DEPARTMENT OF VETERANS AFFAIRS

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DEPARTMENT OF VETERANS AFFAIRS

VHA Can Improve Controls Over Its Use of Supplemental Funds

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Executive Summary

On March 27, 2020, the Coronavirus Aid, Relief, and Economic Security (CARES) Act was signed into law.[1] Congress provided VA with approximately $19.6 billion in CARES Act funds, of which approximately $17.2 billion was appropriated to the Veterans Health Administration (VHA) to support VA's efforts to prevent, prepare for, and respond to the COVID-19 pandemic. Of these funds, about $14.4 billion was allocated to the VHA medical services fund.[2] CARES Act funds were considered supplemental appropriations because they were enacted after a regular annual appropriations act.[3]

For payroll and fee-basis expenses, such as contracting for nursing services, VA's Financial Management System (FMS) does not support the direct obligation of supplemental funds. Therefore, medical facility staff had to use expenditure transfers to execute CARES Act supplemental funding for these expenses. Expenditure transfers are manual or system-generated adjustments that are documented in VA's FMS. For medical supply and material purchases, however, VA's FMS does support direct obligation of supplemental funds, which helps provide an audit trail. Medical facilities had to use VHA's regular annual appropriations until the CARES Act funds were made available.[4] Once available, staff shifted the expenses from the regular annual appropriations to the CARES Act supplemental funds.

VHA did not mandate that all supply and material expenses be directly charged to the CARES Act medical services appropriation. Rather, VHA left the decision to each of the medical facilities' chief financial officers as to whether staff would directly obligate the funds or use a manual expenditure transfer. In turn, some medical facilities directed that medical supply and material purchases be made by directly obligating to the CARES Act medical services appropriation, while other medical facilities continued to use manual expenditure transfers for the purposes of tracking COVID-19-related expenses.

These manual expenditure transfers provided flexibility in accounting for the use of the CARES Act funds by allowing staff to shift funds between annual and supplemental appropriation accounts for COVID-19-related expenses. Staff used journal vouchers to document the expenditure transfers. A journal voucher is a written document that serves as an integral part of the audit trail and should include sufficient documentation to explain the purpose and details of

[1] Coronavirus Aid, Relief, and Economic Security (CARES) Act, Pub. L. 116-136, 134 Stat. 281 (2020).

[2] The $17.2 billion was distributed among VHA's medical community care, medical facilities, medical services, and medical support and compliance funds.

[3] Office of Management and Budget (OMB) Circular A-11, *Preparation, Submission, and Execution of the Budget*, August 2022. The circular defines supplemental appropriations as those enacted after a regular annual appropriations act, when the need for funds is too urgent to be postponed until the next regular annual appropriations act.

[4] OMB Circular A-11. The circular defines a regular annual appropriation as enacted normally in the current year and available for obligation in the budget year and subsequent years if specified in the appropriation language.

the transaction. For example, journal vouchers include fields that require medical facility staff to manually enter information, such as the fund account(s) involved and a detailed explanation to justify the expenses being transferred.

The Office of Management and Budget's (OMB) guidance states that offices of inspectors general (OIG) should plan to use resources to prevent and detect waste, fraud, and abuse related to an agency's implementation of the relief legislation.[5] Federal and VA policies provide that assigning purchasing authority, segregating duties, properly certifying and paying invoices, and tracking the receipt of goods are necessary to establish controls over purchases.[6] These controls are intended to establish authority; ensure accountability; and reduce the risk of fraud, waste, and abuse. The OIG conducted this audit to assess the effectiveness of VA's controls over VHA's use of CARES Act supplemental funds. The OIG recognizes VA faced challenges in quickly distributing critical funds during the pandemic, especially in light of its FMS limitations. This report discusses how the limitations hindered VA's financial controls over the use of the funds.

What the Audit Found

The OIG found that the use of manual expenditure transfers limited transparency and accountability of employee payroll, other contractual services, and medical supply purchases. Similarly, VHA lacked general controls over its medical facilities' use of COVID-19 funds.[7] Based on a sample of 160 transactions from Veterans Integrated Service Networks (VISNs) 8, 10, and 22, the audit team estimated that staff relied on manual expenditure transfers to process approximately 82 percent of transactions.[8]

However, the audit team found that staff did not always sufficiently prepare journal vouchers or maintain adequate documentation to support the vouchers used to manually record expenditure transfers. This occurred because VHA's Office of Finance did not follow established VA financial policy and develop supplemental guidance for the type of documentation required so that an adequate audit trail was established. For example, journal vouchers did not always include supporting documentation for the amounts identified on them, nor did they include the preparer's and authorizing official's signatures indicating the journal vouchers were reviewed

[5] OMB Memo M-20-21, "Implementation Guidance for Supplemental Funding Provided in Response to the Coronavirus Disease 2019 (COVID-19)," April 10, 2020.

[6] Federal Acquisition Regulation (FAR) 1.602-3(a) (2014); VA Financial Policy, "Invoice Review and Certification," in vol. 8, *Cash Management* (October 2013 and June 2021), chap. 1A; VA Financial Policy, "Government Purchase Card for Micro Purchases," in vol. 16, *Charge Card Programs* (July 2021), chap. 1B; VA Financial Policy, "Management's Responsibility for Internal Controls," in vol. 1, *General Accounting* (February 2019), chap. 5.

[7] Appendix A details the team's scope and methodology.

[8] See appendix B for details on the statistical sampling process. The audit team selected VISNs 8, 10, and 22 because, according to VHA's Office of Finance, they received the highest CARES Act supplemental fund distribution of all the VISNs.

and approved. Consequently, staff could not always identify what was purchased, nor could they provide evidence to support the proper use of CARES Act supplemental funds. Because VA's information system was not configured to support all transactions that used supplemental funds and VHA had not established guidance for journal voucher documentation requirements, it lacked assurance that CARES Act funds were used for veterans' COVID-19-related needs.

Finally, the audit team estimated that over 10,000 COVID-19-related transactions that were directly obligated from the CARES Act fund were noncompliant with key fiscal controls such as those set out in VA's policies and procedures in the following respects: medical facility staff did not (a) have documented purchase authority, (b) segregate duties, (c) properly track the receipt of goods to ensure the quantities ordered were received, or (d) properly certify and pay invoices. This occurred because VHA did not develop guidance that included protocols for accounting processes and procedures that outlined clear roles and expectations related to the oversight of its supplemental funds purchases. As a result, the OIG questioned costs totaling an estimated $187.2 million.[9] Until controls over payments are strengthened, VHA cannot be sure that these payments have been properly made. Further, Congress lacks reasonable assurance that funds allocated for veterans' COVID-19-related care are being spent as intended.

What the OIG Recommended

The OIG made one recommendation to VA's assistant secretary for management and chief financial officer to (1) assess the Integrated Financial and Acquisition Management System configuration to determine whether integration with the payroll subsystems can be accomplished to resolve some of the payroll-related issues that require the need for expenditure transfers.

The OIG made an additional eight recommendations to VA's under secretary for health: (2) establish guidance that outlines the type of documentation required to support the amounts identified in the manual journal vouchers when processing expenditure transfers; (3) require medical facility staff have the documented authority, through proper delegation, to make purchases; (4) verify that medical facility staff segregate duties; (5) make certain the purchase card holder is not the requestor or approver for the purchase; (6) ensure contracting officer's representatives (CORs) know and understand their duties and responsibilities for the certification and payment of invoices; (7) check vendors' compliance with the contract terms to include the comparison of invoiced amounts with contract line-item costs; (8) ensure that medical facility staff track the receipt of goods to make certain they are the correct quantity; and (9) conduct an assessment of lessons learned from the emergency response to the pandemic and develop

[9] See appendix C for details on questioned costs. The Inspector General Act of 1978 provides that a cost is questioned because of an alleged violation of a provision of a law, regulation, contract, grant, or agreement or document governing the expenditure of funds; inadequate documentation to support the cost; or the expenditure of funds for the intended purpose is unnecessary or unreasonable.

appropriate action plans to integrate oversight roles, responsibilities, and clear guidance into the use of supplemental funds.

VA Management Comments and OIG Response

VA's assistant secretary for management and chief financial officer concurred with recommendation 1 and determined that the Integrated Financial and Acquisition Management System has the functionality to integrate with, and support, labor distribution. However, because multiple subsidiary systems for payroll and time and attendance will require upgrading for the required functionality, an end-to-end automated solution will likely not be achieved before September 2030. As VA's action plan is responsive, the OIG closed the recommendation. Appendix D provides the full text of VA's response.

The under secretary for health concurred in principle with recommendation 2, stating that VHA's Office of Finance will identify guidance with standardized supporting documentation for processing expenditure transfers. Recommendations 3 through 8 all received concurrences from the under secretary, and VHA will take steps to ensure the proper delegations, staff training, and controls are in place to implement these recommendations by March 2024. Finally, the under secretary for health concurred in principle with recommendation 9 and stated that VHA's Office of Finance will review the key emergent procedures implemented during the pandemic and identify oversight roles and responsibilities to allow guidance for use of future supplemental funds. Appendix E provides the full text of VHA's responses.

