days-of-stock-on-hand performance metric. Noncompliance with the performance metric was attributed to supply chain management staff's unfamiliarity

regarding the conversion factor calculation, MSPV bridge contract issues, an inconsistent secondary inventory framework, and other factors.<sup>8</sup> For example, due to the COVID-19 pandemic, supply chain issues beyond the control of staff, including long back orders, resulted in alternative choices for items being made.

The review team also assessed oversight of required physical inventory of “A” classified items, which are inventory items with the highest 80 percent of annual usage dollars.<sup>9</sup> Physical inventories of “A” classified items must be conducted each quarter, and the review must be documented and signed by the VA medical facility chief supply chain officer, who transmits the report to the facility’s Veterans Integrated Service Network (VISN) chief logistics officer and deputy network director.<sup>10</sup> The team found that although physical inventories for “A” classified items were completed, an accompanying memorandum documenting an inventory count was signed by the assistant chief of supply chain management instead of the chief supply chain officer, per VHA policy. Additionally, VISN personnel were not informed following the completion of inventory counts, and not all memorandums were uploaded to a designated SharePoint site on completion. Issues pertaining to the signing and routing of the completed “A” classified physical count inventories were attributed to the healthcare system’s chief of supply chain management not ensuring full compliance with VHA policy. Failure to properly manage processes and systems and to meet metrics for days of stock on hand across the supply chain results in inefficient management of product and service planning, sourcing, purchasing, delivering, and receiving and could adversely affect patient care. By not managing inventory and supply, the healthcare system cannot effectively plan and budget for the purchase of supplies to operate and meet patient care needs.

**IV. Pharmacy operations.** The review team found that the healthcare system had approximately \$69.3 million in observed prescription drug costs compared to about \$70.3 million in expected drug costs during the review period.<sup>11</sup> The healthcare system’s drug costs did not exceed the expected costs and contributed to the

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<sup>8</sup> VHA, *Integrated Funds Distribution, Control Point Activity, Accounting and Procurement (IFCAP) Generic Inventory User’s Guide*, ver. 5.1, October 2000, rev. October 2011. A conversion factor expresses the ratio between the vendor’s unit of measure and the unit of issue and is used to translate the order quantities into supply station amounts (conversion factor = unit received or measured divided by unit of issue).

<sup>9</sup> In the ABC classification method, inventory point items with the highest 80 percent of the inventory annual usage dollars are classified as “A.” Items with the next highest 10 percent of inventory annual usage dollars are classified as “B.” Lastly, items representing the remaining 10 percent of inventory annual usage dollars are classified as “C.”

<sup>10</sup> VHA divides the United States into 18 regional networks, known as VISNs. A VISN manages day-to-day functions of medical centers and provides administrative and clinical oversight.

<sup>11</sup> “VHA OPES Efficiency Opportunity Grid FY 2021 (based on 2020 data),” VHA OPES, accessed September 8, 2021, <https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx>. (This is an internal VA website not publicly accessible.)

efficient operations of its pharmacy. The healthcare system has averaged just under \$1 million in savings opportunity over the last three fiscal years.

The healthcare system's pharmacy turnover rate, however, could be improved. The turnover rate is a measure of the number of times inventory is replaced during the year. In FY 2021, the healthcare system reported an inventory turnover rate of 8.2 compared to the recommended rate of 12. Healthcare system officials acknowledged this rate was too low and reported efforts continue to ensure only knowledgeable pharmacy procurement technicians order pharmaceuticals and pharmacy-experienced personnel account for the inventory. Low inventory turnover rates could indicate the inefficient use of financial resources and an inability to properly forecast needed drug inventories. Failure to monitor and adjust inventory levels could lead to drug diversion, overstocks, spoilage, and stock outs, which could adversely affect patient care.

## What the OIG Recommended

The OIG made seven recommendations for improvement to the healthcare system director and one recommendation to the director of contracting for the Network Contracting Office 1, VA New England Healthcare System.<sup>12</sup> The number of recommendations should not be used, however, as a gauge of 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 financial efficiency practices and the strong stewardship of VA resources.

The OIG recommended that the director of the VA Boston Healthcare System ensure that healthcare system finance office staff are made aware of policy requirements, that reviews are conducted on all inactive open obligations, and that any identified excess funds are deobligated as required by VA policy.<sup>13</sup>

The OIG also made purchase card oversight-related recommendations to the director of the VA Boston Healthcare System to ensure cardholders comply with record retention requirements as stated in VA policy and to establish controls to confirm approving officials and purchase cardholders review purchases properly and make sure contracting is used when it is in the best interest of the government.<sup>14</sup> In addition, purchase cardholders should request approval for any unauthorized payments identified by the OIG team or by the healthcare system's review process. Lastly, the director of contracting for the Network Contracting Office 1, VA New England

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<sup>12</sup> Network Contracting Office 1, VA New England Healthcare System, provides local, regional, and national procurement support to the VA Boston Healthcare System and other VISN 1 facilities.

<sup>13</sup> VA Financial Policy, vol. 2, chap. 5, "Obligations Policy," October 2020.

<sup>14</sup> VA Financial Policy, "Government Purchase Card for Micro-Purchases."



Healthcare System, should ensure quarterly purchase card audits are performed as required by VHA’s standard operating procedure.<sup>15</sup>

Related to inventory and supply management, the OIG recommended that the healthcare system director improve the reliability of data within the Generic Inventory Package system and ensure compliance with “A” classified items physical inventory.

The OIG made one recommendation regarding pharmacy operations. The healthcare system director should continue to develop and implement a plan to increase inventory turnover closer to the recommended rate as established by the Pharmacy Benefits Management Office.

## **VA Comments and OIG Response**

The director of the VA Boston Healthcare System concurred with recommendations 1 through 4 and 6 through 8 and provided responsive corrective action plans for each of these recommendations. The director of contracting for the Network Contracting Office 1 concurred with recommendation 5 and provided a responsive corrective action plan. Appendix E includes the healthcare system director’s comments, and appendix F includes the director of contracting’s comments.

The OIG considers all recommendations still open. The OIG will monitor the implementation of all planned actions and will close the recommendations when the VA Boston Healthcare System and the Network Contracting Office 1 provide sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified.



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<sup>15</sup> VHA Government Purchase Card Program, “Internal Audits—Purchase Cards and Convenience Checks,” Standard Operating Procedure, June 20, 2019.

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## Abbreviations

FMS	Financial Management System
FTE	full-time equivalent
FY	fiscal year
IFCAP	Integrated Funds Distribution, Control Point Activity, Accounting and Procurement System
MSPV	Medical/Surgical Prime Vendor
OIG	Office of Inspector General
OPES	VHA Office of Productivity, Efficiency and Staffing
SCCOP	Supply Chain Common Operating Picture
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



## Introduction

The VA Office of Inspector General (OIG) conducts financial efficiency reviews to assess stewardship and oversight of funds at VA healthcare systems and to identify opportunities to achieve cost efficiencies. Review teams identify and examine financial activities that are under the healthcare system's control and can be compared to healthcare systems similar in size and complexity across VA to promote best practices.<sup>16</sup>

This review focused on the VA Boston Healthcare System in Massachusetts. The OIG assessed the following four financial activities and administrative processes to determine whether appropriate controls and oversight were in place from October 2020 through September 2021:

- I. **Open obligations oversight.** An open obligation is funding for an item or service that is not considered closed or complete and has an associated balance, whether undelivered or unpaid. Open obligations should be reviewed and reconciled by the healthcare system finance office to ensure that time frames are correct (i.e., beginning and ending dates are accurate), open balances are accurate and agree with source documents (e.g., contracts and purchase orders, receiving reports, invoices, and payments), and obligations beyond 90 days of the period of performance end date or without activity in the past 90 days are valid and should remain open. The review team evaluated whether the healthcare system performed monthly reviews and reconciliations of sampled obligations.
- II. **Purchase card usage.** The team examined whether the healthcare system's purchase card program ensured compliance with policies and procedures that reduce the risk of error, fraud, waste, and abuse. The review also focused on the use of contracts for repetitively ordered goods or services to garner greater savings for VA.
- III. **Inventory and supply management.** The team examined whether the healthcare system's inventory management was compliant with policies and procedures that require efficient inventory management in response to the needs of the healthcare system. The review focused on the performance metric for days of stock on hand, a nationally set level of inventory for expendable clinical Medical/Surgical Prime Vendor (MSPV) and non-MSPV items, efficient purchasing, and use of supplies.<sup>17</sup>
- IV. **Pharmacy operations.** The team assessed whether the healthcare system complied with

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<sup>16</sup> The Veterans Health Administration (VHA) uses a facility complexity model that classifies its facilities at levels 1a, 1b, 1c, 2, or 3, with level 1a being the most complex and level 3 being the least complex. The VA Boston Healthcare System was rated as a level 1a, high-complexity facility.

