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Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Financial Efficiency Inspection of the VA Tampa Healthcare System

Financial Inspection	**24-00103-27**	**February 13, 2025**

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Executive Summary

The VA Office of Inspector General (OIG) conducted this inspection to assess the oversight and stewardship of funds by the VA Tampa Healthcare System and to identify potential cost efficiencies in carrying out healthcare system functions.[1] To determine whether the healthcare system had appropriate controls and oversight in place, the OIG inspection team identified four financial activities and administrative processes that draw on considerable VA resources and made recommendations to promote the responsible use of VA's appropriated funds: (1) use of managerial cost accounting information, (2) open obligations oversight, (3) purchase card use and oversight, and (4) supply chain management operations.[2]

What the Inspection Found

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

Use of managerial cost accounting information. Obligations at the healthcare system grew from about $1.4 billion in fiscal year (FY) 2021 to just under $1.8 billion in FY 2023, an increase of more than $326.4 million (about 23 percent).[3] The inspection team reviewed the healthcare system's FY 2023 monthly budget reports, which showed the healthcare system used financial information to compare budgeted amounts to actual results as described in VA policy.

The inspection team determined that the healthcare system could use managerial cost accounting information more effectively to help make financial decisions and improve its performance measurement process for identifying and correcting cost inaccuracies. Although the healthcare system generally had processes in place for the use of managerial cost accounting information, the healthcare system's chief financial officer said the finance office does not use these data in its daily operations. Instead, the data are used to assist in preparing the annual budget and to assess requests for additional staffing. Last, the team found the healthcare system does not compare costs of similar products within the healthcare system. Comparing costs of similar products could help identify causes for cost differences, which can help reduce costs and avoid waste.

Open obligations oversight. Open obligations can be either undelivered orders or delivered unpaid orders, known as accruals. The inspection team evaluated whether the healthcare system followed VA policy by performing monthly reviews and reconciliations of sampled open

[1] The VA Tampa Healthcare System serves veterans at 20 locations in central Florida. Facilities include the James A. Haley Veterans' Hospital in Tampa and 16 community-based outpatient clinics in locations such as Brooksville, Hidden River, Lakeland, Lecanto, New Port Richey, South Hillsborough, and Zephyrhills.

[2] For more information about the inspection's scope and methodology, see appendix A. For more information about the statistical methods, see appendix B.

[3] Numbers do not sum due to rounding. In this case, the healthcare system's obligations were $1,425,950,015.16 in FY 2021 and $1,752,396,815.53 in FY 2023, representing an increase of $326,446,800.37.

obligations to ensure they were valid and should remain open and to reconcile end dates and order amounts between the VA Financial Management System (FMS) and the Integrated Funds Distribution, Control Point Activity, Accounting and Procurement System (IFCAP).[4] The OIG found the healthcare system did not always perform monthly reviews and deobligate funds that were no longer needed.[5] Furthermore, it appeared that the healthcare system used funds from the wrong fiscal year to pay for services, which may have violated the "bona fide needs" rule.[6] Additionally, the team reviewed FMS-to-IFCAP reconciliations and found that the end dates and order amounts generally matched. The team estimated that $6.3 million in open obligations was invalid due to the healthcare system's lack of monthly follow-up and reconciliations.[7] The team estimated $5.9 million in invalid obligations should have been deobligated and could have been put to better use.[8]

Purchase card use and oversight. VA's Government Purchase Card Program was established to reduce administrative costs related to the acquisition of goods and services. The team examined whether healthcare system staff complied with purchase card program policies and procedures and considered the use of a contract for frequently purchased goods or services—a process known as strategic sourcing—to provide optimal savings to VA. The inspection team

[4] Open obligations include those obligations that are not considered closed or complete and that have a balance associated with them, whether undelivered or unpaid. Both of the systems the OIG team used for its evaluation, FMS and IFCAP, are accounting systems. FMS is considered the primary accounting system for VA. All accounting transactions record in FMS, but not all transactions record in IFCAP. Finance is the only service that has the ability to perform transactions in FMS, and it is considered to contain the most current, accurate information for monitoring and reporting purposes. IFCAP, also referred to as VistA, is considered the "front end" of the accounting system—automating the creation, approval, forwarding, monitoring, and payment of requests for supplies and services. Each day FMS interfaces with IFCAP, passing along accounting activity in the form of fund control point balance adjustment. A transaction's end date, which is critical to determining whether an obligation should remain open, may be modified due to delays or scope changes. The modification might not be consistently recorded in both systems because staff can manually change end dates in one system without changing them in the other. VA Financial Policy, "Obligation," in vol. 2, *Appropriations, Funds and Related Information* (May 2023), chap. 5. In March 2024, the Office of Finance moved this policy from vol. 2, chap. 5 to vol. 3, chap. 2. The team determined this change did not affect the policy requirements relevant to the financial inspection.

[5] Deobligation means a cancellation or downward adjustment of previously incurred obligations. VA Financial Policy, "Obligation."

[6] 31 U.S.C. § 1502(a). The "bona fide needs" rule states that an appropriation may only be obligated to meet a legitimate need arising during the appropriation's period of availability.

[7] The inspection team considered obligations invalid when the healthcare system confirmed that the residual funds were no longer needed or could not provide documentation that services were still needed. This amount included an estimated $6 million from invalid accruals, residual obligations totaling more than $162,000 due to end-date discrepancies, and just under $191,000 from amount discrepancies—which brought the total amount to an estimate of more than $6.3 million.

[8] The better use of funds is related to various open obligation monitoring and administrative deficiencies identified in the sampled obligations. This amount includes an estimated $5.6 million from accruals, undelivered orders totaling more than $162,000 due to end-date discrepancies, and just under $191,000 from amount discrepancies—which brought the total monetary benefits to an estimate of more than $5.9 million. Numbers do not sum due to rounding. For more information about the monetary benefits, see appendix C.

reviewed a statistical sample of 46 purchase card transactions from November 1, 2022, through October 31, 2023, (totaling about $677,000) and determined whether these transactions were processed in compliance with VA policy concerning prior approvals, prompt reconciliations, record retention, and segregation of duties.[9] The team found violations involving lack of prior approvals, lack of supporting documentation, and lack of segregation of duties.

Cardholders and approving officials did not always ensure compliance throughout the transaction process or fulfill roles and responsibilities in accordance with VA policy. The inspection team also assessed whether the healthcare system maintained accurate VA 0242 forms, which are used to delegate authority for an individual to use a VA purchase card; the healthcare system was able to provide completed copies for each cardholder in the inspection sample.[10]

Supply chain management operations. Supply chain management integrates people, processes, and systems for the management of product and service planning, sourcing, purchasing, delivery, receiving, and disposal. Veterans Health Administration (VHA) policy requires healthcare systems to establish, operate, and maintain a supply chain management program that is effective, cost-efficient, transparent, and responsive to customer requirements and to continually identify ways to ensure high-quality veteran care. The inspection team evaluated whether the healthcare system managed supply chain operations effectively, maintained accurate inventory data, and met the days-of-stock-on-hand performance metric—a nationally set level of inventory for expendable items both within and outside the Medical Surgical Prime Vendor (MSPV) program.[11]

The team found the healthcare system did not meet the days-of-stock-on-hand metric or maintain accurate supply chain data. Establishing local processes and procedures for the timely review of data to detect and correct data errors would increase the reliability of inventory data and help ensure metrics are met. The healthcare system and the Strategic Acquisition Center also did not fulfill their duties to ensure that MSPV ordering officers and a facility contracting officer's representative (COR) were nominated and delegated to ensure the MSPV program achieved its goals and objectives and effectively safeguarded the government's interests and resources.

What the OIG Recommended

The OIG made 12 recommendations for improvement to the healthcare system director. The intent is for system leaders to use these recommendations as a road map to improve financial

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

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

[11] VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020. The MSPV program is a national program providing a customized distribution system to meet or exceed facility requirements through an efficient, cost-effective, just-in-time distribution catalog ordering process.

operations. The recommendations address issues that, if left unattended, may eventually interfere with the healthcare system's financial efficiency and stewardship of VA resources.

The OIG recommended that the healthcare system medical center director establish a plan to use VA's managerial cost accounting system to identify additional ways to reduce costs, enhance efficiency, and inform business decisions and to ensure the healthcare system has a process to identify cost outliers, such as using the Intermediate Product Cost Outlier report to identify cost outliers that may occur at the healthcare system on a regular basis. The director should also ensure healthcare system service lines update the national labor mapping tool and report workload to the Veterans Integrated Service Network (VISN) 8 managerial cost accounting team in a timely manner.

To strengthen the review of open obligations, the director should ensure healthcare system staff comply with policy requirements. The responsible finance office should review all open obligations to ensure balances are valid and should remain open or are closed in a timely manner to ensure funds are used in the manner intended by Congress and as required by VA financial policy. The director should also consult with the Office of General Counsel and the Office of Acquisitions, Logistics, and Construction to determine whether a bona fide needs or other appropriations law violation occurred and, if so, take appropriate remedial and preventive actions to address those violations.

Related to purchase card transactions, the director should establish controls to confirm approving officials and cardholders review purchases for VA policy compliance and pursue strategic sourcing for ongoing or repetitive purchases.

For supply chain management, the OIG recommended the director implement a plan to ensure data accuracy and reliability in the Generic Inventory Package, monitor performance metrics in accordance with VHA policy, and develop and maintain an effective standardized training program for new and current inventory staff.

Finally, the OIG recommended that the healthcare system director, in coordination with the Strategic Acquisition Center associate executive, ensure that ratifications for unauthorized commitments are submitted in accordance with the Federal Acquisition Regulation and ensure that the facility-level MSPV COR and ordering officers are appointed and delegated appropriately and perform all required duties according to the scope and limitation of the designee's authority.

VA Management Comments and OIG Response

The director of the Tampa VA Healthcare System concurred with recommendations 1 through 12. Corrective action plans were provided for all recommendations. The director of the healthcare system reported the actions for three recommendations were completed during October, November, and December 2024. However, no evidence or supporting documentation

was provided for the OIG to evaluate. The OIG considers all recommendations open. The proposed corrective measures in the action plans appear responsive to the recommendations, and the OIG will monitor their implementation until all stated actions are documented as completed. Comments from the healthcare system director are presented in appendix D.

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Contents

Abbreviations

COR	contracting officer's representative
FMS	Financial Management System
FY	fiscal year
IFCAP	Integrated Funds Distribution, Control Point Activity, Accounting and Procurement System
MSPV	Medical Surgical Prime Vendor
OIG	Office of Inspector General
SCCOP	Supply Chain Common Operating Picture
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducts financial efficiency inspections to assess stewardship and oversight of funds at VA healthcare systems and to identify opportunities to achieve cost efficiencies. Inspection teams identify and examine financial activities that are under the healthcare system's control and can be compared to healthcare systems similar in size and complexity across VA to promote best practices.[12]

This inspection focused on the VA Tampa Healthcare System. The OIG assessed four financial activities and administrative processes to determine whether appropriate controls and oversight were in place during fiscal year (FY) 2023. The managerial cost accounting review also covered FYs 2021 and 2022.

I. **Use of managerial cost accounting information.** Managerial cost accounting identifies, measures, and analyzes cost information to help managers make informed decisions about allocating federal resources, authorizing and modifying programs, and evaluating program performance. The inspection team evaluated how healthcare system officials used VA's managerial cost accounting system to identify the cost of goods and services, review workload data, identify alternatives to reduce costs, enhance efficiency, and make effective business decisions. If healthcare system officials do not consistently use reliable and timely cost information for these purposes, they increase the risk that resources are not used efficiently.

II. **Open obligations oversight.** An obligation is a legally binding commitment of appropriated funds for goods or services.[13] Open obligations include those that are not considered closed or complete and that have a balance associated with them. They can be either undelivered orders or delivered unpaid orders, which are known as accruals.[14] VA financial policy requires all finance offices with open obligations to perform monthly reviews to ensure that their obligations are valid, beginning and ending dates are accurate, and open and accrued balances are accurate and agree with source documents,

[12] The Veterans Health Administration (VHA) uses a facility complexity model that classifies its facilities at levels 1a, 1b, 1c, 2, or 3, with level 1a being the most complex and level 3 being the least complex. The VA Tampa Healthcare System is rated as a 1a high-complexity facility, meaning it has the largest levels of volume, patient risk, and teaching and research, and it contains a level 5 intensive care unit.

[13] VA Financial Policy, "Obligation," in vol. 2, *Appropriations, Funds, and Related Information* (September 2021 and April 2022), chap. 5. The Office of Finance moved this policy from vol. 2, chap. 5 to vol. 3, chap. 2 in March 2024. The team determined this change did not affect the policy requirements relevant to the financial inspection.

[14] Undelivered orders are supplies and services that have been approved and awarded on an obligation but have not been delivered to or accepted by the government. This includes any orders for which advance payment has been made, but delivery or performance has not yet occurred. Delivered unpaid orders occur when goods and services are ordered and have been received, but payment has not been made.

such as contracts, purchase orders, receiving reports, invoices, and payment records.[15] VA is also required to deobligate stale obligations not established by a contracting officer unless the requesting office can demonstrate that the obligations are valid and should remain open.[16] For those obligations established by a contracting officer, the requesting office must coordinate necessary actions to deobligate funds with the logistics and procurement offices. The inspection team evaluated whether the healthcare system performed monthly reviews and reconciliations of sampled obligations to ensure valid balances and prompt deobligation of excess funds. When excess funds are not deobligated in a prompt manner, the risk increases that unused funds will not be reallocated for other goods and services to benefit veterans. Furthermore, failure to properly manage accruals may lead to misstatements in VA's annual financial statements.

III. **Purchase card use and oversight.** VA's Government Purchase Card Program was established to reduce administrative costs related to the acquisition of goods and services. The inspection team examined whether healthcare system staff complied with purchase card program policies and procedures and considered the use of contracts for frequently purchased goods or services, which is an aspect of strategic sourcing.[17] When used properly, purchase cards can help healthcare systems simplify acquisition procedures and provide an efficient vehicle for obtaining goods and services directly from vendors. Documenting transactions as required helps VA and other oversight authorities identify potential fraud, waste, and abuse—while using contracts for common purchases has several benefits, such as allowing VA to leverage purchasing power and obtain competitive pricing.

IV. **Supply chain management operations.** Supply chain management integrates people, processes, and systems to manage the sourcing, purchasing, delivery, and receiving of products and services. Veterans Health Administration (VHA) policy requires medical facilities to establish, operate, and maintain a supply chain management program that is effective, cost-efficient, transparent, and responsive to customer requirements and to continually identify ways to ensure high-quality veteran care.[18] The inspection team evaluated whether the healthcare system managed supply chain operations effectively, maintained accurate inventory data, and met the days-of-stock-on-hand performance

[15] VA Financial Policy, "Obligation."

[16] A stale obligation is more than 90 days beyond the period of performance end date or has had no activity in the past 90 days. The period of performance, also referred to as start and stop dates, refers to the period when the terms and conditions of an obligation remain in effect. The term "requesting office" is used to encompass the individual or program office that initiated the request for the obligation.

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

[18] VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020, p. 6.

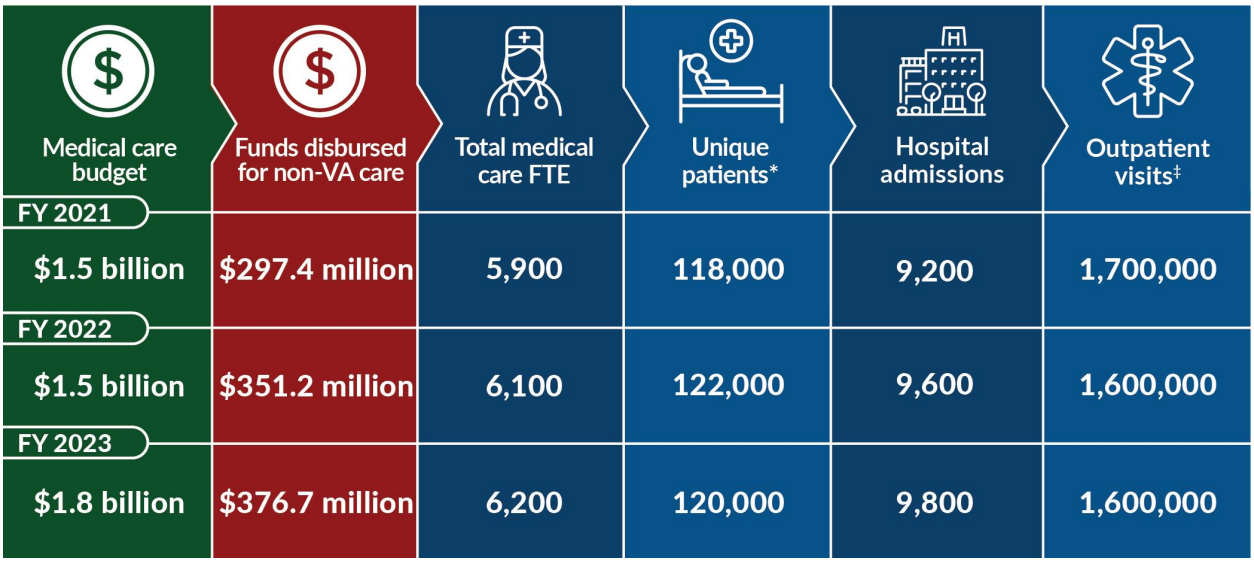
metric—a nationally set level of inventory for expendable items both inside and outside the Medical Surgical Prime Vendor (MSPV) program.[19] Unreliable inventory data can lead to the purchase of unnecessary supplies, overstocking, and spoilage. Overstocking increases the risk that inventory items will become damaged, outdated, contaminated, or obsolete. It also is an inefficient use of financial resources because more inventory is purchased and stored than is required. More importantly, inaccurate records that indicate supplies are available when they are not could adversely affect the healthcare system's ability to effectively plan its supply purchases and meet patient care needs.