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Contents

Abbreviations

CARES Act	Coronavirus Aid, Relief, and Economic Security Act
CFO	chief financial officer
COR	contracting officer's representative
FAR	Federal Acquisition Regulation
FMS	Financial Management System
GAO	Government Accountability Office
iFAMS	Integrated Financial and Acquisition Management System
IFCAP	Integrated Funds Distribution Control Point Activity, Accounting and Procurement System
OIG	Office of Inspector General
OMB	Office of Management and Budget
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The COVID-19 pandemic was declared a national emergency on March 13, 2020.[10] On March 27, 2020, the Coronavirus Aid, Relief, and Economic Security (CARES) Act was signed into law.[11] Congress provided VA with approximately $19.6 billion in CARES Act funds, of which approximately $17.2 billion was appropriated to the Veterans Health Administration (VHA). About $14.4 billion of the $17.2 billion (84 percent) was allocated to VHA's medical services fund.[12] This one-time appropriation of funds, available until September 30, 2021, was to provide support for VA's efforts to prevent, prepare for, and respond to COVID-19, including related impacts on healthcare delivery, as well as to provide support to veterans who were homeless or at risk of becoming homeless.[13] As of September 30, 2022, VA reported that VHA's CARES Act medical services fund obligations totaled about $7.8 billion, and the expenditures for the medical services fund totaled about $7.6 billion.[14]

The Office of Management and Budget (OMB) guidance states that offices of inspectors general should plan to use resources to prevent and detect waste, fraud, and abuse related to an agency's implementation of the relief legislation.[15] As noted in a 2021 VA Office of Inspector General (OIG) publication, variances found in supplemental funding reporting underscored the need for additional data validation measures to ensure the data being reported to OMB and Congress are accurate.[16] The OIG conducted this audit to assess the effectiveness of VA's controls over VHA's use of CARES Act supplemental funds. The OIG recognizes that the controls to track COVID-19-related expenses were developed during the pandemic, when VA needed to quickly disburse funds to the areas of greatest need. Nonetheless, the analysis in this report could inform VHA's planning to ensure appropriate controls for future supplemental funds usage.

[10] Presidential Proclamation 9994, "Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak," March 13, 2020.

[11] Coronavirus Aid, Relief, and Economic Security (CARES) Act, Pub. L. 116-136, 134 Stat. 281 (2020).

[12] The $17.2 billion was distributed among VHA's medical community care, medical facilities, medical services, and medical support and compliance funds.

[13] CARES Act § 19011(c).

[14] An obligation is a definite commitment that creates a legal liability of the government for payment of goods and services ordered or received, while an expenditure is the actual spending of money.

[15] Office of Management and Budget (OMB) Memo M-20-21, "Implementation Guidance for Supplemental Funding Provided in Response to the Coronavirus Disease 2019 (COVID-19)," April 10, 2020.

[16] VA OIG, *Review of VHA's Financial Oversight of COVID-19 Supplemental Funds*, Report No. 20-02967-121, June 10, 2021.

VHA's Execution of CARES Act Supplemental Funds

CARES Act funds were considered supplemental appropriations because they were enacted after a regular annual appropriations act.[17] To execute CARES Act medical services funding, and to process and classify transactions, VHA relied on expenditure transfers to shift funds between its annual and supplemental appropriation accounts and also obligated funds directly from the CARES Act fund.

VA and VHA officials informed the audit team that due to limitations with VA's Financial Management System (FMS), VHA staff could not directly obligate funds for payroll-related purposes to CARES Act funds. In addition, according to VA and VHA staff, once CARES Act funding was available, VHA staff could directly obligate CARES Act funds for supplies and materials. VA and VHA staff also informed the audit team that VHA did not mandate that all supply and material expenses be directly charged to the CARES Act medical services appropriation. Rather, according to VHA staff, VHA left the decision as to whether staff would directly obligate the funds or use a manual expenditure transfer to the chief financial officer (CFO) at each medical facility. According to medical facility CFOs, some medical facilities made medical supply and material purchases by directly obligating to the CARES Act medical services appropriation, while others continued to use manual expenditure transfers for the purposes of tracking COVID-19-related expenses.

The medical facilities used a manual journal entry to transfer the costs from the regular annual appropriation to the CARES Act supplemental appropriation. Expenditure transfers are manual or system-generated adjustments that are documented in FMS. Manual expenditure transfers are documented with a journal entry, referred to as a journal voucher, which is a written document that serves as an integral part of the audit trail and should include sufficient documentation to explain the purpose and details of the transaction. It includes fields that require medical facility staff to manually enter information, such as the fund account(s) involved and a detailed explanation to justify the expense being transferred.

VA financial policy provides guidance on the use of journal vouchers designed to help with the traceability of the transferred expense to the purchase. The policy states that staff must complete a journal voucher using OF 1017-G, which is a Government Accountability Office (GAO) optional form and include all supporting documentation for approval by the journal voucher

[17] OMB Circular A-11, "Preparation, Submission, and Execution of the Budget," August 2022. The circular defines a regular annual appropriation as enacted normally in the current year and available for obligation in the budget year and subsequent years if specified in the appropriation language. The circular defines supplemental appropriations as those enacted after a regular annual appropriations act, when the need for funds is too urgent to be postponed until the next regular annual appropriations act.

approving official.[18] The form's use and supplemental documentation to support amounts listed in the form are mandatory under VA financial policy. However, even if another mechanism is used, the same information is required as part of the journal voucher package. In particular, the policy provides that, at a minimum, the following documentation will be completed and maintained for journal vouchers:[19]

- Supporting documentation packages clearly labeled with the document identification number, which also serves as the journal voucher identification number
- Clear description of the purpose of the journal voucher and an adequate detailed explanation supporting why the journal voucher must be processed
- Documents to support the amounts and general ledger accounts to be posted, such as reconciliations or transaction details, that would enable anyone reviewing the journal voucher to reperform calculations or verify summarized amounts
- Sufficient evidence proving that the journal voucher was properly posted to the appropriate general ledger accounts
- Documentation that properly identifies the journal voucher preparer and approving official by name, title, and office symbol[20]
- Signatures of the journal voucher preparer and approving official and dates of signatures

By ensuring staff follow established VA financial policy, VHA will be better positioned for improved compliance when using future supplemental appropriations.

[18] An optional form means that it was developed by a federal agency for use in two or more agencies and approved by the General Services Administration for nonmandatory government-wide use. The OF 1017-G was developed by the Government Accountability Office, and VA mandated its use.

[19] VA Financial Policy, "VA's Accounting Classification Structure," in vol. 2, *Appropriations, Funds, and Related Information* (September 2018), chap. 1; VA Financial Policy, "VA Journal Vouchers," in vol. 2, *Appropriations, Funds, and Related Information* (June 2020), chap. 1A. Both financial policies were in place during the time of the events discussed in this report. VA Financial Policy on VA's accounting classification structure was replaced by VA Financial Policy on VA journal vouchers. Both financial policies contain the same or similar language regarding minimum documentation requirements for journal vouchers.

[20] To satisfy segregation of duties requirements, the journal voucher preparer and approving official must be different individuals, and the approving official should have a level of authority above that of the preparer. The journal voucher approving official is to deny any journal voucher not supported by accurate or proper documentation and to request additional information required to process the journal voucher.

VA Office of Management

The mission of VA's Office of Management is to provide strategic and operational leadership in several areas, including budget, financial management, and business oversight. The Office of Management distributes VA-wide policies for effective financial management and control. VA's assistant secretary for management and CFO is responsible for carrying out the Office of Management functions and advising the VA Secretary on financial stewardship of VA resources. Moreover, VA's CFO is responsible for the oversight of VA's budgetary and financial management functions, such as payroll and other payment processing. The Office of Management oversees the VA Office of Financial Management Business Transformation Service and the VA Office of Budget.

VHA Office of the Chief Financial Officer

The VHA Office of the CFO has overarching responsibility for developing VHA's budget, allocating funding, and monitoring the use of funds by Veterans Integrated Service Networks (VISNs). In addition, the office guides and oversees financial management and accounting operations. The VHA CFO serves as the principal financial adviser to the under secretary for health and provides support to the assistant under secretary for health for operations on financial matters. The VHA Office of the CFO is responsible for adhering to and implementing VA financial policies. Likewise, the office is responsible for establishing the controls necessary to ensure CARES Act funds are used in accordance with laws, regulations, and VA financial policy.

Veterans Integrated Service Networks

The VISNs are responsible for overseeing VHA medical facilities across the nation. VISN CFOs work directly with the VHA Office of the CFO to ensure the medical facilities under their jurisdictions receive enough funding and that any issues reported by the medical centers related to CARES Act funding are remedied.

Results and Recommendations

Finding 1: Medical Facility Staff Did Not Always Properly Prepare Journal Vouchers to Manually Record Expenditure Transfers

VHA used expenditure transfers to execute CARES Act supplemental funding. According to VA and VHA officials, expenditure transfers were used due to the limitations of VA's financial system. Expenditure transfers are documented using journal vouchers, which help create an audit trail when used correctly. However, the audit team found that medical facility staff did not always sufficiently prepare journal vouchers or maintain adequate documentation to support the vouchers used to record manual expenditure transfers.[21] This occurred because VHA's Office of Finance did not follow established VA financial policy and develop guidance for the type of documentation required so that an adequate audit trail was established.

Based on a sample of 160 transactions reviewed, the audit team estimated that VISNs 8, 10, and 22 relied on manual expenditure transfers to process approximately 82 percent of transactions.[22] Without guidance on the type of journal voucher documentation needed to support an audit trail, medical facility staff took on the responsibility of determining the most appropriate way to document the journal vouchers and satisfy the audit trail requirements. Consequently, medical facility staff could not always identify or provide evidence for this audit to support the dollar amounts denoted on the journal vouchers that were transferred for purchases using CARES Act supplemental funds. As a result, the medical facilities experienced challenges identifying specific purchases for which the expenses were transferred.

Preparing and maintaining appropriate supporting documentation when using journal vouchers is essential and necessary due to FMS limitations. Until VHA establishes specific guidance on journal voucher documentation requirements for supplemental funds and VA updates its financial reporting systems, purchases made using supplemental funds will lack transparency.

This finding discusses the following two issues that contributed to insufficient journal voucher preparation and the lack of adequate documentation to manually record expenditure transfers:

- FMS configuration does not fully support transaction processing.
- VHA's Office of Finance did not establish guidance for the type of documentation required to support an audit trail.