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

applicable policies and used cost and performance data to track progress toward goals, improve pharmacy program operations, and identify and correct problems.

To assess these areas, the review team performed a virtual site visit at the VA Boston Healthcare System during the week of November 1, 2021; interviewed healthcare system leaders and staff; and reviewed data, supporting documents, and processes related to the healthcare system's financial efficiency. For more information about the healthcare system, see appendix A. For more information about the review's scope and methodology, see appendixes B and C.

## **VA Boston Healthcare System**

In 2000, two formerly independent medical centers were integrated into the current VA Boston Healthcare System to improve the quality of care and reduce healthcare costs for veterans in the Boston area. The VA Boston Healthcare System now has three major campuses in Jamaica Plain, West Roxbury, and Brockton, with additional outpatient clinics in Framingham, Boston, Lowell, Quincy, and Plymouth. These campuses and clinics serve veterans from Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, and Connecticut and provide comprehensive outpatient, inpatient, extended care, and telehealth services. These services are provided through both VA staff and contractual arrangements with non-VA providers.<sup>18</sup>

In fiscal year (FY) 2021, the VA Boston Healthcare System operated 331 hospital beds, with over 4,000 full-time equivalent (FTE) staff and provided services to almost 61,000 veterans. The reported FY 2021 medical care budget exceeded \$1 billion, a \$65 million increase (7 percent) over the FY 2020 budget of approximately \$940 million, which was an increase of almost \$34 million (4 percent) from the FY 2019 budget of approximately \$907 million.

## **Facility and Review Area Selection**

The review team evaluated VA data to identify healthcare systems with the greatest potential for financial efficiency improvements based on data from the Veterans Health Administration (VHA) Office of Productivity, Efficiency and Staffing (OPES) efficiency opportunity grid. VHA developed the efficiency opportunity grid, a collection of 12 statistical models, to give facility leaders insight into areas of opportunity for improving efficiency. The grid allows for comparisons between VHA facilities by adjusting data for variations in patient and facility characteristics and in geography. It 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 the stochastic frontier analysis model in the grid to assist in selecting facilities for financial efficiency reviews. The review is limited in scope and is not intended to be a comprehensive review of all financial operations at the healthcare system.

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<sup>18</sup> VA Boston Healthcare System Strategic Plan, FY 2019–FY 2023.

## Results and Recommendations

### I. Open Obligations Oversight

VA's management of open obligations has been a long-standing issue and was included as a significant deficiency in VA's FY 2021 audited financial statements and as a material weakness in VA's FY 2019 and FY 2020 audited financial statements.<sup>19</sup> Additionally, a 2019 OIG report on undelivered orders recommended VHA ensure that staff review and reconcile open orders, identify and deobligate excess funds on those orders, and ensure that staff follow VA policy regarding required reviews of open obligations.<sup>20</sup> 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.

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

- **Inactive obligations.** The review team assessed whether the healthcare system performed monthly reviews and reconciliations to ensure that the sampled 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 a sample of open obligations with modifications to the period of performance end date and reviewed evidence from the healthcare system that supported those changes. The period of performance is the time frame during which the goods or services are to be provided.
- **Financial Management System (FMS)-to-Integrated Funds Distribution, Control Point Activity, Accounting and Procurement System (IFCAP) reconciliations.** The team identified open obligations with different dates or order amounts between FMS and IFCAP to ensure the healthcare system reconciled end dates and order amounts between the systems for the sampled obligations.

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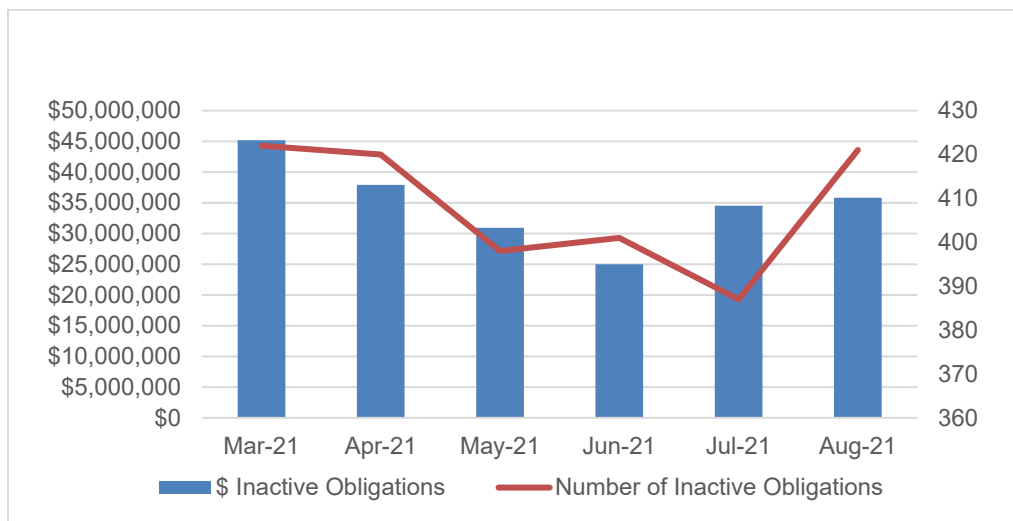
<sup>19</sup> VA OIG, [Audit of VA's Financial Statements for Fiscal Years 2021 and 2020](#), Report No. 21-01052-33, November 15, 2021; VA OIG, [Audit of VA's Financial Statements for Fiscal Years 2020 and 2019](#), Report No. 20-01408-19, November 24, 2020; VA OIG, [Audit of VA's Financial Statements for Fiscal Years 2019 and 2018](#), Report No. 19-06453-12, November 19, 2019. A material weakness is defined by CliftonLarsonAllen LLP as a deficiency, or combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented or detected and corrected on a timely basis. 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.

<sup>20</sup> VA OIG, [Insufficient Oversight of VA's Undelivered Orders](#), Report No. 17-04859-196, December 16, 2019. All recommendations from this report have been implemented and closed.

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

VA policy requires finance offices to perform monthly reviews and reconciliations of open obligations that are 90 days beyond the period of performance end date or that have been inactive for more than 90 days to ensure each obligation is still valid and funds are not underutilized.<sup>21</sup> For these obligations, healthcare system 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 FMS against supporting documentation on a monthly basis to ensure reports, subsidiary records, and systems reflect proper costing, an accurate delivery date and end date, and a correctly calculated unliquidated balance.<sup>22</sup>

Figure 1 shows the number and dollar amounts of inactive obligations for the VA Boston Healthcare System from March through August 2021.



**Figure 1.** VA OIG analysis of inactive obligations for the VA Boston Healthcare System, March through August 2021.

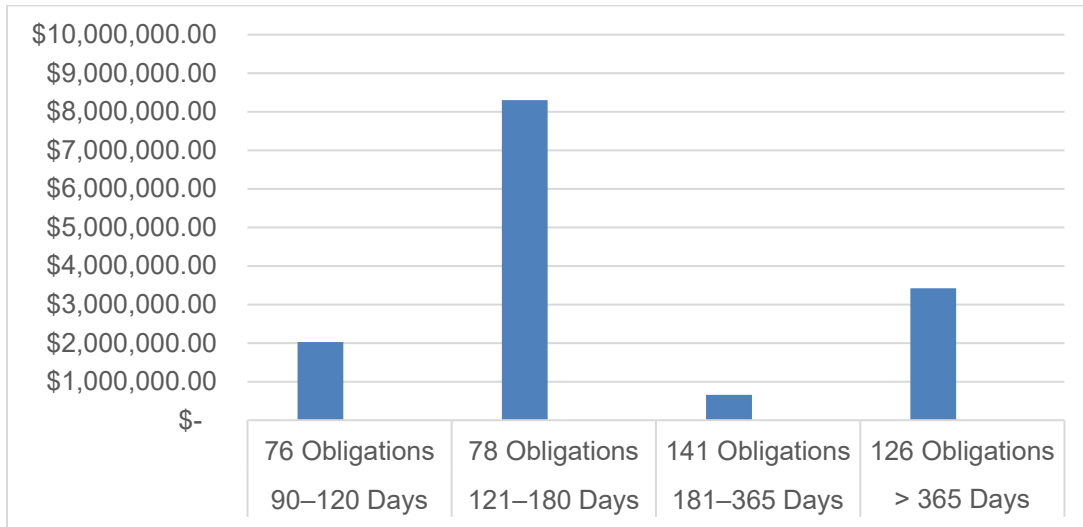
Source: VA Financial Management System F850 Report.