Facility Profile

The VA Tampa Healthcare System, part of Veterans Integrated Service Network (VISN) 8, serves veterans at 20 locations in central Florida.[20] Facilities include the James A. Haley Veterans' Hospital in Tampa and 16 community-based outpatient clinics in locations such as Brooksville, Hidden River, Lakeland, Lecanto, New Port Richey, South Hillsborough, and Zephyrhills. The healthcare system also operates two mobile clinics in the Tampa area. The VA Tampa Healthcare System has academic affiliations with several educational institutions and associated health training in nursing, psychology, audiology, social work, dietetics, and pharmacy. Figure 1 provides general background information for this 1a high-complexity level healthcare system.

[19] The MSPV program is a national program providing a customized distribution system to meet or exceed facility requirements through an efficient, cost-effective, just-in-time distribution catalog ordering process.

[20] VHA divides the United States into 18 Veterans Integrated Service Networks (VISNs), regional systems that work together to meet local healthcare needs and provide greater access to care.



	Medical care budget	Funds disbursed for non-VA care	Total medical care FTE	Unique patients*	Hospital admissions	Outpatient visits‡
FY 2021	$1.5 billion	$297.4 million	5,900	118,000	9,200	1,700,000
FY 2022	$1.5 billion	$351.2 million	6,100	122,000	9,600	1,600,000
FY 2023	$1.8 billion	$376.7 million	6,200	120,000	9,800	1,600,000

Figure 1. *Facility profile for VA Tampa Healthcare System, FYs 2021–2023.*

Source: VA OIG analysis of data from the VHA Support Service Center, Trip Pack Operational Statistics report.

** Unique patients include VA and non-VA patients but exclude pharmacy-only patients.*

‡ Outpatient visits exclude non-VA care visits.

Note: The medical care budget was $1,456,654,948 for FY 2021 and $1,515,890,838 for FY 2022; however, they appear to be the same due to rounding. FTE is full-time equivalent positions. This category includes both direct medical care FTE positions in budget object code 1000–1099 (Personal Services) and all cost centers. The inspection team did not assess VA's data for accuracy or completeness.

Facility Selection

The inspection team evaluated data from the VHA Office of Productivity, Efficiency, and Staffing's efficiency opportunity grid to identify healthcare systems with the greatest potential for financial efficiency improvements. VHA developed the efficiency opportunity grid, a collection of 12 statistical models, to give facility leaders insight into areas of opportunity for improving efficiency. The grid allows users to compare VHA facilities by adjusting data for variations in patient attributes, facility characteristics, and geography. The grid also describes possible inefficiencies and areas of success by showing the difference between a facility's actual and expected costs. The team used facility rankings from the grid's stochastic frontier analysis model to select healthcare systems for financial efficiency inspections.[21] The inspection, which was limited in scope and not intended to be a comprehensive inspection of all financial

[21] Stochastic frontier analysis is a modeling principle used to estimate the optimal or minimum cost (or other input) after controlling for risks and random factors for each VA medical center given a set of outputs and output characteristics. Based on the minimum cost, an efficiency score is derived for each facility; an efficiency score of 1 is most efficient, and values greater than 1 are associated with increasing inefficiency.

operations at the VA Tampa Healthcare System, aimed to recommend opportunities for process improvement, greater efficiencies, and more responsive use of appropriated funds.

Results and Recommendations

I. Use of Managerial Cost Accounting Information

VA financial policy says managerial cost accounting should be a fundamental part of the department's overall financial management system and should provide information to support process and performance improvement by measuring quality, outcomes, and financial impact.[22] The policy also requires that VA cost accounting provide the information necessary to accomplish objectives associated with planning, decision-making, and reporting in accordance with federal financial accounting standards.[23]

Managers should measure and analyze cost information to make informed operational decisions and meet the objectives of their organizations. Standards from the Federal Accounting Standards Advisory Board require that each reporting entity collect and report the cost of its activities on a regular basis for management information purposes.[24] VA policy reflects these standards and states that administrations and staff offices will establish a plan to align financial management practices with federal financial accounting standards and utilize cost accounting information to measure performance, budgeting, cost control and reduction, as well as enhance efficiency, establish pricing of services, and make informed business decisions.[25] For VA, this applies to critical decisions regarding veteran care, such as deciding whether to expand services at VA facilities rather than relying on community care. If healthcare system officials fail to consider reliable and timely cost information for these purposes, they increase the risk of inefficient use of resources, waste, and decreased quality of care for patients.

[22] VA Financial Policy, "Managerial Cost Accounting," in vol. 13, *Cost Accounting* (December 2019), chap.3.

[23] Federal Accounting Standards Advisory Board, *Statement of Federal Financial Accounting Standards 4: Managerial Cost Accounting Standards and Concepts* in FASAB Handbook of Federal Accounting Standards and Other Pronouncements, as amended, version 21 (June 30, 2022).

[24] Federal Accounting Standards Advisory Board, *Statement of Federal Financial Accounting Standards 47*. An entity's managers are responsible for controlling and deploying resources, producing outputs and outcomes, and executing the budget or a portion thereof (assuming the entity is included in the budget), and are held accountable for the entity's performance.

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

The inspection team reviewed the following related areas:

- **Obligation trends.** The team reviewed obligation amounts recorded in the Financial Management System (FMS) to identify trends and areas of significant obligation.
- **Healthcare system internal reporting.** The team reviewed cost and performance reports used for planning, budgeting, cost reduction, efficiency improvement, and comparison of budgeted amounts to actual results. The team reviewed documents and interviewed healthcare system personnel to determine whether the healthcare system's use of managerial cost accounting information aligned with federal financial accounting standards and VA financial policy.[26]

Finding 1: The Healthcare System Should Improve Its Use of Managerial Cost Accounting Information

The OIG found that the healthcare system could use managerial cost accounting information more effectively to help make financial decisions and improve its performance measurement process to identify and correct cost inaccuracies. While the healthcare system generally had processes in place for using managerial cost accounting information, the healthcare system's chief financial officer said the finance office does not use this information in its daily operations. Instead, the data are used to assist in preparing the annual budget and to assess requests for additional staffing.

Obligation Trends

According to FMS reports, the healthcare system's obligations grew from about $1.4 billion in FY 2021 to just under $1.8 billion in FY 2023, an increase of about $326.4 million (23 percent) as shown in figure 2.[27]

[26] VA Financial Policy, "Managerial Cost Accounting." For more information about the inspection's scope and methodology, see appendix A. For more information about the inspection's statistical methodology, see appendix B.

[27] Numbers do not sum due to rounding. In this case, the healthcare system's obligations were $1,425,950,015.16 in FY 2021 and $1,752,396,815.53 in FY 2023, representing an increase of $326,446,800.37.

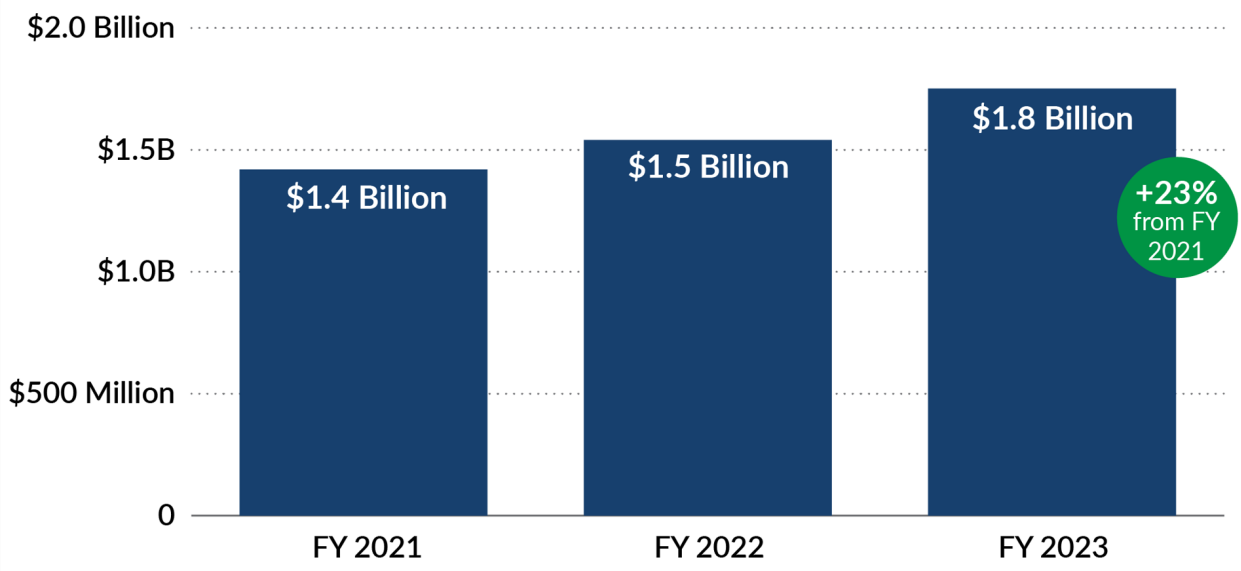


Figure 2. *VA Tampa Healthcare System obligations, FYs 2021–2023.*
Source: VA OIG analysis of FMS 887 Obligations report.
Note: Numbers do not always sum due to rounding.

Using VA's budget object class codes, the inspection team identified obligations growth for personnel, drugs, chemotherapy supplies, medical care contracts and agreements, and prosthetics supplies.[28] These areas accounted for about $272 million (83 percent) of the overall growth in obligations. Table 1 shows the personnel category accounted for almost $130 million, or 25 percent of the growth from FY 2021 to FY 2023.

Table 1. Largest Increases in Obligations for the Personnel Budget Object Class Code Category from FY 2021 to FY 2023

Budget object code	FY 2021–FY 2023 amount change	FY 2021–FY 2023 percent change
(1061) Registered nurses	$54,444,309	29%
(1081) Physicians—full time	$31,334,359	20%
(1001) Administrative personnel not otherwise classified	$18,940,802	21%
(1024) Pharmacists	$5,289,029	20%
(1020) Social worker	$6,819,011	38%
(1066) Nursing aides and nursing assistants	$5,090,539	28%
(1064) Nurse practitioners	$5,513,691	35%

[28] Budget object class codes are used to categorize obligations and expenses based on the type of services or items purchased and are mandatory on all spending transactions.

Budget object code	FY 2021–FY 2023 amount change	FY 2021–FY 2023 percent change
(1082) Physicians—part time	$2,575,369	22%
Personnel growth	$130,007,109	25%

Source: VA OIG analysis of FMS 887 Obligations report.

Note: Numbers do not always sum due to rounding.

The inspection team confirmed the accuracy of obligation data for the areas identified in table 1 with the healthcare system's chief financial officer. To understand the healthcare system's financial management practices in areas where obligations are growing, the inspection team reviewed internal managerial cost accounting reports, analyzed performance measurement data, and interviewed the healthcare system's leaders.

Healthcare System Internal Reporting

The OIG determined the healthcare system prepared financial information and compared planned amounts to actual results as described by VA policy. The inspection team reviewed FY 2023 monthly budget reports compiled by the healthcare system finance office. The healthcare system reported a surplus for each quarter in FY 2023, totaling $111.6 million for the full fiscal year. According to the chief financial officer, some of these funds were obligated for additional salaries and supplies. The chief financial officer informed the inspection team that the healthcare system returned surplus funds to the VISN at the end of each quarter. The team did not evaluate the accuracy of these budget projections or assess the healthcare system's methodology for compiling them.

To understand how the healthcare system used managerial cost accounting data, the inspection team interviewed healthcare system leaders and three members of the VISN 8 managerial cost accounting team. The team also determined the healthcare system reviewed VISN 8 stop code and specialty outlier reports, a labor-mapping-history dashboard, and a national managerial cost accounting dashboard, and confirmed that the medical center director completed the annual certification that the managerial cost accounting system was used.[29] The healthcare system's chief financial officer said the finance office does not use managerial cost accounting data in its

[29] VA Financial Policy, "Managerial Cost Accounting." Each year, facilities are required to submit an annual certification of cost that affirms that the data within the managerial cost accounting system accurately represent the costs of operations. Stop codes are used by VHA staff to identify and capture clinical workload and can be used to compare costs between facilities. VHA managerial cost accounting teams are required to review stop codes. Facilities also are required to review specialty outliers. "A Lexicon for MCA" (webpage), VHA Managerial Cost Accounting Office, accessed February 25, 2024, https://mcareports.va.gov/docs/MCA-Lexicon.docx. Outliers are observations among specialties that are distant from the rest of the service line data (for example, a significant deviation in cost or utilization from the patient population average).

day-to-day operations but did use these data to help maintain appropriate clinical staffing levels and to assist in preparing the annual budget.

According to the chief financial officer, the healthcare system uses cost accounting data to determine whether to hire new staff or reassign existing staff. For example, the healthcare system's data acquisition and analytics service team uses managerial cost accounting reports to review service line requests for additional full-time equivalent positions. Those reports include the VISN 8 stop code and specialty outliers report; VHA Office of Productivity, Efficiency, and Staffing productivity models; and Allocation Resource Center workload reports.[30] These resources help assess whether the service lines need additional full-time equivalent positions. The analysis by the data acquisition and analytics service team forms the basis for recommendations, which are submitted to the Resource Management Board for approval.[31] Based on these recommendations, as well as consideration of current staffing levels, established guidelines, and clinical feasibility, the Resource Management Board recommends the best use of resources to maintain overall staffing levels. If the board deems that reassigning existing staff would negatively affect clinical care, then it will propose hiring a new staff member.

Performance Measurement

Federal financial accounting standards state that measuring cost is integral to measuring performance in terms of efficiency and cost-effectiveness.[32] Specifically, the standards highlight the use of cost per unit of output as a method for evaluating the efforts and accomplishments of a government entity. Additionally, VA financial policy states that the managerial cost accounting system will identify the cost of products and services.[33] Although the healthcare system does identify the cost of products and services, the OIG determined the healthcare system had inaccuracies in its managerial cost accounting data. Also, the OIG determined the healthcare system does not compare the cost of similar products throughout the system.

The VHA Managerial Cost Accounting Office developed a modeling tool to help cost accounting staff and managers analyze cost accounting information. The model's training guide

[30] "Allocation Resource Center – About Us" (web page), Allocation Resource Center, accessed July 2, 2024, http://vaww.arc.med.va.gov/arc_brochure3.htm. (This website is not publicly accessible.) The Allocation Resource Center is a financially and clinically focused health information and management group organized under the VHA Office of the Chief Financial Officer. It assists VHA policy and operations management by developing, maintaining, and utilizing decision support patient-specific workload and expenditure databases. The Allocation Resource Center's major responsibility lies in the development, implementation, and maintenance of the management information system that supports the VHA's budget process.

[31] The Resource Management Board is a governing committee for the effective and efficient management of financial resources at the James A. Haley Veterans' Hospital and clinics. The purpose of the committee is to ensure that resource needs, expenditures, and holdings adequately support VA, VHA, VISN 8, and the James A. Haley Veterans' Hospital's mission, vision, values, and strategic objectives.

[32] Federal Accounting Standards Advisory Board, *Statement of Federal Financial Accounting Standards 4*.

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

recommends that cost accounting staff analyze costs and workload in various ways.[34] Relative value units are weighted units of measure that allow for relative comparison between different complexities and mixes of intermediate products.[35] For example, users could identify the highest-cost products and assess whether those costs seem reasonable or can be considered outliers, which are candidates for improvement.[36]

High-Cost Products

The inspection team used the modeling tool to identify 10 of the healthcare system's high-cost products for September 2023 and asked the healthcare system and the VISN 8 managerial cost accounting team to verify whether the costing was accurate. The team found that four of these high-cost products had inaccurate costing.

The team also used the Intermediate Product Cost Outlier report to identify 10 outliers for September 2023 and asked the healthcare system and VISN 8 managerial cost accounting team to verify whether the costing was accurate.[37] This report identifies potential costing errors based on site-specific costs per product. One indication of a costing error is when a cost appears to be too extreme to be considered a normal cost variation for a product or service. The VISN 8 managerial cost accounting team reported that all 10 intermediate product cost outliers had inaccurate costing. The VISN managerial cost accounting team said both reports—the high-cost products and the intermediate product cost outliers—showed inaccurate product costs due to incorrect labor mapping and workload information. These errors were corrected by the VISN 8 managerial cost accounting team as of May 2024. Example 1 describes one of the intermediate cost product outliers with inaccurate costs.

Example 1

The OIG team's analysis of the September 2023 Intermediate Product Cost Outlier report showed one product had 195 encounters, which were costed

[34] VA Managerial Cost Accounting Office "MCA RVU Modeling Tool Training Guide," June 2022.

[35] Managerial Cost Accounting Processing Guide, *Attachment A - Financial Lexicon for MCA*, February 2024. Relative value units take into account the differing amounts of input, such as labor or materials, required for the different intermediate products. "Guidebook for the Decision Support System Intermediate Product Department" (web page), Health Economics Resource Center, accessed June 28, 2024, https://www.herc.research.va.gov/files/BOOK_688.pdf. Intermediate products are the procedures and services used in treating a patient during an episode of care. These intermediate products represent work performed in each department and are bundled to make up the end product—the encounter—which is either an inpatient stay or outpatient visit. Some examples are a bed day in the surgical ward, a 15-minute health risk assessment, a single drug dispensed, or an MRI brain scan.

