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Financial Efficiency Inspection of the Northern Arizona VA Health Care System

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Executive Summary

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

This inspection assessed four financial activities and administrative processes to determine whether the healthcare system had appropriate controls and oversight in place:

I. **Open obligations oversight.** An obligation is a legally binding commitment of appropriated funds for goods or services.[2] Open obligations include those obligations that are not considered closed or complete and have a balance associated with them, whether undelivered or unpaid. Open obligations should be reviewed by the healthcare system finance office to ensure that beginning and ending dates are accurate; open balances are accurate and agree with source documents, such as contracts and purchase orders, receiving reports, invoices, and payments; and obligations beyond 90 days of the period of performance end date or without activity in the past 90 days are valid and should remain open.[3] The inspection team evaluated whether the healthcare system performed monthly reviews and reconciliations of sampled obligations.

II. **Purchase card use.** The VA Government Purchase Card Program was established to reduce administrative costs related to the acquisition of goods and services. When used properly, purchase cards can help facilities simplify acquisition procedures and provide an efficient vehicle for obtaining goods and services directly from vendors. The team examined whether the healthcare system's purchase card program ensured compliance with policies and procedures that reduce the risk of error, fraud, waste, or abuse. The inspection team evaluated whether the healthcare system adhered to strategic sourcing guidelines and considered establishing contracts when making common purchases and whether it properly documented sampled transactions.[4] Documenting transactions as required helps VA and other oversight entities identify potential fraud, waste, and abuse.

[1] The healthcare system consists of the Bob Stump VA Medical Center in Prescott, Arizona, and community-based outpatient clinics in Anthem, Flagstaff, Cottonwood, Kingman, and Lake Havasu City, all in Arizona. For more information about the healthcare system budget, capacity, and daily census, see appendix A.

[2] VA Financial Policy, "Obligations Policy," in vol. 2, *Appropriations, Funds, and Related Information*, chap. 5, May 2021 and September 2021.

[3] VA Financial Policy, "Obligations Policy."

[4] VA Financial Policy, "Government Purchase Card for Micro-Purchases," in vol. 16, *Charge Card Programs*, chap. 1B, October 22, 2019, and July 14, 2021. This policy defines "strategic sourcing" as ensuring employees obtain proper contracts when procuring goods and services on a regular basis.

Using contracts for common purchases has several benefits, such as allowing VA to optimize purchasing power and obtain competitive pricing.

III. **Inventory and supply management.** Supply chain management is the integration and alignment of people, processes, and systems to manage planning, sourcing, purchasing, delivering, receiving, and disposal.[5] Veterans Health Administration (VHA) policy requires medical facilities to establish, operate, and maintain a supply chain management program that is effective, cost-efficient, transparent, and responsive to customer requirements and to continually identify ways to ensure high-quality veteran care.[6] The team evaluated whether the healthcare system managed its supply chain operations effectively using days of stock on hand as a performance metric.

IV. **Pharmacy operations.** An efficient healthcare system anticipates how much drugs will cost and when inventory needs to be restocked by analyzing available data, such as prime vendor inventory management reports and inventory turnover rates.[7] Doing so helps ensure that the system makes the best use of appropriated funds and has inventory when needed. The team evaluated whether the healthcare system managed its pharmacy operations effectively and provided adequate oversight of inventory management.

The inspection team performed a site visit at the Northern Arizona VA Health Care System during the week of April 11, 2022; 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 inspection's scope and methodology, see appendixes B and C.

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

What the Inspection Found

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

I. **Open obligations oversight.** As of December 31, 2021, the healthcare system had 73 inactive obligations totaling over $7.8 million. Of those, 45, totaling over $4.3 million, had no activity for 181 days or more. The inspection team selected 20 obligations that had been inactive for more than 90 days, totaling almost $6.5 million, and examined whether the healthcare system performed required reviews to assess the validity and necessity of the remaining funds associated with each one. The team was not able to

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

[6] VHA Directive 1761.

[7] The inventory turnover rate is the number of times inventory is replaced during the year. Low inventory turnover rates indicate inefficient use of financial resources.

verify that a review was completed on eight of the 20. Five also had funds totaling approximately $81,900 that should have been deobligated.[8]

The healthcare system uses a web-based tool created by Veterans Integrated Service Network 20 (VISN) that identifies all open obligations and color-codes the "days" column to easily identify items over 90 days. However, according to finance office personnel, the healthcare system does not review all inactive obligations due to lack of staffing, lack of urgency from initiating services, and competing priorities. Other healthcare systems could benefit by adopting and using this web-based tool to review open obligations.

The inspection team selected and evaluated 13 additional open obligations to determine if end dates reconciled and order amounts were accurate and reconciled between VA's Financial Management System (FMS) and the Integrated Funds Distribution, Control Point Activity, Accounting and Procurement System (IFCAP).[9] Eight of these obligations contained end-date discrepancies that had existed for three months or more, with variances ranging from 31 to 334 days. The remaining five contained order amount discrepancies that had existed for three months or more and totaled about $15,900. Of the five, three had been corrected. The unreconciled amount totaled about $3,700. The inspection team also identified that one of the reviewed obligations had outstanding funds that were no longer needed and resulted in about $700 being overobligated in FMS. These discrepancies occurred because the finance office does not reconcile order amounts between systems, as required.[10]

The inspection team determined the healthcare system had not conducted the finance quality assurance review specific to accounting operations and undelivered orders for fiscal year (FY) 2019 through FY 2021. According to finance personnel, this occurred due to lack of staff. Failure to properly manage open obligations increases the risk of failing to spend appropriations within the associated fiscal year and to repurpose funds to benefit veterans.[11]

II. **Purchase card use.** The inspection team assessed a judgmental sample of 35 purchase card transactions totaling about $840,000 from July 1 through December 31, 2021, to see

[8] VA Financial Policy, "Obligations Policy."

[9] IFCAP is used for the processing of certified invoices and electronic transmission of receiving documents to FMS. In addition, IFCAP transfers obligation information back to the control point balance automatically.

[10] VA Financial Policy, "Obligations Policy."

[11] Appendix D presents the estimated monetary benefits associated with these obligations.

whether they were processed in compliance with VA policy.[12] Of the 35 sampled transactions, nine had delayed reconciliations and two showed that cardholders and approving officials did not adhere to the separation of duties designed by policy to reduce fraud, waste, and abuse.

The team selected 10 transactions totaling approximately $33,400 to determine if these transactions were modified into smaller parts to avoid exceeding the purchase card limit. The team reviewed transaction documentation and interviewed purchase cardholders and approving officials and determined that none of the transactions were split purchases. The team also determined that contracts could have been considered for eight of the 35 sampled transactions (23 percent), totaling almost $40,100. Additionally, 12 of the 35 (34 percent) were missing some required supporting documentation, which resulted in almost $54,000 in questioned costs.[13] Cardholders and approving officials did not always work together to ensure compliance throughout the transaction process and fulfill roles and responsibilities in accordance with VA policy.[14] 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 facility for each cardholder in the inspection sample. The facility's purchase card coordinator conducted purchase card reviews during FY 2021, as required by policy.[15]

III. **Inventory and supply management.** The healthcare system provided oversight to monitor and maintain stock levels for expendable supply items and met the required accuracy rate for inventory counts as required by VHA policy.[16] The healthcare system also created a local dashboard to monitor various metrics weekly. However, the healthcare system did not always ensure that inventory recorded in the Generic Inventory Package was accurate.[17] This led to increased reliance on manual counts, inaccurate inventory values, and use of manual adjustments to correctly record inventory.

[12] A judgmental sample is a nonstatistical sample selected based on auditors' opinions, experience, and knowledge. VA requires that the duties of the cardholder, approving official, requesting official, and receiving official be segregated. An agency/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.

[13] The term "questioned cost" is a cost that is questioned by the auditor because of an audit finding where the cost, at the time of the audit, is not supported by adequate documentation. See appendix D for monetary benefits associated with the questioned costs. 2 C.F.R. § 200.1 (2021).

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

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

[16] VHA Directive 1761.

[17] The Generic Inventory Package is the software system authorized to manage the receipt, distribution, and maintenance of expendable supplies used throughout VA.

VHA requires responsible staff to ensure correct reorder points and inventory levels are maintained.[18] Expendable supplies purchased through the Medical Surgical Prime Vendor (MSPV) program should have 15 days' or less stock on hand, while non-MSPV items should have 30 days' or less stock on hand.[19] From July 1 through December 31, 2021, the healthcare system had an average of 14.7 days' stock for MSPV items and met the metric for three of six months. The average for non-MSPV items was 27.9 days' stock, and the metric was met for four of six months.[20] As of March 31, 2022, the average days of stock on hand for MSPV items and non-MSPV items were 20.3 and 44.6, respectively. Because of the COVID-19 pandemic, the healthcare system received a waiver to suspend days-of-stock-on-hand performance measures from March 3, 2021, through March 31, 2022.

Conversion factor errors, if not identified and corrected, can cause the quantity on hand and value of supplies in the Generic Inventory Package to be unreliable.[21] According to the Supply Chain Common Operating Picture (SCCOP), as of March 31, 2022, 355 of 2,327 supply items, or 15 percent, had potential conversion factor errors. As a result of the team's inspection, the healthcare system conducted a 100 percent count of the contingency inventory point. After combining both positive and negative adjustments made by inventory management staff, the extent of the adjustments totaled 5,344 items valued at $151,810. This dollar amount represented 62.4 percent of the initial inventory value.

IV. **Pharmacy operations.** The healthcare system has narrowed the gap between the facility's observed and expected drug costs but could improve pharmacy efficiency by bringing the turnover rates closer to the VHA-recommended level and completing the B09 reconciliation process, which is how VA medical center pharmacies assure they are making correct payments for the drugs they receive. VHA policy requires reconciliation of billing statements, verification of ordered items being received, and certification as to accuracy including maintaining supporting documentation such as receipts, invoices, and packing slips.[22] The chief of pharmacy must provide a monthly report, with adequate

[18] The reorder point represents the level at which the item is to be replenished.

[19] MSPV is a national program that provides a customized distribution system to meet or exceed facility requirements through a just-in-time distribution catalog ordering process.

[20] Data are obtained from the Supply Chain Common Operating Picture (SCCOP) intranet, an internal VA website that publishes supply chain management benchmarks and reports.