As of August 2021, the healthcare system had 421 inactive obligations totaling \$35.8 million. Figure 2 shows the age and dollar amounts of these obligations. As shown, 267 obligations totaling over \$4.08 million had no activity for 181 days or more.

<sup>21</sup> VA Financial Policy, vol. 2, chap. 5, “Obligations Policy,” October 2020.

<sup>22</sup> 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.





**Figure 2.** VA OIG analysis of inactive obligations for the VA Boston Healthcare System in August 2021.

Source: VA Financial Management System F850 Report.

## Inactive Obligations

The review team selected 20 inactive obligations as of August 2021 totaling almost \$20.6 million. The team reviewed supporting documentation to assess whether the healthcare system identified and reviewed the obligations to determine if they were still valid and needed to remain open in accordance with VA policy.<sup>23</sup> Ten obligations were still within the performance period, whereas the remaining 10 were more than 90 days past the performance period end date. The team was not able to verify that a monthly review was completed on seven of these 20 obligations. See appendix B for additional details on the review’s scope and methodology and appendix C for details on the review’s sampling.

VA policy states that open obligations should be reviewed by the finance office, in coordination with the initiating service, to ensure that obligations that are 90 days beyond the period of performance end date or without activity in the past 90 days are valid and should remain open. If funds remain on the obligation after the delivery and the initiating service has confirmed acceptance of all goods or services and invoices have been received and paid, the acquisition office will modify the contract or order to reflect the final cost and quantity of the goods or services and decrease the remaining funds on the obligation. The review of obligations is divided among several healthcare system personnel depending on the specific type of obligation. According to VA Boston Healthcare System finance office personnel, reviews for obligations inactive beyond 90 days were not always conducted due to a lack of awareness of the VA policy.

<sup>23</sup> VA Financial Policy, “Obligations Policy.”

One employee was not aware of the policy until June 2021, and another was not aware of it until the OIG's review in November 2021.

## **End-Date Modifications**

To determine whether the modifications were valid and supported, the review team selected and evaluated 10 additional open obligations, totaling over \$2.8 million, with modifications to the period of performance end date in the VA's FMS. The period of performance is the time frame during which the goods or services are to be provided. For the 10 sampled modifications, all were valid changes caused by period of performance extensions due to delays and scope changes.

## **End-Date and Order Amount Discrepancies in FMS to IFCAP Reconciliation**

IFCAP handles the processing of certified invoices and receiving documents to FMS. In addition, IFCAP transfers obligation information back to the control point and updates the control point balance automatically.<sup>24</sup> The end dates in both systems should be the same.

The review team selected and evaluated 20 additional open obligations from the VA's FMS to IFCAP Reconciliation Reports to determine if end dates and order amounts were accurate and reconciled between the two systems.<sup>25</sup> Ten of these obligations had end-date discrepancies with variances of 244 to 1,493 days, and 10 of these obligations had order amount discrepancies with differences totaling about \$48.9 million. The discrepancies were mostly due to timing issues of dates or amounts posting between both systems. Also, modifications to end dates or amendments for order amounts would also cause discrepancies if the modifications or amendments were not posted in a timely manner. The team determined that FMS and IFCAP were corrected by the healthcare system before the review and reflected accurate end dates and order amounts for all 20 obligations reviewed, as the healthcare system does perform monthly reviews of the FMS-to-IFCAP reconciliation. During this review of the end dates and order amounts, the team identified two obligations that had residual funds totaling approximately \$4,439 that should have been deobligated in a timely manner after the goods were received.

For the two obligations with residual funds, the healthcare system did not deobligate purchase orders and obligations when the initiating service had confirmed acceptance of all goods or services and that all invoices had been received and paid. The acquisition office should modify the contract or order to reflect the final cost and quantity of the goods or services and decrease

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<sup>24</sup> A control point is a financial element used to permit the tracking of monies from an appropriation or fund to a specified service, activity, or purpose.

<sup>25</sup> "FMS to IFCAP Reconciliation Report," VHA, accessed October 1, 2021, <https://vssc.med.va.gov/VSSCMainApp/products.aspx?PgmArea=59>. (This is an internal VA website not publicly accessible.)

the remaining funds on the obligation. The failure to deobligate residual funds occurred due to a lack of communication among contracting staff and the service line staff to complete the deobligation in FMS in a timely manner. If the end date has passed and the obligation is no longer valid, those funds could be deobligated and used elsewhere.

## **Finding 1 Conclusion**

The healthcare system personnel were noncompliant with VA policies and reported that lack of VA policy awareness among relevant healthcare personnel prevented routine follow-up of open obligations. The review team found that, specifically for open obligations with no activity for more than 90 days, monthly reviews were not always conducted. Also, the review team found that for two obligations with residual balances totaling approximately \$4,439, funds were not promptly deobligated after the goods were received.<sup>26</sup> Failure to properly manage open obligations increases the risk of failing to spend appropriations within the associated fiscal year and leaves funds attached to orders that could be closed so that the funds could be used for other purposes to benefit veterans.

## **Recommendation 1**

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

1. Ensure that healthcare system finance office staff are made aware of policy requirements and that reviews are conducted on all inactive open obligations, and deobligate any identified excess funds as required by VA Financial Policy, vol. 2, chap. 5, “Obligations Policy.”

## **VA Management Comments**

The director of the VA Boston Healthcare System concurred with recommendation 1. The responses to all report recommendations are provided in full in appendixes E and F.

To address recommendation 1, the director reported healthcare system finance office staff are now aware of the policy requirements, and reviews are being conducted on all inactive obligations that are 90 days beyond the period of performance end date. Finance staff do not have the authority to deobligate obligations that are established by a contracting officer. Finance staff conduct follow-up reviews, and service staff submit the required paperwork to the contracting officer to deobligate open orders.

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<sup>26</sup> See appendix D for more information about better use of funds.

## **OIG Response**

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

## II. Purchase Card Use

The VA Government Purchase Card Program was established to reduce the administrative costs related to acquiring goods and services. When used properly, purchase cards can help facilities simplify acquisition procedures and provide an efficient vehicle for obtaining goods and services directly from vendors. From October 1, 2020, through September 30, 2021, the VA Boston Healthcare System spent approximately \$63 million through purchase cards, representing approximately 55,000 transactions. The amount and volume of spending through the VA Government Purchase Card Program make it important to have strong controls over purchase card use to safeguard government resources and ensure compliance with policies and procedures that reduce the risk of error, fraud, waste, and abuse.

The team reviewed the following areas:

- **Supporting documentation.** Support 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.<sup>27</sup> Supporting documentation enables VA and other oversight entities to identify and prevent fraud, waste, and abuse.
- **Purchase card transactions.** The review team assessed whether the healthcare system processed purchase card transactions in accordance with VA policy, such as avoiding split purchases. Additionally, the team evaluated whether the healthcare system considered obtaining contracts when procuring goods and services on a regular basis, referred to as “strategic sourcing.” Using contracts reduces open market or individual purchases and enables VA to leverage its purchasing power.<sup>28</sup>
- **Oversight of the purchase card program.** The review team determined whether approving officials ensured segregation of duties, conducted prompt reconciliation of cardholder transactions, and worked in conjunction with purchase card coordinators to conduct thorough quarterly purchase card audits.<sup>29</sup> These activities

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<sup>27</sup> VA Financial Policy, vol. XVI, chap. 1B, “Government Purchase Card for Micro-Purchases,” October 2019 and July 2021. 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, EMoney, E-Account, Amazon Marketplace, Google Checkout, and Venmo.

<sup>28</sup> VA Financial Policy, “Government Purchase Card for Micro-Purchases.” “Strategic sourcing” is defined as ensuring employees regularly obtain proper contracts when procuring goods and services on a regular basis.

<sup>29</sup> VA requires that the duties of the cardholder, approving official, requesting official, and receiving official be segregated. An agency or organization program coordinator cannot be a cardholder or an approving official. No one person may order, receive, certify funds, and approve his or her own purchase card purchase.

are examples of systematic controls that help reduce errors and ensure a facility complies with VA policy.

## **Finding 2: The Healthcare System Did Not Always Maintain Supporting Documentation or Consider Using Contracts**

The review team evaluated a judgmental sample of 36 purchase card transactions totaling approximately \$441,000 during the review period to determine whether the VA Boston Healthcare System maintained required purchase card transaction documentation and if transactions were processed in accordance with VA policy for the sampled transactions.<sup>30</sup> Though healthcare system leaders did oversee the program, the OIG found that these leaders failed to ensure cardholders consistently maintained documentation and processed card transactions in accordance with policy.

These issues occurred, in part, because approving officials, purchase card coordinators, and cardholders did not closely review purchases as they were processed in accordance with policy. Proper approving official and purchase card coordinator reviews in compliance with policy reduce the risk of error, fraud, waste, and abuse and promote the good stewardship of government money.