[21] VA Financial Policy, "Expenditure Transfers," in vol. 1, *General Accounting* (June 2012), chap. 9. The policy defines expenditure transfers as shifting funds between appropriations that are documented in VA's financial management system with a journal voucher. Expenditure transfers can also be defined as manipulations by way of manual journal voucher entries, manual processes, and reconciliations to execute CARES Act supplemental funding.

[22] The audit team selected VISNs 8, 10, and 22 because, according to VHA's Office of Finance, they received the highest CARES Act supplemental funds distribution of all the VISNs.

What the OIG Did

The audit team reviewed a statistical sample of 160 COVID-19-related transactions processed by VISNs 8, 10, and 22. Expenditure transfers accounted for 87 of the 160 (54 percent) transactions.[23] The team reviewed the journal vouchers and any other available documentation, such as VA's FMS screens, spreadsheets, journal voucher logs, personnel listings, and purchase orders that the audit team obtained from medical facility staff.

To gain an understanding of the processes and internal controls related to the transactions, the team reviewed federal laws and regulations, prior GAO and OIG reports, VA financial policy, and VHA's COVID-19 Questions and Answers document. In addition, the audit team conducted multiple interviews with officials from VA's Office of Management, including the assistant secretary for management and CFO; VA's Office of Financial Policy; VHA's Office of Finance; three VISN CFOs; and eight medical facility CFOs and fiscal service staff.

FMS Configuration Does Not Fully Support Transaction Processing

According to VA and VHA officials, the FMS configuration contributed to the need for VHA to use its regular annual appropriations to process COVID-19-related personnel, compensation, benefits, and other contractual services transactions and then complete an expenditure transfer to the appropriate CARES Act supplemental appropriation.[24] FMS is currently VA's core financial management system and, according to VA and VHA officials, is configured so that employee payroll uses the fund code associated with each employee's cost center.[25] According to one VA official, employee fund codes are mapped to the employee cost center and VHA's regular annual appropriations. Accordingly, if an employee is performing work in support of COVID-19 that would require pay from the CARES Act supplemental funds but the employee's cost center has not changed, then FMS posts to the default fund that is associated with that employee's cost center.

VA representatives informed the audit team that to properly apportion hours for employees who work COVID-19- and non-COVID-19-related payroll expenses, there would be a need for

[23] The OIG statistician stated that the two percentages (raw sample, 54 percent; estimated, 82 percent) differ due to the weights associated with each stratum from which the samples were drawn. With complex sampling, a percentage that is calculated with raw responses does not account for the portion of the population that each sampled unit represents. Some sampled units, based on the selection method, represent a greater portion of the population than other units.

[24] FMS is an integrated, VA-wide system that interfaces externally with the Department of the Treasury, General Services Administration, Internal Revenue Service, Defense Logistics Agency, and various commercial vendors and banks for electronic billing and payment purposes. This system supports the collection, processing, and dissemination of several billion dollars of financial information and transactions each fiscal year.

[25] VA Financial Policy, "Budget Object Class Codes," in vol. 13, *Cost Accounting* (May 2020), chap. 2. The policy defines cost center as a mechanism used in FMS to accumulate costs incurred by area of responsibility or geographic region.

configuration work to make CARES Act funds available in HR Smart—VA's human resources information system that manages personnel records—and the VA Time and Attendance System. One VA official further stated that the information would then need to be routed to the Defense Finance and Accounting System, where a cost center would have to be created to allow FMS to accept the new fund in the payroll interface. Moreover, the same VA official also informed the audit team that the new Integrated Financial and Acquisition Management System (iFAMS) could resolve some of the payroll-related issues that require expenditure transfers but only if the payroll subsystems also have that ability. VA is in the process of deploying iFAMS, a multiyear finance and acquisition system modernization project, which is scheduled to replace FMS. iFAMS would not, however, resolve VA's reliance on subsystems that default to VHA's regular annual appropriations.

One VA Office of Finance official stated that there is a need for more system integration. There are also risks associated with VHA's reliance on several subsystems for the recording of COVID-19-related costs that are then manually transferred, via journal vouchers, into FMS from the regular annual appropriations to be paid for using CARES Act supplemental appropriations. Without information systems to fully support the transactions that VHA processes using supplemental appropriations, VA lacks the ability to provide complete transparency and visibility in the execution of the approximately $14.4 billion of CARES Act funds used to support medical services expenses. VA should determine, as part of the iFAMS implementation, whether integration with the subsystems in the payroll process can be accomplished. Until VA builds something more automated that can track activity at the line-item or deliverable level, it is important VHA prepares journal vouchers supported with sufficient justification and documentation for the expenses.

VHA's Office of Finance Did Not Establish Guidance for Audit Trail Requirements to Support Manual Journal Vouchers

VA financial policy states that journal vouchers are used to enter, adjust, or correct accounting and financial information. The policy also provides broad guidance that when using a manual journal voucher to enter, adjust, or correct accounting and financial information, staff will maintain adequate documentation to support the event and ensure a detailed audit trail exists.[26] A journal voucher could consist of many—sometimes hundreds—of smaller transactions that have been recorded in FMS.

Staff at medical facilities used journal vouchers to record manual expenditure transfers for personnel, compensation, and benefits, as well as at some facilities for supplies, materials, and other contractual services. The expenditure transfers provided flexibility in accounting for the

[26]VA Financial Policy, "VA Journal Vouchers," in vol. 2, *Appropriations, Funds, and Related Information* (June 2020), chap. 1A.

use of the CARES Act funds by allowing staff to shift funds between their annual and supplemental appropriation accounts for COVID-19-related expenses. However, the transfers between funds created challenges when medical facilities attempted to identify their purchases and when the audit team attempted to trace the expenses denoted on the journal vouchers to what the medical facilities purchased with the CARES Act funds.

Personnel, Compensation, and Benefits

Personnel, compensation, and benefits include expenses related to employees hired by VHA to perform a service. As stated earlier, generally VHA used its regular annual appropriation for these purposes, until CARES Act funds were made available, and recorded the expenses in FMS once the funds were made available.[27] These COVID-19-related expenses for personnel, compensation, and benefits from the CARES Act supplemental appropriation were manually transferred in FMS using journal vouchers.[28] As the audit team assessed the journal vouchers that were created to support the manual FMS entries, the team recognized that VHA aggregated the amounts to be transferred. Often, the vouchers included transfers from several of VHA's regular annual appropriations to VHA's CARES Act supplemental appropriations. Additionally, the audit team could not always trace sample transactions to any documentation to support the transferred amount. The OIG recognizes balancing patient care demands with disbursing large amounts of funding quickly can be challenging. However, even when staff are overburdened, certain controls need to be established and implemented for supplemental funding to help ensure that risks associated with executing large amounts of funding for appropriate uses are minimized. The following examples highlight the importance of adequate controls.

Example 1

A medical facility initiated an expenditure transfer totaling approximately $714,235 for nurses' salaries during the COVID-19 pandemic. The documentation that the medical facility provided to the audit team did not support the transferred amount. When the audit team made a follow-up request for supporting documentation, the medical facility's deputy CFO stated that it was not available because the budget analyst who prepared the journal voucher had retired. According to VA policy, documents supporting the transferred expenditure amounts must be completed and maintained for journal vouchers.

[27] OMB Circular A-11. The circular defines a regular annual appropriation as enacted normally in the current year and available for obligation in the budget year and subsequent years if specified in the appropriation language.

[28] OMB Circular A-11. The circular defines supplemental appropriations as those enacted after a regular annual appropriations act, when the need for funds is too urgent to be postponed until the next regular annual appropriations act.

Additionally, the preparer and approving official did not sign the journal voucher.[29] The medical facility's deputy CFO informed the audit team that a signed journal voucher could not be provided because the staff who prepared and subsequently approved the transaction were no longer with VA. As a result, this expenditure transfer was not prepared in accordance with VA policy. Because the facility did not maintain documentation to support an audit trail, the audit team was unable to validate the transferred amount or determine if the expenditure transfer was authorized before it occurred.

Example 2

A medical facility initiated an expenditure transfer totaling approximately $3,831 for overtime pay. The documentation that the medical facility provided to the audit team did not justify the expenditure transfer. In addition, the documents provided did not reconcile to the recorded payments. When asked about the payments that were recorded, the medical facility's CFO stated that the overtime rate used ($84.38) was an average for the facility and that the average was calculated using the VHA Support Service Center's published average salary at the time of the transfer: annual salary divided by annual hours and then multiplied by time and a half.[30]

($117,000/2,080 annual hours) x 1.5

The medical facility CFO informed the audit team that the average overtime rate was established because obtaining individuals' salary rates each pay period would not be efficient while also working to execute the facility's budget, track COVID-19 and other special-purpose program expenditures, and transfer costs. The medical facility CFO also stated that VHA guidance could not be found that stipulated the use of actual overtime expenses versus using the average overtime expenses. Because the medical facility CFO chose to use an average overtime expense to calculate overtime pay, the audit team was unable to determine whether the $3,831 expenditure transfer was the result of actual overtime payments or was understated or overstated by using an average salary of $117,000.

While the OIG appreciates that this work was done during the pandemic, this example illustrates two concerns. The CFO could not find national guidance providing direction to the facilities to

[29] A preparing official and an approving official are required to sign the journal voucher. To satisfy segregation of duties requirements, these two officials must be different officials.

[30] The VHA Support Service Center provides data to established internal VA organizations and program offices for healthcare delivery analysis and evaluation.

support the decision to use an average overtime rate, and as a result, this particular facility chose the method of using average overtime. Moreover, by using this approach, there was no way to compare that the overtime for an individual was correct, since an average was used.

Supplies, Materials, and Other Contractual Services

Supplies and materials include expenses for all products whether acquired by formal contract or another form of purchase. Other contractual services are expenses for consulting and purchases of goods and services.