[21] A conversion factor connects how a supply item is purchased and used. The conversion factor is computed by dividing the quantity purchased by the quantity issued and equals one when the unit of purchase and the unit of issue are the same. Any calculation error in the conversion factor causes inaccurate quantities and values in the Generic Inventory Package.

[22] VHA Directive 1108.07(1).

documentation, to the chief of fiscal service stating the VA Form 1358s and B09 reports were reconciled and noting any unresolved discrepancies.

The healthcare system went from reporting almost $1.7 million over expected costs for FY 2019 to more than $1.4 million below expected costs for FY 2021. However, in February 2022, the healthcare system reported an inventory turnover rate of 4.83 times compared with VHA's recommended level of 12 times. According to pharmacy personnel, inpatient pharmacy drug inventories were managed by "walking the shelves" instead of using calculated reorder points and reorder quantities determined via demand forecasting for more accurate inventory management as required by policy.[23] Pharmacy personnel also were not implementing inventory management practices, such as placing barcodes on stock at all locations, using handheld barcode readers, and using the ABC inventory analysis methods as required by VHA policy.[24]

The healthcare system's B09 reconciliation process did not fully comply with VHA policy.[25] Pharmacy staff said they were not recording the receipt of supplies because scanners were needed for this function and had not been in operation at the medical center for over a year and a half due to network issues. The OIG also found that the healthcare system was not reconciling drug purchases as outlined by VHA procedures because invoices were not always signed, dated, or maintained, and staff sometimes used packing slips that did not include drug costs. Pharmacy service personnel did not always sign the B09 report when the weekly reconciliation was completed and did not always forward supporting documentation, which prevented the inspection team from determining whether reconciliations were being completed fully or on time.

What the OIG Recommended

The OIG made 10 recommendations for improvement to the healthcare system director. 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.

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

[24] VHA Directive 1108.08(1). The ABC classification method states that inventory point items with approximately 70 percent of the inventory dollars and 10 percent of the products are classified as "A." Items with approximately 20 percent of the inventory dollars and 20 percent of products are classified as "B." Lastly, items representing approximately 10 percent of the inventory dollars and 70 percent of the products are classified as "C."

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

The OIG recommended the healthcare system director ensure staff conduct reviews on all open obligations and conduct the accounting operations finance quality assurance review as required.

To strengthen oversight of purchase card transactions, the OIG recommended the director establish controls to confirm approving officials and cardholders review their purchases and make sure contracting is used when it is in the best interest of the government, review all invoices for continuous positive airway pressure machines for overcharges, and establish procedures to ensure required supporting documentation is received from vendors shipping directly to veterans.

Related to inventory and supply management, the OIG recommended ensuring all supplies are recorded in the Generic Inventory Package as required and developing and implementing a plan to ensure data accuracy and reliability.

The OIG also made three recommendations regarding pharmacy operations: develop and implement a plan to increase inventory turnover closer to the VHA-recommended level; develop a plan to align inventory management practices, such as the use of handheld scanners, barcode labeling, and ABC inventory analysis methodology with VHA policy; and establish processes to ensure compliance with the VHA directive to complete the B09 reconciliation process.

VA Management Comments and OIG Response

The director of the Northern Arizona VA Health Care System concurred with all recommendations and provided responsive corrective action plans. Appendix E includes the healthcare system director's comments.

The OIG considers all recommendations still open and will monitor the implementation of the planned actions. The director of the healthcare system reported the actions for one of the recommendations would be completed by the end of December 2022; no evidence or supporting documentation was provided for the OIG to evaluate. The OIG will close the recommendations when the Northern Arizona VA Health Care System provides sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified.

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Contents

Abbreviations

CPAP	continuous positive airway pressure
FMS	Financial Management System
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	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 inspections to assess stewardship and oversight of funds at VA healthcare systems and to identify opportunities to achieve cost efficiencies. Inspection teams identify and examine financial activities that are under the healthcare system's control and can be compared across VA healthcare systems similar in size and complexity to promote best practices.[26]

This inspection focused on the Northern Arizona VA Health Care System. The OIG assessed four financial activities and administrative processes to determine whether appropriate controls and oversight were in place from July through December 2021:

I. **Open obligations oversight.** An obligation is a legally binding commitment of appropriated funds for goods or services.[27] Open obligations include those obligations that are not considered closed or complete and have a balance associated with them, whether undelivered or unpaid. Open obligations should be reviewed by the healthcare system finance office to ensure that beginning and ending dates are accurate; open balances are accurate and agree with source documents, such as contracts and purchase orders, receiving reports, invoices, and payments; and obligations beyond 90 days of the period of performance end date or without activity in the past 90 days are valid and should remain open.[28] The inspection team evaluated whether the healthcare system performed monthly reviews and reconciliations of sampled obligations.

II. **Purchase card usage.** The VA Government Purchase Card Program was established to reduce administrative costs related to the acquisition of goods and services. When used properly, purchase cards can help facilities simplify acquisition procedures and provide an efficient vehicle for obtaining goods and services directly from vendors. Documenting transactions as required helps VA and other oversight authorities identify potential fraud, waste, and abuse. Using contracts for common purchases has several benefits, such as allowing VA to optimize purchasing power and obtain competitive pricing. The team examined whether the healthcare system's purchase card program ensured compliance with policies and procedures, and focused on the consideration of contracts for commonly purchased products, known as strategic sourcing, to provide optimal savings to VA.

[26] The Veterans Health Administration uses a facility complexity model that classifies its facilities at levels 1a, 1b, 1c, 2, or 3, with level 1a being the most complex and level 3 being the least complex. The Northern Arizona VA Health Care System was rated as a level 3 (low complexity) facility.

[27] VA Financial Policy, "Obligations Policy," in vol. 2, *Appropriations, Funds, and Related Information*, chap. 5, May 2021 and September 2021.

[28] VA Financial Policy, "Obligations Policy."

III. **Inventory and supply management.** The inspection team evaluated whether the healthcare system provided oversight to maintain stock levels, complied with policies and procedures, and ensured inventory quantities and values were recorded correctly for expendable items. The inspection also focused on the days-of-stock-on-hand performance metric, a nationally set level of inventory for expendable Medical Surgical Prime Vendor (MSPV) program items and non-MSPV items that facilitates efficient purchasing and use of supplies.[29]

IV. **Pharmacy operations.** An efficient healthcare system anticipates how much drugs will cost and when inventory needs to be restocked by analyzing available data, such as prime vendor inventory management reports and inventory turnover rates. Doing so helps ensure that the system makes the best use of appropriated funds and has inventory when needed. The team evaluated whether the healthcare system complied with applicable policies and used cost and performance data to track progress toward goals developed by the national Pharmacy Benefits Management office, improve pharmacy program operations, and identify and correct problems.

The inspection team performed a site visit at the Northern Arizona VA Health Care System during the week of April 11, 2022; 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 inspection's scope and methodology, see appendixes B and C.

Northern Arizona VA Health Care System

The Northern Arizona VA Health Care System provides medical care to veterans across 65,000 square miles of territory, including inpatient medicine and ambulatory care, general medicine, ambulatory procedures, and selected specialized medical clinics for veterans residing in northern and central Arizona. Care is delivered through the Bob Stump VA Medical Center in Prescott, Arizona, and community-based outpatient clinics located in Anthem, Flagstaff, Cottonwood, Kingman, and Lake Havasu City, all in Arizona. The healthcare system also has six telehealth clinics in Arizona, located in Holbrook, Page, Tuba City, Polacca, Chinle, and Kayenta. In fiscal year (FY) 2021, the healthcare system operated 220 beds with over 1,100 total full-time equivalent staff and provided services to over 28,800 veterans. The reported FY 2021 medical care budget exceeded $367 million, an almost $53.6 million increase (17 percent) over the FY 2020 budget of approximately $313.5 million and an increase of almost $142.5 million (63.5 percent) from the FY 2019 budget of approximately $224.5 million.

[29] 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.

Facility and Inspection Area Selection

The inspection team identified 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's (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. The grid also 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 inspections.[30]

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

Results and Recommendations

I. Open Obligations Oversight

VA's management of open obligations has been a long-standing problem and was included as a significant deficiency in VA's FY 2021 audited financial statements and as a material weakness in VA's FY 2019 and FY 2020 audited financial statements.[31] 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 staff follow VA policy regarding required reviews of open obligations.[32]

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

- **Inactive obligations.** The inspection team assessed whether the healthcare system performed monthly reviews and reconciliations to ensure that the sampled inactive obligations were valid and should remain open.[33] Inactive obligations have had no activity for more than 90 days.
- **Financial Management System (FMS)-to-Integrated Funds Distribution, Control Point Activity, Accounting and Procurement System (IFCAP) reconciliations.** The team identified open obligations with different end 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.
- **Internal obligation reviews.** The team assessed whether the healthcare system performed financial quality assurance reviews for undelivered orders. The review is designed to help managers analyze, evaluate, and report on the healthcare system's financial procedures, accounting records, and internal controls. It can serve as a management tool to identify strengths and weaknesses in VHA financial management operations and a tool to design corrective action plans for findings.

[31] 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. In the reports, CliftonLarsonAllen LLP defines a material weakness as a deficiency, or combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented or detected and corrected 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.

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

[33] VA Financial Policy, "Obligations Policy."

Finding 1: Inactive Obligations Were Not Always Being Reviewed, Some Were Not Deobligated, and Quality Assurance Reviews Were Not Always Completed

VA policy requires finance offices to perform monthly reviews and reconciliations of open obligations that are at least 90 days beyond the period of performance end date or that have been inactive for more than 90 days to ensure the obligation is still valid and that funds are not left unused.[34] For these obligations, finance office personnel should verify with the initiating service or contracting officer, if applicable, that the goods or services have not been received and are still needed. The responsible finance office should review data from VA's FMS against supporting documentation monthly to ensure reports, subsidiary records, and systems reflect proper costing, accurate delivery date or end date, and a correctly calculated unliquidated obligation.[35] 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 decrease the remaining funds on the obligation.

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

[35] 2 C.F.R. § 200.1 (2021). The term "unliquidated obligation" means an obligation incurred by a nonfederal entity that has not been paid (liquidated) or for which the expenditure has not been recorded.

Figure 1 shows the number and dollar amounts of inactive obligations for the Northern Arizona VA Health Care System from July through December 2021.