[36] Outliers are costs that are misaligned with data for similar products.

[37] "Guidebook for the Decision Support System Intermediate Product Department" (web page), Health Economics Resource Center.

incorrectly at $4,887.69 each, totaling $953,099.55.[38] The reported product cost for each encounter should have been $2,138.00, for a total of $416,910. This costing error resulted in an overstatement of patient care cost for that department of $536,189.55. The VISN 8 managerial cost accounting team found that labor costs were not mapped to the same department where the workload was captured. Based on this analysis, the VISN 8 team reassessed the healthcare system's product costs and determined both relative value unit information and labor mapping needed to be updated to ensure relevant facility costs, such as labor, equipment, and supplies, were associated with the department where the work was being captured. The VISN 8 managerial cost accounting team adjusted mapping for this product to reflect more accurate costing during FY 2024.

The healthcare system said inaccurate costs were not identified before the OIG inspection because it did not have enough time to perform monthly reviews of all cost outliers. The VISN 8 managerial cost accounting team said they identify outliers by using the modeling tool, Intermediate Product Cost Outlier report, and Outpatient Stop Code Average Cost report. The cost accounting team also said they cannot investigate each outlier because they must meet deadlines for other audit tasks assigned to them by VA's Managerial Cost Accounting Office, and they cannot keep up with the work needed to ensure data integrity.

The VISN 8 managerial cost accounting manager further explained that these inaccuracies occurred because healthcare system service lines did not always update their labor mapping information. VA policy requires that administration field offices ensure employee hours and salary are correctly mapped into the functional cost centers and that the healthcare system's service chiefs and leaders review labor mapping for accuracy and completeness.[39] Because the VISN 8 managerial cost accounting team relies on the healthcare system for up-to-date cost information, they initiated the process of sending biweekly emails to remind healthcare system service lines to review and certify their information in the national labor mapping tool. However, the OIG found that about 70 percent of the healthcare system's service lines did not certify their information for the first six pay periods of FY 2024. The VISN 8 managerial cost accounting team was aware of the VA policy, but they did not escalate the issue of improving responsiveness by notifying healthcare system leaders.[40] Instead, the VISN team performed monthly labor mapping reviews using outdated information. Without accurate, current

[38] This product was related to Physical Medicine and Rehabilitation Services, which comprises the following rehabilitation disciplines: kinesiotherapy, occupational therapy, physical therapy, and physiatry.

[39] VA Financial Policy, "Managerial Cost Accounting." Service chiefs and organizational leaders periodically review labor mapping for accuracy and completeness. Managerial cost accounting field staff adjust labor mapping as necessary.

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

information from the service lines, the VISN 8 managerial cost accounting team increases the risk of making important business decisions with inaccurate cost information.

The healthcare system's chief financial officer said he was not aware of the lack of response from the healthcare system service lines until the issue was raised by the OIG inspection team. He mentioned that formal guidance had not been issued to prioritize unresolved labor mapping issues. However, he felt the healthcare system would benefit from a process to ensure prompt responses. The chief financial officer said the healthcare system would work on improving this process. These issues impede effective oversight of the healthcare system and limit the accuracy and completeness of labor mapping.

VA policy requires the use of labor mapping for every VHA staff member and requires healthcare system service chiefs and organizational leaders to periodically review the mapping to ensure accuracy and completeness.[41] Therefore, it is important for the healthcare system's service chiefs and leaders to ensure labor costs are mapped to the same department where workload is produced. Otherwise, the healthcare system is at increased risk of using inaccurate information when making important business decisions.

Primary Care Products

Using the Managerial Cost Accounting Office modeling tool, the inspection team conducted a product comparison for 30-minute primary care visits. Using the FY 2023 product cost report, the inspection team identified 10 clinics that provide 30-minute primary care visits with a physician and asked the healthcare system and VISN managerial cost accounting team to verify whether the costing was accurate. The VISN managerial cost accounting team did not identify any inaccurate costing for the 30-minute primary care visits. The report listed close to 60,400 visits among the 10 clinics with costs per visit ranging from $631.72 to $1,436.73. The team further noted that indirect, direct, and variable cost inputs varied significantly among the locations. Table 2 shows the costs associated for 30-minute primary care visits at these 10 clinics within the healthcare system.

Table 2. 30-Minute Primary Care Visits

Clinic type	Location type	Number of visits	Actual cost per visit	Fixed indirect cost*	Fixed direct cost‡	Variable cost§
Primary Care #1	Lakeland community-based outpatient clinic	11,525	$712.40	$322.45	$5.63	$384.33

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

Clinic type	Location type	Number of visits	Actual cost per visit	Fixed indirect cost*	Fixed direct cost‡	Variable cost§
Primary Care #2	Riverview community-based outpatient clinic	10,671	$631.72	$299.36	$6.23	$326.14
Primary Care #3	Lecanto community-based outpatient clinic	9,314	$886.62	$473.74	$60.16	$352.72
Primary Care #4	Hidden River VA Clinic, Tampa	5,363	$759.54	$361.05	$0.00	$398.49
Primary Care #5	Hidden River VA Clinic, Tampa	5,294	$904.17	$441.16	$3.51	$459.50
Primary Care #6	Zephyrhills community-based outpatient clinic	5,187	$648.99	$287.91	$1.42	$359.65
Primary Care #7	Hidden River VA Clinic, Tampa	5,146	$721.60	$343.16	$0.00	$378.44
Primary Care #8	James A. Haley Veterans' Hospital, Tampa	3,291	$1,436.73	$776.97	$25.97	$633.79
Primary Care #9	Hidden River VA Clinic, Tampa	3,024	$1,092.41	$550.55	$0.69	$541.17
Primary Care #10	James A. Haley Veterans' Hospital, Tampa‖	1,581	$865.46	$459.67	$0.00	$405.79

Source: VA OIG analysis of cost associated with 30-minute primary care visit data from VHA's Managerial Cost Accounting Office modeling tool.

Note: The inspection team did not test the accuracy of the costs reported by the healthcare system.

* *Fixed indirect costs are not directly related to patient care and, therefore, are not specifically identified with an individual patient or group of patients. These costs are allocated to direct departments through the indirect cost allocation process. Examples include utilities, maintenance, and administration costs. All indirect costs are classified as fixed.*

‡ *Fixed direct costs are costs of direct patient care that do not vary in direct proportion to the volume of patient activity. The word "fixed" does not mean that the costs do not fluctuate but rather that they do not fluctuate in direct response to workload changes. Examples include depreciation of medical equipment and salaries of administrative positions in clinical areas.*

§ *Variable costs are costs of direct patient care that vary directly and proportionately with fluctuations in workload. Examples include salaries of providers and the cost of medical supplies. Variable direct cost is the sum of variable supply cost and variable labor cost.*

‖ *The James A. Haley Veterans' Hospital is the main location of the VA Tampa Healthcare System.*

The inspection team provided its analysis to the healthcare system and the VISN 8 managerial cost accounting team to determine whether they identified and analyzed cost differences among similar products within the healthcare system. Based on the response provided, the OIG

determined the healthcare system did not always compare the costs of similar products throughout the healthcare system. The healthcare system's chief financial officer said the Resource Management Board only reviews analyses of similar products when service lines request additional resources. He further explained that variable costs are typically higher for certain primary clinics.

For example, at the Hidden River VA clinic, where four primary care teams are located, staff are rotated daily to meet patient needs, and staff reported that mapping costs accurately is challenging because of the effort required. The healthcare system's chief financial officer told the inspection team that a proposal would be made to consolidate the four primary care clinics at Hidden River into a single, local intermediate product department in the future.[42] In addition, primary clinics 8 and 10—which are located on the main campus of the healthcare system—have higher reported costs than other primary care clinics due to their location, volume of high-risk patients, and teaching program affiliations. The VISN managerial cost accounting manager said staff do not compare similar products across clinics within the healthcare system due to variations in overhead costs among the clinics, and staff would only conduct this level of review if a similar product's cost was significantly different.

Although it may be normal for product costs to vary among different clinics within a healthcare system and across different VA healthcare systems, failure to compare cost differences among similar products could lead to missed opportunities for correcting inaccurate costs and improving cost efficiency. Federal financial accounting standards say federal managers should compare costs of similar activities with appropriate cost information and find causes for cost differences, which can help reduce costs and avoid waste.

Budgeting and Cost Control

Federal financial accounting standards state that information on program activity costs can be used as a basis to estimate future costs in preparing and reviewing budgets.[43] The standards also explain that federal managers can use cost information to control and reduce costs and avoid waste. The inspection team found that the healthcare system used managerial cost accounting information to help formulate its budget. According to the chief financial officer, the healthcare system shared managerial cost accounting budget reports from the VISN with the healthcare

[42] "Guidebook for the Decision Support System Intermediate Product Department" (web page), Health Economics Resource Center. Intermediate product departments are organizational units categorized by distinct intermediate products and a discrete labor pool.

[43] Federal Accounting Standards Advisory Board, *Statement of Federal Financial Accounting Standards 4: Managerial Cost Accounting Standards and Concepts*.

system's Patient Flow Committee on a quarterly basis.[44] The reports, which included the Cost per Treating Specialty report and the Cost per Clinic Stop Code report, showed trends since 2018 and identified opportunities for community-based outpatient clinics to reduce community care costs in conjunction with the service line input.

The chief financial officer provided an example of how the healthcare system used the Cost per Clinic Stop Code report to reduce community care spending. In this example, the chief financial officer identified an infusion clinic where the average cost per patient visit was lower than the national average. However, the cost of infusions provided in the pharmacy was significantly higher. This difference highlighted an opportunity to improve cost efficiency and patient convenience by moving services closer to a patient's home. As a result, the healthcare system executed a plan to offer infusion services at the New Port Richey community-based outpatient clinic. The change made infusions accessible within an hour's drive for patients from three other clinics, who otherwise would be referred—at a much higher cost—to the community under the MISSION Act due to their travel distances.[45] As a result, the healthcare system potentially saved almost $5.1 million (about 36 percent of the costs).

Economic Choices

Agencies and programs face choices, such as whether to complete a project in-house or contract it out, whether to accept or reject a proposal, or whether to continue or drop a product or service. The OIG determined a group practice manager at the healthcare system performed make-or-buy analyses to compare the cost of some services at the healthcare system against the cost of similar services obtained through contracts with community care providers.[46] To enhance data analysis and reporting capabilities, the group practice manager developed a Microsoft Power Business Intelligence application that connects to VHA Support Service Center data to facilitate informed decisions based on accurate, current information.[47]

The group practice manager provided the inspection team with a make-or-buy analysis for physical therapy during FY 2023. As a result of this analysis, the healthcare system increased its

[44] "Streamlining patient flow and enhancing operational efficiency through case management implementation" (web page), National Institutes of Health National Library of Medicine, accessed June 18, 2024, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10910643/pdf/bmjoq-2023-002484.pdf. Effective patient flow management within hospital settings highlights the crucial need for structured and coordinated processes to elevate the overall experience and optimize the allocation of resources.

[45] John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, § 101 (2018). The act describes conditions in which furnishing care and services through a non-department entity or provider would be in the best medical interest of the covered veteran, based upon criteria which considers the distance between the covered veteran and the facility that provides the care.

[46] Group practice manager is a facility-level position intended to oversee access to care in outpatient clinic services.

[47] The VHA Support Service Center provides data within its stewardship to established internal VA organizations and program offices for the purpose of healthcare delivery analysis and evaluation.

internal capacity to see new patients, decreasing spending on community care physical therapy from almost $1.2 million in the fourth quarter of FY 2022 to about $440,000 in the fourth quarter of FY 2023.

The OIG also determined the group practice manager monitored the healthcare system's internal capacity to improve veterans' access to care for various medical specialties. For example, the group practice manager informed the team that the staff reviewed consult processing procedures to improve consult timeliness. This review assessed whether the healthcare system had the resources to serve veterans before referring them to community care. The manager reported that by reviewing consult processing procedures, the healthcare system reduced its average wait time for new acupuncture appointments from 59.8 days to 24.7 days in February 2024 and, by extension, reduced community care acupuncture consults to a seven-month low of 322.

Finding 1 Conclusion

VA expects its healthcare systems to use managerial cost accounting information to enhance efficiency, help reduce costs, and make informed business decisions as described in VA financial policy.[48] The OIG found that leaders of the VA Tampa Healthcare System used managerial cost accounting information to assist in preparing the annual budget and to assess requests for additional staffing. The healthcare system should enhance its performance measurement process to identify and correct cost discrepancies. These issues impede effective oversight of the healthcare system and limit the accuracy and completeness of labor mapping. The significant growth of obligations at the healthcare system makes it more important to consistently use managerial cost accounting information to promote more efficient use of taxpayer resources.

Recommendations 1–3

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

1. Establish a plan to use VA's cost accounting system information to identify additional ways to reduce costs, enhance efficiency, and inform business decisions as identified by VA financial policy.
2. Ensure the facility has a process to identify cost outliers, such as using the Intermediate Product Cost Outlier report to identify cost outliers that may occur at the healthcare system on a regular basis.

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

3. Ensure healthcare system service lines review and update the national labor mapping tool to the Veterans Integrated Service Network managerial cost accounting team as required by VA financial policy to ensure workload is being captured correctly.

VA Management Comments

The director concurred with recommendations 1 through 3. The responses are provided in full in appendix D. To address recommendation 1, the director reported that the facility will enhance managerial cost accounting modeling tools and reporting processes to monitor and reduce outliers; the facility will also use the Managerial Accounting Dashboard (MCAD) to verify workload and resource mapping. To address recommendation 2, the director reported that the facility will review the Intermediate Product Cost Outlier report with the executive leadership team monthly to address outlier trends to justify variances, and ongoing reviews will aim to bring outliers into compliance or document justification for variance. To address recommendation 3, the director reported that the facility will complete a monthly compliance report on the response rate and provide education to the service level and accountability at the executive leadership level to improve the response rate.

OIG Response

The healthcare system's action plans are responsive to the OIG's recommendations. The OIG will monitor implementation of the planned actions and will close the recommendations when sufficient evidence is received demonstrating progress in addressing the intent of the recommendations and the issues identified.

II. Open Obligations Oversight

VA policy requires finance offices to perform monthly reviews and reconciliations to ensure that their obligations, including undelivered orders and delivered unpaid orders, which are known as accruals, are valid.[49] The healthcare system's finance office personnel should verify with the requesting office or contracting officer to ensure the obligations' period-of-performance dates are correct, open balances are accurate and agree with source documents, obligations aged beyond 90 days of the period of performance or without activity in the past 90 days are valid and should remain open, the accrual flag is set appropriately, and proper accruals have occurred.[50]

VA's mismanagement of open obligations has been a long-standing issue and was included as a significant deficiency in the department's FY 2021, FY 2022, and FY 2023 audited financial statements and as a material weakness in its FY 2020 audited financial statements.[51] Additionally, a 2019 OIG report on undelivered orders recommended VHA ensure staff review and reconcile open orders, identify and deobligate excess funds on those orders, and follow VA policy regarding required reviews of open obligations.[52] Failure to promptly deobligate excess funds increases the risk that unused funds will not be reallocated for other goods and services to benefit veterans. Furthermore, the healthcare system risks that activities are not accurately reflected in its financial records and, ultimately, in its financial statements and budget requests.

[49] Undelivered orders are supplies and services that have been approved and awarded on an obligation but have not been delivered to or accepted by the government. This includes any orders for which advance payment has been made but delivery or performance has not yet occurred.

[50] VA Financial Policy, "Obligation," in vol. 2, *Appropriations, Funds, and Related Information* (September 2021, April 2022, and May 2023), chap. 5; VA Accrual Flag National Monitoring Guidance (February 2021). An accrual flag is used to automate the accrual process. The automated accrual works well for service orders where about the same amount of service is received each month. However, it is not appropriate to automate all accruals. For example, when projects are paid in advance, if the obligation is accrued it will result in an overstatement of payables and an abnormal balance in certain general ledger accounts. Obligations not set for automated accrual reflect payable amounts upon processing of receiving actions or reports by the facility's logistics office. The Office of Finance moved this policy from vol. 2, chap. 5 to vol. 3, chap. 2 in March 2024. The team determined this change did not affect the policy requirements relevant to the financial inspection.

[51] VA OIG, *Audit of VA's Financial Statements for Fiscal Years 2023 and 2022*, Report No. 23-00940-18, November 15, 2023; VA OIG, *Audit of VA's Financial Statements for Fiscal Years 2022 and 2021*, Report No. 22-01155-14, November 15, 2022; VA OIG, *Audit of VA's Financial Statements for FY 2021 and 2020*, Report No. 21-01052-33, November 15, 2021. In these reports, CliftonLarsonAllen LLP defines a material weakness as a deficiency, or combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented or detected and corrected in a timely manner. A significant deficiency is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

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

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

- **Undelivered orders.** The team assessed whether healthcare system staff performed monthly reviews and reconciliations to ensure that the sampled undelivered orders with no activity for more than 90 days were valid and should remain open.
- **Outstanding accruals.** The team assessed whether the healthcare system performed monthly reviews and reconciliations to ensure that the sampled outstanding accrued orders were valid and should remain open.
- **Financial Management System (FMS)–to–Integrated Funds Distribution, Control Point Activity, Accounting and Procurement System (IFCAP) reconciliations.** The team identified outstanding obligations in the sample that had different end dates or order amounts between FMS and IFCAP to ensure healthcare system staff reconciled end dates between the systems.[53]

Finding 2: The Healthcare System Did Not Always Review Inactive Obligations, Ensure Accruals Were Valid, or Confirm Order End Dates and Amounts Were Accurate

The OIG found healthcare system staff could improve management of open obligations by reviewing inactive open obligations in conjunction with the requesting office. Failure to properly manage open obligations increases the risk that appropriations will not be spent within the correct fiscal year and, potentially, that funds will remain attached to orders when they could be used for other purposes.