One VA official informed the audit team that once CARES Act funding was available, direct obligation of the CARES Act medical services appropriation was possible for supplies and materials, but VHA officials and staff stated that VHA did not mandate that all supply and material expenses be directly charged to the CARES Act medical services appropriation.[31] In turn, one medical facility CFO stated that he directed that supply and material purchases be made by directly obligating to the CARES Act medical services appropriation, while another CFO informed the audit team that he continued to use manual expenditure transfers for the purposes of tracking COVID-19-related expenses. For example, one CFO wanted to minimize his facility's use of manual expenditure transfers, but other CFOs said they chose not to change anything and continued with the manual expenditure transfers because they thought it helped track COVID-19 purchases. In such instances, the medical facilities then used manual journal entries to transfer the costs from the regular annual appropriation to the CARES Act supplemental appropriation.

In the audit team's assessment of the journal vouchers that supported the FMS entries, a medical facility may compile multiple transactions into one journal voucher to record the expenditure transfer. The vouchers included several expenditure transfers assigning costs from VHA's regular annual appropriations to VHA's CARES Act supplemental appropriations. The following examples highlight this issue.

Example 3

A medical facility initiated an expenditure transfer totaling $11,235. The medical facility provided documentation that included 26 previously processed expenditure transfers that were used to reconcile the amount of the expenditure transfer being processed. However, not all the amounts could be reconciled to all purchased items. The audit team requested the medical facility's reported amounts and documentation to support the multiple expenditure transfers to try to trace what was purchased with the $11,235, but the medical facility CFO was unable to provide documentation supporting the amount. Moreover, the journal

[31] Of note, before funding was available, staff were unable to directly obligate CARES Act funds.

voucher did not include a clear description of the purpose of the expenditure transfer, as required by VA financial policy, and how the costs were related to COVID-19. Finally, the journal voucher did not include dates of signature. Therefore, the audit team could not determine what was purchased, whether the transfer was for COVID-19-related needs, and whether the request to transfer the costs was approved prior to the entry into FMS.

Example 4

A medical facility initiated an expenditure transfer totaling $81,982 for accrued expenses, not paid expenses. As a result, the team could not trace the accrued expenses to any purchases.[32] VA financial policy requires that VA record an expenditure transfer when a payment is made.[33] The medical facility transferred the accrued expenses because the COVID-19 Questions and Answers document, issued by VHA's Office of Finance, stated that purchase card transactions could be transferred when the order was placed despite VA financial policy stating that VA will process adjustments to expenditures only after the expenditure has been recorded.[34] When the audit team presented this example to VHA's Office of Finance, one official within the office acknowledged that VHA did not comply with VA's financial policy as an exception due to the pandemic to ensure operational funds were available and that veteran care was not disrupted. In addition, the medical facility CFO stated that if the accrued expenses had not been transferred, VA's COVID-19-related expenses would have been understated.

Similarly, the journal vouchers did not always meet VA financial policy requirements to include the preparer's and authorizing official's signatures, clear descriptions of the purpose, and "detailed explanation" supporting why it must be processed. All of this information is necessary to prove an actual expense occurred and a legitimate purchase was made that required an expense transfer. Consequently, the audit team could not always trace sample transactions to supporting documentation.

Although VA financial policy provides broad guidance on the need to maintain documentation to support journal vouchers, it does not explicitly state the type of documentation staff will maintain to allow anyone reviewing the journal voucher to reperform calculations or verify summarized amounts identified on the voucher. The policy makes VHA and staff office CFOs

[32] Accrual is a basis of accounting used for financial reporting to record expenses when goods are received or services are performed, even though the actual payment for those goods or services may occur at a different time.

[33] VA Financial Policy, "Expenditure Transfers." The policy states that VA may record an expenditure transfer when a specific law mandates that a payment be made by one appropriation on behalf of another appropriation, or when the payment is recorded in one appropriation and an adjustment is needed to record the payment properly.

[34] VA Financial Policy, "Expenditure Transfers."

responsible for ensuring they have adequate internal controls, such as guidance and procedures, in place to adhere to VA's broad financial policy and oversee the work performed.[35] GAO standards state that necessary policies be documented for an organization to achieve its process objectives and respond to related risks.[36] Without this information, there is no reasonable assurance that CARES Act funds were used for COVID-related needs—a requirement of the CARES Act.

The OIG fully supports prioritizing patient safety and prompt access to quality care and recognizes that VHA was dealing with an unprecedented situation. Having clearer policy in place may support proper fund control in the future, even in the midst of a public health crisis. VHA could use this as an opportunity to build audit trail requirements into protocols moving forward to ensure amounts identified on journal vouchers are adequately supported.

The audit team discussed the use of expenditure transfers to account for most of its CARES Act spending with VA's Office of Management and VHA's Office of the CFO. Officials from both offices acknowledged that the use of expenditure transfers to execute most of the budget was not the most ideal method and that expenditure transfers should be used, primarily, to make cost corrections. One official from the Office of Management stated that when massive expenditure transfers are performed and other independent auditors have attempted to identify what was spent by a particular category, VA could not provide that level of detail.

Finding 1 Conclusion

VHA has a responsibility to be a good steward of its resources. Medical facility staff were performing manual adjustments without supplemental guidance to help satisfy audit trail requirements and ensure resources were properly accounted for. In addition, the FMS configuration contributed to the need for medical facility staff to make manual adjustments as a workaround for processing an estimated 82 percent of transactions. Accordingly, medical facilities experienced challenges identifying the items purchased with CARES Act medical services supplemental appropriations.

Without established guidance, VHA staff and departments within the medical facilities took on the responsibility of determining when an expenditure transfer should be processed and what documentation satisfied the audit trail requirements, without the benefit of proper internal controls to help make certain that what the funds were being used for was clear. Consequently, VHA's use of manual expenditure transfers limited the transparency and accountability of employee payroll, other contractual services, and medical supply purchases.

[35] VA Financial Policy, "VA Journal Vouchers."

[36] GAO, Standards for Internal Control in the Federal Government, GAO-14-704G, September 2014.

VHA needs to establish guidance that provides the type of documentation required to support manual journal vouchers when processing expenditure transfers. Developing this guidance could help provide standard processes for quickly identifying documentation needed to support an audit trail when supplemental funds are required to be used. This is especially important given that the FMS configuration does not fully support transaction processing.

As a result of this audit, one medical facility stated they took action to develop written procedures for what documentation needs to be present prior to processing an expenditure transfer. Another medical facility plans to start providing more detailed explanations on the journal voucher.

Recommendations 1–2

The OIG made one recommendation to VA's assistant secretary for management and chief financial officer:

1. Assess the iFAMS configuration to determine whether integration with the payroll subsystems can be accomplished to resolve some of the payroll-related issues that require the need for expenditure transfers.

The OIG made one recommendation to VA's under secretary for health:

2. Establish guidance that outlines the type of documentation required to support the amounts identified in the manual journal vouchers when processing expenditure transfers.

VA Management Comments

VA's assistant secretary for management and chief financial officer concurred with recommendation 1, stating that integration is possible but will take several years due to the need to update subsidiary systems used for payroll and for time and attendance. According to the assistant secretary, VA will collaborate with all stakeholders of these systems to develop interfaces for an end-to-end automated solution by September 2030. Appendix D provides the full text of the assistant secretary's comments.

The under secretary for health concurred in principle with recommendation 2, stating that, while VHA takes documentation needs seriously, establishing guidance for every transaction "related to the multitude of expenditure transfers" is not feasible. VHA's Office of Finance will identify guidance with standardized supporting documentation for the categories of salaries for full-time equivalent employees and supplies and materials. This guidance will allow for alternate documentation when appropriate. VHA provided a target completion date of October 2023 for updating guidance. Appendix E provides the full text of the under secretary's comments.

OIG Response

The assistant secretary for management and chief financial officer determined that iFAMS has the functionality to integrate with, and support, labor distribution—provided that multiple systems are upgraded to achieve the required functionality. Because the assistant secretary determined that integration with iFAMS is possible to develop an automated solution, the OIG considered the action plan responsive to the intent of the recommendation and is closing recommendation 1 as implemented.

The under secretary for health's comments and corrective action plans are responsive to the intent of recommendation 2. The OIG will close the recommendation once VHA provides evidence the guidance has been established.

Finding 2: Medical Facility Staff Did Not Comply with Key Fiscal Controls When Making COVID-19-Related Purchases

Obligating funds directly from the CARES Act fund, such as for medical supplies, does not require a manual journal voucher to shift funds between VHA's appropriations. Directly obligating the funds also helps provide an audit trail. However, the audit team estimated that medical facilities within the three VISNs made all 10,064 of their COVID-19-related direct obligation transactions for purchases of medical supplies and other contractual services without adhering to key fiscal controls. Purchases were therefore not consistent with VA policies and procedures in the following respects:

- Medical facility staff did not always have documentation granting them proper authority to make COVID-related purchases.
- Medical facility staff did not segregate duties so that the same individual was not approving the purchase or acting as the purchase card holder and the requestor or approver, actions that ensure the integrity of procurement processes.
- Contracting officer's representatives improperly certified and paid invoices.
- Medical facility staff did not properly track the receipt of goods to ensure the quantities ordered were received.

Noncompliance with key fiscal controls occurred because VHA did not develop guidance that included protocols for accounting processes and procedures that outlined clear roles and expectations related to the oversight of its supplemental funds purchases. As a result, the OIG questioned costs totaling an estimated $187.2 million.[37] Without strengthening controls over payments, VHA is at continued risk of making additional improper payments and is at increased risk of fraud, waste, and abuse.

What the OIG Did

The audit team reviewed a statistical sample of 160 COVID-19-related transactions. Of the 160 transactions, 73 (46 percent) were directly obligated to the CARES Act supplemental appropriation. Journal vouchers accounted for the remaining 87 transactions. The team reviewed contracts, invoices, receipts, and authorization documentation to assess the controls over COVID-19-related purchases.