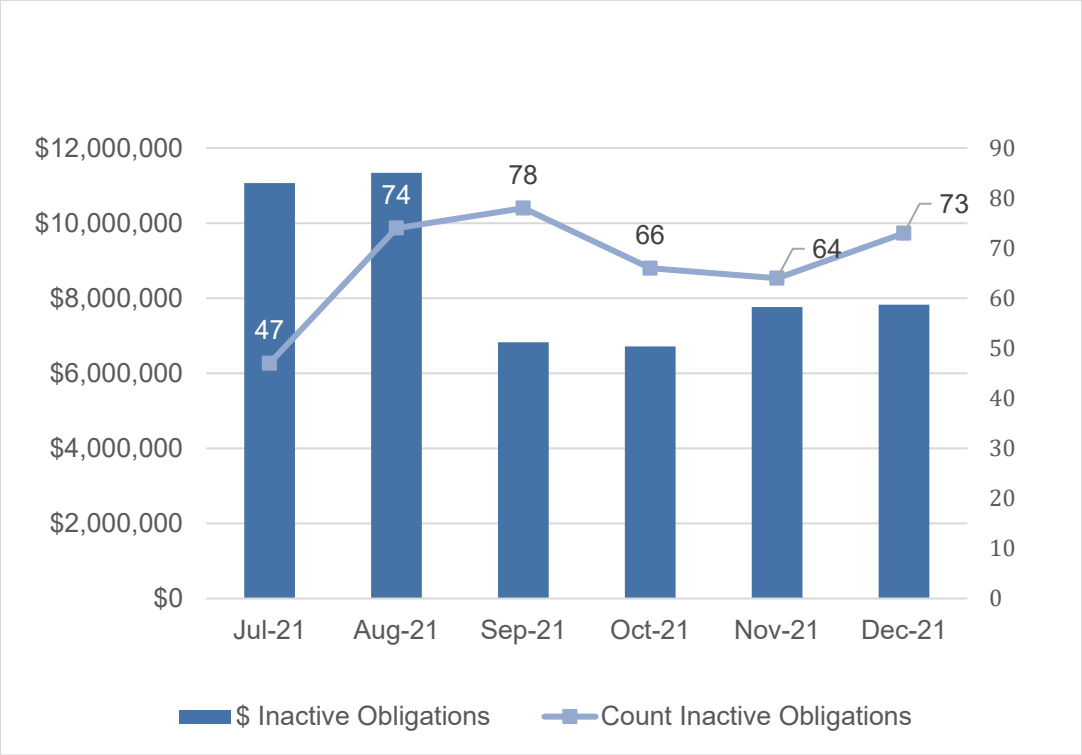

Figure 1. *VA OIG analysis of inactive obligations for the Northern Arizona VA Health Care System, July through December 2021.*

Source: VA FMS F850 Report.

As of December 31, 2021, the healthcare system had 73 inactive obligations totaling over $7.8 million. Figure 2 shows the age and dollar amounts of the 73 obligations. As shown, 45 obligations totaling over $4.3 million had no activity for 181 days or more.

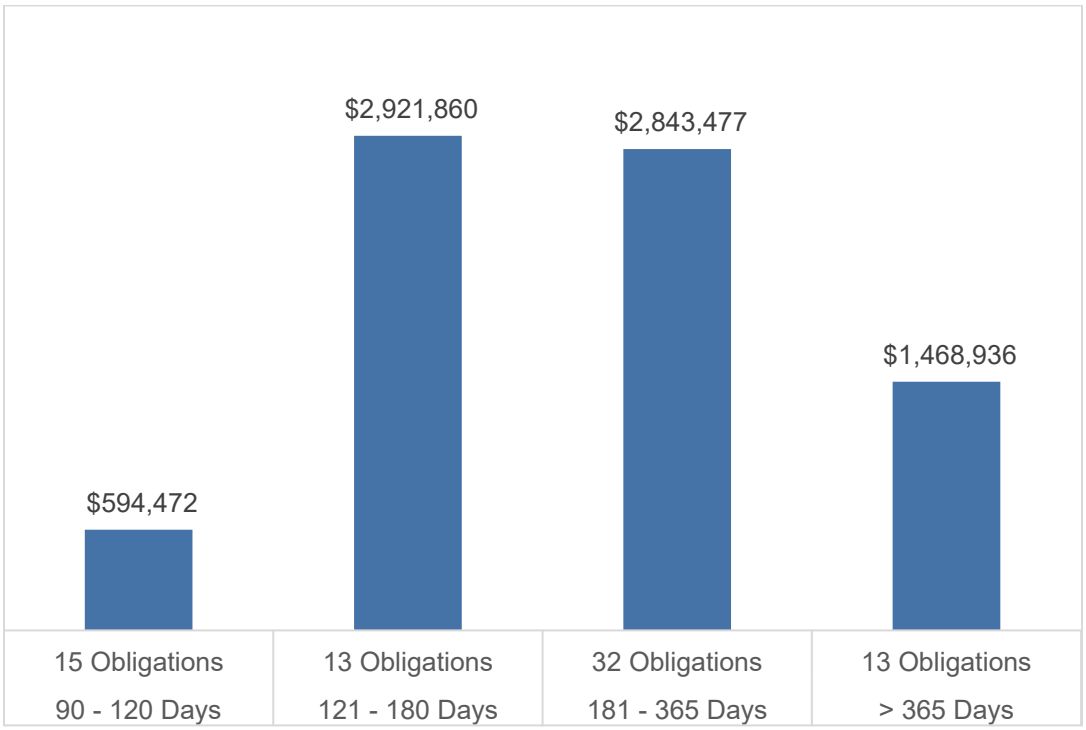

Figure 2. *VA OIG analysis of inactive obligations for December 2021.*
Source: VA FMS F850 Report.

Inactive Obligations

The inspection team performed data analysis and selected 20 inactive obligations through December 2021 totaling almost $6.5 million. The team reviewed supporting documentation to assess whether the healthcare system identified and reviewed the sampled obligations to determine if they were still valid and needed to remain open in accordance with VA financial policy.[36] Thirteen obligations were still within the performance period, whereas the remaining seven were more than 90 days past the performance period end date. See appendix B for additional details on scope and methodology and appendix C for details on the inspection's sampling. The team was not able to verify that a review was completed on eight of these 20 obligations, totaling approximately $452,000. Additionally, five of the 20 obligations had residual funds totaling almost $81,900 that should have been deobligated.

The healthcare system uses a web-based tool, Veterans Integrated Service Network (VISN) Undelivered Orders (UDO) Accrued Services Payable (ASP) Review Web Portal to streamline and capture the monthly review process of open obligations. The tool was created by VISN 20 and identifies all open obligations and color-codes the "days" column to easily identify

[36] VA Financial Policy, "Obligations Policy."

items over 90 days.[37] A valid status response from the initiating service is required for each obligation that is over 90 days old. Other healthcare systems could benefit by adopting and using this web-based tool to review open obligations.

Although the portal identified and required review of obligations that were past their period of performance end date, the initiating service did not always review those obligations to determine whether they were valid and should remain open. The healthcare systems average response rate for obligations over 90 days old was 57 percent for July through December 2021.

The assistant finance officer said the portal did not identify inactive obligations for review and confirmed the healthcare system does not review all inactive obligations due to lack of staffing, lack of urgency from initiating services, and competing priorities; however, the VHA associate chief financial officer clarified the portal was updated in July 2021 to identify inactive obligations. The chief of facilities management services, whose department had an average 2 percent response rate to the portal, indicated he was never trained on VA financial policy that outlines the initiating service's responsibility to coordinate review of open obligations with the finance office. Positions the service chief believed to be responsible for responses to the portal were vacant at the time of the OIG's review; however, the service chief acknowledged others should assume that responsibility as they have daily knowledge of open obligation status. The service chief attributed the lack of response to workload, lack of staff in critical key positions, not monitoring response rate reports, and not understanding the importance of response or policy requirements.

End-Date and Order Amount Discrepancies between FMS and IFCAP

IFCAP handles the processing of certified invoices and electronic transmission of receiving documents to FMS. In addition, IFCAP transfers obligation information back to the control point and updates the control point balance automatically.[38] The end dates in both systems should be the same. However, staff can manually change end dates in one system without changing them in the other. Open obligations should be reviewed monthly by the healthcare facility's finance office, in coordination with the initiating service, to ensure period of performance dates are correct and match in all systems.[39] The inspection team selected and evaluated 13 additional open obligations to determine if end dates were reconciled and order amounts were accurate and reconciled between VA's FMS and IFCAP.

[37] VHA divides the United States into 18 regional networks, known as VISNs—regional systems of care working together to better meet local healthcare needs and provide greater access to care.

[38] 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.

[39] VA Financial Policy, "Obligations Policy."

Eight of the 13 obligations contained end-date discrepancies that had existed for three months or more, with variances between systems ranging from 31 to 334 days. Facility personnel said this occurred because finance staff are not always notified when contracting or initiating services change end dates in IFCAP. Additionally, end-date discrepancies cannot be corrected due to a system limitation that does not allow end-date changes in IFCAP for Form 1358 obligations, which accounted for four of the eight obligations.[40] Finance staff confirmed they do not review end dates of open obligations to ensure they match in all systems as required by policy.[41]

The remaining five of the 13 obligations contained order amount discrepancies that had existed for three months or more with differences totaling about $15,900. Two of the five the team identified still had order amount discrepancies in FMS and IFCAP as of December 14, 2021. As of March 15, 2022, one discrepancy had been resolved. The difference between the amount recorded in the systems for the remaining obligation, or the unreconciled amount, totaled about $3,700. These discrepancies occurred because the finance office does not reconcile order amounts between systems, as required.[42] The assistant finance officer confirmed the finance office does not use VA's FMS-to-IFCAP reconciliation report.[43]

The inspection team determined one of the reviewed obligations had outstanding funds that were no longer needed and resulted in about $700 being overobligated in FMS. Had the finance office monitored end-date and order amount discrepancies, the accrual and entry errors could have been identified and corrected promptly, thereby freeing up funds that could be used for other purposes to benefit veterans.

Internal Obligation Review

VHA policy requires quality assurance reviews to be used for the internal review and evaluation of financial management operating activities occurring within VHA.[44] Financial quality assurance reviews are a method to evaluate program performance and report on significant VHA financial management activities. Quality assurance reviews comprise nine review areas, one being the accounting review of undelivered orders. Staff conducting the accounting review should validate that there are remarks and comments indicating a review of undelivered orders aged over 90 days took place in accordance with VA policy.[45] Furthermore, a random sample of

[40] VA Financial Policy, "VA Form 1358 Approved Uses," in vol. 2, *Appropriations, Funds and Related Information*, chap. 6, app. A, September 2021. VA offices may use VA Form 1358 (1358) as an obligation control document only for certain limited uses.