### **Supporting Documentation**

Cardholders are required by policy to electronically upload and store supporting documents for purchase card transactions to a VA-approved document-imaging system.<sup>31</sup> When using a purchase card to buy goods and services, healthcare system staff must maintain supporting documentation, such as approved purchase requests, vendor invoices, purchase orders, and receiving reports, for six years. This documentation can be used to verify that purchase card transactions were properly approved, and payments were accurate.

The review team found that 28 of the 36 sampled transactions were missing some required supporting documentation, which resulted in approximately \$375,000 in questioned costs.<sup>32</sup> This occurred because the healthcare system has not implemented a consistent method for electronically storing documentation on the Charge Card Portal or another VA-approved document-imaging system. In addition, approving officials did not ensure cardholders retained sufficient documentation to support purchase card transactions.

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<sup>30</sup> *Oxford Reference*, “judgmental sample,” accessed May 20, 2021, <https://www.oxfordreference.com/view/10.1093/oi/authority.20110803100026339>. A judgmental sample is a nonstatistical sample that is selected based on auditors’ opinion, experience, and knowledge.

<sup>31</sup> VA Financial Policy, “Government Purchase Card for Micro-Purchases.”

<sup>32</sup> See appendix D for a summary of better use of funds and questioned costs.

## Purchase Card Transactions

VA policy requires purchase cardholders to meet three requirements when using a government purchase card to acquire goods and services. Specifically, the review team assessed the documentation provided by the healthcare system to determine if

- **prior approval** was obtained to ensure the cardholder had a valid business need before initiating a purchase (the approval may vary in form or content but must be retained as supporting documentation);<sup>33</sup>
- **reconciliation** of a purchase was approved no later than the 15th calendar day of the month after the closing of the previous month’s billing cycle (accounts not reconciled within 30 days of the due date will have their single purchase threshold lowered); and
- **segregation of duties** was maintained to ensure roles and responsibilities do not overlap among the cardholder, approval official, or purchase card coordinator to reduce the risk of fraud, waste, and abuse.

Table 1 describes in further detail the results of the sampled assessment. These issues occurred because approving officials did not provide sufficient oversight of the transaction process to ensure compliance with roles and responsibilities in accordance with VA policy.

**Table 1. Sample Transactions That Did Not Comply with Policy**

VA purchase card policy requirement	Sample transactions that <u>did not</u> comply with policy	Percent of sample that <u>did not</u> comply with policy
Obtain prior approval	11	31%
Reconciliation approved by the approving official no later than the 15th calendar day of the month after the closing of the previous month’s billing cycle	5	14%
Segregation of duties maintained over the transaction	25	69%

*Source: VA OIG team assessment results of 36 sampled transactions.*

<sup>33</sup> VA Financial Policy, “Government Purchase Card for Micro-Purchases.” Approval documentation may vary in form and content. Some examples include e-mails, requisitions, memos, consults, or notes. Regardless of the form, the documentation must contain a certification from the requestor that the proposed purchase is for a legitimate government need, not for personal benefit, as well as a list of all items to be purchased. A copy of the approval must be retained as supporting documentation.

The review team also assessed the sampled transactions for evidence that healthcare system staff had considered the most appropriate purchasing mechanism. In accordance with policy, VA cardholders should consider establishing contracts, which generally provide greater savings to VA than using purchase cards for open-market acquisitions without a negotiated price.<sup>34</sup> Approving officials, the agency or organization program coordinator, and cardholders must review purchases to determine when it is in the best interest of the government to obtain contracts and ensure purchasers are obtaining the most competitive prices. Generally, VA should use contracts if the purchase is for an ongoing repetitive order of goods or services. Contracts must also be used when the total value of the requirement exceeds the micropurchase threshold or the cardholder's authorized single purchase limit.<sup>35</sup> Cardholders must not modify a requirement or split purchases (i.e., split an order into smaller parts to avoid exceeding their purchase card limit or the use of formal contracting procedures). The requirement for the goods or services should be communicated to the contracting office for procurement.<sup>36</sup>

The review team assessed if cardholders split purchases into two or more acquisitions to circumvent their authorized single purchase limit. The team selected 22 transactions totaling approximately \$370,000 to determine if cardholders split purchases. The team reviewed documentation and consulted purchase cardholders and approving officials via email to discuss the transactions. Based on the team's analysis of the 22 transactions and the interviews, the team identified split purchases and unauthorized commitments for 10 of 36 sampled transactions, totaling approximately \$122,000.<sup>37</sup> Procuring these items by contract could lower the risk of split purchases and potentially garner additional savings for VA. Example 1 illustrates a sampled transaction identified as a split purchase and unauthorized commitment.

### **Example 1**

*In April 2021, the VA Boston Healthcare System purchased disposable medical gloves totaling \$39,998.90. On April 29, 2021, the cardholder placed the first order (one pallet) for extra-large gloves totaling \$19,999.45 (\$19,836 for the gloves plus \$163.45 for shipping and handling). On April 30, 2021, the cardholder placed a second order (one pallet) for medium gloves, which also totaled \$19,999.45 (\$19,836 for the gloves plus \$163.45 for shipping and*

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<sup>34</sup> VA Financial Policy, "Government Purchase Card for Micro-Purchases."

<sup>35</sup> VHA Executive Director, Office of Acquisition and Logistics and Senior Procurement Executive Memorandum, "Emergency Acquisition Flexibilities – Emergency Assistance Activities in support of Global Pandemic for Coronavirus Disease 2019 (COVID-19), March 15, 2020. This memorandum increased the micropurchase threshold to \$20,000 for goods and services purchased in the United States due to the COVID-19 pandemic and has not been rescinded. The previous micropurchase threshold was \$10,000.

<sup>36</sup> VA Financial Policy, "Government Purchase Card for Micro-Purchases."

<sup>37</sup> Unauthorized commitments occur when a purchase is made by a government representative who lacks the authority to bind the government or who exceeds his or her delegated authority, or purchases are made that are not in accordance with the Federal Acquisition Regulation and VA Acquisition Regulation.



*handling). Both orders were shipped in the same shipment (one packing list and bill of lading) on May 4, 2021. The single requirement was known by the requesting official at the time of the purchase request. The cardholder did not provide the review team with documentation of the order request, nor was evidence provided of prior approval for the purchases. However, the total need and cost were known at the time of purchase to exceed the cardholder's authorized micropurchase threshold of \$20,000. In March 2020, certain cardholders were authorized a temporary micropurchase threshold increase to \$20,000 for emergency purchases related to the COVID-19 pandemic. These transactions represent a split purchase.*

The proper way to purchase commonly needed or high-cost goods above the purchase card limit is to send the service request to the contracting office for purchase. This requires planning to ensure there is sufficient time for a contract to be expanded or established, if none exists, to purchase the products in time for scheduled use. Any VA purchase cardholder who makes an unauthorized commitment, including a split purchase, exceeding his or her level of authority has made an improper payment and must submit a request for ratification to the chief of the contracting office that provides contracting support to the organization involved.<sup>38</sup>

Generally, the improper reliance on purchase cards and any related unauthorized commitments, instead of communicating with the procurement office to establish contracts, appeared to persist because the approving officials and cardholders did not work together to ensure compliance throughout the transaction process and that roles and responsibilities were carried out in accordance with VA policy. It is required that cardholders work with the contracting office to determine if alternative contracting options are warranted or available.

## **Purchase Card Oversight**

Quarterly purchase card audits are intended to evaluate and improve the effectiveness of internal controls and compliance with regulations and policies. VHA procedures require the purchase card coordinator to send a formal memorandum of the quarterly audit results to the medical center director, with copies to the approving official or supervisor, no later than the end of the calendar month after the close of the quarter.<sup>39</sup> During the review period, the OIG team determined that the purchase card coordinator conducted internal quarterly audits but did not provide evidence that the memorandums were sent to or acknowledged by the medical center director (or healthcare system equivalent) in accordance with policy. The healthcare system therefore missed the opportunity to bring an additional level of awareness to compliance issues

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<sup>38</sup> VA Directive 7401.7, *Unauthorized Commitments and Ratification*, October 7, 2004. The directive defines ratification as the process by which an authorized official converts an unauthorized commitment to a legal contract.

<sup>39</sup> VHA Government Purchase Card Program, "Internal Audits—Purchase Cards and Convenience Checks," Standard Operating Procedure, June 20, 2019.

within the purchase card program and continue to improve the effectiveness of internal controls. Following the OIG site visit, the VA Boston Healthcare System reported that going forward for FY 2022, a new process will ensure the internal quarterly audit memorandum is presented to the medical center director during the monthly leadership briefing.