[37] The Inspector General Act of 1978 provides that a cost is questioned because of an alleged violation of a provision of a law, regulation, contract, grant, or agreement or document governing the expenditure of funds; inadequate documentation to support the cost; or the expenditure of funds for the intended purpose is unnecessary or unreasonable.

To gain an understanding of the processes and internal controls related to the transactions, the team reviewed federal laws and regulations, prior GAO and OIG reports, VA financial policy, and VHA's COVID-19 Questions and Answers document. The audit team conducted multiple interviews with officials from VA's Office of Management, including the assistant secretary for management and CFO; VA's Office of Financial Policy; VHA's Office of the CFO; three VISN CFOs; and eight medical facility CFOs.

Medical Facility Staff Did Not Always Have Documentation Granting Them Proper Authority to Make COVID-Related Purchases

The OIG estimated that in 93 percent of the transactions, documentation of medical facility staff's authority to make COVID-19-related purchases was missing. This occurred because fiscal service staff did not maintain documentation granting the staff authority to make the purchase. VA requires that an individual acting on behalf of the government to obligate funds and make purchases be delegated the proper authority. The audit team found that medical staff who made COVID-19-related purchases either did not have the proper authority delegated to them in writing or did not have an approved Governmentwide Purchase Card Certification Form before making a purchase with such a card. For example, for 13 of 18 sample transactions at three medical facilities, the staff either could not provide or did not issue the required delegation of authority for officials who made COVID-19-related supply purchases.

A delegation of authority is a formal transfer of authority to take certain actions or make specific decisions, such as making purchases from a fund control point (an account that is used to track a specific medical service's money) or placing orders under a contract, which have legal or administrative significance (such as a contract or other obligation). Generally, the delegation of authority is documented via a memorandum and provides justification for an employee to make purchases. Similarly, an employee can be delegated the authority of an ordering officer so that they can perform duties, such as placing orders, under a contract.

Likewise, to make purchases using a government purchase card, a VA employee is granted authority through an approved Governmentwide Purchase Card Certification Form. The approved form authorizes a VA employee to become a card holder and obligate funds on behalf of the government. If an employee makes a purchase without the approved form, then an unauthorized commitment occurs, which is a violation of the Federal Acquisition Regulation (FAR).[38]

GAO standards state that to ensure only valid transactions occur, management should clearly communicate authorizations to personnel so that transactions are executed by individuals acting

[38] An unauthorized commitment is "an agreement that is not binding solely because the government representative who made it lacked the authority to enter into that agreement on behalf of the government." FAR 1.602-3(a) (2014).

within the scope of their authority.[39] Because medical facility staff made purchases without having the proper authority documented, VHA's payments for those purchases led to questioned costs by the OIG.

Medical Facilities Did Not Segregate Staff Duties

At some medical facilities, the audit team found that a single individual was controlling all key aspects of some purchase transactions. VA guidance holds that key duties and responsibilities must be divided or segregated among different individuals to reduce the risk of error or fraud.[40] The audit team estimated that for 43 percent of the total transactions, duties were not segregated, which increased the risk of incorrect or fraudulent purchases. For example, the same staff member authorized the purchases and certified receipt of the goods in five of the six certified invoice transactions reviewed at one medical facility. This is contrary to VA financial policy stipulating that the same individual will not have the authority for authorizing the request and certifying the receipt of those goods and services.[41] In another example, the purchase card holder also performed the roles of requesting official and approving official for eight of the nine purchase card transactions, contrary to the VA financial policy requirement that the duties of a purchase card holder, requesting official, and approving official be segregated.[42] VHA's payments for transactions that lacked segregated duties resulted in the OIG questioning those costs because of policy violations and the lack of controls that could leave VHA vulnerable to the potential for error and fraud.

Contracting Officer's Representatives Improperly Certified and Paid Invoices

VA financial policy holds certifying officials responsible for the verification and accuracy of facts stated on an invoice.[43] A certifying official informed the audit team that they did not verify the information on an invoice in support of a VISN-wide contract for COVID-19 nursing support services. As a result, the audit team's transaction review identified that the contracting officer's representative (COR) improperly certified and paid two invoices submitted by the vendor.

The terms of the contract stipulated that the nurses would receive lodging and per diem if qualified. To qualify for lodging, the contracted nurses could not live within 50 miles of the duty location and could not qualify for per diem unless they qualified for lodging. The COR did not

[39] GAO, Standards for Internal Control in the Federal Government.

[40] VA Financial Policy, "Invoice Review and Certification," in vol. 8, *Cash Management* (June 2021), chap. 1A.

[41] VA Financial Policy, "Invoice Review and Certification."

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

[43] VA Financial Policy, "Invoice Review and Certification."

require documentation to support that they qualified for lodging and per diem, so it is unknown whether the lodging and per diem amounts paid were allowable under the contract.

Moreover, pursuant to the contract, the salary, lodging, and per diem were to be billed as individual line items with separate units of pay. However, the COR accepted invoices with the vendor's aggregated amounts rather than require the vendor to provide an invoice with separate units of pay. The team attempted to validate the accuracy of the invoiced amounts and could not. When the team asked the COR to explain how the per diem rates and units of pay were calculated, the COR could not explain and asked the vendor, who stated that the invoiced per diem rate included lodging plus per diem daily rates divided by the hours the contracted nurses worked. The vendor's calculation does not comply with the contract. Furthermore, even if the calculation were accurate, the vendor invoice included hours worked that totaled more than what their timesheets reflected. The incorrect billing resulted in improper payments, leading the OIG to question costs associated with these transactions.

Because lodging and per diem were being invoiced the same way across the VISN, the audit team reviewed other invoices that were associated with the contract. The audit team found four medical facilities in the VISN's jurisdiction made purchases using the contract and also improperly certified and paid similar invoices. As of April 2022, payments under this contract totaled about $9 million. Although these payments are outside of the audit team's sample transactions, and the OIG is not making a recommendation regarding them at this time, VHA should consider reviewing the other invoices associated with this contract to ensure any payments made to the vendor were correct.

Similarly, under a separate contract for COVID-19 health screeners, the audit team's transaction review identified that CORs improperly certified and paid three additional invoices.[44] The CORs did not compare the invoice by line-item amount against the supporting documentation, such as the employee's time sheets; therefore, the CORs could not validate that the hours invoiced aligned with the hours worked. The audit team did compare them and found that the amounts paid were incorrect, resulting in overpayments. As a result, VHA made payments the OIG determined were questioned costs.

Medical Facility Staff Did Not Track the Receipt of Goods

The audit team found that under a VISN-wide contract for masks and gowns, three sampled transactions were classified as having a "certified invoice" from a menu that then required external manual processing instead of electronic processing in the Integrated Funds Distribution Control Point Activity, Accounting and Procurement (IFCAP) system.[45] Medical facility staff

[44] VHA employed health screeners during COVID-19 to ensure safety measures were being adhered to when employees and visitors entered medical facilities.

[45] IFCAP, which interfaces with FMS, is used to manage acquisitions and facilitate funds control.

incorrectly selected "certified invoice" instead of "invoice/receiving report" as the method of processing, which bypassed the IFCAP receiving controls and required receipt of goods to be tracked manually. A certified invoice has to be tracked manually because it must be signed by an official who certifies that the good has been received or the service rendered and that the medical facility that generated the purchase order will pay the vendor. An invoice/receiving report is created by warehouse personnel taking delivery of the goods, and it is tracked and paid in FMS.[46] Tracking receipt of goods manually creates additional opportunities for human error, which could result in payments not being made correctly. Because the incorrect method of processing was used, the OIG questioned the costs associated with the sampled transactions.

Under the same contract, but not directly related to the three sampled transactions, the manual process contributed to seven medical facilities and the VISN accepting (and later paying for) additional cases of masks and gowns beyond what was contracted. According to VISN personnel, they accepted 340 cases of masks above the amount contracted at a cost of approximately $58,000. VISN personnel also informed the contracting officer that they decided to keep 190 cases of gowns, also more than the contract, costing about $48,000. The staff member who accepted the masks and gowns beyond what the contract allowed did not have the authority to commit the government to the obligation, thereby triggering an unauthorized commitment totaling about $106,000.[47] The contract was later amended to pay for all the goods.

Although the unauthorized commitment was not directly related to the three samples reviewed and did not contribute to the monetary projections included in this report, it highlights the risks involved when controls are bypassed. For example, had personnel complied with the receiving controls, the system might have identified the goods had already been accepted.

VHA Did Not Develop Guidance for the Oversight of Supplemental Funds Purchases

VA financial policy holds VHA management responsible for oversight to mitigate the risk of fraud, waste, and abuse and to ensure funds are being used as intended.[48] At the onset of the pandemic, VHA needed to establish a method for tracking and accounting for COVID-19-related costs. To that end, it developed multiple alerts, memoranda, and a COVID-19 Questions and Answers document. However, none of these documents addressed oversight of transaction processing.

[46] IFCAP Purchasing Agent User Guide, version 5.1, January 2014.

[47] An unauthorized commitment is "an agreement that is not binding solely because the government representative who made it lacked the authority to enter into that agreement on behalf of the government." FAR 1.602-3(a) (2014).

[48] VA Financial Policy, "Management's Responsibility for Internal Controls," in vol. 1, *General Accounting* (February 2019), chap. 5.

The alerts and memoranda did provide staffing guidance and define emergency budget object classification codes and national disaster account classification codes to support VHA tracking and accounting for COVID-19 costs. The COVID-19 Questions and Answers document discussed information such as account classification codes to ensure accuracy in accounting for CARES Act funds, not the oversight of CARES Act supplemental funds. VHA officials informed the audit team that VA's existing financial policies were to govern the use of all CARES Act supplemental funds. The OIG acknowledges the challenges in applying the same level of oversight during the COVID-19 pandemic versus pre-pandemic. However, VHA could use this as an opportunity to build oversight mechanisms and accounting processes and procedures into protocols moving forward.