[41] VA Financial Policy, "Obligations Policy."

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

[43] The monthly report assists facilities in reconciling FMS obligation data with the source data from IFCAP in accordance with financial policies.

[44] VHA Directive 1733, *VHA Finance Quality Assurance Reviews*, September 2017.

[45] VA Financial Policy, "Obligations Policy."

undelivered orders should be examined to ensure that all FMS data are valid and fully supported and that finance offices perform monthly reviews and reconciliations of aged and inactive obligations as outlined in VA policy.[46]

The inspection team determined the healthcare system had not conducted the financial quality assurance review specific to accounting operations in accordance with VHA policy, which included a review of undelivered orders for FYs 2019 through 2021.[47] According to finance personnel, this occurred due to lack of staff at the healthcare facility. While an extension was requested for the 2021 accounting review, no formal response or course of action was provided by the VISN 22 network director's office. Had the healthcare facility conducted the quality assurance review of undelivered orders, staff could have identified areas of VA policy that were not being met, including the review of inactive obligations.

Finding 1 Conclusion

Healthcare system personnel did not comply with VA policies. The OIG found that open obligations with no activity for more than 90 days were not reviewed for validity and accurate end dates, and that FMS and IFCAP amounts were not always reconciled. In addition, required quality assurance reviews were not being conducted. Failure to properly manage open obligations increases the risk of failing to spend appropriations within the associated fiscal year and to repurpose the funds to benefit veterans.

Recommendations 1–2

The OIG made the following recommendations to the director of the Northern Arizona VA Health Care System:

1. Ensure that healthcare system finance office staff and initiating services are made aware of policy requirements to conduct reviews on all inactive open obligations and deobligate any identified excess funds as required by VA Financial Policy, vol. 2, chap. 5, "Obligations Policy."
2. Ensure the healthcare system staff are conducting the accounting operations finance quality assurance review, including the review of undelivered orders, as required by Veterans Health Administration Directive 1733, *VHA Finance Quality Assurance Reviews*.

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

[47] VHA Directive 1733, *VHA Finance Quality Assurance Reviews*, September 2017.

VA Management Comments

The director of the Northern Arizona VA Health Care System concurred with recommendations 1 and 2. The responses to all report recommendations are provided in full in appendix E. To address recommendation 1, the director reported the healthcare system has adjusted its open obligation review process to ensure that both inactive and aged orders are captured, and finance office staff will be trained on the website location where all current VA financial policies and procedures are stored. For recommendation 2, the director reported that the FY 2022 quality assurance review was completed on August 11, 2022, and the next review is scheduled to be completed in August 2023.

OIG Response

The healthcare system director's action plans are responsive to the recommendations. While the director reported the actions for recommendation 1 would be completed in December 2022, no evidence or supporting documentation was provided for the OIG to evaluate. The quality assurance review referenced in the response to recommendation 2 was completed after the OIG's site visit. The OIG will monitor implementation of the planned actions and close the recommendations when the OIG receives sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified.

II. Purchase Card Use

The VA Government Purchase Card Program was established to reduce administrative costs related to 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 July 1 through December 31, 2021, the healthcare system spent over $5.8 million through purchase cards, representing approximately 8,600 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 for the sampled transactions:

- **Purchase card transactions.** The inspection team assessed whether the healthcare system processed purchase card transactions in accordance with VA policy, such as whether cardholders obtained prior approvals before initiating a purchase, transactions were reconciled by the cardholder and approved by the approving official in a timely manner, and segregation of duties was maintained.[48] Additionally, the team inquired whether the healthcare system considered obtaining contracts when regularly procuring goods and services, which VA refers to as "strategic sourcing." The use of contracts in place of open market or individual purchases lowers the risk for split purchases on purchase cards. VA is also able to leverage its purchasing power through using competitively priced contracts.[49]
- **Purchase card oversight.** The inspection team assessed whether the healthcare system tracked purchase card training, had purchase card policies in place, and maintained an accurate VA Form 0242, as well as whether approving officials were assigned no more than 25 purchase card accounts.[50] The team also assessed whether the facility's purchase card coordinator provided oversight of the purchase card program by doing purchase card reviews. These activities are examples of systematic controls that help reduce errors and ensure a facility complies with VA policy.[51]

[48] VA Financial Policy, "Administrative Actions for Government Purchase Card," in vol. 16, *Charge Card Programs*, chap. 1A, June 14, 2018.

[49] VA Financial Policy, "Government Purchase Card for Micro-Purchases," in vol. 16, *Charge Card Programs*, chap. 1B, October 22, 2019, and July 14, 2021. This policy defines "strategic sourcing" as ensuring employees obtain proper contracts when regularly procuring goods and services. Purchases that exceed the cardholder's single purchase threshold cannot be made on purchase cards. Split purchases occur when a cardholder circumvents this requirement by dividing a single purchase or need into two or more smaller purchases.

[50] An approved VA Form 0242 is used to delegate authority to an individual to use the purchase card to procure and pay for goods and services.

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

- **Supporting documentation.** Maintaining documentation is required for purchases to provide assurance of payment accuracy and to justify the need to purchase a good or service. This includes approved purchase requests, purchase orders, receiving reports, and vendor invoices.[52] Supporting documentation enables program oversight and helps prevent fraud, waste, and abuse.

Finding 2: The Healthcare System Did Not Always Reconcile Transactions Promptly or Consider Using Contracts

The inspection team evaluated a judgmental sample of 35 purchase card transactions totaling approximately $840,000 from July 1 through December 31, 2021, to determine whether the healthcare system's personnel processed the sampled transactions in accordance with policy, including considering using contracts; provided oversight; and maintained required supporting documentation.[53] See appendix B for a full description of the inspection's scope and methodology and appendix C for details on its sampling. Though healthcare system leaders did provide oversight of the purchase card program by having policies in place, maintaining accurate VA Forms 0242, and tracking cardholder training, the team found that for 11 of the 35 sampled transactions reviewed, or 31 percent, totaling almost $367,600, the healthcare system did not process transactions in compliance with VA policy.[54] The team also noted contracts could have been considered for eight of the 35 sampled transactions, or 23 percent, totaling almost $40,100. Additionally, 12 of the 35 sampled transactions, or 34 percent, were missing some required supporting documentation, which resulted in almost $54,000 in questioned costs.[55]

These issues occurred because the healthcare system did not have controls designed to obtain packing slips or receiving reports from prosthetic vendors that shipped items directly to veterans. In addition, approving officials, purchase card coordinators, and cardholders did not always work together to communicate with the procurement office for goods and services before completing open market purchase card transactions. VA policy requires a review to ensure cardholders properly communicate with the contracting office when a contract is warranted for the regular purchase of goods or services.[56]

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

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

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

[55] A "questioned cost" is a cost that is questioned by the auditor because of an audit finding where the cost, at the time of the audit, is not supported by adequate documentation. See appendix D for monetary benefits associated with the questioned costs. 2 C.F.R. § 200.1 (2021).

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

Purchase Card Transactions

When using a government purchase card to acquire goods and services, VA policy requires the following:[57]

- Purchase cardholders should obtain prior approval to ensure a valid business need before initiating a purchase. Approval may vary in form and content but must be retained as supporting documentation.[58]
- Purchases should be reconciled and approved in a timely manner, no later than the 15th calendar day of the month after the closing of the previous month's billing cycle.
- Segregation of duties ensures roles and responsibilities do not overlap among cardholder, approval official, or purchase card coordinator to reduce the risk of fraud, waste, and abuse.[59]

The inspection team assessed the documentation of purchase card transactions provided by healthcare system personnel to determine if these requirements were met. Table 1 shows the results of the sample review. Of the 11 sample transactions reviewed that healthcare system staff did not always process in compliance with VA policy, nine were not reconciled and approved by the 15th day of the month after the closing of the previous month's billing cycle, and two did not maintain segregation of duties. Untimely reconciliations and segregation of duty issues create opportunity for data integrity errors and fraud.

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

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

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

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

Requirement	Number of noncompliant transactions	Percent of noncompliant transactions
Obtain prior approval	0	0
Have reconciliation approved by the approving official no later than the 15th day of the month after the closing of the previous month's billing cycle	9	26
Maintain segregation of duties over the transaction	2	6

Source: VA OIG team assessment results of 35 sampled transactions.

The inspection team also assessed if cardholders split purchases into two or more acquisitions to circumvent their authorized single purchase limit. Contracts must be used when the total value of the requirement exceeds the micro-purchase threshold or the cardholder's authorized single purchase limit. Cardholders are instructed not to modify a requirement or split purchases into smaller parts to avoid exceeding their purchase card limit or the use of formal contracting procedures; instead, cardholders should communicate the need for the order of goods or services to the contracting office for procurement.[60] The team selected 10 transactions totaling approximately $33,400 to determine if cardholders split purchases, reviewed documentation, and consulted purchase cardholders and an approving official to discuss the transactions. After conducting the review and interviews, the team determined that none of the transactions were modified into smaller parts to avoid exceeding the purchase card limit. However, the inspection found that for three transactions for continuous positive airway pressure (CPAP) machines, the invoiced amount did not match the contract price.[61] The invoiced price was $255 greater than the contract price for each item. The team confirmed with the chief of Prosthetics and Sensory Aids Service that this was a purchasing oversight and a refund would be requested.

Use of Contracts

The inspection team also assessed the sampled transactions for consideration of the most appropriate purchasing mechanism. In accordance with policy, VA cardholders are instructed to pursue strategic sourcing—establishing contracts that generally provide greater savings to VA rather than using purchase cards for open market acquisitions without a negotiated price—for goods that are purchased on a recurring or ongoing basis. Approving officials, the agency or

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

[61] CPAP therapy is a common treatment for obstructive sleep apnea. A CPAP machine uses a hose connected to a mask or nosepiece to deliver constant and steady air pressure to help with breathing during sleep.

organization program coordinator, and cardholders must review purchases to determine when establishing contracts is in the best interest of the government and must communicate accordingly with the procurement office. The team determined that contracts could have been considered for eight of the 35 sampled transactions, or 23 percent, totaling almost $40,100, due to multiple orders of similar products. The following example shows a transaction in which a contract could have been considered rather than using a purchase card.