Undelivered Orders

As of November 15, 2023, the healthcare system had 38 undelivered orders valued at just over $15.6 million that had been inactive for more than 90 days. VA financial policy states that open obligations should be reviewed by the finance office, in coordination with the requesting office, to ensure that obligations without activity in the past 90 days are valid and should remain open.[54] If funds remain on an obligation after delivery, after the requesting office has confirmed

[53] FMS is considered the primary accounting system for VA. All accounting transactions record in FMS, but not all transactions record in IFCAP. Finance is the only service that has the ability to perform transactions in FMS, and it is considered to contain the most current, accurate information for monitoring and reporting purposes. IFCAP, also referred to as VistA, is considered the "front end" of the accounting system—automating the creation, approval, forwarding, monitoring, and payment of requests for supplies and services. Each day FMS interfaces with IFCAP, passing along accounting activity in the form of fund control point balance adjustments. A transaction's end date (which is critical to determining whether an obligation should remain open) may be modified due to delays or scope changes. The modification might not always be recorded in both systems because staff can manually change end dates in one system without changing them in the other.

[54] VA Financial Policy, "Obligation."

acceptance of all goods or services, and after invoices have been received and paid, then the procurement office will modify the contract or order to reflect the final cost and quantity and decrease the remaining funds on the obligation.

Figure 3 shows the number and dollar amount of obligations inactive for more than 90 days from June 15 through November 15, 2023.

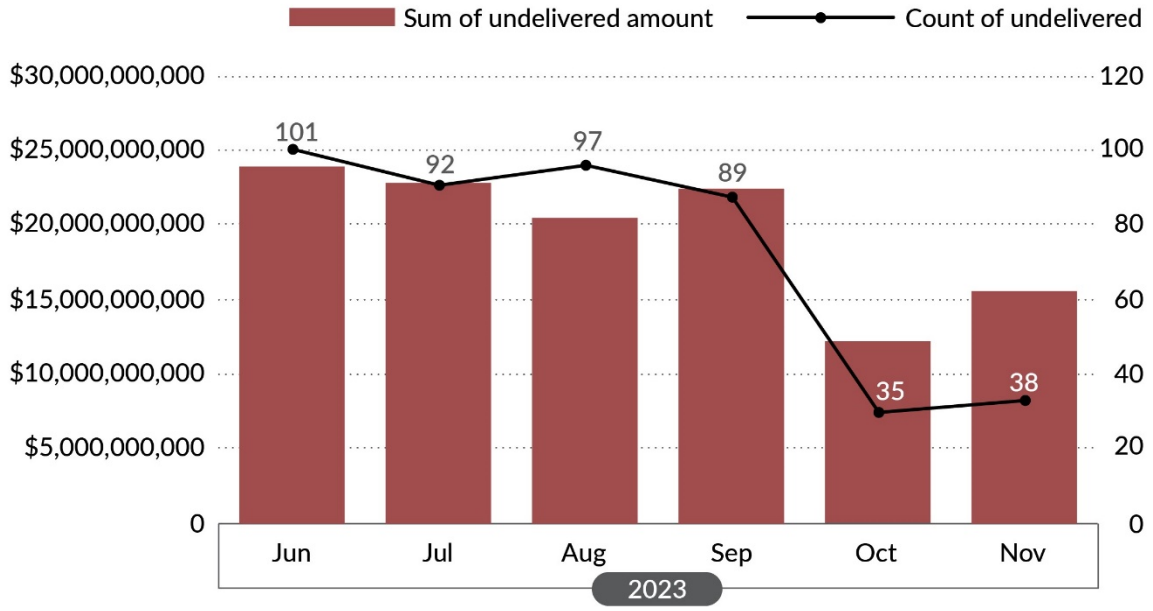


Figure 3. *Number and dollar amount of inactive obligations for the VA Tampa Healthcare System from June 15 through November 15, 2023.*

Source: VA OIG analysis of VA FMS F850 report.

Figure 4 on the next page shows the age and undelivered dollar amounts of the 38 obligations as of November 15, 2023. Of the 38 obligations, 24 totaling more than $9.8 million had no activity for at least 181 days.

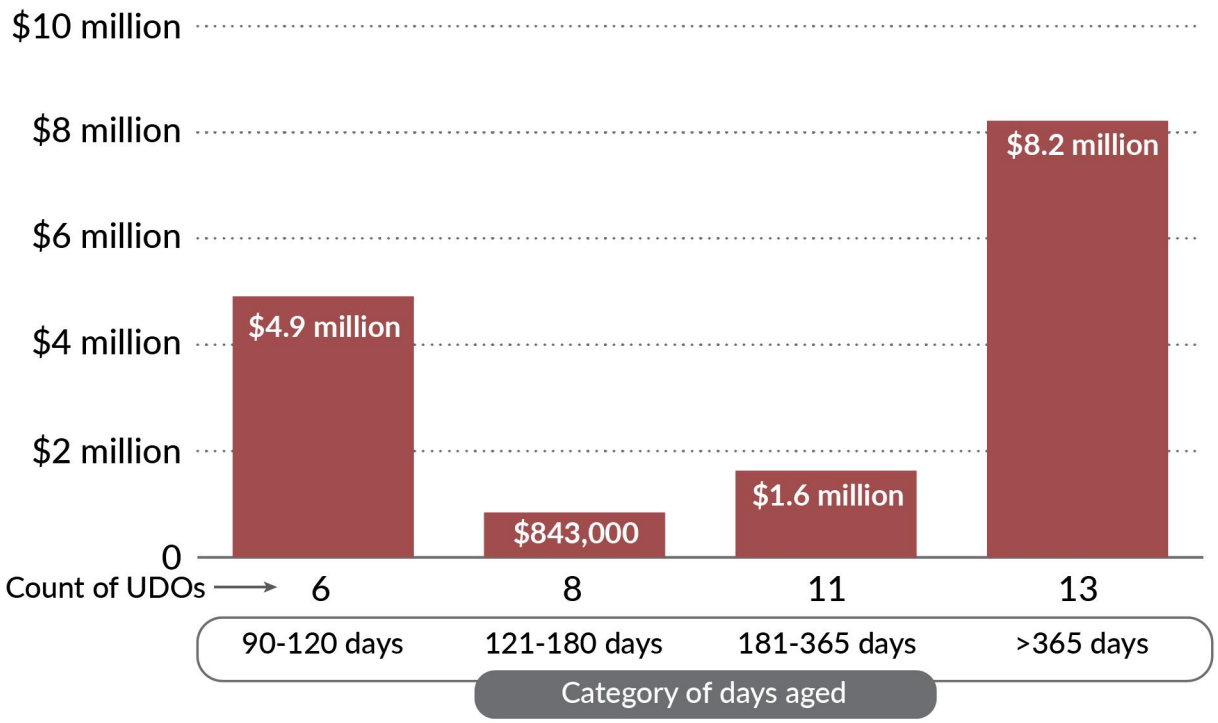


Figure 4. *Inactive obligations for the VA Tampa Healthcare System as of November 15, 2023.*
Source: VA OIG analysis of VA FMS F850 Report.
Note: UDO stands for undelivered orders.

The inspection team analyzed obligation data for the 38 obligations and selected 10 inactive obligations open as of November 15, 2023, totaling almost $9 million.[55] The team reviewed supporting documentation to assess whether healthcare system staff identified and reviewed the sampled obligations to determine if they were still valid and needed to remain open in accordance with VA financial policy.[56] During a review of the supporting documentation, the team verified that the finance office completed a monthly review of all 10 obligations, which were still within the performance period.

Starting in February 2020 and continuing during the team's period of review, the healthcare system used a web-based tool, referred to as the "VISN UDO ASP Review" web portal, to streamline and capture the monthly review process of open obligations.[57] The tool, developed by VISN 8, identifies all open obligations so the healthcare system's finance office staff can easily identify obligations that require follow-up because they had no activity for more than 90 days. A valid status response from the requesting office is required for each of these obligations.

[55] See appendix A for additional details on the inspection's scope and methodology, appendix B for details on the inspection's statistical sampling methodology, and appendix C for details on the monetary impact.
[56] VA Financial Policy, "Obligation."
[57] UDO means undelivered orders; ASP means accrued services payable (accruals).

Although the portal identified and required a review of inactive obligations, the requesting office did not always review those obligations to determine whether they were valid and should remain open. Specifically, the requesting office did not review and provide a response for two of the 10 obligations. Although the requesting office did not always review obligations, the team determined the funds were still valid based on the documents that were provided and the requesting office's confirmation to substantiate the validity of these obligations. The supervisory accountant attributed the lack of responses to an absence of oversight by the finance office and requesting offices.

The VISN UDO ASP Review web portal was offline during the OIG team's site visit because the VISN staff member who had the credential to log into and maintain the portal had recently left for another position. The VISN data team tried but was unsuccessful in training other VISN staff to maintain the portal due to access errors. According to the supervisory accountant, the finance office managed this outage by sending monthly emails to notify the healthcare system's requesting office about obligations that required their attention. The VISN team decided to replace the portal and make access available to more users. The supervisory accountant informed the OIG team that the VISN and healthcare system were working on a similar replacement system; he was hopeful that the replacement system would be operational in October 2024, at which time the temporary work-around process would no longer be required. The supervisory accountant said using a web-based tool for reviewing open obligations has been beneficial as the number of inactive undelivered orders has trended downward. He also credited the finance office's effort in filling critical positions to meet the workload requirements for this improvement.

Outstanding Accruals

As of November 15, 2023, the healthcare system had 493 outstanding accruals totaling just over $22 million. Figure 5 shows the number and dollar amounts of outstanding accruals from June 15 through November 15, 2023.

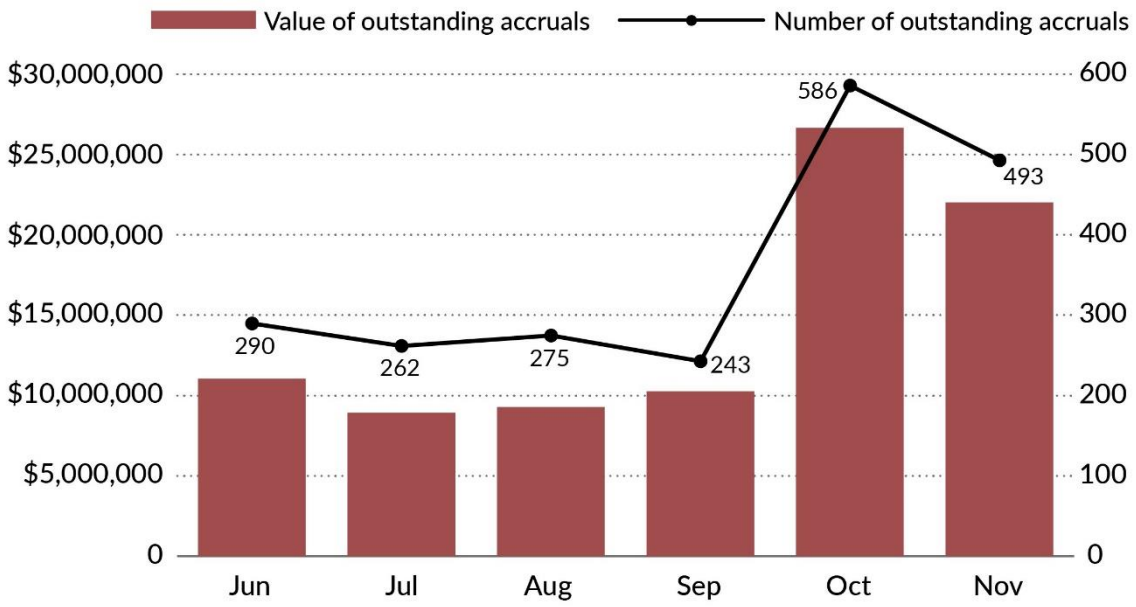


Figure 5. *Number and dollar amount of outstanding accruals for the VA Tampa Healthcare System from June 15 through November 15, 2023.*

Source: VA OIG analysis of VA FMS F851 report.

Note: The increased number of accruals from September 15 to October 15, 2023, resulted from recording fiscal year-end accruals for accounts payable.

From the 493 outstanding accruals, the team identified 148 totaling more than $7.3 million that had been open for more than 90 days.[58] Figure 6 on the next page shows the age and dollar amounts of the 148 accruals. As shown, 116 accruals totaling more than $6.2 million had been open for 181 days or more.

[58] The initial population of accruals included multiple obligations with low-dollar amounts of less than $100. To avoid spending time reviewing low-dollar amounts, the team filtered the accrual population to include only obligations valued at over $100 that were at least 90 days old.

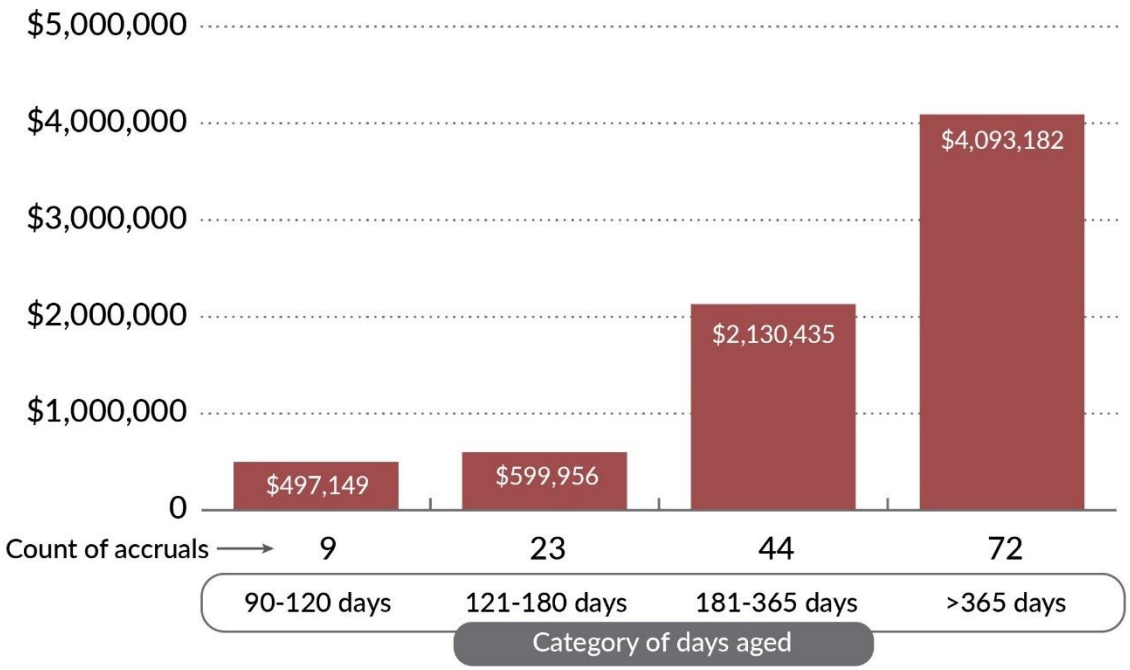


Figure 6. *Outstanding accruals for the VA Tampa Healthcare System as of November 15, 2023. Source: VA OIG analysis of VA FMS F851 report.*

The inspection team selected 25 accruals outstanding as of November 15, 2023, totaling close to $4.2 million, with accrual balances that had been open between 137 and 1,506 days.[59] The team reviewed supporting documentation to assess whether the healthcare system identified and reviewed the sampled accruals to determine if they were valid and needed to remain open in accordance with VA financial policy.[60] The team found that the finance office had identified and reviewed all 25 accruals requiring a monthly review. However, the team also found that the reviews by the finance office and requesting offices did not always effectively identify invalid accruals that were no longer needed for the intended purpose.

Based on the results of the review, the team estimated that 83 of the 148 outstanding accruals (about 56 percent), totaling an estimated $6 million, were invalid and needed to be reversed. Of the $6 million, the team estimated $5.6 million could be put to better use for the healthcare system because the requesting office confirmed that the obligations were no longer needed. The supervisory accountant attributed the failure to deobligate to a lack of responses from the requesting office; insufficient training and awareness of VA policy; insufficient communication between finance, requesting, and contracting offices to ensure deobligation; and lack of oversight

[59] Each obligation may have multiple line items of accrued expenses. See appendix A for additional details on the inspection's scope and methodology and appendix B for details on the inspection's sampling.

[60] VA Financial Policy, "Obligation."

and follow-up by the finance office to ensure that requesting offices responded and took prompt action as required by VA policy.[61] Example 2 shows an instance of improper accrual.

Example 2

One obligation in the amount for $643,256.80 incurred an expenditure amount of $39,906. The remaining balance of $603,359.80 auto-accrued at the end of the performance period on September 30, 2022.[62] Even though the finance office provided evidence showing a review of the outstanding accrual, it did not adequately follow up with the service or take necessary action to ensure prompt deobligation when the service staff confirmed that goods and services were delivered. When the inspection team requested a status update, the finance and service staff confirmed the amount was invalid and deobligated it on March 6, 2024. The accrual was invalid for more than 17 months.[63]

Failure to properly manage accruals increases the risk of disbursing funds for goods or services not received, may prevent the healthcare system from obtaining the maximum benefit for any unused funds, and increases the risk of misstatement in VA financial statements and budget requests.