When the audit team asked VHA officials about their roles in the oversight of CARES Act funds, the team identified a pattern of shifting responsibility. VHA officials in the Office of the CFO stated that the responsibility for financial oversight is delegated to the VISNs. Accordingly, their expectation was that the VISN offices were either following established VA financial policy or had established the controls to ensure compliance with existing policy. The VISN CFOs, in turn, either stated that it was the responsibility of each individual medical facility CFO to establish the necessary controls to ensure financial oversight occurred, or that their oversight included reviews of the required COVID-19 tracking report. Medical facility CFOs stated that they followed the COVID-19 Questions and Answers document as they executed their CARES Act funds. The OIG recognizes that executing a budget of this magnitude, coupled with meeting the demands of patient care, contributed to the control breakdowns identified by the audit team. Moreover, the OIG appreciates that balancing patient care demands with disbursing large amounts of funding quickly can be challenging. However, even when staff are overburdened, certain controls need to be established and implemented for supplemental funding during a crisis to help ensure that risks associated with executing large amounts of funding for appropriate uses are minimized.

The lack of established oversight mechanisms contributed to the financial control deficiencies the audit team identified at the medical facilities. VHA should take the opportunity to conduct an assessment of lessons learned from the emergency response to the pandemic and develop appropriate action plans that include outlining clear roles and expectations related to the oversight of its supplemental funds. This guidance could help to mitigate the risk of control deficiencies over supplemental fund purchases and help strengthen VHA's oversight of supplemental funds, allowing them to quickly make funds available and have an oversight structure in place should supplemental funds be provided for the next emergency or pandemic.

Finding 2 Conclusion

VHA lacked general controls over its facilities' medical supply purchases and other contractual services. There was lack of documentation delegating medical staff purchasing authority; failures in not segregating duties for requesting, approving, and certifying goods; and deficiencies in tracking the receipt of goods. Moreover, the audit team found instances in which medical facility

staff were not properly certifying and paying invoices and estimated that key fiscal controls were missing for all COVID-19-related transactions that were directly obligated using CARES Act funds. As a result, the OIG estimated questioned costs totaling about $187.2 million. Without strengthening controls, VHA increases the risk for continued improper payments and the potential for fraud, waste, and abuse. Further, Congress lacks reasonable assurance that funds allocated for veterans' COVID-19-related care are being spent as intended.

Recommendations 3–9

The OIG made seven recommendations to VA's under secretary for health:

3. Require medical facility staff have documented authority, through proper delegation, to make purchases.
4. Verify that medical facility staff segregate duties so that the same person is not both authorizing and receiving goods and services.
5. Make certain the purchase card holder is not the requestor or approver for the purchase.
6. Ensure contracting officer's representatives know and understand their duties and responsibilities for the certification and payment of invoices.
7. Check vendors' compliance with contract terms to include the comparison of invoiced amounts with the contract line-item unit costs.
8. Ensure that medical facility staff track the receipt of goods to make certain they are the correct quantity.
9. Conduct an assessment of lessons learned from the emergency response to the pandemic and develop appropriate action plans to integrate oversight roles, responsibilities, and clear guidance into the use of supplemental funds.

VA Management Comments

The under secretary for health concurred with recommendations 3 through 8, stating that the Office of Integrity and Compliance will coordinate with the appropriate entities and subject-matter experts—including VISNs, the assistant under secretary for health for operations, as well as VHA's Office of Support Services and Office of Finance—to implement each of these recommendations by March 2024. Regarding recommendation 9, the under secretary concurred in principle and reported that the Office of Finance will review the key emergent procedures implemented during the pandemic and identify oversight roles and responsibilities to allow guidance for use of future supplemental funds. Appendix E provides the full text of the under secretary's comments.

OIG Response

VHA's comments and corrective action plans are responsive to the intent of the recommendations. The OIG will monitor the implementation of recommendations 3 through 9 until all stated actions are documented as completed.

Appendix A: Scope and Methodology

Scope

The audit team performed its work from September 2021 through December 2022. The audit focused on CARES Act supplemental funds distributed to the medical services fund.[49] The team selected three VISNs to review:

- VISN 8: VA Sunshine Healthcare Network
- VISN 10: VA Healthcare System Serving Ohio, Indiana, and Michigan
- VISN 22: VA Desert Pacific Healthcare Network

To select the VISNs, the audit team used the initial COVID-19 supplemental funds distribution amounts reported by VHA's Office of Finance. The eight medical facilities were selected based on probability proportional to size compared to the total amount spent per medical facility within each of the three VISNs.[50] Details on site selection can be found in appendix B. Within the VISNs, the team selected eight medical facilities to review, as shown in table A.1.

Table A.1. Medical Facilities Reviewed

VISN	Medical facility	Location
8	Bay Pines VA Healthcare System	Bay Pines, FL
8	North Florida/South Georgia Veterans Health System	Gainesville, FL
10	Lieutenant Colonel Charles S. Kettles VA Medical Center	Ann Arbor, MI
10	Cincinnati VA Medical Center	Cincinnati, OH
10	Richard L. Roudebush VA Medical Center	Indianapolis, IN
22	New Mexico VA Health Care System	Albuquerque, NM
22	Phoenix VA Health Care System	Phoenix, AZ
22	Southern Arizona VA Health Care System	Tucson, AZ

Source: VHA facility listing.

[49] VHA received CARES Act funds totaling approximately $17.2 billion. About $14.4 billion in CARES Act funding was distributed to VHA's medical services fund.

[50] Two medical facilities were selected for VISN 8 because the difference in the overall expenditures at each medical facility in the VISN was low, whereas VISNs 10 and 22 had significant differences in their overall expenditures.

Then, the audit team selected three program categories on which to conduct a detailed transaction review:

- 10: Personnel Compensation and Benefits
- 25: Other Contractual Services
- 26: Supplies and Materials

The audit team selected these program categories because when the audit began, VA reported to OMB that these categories composed about 84 percent of obligations and about 86 percent of expenditures for CARES Act funds.

Methodology

The audit team reviewed a statistical sample of 160 COVID-19-related transactions. Of these, journal vouchers accounted for 87 and the remaining 73 were directly obligated to the CARES Act medical services supplemental appropriation.

The audit team reviewed the journal vouchers and any documentation, such as VA's FMS screens, spreadsheets, journal voucher logs, personnel listings, and purchase orders that the medical facility provided. In addition, to assess the remaining 73 transactions, the team reviewed payment documentation such as contracts, invoices, receipts, and authorization documentation. To gain an understanding of the processes and internal controls related to the transactions, the team reviewed federal laws and regulations, prior GAO and OIG reports, VA financial policy, and VHA's COVID-19 Questions and Answers document.

Finally, the audit team conducted multiple interviews with officials from VA's Office of Management, including the assistant secretary for management/CFO, VA's Office of Financial Policy, VHA's Office of the CFO, the VISN CFOs, and the eight medical facility CFOs.

Internal Controls

The audit team assessed VA and VHA's internal controls over the use of CARES Act funds. This included an assessment of five internal control components: control environment, risk assessment, control activities, information and communication, and monitoring.[51] In addition, the team reviewed the principles of internal controls as associated with the objective. The team identified the following three components and five principles as significant to the objective.[52]

[51] GAO, Standards for Internal Control in the Federal Government.

[52] Since the audit was limited to the internal control components and underlying principles identified, it may not have disclosed all internal control deficiencies that may have existed at the time of this audit.

The team identified internal control weaknesses during this audit and proposed recommendations to address the control deficiencies summarized in table A.2.

Table A.2. Internal Control Components and Principles Significant to Using CARES Act Supplemental Funds

Component	Principle	Deficiency identified by this report
Control environment	3. Establish structure, responsibility, and authority	VHA did not clearly communicate authorizations to personnel so that COVID-19 transactions were executed by individuals acting within the scope of their authority.
Control activities	10. Design control activities to achieve objectives and respond to risks	VHA did not ensure duties were segregated, invoices were properly certified and paid, and the receipt of goods was properly tracked.
	11. Design activities for the information system	VA's core financial system, FMS, does not have the functionality to directly process transactions that use supplemental appropriations.
	12. Implement control activities through policy	VHA did not establish policy for documentation requirements to support the journal vouchers used to document the expenditure transfers.
Monitoring activities	16. Perform monitoring activities	Approximately 100 percent of the transactions reviewed identified at least one internal control error. VHA did not establish ongoing monitoring activities to attempt to mitigate the risk of internal control breakdowns when processing its COVID-19-related transactions.

Source: VA OIG analysis. The principles listed are consistent with the GAO's Standards for Internal Control in the Federal Government.

Fraud Assessment

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

Data Reliability

The audit team used computer-processed data provided by the OIG Data Analysis Division. The data analysis team obtained the data from FMS journal tables for the period from April 2020 through June 2021. The data consisted of all transactions that occurred under the

selected general ledger payment accounts.[53] To test for reliability, the team determined whether any data were missing from key fields, included any calculation errors, or were outside the time frame requested. The team also assessed whether the data contained obvious duplication of records, alphabetic or numeric characters in incorrect fields, or illogical relationships among data elements. Furthermore, the team randomly selected a sample of 10 transactions from the data and compared the fund, organization, cost center, accounting classification code, budget object code, acceptance date, budget fiscal year, and amounts to payment voucher and journal voucher information directly from FMS. Testing of the data disclosed that they were sufficiently reliable to form a population, select a sample of transactions, and project an error rate and monetary amount to the overall population.

Government Standards

The OIG conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that the OIG plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for the findings and conclusions based on audit objectives. The OIG believes the evidence obtained provides a reasonable basis for the findings and conclusions based on the audit objectives.