Example 1

On December 14, 2021, the Northern Arizona VA Health Care System used a purchase card to obtain a prosthetic limb totaling $9,999.99. This occurred because the vendor intentionally lowered the invoice amount to avoid the $10,000 micro-purchase threshold or the need to leverage contracting.

Generally, the improper reliance on purchase cards instead of communicating with the procurement office appeared to persist because the approving officials and cardholders did not work together to ensure compliance throughout the transaction process or that roles and responsibilities were carried out in accordance with VA policy. Such prior reviews of purchases ensure that every effort is made to consider whether alternative contracts were warranted or available when purchasing goods and services on a regular basis. Cardholders are required to work with the contracting office to determine if alternative contracting options were warranted or available.[62]

Purchase Card Oversight

Responsible officials are accountable for compliance with the government purchase card program and for implementing internal controls to protect and conserve federal funds.[63] Oversight activities such as periodic and continuous monitoring, checks and balances, policies, procedures, and segregation of duties reduce the risk of error, fraud, waste, and abuse in the purchase card program.

To assess oversight of the program and compliance with VA policy, the inspection team sought to determine whether the healthcare system tracked purchase card training, had purchase card policies in place, assigned approving officials to no more than 25 purchase card accounts, maintained a VA Form 0242 for each cardholder in the inspection sample, and conducted reviews of cardholder transactions. An approved VA Form 0242 is used to delegate authority to an individual to use the purchase card to procure and pay for goods and services. This form also establishes purchase limits and responsibilities and certifies that cardholders and approving officials understand the policies and regulations governing the purchase card program. A revised

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

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

form is required when the approving officer changes, cardholders legally change their names, or the single purchase limit is changed from the originally requested amount.

The inspection team found that the healthcare system provided oversight of the purchase card program. Specifically, healthcare system staff tracked cardholder training, had purchase card policies in place, and conducted required reviews of cardholder transactions. Purchase card reviews are intended to evaluate the effectiveness of internal controls and compliance with regulations and policies. Additionally, none of the cardholders responsible for the 35 sampled transactions had an inaccurate VA Form 0242.

Supporting Documentation

VA financial policy requires cardholders to upload and electronically store supporting documents for purchase card transactions to a VA-approved document-imaging system.[64] When healthcare system staff buy goods and services using a purchase card, they must maintain supporting documentation, such as approved purchase requests, vendor invoices, purchase orders, and receiving reports, for six years. This documentation verifies that purchase card transactions were properly approved and that payments were accurate. The inspection team found that 12 of the 35 sampled transactions were missing some required supporting documentation, which resulted in approximately $54,000 in questioned costs. This occurred because the healthcare system did not have controls designed to obtain receiving reports from prosthetic vendors who shipped items directly to veterans.

Finding 2 Conclusion

While the healthcare system provided oversight of the purchase card program, it did not always process transactions in compliance with VA policy, consider the most appropriate purchasing mechanism, leverage its purchasing power through using competitively priced contracts, or maintain supporting documentation for some of the sampled purchase card transactions. These issues could have been identified with more effective reviews of purchases by approving officials and controls designed to obtain documentation from vendors.

Recommendations 3–5

The OIG made the following recommendations to the director of the Northern Arizona VA Health Care System:

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

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. Review all invoices for continuous positive airway pressure machines for overcharges.
5. Develop a control to ensure required supporting documentation is received from vendors that ship directly to veterans.

VA Management Comments

The director of the Northern Arizona VA Health Care System concurred with recommendations 3 through 5. The director reported that the supply chain management officer will partner with the commodities supervisor to review internal control measures to confirm approving officials and cardholders review their purchases and make sure contracting is used when it is in the best interest of the government, review all invoices for CPAP machines for overcharges, and establish procedures to ensure required supporting documentation is received from vendors shipping directly to veterans.

OIG Response

The healthcare system director's action plans 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.

III. Inventory and Supply Management

Supply chain management is the integration and alignment of people, processes, and systems across the supply chain for product and service planning, sourcing, purchasing, delivering, receiving, and disposal. 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 support high-quality veteran care.[65] The Generic Inventory Package is the software system authorized to manage the receipt, distribution, and maintenance of expendable supplies used throughout VA. This system features an item master file, which uses a number for the storage of item information, such as the description, vendor, unit price, and packaging for tracking. Inventory data, if properly recorded in the Generic Inventory Package, identify the quantity and dollar values of supply items in stock. After they are received at the warehouse, supplies are distributed to a primary inventory point and then, from there, to secondary inventory points in the VA medical facility. Secondary locations are generally storage rooms within the clinical areas that use those items. The team reviewed the following areas:

- **Supply chain management oversight.** The team assessed how the healthcare system ensured stock levels and inventory values were accurate for expendable items by analyzing Supply Chain Common Operating Picture (SCCOP) reports for performance metrics for days of stock on hand, conversion factor errors, and the number of manual adjustments needed to be made to inventory records. 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. The conversion factor is required for all supply purchases and connects how a supply item is purchased and how it is issued—for example, purchased by the case but issued individually. Manual adjustments are used to make corrections to the quantity or value of supplies recorded in the Generic Inventory Package.
- **Inventory data accuracy.** Based on analysis of SCCOP reports and testimony received from interviews during the inspection, the team completed a physical count of some of the larger dollar items in the contingency primary inventory point to assess accuracy.

Finding 3: The Healthcare System Needs to Improve the Accuracy of Inventory Data

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 effectiveness and efficiency of inventory management by ensuring inventory values are recorded

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

correctly in the Generic Inventory Package. The healthcare system used reports and data in the SCCOP to monitor stock levels and met the required accuracy rate for inventory counts as stated in VHA Directive 1761. The healthcare system also created a local dashboard where staff monitored various metrics weekly. However, the healthcare system did not always ensure that inventory recorded in the Generic Inventory Package was accurate. Specifically, facility inventory managers failed to monitor reported conversion factor errors and properly record supplies moving in and out of the contingency inventory point. This led to increased reliance on manual counts, inaccurate inventory values, and use of manual adjustments to correctly record inventory in the Generic Inventory Package.

Supply Management Oversight

To avoid overstocking or understocking, VHA requires responsible staff to ensure correct reorder points and inventory levels are maintained.[66] Expendable supplies purchased through the MSPV program should have 15 days or less of stock on hand, while non-MSPV items should have 30 days or less of stock on hand.[67] From July 1 through December 31, 2021, the healthcare system had an average of 14.7 days of stock for MSPV items and met the metric for three of six months. The average for non-MSPV items was 27.9 days of stock, and the metric was met for four of six months.[68] As of March 31, 2022, the average days of stock on hand for MSPV items and non-MSPV items was 20.3 and 44.6, respectively. Because of the COVID-19 pandemic, the healthcare system received a waiver to suspend days-of-stock-on-hand performance measures from March 3, 2021, until March 31, 2022.

The inspection team analyzed SCCOP reports and interviewed supply chain management leaders and staff to determine how they ensured stock levels and inventory values were accurate and what challenges they faced managing stock levels. According to supply chain management personnel, inventory managers are expected to check the SCCOP dashboard at least once a week, and leaders can see which inventory managers have been in the tool and which have not. Additionally, a local dashboard was created to monitor other various metrics, such as long supply and inactive items, on a weekly basis.[69] Despite these efforts, supply chain managers reported difficulty maintaining stock during the COVID-19 pandemic and related supply chain challenges. They had to buy some supply items from multiple vendors in large quantities to carry them through the weeks where those vendors did not have any available stock. As a result, there were large swings in days of stock on hand for certain supply items. This not only affected the

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

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

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

[69] According to the spreadsheets provided by the healthcare system, long supply items are those with greater than 90 days of stock and inactive items are those with no usage for 90 days.

days of stock on hand for those items but also the overall performance metric. During the pandemic, it is understandable that there was an increased need to have extra supplies on hand, and the healthcare system ordered as much as possible to avoid shortfalls. The OIG made no recommendations related to the days of stock on hand at the healthcare system.

Conversion Factors

In the Generic Inventory Package, an accurate conversion factor for individual supply items is necessary to determine both the cost and the value of the inventory. The unit conversion factor connects how a supply item is purchased and used.[70] Any calculation error in the conversion factor causes inaccurate quantities and values in the system. For example, if the healthcare system purchased a case of 10 bottles of water for $10 and issued one bottle at a time, the correct conversion factor is 10 (quantity purchased of 10 divided by quantity issued of one), and, after issuing one bottle, the inventory quantity and value should be nine bottles and $9. However, if the conversion factor was incorrectly set at 1 (case), the Generic Inventory Package will remove all 10 bottles (one case) after the first issuance of a bottle, and the inventory value will be $0 with zero quantity in the system. In this scenario, the difference is $9 and nine bottles, requiring supply chain management staff to manually adjust the quantity and the value of inventory on hand. To reconcile the unit cost when purchased and the unit cost when issued, the supply chain management staff therefore had to divide the cost of the case by 10 to reach the cost of each unit. This number is called the conversion factor.

The team analyzed the SCCOP conversion factor error report and identified conversion factor errors that, if not identified and corrected, can cause the quantity on hand and value of supplies in the Generic Inventory Package to be unreliable. According to SCCOP, as of March 31, 2022, 355 of 2,327 supply items, or 15 percent, had potential conversion factor errors. One inventory manager stated this occurred because he did not look at the accuracy of the conversion factors and was not familiar with the report or the effect conversion factor errors could have on inventory. Additionally, another inventory manager was not running the conversion factor report regularly. To illustrate the effect, the inspection team showed the inventory manager an inventory report identifying 32 tubes valued at $7,785 ($243.29 per item). However, the inventory manager confirmed these items were purchased in a flat of 100 cases for $1,290; therefore, each case cost $12.90 ($1,290/100 = $12.90). This means that the value on hand should be $412.80 ($12.90 × 32) instead of the reported value on hand of $7,785. The inventory manager also confirmed that there was a conversion factor error for this item based on that day's conversion factor error report. Conversion factor errors can lead to increased reliance on manual

[70] The unit conversion factor is computed by dividing the quantity purchased by the quantity issued and equals one when the unit of purchase and the unit of issue are the same.

inventory counts, manual ordering processes, and incorrect inventory values and quantities in the Generic Inventory Package that require manual adjustments.