Potential "Bona Fide Needs" Rule Violation

During the review of accrued obligations, the OIG also found that the healthcare system may have violated the "bona fide needs" rule for a service contract.[64] Federal law requires appropriated funds to be used only for goods and services for which a need arises in the year that the appropriations are available for obligations.[65] The healthcare system awarded a service contract with a base year and four option years with a six-month extension. The OIG found that the healthcare system staff paid for services rendered with funds that were not available for the period of performance of those services because the funds were appropriated for a different fiscal year. Specifically, the OIG found that the healthcare system used $3,592 obligated for option year three to pay for expenditures incurred during option year four of the contract.[66] The

[61] Deobligation means a cancellation or downward adjustment of previously incurred obligations. VA Financial Policy, "Obligation."

[62] An automated accrual is when an accrual is processed automatically in FMS for the remaining unpaid balance.

[63] Potential overstatement of accrued expenses occurs when VA liquidates obligations and records accruals for accounts payable without evidence of goods or services received during the accounting period. Without proper adjustments, VA increases the risk of not reporting accurate financial accounting that is intended to provide an explanation of the relationship between budgetary and financial accounting information.

[64] 31 U.S.C. § 1502(a). The "bona fide needs" rule states that to use appropriated funds, a legitimate need must exist for the requirement in the period for which the appropriations are available for obligation.

[65] 31 U.S.C. § 1502(a).

[66] The OIG added all expenses from multiple invoices to calculate the total funds used to pay for services incurred outside the fiscal year periods of performance.

healthcare system also used $9,962 that was obligated for option year four to pay for expenditures incurred during option year three, the six-month contract extension, and a subsequent, separate contract. By using $13,554 from past and future obligations to pay for services when those needs did not appear to be directly related to the relevant option year, the extension, or the new contract, healthcare system officials may have violated the bona fide needs rule. By using funds from future obligations, the healthcare system also risked not having funds available to pay for goods at the time of delivery or services when they would be rendered.

Additionally, as part of the review of the contract and invoices, the team found that the healthcare system made improper payments totaling $22,138 because the staff used funds from two FY 2023 obligations covering the six-month extension and the new contract to pay for services rendered outside their respective FY 2023 periods of performance.[67]

The supervisory accountant agreed with the team's findings and said this occurred due to an invoice certifier's oversight. The supervisory accountant also attributed the violation to the Invoice Payment Processing System automatically certifying invoices under $2,500 for payments in order to avoid interest penalties when the station certifying officer does not certify within 25 days.[68] Ultimately, finance office staff are responsible for implementing a system of internal controls to ensure they obligate funds and make payments for a given purpose.[69] The finance office, as of February 2024, processed expenditure transfers to remedy the violations.

Reconciliation of FMS and IFCAP End Dates and Amounts

IFCAP manages the processing of certified invoices and electronic transmission of receipt documents to FMS. In addition, IFCAP transfers obligation information back to the control point

[67] Appendix C of Office of Management and Budget (OMB) Circular A-123, *Requirements for Payment Integrity Improvement*, (March 2021). Improper payments are payments that should not have been made or were made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements; payments made to ineligible recipients; and payments where an agency's review is unable to discern it is proper due to insufficient documentation. Monetary loss improper payments have an overpayment amount that, in theory, could and should be recovered. Unintentional monetary loss improper payments are overpayments that are accidental in nature because at the time of the payment the program is unaware that the payment is an overpayment, and the recipient has also not purposefully falsified information for gain.

[68] VA Financial Policy, "*Invoice Review and Certification*," in vol. 8, Cash Management (June 14, 2023), chap. 1A. Payments may be made on a single invoice under $2,500 as soon as the contract, proper invoice, receipt, and acceptance documents are matched. "Invoice Payment Processing System" (web page), VA Enterprise Architecture Repository, accessed May 13, 2024, https://vaww.vear.ea.oit.va.gov/#system_and_application_domain_defs_system_24337.htm. (This website is not publicly accessible.) The Invoice Payment Processing System is a VA internet portal for invoice processing that receives electronic invoice data, provides approval/acceptance workflow, and is primarily used to handle VA payments to commercial vendors.

[69] VA Financial Policy, "Obligation."

and automatically updates the control point balance.[70] The end dates in both systems should be the same. However, staff can manually change end dates in one system without changing them in the other. Furthermore, monthly accrual amounts are calculated based on the end date. Therefore, to ensure accurate financial reporting, open obligations should be reviewed monthly by the healthcare system's finance office, in coordination with the requesting office, to ensure period-of-performance dates are correct and match in all systems.[71]

End-Date Discrepancies

The inspection team analyzed FMS-to-IFCAP reconciliation reports from June through November 2023 and identified and evaluated all six open obligations, with a total value of more than $7.8 million, that had end-date discrepancies between FMS and IFCAP for three or more months. The team determined five of the six were flagged to auto-accrue the remaining balance of the obligations at the end of the performance period.[72] Obligations flagged to auto-accrue in FMS that have inaccurate end dates result in potentially invalid accruals. The team determined FMS and IFCAP discrepancies for all six obligations had been corrected by the healthcare system to reflect the correct end dates prior to the OIG's site visit.

The team also determined five of the corrected obligations, totaling more than $162,000, were deobligated as a result of the inspection. In these five cases, the healthcare system did not deobligate in a timely manner after the goods or services were received because of the lack of communication among finance staff, requesting office staff, and contracting staff.

Order Amount Discrepancies

The inspection team identified 12 open obligations, valued at close to $12.4 million, that had order amount discrepancies between FMS and IFCAP for three or more months. To determine if order amounts were accurate and reconciled between the two systems, the team selected and evaluated six open obligations from FMS-to-IFCAP reconciliation reports with order amount discrepancies totaling more than $7.3 million. The team determined FMS and IFCAP had been corrected by the healthcare system prior to the site visit and that both systems reflected the correct amounts for five of the six obligations. The remaining discrepancy of $3,000 had not been corrected as of May 2024 because the healthcare system could not make an adjustment as a result of an overpayment. The healthcare system issued a bill of collection to recoup the $3,000. During the team's review of order amounts, they also determined all six obligations had residual balances totaling just under $191,000 that were deobligated as result of the inspection. The

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

[71] VA Financial Policy, "Obligation."

[72] Auto-accrue is processed automatically in FMS for the remaining unpaid balance; specifically, it is processed when there is no interaction by the healthcare system personnel.

healthcare system did not deobligate in a timely manner after the goods or services were received because of the lack of communication among finance staff, requesting office staff, and contracting staff.

The supervisory accountant confirmed the finance office uses VA's FMS-to-IFCAP reconciliation report to identify order amount discrepancies. However, the team found that the finance office and the requesting offices did not always take prompt actions to ensure amounts were correct or to deobligate excess funds as outlined in VA policy to protect the department from financial risk. If finance office staff had better managed open obligations, they could have addressed inconsistencies between FMS and IFCAP records and reduced the risk of failing to spend appropriations within the associated fiscal year and the risk of funds not being repurposed to benefit veterans.

Finding 2 Conclusion

Healthcare system personnel did not always comply with VA policies requiring routine follow-up to improve management and oversight of open obligations and prevent or minimize the possibility of appropriations law violations. The inspection team found that open obligations, including undelivered orders and accruals, were not always reviewed for validity, and end dates and order amounts were not always reconciled between systems. Due to the finance office not ensuring adequate monthly reviews and reconciliations of open obligations, the team estimated $6.3 million in obligations was invalid, of which an estimated $5.9 million should have been deobligated and could have been put to better use.[73] Failure to properly manage open obligations and accrued expenses increases the risk that financial statements will be misstated, that appropriated funds will be left attached to orders instead of being used for other purposes to benefit veterans, that funds will be erroneously used to pay for goods or services not received, and that appropriations law will be violated.

[73] The inspection team considered obligations invalid when the healthcare system confirmed that the residual funds were no longer needed or could not provide documentation that services were still needed. This amount included an estimated $6 million from invalid accruals, residual obligations totaling more than $162,000 due to end-date discrepancies, and about $191,000 from amount discrepancies, which brought the total amount to an estimate of more than $6.3 million. The better use of funds is related to various open obligation monitoring and administrative deficiencies identified in the sampled obligations. This amount includes an estimated $5.6 million from accruals, more than $162,000 due to end-date discrepancies, and just under $191,000 due to amount discrepancies, which brought the total monetary benefits to an estimated $5.9 million. Numbers do not sum due to rounding.

Recommendations 4–6

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

4. Ensure that healthcare system staff and responsible finance office staff review all open obligations to ensure balances are valid and should remain open or are closed in a timely manner as required by VA Financial Policy, "Obligations," as updated in March 2024.
5. Ensure that the healthcare system uses appropriated funds in the manner intended by Congress, as required by the VA Financial Policy, "Obligations," as updated in March 2024.
6. Consult with the Office of General Counsel and the Office of Acquisitions, Logistics, and Construction to determine whether a bona fide needs or other appropriations law violation occurred and, if any violations did occur, take appropriate remedial and preventive actions to address them.

VA Management Comments

The director concurred with recommendations 4 through 6. The responses are provided in full in appendix D. To address recommendation 4, the director reported that the VISN is making improvements to its VISN UDO ASP Review portal, which provides centralized reporting on automated email requests and responses. If services do not respond to requests for updates on open obligations by the 15th day of each month, the fiscal staff will continue to pursue a remedy for invalid orders and work with senior leadership for a solution. To address recommendation 5, the director reported that the facility will retrain certifying officials on their responsibilities to ensure proper invoice review. To address recommendation 6, the director reported that the facility submitted a request to the VA's Office of General Counsel for a legal review of the potential bona fide needs or appropriation law violation and associated remedial actions.

OIG Response

The healthcare system's action plans are responsive to the OIG's recommendations. The OIG will monitor implementation of the planned actions and will close the recommendations when sufficient evidence is received demonstrating progress in addressing the intent of the recommendations and the issues identified.

III. Purchase Card Use and Oversight

From November 1, 2022, through October 31, 2023, the healthcare system had 108,290 transactions totaling just under $129.6 million. This volume of spending makes it important to have strong controls over purchase card use to safeguard government resources and ensure compliance with policies and procedures that reduce the risk of error, fraud, waste, and abuse.[74]

The team reviewed the following areas through sampled transactions:

- **Purchase card transactions.** The team determined whether the healthcare system processed purchase card transactions in accordance with VA policy, including whether cardholders obtained prior approvals before initiating a purchase and reconciled their transactions in a timely manner, whether approving officials promptly approved the transactions, and whether staff maintained segregation of duties.[75] The team also assessed if cardholders split purchases—that is, intentionally divided a single purchase into two or more purchases to avoid exceeding the micropurchase threshold.[76]
- **Supporting documentation.** The team examined whether the healthcare system maintained supporting documentation for purchases, as required, to provide assurance of payment accuracy and to justify the need to purchase a good or service. Such documentation includes approved purchase requests, purchase orders, receiving reports, and vendor invoices.[77] Supporting documentation enables program oversight and helps prevent fraud, waste, and abuse.
- **Use of contracts.** The team examined whether the healthcare system considered obtaining contracts when regularly procuring the same or similar goods and services, which VA refers to as "strategic sourcing." The use of contracts in place of open market or individual purchases lowers the potential risk for split purchases on purchase cards and allows VA to leverage its purchasing power using competitively priced contracts.[78]
- **Purchase card oversight.** The team assessed whether the healthcare system had purchase card policies in place and maintained accurate VA 0242 forms, as well as

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

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

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

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

[78] VA Financial Policy, "Government Purchase Card for Micro-Purchases." According to this policy, "strategic sourcing" includes ensuring employees obtain proper contracts when regularly procuring goods and services. Purchases that exceed the cardholder's single purchase threshold cannot be made on purchase cards. Split purchases occur when a cardholder intentionally circumvents this requirement by dividing a single purchase or need into two or more smaller purchases.

whether approving officials were assigned no more than 25 purchase card accounts each.[79] The team also assessed whether the healthcare system's purchase card coordinator provided oversight of the purchase card program by completing purchase card reviews. These activities are examples of systematic controls that help reduce errors and ensure a healthcare system complies with VA policy.

Finding 3: Purchase Card Transaction Processing Needs Improvement

The OIG found healthcare system leaders could ensure transactions are processed in compliance with VA policy and improve efficiency by consistently ensuring approving officials and cardholders properly review transactions to validate purchases. The inspection team assessed the documentation of purchase card transactions provided by healthcare system personnel to determine if the cardholders followed VA policy. Based on the results of the areas reviewed, the team projected errors could exist in about 94,500 of 108,290 transactions, or 87 percent, totaling just under $108.3 million in questioned costs.[80] Violations included lacking prior approvals, supporting documentation, and segregation of duties.

Purchase Card Transactions

VA policy requires cardholders to adhere to certain requirements when using government purchase cards to acquire goods and services, including the following three requirements:[81]

- **Prior approval.** Before initiating a purchase, the cardholder must obtain prior approval for the purchase and ensure the requester certifies that it is for a valid business need. Approval may vary in form and content but must be retained as supporting documentation.[82]
- **Reconciliation.** Reconciliation of a purchase should be completed by the cardholder and approved by the approving official no later than the 15th calendar day of the month after

[79] An approved VA Form 0242 is used to delegate authority to an individual to use the purchase card to procure and pay for goods and services. VA Financial Policy, "Government Purchase Card for Micro-Purchases" requires that, to ensure that approving officials can perform an adequate review and verification of cardholder transactions, each approving official is limited to no more than 25 purchase card accounts under their purview.

[80] According to 2 C.F.R. § 200.84 (2014), the term "questioned cost" means a cost that is questioned by the auditor because the cost, at the time of the audit, is not supported by adequate documentation. See appendix C for monetary benefits associated with the questioned costs.

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

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

the closing of the previous month's billing cycle. An account not reconciled within 30 days of the due date will have its single-purchase limit lowered.[83]

- **Segregation of duties.** To reduce the risk of fraud, waste, and abuse, healthcare system staff must maintain segregation of duties to ensure roles and responsibilities do not overlap among the cardholder, approving official, receiver of purchased items or services, or requesting official.[84]

The team projected that at least 7,400 transactions did not have a proper approval, totaling at least $8.8 million in questioned costs.

Further, the team also could not verify that segregation of duties was maintained for an estimated 77,300 transactions, which resulted in approximately $88.6 million in questioned costs. Healthcare system cardholders did not provide sufficient documentation, such as written requests from the respective service, prior approvals, receiving reports, and invoices as evidence that duties were properly segregated.[85] VA requires that the duties of the cardholder, approving official, requesting official, and receiving official be segregated.[86] These issues occurred because the healthcare system did not have controls designed to ensure cardholders obtained and maintained all required documentation, including documentation demonstrating that segregation of duties was maintained.

Additionally, the inspection team assessed if cardholders had split purchases into two or more acquisitions to circumvent their micropurchase threshold.[87] The team reviewed transaction documentation and interviewed purchase cardholders and approving officials and determined none of the reviewed transactions were split purchases.

Supporting Documentation

VA policy requires cardholders to upload and store supporting documents for purchase card transactions on a VA-approved document-imaging system.[88] When using a purchase card to buy goods and services, healthcare system staff must maintain supporting documentation for six years. This documentation—such as approved purchase requests, vendor invoices, purchase

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

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

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

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

[87] Cardholders are instructed not to modify a requirement or split purchases into smaller parts to avoid exceeding their purchase card limit or the use of formal contracting procedures; instead, cardholders should communicate the need for the order of goods or services to the contracting office for procurement.

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

orders, and receiving reports—can be used to verify that purchase card transactions were properly approved and that payments were accurate.

The inspection team estimated that cardholders did not have sufficient supporting documentation for approximately 60,200 transactions, which resulted in an estimated $69.2 million in questioned costs. These issues occurred because the healthcare system did not have controls designed to ensure cardholders obtained and maintained all required documentation such as packing slips, receiving reports, or proof of delivery from vendors that shipped items directly to patients. While some cardholders maintained supporting documentation in paper copy format, they did not use any form of document-imaging system as required.[89]

Use of Contracts

The inspection team also assessed the sampled transactions for evidence that the healthcare system staff had used the most appropriate purchasing mechanism. Approving officials, the agency or organization program coordinator, and cardholders must review purchases to determine when establishing contracts is in the best interest of the government and must communicate accordingly with the procurement office. Generally, VA should use contracts if the purchase is for an ongoing order of goods or services.