[53] General ledger accounts selected were 490P, "the paid expenditures to non-federal entities," and 490G, "the paid expenditures to federal entities."

Appendix B: Statistical Sampling Methodology

Approach

To accomplish the objective, the audit team reviewed a statistical sample of COVID-19-related transactions expensed from the CARES Act medical services supplemental appropriation from April 2020 through June 2021. The team used statistical sampling to quantify an error rate for control deficiencies related to the transactions processed for eight medical facilities within VISNs 8, 10, and 22.

Population

The universe of transactions consisted of 56,942 journal lines that

- occurred from April 2020 through June 2021;
- posted to the general ledger payment accounts under the CARES Act medical services supplemental fund;
- belonged to facilities within VISN 8, 10, and 22;
- were within the 10, 25, and 26 program categories; and[54]
- resulted in a net expense of more than $1,000.

To avoid selecting duplicate transactions, journal lines with the same transaction characteristics were combined to account for adjustments that were made to the transaction after it was originally posted to the financial system.[55] This resulted in 55,755 unique transactions totaling $1,132,634,461. Table B.1 identifies the unique transactions by VISN, and the total dollar amount expensed.

Table B.1. Adjusted Population

VISN	Unique transactions	Total expended
8	21,255	$513,000,000
10	11,760	$238,000,000

[54] A program category is synonymous with object class, which is a categorization of financial obligations and expenditures according to the nature of the services or items purchased as defined in OMB Circular A-11. Program category 10 is used for personnel, compensation, and benefits; 25 is used for other contractual services; and program category 26 is used for supplies and materials.

[55] The transaction characteristics the audit team used to identify the population of unique transactions are Trans_Number, Trans_Line, Trans_Code, REF_Trans_Code, REF_Trans_Number, and REF_Trans_Line.

VISN	Unique transactions	Total expended
22	22,740	$382,000,000
Totals	**55,755**	**$1,133,000,000**

Source: OIG statistical analysis performed in consultation with the statistician.
Note: Numbers were rounded.

Sampling Design

The audit team used a two-stage sample design to select eight medical facilities within three judgmentally selected VISNs and unique transactions at each of the eight medical facilities within three program categories.

In stage 1, the audit team selected medical facilities using probability proportional to size to the aggregate expensed amount at each medical facility within each VISN. There were a total of 26 medical facilities among the three VISNs and the OIG selected eight: two from VISN 8 and three each from VISNs 10 and 22.

In stage 2, the OIG selected unique transactions from three program categories at each medical facility. At least 20 unique transactions were selected per medical facility as shown in table B.2.

Table B.2. Unique Transactions and Sample Size by Strata

VISN	Medical facilities	Budget object classification	Unique transactions	Sample size
8	Bay Pines VA Healthcare System	10: Personnel Compensation and Benefits	1,486	7
		25: Other Contractual Services	80	9
		26: Supplies and Materials	685	7
	North Florida/South Georgia Veterans Health System	10: Personnel Compensation and Benefits	1,304	7
		25: Other Contractual Services	43	6
		26: Supplies and Materials	368	7
10	Lieutenant Colonel Charles S. Kettles VA Medical Center	10: Personnel Compensation and Benefits	932	7
		25: Other Contractual Services	20	6
		26: Supplies and Materials	633	7
	Cincinnati VA Medical Center	10: Personnel Compensation and Benefits	545	7
		25: Other Contractual Services	5	5
		26: Supplies and Materials	292	8
	Richard L. Roudebush VA Medical Center	10: Personnel Compensation and Benefits	1,374	7
		25: Other Contractual Services	14	6
		26: Supplies and Materials	230	7
22	New Mexico VA Health Care System	10: Personnel Compensation and Benefits	1,157	7
		25: Other Contractual Services	712	6
		26: Supplies and Materials	506	7
	Phoenix VA Health Care System	10: Personnel Compensation and Benefits	570	7
		25: Other Contractual Services	353	6
		26: Supplies and Materials	647	7
	Southern Arizona VA Health Care System	10: Personnel Compensation and Benefits	3,723	8
		25: Other Contractual Services	1,523	6
		26: Supplies and Materials	194	7
	Total		**17,396**	**164***

Source: OIG statistical analysis performed in consultation with the statistician.

** Four of the selected transactions were determined to be outside of the scope of this audit.*

Weights

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

For the two-stage design, the sampling weight for each encounter is the product of the following:

- Stage 1. The selection factor for each of the eight sampled medical facilities of the 26 total medical facilities, selected in proportion to the aggregate expensed amount at each medical facility within each VISN.
- Stage 2. The selection factor based on the selection probability for each unique transaction randomly selected from the three program categories at each medical center.

Projections and Margins of Error

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

The OIG statistician employed statistical analysis software to calculate the weighted population estimates and associated sampling errors. This software uses replication or Taylor series approximation methodology to calculate margins of error and confidence intervals that correctly account for the complexity of the sample design.

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

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

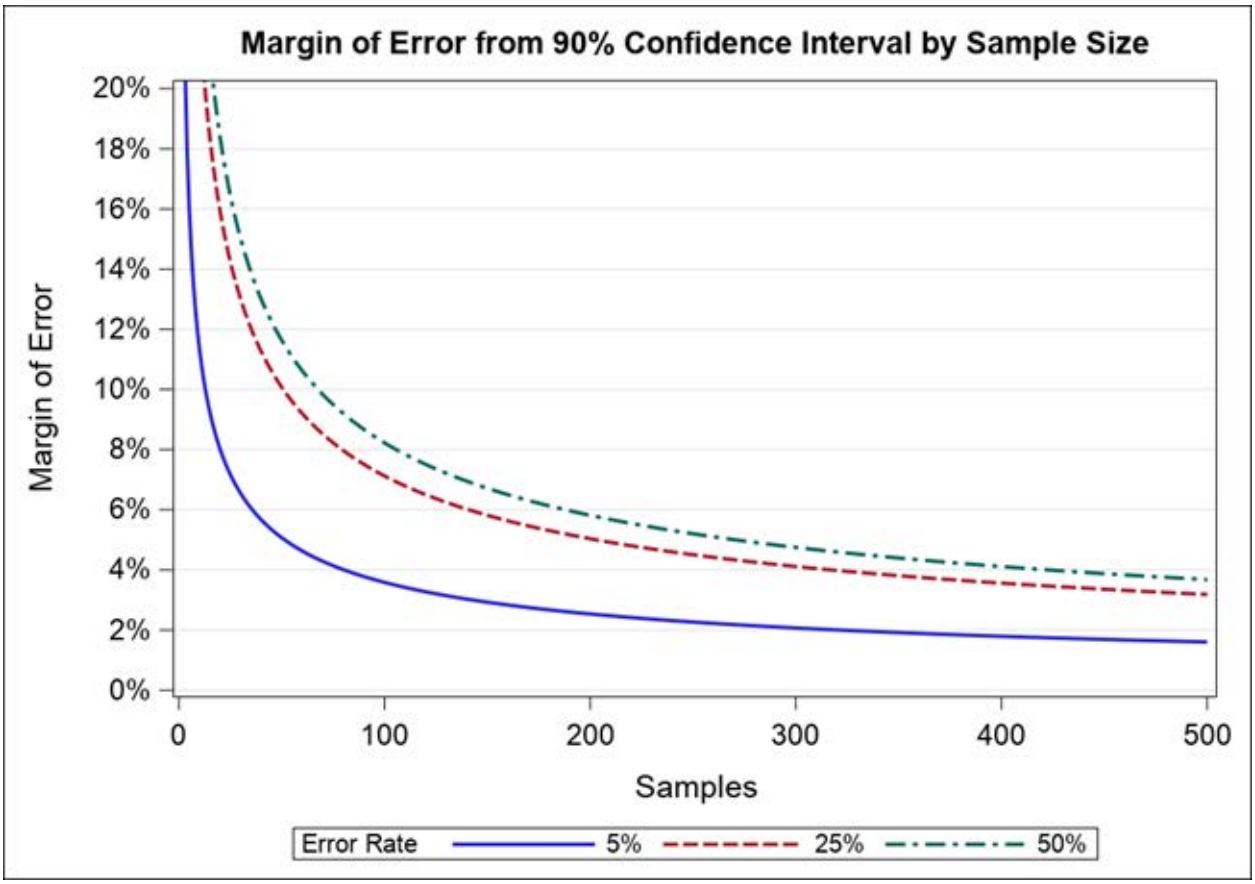

Figure B.1. *Effect of sample size on margin of error.*

Source: VA OIG statistician's analysis.

Projections

The following tables present projections from the sample results, including the estimate, margin of error, lower 90 percent value, and upper 90 percent value. Table B.3 summarizes the statistical projections and the confidence intervals for the count and percentage of unique transactions in VISNs 8, 10, and 22 that align with the audit scope.

Table B.3. Unique Transactions Statistical Projections Summary

Estimate name	Estimate number	90 percent confidence interval			Sample size
		Margin of error	Lower limit	Upper limit	
In-scope transactions	54,673 (98.1%)	1,668 (1.9%)	53,005 (95.1%)	56,341 (100%)	160

Source: OIG statistical analysis performed in consultation with the statistician.

Table B.4 summarizes the statistical projections and the confidence intervals for the count and percentage of manual expense transfers and other transactions in VISNs 8, 10, and 22 that align with the audit scope.

Table B.4. Unique Transactions Statistical Projections

Estimate name	Estimate number	90 percent confidence interval			Sample size	Total sample
		Margin of error	Lower limit	Upper limit		
Manual expenditure transfers	44,609 (81.6%)	1,761 (1.2%)	42,848 (80.4%)	46,370 (82.8%)	87	160
All other transactions	10,064 (18.4%)	563 (1.2%)	9,501 (17.2%)	10,627 (19.6%)	73	160

Source: OIG statistical analysis performed in consultation with the statistician.