Additionally, the team found that all 13 cardholders responsible for the 36 sampled transactions had a VA Form 0242 that listed an accurate approving official or alternate approving official and accurate spending limits. An approved VA Form 0242 is used to delegate authority to an individual to use the purchase card to pay for goods and services. This form also establishes purchase limits and responsibilities and is essential for accountability for cardholders and approving officials. A revised form is required when the approving officer changes, cardholders legally change their names, or the single purchase limit is increased above the originally requested amount.<sup>40</sup>

## **Finding 2 Conclusion**

The healthcare system did not communicate with the contracting office when purchasing frequently used goods. In addition, some of the sampled purchase card transactions lacked proper documentation. These issues, which resulted in approximately \$375,000 in questioned costs, could have been detected by greater visibility of quarterly audits of the purchase card program and effective reviews by approving officials.

## **Recommendations 2–5**

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

2. Ensure cardholders comply with record retention requirements as stated in VA’s Financial Policy, vol. XVI, “Charge Card Programs.”
3. Establish controls to confirm approving officials and purchase cardholders review their purchases and make sure contracting is used when it is in the best interest of the government.
4. Require purchase cardholders to submit a request for ratification for any unauthorized commitments identified.

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<sup>40</sup> VA Financial Policy, vol. XVI, chap. 1A, “Administrative Actions for Government Purchase Cards,” June 14, 2018.

The OIG made the following recommendation to the director of contracting for the Network Contracting Office 1, VA New England Healthcare System:<sup>41</sup>

5. Ensure quarterly purchase card audits are performed as required by the Veterans Health Administration’s standard operating procedure, “Internal Audits—Purchase Cards and Convenience Checks.”

## **VA Management Comments**

The director of the VA Boston Healthcare System concurred with recommendations 2 through 4. The director of contracting for Network Contracting Office 1 concurred with recommendation 5.

To address recommendations 2 through 4, the director reported that the VA Boston Healthcare System will conduct cardholder training and work with contracting staff more closely. For recommendation 5, the director of contracting for Network Contracting Office 1 reported the purchase card quarterly audits were uploaded to a SharePoint site, which is accessible to the associate director, medical center director, and Purchase Card Operations staff. The director of contracting also reported that since the OIG audit was completed, the internal standard operating procedure has been rescinded and is no longer required. However, Network Contracting Office 1 reported that it has decided to continue performing the quarterly audits and send findings to the associate directors.

## **OIG Response**

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

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<sup>41</sup> Network Contracting Office 1, VA New England Healthcare System, provides local, regional, and national procurement support to the VA Boston Healthcare System and other VISN 1 facilities.

### III. Inventory and Supply Management

Supply chain management is the integration and alignment of people, processes, and systems across the supply chain to manage all product and service planning, sourcing, purchasing, delivering, receiving, and disposal activities. VHA policy requires medical facilities to establish, operate, and maintain a supply chain management program that is effective, cost efficient, transparent, and responsive to customer requirements and to continually identify ways to ensure veterans receive high-quality care.<sup>42</sup> The Generic Inventory Package is the system authorized to manage the receipt, distribution, and maintenance of expendable supplies used throughout VA. Within IFCAP, an item master file is created, which stores information such as the description, vendor details, unit price, and packaging for each item. Inventory data, if properly recorded in the Generic Inventory Package system, identify the quantity, dollar values, and specific supply items in stock. Supplies are received at the warehouse and distributed to a primary inventory point and, when available, to a secondary inventory point at a medical facility. Secondary locations are generally storerooms maintained by the service lines that use certain supplies.

The team reviewed the following areas:

- **Stock performance metrics.** The team assessed the use of the performance metric for days of stock on hand. Days of stock on hand is a nationally set level of inventory for MSPV and non-MSPV items that facilitates efficient purchasing and use of supplies.
- **Supply chain management oversight.** The team assessed whether the healthcare system was compliant with quarterly physical inventory policies and procedures for “A” classified items.<sup>43</sup>

### Finding 3: The Healthcare System Could Strengthen Controls to Ensure Accuracy of Inventory Data and Achieve Complete Physical Inventories of “A” Classified Items

The healthcare system provided oversight to maintain stock levels and conducted physical inventory counts as required by VHA policy. However, the healthcare system could improve the accuracy of inventory data stored in the Generic Inventory Package and ensure completion of the required “A” classified items physical inventory. Failure to properly align processes and systems across the supply chain threatens the healthcare system’s ability to effectively plan and budget for the purchase of supplies to operate and meet patient care needs.

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<sup>42</sup> VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

<sup>43</sup> “A” classified items, which garner the highest 80 percent of budgeted funding for a given year, are reviewed on a quarterly basis.

## Supply Chain Management Oversight and Stock Levels

The Power Business Intelligence Supply Chain Common Operating Picture (SCCOP) dashboard tracks the use of expendable and nonexpendable stock items. The dashboard, which receives data from the Generic Inventory Package system, lists the performance measure for expendable supplies purchased from MSPV as 15 days or less of stock on hand, whereas non-MSPV items should have 30 days or less of stock on hand. The OIG team accessed the SCCOP dashboard and downloaded the healthcare system’s “MSPV Days of Stock on Hand” and “Non-Prime Vendor Days of Stock on Hand” reports for FY 2021, available from October 2020 through August 2021 at the time the data were pulled. The team reviewed the healthcare system’s overall performance and primary inventory points within the supply chain management service line and subject to the days-of-stock-on-hand metric to determine if MSPV and non-MSPV items met the performance metric. The team also reviewed other data in the SCCOP dashboard that could impact the days of stock on hand levels.

The review team determined that the healthcare system averaged 30 days of stock on hand for MSPV items and 52 days of stock on hand for non-MSPV items during the review period. In response to the COVID-19 pandemic, the healthcare system received a waiver to suspend the corresponding days-of-stock-on-hand performance oversight measures and order accordingly to avoid potential shortfalls. The memorandum was first issued May 7, 2020, and was extended through March 31, 2022.

The review team evaluated primary inventory points within the supply chain management service line that were subject to days-of-stock-on-hand metrics. The team found seven of nine MSPV (78 percent) and seven of 10 non-MSPV inventory points (70 percent) did not meet the metrics; this included two top-dollar value, stand-alone inventory points, C-SURGERY WR and C-CATHRTL.<sup>44</sup> Stand-alone inventory points are primary inventory that also serve as the point of consumption—that is, inventory points that do not have (secondary) distribution points from which hospital staff obtain supplies. When established, secondary inventory points are maintained by the service line using the supplies rather than by supply chain management. Inventory in secondary inventory points is replenished from their primary inventory and can help reduce days of stock on hand. Not all primary inventory points have a secondary location, in part due to the lack of space at the VA Boston Healthcare System; if more secondary locations are established, days of stock on hand could be reduced. Logistics staff successfully established a secondary location for C-SURGERY WR, one of supply chain management staff’s largest inventories by dollar value, which was scheduled to be operational in January 2022.

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<sup>44</sup> C-SURGERY WR represents the inventory point that captures any new items added during the fiscal year for West Roxbury Surgical. C-CATHRTL represents the inventory point that captures any new items added during the fiscal year for the catherization laboratory.

The OIG team accessed the SCCOP dashboard and downloaded the healthcare system’s “Conversion Factor Primary Inventory Report.” A unit conversion factor is computed by dividing the quantity purchased by the quantity issued. This factor connects how a supply item is purchased and issued—for example, an item may be purchased by the case but issued individually. When recorded incorrectly, a conversion factor can cause misstated item levels in the Generic Inventory Package system and thereby erroneously state the quantity and value of stock on hand.

At the time the report was accessed, primary inventory points at the healthcare system reported 757 of 14,051 conversion factors (5.4 percent) with a FALSE result. Of the FALSE results, 37 items had no conversion factor listed.<sup>45</sup> Conversion factor inaccuracies are a significant hurdle for the healthcare system to meet the performance metric for days of stock on hand and to ensure supply quantities are properly maintained and dollar values are recorded correctly in the Generic Inventory Package system. An accurate unit conversion factor is also necessary for the inventory controls to correctly automate supply orders when a reorder point is met, as well as to track stock on hand.<sup>46</sup> Supply chain management staff acknowledged the conversion factor FALSE results and stated that explaining the conversion factor calculation to logistics personnel has been difficult. The healthcare system informed the OIG team that they now obtain and review conversion factor reports, hold monthly meetings regarding conversion factors, and are creating a written process for the review of conversion factor data.<sup>47</sup>

The review team also interviewed supply chain management leaders to determine how they ensure stock levels and inventory values are accurate. According to supply chain management personnel, expendable supply metrics are checked in the SCCOP dashboard daily by the assistant chief of logistics and inventory management supervisor. The chief and assistant chief of logistics stated that the SCCOP dashboard tracks performance in meeting the metrics for days of stock on hand, inactive items, and long supply items. The assistant chief and inventory management supervisor also informed the OIG team that physical inventory counts are conducted frequently to monitor stock levels, determine demand, and calculate subsequent reordering points.<sup>48</sup>

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<sup>45</sup> When a conversion factor does not equal an item’s unit of receipt (i.e., bought by the case) divided by the unit of issue (distributed by the case), it is flagged as a “FALSE” result.