Inventory Adjustments

The team analyzed the SCCOP Generic Inventory Package Adjustments report for the 90 days prior to March 31, 2022, to determine the number of adjustments for all inventory points made at the Northern Arizona VA Health Care System, and the associated value for those adjustments. The report shows positive and negative adjustments in the Generic Inventory Package to correct inventory points due to a variety of reasons, such as the result of a physical count, outdated or expired stock, or conversion factor errors. According to the report, the healthcare system made over 260 adjustments affecting about 25,200 items totaling approximately $154,700 for the 90 days prior to March 31, 2022. There were 24 adjustments affecting almost 4,800 items totaling over $64,300 in the contingency inventory point alone. According to an inventory manager, these adjustments were made because the contingency inventory point had "blown up during COVID," meaning it had grown significantly, but had been around before the pandemic. The inventory manager explained that managers try to run contingency like any other inventory point. The managers still look at days of stock on hand, long supply, and rotation of items to avoid expiration, and try to do a 100 percent scan every month. However, according to the chief of supply chain management and an inventory manager, unlike other inventory points, only adjustments can move inventory in and out of the contingency inventory point. The inventory manager further explained that his day-to-day duties include transferring items to and from the contingency inventory point and adding items to it when he knew they would have a hard time getting or buying items. The manager stated that it was at times difficult to manage, adding that large quantities of items could not be kept in the primary inventory points because it would adversely affect the healthcare system's inventory metrics. The chief of supply chain management confirmed that the healthcare system could reduce the days of stock on hand in primary inventory points by moving supplies from those into the contingency inventory point to meet the performance metrics.

As stated previously, conversion factor errors can lead to adjustments in the Generic Inventory Package. To determine if this was the case for the contingency inventory point, the team found that 71 of the 210 supply items in the inventory point, or 33.8 percent, had a "false" conversion factor and began asking questions about the accuracy of the value and quantities as shown on the days-of-stock-on-hand report. When asked about a line of the report showing over $22,700 of hand sanitizer, the inventory manager stated that those bottles were destroyed but were never removed from inventory. According to the chief of supply chain management, the hand sanitizer had expired and was destroyed the week before the OIG's site visit and should have been removed from inventory. The chief stated that supply chain personnel reached out to other medical centers around them, but the hand sanitizer was in four-ounce bottles, and nobody wanted those, and they could not be donated. The facility spent over $22,700 on hand sanitizer

that expired and needed to be destroyed. Based on analysis of SCCOP reports and interviews during the inspection, the team completed a physical count of some of the larger-dollar items in the contingency primary inventory point to assess the accuracy.

Inventory Data Accuracy

During the physical count within the contingency inventory storage area, the inspection team identified additional discrepancies between what was reported in the Generic Inventory Package and what was physically located in the inventory point. The team counted powered air-purifying respirators and supplied-air hoods that cover the head and face to allow clean air to be directed to a worker. The inspection team's physical count was roughly double that reported in SCCOP. The SCCOP quantity on hand was 47 boxes, and the inspection team's count was about 100 boxes. Due to the layout and congestion of the space, it was difficult to get an exact count. Next, the team counted latex gloves of various sizes. Again, counts did not match what was in SCCOP. The Generic Inventory Package data showed 2,615 boxes as the quantity on hand for these gloves, but the inspection team counted approximately 1,300 boxes. The inventory manager stated that about half of these gloves were moved to a different inventory point but never removed from the contingency inventory. He further explained that these gloves are double counted and should be removed from the contingency inventory point in the Generic Inventory Package.

Finally, the inventory manager walked the team through the contingency inventory storage areas, pointed to a pallet of N95 masks, and stated that they were a shipment received from VA Central Office. He further explained that the previous inventory manager had instructed staff not to enter the masks into the Generic Inventory Package because it would affect the metrics. Additional items being held for the VHA Development of Equipment Recertification and Management of Surge Capacity program were also not recorded in the Generic Inventory Package. This was described by the inventory manager as a VHA program that collects excess stock for redistribution across VHA. VHA policy states that medical facilities must enter all expendable supplies into the Generic Inventory Package.[71]

As a result of the OIG inspection of the contingency inventory point, the healthcare system conducted a 100 percent count and took these actions:

- Removed the $22,706 of hand sanitizer from the inventory.
- Made $22,795 in adjustments for items that were physically in inventory but never recorded in the Generic Inventory Package system. This included $4,148 in N95 masks, $1,080 in other respirator masks, and $17,567 in powered air-purifying respirator hoods.

[71] VHA Directive 1761, app. B.

- Identified gloves that were incorrectly recorded as a case instead of as a box. This required an additional adjustment to both the count and dollar value of those gloves in the Generic Inventory Package. In total, the healthcare system made both positive and negative adjustments to the extent of 2,745 boxes of gloves valued at $59,363.

After healthcare system staff performed the 100 percent count of the contingency inventory point, they created an adjustment voucher to correct the inventory point. The inspection team analyzed the voucher and determined that after combining both positive and negative adjustments made by inventory management staff, the adjustments totaled 5,344 items valued at $151,810. This dollar amount represented 62.4 percent of the initial inventory value.

Finding 3 Conclusion

The healthcare system has provided oversight of expendable supplies to avoid stock shortages and ensure that patient needs are met during the pandemic. However, the healthcare system could improve efficiency by improving the accuracy of inventory quantities and values in the Generic Inventory Package. VHA policy states that it is essential that Generic Inventory Package information is complete and accurate.[72] Unreliable inventory data can lead to the purchase of unnecessary supplies, overstocking, and spoilage. More importantly, errors indicating that supplies are available when they are not could adversely affect the healthcare system's ability to effectively plan and budget for the purchase of supplies to operate and meet patient care needs.

Recommendations 6–7

The OIG made the following recommendations to the director of the Northern Arizona VA Health Care System:

6. Ensure all supplies are entered into the Generic Inventory Package as required by Veterans Health Administration policy.
7. Develop and implement a plan to ensure data accuracy and reliability in the Generic Inventory Package per Veterans Health Administration policy.

VA Management Comments

The director of the Northern Arizona VA Health Care System concurred with recommendations 6 and 7. To address recommendation 6, the director reported that the supply chain management officer will facilitate training on the Generic Inventory Package to manage the receipt, distribution, and maintenance of expendable supplies and to improve oversight for supplies received at the warehouse. For recommendation 7, the director reported the supply chain

[72] VHA Directive 1761.

management officer will work with the commodities supervisor to develop a written plan to ensure data capturing is accurate and reliable.

OIG Response

The healthcare system director's action plans 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.

IV. Pharmacy Operations

In FY 2021, prescription drug spending at the Northern Arizona VA Health Care System was over $24.1 million, which represented about 7 percent of the healthcare system's $367 million budget. Because pharmacy accounts for millions of dollars of any medical center's budget, medical center leaders need to analyze spending and identify opportunities to use pharmacy dollars more efficiently. The inspection team used the pharmacy cost model in the OPES efficiency grid as a baseline for pharmacy operational efficiency at the healthcare system.

The team reviewed the following pharmacy areas:

- **OPES pharmacy expenditure data** are designed to allow VHA facilities to track cost performance 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.[73] Low inventory turnover rates can indicate inefficient use of financial resources.
- **The B09 reconciliation process** is how VA medical center pharmacies assure they are making correct payments for the drugs they receive. It is necessary because medical centers make payments to the prime vendor before receiving the pharmaceuticals. Without the reconciliation there is no assurance that the amount paid to the prime vendor agrees with the amount of goods received.

Finding 4: The Healthcare System Could Increase Inventory Turnover and Needs to Ensure the B09 Reconciliation Process Is Completed

The OIG found the healthcare system has improved pharmacy efficiency and reduced the difference between observed and expected drug costs. However, the healthcare system could achieve an inventory turnover rate closer to the VHA-recommended level and needs to ensure payments to the prime vendor agree with the amount of actual goods received by fully completing the B09 reconciliation process in alignment with policy.[74] 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.

[73] VHA Directive 1761, app. H. Inventory turnover is based on total dollar value purchased for the year divided by dollar value of items on the shelf.

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

OPES Pharmacy Expenditure Data

The OPES pharmacy expenditure model, which identifies variations in pharmacy costs among VHA facilities, showed that the healthcare system had about $24.1 million in drug costs in FY 2021. According to the model, this amount was approximately $1.4 million lower than the expected costs of about $25.6 million. On that basis, the healthcare system's observed-to-expected ratio was 0.944, which ranked it 43rd among 139 VHA facilities for pharmacy drug cost efficiency.

For FY 2019 through FY 2021, the healthcare system demonstrated continuous improvement, going from almost $1.7 million over expected costs for FY 2019 to approximately $1.4 million under expected costs for FY 2021. Pharmacy leaders stated that actions taken by staff, specifically the pharmacoeconomist, had made a difference. Some of these actions included monitoring drug conversion opportunities, high-cost prescriptions, and nonformulary medication spending; encouraging increased use of the centralized mail order pharmacy; optimizing the local drug file; establishing training and process improvements to the prior authorization drug request process; and using "quick order" menus to guide VHA providers to approved formulary drugs when appropriate. The pharmacy chief also highlighted the use of the VISN Pharmacy Report Card to track data and make improvements to efficiency. Figure 3 shows the decreasing difference between observed and expected drug costs for the Northern Arizona VA Health Care System.

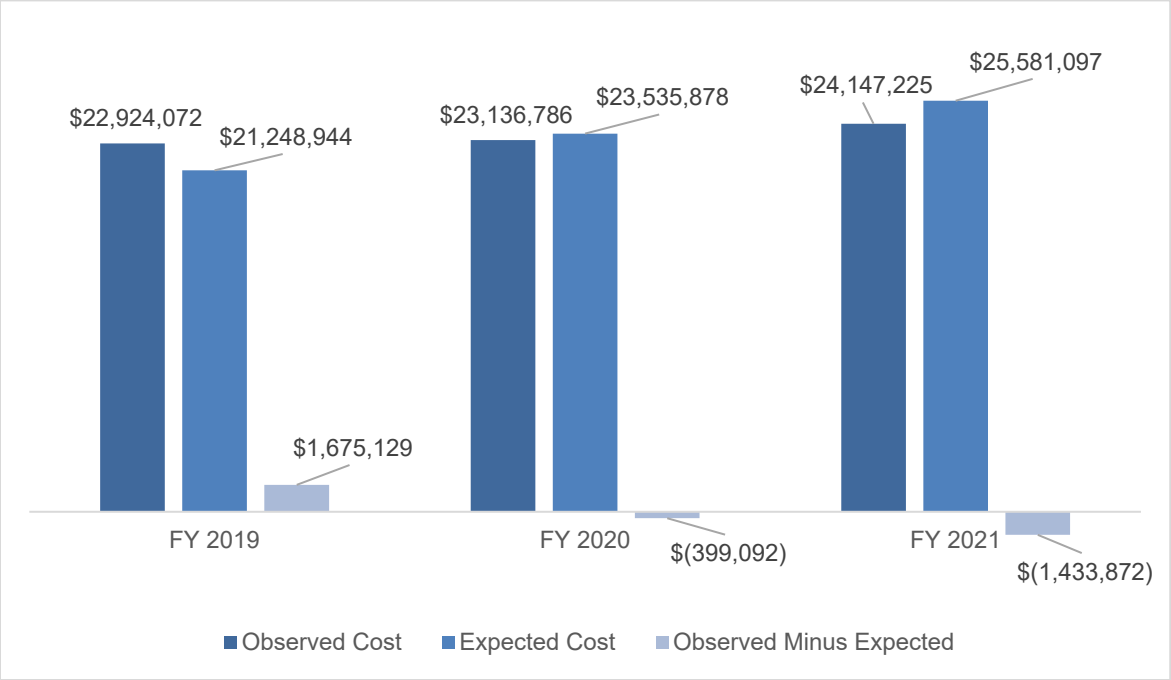

Figure 3. *Observed versus expected drug cost, FY 2019–FY 2021.*

Source: OPES pharmacy expenditure model.