During the review, the team determined cardholders were using established contracts when procuring valid goods and services for the healthcare system. However, the team learned through interviews that cardholders and approving officials were not fully aware of the policy requirement to review their purchases and obtain proper contracts when procuring goods on a regular basis. This occurred because cardholders and approving officials were not fully aware of the policy requirement to review their purchases and determine when it is in the best interest of the government to use strategic sourcing for recurring goods or services. Making open market purchases when a contract might be a better vehicle increases the risk that VA will not receive the best possible pricing for goods and services.[90]

Purchase Card Oversight

Responsible officials are accountable for compliance with the Government Purchase Card Program and for implementing internal controls to protect and conserve federal funds.[91] Purchase card coordinators should identify and report any issues and ensure remediation actions are effective.[92] Internal controls include periodic and continuous monitoring, checks and balances,

[89] VA Financial Policy, "Government Purchase Card for Micro-Purchases."
[90] VA Financial Policy, "Government Purchase Card for Micro-Purchases."
[91] VA Financial Policy, "Government Purchase Card for Micro-Purchases."
[92] VA Financial Policy, "Government Purchase Card for Micro-Purchases."

policies, procedures, and the segregation of duties to reduce the risk of error, fraud, waste, and abuse in the purchase card program.[93]

To assess oversight of the program and compliance with VA policy, the inspection team determined whether the healthcare system had purchase card policies in place, assigned approving officials no more than 25 purchase card accounts each, maintained segregation of duties, and maintained an approved VA Form 0242 for each cardholder in the inspection sample.[94]

To ensure approving officials can adequately review and verify cardholder transactions, approving officials are limited to no more than 25 purchase card accounts under their purview. VHA purchase cards for prosthetics are permitted to have a ratio as high as 40 purchase card accounts to one approving official.[95] An approved VA Form 0242 is used to delegate authority to an individual to use the purchase card to procure and pay for goods and services. This form also establishes purchase limits and responsibilities and certifies that the purchase card is issued appropriately and that the cardholder and approving official understand the adverse actions that may be taken as a result of inappropriate or unauthorized use of the card. A revised form is required when the approving official changes, the cardholder changes their legal name, or the single-purchase limit is changed.[96]

The OIG found that the healthcare system had gaps in purchase card oversight. For example, all 23 cardholders responsible for the sampled purchase card transactions had an approved VA Form 0242, the healthcare system had purchase card policies in place, and approving officials did not have more than 25 purchase card accounts under their purview.[97] However, as mentioned, the healthcare system could improve its oversight related to the processing of purchase card transactions and the maintenance of supporting documentation.

Finding 3 Conclusion

While the healthcare system demonstrated some oversight of the purchase card program, the inspection team identified areas for improvement. Purchase card transactions were not always supported by necessary documentation, such as evidence of requests from the service, prior approvals, delivery confirmation, or invoices. Also, the healthcare system's purchase card transaction process did not always maintain segregation of duties. Based on the results of all areas reviewed, the team projected that the healthcare system could have noncompliance errors

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

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

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

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

[97] "VA Form 0242, Governmentwide Purchase Card Certification Form" (website), https://vaww.ccp.fsc.va.gov/prweb/PRWebLDAP1/app/CCP_/BsEaQJh455Qb6C31ug63yw*/!STANDARD?pzPostData=-690502262. (This website is not publicly accessible.)

in approximately 94,500 purchase card transactions, totaling an estimated $108.3 million in questioned costs. These issues could have been identified with more effective reviews by approving officials and with controls designed to ensure cardholders maintain complete supporting documentation for transactions and obtain documentation from vendors.

Recommendations 7–8

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

7. Ensure cardholders comply with prior approval, segregation of duties, and record retention requirements as required by VA Financial Policy, volume 16, chapter 1B, "Government Purchase Card for Micro-Purchases."
8. Ensure cardholders and approving officials are aware of the requirement to review purchases and determine when it is in the best interest of the government to use strategic sourcing.

VA Management Comments

The director concurred with recommendations 7 and 8. The responses are provided in full in appendix D. To address recommendation 7, the director will require all cardholders, approving officials, and their responsible services to maintain a standardized recordkeeping system for purchase card documentation, ensuring record retention and enabling more timely review and prevention of prior approval and segregation of duty violations. Additionally, services will ensure cardholders and approving officials' performance plans address these purchase card duties. The facility will also conduct monthly, quarterly, and annual auditing of sampled purchase card transactions and documentation to identify and report noncompliance and monitor corrective actions.

To address recommendation 8, services will verify regular reviews of routine and recurring purchases including follow-up in support of strategic sourcing.

OIG Response

The healthcare system's action plans are responsive to the OIG's recommendations. The OIG will monitor implementation of the planned actions and will close the recommendations when sufficient evidence is received demonstrating progress in addressing the intent of the recommendations and the issues identified.

IV. Supply Chain Management Operations

The Generic Inventory Package is the software system authorized to manage the receipt, distribution, and maintenance of expendable supplies used throughout VA. Inventory data, if properly recorded in this system, should reflect the actual quantity and dollar value of supply items in stock. Supplies are received at the warehouse, stored in a primary inventory point, and distributed as needed to secondary inventory points, such as storage rooms within the clinical areas that use those items.[98] The team reviewed the following areas:

- **Inventory performance metrics.** The team assessed whether the healthcare system met the performance metrics for days of stock on hand for both Medical Surgical Prime Vendor (MSPV) and non-MSPV expendable items.
- **Inventory data accuracy.** After analyzing Supply Chain Data Informatics Office reports and interviewing staff, the team completed a physical count of some of the larger-dollar items in two primary inventory points to assess accuracy.
- **Supply chain management oversight.** The team assessed processes that affected the healthcare system's supply chain management.

Finding 4: The Healthcare System Should Ensure that Supply Chain Operations Comply with VHA Policy and that Inventory Data Are Accurate

The OIG found that the healthcare system could improve the efficiency of inventory management by establishing local processes and procedures to ensure stock levels and their associated expendable inventory data values are recorded correctly and are routinely monitored in the Generic Inventory Package. Establishing local processes and procedures for the timely review of data to detect and correct data errors would increase the reliability of inventory data and help ensure metrics are met. Specifically, supply chain management staff failed to properly record the distribution of supplies for inventory areas reviewed by the inspection team. In addition, the healthcare system did not fully meet days-of-stock-on-hand performance metrics. The days-of-stock-on-hand metrics measure the efficient management of expendable item inventories and help avoid overstocking or understocking. Overstocking can increase the risk that inventory held in stock could become damaged, contaminated, or outdated before items are used. Understocking can increase the risk that supplies will be unavailable when needed, which could interrupt or delay patient care. Staffing and retention issues may have affected the healthcare system's ability to establish local processes and procedures, develop training plans, and conduct supply chain oversight. The healthcare system also failed to ensure that delegations of authority were recorded in writing for staff placing orders on the MSPV contract and for the

[98] VHA Directive 1761.

MSPV facility-level contracting officer's representative (COR). Failure to properly align systems, personnel, and processes across the supply chain can weaken the healthcare system's ability to effectively plan, mitigate issues, and budget for the purchase of supplies to meet patient care needs.

Inventory Performance Metrics

Supplies are received at the warehouse and distributed to inventory points throughout the facility.[99] The Supply Chain Common Operating Picture (SCCOP) dashboard tracks the use of these supplies. The dashboard, which receives part of its data from the Generic Inventory Package, states that the performance goal for expendable supplies purchased through the MSPV program is to maintain 30 days or fewer of stock on hand, whereas non-MSPV items should have 45 days or fewer of stock on hand.[100] To avoid overstocking or understocking, VHA requires responsible staff to ensure correct reorder points and inventory levels are maintained.[101] Before the inspection site visit, the team accessed the SCCOP dashboard and downloaded the healthcare system's days-of-stock-on-hand reports for both MSPV and non-MSPV items and found that from May through November 2023, the healthcare system had an average of 29 days of stock for MSPV items and 45 days of stock for non-MSPV items during the inspection period, as detailed in table 3.

Table 3. Days of Stock on Hand

Purchase category benchmark (in days)		May through November 2023 monthly average (in days)	December 2023 monthly average (in days)	May through December 2023 monthly average (in days)
MSPV items	30	29	49	32
Non-MSPV items	45	45	113	54

Source: OIG analysis of MSPV and non-MSPV days-of-stock-on-hand cost information extracted from the Power Business Intelligence Production SCCOP dashboard.

Therefore, the seven-month average from May through November 2023 met the 30-day and 45-day performance metrics. However, the team's review of individual monthly reports during this time led to the conclusion that these averages were understated. The September and October 2023 reports showed negative MSPV days of stock on hand, which resulted from supply

[99] VHA Directive 1761. Primary inventory points contain all expendable items for an inventory account and are replenished by ordering from sources outside the VA healthcare system. Secondary inventory points may also be established for the distribution to, and replenishment from, a primary inventory. A primary inventory point with no secondary inventory point is referred to as a stand-alone primary inventory.

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

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

chain personnel improperly adjusting stock levels using a process they referred to as "reverse distribution orders." This process was used during the healthcare system's inventory count to make records in the Generic Inventory Package match on-hand quantities. According to the deputy chief supply chain officer, reverse distribution orders move items listed in the healthcare system's Generic Inventory Package from secondary inventory points back to the primary inventory points from which they were initially distributed. He explained that the intent of reverse distributions orders is to correct administrative mistakes, such as quantity-on-hand errors when the actual quantities on hand do not match the quantities identified in the Generic Inventory Package. However, the process can cause reporting to be inaccurate and reflect negative days of stock on hand. Because supply chain personnel used reverse distribution orders, the overall days of stock on hand reported in SCCOP showed negative days of stock on hand, and these errors remained in the system for 90 days.

Furthermore, the inspection team found that in December 2023, at the end of that 90-day period, days of stock increased sharply—from 29 days to 49 days for MSPV items and from 45 days to 113 days for non-MSPV items. The healthcare system did not meet the performance measures during the eight-month period that the OIG reviewed; from May through December 2023, the averages were 32 days and 54 days of stock on hand for MSPV and non-MSPV items, respectively. The deputy chief supply chain officer said the appropriate way to correct quantity-on-hand errors is to use adjustment vouchers. He explained that an adjustment voucher is an adjustment method logistics staff use to correct the quantity on hand without physically moving items. As a result of the OIG's inspection, the chief supply chain officer verbally instructed the supervisor and staff to use adjustment vouchers, as appropriate, for all future inventory counts. In addition, the deputy chief supply chain officer said the annual training plan will include training that emphasizes the importance of adjustment vouchers and how to perform them.

The team also evaluated 30 clinical primary inventory points with MSPV items and 32 with non-MSPV items that were subject to the days-of-stock-on-hand metrics. Twenty of the 30 clinical primary inventory points with MSPV items (67 percent) did not meet the performance metrics for days of stock on hand, and 21 of 32 clinical primary inventory points with non-MSPV items (66 percent) did not meet the metrics.

The healthcare system's inability to meet the days-of-stock-on-hand performance metrics was due to multiple factors, which included the improper inventory adjustments made to correct quantity-on-hand errors, as discussed above; inventory managers' ineffective use of the Generic Inventory Package auto-generation scanning tool that generates reports indicating when inventory should be reordered; and the inventory staff's lack of familiarity with the metrics. The team determined a lack of local processes and procedures hindered the monitoring efforts needed to manage and reduce data integrity issues and to perform oversight of stock levels. After the inspection team's visit, the healthcare system provided the team with an approved and signed copy of a supply chain management standard operating procedure dated March 2024. The

standard operating procedure outlines the processes and procedures for monitoring inventory reports. Even though the implementation of this procedure steers the healthcare system in the right direction, the healthcare system needs to ensure supply chain leaders and staff adhere to it.

Inventory Data Accuracy

The team accessed the SCCOP dashboard on January 16, 2024, and downloaded the days-of-stock-on-hand report summary to identify the top inventory points measured by dollar value on hand. The SCCOP report showed the inventory points with the highest dollar value on hand were "distribution" and "interventional radiology."[102] The team interviewed staff and conducted walk-throughs for both inventory points during its site visit, which ran from January 29 through February 1, 2024.

The team used Generic Inventory Package reports (accessed from the Supply Chain Data Informatics Office Toolbox prior to the walk-through) to identify the top six items by total inventory value at each of the two inventory points and physically counted the items in stock to assess data accuracy.[103] During the physical counts, the inspection team found discrepancies between what was reported in the Generic Inventory Package and what was physically located at both inventory points. The team counted quantities and identified dollar values that did not agree with Generic Inventory Package records. Tables 4 and 5 show counts and discrepancies for the items selected at the distribution and interventional radiology inventory points.

Table 4. Discrepancies Between Generic Inventory Package Data and the Physical Count in the Clinical Distribution Inventory Point[104]

Item description	System data		Physical inventory count		Decrease in value on hand
	Number of items	Value on hand	Number of items	Value on hand	
Headphones, black	4,317	$1,726,800	1,529	$68,805	-$1,657,995
IV stabilization kit with PI extension set	1,101	$190,468	0	$0	-$190,468

[102] VHA Directive 1761. The Inventory Point Identifier is a naming convention that is automatically assigned when the inventory point is created. Distribution inventory represents a clinical inventory point with inventory items for the medical supply distribution at the VA Tampa Healthcare System. Items include bandages, catheters, gloves, gowns, sterile water, and wipes. Interventional radiology inventory represents a clinical inventory point with items for interventional radiology, including catheters, guide wires, and contrast solutions.

[103] The top two clinical primary inventory points and top six items within each inventory point were selected based on highest dollar values. The inventory points and items were selected from a point-in-time determination using the "All Days-of-Stock-on-Hand Summary by Inventory Point" report from the SCCOP dashboard on January 16, 2024.

[104] The clinical distribution inventory point is a functional area with the purpose of stocking, maintaining, and distributing clean medical supplies needed to support the VA Tampa Healthcare System.

Item description	System data		Physical inventory count		Decrease in value on hand
	Number of items	Value on hand	Number of items	Value on hand	
IV stabilization kit with extension set	21,950	$142,120	1,953	$12,636	-$129,484
Pack, cataract-eye	373	$104,749	94	$26,398	-$78,351
Level 2 gowns	8,500	$84,176	0	$0	-$84,176
Device, blood Luer-lock	7,250	$66,880	6,643	$66,098	-$782

Source: VA OIG analysis of clinical distribution inventory data versus a physical inventory count.

According to the inspection team's count of six items at the distribution inventory point, the total quantities were overstated in the Generic Inventory Package by 33,272 items, totaling over $2.1 million. The inventory system showed a total quantity of 43,491 items in stock, but the inspection team counted only 10,219 items in the storage area.

The team considered the possibility of fraud as a cause for the inventory variances shown above, especially for headphones, and asked supply chain management personnel about the fraud risks and indicators. The team also reviewed the conversion factors and price data used for headphones in the Generic Inventory Package. Based on its analysis, the team concluded the large variances most likely were not due to fraud but rather to a conversion factor error and erroneous pricing data. Despite these missing items, the deputy chief supply chain officer said he was not concerned about theft, spoilage, loss, or damage to inventory items because they conducted monthly inventory to adhere to VA policy requirements for inventory accuracy.

Table 5. Discrepancies Between Generic Inventory Package Data and the Physical Count in Interventional Radiology Inventory

Item description	System data		Physical inventory count		Decrease in value on hand
	Number of items	Value on hand	Number of items	Value on hand	
Ice gel coldspot	250	$187,500	420	$1,764	-$185,736
Roo catheter cover	300	$150,000	0	$0	-$150,000
Minor-procedure-drape	241	$80,647	215	$5,601	-$75,046
Marker-skin-BB	1,500	$71,603	0	$0	-$71,603

Item description	System data		Physical inventory count		Decrease in value on hand
	Number of items	Value on hand	Number of items	Value on hand	
Syringe-alphabet	1,490	$60,271	0	$0	-$60,271
Syringe, inj & cont	186	$53,218	0	$0	-$53,218

Source: VA OIG analysis of interventional radiology inventory data versus a physical inventory count.

Note: Numbers do not always sum due to rounding.

The inspection team found that total quantities for the six items counted in the interventional radiology primary inventory point were overstated in the General Inventory Package by 3,332 items, totaling almost $596,000. The inventory system showed a quantity of 3,967 stock items, but the inspection team only counted 635 stock items in the storage area.

The OIG team and the inventory managers searched for these items in multiple locations but could not find the quantities reflected in the Generic Inventory Package and in some cases could not find them at all. The inventory managers explained that one inventory item was replaced by a similar product, but they did not take the item out of Generic Inventory Package. For six items, the inspection team could not find any quantities on hand. The inventory managers told the team they did not know where the items were located or what had happened to them.

Following the team's walk-throughs, supply chain managers acknowledged the errors, agreed that adjustments were needed, and made some corrections. According to VHA policy, inventory managers and functional area employees must review inventory points at least quarterly to ensure correct items and levels are maintained in the Generic Inventory Package. Specifically, inventory managers must use the auto-generation option in the VHA-approved inventory management system to create orders to replenish inventories.[105] The scanning tool generates reports indicating when inventory should be reordered. However, during the site visit, inventory staff mentioned that they were not fully using this tool for inventory management for various reasons: time constraints, too many hands involved that resulted in staff pulling items from stock but not adjusting Generic Inventory Package as required, inexperienced supervisory managers, and difficulty retaining staff. The healthcare system could improve efficiency and data reliability by using the auto-generation option in the Generic Inventory Package and implementing a process to verify supply data.

The team also assessed conversion factor data, which can affect the accuracy of days-of-stock-on-hand metrics.[106] The conversion factor is a critical component of inventory

[105] VHA Directive 1761.

[106] The inspection team accessed the "Conversion Factor Primary Inventory Point" report from the SCCOP dashboard on January 8, 2024; this report details point-in-time conversion factor data at the healthcare system.

management that allows for receiving a large unit of measure into inventory and distributing it in smaller units.[107] For example, VA may receive a case of 24 bottles of water from a vendor, but hospital staff might later issue that water to patients one bottle at a time. A unit conversion factor is computed by dividing the quantity purchased by the quantity issued.[108] To continue the example, the 24 bottles received are divided by the individual bottle issued, and the conversion factor would be 24. This factor connects how a supply item is received to how it is issued.