<sup>46</sup> VHA Directive 1761. A periodic automatic replacement-level inventory system determines the minimum level of inventory necessary to be on hand for a specific period and requires automatic replenishment if inventory falls below that level. Inventory managers must use the auto-generation option in the VHA-approved inventory management system for creating orders to replenish inventories.

<sup>47</sup> Department of Veterans Affairs, Office of Information and Technology, Product Development, Integrated Funds Distribution Control Point Activity, Accounting and Procurement (IFCAP), IFCAP Application Coordinator User’s Guide, ver. 5.1, October 2000, rev. October 2019. A conversion factor expresses the ratio between the vendor’s unit of measure and the unit of issue, and is used to translate the order quantities into supply station amounts (conversion factor = unit received or measured divided by unit of issue).

<sup>48</sup> Long supply items are those with more than 90 days of stock on hand.

Supply chain management staff also reported issues related to inventory management with the implementation of the temporary bridge contract after the prime vendor went out of business. The bridge contract did not provide for an on-site representative, which made prompt communication with the vendor challenging. Also, the inventory management supervisor informed the OIG team that the bridge contract omitted key pieces of data that ensured efficient ordering, such as the formulary item “drop” lead time and the lowest unit of measure purchase features.<sup>49</sup> Despite these issues, the healthcare system reported that a permanent contract is now in place, and staff receive more training to address the factors that could potentially lead to supply chain inefficiencies.

The chief of logistics also reported that during the COVID-19 pandemic, the VA Boston Healthcare System encountered supply chain issues beyond the control of staff, including long back orders resulting in alternative choices for items. It is understandable that there was an increased need to have extra supplies on hand. As a result, the OIG makes no recommendations related to the days of stock on hand at the healthcare system.

## Quarterly Physical Inventories

The team also assessed oversight related to the required quarterly physical inventory of “A” classified items, which correlates with the highest 80 percent of annual usage dollars.<sup>50</sup> Physical inventories of “A” classified items must be conducted each quarter. Although the physical inventories were conducted, the VA Boston Healthcare System chief of supply chain management did not sign or forward notification of reported memorandums to the Veterans Integrated Service Network (VISN) for any of the review periods, as required by VHA policy. VHA policy states that the chief of supply chain management is the proper official designated to sign and send such memorandums to the VISN chief logistics officer and deputy network director.<sup>51</sup> Also, one of the four physical inventories was not uploaded to a designated SharePoint site, identified by a supply chain management staff member as an informal process by which VISN personnel access and review documentation upon completion. Issues pertaining to the signing and routing of completed “A” classified physical inventories were attributed to the healthcare system chief of supply chain management not ensuring full compliance with VHA policy.

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<sup>49</sup> A formulary item “drop” lead time is a data element that alerts logistics staff that an item has been temporarily dropped from the formulary due to unavailability and gives a corresponding period when it is anticipated to be restocked. The lowest unit of measure purchase feature alerts logistics staff to the lowest quantity of an item that may be purchased.

<sup>50</sup> In the ABC classification method, inventory point items with the highest 80 percent of the inventory dollars are classified as “A.” Items with the next highest 10 percent of inventory dollars are classified as “B.” Lastly, items with approximately 10 percent of the inventory dollars are classified as “C.”

<sup>51</sup> VHA divides the United States into 18 regional networks, known as Veterans Integrated Service Networks, which manage day-to-day functions of medical centers and provide administrative and clinical oversight.

## Finding 3 Conclusion

The VA Boston Healthcare System has provided oversight of expendable supplies to avoid stock outs and ensured the healthcare system is responsive to the needs of each facility. Improving the accuracy of inventory quantities and values in the Generic Inventory Package system could make the healthcare system more efficient. Unreliable inventory data could lead to purchasing unnecessary supplies and could adversely affect patient care. By addressing the recommendations, the healthcare system can effectively plan and budget for supplies to operate and meet patient care needs.

## Recommendations 6–7

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

6. Ensure supply chain management staff implement a plan to improve data reliability within the Generic Inventory Package system.
7. Ensure the chief of supply chain management signs quarterly physical inventory memorandums of “A” classified items and makes them available to Veterans Integrated Service Network personnel as required in the VHA’s Directive 1761 *Supply Chain Management Operations*.

## VA Management Comments

The director of the VA Boston Healthcare System concurred with recommendations 6 and 7. To address recommendation 6, the director reported logistics staff have a schedule to review certain SCCOP reports weekly, and supervisors and inventory managers hold weekly calls to discuss selected SCCOP metrics. Further, he reported staff discuss conversion factors and correct any errors at a monthly meeting. Regarding recommendation 7, the director reported that the FY 2022 memorandums for the physical inventories of “A” classified inventories have been signed by the chief of logistics and posted to a SharePoint site that is accessible to the VISN, as required by VHA Directive 1761.

## OIG Response

The healthcare system director’s action plans are responsive to the recommendations. Regarding recommendation 7, the director reported that corrective actions were implemented as of the start of FY 2022, which was after the scope of this review. During the site visit, the facility did not provide the OIG team evidence to support that the actions had been completed. Therefore, the OIG still considers this recommendation open. The OIG will monitor implementation of the planned actions and will close each recommendation when the OIG receives sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified.



## IV. Pharmacy Operations

According to the OPES FY 2021 Pharmacy Expenditure Model (based on FY 2020 data), the VA Boston Healthcare System spent almost \$69.3 million on prescription drugs, which represented about 6.9 percent of the healthcare system's budget of over \$1 billion for the year.<sup>52</sup> Because pharmacy expenses account for a substantial percentage of any medical center's budget, 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 grid to identify opportunities for improvement.

The team reviewed the following pharmacy areas:

- **OPES pharmacy expenditure data** are designed to allow VHA facilities to track costs and identify potential opportunities for improvement.
- **Inventory turnover rate**, or the number of times inventory is replaced during the year, is the primary measure to monitor the effectiveness of inventory management per VHA policy.<sup>53</sup> Low inventory turnover rates can indicate inefficient use of financial resources.

### Finding 4: The Healthcare System Could Improve Pharmacy Efficiency by Increasing the Inventory Turnover Rate

The review team found the healthcare system could improve pharmacy efficiency by increasing its inventory turnover rate to meet the VHA-recommended rate. Failure to properly manage pharmacy operations can lead to increased replenishment costs, overstocking, spoilage, and diversion of drugs and can decrease the funding available to meet other healthcare system and patient care needs.

#### OPES Pharmacy Expenditure Data

The OPES pharmacy expenditure model identifies variations in pharmacy costs among VHA facilities within VISN 1. According to the OPES FY 2021 model (based on FY 2020 data), the VA Boston Healthcare System had approximately \$69.3 million in observed drug costs, which is about \$1 million lower than the \$70.3 million in drug costs expected during this period. On the basis of these numbers, the healthcare system's observed-to-expected ratio was 0.986 for pharmacy drug cost efficiency.