Note: The OPES data models are based on the previous FY data (i.e., the FY 2022 data model was based on FY 2021 data).

Inventory Turnover Rate

VHA policy states that inventory turnover is the primary measure of the effectiveness of inventory management.[75] Increasing the inventory turnover rate decreases inventory carrying cost, 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.

In February 2022, according to prime vendor reports, the healthcare system reported an inventory turnover rate of 4.83 times for the Northern Arizona VA Health Care System, compared with VHA's recommended level of 12 times, as established by the national program office, Pharmacy Benefits Management. Low inventory turnover could indicate the inefficient use of financial resources and the inability to properly forecast needed amounts of pharmacy drugs to meet patient care needs. However, when healthcare system staff completed a wall-to-wall inventory in February 2022, staff calculated an inventory turnover rate of 16.93 times. According to pharmacy staff, the gap between the prime vendor report and the self-reported inventory turnover rate occurred because the prime vendor report requires that users manually debit all dispensing transactions and does not include purchases made from other

[75] VHA Directive 1761, app. H.

vendors. This would be a tremendous amount of work and would duplicate the current ScriptPro Inventory Management System, which automatically tracks inventory as it is dispensed.

The OIG also found pharmacy staff were not implementing inventory management practices, such as placing barcodes on all stock locations, using handheld barcode readers, and using the ABC inventory analysis methods required by VHA policy.[76] Pharmacy officials stated that they were unable to use handheld scanners due to a connectivity issue. Specifically, the structure of the building prevents them from getting Wi-Fi, and they do not have a hot spot.

Finally, according to a procurement technician for pharmacy, implementation of the ScriptPro Information Management System in early 2020 has been helpful for the outpatient pharmacy procurement staff because they can run reports to see drug use and establish reorder points and quantities. However, there was no standard operating procedure or plan for routinely reviewing reorder points and reorder quantities. Additionally, inpatient pharmacy drug inventories were not in the ScriptPro system. These inventories were managed by "walking the shelves" instead of using more accurate inventory management practices, such as calculated reorder points and reorder quantities using demand forecasting, as required by VHA policy.[77] Demand forecasting applies weighting factors to past purchases and must be used in calculating both the reorder points and reorder quantities for more accurate inventory management.

B09 Reconciliation Process

VHA policy requires a review of the B09 report and reconciliation of that report with VA Form 1358 and other supporting documentation.[78] VA offices may use VA Form 1358 as an obligation control document only for certain limited uses.[79] This is to ensure that the pharmacy is making correct payments for what is received and there is documented evidence, such as signature and date of review, that the reconciliation has been completed. The report is generated weekly and is a summary of multiple invoices. VHA policy requires reconciliation of billing statements, verification of ordered items being received, and certification as to accuracy including maintaining supporting documentation such as receipts, invoices, and packing slips.[80] The chief of pharmacy must provide a monthly report, with adequate documentation, to the chief of fiscal service stating the VA Form 1358s and B09 reports were reconciled and noting any

[76] VHA Directive 1108.08(1), *VHA Formulary Management Process,* November 2, 2016, amended August 29, 2019. The ABC classification method states that inventory point items with approximately 70 percent of the inventory dollars and 10 percent of the products are classified as "A." Items with approximately 20 percent of the inventory dollars and 20 percent of products are classified as "B." Lastly, items representing approximately 10 percent of the inventory dollars and 70 percent of the products are classified as "C."

[77] VHA Directive 1108.08(1).

[78] VHA Directive 1108.07(1).

[79] VA Financial Policy, "VA Form 1358 Approved Uses."

[80] VHA Directive 1108.07(1).

unresolved discrepancies.[81] VHA policy also states that the pharmacy must maintain separation of duties so that different pharmacy staff members place and receive an order.[82] Different staff members must be involved in the Form 1358 process including establishing, approving, and obligating the 1358, and receiving goods ordered on the 1358. The staff member who establishes the 1358 cannot receive any orders they themselves placed to the prime vendor via the 1358.

The team found that the healthcare system's B09 reconciliation process did not fully comply with VHA policy. When an order is delivered, pharmacy service staff should verify that the amount and type of medication match the invoice received at the time the order is delivered and record the receipt of supplies into McKesson Connect.[83] According to pharmacy staff, the healthcare system was not recording the receipt of supplies into McKesson Connect because scanners were needed for this function, and they had not been in operation at the medical center for over a year and a half due to network issues. The team also found that invoices were not always signed, dated, or maintained, and sometimes recipients used the packing slip instead of the invoice for reconciliation. While the packing slip does contain the names and quantities of the specific drugs, it does not contain the cost of the drugs. Since the cost of the drugs received is not on the packing slip, the inspection team determined that the facility finance department cannot complete the full reconciliation as outlined by VHA procedures. Additionally, the inspection team found that pharmacy service staff did not always sign the B09 report when the weekly reconciliation was completed and were not always supplying the supporting documentation to fiscal service. Without the documentation, the inspection team was unable to determine if reconciliations were being completed on time, and fiscal service could not complete the full reconciliation as required. If a reconciliation cannot be completed, there is no assurance that the amount paid to the prime vendor was proper and agrees with the amount of goods received.

Finding 4 Conclusion

The healthcare system has improved pharmacy efficiency by actively monitoring high-cost prescription use and nonformulary medication spending, leading to a reduction in the gap between observed and expected drug costs. However, to further improve efficiency and policy compliance, healthcare system managers could increase inventory turnover, align inventory management practices with policy, and complete the B09 reconciliation process to ensure that the amount paid to the prime vendor agrees with the amount of goods received. An efficient healthcare system anticipates how much drugs will cost and when inventory needs to be

[81] VHA Directive 1108.07(1).

[82] VHA Directive 1108.07(1).

[83] VHA, *B09 Reconciliation Standard Operating Procedures*. McKesson Connect is an online pharmaceutical ordering platform that offers real-time pricing and inventory levels, order status tracking, advanced search functionality, robust reporting, and an interactive pharmacy peer community.

restocked, helping ensure that the system makes the best use of appropriated funds and has inventory when needed.

Recommendations 8–10

The OIG made the following recommendations to the director of the Northern Arizona VA Health Care System:

8. Develop and implement a plan to achieve an inventory turnover rate closer to the Veterans Health Administration–recommended level.
9. Develop a plan to align inventory management practices, such as the use of handheld scanners, barcode labeling, and ABC inventory analysis methodology, with VHA policy.
10. Establish processes to ensure compliance with the Veterans Health Administration directive to complete the B09 reconciliation process.

VA Management Comments

The director of the Northern Arizona VA Health Care System concurred with recommendations 8 through 10. To address recommendation 8, the director reported that the healthcare system will make necessary process adjustments, including the optimization of the ScriptPro Inventory Management System, to achieve turnover rates that closely align with VHA-recommended levels. For recommendation 9, the director stated that the Northern Arizona VA Health Care System will review internal inventory management procedures and make the necessary adjustments to ensure compliance with the inventory management procedures required by current VA policy. For recommendation 10, the director acknowledged opportunities for improvement and reported that pharmacy and fiscal staff will review the process.

OIG Response

The healthcare system director's action plans 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.

For recommendation 9, the OIG became aware of an updated version of VHA Directive 1108.08 after the site visit that removed some requirements for pharmacy inventory management. The OIG contacted the Pharmacy Benefits Management Office for guidance about the use of handheld scanners, barcode labeling, and the ABC inventory analysis methodology. Pharmacy Benefits Management leadership responded that inventory management practices identified in 1108.08 were being moved into an updated version of VHA Directive 1108.07 but were still being communicated as requirements until the issuance of the updated directive. The update to VHA Directive 1108.07 was effective November 28, 2022. The updated directive did

not include mandates for the utilization of handheld scanners, barcode labeling, and the ABC inventory analysis methodology for inventory management. However, as the director noted in his response, the pharmacy will review its internal procedures and make the necessary adjustments to assure compliance with current inventory management procedures.

Appendix A: Healthcare System Profile

Table A.1 provides general background information for this level 3 (low complexity) facility in VISN 22.[84]

Table A.1. Data for Northern Arizona VA Health Care System as of September 30, 2021

Item	FY 2019	FY 2020	FY 2021
Total medical care budget	$224,542,769	$313,454,727	$367,040,319
Number of patients	28,146	28,594	28,811
Outpatient visits	286,930	254,812	289,516
Total medical care full-time equivalent staff	1,074	1,126	1,132
Number of operating beds:			
Hospital	15	15	15
Community living center	85	85	85
Domiciliary	120	120	120
Average daily census:			
Hospital	8	8	9
Community living center	55	37	18
Domiciliary	104	64	50

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 data from VHA's Support Service Center, the healthcare system's medical care budget increased by almost $142.5 million, or about 63.5 percent, between FY 2019 and FY 2021, while the number of patients and outpatient visits increased by only 665 and 2,586, respectively. The chief financial officer told the inspection team that community-managed care is where the increase went. According to the chief financial officer, community-managed care was 27 percent to 32 percent of the budget, but now it is 50 percent of the budget. Because Northern Arizona is a level 3 facility that serves rural areas, there is no VA specialty care available, and many patients are sent out to community providers for care. The chief financial officer also stated the facility had a new radiology suite with all new equipment that contributed to the increase. Table A.2 shows the healthcare system's community care expenditures and community care consults from the last three fiscal years.