Table B.5 summarizes the statistical projections and the confidence intervals for the count and percentage of other transactions in VISNs 8, 10, and 22 that had at least one control error, and lacked proper authorization and segregation of duties.

Table B.5. All Other Transactions Statistical Projections

Estimate name	Estimate number	90 percent confidence interval			Samples in error	Total sample
		Margin of error	Lower limit	Upper limit		
At least one control error	10,064 (100%)	563 (0%)	9,501 (100%)	10,627 (100%)	73	73
Lack of proper authorization	9,311 (92.5%)	670 (3.6%)	8,641 (88.9%)	9,981 (96.2%)	63	73
Lack of segregation of duties	4,340 (43.1%)	1,047 (9.8%)	3,293 (33.3%)	5,387 (53.0%)	30	73

Source: OIG statistical analysis performed in consultation with the statistician.

Table B.6 summarizes the statistical projections and the confidence intervals for the monetary estimates for VISNs 8, 10, and 22 that were determined to be in scope for this audit.

Table B.6. Monetary Estimates Statistical Projections

Estimate name	Estimate number	90 percent confidence interval			Samples in error
		Margin of error	Lower limit	Upper limit	
Questioned costs	$187,164,331	$81,991,310	$105,173,021	$269,155,641	73

Source: OIG statistical analysis performed in consultation with the statistician.

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

Recommendations	Explanation of Benefits	Better Use of Funds	Questioned Costs
4–9	The OIG determined that VHA lacked general controls over its medical facilities' COVID-19 medical supply purchases and contracted services.	$0	$187,200,000
	Total	**$0**	**$187,200,000**

Appendix D: VA Management Comments, Assistant Secretary for Management and Chief Financial Officer

Department of Veterans Affairs Memorandum

Date: February 27, 2023

From: Assistant Secretary for Management and Chief Financial Officer (004)

Subj: Draft Report, VHA Can Improve Controls Over Its Use of Supplemental Funds (project number 2021-03101-AE-0149)

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

1. Thank you for the opportunity to review the Office of Inspector General (OIG) draft report on VHA Can Improve Controls Over Its Use of Supplemental Funds. OIG assigned one recommendation to the Assistant Secretary for Management and Chief Financial Officer. The Office of Management (OM) concurs with the finding and recommendation. OM's action plan is attached.

The OIG removed point of contact information prior to publication.

(Original signed by)

Jon J. Rychalski

Attachment

ASSISTANT SECRETARY FOR MANAGEMENT AND CHIEF FINANCIAL OFFICER
Action Plan
VHA Can Improve Controls Over Its Use of Supplemental Funds
(Project number 2021-03101-AE-0149)

Recommendation 1. Assess the iFAMS configuration to determine whether integration with the payroll subsystems can be accomplished to resolve some of the payroll-related issues that require the need for expenditure transfers.

Concur. Integration is possible as described in this Action Plan, but there are multiple systems and complexities that need to be addressed to achieve the functionality envisioned in the recommendation. We agree with the Office of Inspector General's assessment that doing so will greatly strengthen our financial controls and are committed to achieving that outcome. Realistically, the timeframe could be several years for reasons illustrated below.

The Integrated Financial and Acquisition Management System (iFAMS) has the functionality to integrate with, and support labor distribution when payroll and time and attendance systems are updated to capture the allocation of time to multiple funding lines. The development of iFAMS labor distribution capabilities relies entirely on upgrading subsidiary systems such as VATAS, HR Smart and DCIPS.

The Department is committed to collaborating with all stakeholders of these systems to develop interfaces for an end-to-end automated solution by September 2030.

Status: Completed Target Completion Date: Request Closure

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

Appendix E: VA Management Comments, Under Secretary for Health

Department of Veterans Affairs Memorandum

Date: March 15, 2023

From: Under Secretary for Health (10)

Subj: OIG Draft Report, VHA Can Improve Controls Over Its Use of Supplemental Funds (2021-03101-AE-0149) (VIEWS 9676228)

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

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report, "VHA Can Improve Controls Over Its Use of Supplemental Funds."
2. The Coronavirus Aid, Relief, and Economic Security (CARES) Act medical appropriation was a one-time funding that supported the Veterans Health Administration's (VHA) emergency response to the coronavirus (COVID-19) pandemic. VHA experienced unforeseeable demands during the COVID-19 emergency, and the well-being of Veterans continued to be our top priority. In that environment of unprecedented urgency, medical facilities made prompt decisions regarding CARES Act funding to prevent delays in delivering health care. VHA understands its emergency responsiveness may have resulted in documentation gaps and appreciates OIG's post-pandemic retrospective audit of the use of supplemental funds.
3. The Assistant Secretary for Management and Chief Financial Officer is responsible for recommendation 1 and the action plan is attached. The VHA concurs with recommendations 3 through 8 and concurs in principle with recommendations 2 and 9, which is further explained in the attached VHA action plan.
4. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at [redacted]. Thank you again for partnering with VHA to ensure our Veterans receive the high-quality health care they deserve.

The OIG removed point of contact information prior to publication.

(Original signed by)

Shereef Elnahal, M.D., MBA

Attachments

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan
VHA Can Improve Controls Over Its Use of Supplemental Funds
2021-03101-AE-0149

Recommendation 2. Establish guidance that outlines the type of documentation required to support the amounts identified in the manual journal vouchers when processing expenditure transfers.

VHA Comments: Concur in Principle. VHA takes these documentation needs seriously and, while it is not feasible to establish guidance related to every transaction related to the multitude of expenditure transfers that are available for processing within the current financial system, VHA's Office of Finance (VHA Finance) will identify guidance with standardized supporting documentation based on VA Financial Policy Vol. I Chapter 9 (Expenditure Transfers) and Vol. II Chapter 1A (Journal Vouchers) for the categories of salaries for full-time employee equivalent and supplies and materials. This guidance will allow for alternate documentation when appropriate.

Status: In progress Target Completion Date: October 2023

Recommendation 3. Ensure medical facility staff have documented authority, through proper delegation, to make purchases.

VHA Comments: Concur. The Office of Integrity and Compliance (OIC) will coordinate with VHA's Assistant Under Secretary for Health for Operations, Veterans Integrated Service Networks (VISNs) and appropriate subject-matter experts in VHA Finance to ensure medical facility staff have documented authority, through proper delegations, to make purchases in compliance with VA Financial Policy Vol. XVI Chapter 1A (Administrative Actions for Government Purchase Cards) and Vol. XVI Chapter 1B (Government Purchase Card for Micro-Purchases) regarding delegations associated with purchases.

Status: In progress Target Completion Date: March 2024

Recommendation 4. Verify that medical facility staff segregate duties so that the same person is not both authorizing and receiving goods and services.

VHA Comments: Concur. OIC will coordinate with VHA's Assistant Under Secretary for Health for Operations, VISNs and appropriate subject-matter experts in VHA Finance to ensure medical facility staff have received appropriate training and are segregating duties so that the same person is not both authorizing and receiving goods and services in compliance with VA Financial Policy Vol. XVI Chapter 1B (Government Purchase Card for Micro-Purchases).

Status: In progress Target Completion Date: March 2024

Recommendation 5. Make certain the purchase card holder is not the requestor or approver for the purchase.

VHA Comments: Concur. OIC will coordinate with VHA's Assistant Under Secretary for Health for Operations, VISNs, VHA's Office of Support Services- and appropriate subject-matter experts in VHA Finance to ensure medical facility staff who are purchase card holders have received appropriate training and are not the requestor or approver for purchases in compliance with VA Financial Policy Vol. XVI Chapter 1B (Government Purchase Card for Micro-Purchases).

Status: In progress Target Completion Date: March 2024

Recommendation 6. Ensure contracting officer's representatives know and understand their duties and responsibilities for the certification and payment of invoices.

VHA Comments: Concur. OIC will coordinate with VHA's Assistant Under Secretary for Health for Operations, VISNs, VHA's Office of Support Services, appropriate subject-matter experts in VHA Finance and other relevant program offices to ensure contracting officer's representatives know and understand their duties and responsibilities for the certification and payment of invoices.

Status: In progress Target Completion Date: March 2024

Recommendation 7. Check vendors' compliance with contract terms to include the comparison of invoiced amounts with the contract line-item unit costs.

VHA Comments: Concur. OIC will coordinate with VHA's Assistant Under Secretary for Health for Operations, VISNs and appropriate subject member experts in VHA Finance to ensure medical facility staff have received appropriate training and are complying with VA Financial Policy Vol. II, Chapter 5 (Obligations Policy), Vol. VIII Chapter 1A (Invoice Review and Certification) and Vol. XVI, Chapter 1B (Government Purchase Card for Micro-Purchases) with respect to contract terms.

Status: In progress Target Completion Date: March 2024

Recommendation 8. Ensure that medical facility staff track the receipt of goods to make certain they are the correct quantity.

VHA Comments: Concur. OIC will coordinate with VHA's Assistant Under Secretary for Health for Operations and VHA Finance to ensure medical facility staff are appropriately trained and comply with VA Financial Policy Vol. V Chapter 8 (Inventories, Materials, and Supplies) regarding tracking the receipt of goods.

Status: In progress Target Completion Date: March 2024

Recommendation 9. Conduct an assessment of lessons learned from the emergency response to the pandemic and develop appropriate action plans to integrate oversight roles, responsibilities, and clear guidance into the use of supplemental funds.

VHA Comments: Concur in principle. During an emergency, VHA's priority is to save Veteran lives and ensure the safety of its employees. VHA Finance will review the key emergent procedures implemented during the pandemic and identify oversight roles and responsibilities to allow guidance for use of future supplemental funds.

Status: In progress Target Completion Date: March 2024

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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