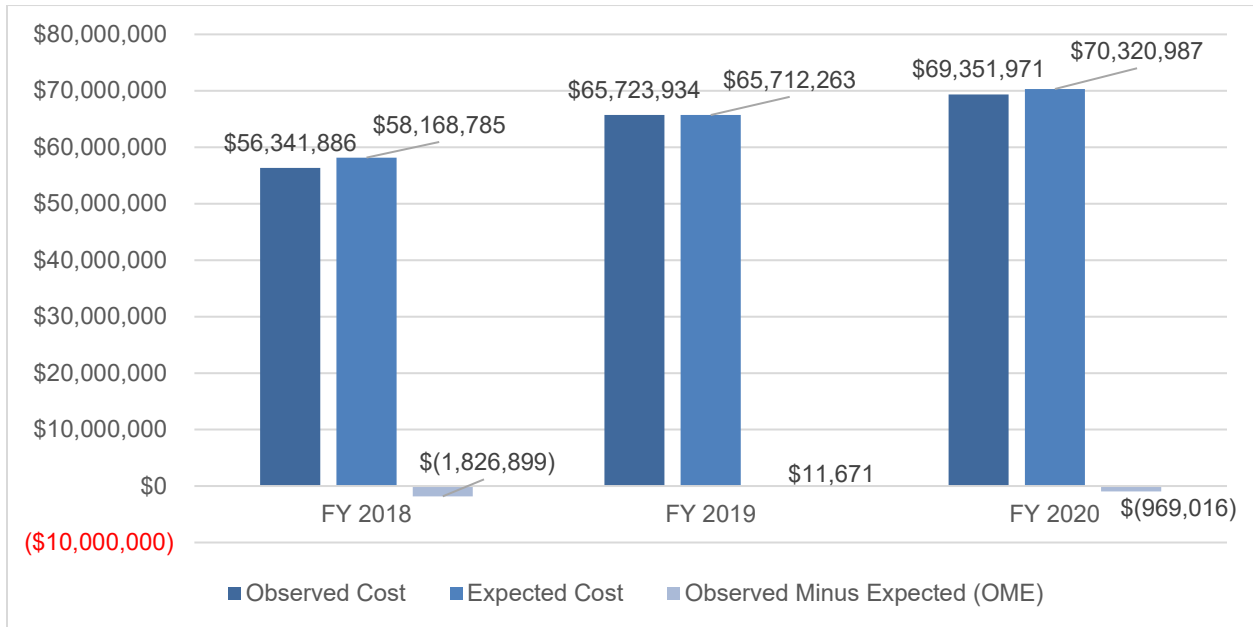
As figure 3 shows, over the last three fiscal years, the healthcare system managed drug costs effectively and averaged just under \$1 million in savings opportunity as a result. Pharmacy

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<sup>52</sup> OPES Pharmacy Expenditure Model (based on FY 2020 data), OPES, accessed September 8, 2021, <http://opes.vssc.med.va.gov/Pages/Pharmacy-Model.aspx>. (This is an internal VA website not publicly accessible.)

<sup>53</sup> VHA Directive 1761. Inventory turnover is based on the total dollar value purchased for the year divided by the dollar value of items on the shelf.

leaders attribute this cost savings to adopting cost avoidance initiatives and hiring knowledgeable pharmacy procurement technicians to ensure proper purchasing and inventory management.



**Figure 3.** Observed versus expected drug cost, FY 2018–FY 2020.

Source: OPES pharmacy expenditure model.

Note: The OPES data models are based on the previous fiscal year data (i.e., the FY 2021 data model was based on FY 2020 data).

## Inventory Turnover Rate

VHA policy states that inventory turnover is the primary measure of the effectiveness of inventory management.<sup>54</sup> Increasing the inventory turnover rate decreases inventory carrying cost, which is the cost associated with storing inventory. VHA policy also mandates the use of prime vendor inventory management reports to manage all VA medical facility pharmacy inventories.<sup>55</sup>

In FY 2021, the healthcare system reported an inventory turnover rate of 8.2 compared to the VHA’s recommended 12 turns per year, as established by the Pharmacy Benefits Management Office. Low inventory turnover could indicate the inefficient use of financial resources and the inability to properly forecast amounts of drugs needed to care for patients. The chief of pharmacy attributed the low turnover rate to procurement personnel who were from the logistics team, which was responsible for ordering and purchasing drugs for the pharmacy. Compared with procurement pharmacy technicians, logistics personnel did not have proper training or

<sup>54</sup> VHA Directive 1761.

<sup>55</sup> VHA Directive 1761.

institutional knowledge of pharmacy drug cost and inventory management processes. The chief of pharmacy explained that the healthcare system addressed this issue in May 2021 by hiring knowledgeable and experienced pharmacy procurement technicians throughout the healthcare system.

## **Finding 4 Conclusion**

The healthcare system could improve pharmacy efficiency by increasing inventory turnover. An efficient healthcare system anticipates how much drugs will cost and when inventory needs to be restocked, which helps ensure that the system makes the best use of appropriated funds and has inventory when needed.

## **Recommendation 8**

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

8. Develop and implement a plan to increase inventory turnover to meet the level recommended by the Veterans Health Administration Pharmacy Benefits Management Office.

## **VA Management Comments**

The director of the VA Boston Healthcare System concurred with recommendation 8. To address the recommendation, the director reported that the VHA Pharmacy Benefits Management Office will develop and implement a plan to increase inventory turnover to the recommended rate by October 1, 2022.

## **OIG Response**

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

## Appendix A: Healthcare System Profile

Table A.1 provides general background information for the VA Boston Healthcare System, which is a level 1a, high-complexity facility reporting to VISN 1.<sup>56</sup>

**Table A.1. Facility Data for VA Boston Healthcare System from FY 2019 through September 30, 2021**

Item	FY 2019	FY 2020	FY 2021
Total medical care budget	\$906,549,687	\$940,493,929	\$1,005,334,090
Number of patients	59,180	55,066	61,479
Outpatient visits	738,459	669,848	759,126
Total medical care FTEs <sup>57</sup>	4,135	4,135	4,001
Number of operating beds:			
Hospital	349	334	331
Community living center	98	98	98
Domiciliary	87	87	87
Average daily census:			
Hospital	282	249	235
Community living center	73	41	25
Domiciliary	109	77	68

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

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

According to VHA Support Service Center data, the healthcare system's medical care budget increased by over \$98.7 million, or about 10 percent, between FY 2019 and FY 2021, while the number of patients increased by 2,299, which is only about a 4 percent change. The chief financial officer concurred with the reported budgetary increases between FY 2019 and FY 2021 and told the review team outpatient visits increased by about 5 percent over the period. The chief financial officer identified contributing factors for the budget increases, including rising inflation of medical and nonmedical supplies and pharmaceuticals as well as continued increases in cost-of-living expenses. Additionally, the chief financial officer explained that cost-of-living expenses for the Boston area are very high, which results in the need for increased labor funding to attract and retain skilled medical personnel.

<sup>56</sup> The facility 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.

<sup>57</sup> Total medical care FTE includes both direct medical care FTEs in budget object code 1000–1099 (Personal Services) and all cost centers.

## Appendix B: Scope and Methodology

### Scope

The OIG team conducted its review of the VA Boston Healthcare System from November 2021 to May 4, 2022, including a virtual site visit during the week of November 1, 2021. The review team evaluated financial efficiency practices for FY 2021 related to open obligations, days of stock on hand for expendable supplies, and 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; however, the FY 2021 data model was 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 managing open obligations, overseeing purchase card transactions, calculating days-of-stock-on-hand metrics, and addressing inefficiencies in pharmacy costs; and
- judgmentally sampled
  - 20 inactive obligations to assess whether the healthcare system identified and reviewed the obligations to determine if they were still valid and needed to remain open in accordance with VA financial policy,
  - an additional 10 obligations to review end-date modifications,
  - 10 obligations with different end dates and 10 obligations with different order amounts from VA's FMS to IFCAP Reconciliation Reports to determine if end dates and order amounts were accurate and reconciled between VA's FMS and IFCAP, and
  - 36 purchase card transactions to determine if there was proper oversight and governance of the purchase card program, as well as to assess the risk for illegal, improper, or erroneous purchases.

### Data Reliability

The review team used computer-processed data obtained from US Bank files through a corporate data warehouse, a central repository for such bank information that is updated monthly, and the OPES efficiency opportunity grid. To test for reliability, the team determined whether any data were missing from key fields, included any calculation errors, or were outside the time frame requested. The team also assessed whether the data contained obvious duplication of records,

alphabetic or numeric characters in incorrect fields, or illogical relationships among data elements. Furthermore, the team compared purchase order numbers, payment dates, payee names, payment amounts, vendor 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, the team used computer-processed data included in reports from FMS to determine open obligation amounts. The team found that summary-level data were sufficiently reliable for reporting on the healthcare system's open obligations.

## **Government Standards**

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

## Appendix C: Sampling Methodology

### Open Obligations

The team evaluated a judgmental sample of open obligation transactions from March through August 2021 to determine if (1) the VA Boston Healthcare System performed monthly reviews and reconciliations of the reviewed obligations with no activity for more than 90 days to ensure the obligations were valid and should remain open, (2) the healthcare system had evidence to support end-date modifications to the period of performance for sampled obligations, and (3) the healthcare system reconciled end dates and order amounts between FMS and IFCAP for sampled obligations.

### Population

During August 2021, the healthcare system had 421 open obligations, totaling approximately \$35.8 million. Of those open obligations, 267 obligations, totaling approximately \$4 million, had no activity for over 180 days. From March through August 2021, there were 58 obligations totaling approximately \$30.6 million with end-date modifications. From May through August 2021, there were 59 obligations with end-date discrepancies outstanding for three or more months between FMS and IFCAP. Additionally, there were 66 obligations with order amount discrepancies between FMS and IFCAP for three or more months.