A "false" conversion factor showing in the SCCOP dashboard may be the result of a conversion being entered into the Generic Inventory Package system incorrectly. When the team accessed the conversion factor report on January 16, 2024, 957 of 14,510 conversion factors (almost 7 percent) had false results.[109] Since supply vendors are generally not consistent in how they sell stock—such as by the case, box, or package—supply chain management staff should ensure purchased items are converted correctly. Two of the three inventory managers interviewed acknowledged they did not review conversion factor reports and needed training on conversion factors. Not reviewing conversion factor reports and not having training on conversion factor calculation may have contributed to errors in the inventory system.

To determine the number and associated value of adjustments for the clinical inventory points made at the healthcare system, the team analyzed the SCCOP "Generic Inventory Package Adjustments" report for the 90 days prior to January 16, 2024. The report showed positive and negative adjustments in the Generic Inventory Package to correct inventory point data. According to the SCCOP report, over 740 adjustments were made, affecting over 221,700 items totaling almost $1 million. Supply chain managers explained that these adjustments were made in response to annual inventory adjustments, purchase order amendments, damaged and expired items, pricing changes, and donations and disposition of items.

Supply Chain Management Oversight

The inspection team conducted interviews with supply chain managers and staff to evaluate oversight controls and the efficiency of the healthcare system's supply chain management. Managers and staff reported two primary areas of concern: inexperienced supervisory management specialist with retention issues and warehouse space.

[107] "How to Identify Conversion Factor Errors and Correct Them" (website), VHA Procurement & Logistics Office, accessed June 13, 2024. (This SharePoint website is not publicly accessible.)

[108] Department of VA Office of Information and Technology Product Development, Integrated Funds Distribution, Control Point Activity, Accounting and Procurement, IFCAP Application Coordinator User's Guide, Version 5.1, October 2000, rev. October 2019. A conversion factor expresses the ratio between the vendor's unit of measure and the unit of issue and is used to translate the order quantities into supply station amounts.

[109] When a conversion factor does not equal an item's unit of receipt divided by the unit of issue, it is flagged as a "false" result.

Logistics staff further said the lack of warehouse and secondary inventory closet space contributed to the healthcare system's ineffective oversight controls and inefficient inventory management practices. The deputy chief supply chain officer said the healthcare system adapted to this space issue by restocking inventory more frequently using medical supply technicians. He also mentioned that with so many hands involved, there is an increased risk of inventory errors, and it created an environment where service lines could begin to hoard items for future use and relocate items outside designated medical supply closets due to a fear of rapid consumption. To address these space issues, the healthcare system was working with the General Services Administration to secure a 32,000-square-foot warehouse and hoped to move in by 2025. These challenges highlight the critical need to address staffing and space challenges, as well as provide adequate training and resources to enable effective oversight and efficiency in supply chain management.

Contract Performance Monitoring

The healthcare system had one MSPV contract during the inspection period from May 1, 2023, through February 2, 2024.[110] The team found deficiencies in the management and oversight of purchases under that contract, which led to over $1.2 million in unauthorized commitments and almost $507,000 in questioned costs. Two factors led to this conclusion:

- Healthcare system staff placed orders against the MSPV contract without delegations of authority.
- A staff member without delegation of authority reviewed and authorized payments for distribution fee invoices.

MSPV ordering officers are required to be nominated by logistics leaders and appointed by the MSPV contracting officer.[111] Without authorized ordering officers in place, facilities are not permitted to purchase items under MSPV contracts and must use other approved ordering

[110] MSPV Gen-Z Transition 2 Contract 36C10X23D0003, effective starting November 16, 2022.

[111] According to Veterans Affairs Acquisition Regulations (VAAR) 801.601-General, "HCAs [heads of contracting activities] may authorize the use of ordering officers to order supplies and services in accordance with the ordering limits identified in the contract or agreement or the specific ordering guide. The written delegation must be specific to the contract or agreement and articulate the limitations of the delegated authority." Associate deputy assistant secretary for procurement policy, systems and oversight and deputy senior procurement executive, "VA Procurement Policy Memorandum (2016-02) – VA Wide Procedures Regarding the Use of Ordering Officers (VAIQ7696245)" memorandum to under secretaries for health, benefits, and memorial affairs; chief facilities management officer, Office of Facilities Management; Head Contracting Activities, Directors, VHA service area offices; directors and network contract managers, Veterans Integrated Service Networks; directors, VA medical center activities, domiciliary, outpatient clinics, medical and regional office centers, and regional offices; directors, Denver Acquisition and Logistics Center, Corporate Franchise Datacenter, Records Management Center, VBA benefits delivery centers, and VA Health Administration Center; and the executive director and chief operating officer, VA National Acquisition Center, National Cemetery Administration. April 28, 2016.

methods.[112] The inspection team found that 13 healthcare system personnel placed orders using the MSPV contract despite not being delegated or authorized during the contract period of May 1, 2023, through February 2, 2024. This occurred because the healthcare system did not submit delegation of authority nominations, which led to the contracting officer not providing letters of delegation. The deputy chief supply chain officer attributed this deficiency to an administrative oversight and turnover in logistics leadership. As a result, the healthcare system staff made improper payments resulting from unauthorized commitments totaling over $1.2 million.[113] The healthcare system should coordinate with the contracting office to submit ratifications for unauthorized commitments.[114]

Delegations authorizing CORs to take certain actions must be in writing.[115] MSPV guidance explains that the facility-level COR plays a crucial role in ensuring that prime vendors meet their contractual obligations within the MSPV program. The COR acts as a liaison between the healthcare system and the prime vendor on-site representative to ensure compliance with contract terms, monitor prime vendor performance, and identify program risks.[116] The healthcare system must have at least one certified facility-level MSPV COR, nominated by logistics leaders and appointed by the MSPV contracting officer.[117]

The inspection team found that the staff member performing the facility-level COR duties for the MSPV contract effective during the inspection period was the same person designated as the COR on the prior MSPV contract, which ended on November 30, 2022.[118] However, when the newer contract started, the contracting officer did not properly delegate that staff member for the COR role on the newer contract. The duties associated with the COR role included reviewing invoices for monthly distribution fees to ensure they are accurate and in accordance with contract requirements. Despite having a staff member who performed facility-level COR duties without

[112] VA Procurement and Logistics Office, Medical Supply Program Office, *MSPV Field Guide, Ordering Officer Nomination Guide*, May 2023, p. 6.

[113] FAR 1.602-3 (2023). Unauthorized commitments are not binding because the government representative who made them lacked the authority to enter into that agreement.

[114] FAR 1.602-3 (2023). Ratification means the act of approving an unauthorized commitment by an official who has the authority to do so.

[115] FAR 1.602-2(d) (2023). "Contracting officers must designate and authorize in writing and in accordance with agency procedures, a COR on all contracts and orders other than those that are firm-fix price and firm-fixed price contracts and orders as appropriate, unless the contracting officer retains and executes the COR duties."

[116] VHA One Book, Supply Chain Operating Plan, April 2019, http://vaww.hefp.va.gov/sites/default/files/files/2019-12/VHASupplyChainProgramOffice%28PLO%29One-Book.pdf. (This website is not publicly accessible.)

[117] MSPV Gen-Z Transition Contract #36C10X22D0003, effective November 30, 2021, through November 30, 2022, section C, Contract Clauses, VAAR 852.270-1, Representatives of Contracting Officers.

[118] MSPV Gen-Z Transition Contract #36C10X22D0003, effective November 30, 2021, through November 30, 2022; MSPV Gen-Z Transition 2 Contract #36C10X23D0003, effective November 16, 2022, through TBD. According to the program office, staff are expected to use the MSPV Gen-Z Transition contracts until the MSPV Gen-Z, V1 begins.

being delegated, the healthcare system and Strategic Acquisitions Center contracting officer did not take necessary measures to ensure the staff member was properly delegated to carry out those designated responsibilities.

Payments do not meet federal regulations when contractor performance is monitored and invoices are approved by an individual who is not delegated in writing as a COR.[119] Therefore, due to the lack of COR delegation letters, the team found that the healthcare system improperly approved invoices, leading to questioned costs totaling almost $507,000 for the period of May through November 2023.[120] The deputy chief supply chain officer attributed the failure to delegate authority to the COR over an almost eight-month period to an administrative oversight error and supervisory turnover in the logistics service.

As a result of the OIG inspection, the healthcare system officially nominated the same individual who had previously held the role as the COR for the MSPV contract on December 18, 2023. The MSPV contracting officer then signed and issued the delegation letter to the healthcare system on December 22, 2023.

Finding 4 Conclusion

The healthcare system's oversight of supply chain management can be improved to ensure MSPV ordering officers and contracting officer's representatives are properly appointed and delegated, performance metrics for days of stock on hand are met for all clinical inventory points, and inventory data are accurate in the Generic Inventory Package. Deficient contract administration practices by the healthcare system resulted in staff placing orders and approving invoices without proper authority that totaled over $1.2 million in unauthorized commitments and questioned costs of almost $507,000. Additionally, increased reliance on manual inventory counts, manual ordering processes, and incorrect inventory quantities and dollar values in the Generic Inventory Package necessitate manual adjustments and affected the healthcare system's performance metrics. More importantly, errors indicating that supplies are available when they are not will adversely affect the healthcare system's ability to effectively plan and budget for the purchase of supplies to meet patient care needs.

Recommendations 9–12

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

[119] FAR 32.905 (2023). Payment documentation and process.

[120] 2 C.F.R. § 200.1. Questioned cost means a cost that is questioned by the auditor because of an audit finding (1) that resulted from a violation or possible violation of a statute, regulation, or the terms and conditions of a federal award, including for funds used to match federal funds; (2) where the costs, at the time of the audit, are not supported by adequate documentation; (3) where the costs incurred appear unreasonable and do not reflect the actions a prudent person would take in the circumstances; or (4) questioned costs are not an improper payment until reviewed and confirmed to be improper as defined in OMB Circular A-123, appendix C.

9. Develop and implement a plan to ensure data accuracy and reliability in the Generic Inventory Package and ensure processes are in place to monitor performance metrics in accordance with Veterans Health Administration policy.
10. Develop and maintain an effective standardized training program for new and current inventory staff and monitor the staff's knowledge and skill level.
11. In coordination with the Strategic Acquisition Center, ensure that the Medical Surgical Prime Vendor facility-level contracting officer's representatives and ordering officers are appointed and delegated properly and perform all required duties according to the scope and limitation of the designee's authority.
12. In coordination with the Strategic Acquisition Center, submit ratifications for any Medical Surgical Prime Vendor unauthorized commitments in accordance with the Federal Acquisition Regulation.

VA Management Comments

The director concurred with recommendations 9 through 12. The responses are provided in full in appendix D. To address recommendation 9, supply chain management has established an inventory accuracy project to address data accuracy issues in the Generic Inventory Package. To address recommendation 10, supply chain management is implementing a training plan that will address critical knowledge, skills, and abilities needed to maintain an accurate medical supply inventory. To address recommendations 11 and 12, the chief supply chain officer reported that MSPV COR and ordering officers' appointments were completed, a dashboard was created to monitor MSPV program activities, and the service has an internal process to monitor staff designations. The chief supply chain officer also reported that the facility was not required to submit ratifications because it resolved all payment issues.

OIG Response

The healthcare system's action plans are responsive to the OIG's recommendations. The OIG will monitor implementation of the planned actions and will close the recommendations when sufficient evidence is received demonstrating progress in addressing the intent of the recommendations and the issues identified.

Appendix A: Scope and Methodology

Scope

The team conducted its inspection of the VA Tampa Healthcare System from January 2024 to November 2024, including a site visit during the week of January 29, 2024. The inspection was limited in scope and is not intended to be a comprehensive inspection of all financial operations at the healthcare system.

Methodology

The inspection team evaluated financial efficiency practices for fiscal year (FY) 2023 related to the use of managerial cost accounting information, open obligations, purchase card transactions, and inventory and supply chain management.

To conduct the inspection, the team interviewed healthcare system leaders and staff and identified and reviewed applicable laws, regulations, VA policies, operating procedures, and guidelines.

The team statistically selected

- 25 accrued expenses to assess whether healthcare system staff identified and reviewed the obligations to determine whether they were still valid and needed to remain open in accordance with VA financial policy and
- 46 purchase card transactions to determine if there was proper oversight and governance of the purchase card program, as well as to assess the risk for illegal, improper, or erroneous purchases.

To review the purchase card transactions selected in the sample, the team requested supporting documentation for each of the 46 transactions, VA Form 0242 for all 23 unique cardholders associated with the selected transactions, and documentation to support the completion of the reviews.

The team also judgmentally selected

- 10 high-cost products from the Managerial Cost Accounting Office modeling tools for FY 2023 product cost report (from a total of 16,282 products available for review);
- 10 30-minute primary care appointments from 14 healthcare system primary care clinics for FY 2023;
- 10 products with the highest cost outliers for FY 2023 (out of 138 available products);

- 10 inactive undelivered order obligations to assess whether healthcare system staff identified and reviewed the sampled obligations to determine if they were still valid and needed to remain open;
- six obligations with different end dates from VA's Financial Management System (FMS)–to–Integrated Funds Distribution, Control Point Activity, Accounting and Procurement System (IFCAP) reconciliation reports to determine if end dates reconciled between VA's FMS and IFCAP;
- six obligations with different order amounts from VA's FMS-to-IFCAP reconciliation reports to determine if order amounts were subsequently reconciled between VA's FMS and IFCAP; and
- two clinical primary inventory points selected by highest total dollar value on hand to determine the top six items by total inventory value in each inventory point selected for review.

Internal Controls

The inspection team assessed the internal controls of the VA Tampa Healthcare System significant to the inspection objective. This included an assessment of the five internal control components: control environment, risk assessment, control activities, information and communication, and monitoring.[121] In addition, the team reviewed the principles of internal controls as associated with this objective. The team identified internal control weaknesses during this inspection in all four sub-objectives assessed—use of managerial cost accounting information, open obligations oversight, purchase cards, and inventory and supply chain management—and proposed recommendations to address the weaknesses.

Data Reliability

The inspection team used computer-processed data obtained from US Bank files through a corporate data warehouse, Supply Chain Common Operating Picture reports, FMS reports, and cost accounting data from the relative value unit modeling tool. To test for reliability, the team determined whether any data were missing from key fields (including any calculation errors) or were outside the time frame requested. The team also assessed whether the data contained obvious duplication of records, alphabetic or numeric characters in incorrect fields, or illogical relationships among data elements. Furthermore, the team compared purchase identification numbers, purchase dates, cardholder names, payment amounts, and vendor and merchant names

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

as provided in the data received for the samples reviewed. Testing of the data disclosed that they were sufficiently reliable for the inspection objectives.

In addition, the team used computer-processed data included in reports from FMS to determine open obligation amounts. The Office of Inspector General (OIG) found the summary-level data were sufficiently reliable for reporting on the healthcare system's open obligations.

Government Standards

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

Appendix B: Statistical Sampling Methodology

Open Obligations

The inspection team evaluated a judgmental sample of undelivered orders and a statistical sample of outstanding accruals as of November 15, 2023, to determine whether the VA Tampa Healthcare System performed monthly reviews and reconciliations to ensure its obligations were valid and should remain open. The team also evaluated a judgmental sample of open obligations as of November 2023 to determine if the end dates and amounts were accurate and reconciled between the Financial Management System (FMS) and Integrated Funds Distribution, Control Point Activity, Accounting and Procurement System (IFCAP).

Population

As of November 15, 2023, the healthcare system had 186 open obligations totaling more than $22.9 million that had been open for more than 90 days. Of those obligations, 38 were undelivered orders valued at just over $15.6 million and 148 were outstanding accruals valued at more than $7.3 million.[122] The inspection team also analyzed FMS-to-IFCAP reconciliation reports for the period of June 2 through November 29, 2023, for end-date and order amount discrepancies. The team identified six open obligations totaling more than $7.8 million with end-date discrepancies and 12 obligations totaling close to $12.4 million in order amount discrepancies between FMS and IFCAP for three or more months, respectively.

Sampling Design

The inspection team used the following FMS reports to design its samples:

- **Undelivered orders.** The team judgmentally selected 10 obligations with no activity for more than 90 days from the November 15, 2023, FMS F850 report. All 10 obligations were still within the period of performance.
- **Outstanding accruals.** The team used a method of probability proportionate to size selection where the probability of selection was based on the number of days open being greater than or equal to 90 days and the associated outstanding balance for those with a balance greater than $100. The sampling design resulted in the review of 25 outstanding accrued expenses from the November 15, 2023, FMS F851 report and allowed the inspection team to project their findings from the sample to the population. This report lists each accrual and its outstanding balance.

[122] The initial population of accruals included multiple obligations with low-dollar amounts of less than $100. To avoid spending time reviewing low-dollar amounts, the team filtered the accrual population to include only obligations valued at $100 or more that were at least 90 days old.

- **FMS-to-IFCAP reconciliations.** The team reviewed VA's FMS-to-IFCAP reconciliation report for November 2023 and judgmentally selected six obligations with different end dates and six with different order amounts between FMS and IFCAP.

The samples included 47 total open obligations: 10 outstanding undelivered orders totaling almost $9 million; 25 outstanding accruals totaling close to $4.2 million aged 90 days or more; six open obligations with different end dates between FMS and IFCAP totaling more than $7.8 million; and six open obligations with different order amounts between FMS and IFCAP totaling more than $7.3 million.

The team requested supporting documentation for each of the 47 sampled transactions, including monthly reviews and reconciliations, financial system screen prints and reports, and emails related to the obligations.