[84] The facility complexity model classifies VHA facilities at levels 1a, 1b, 1c, 2, or 3, with level 1a being the most complex and level 3 being the least complex.

Table A.2. Community Care Expenditures and Consults for Northern Arizona VA Health Care System as of September 30, 2021

Item	FY 2019	FY 2020	FY 2021
Total community care expenditures	$76,007,896	$97,449,475	$120,235,723
Community care consults	41,895	48,162	60,696

Source: VHA Support Service Center, Care in the Community Model Efficiency Profile and Community Care Consult Counter Report.

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

Appendix B: Scope and Methodology

Scope

The OIG team conducted its inspection of the Northern Arizona VA Health Care System from April to November 2022, including a virtual site visit during the week of April 11, 2022. The inspection is limited in scope and is not intended to be a comprehensive inspection of all financial operations at the Northern Arizona VA Health Care System.

Methodology

The inspection team evaluated financial efficiency practices for FY 2021, as well as data for FY 2022 if available, 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 facility's pharmacy costs using the FY 2022 OPES data model; however, the FY 2022 data model was based on FY 2021 data.

To conduct the inspection, the team

- interviewed facility 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;
    - eight obligations with different end dates and five 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
    - 35 purchase card transactions to determine if there was proper oversight and governance of the purchase card program, as well as to assess the risk for illegal, improper, or erroneous purchases.

Internal Controls

The inspection team assessed the internal controls of the Northern Arizona VA Health Care System significant to the inspection objective. This included an assessment of the five internal control components: control environment, risk assessment, control activities, information and communication, and monitoring.[85] In addition, the team reviewed the principles of internal controls associated with this objective. The team identified internal control weaknesses during this inspection in all four subobjectives assessed—Open Obligations, Purchase Cards, Inventory and Supply Management, and Pharmacy—and proposed recommendations to address the control deficiencies.

Fraud Assessment

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

Data Reliability

The inspection team used computer-processed data obtained from US Bank files through a corporate data warehouse, a central repository of US bank data that is updated monthly, and the OPES efficiency opportunity grid. To test for reliability, the team checked whether any data were missing from key fields, including any calculation errors, or were outside the time 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 inspection 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 inspection in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation*.

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

Appendix C: Sampling Methodology

Open Obligations

The team evaluated a judgmental sample of open obligation transactions from July through December 2021 to determine (1) whether the Northern Arizona VA Health Care 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 and (2) whether the healthcare system reconciled order amounts between FMS and IFCAP for sampled obligations.

Population

During December 2021, the healthcare system had 358 open obligations, totaling approximately $36.1 million. Of those open obligations, 73 obligations, totaling approximately $7.8 million, had no activity for more than 90 days. From July through December 2021, there were five obligations with order amount discrepancies between FMS and IFCAP for three or more months.

Sampling Design

The inspection team selected two judgmental samples:

- **Inactive obligations.** The team selected 20 obligations with no activity for more than 90 days from the December 2021 FMS F850 report. This report lists each open obligation and its remaining balance. Thirteen obligations were still within the performance period, and the remaining seven were more than 90 days past the performance period end date.
- **FMS-to-IFCAP reconciliations.** The team selected five obligations with different order amounts between FMS and IFCAP from the VA's FMS-to-IFCAP Reconciliation reports for July through December 2021.

The samples included 25 total open obligations: 20 with no activity for more than 90 days, totaling approximately $6.5 million, and five obligations with different order amounts between FMS and IFCAP.

To review the sampled obligations, the team requested supporting documentation for each of the 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 inspection team did not use projections and margins of error because statistical sampling was not used.

Purchase Cards

The inspection team evaluated a judgmental sample of FY 2021 purchase card transactions to determine (1) if the Northern Arizona VA Health Care System reviewed purchase card payments to ensure they were adequately monitored, approved, and supported by documentation and (2) if the reviewed transactions reflected compliance 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

From July 1 through December 31, 2021, the healthcare system spent over $5.8 million through purchase cards, representing approximately 8,600 transactions.

Sampling Design

The inspection team selected a judgmental sample that included two strata:

- **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 three bundles of potential split purchases that included 10 transactions.
- **Other nonpotential split purchase.** The team identified 25 transactions that involved an area of risk, such as merchants not commonly associated with a medical facility, purchases that included sales tax, or timing of purchases.

The judgmental sample included 35 total individual transactions, 10 potential split purchase transactions totaling approximately $33,400, and 25 high-risk transactions totaling approximately $807,000 in spending.

To review the sampled transactions, the team requested supporting documentation for each of the 35 sampled transactions, VA Form 0242, and documentation to support the completion of quarterly purchase card audits.

Projections and Margins of Error

The inspection 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[86]
1	Ensure that healthcare system finance office staff and initiating services are made aware of policy requirements to conduct reviews on all inactive open obligations and deobligate any identified excess funds as required by *VA Financial Policy*, vol. 2, chap. 5, "Obligations Policy."	$82,600	
	Develop a control to ensure required supporting documentation is received from vendors that ship directly to veterans.		$54,000
	Total	**$82,600**	**$54,000**

[86] A "questioned cost" is 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. 2 C.F.R. § 200.1 (2021).

Appendix E: VA Management Comments Director, Northern Arizona VA Health Care System

Department of Veterans Affairs Memorandum

Date: January 6, 2023

From: Director, Northern Arizona Health Care System

Subj: Draft Report, Financial Efficiency Review of Northern Arizona Healthcare System, (Project Number2022-01721-AE-0075)

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

Finding 1: Inactive Obligations Were Not Always Being Reviewed, Some Were Not Deobligated, and Quality Assurance Reviews Were Not Always Completed

Recommendation 1: Ensure that healthcare system finance office staff and initiating services are made aware of policy requirements to conduct reviews on all inactive open obligations and deobligate any identified excess funds as required by VA Financial Policy, vol. 2, chap. 5, "Obligations Policy."

Concur

Target date for completion: December 31, 2022

Director Comments

The Northern Arizona VA Health Care System concurs with the recommendation. Finance Service has adjusted its open obligation review process to ensure that orders that are both inactive and aged are captured as part of finance's review process. This adjustment to the 889B review will allow the facility to be in full compliance regarding conducting reviews of inactive open obligations as required by VA Financial Policy, Volume 2, Chapter 5. VA policy updates will also be addressed and disseminated to all Finance Staff immediately upon receipt. Finances Service staff will be trained on the website location where all current VA Financial Policies and Procedures are stored (Office of Financial Policy - Office of Finance (va.gov)).

Recommendation 2: Ensure the healthcare system staff are conducting the accounting operations finance quality assurance review, including the review of undelivered orders, as required by Veterans Health Administration Directive 1733, "VHA Finance Quality Assurance Reviews."

Concur

Target date for completion: August 31, 2023

Director Comments

The Northern Arizona VA Health Care System concurs with the recommendation. The FY22 the accounting operations finance quality assurance review was completed August 11, 2022. The next accounting operations finance quality assurance review is scheduled to be completed in August of 2023.

Finding 2: The Healthcare System Did Not Always Reconcile Transactions Promptly or Consider Using Contracts

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.

Concur

Target date for completion: January 31, 2023

Recommendation 4: Review all invoices for continuous positive airway pressure machines for overcharges.

Concur

Target date for completion: January 31, 2023

Recommendation 5: Develop a control to ensure required supporting documentation is received from vendors that ship directly to veterans.

Concur

Target date for completion: January 31, 2023

Director Comments to Recommendation 3, 4 and 5

The NAVAHCS Supply Chain Management Officer will partner with Commodities Supervisor to review internal control measure to confirm approving officials and cardholders review their purchases and make sure contracting is used when it is in the best interest of the government, review all invoices for continuous positive airway pressure machines for overcharges, and establish procedures to ensure required supporting documentation is received from vendors shipping directly to Veterans.

Finding 3: The Healthcare System Needs to Improve the Accuracy of Inventory Data

Recommendation 6: Ensure all supplies are entered into the Generic Inventory Package as required by Veterans Health Administration policy.

Concur

Target date for completion: January 31, 2023

Director Comments

The NAVAHCS Supply Chain Management Officer will facilitate training on the Generic Inventory Package (GIP) to manage the receipt, distribution, and maintenance of expendable supplies used throughout NAVAHCS. Training will improve oversight of inventory data for supplies received at the warehouse, distributed to a primary inventory point, and from there to secondary inventory points at NAVAHCS.

Recommendation 7: Develop and implement a plan to ensure data accuracy and reliability in the Generic Inventory Package per Veterans Health Administration policy.

Concur

Target date for completion: February 28, 2023

Director Comments

The NAVAHCS Supply Chain Management Officer will facilitate with the Commodities Supervisor to develop a written plan to ensure data capturing is accurate and reliable.

Finding 4: The Healthcare System Could Increase Inventory Turnover and Needs to Ensure the B09 Reconciliation Process is Completed

Recommendation 8: Develop and implement a plan to achieve an inventory turnover rate closer to the Veterans Health Administration-recommended level.

Concur

Target date for completion: March 15, 2023

Director Comments

The NAVAHCS concurs that inventory turnover is the primary measure of the effectiveness of inventory management. In February 2023, our pharmacy will conduct their annual physical wall-to-wall inventory. The turn rate calculated from the physical inventory, as well as the turn rate provided by the prime vendor, will be used to evaluate the effectiveness of their inventory management process. The NAVAHCS pharmacy will make necessary adjustments needed to our process, including the optimization of the ScriptPro Inventory Management System (SIMS), to achieve turn rates that closely align with the Veterans Health Administration recommended levels.

Recommendation 9: Develop a plan to align inventory management practices such as the use of handheld scanners, bar code labeling, and ABC inventory analysis methodology with VHA policy.

Concur

Target date for completion: March 15, 2023

Director Comments

The NAVAHCS Pharmacy will review their internal inventory management procedures and make the necessary adjustments to assure compliance with the inventory management procedures required by current VA policy.

Recommendation 10: Establish processes to ensure compliance with the Veterans Health Administration directive to complete the B09 reconciliation process.

Concur

Target date for completion: January 31, 2023

Director Comments

The pharmacy has opportunities to improve our B09 reconciliation process and have partnered with fiscal staff to review the process.

(original signed) by

Steven J. Sample

Medical Center Director

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

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