### Sampling Design

The review team selected three judgmental samples:

- **Inactive obligations.** The team selected 20 obligations with no activity for more than 90 days from the August 2021 FMS F850 report. This report lists each open obligation and its remaining balance. Ten obligations were still within the performance period, and the remaining 10 were more than 90 days past the performance period end date.
- **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 through August 2021.
- **FMS-to-IFCAP reconciliations.** The team selected 20 obligations with different end dates or order amounts between FMS and IFCAP from the VA's FMS to IFCAP Reconciliation Reports for May through August 2021. Ten obligations had end-date discrepancies, and 10 obligations had order amount discrepancies.

The samples included 50 total open obligations: 20 with no activity for more than 90 days, totaling approximately \$20.6 million; 10 with end-date modifications, totaling approximately

\$2.9 million; and 20 obligations with 10 different dates and 10 different order amounts between FMS and IFCAP.

To review the sampled obligations, the team requested supporting documentation for each of the 50 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 statistical sampling was not used.

## Purchase Cards

The review team evaluated a judgmental sample of FY 2021 purchase card transactions to determine if (1) the VA Boston Healthcare System reviewed purchase card payments to ensure they were adequately monitored, approved, and supported by documentation and (2) the reviewed transactions complied with processes to prevent split purchases and transactions exceeding the cardholder's authorized single purchase limit and to ensure goods or services were procured using strategic sourcing procedures.

## Population

During FY 2021 (October 1, 2020, through September 30, 2021), purchase cardholders at the healthcare system made about 55,000 purchase card transactions totaling approximately \$63 million. A total of 405 bundles of transactions were identified as potential split transactions, including 1,397 individual transactions. The other potential high-risk transactions were selected from the remaining 53,000 transactions.

## Sampling Design

The review team selected two judgmental samples:

- **Potential split purchases.** The team identified potential split purchases as transactions with the same purchase date, purchase card number, and merchant and an aggregate sum greater than the cardholder's authorized single procurement limit. The team identified 11 bundles of potential split purchases that included 22 transactions.
- **Other potential high-risk purchase areas.** The team identified 14 transactions that involved an area of potential risk, such as merchants not commonly associated with a medical facility, purchases that included sales tax, or timing of purchases.



The sample included 36 total individual transactions, 22 potential split purchase transactions totaling approximately \$370,000, and 14 high-risk transactions totaling approximately \$71,000 in spending.

To review the sampled transactions, the team requested supporting documentation for each of the 36 sampled transactions, VA Form 0242, and documentation to support the completion of quarterly purchase card audits.

### **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 <sup>58</sup>
1	Ensure healthcare system finance office staff are made aware of policy requirements and reviews are conducted on all inactive open obligations as required by VA Financial Policy, vol. 2, chap. 5, "Obligations Policy"	\$4,439	
2	Ensure cardholders comply with record retention requirements as stated in VA's Financial Policy, vol. XVI, "Charge Card Programs"		\$375,000
	<b>Total</b>	<b>\$4,439</b>	<b>\$375,000</b>

<sup>58</sup> 2 C.F.R. § 200.84. As stated earlier, the term "questioned cost" includes 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.

## Appendix E: VA Management Comments, Director, VA Boston Healthcare System

VA New England Healthcare System  
Building 1  
150 South Huntington Ave.  
Boston, MA 02130

Date: May 20, 2022

From: Mr. Vincent Ng, Medical Center Director, VA Boston Healthcare System.

Subj: Response to Draft Report Financial Efficiency Review of the VA Boston Healthcare System – Boston, MA (2021-03853-AE-0188)

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

The management of the VA Boston Healthcare System concurs with the following findings:

- Finding 1 - Inactive Obligations Were Not Always Being Reviewed, and Some Obligations Were Not Promptly De-obligated.
- Finding 2 - The Healthcare System Did Not Always Maintain Supporting Documentation or Consider Using Contracts
- Finding 3 - The Healthcare System Could Strengthen Controls to Ensure Accuracy of Inventory Data and Achieve Complete “A” Classified Physical Inventories.
- Finding 4 -The Healthcare System Could Improve Pharmacy Efficiency by Increasing the Inventory Turnover Rate.

The management of the VA Boston Healthcare System concurs with the following recommendations:

- Recommendation 1 - Ensure that healthcare system finance office staff are made aware of policy requirements and that reviews are conducted on all inactive open obligations, and de-obligate any identified excess funds as required by VA Financial Policy, vol. 2, chap. 5, “Obligations Policy.”-The recommended action for recommendation 1 has been completed. The effective date was 02/28/2022. The finance staff are now aware of the policy requirements and reviews are conducted on all inactive open obligations. Finance staff do not have the authority to de-obligate obligations which are established by a contracting officer. Finance conducts follow up reviews, services submit the required paperwork to the contracting officer to de-obligate open order(s).
- Recommendation 2 - Ensure cardholders comply with record retention requirements as stated in VA’s Financial Policy, vol. XVI, “Charge Card Programs.” The VA BHS will conduct cardholder training and work with Contracting more closely. Estimated completion date is 11-1-2022.
- Recommendation 3 - Establish controls to confirm approving officials and purchase cardholders review their purchases and make sure contracting is used when it is in the best interest of the government. The VA BHS will conduct cardholder training and work with Contracting. Estimated completion date is 11-1-2022.

- Recommendation 4 - Require purchase cardholders to submit a request for ratification for any unauthorized commitments identified. The VA BHS will conduct cardholder training and work with Contracting. Estimated completion date is 11-1-2022.
- Recommendation 6 - Ensure supply chain management staff implement a plan to improve data reliability within the Generic Inventory Package system. The recommended action for recommendation 6 has been completed. The effective date was 1/1/2022. Logistics has a cadence schedule to review SCCOP reports below weekly and have the Inventory Mangers of the associated primaries act. We also discuss SCCOP Metrics CA2/CB5/CD9/CD11 & CE14 in a weekly huddle call Supervisors hold with Inventory Mangers as well as a monthly meeting to discuss conversion factors and correct any errors.
- Recommendation 7- Ensure the chief of supply chain management signs quarterly physical inventory memorandums of "A" classified items and make them available to Veterans Integrated Service Network personnel as required in the VHA's Directive 1761 "Supply Chain Management Operations." The recommended actions for recommendation 7 have been completed. The effective date was 10/01/2021. The Chief of Logistics signed the FY 22 quarterly physical inventory memorandums of "A" classified items and are available to Veterans Integrated Service Network personnel as required in the VHA's Directive 1761.
- Recommendation 8 - Develop and implement a plan to increase inventory turnover to meet the level recommended by the Veterans Health Administration Pharmacy Benefits Management Office. VA BHS Pharmacy service will develop and implement plan to increase inventory turnover. Estimated completion date is 10-1-2022.

(Original signed by)

Vincent Ng

Medical Center Director, VA Boston Healthcare System

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

## Appendix F: VA Management Comments, Director of Contracting, Network Contracting Office 1

VA New England Healthcare System  
Building 1  
150 South Huntington Ave.  
Boston, MA 02130

Date: May 20, 2022

From: Director of Contracting, NCO1

Subj: Response to Draft Report Financial Efficiency Review of the VA Boston Healthcare System – Boston, MA (2021-03853-AE-0188)

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

The management of the VA Boston Healthcare System concurs with the following finding:

Finding 2 - The Healthcare System Did Not Always Maintain Supporting Documentation or Consider Using Contracts.

The management of Network Contracting Office One (NCO1) concurs with the following recommendation:

Recommendation 5 - Ensure quarterly purchase card audits are performed as required by the Veterans Health Administration's standard operating procedure, "Internal Audits—Purchase Cards and Convenience Checks."-As stated in the Draft Report Financial Efficiency Review of the VA Boston Healthcare System – Boston, MA (2021-03853-AE-0188), the purchase card auditor did conduct quarterly audits, but did not provide evidence that the memorandums were sent to or acknowledged by the medical center (or healthcare system equivalent) in accordance with policy.

Response from Network Contracting Office One (NCO 1):

The purchase card quarterly audits were uploaded to the SharePoint where the Associate Director's (AD's), Medical Center Director's, and Purchase Card Operations had access to review, just as Fiscal does with their audits. They were also sent to the card holders for their awareness. Since your audit report/findings that was completed back in November 2021, the internal SOP has been rescinded and archived, see attachment 1, by VHA Purchase Card Operations and is no longer required. NCO 1 Contracting had decided to continue performing the quarterly audits and since your report has sent the findings to the AD's per the Medical Center Directors direction, see attachment 2 and 3. We acknowledge your recommendation and have already put our corrective action in place with the first quarterly audits sent to the AD's this past April and every quarter going forward. The effective date to fully implement this recommendation is 10/01/2022.

(Original signed by)

William Nalls

Director of Contracting, Network Contracting Office 1 (NCO1)

Attachments (1) (2) (3)

*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

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