Purchase Cards

The inspection team evaluated a statistical sample of purchase card transactions that occurred from November 1, 2022, through October 31, 2023, to determine if the Tampa VA Healthcare System reviewed transactions to (1) ensure they were adequately monitored, approved, and supported by documentation; (2) prevent split purchases; and (3) ensure goods or services were procured using strategic sourcing.

Population

From November 1, 2023, through October 31, 2023, the healthcare system had 109,170 purchase card transactions, which totaled just over $128.5 million. The inspection team removed negative purchase card transaction amounts from the total population of transactions and obtained a population of 108,290 transactions totaling just under $129.6 million.[123] From this population, the team developed two strata to draw statistical samples. The first stratum included potential split transactions that exceeded the $10,000 micropurchase threshold in the aggregate but not individually. The stratum included 451 bundles of transactions composed of 1,945 individual transactions, which totaled approximately $8.2 million. The second stratum included the remaining 106,345 purchase card transactions, totaling just under $121.4 million, that were greater than or equal to $0 and were not included in the first stratum.

[123] The inspection team pulled a statistical sample from positive dollar amount transactions (negative transactions, such as refunds, were excluded).

Sampling Design

For the two strata, 74 sample transactions were selected using probability proportional to size of purchase amount by bundle (for potential split purchases) or by individual transaction (for other purchases):

- **Potential split purchases exceeding the micropurchase threshold.** The team identified potential split purchases as transactions with the same purchase date, purchase card number, and merchant, and an aggregate sum greater than the micropurchase threshold. The statistical sample consisted of eight bundles of potential split purchases that included 49 individual transactions totaling approximately $220,000. From these 49 transactions, the team selected 21 transactions to review. All transactions from each bundle were not included in the review—only enough transactions were reviewed to determine if any purchases in a bundle were split to remain below the micropurchase threshold.
- **Other purchases.** The team selected 25 transactions totaling about $562,600 greater than or equal to $0 after excluding previously identified potential split purchases.

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.

Projections and Margins of Error

The projection is an estimate of the population value based on the sample. The associated margins of error and confidence intervals show the precision of the estimate. If the Office of Inspector General (OIG) statistician 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 estimates, margins of error, and confidence intervals that 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.

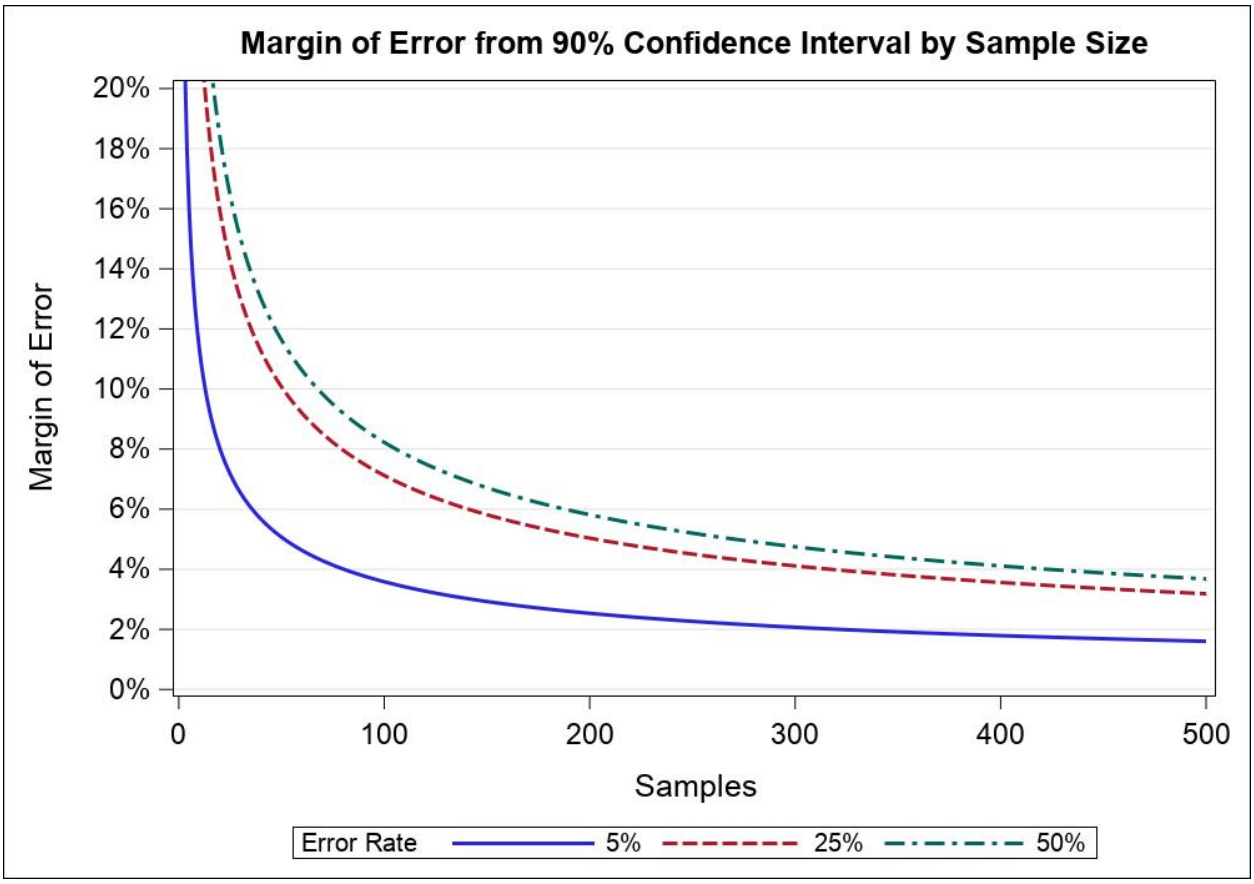


Figure B.1. *Effect of sample size on margin of error.*

Source: VA OIG statistician's analysis.

Projections

Open Obligations

Tables B.1 and B.2 show statistical projections of accruals and the associated dollar amounts.

Table B.1. Statistical Projections for Accrual Errors

Estimate name	Estimate number	90 percent confidence interval			Sample size
		Margin of error	Lower limit	Upper limit	
Invalid accrual	83	33	50	116	17
Invalid accrual: better use of funds	83	33	50	116	17
Invalid accrual (percent)	56	22	34	78	17

Source: VA OIG statistician's analysis and team's review of obligations with accrual balances.

Table B.2. Statistical Projections for Accrual Errors: Dollar Amounts

Estimate name	Estimate number	90 percent confidence interval			Sample size
		Margin of error	Lower limit	Upper limit	
Invalid accrual	$5,972,445	$1,472,834	$4,499,611	$6,212,042	17
Better use of funds	$5,596,150	$1,428,184	$4,167,966	$5,785,788	17

Source: VA OIG statistician's analysis and team's review of obligations with accrual balances.

Purchase Cards

Table B.3 shows purchase card transaction sample errors, and tables B.4 and B.5 show statistical projections of purchase card transaction errors and their dollar amounts.

Table B.3. Purchase Card Transaction Sample Errors

Estimate name	Number of errors	Sample size
Overall errors	32	46
No prior approval	12	46
Supporting documentation	21	46
Segregation of duties	26	46

Source: VA OIG statistician's analysis and team's review of purchase card transactions.

Table B.4. Statistical Projections for Purchase Card Errors

Estimate name	Estimate number	90 percent confidence interval				Sample size
		Margin of error	Lower limit	Upper limit	Lower one-tailed limit	
Overall errors	94,510	11,858	82,652	106,368	N/A	46
Overall errors (percent)	87	11	76	98	N/A	46
Supporting documentation errors	60,202	18,108	42,093	78,310	N/A	46
Prior approval errors	17,756	13,376	4,380	31,132	7,398	46
Segregation of duties errors	77,309	16,381	60,929	93,690	N/A	46

Source: VA OIG statistician's analysis and team's review of purchase card transactions.

Note: For estimates with poor precision, the one-tailed lower limit for the 90 percent confidence interval is reported. This is a more conservative value than the estimate. When reporting on total errors combined, a projected "overall errors" estimate is used to avoid double counting transaction amounts. The use of this estimate causes the overall errors count to be different than the sum of the supporting documentation errors and reconciliation errors.

Table B.5. Statistical Projections for Purchase Card Errors: Dollar Amounts

Estimate name	Estimate number	90 percent confidence interval				Sample size
		Margin of error	Lower limit	Upper limit	Lower one-tailed limit	
Overall errors	$108,297,844	$13,549,643	$94,748,201	$121,847,487	N/A	46
Supporting documentation errors	$69,244,469	$20,677,889	$48,566,579	$89,922,358	N/A	46
Prior approval errors	$20,678,272	$15,280,990	$5,397,282	$35,959,262	$8,845,401	46
Segregation of duties errors	$88,646,217	$18,707,097	$69,939,120	$107,353,314	N/A	46

Source: VA OIG statistician's analysis and team's review of purchase card transactions.

Note: For estimates with poor precision, the one-tailed lower limit for the 90 percent confidence interval is reported. This is a more conservative value than the estimate. When reporting on total errors combined, a projected "overall errors" estimate is used to avoid double counting transaction amounts. The use of this estimate causes the overall errors count to be different than the sum of the supporting documentation errors and reconciliation errors.

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

Recommendation	Explanation of Benefits	Better Use of Funds	Questioned Costs[124]
4	Ensure that healthcare system staff and responsible finance office staff review all open obligations to ensure balances are valid and should remain open or are closed in a timely manner as required by the current edition of VA Financial Policy, "Obligations."	$5,900,000	$0
6	Consult with the Office of General Counsel and the Office of Acquisitions, Logistics, and Construction to determine whether a bona fide needs or other appropriations law violation occurred and, if any violations did occur, take appropriate remedial and preventive actions to address them.	$0	$35,700
7	Ensure cardholders comply with prior approval, segregation of duties, and record retention requirements as required by VA Financial Policy, volume 16, chapter 1B, "Government Purchase Card for Micro-Purchases."	$0	$108,300,000
11	In coordination with the Strategic Acquisition Center, ensure that the Medical Surgical Prime Vendor facility-level contracting officer's representatives and ordering officers are appointed and delegated properly and perform all required duties according to the scope and limitation of the designee's authority.	$0	$507,000

[124] The Office of Inspector General (OIG) questions costs when VA action or inaction (such as spending or failure to fully compensate eligible beneficiaries) is determined by the OIG to violate a provision of law, regulation, contract, grant, cooperative agreement, or other agreement; when costs are not supported by adequate documentation; or when they are expended for purposes that are unnecessary or unreasonable under governing authorities. Within questioned costs, the OIG must, as required by section 405 of the IG Act, report unsupported costs. Unsupported costs are those determined by the OIG to lack adequate documentation at the time of the audit. Of the estimated $110 million in questioned costs, about $69.2 million were unsupported costs.

Recommendation	Explanation of Benefits	Better Use of Funds	Questioned Costs[124]
12	In coordination with the Strategic Acquisition Center, submit ratifications for any Medical Surgical Prime Vendor unauthorized commitments, following the Federal Acquisition Regulation.	$0	$1,200,000
	Total	**$5,900,000**	**$110,042,700**

Note: The better use of funds is related to various open obligation monitoring and administrative deficiencies identified in the sampled obligations. This amount includes an estimated $5.6 million from accruals, more than $162,000 due to end-date discrepancies, and just under $191,000 due to amount discrepancies, which brought the total monetary benefits to an estimated $5.9 million.

Appendix D: VA Management Comments

Department of Veterans Affairs Memorandum

Date: November 26, 2024

From: Director, James A. Haley Veterans' Hospital and Clinics (673/00)

Subj: Draft Report – Financial Efficiency Inspection of the VA Tampa Healthcare System (THCS)

To: Director, Financial Inspections Division (52C05)

1. I have reviewed the draft report and concur with the recommendations identified in the Office of Inspector General Draft Report – Follow up Financial Efficiency Inspection of the VA Tampa Healthcare System.

2. I would like to thank the Office of Inspector General for a thorough review and recommendations. THCS is diligently working on action plans to improve our processes as we remain committed to identifying opportunities for cost efficiency and promotion of best practices.

(Original signed by)

David K. Dunning, MPA

Director

Attachment

Attachment

Recommendations 1-12 (Director of the VA Tampa Healthcare System)

1. Establish a plan to use VA's cost accounting system information to identify additional ways to reduce costs, enhance efficiency, and inform business decisions as identified by VA financial policy.

Healthcare system concurred.

Target date for completion: March 31, 2025

Plan: As of 11/25/2024, the Tampa Veterans' Health Care System continues to use Managerial Cost Accounting for annual budget, additional resource requests, cost per stop code and cost per treating specialty comparisons. Enhancements in using the VHA Managerial Cost Accounting modeling tool and training guide, reporting process to monitor outliers and high-cost services to reduce outliers thereby enhancing efficiency will be implemented. During the second quarter 2025 the Managerial Cost Accounting Dashboard (MCAD) will be used to identify specific service lines with higher cost or low productivity to verify workload and resource mapping compared to like facilities to identify opportunities to lower cost or improve access. Additional details will be reviewed as opportunities are identified with the goal of lowering cost and enhancing efficiency.

2. Ensure the facility has a process to identify cost outliers, such as using the Intermediate Product Cost Outlier report to identify cost outliers that may occur at the healthcare system on a regular basis.

Healthcare system concurred.

Target date for completion: March 31, 2025

Plan: As of 11/25/2024 the VISN MCA group identifies cost outliers but is unable to complete analysis due to timely information from service lines. Enhancements to the cost outlier on the Intermediate Product Outlier report will be reviewed with Executive Leadership Team monthly (part 2) with plan to address outlier trends with ongoing reviews to bring into compliance or document justification for variance. During the second quarter 2025 teams consisting of MCA, Finance, GPM and services will report on results of outlier variances and corrective actions taken.

3. Ensure healthcare system service lines review and update the national labor mapping tool to the VISN managerial cost accounting team as required by VA financial policy to ensure workload is being captured correctly.

Healthcare system concurred.

Target date for completion: June 30, 2025

Plan: Response: As of 11/25/2024 approximately 30% of service lines respond to the bi-weekly labor mapping. The VISN MCA group will prepare monthly compliance report to Integrity and Compliance workgroup with plan to improve response rate to 50% by end of 3rd quarter. The plan to improve the response rate will include both education at the service level and accountability at the Executive Leadership level. The compliance report will be reviewed with Executive Leadership Team during monthly review (part 2).

4. Ensure that healthcare system staff and responsible finance office staff review all open obligations to ensure balances are valid and should remain open or are closed in a timely manner as required by VA Financial Policy, “Obligations,” as updated in March 2024.

Healthcare system concurred.

Target date for completion: December 1, 2024

Plan: The facility reviews all open obligations to ensure balances are valid and need to remain open within the first 5 days of each month. The facility generates and reviews the F850/F851/889B reports monthly for compliance. The Fiscal department disseminates undelivered orders (UDO) reports by FCP and services by the 5th of each month. The Fiscal department will then send Services and follow on email by the 10th day of the month requesting updates on obligations not reported on. The Fiscal department tracks and reviews for compliance responses to UDO reports and required the services to report updates on obligations by the 15th of each month. Thus, each month the Fiscal department makes 3 attempts monthly to review with the services all obligations each month. Service Chiefs are included in final email sent on the 15th on each month. After the 15th day of each month, the Fiscal staff will continue to pursue a remedy for invalid orders and work with Senior Leadership such as the ELT for a solution. Extenuating circumstances often happens such as employee turnover, business environmental factors, and unforeseen events often impact obligations performance. The VISN is currently revamping its UDO/Accrued Services Payable (ASP) portal that provides centralized configuration and reporting on automated email requesting and response gathering for UDO. Since the OIG inspection, the facility has demonstrated the effectiveness of the process in place. For the last 6 months, the facility has consistently decreased the number and amount of invalid UDO and ASP outstanding. The progress is monitored daily using the VSSC Aging of Orders Tool for monitoring obligations and payables. As of 11/27/24, the Tampa Facility has only 3.27% value of all obligations over 90 days and only 10.95% total transactions over 90 days, which far exceeds the standard of 10% and 25% respectively. The plan is to continue to follow up on open obligations and remain below standards.

5. Ensure that the healthcare system uses appropriated funds in the manner intended by Congress, as required by the VA Financial Policy, “Obligations,” as updated in March 2024.

Healthcare system concurred.

Target date for completion: March 31, 2025.

Plan: In accordance with VA Financial Policy Vol VIII, Chapter IA, Invoice Review and Certification, the facility will hold certifying officials responsible for certifying each individual invoice for payment and for ensuring that the invoice is correct, accurate and in accordance with the related obligation document. The obligation creation process ensures appropriate funds are used in a manner intended by Congress. However, the invoice review and payment are the core problem in the findings. Thus, the facility will reiterate/and retrain with certifying officials that invoices are to be reviewed as soon as practical for the following items: a) name of vendor; b) Invoice date; c) obligation number, or other authorization for delivery of goods or services; d) vendor invoice number, account number, and/or any other identifying number agreed to by contract; e) description, price, and quantity of goods and services rendered; f) shipping and payment terms; g) Taxpayer Identifying Number (TIN); (h) and other substantiating documentation or information required by the obligating document. The facility will reiterate that the facility will return incorrect and improper invoices to vendor 20 calendar days for general services or goods. This will prevent automatic payments for goods under the dollar threshold for automatic payment. The correction action is to retrain the Supply Chain Management’s certifying officials responsible for the audit

infractions on both the mandatory timelines for taking actions on pending invoices in IPPS and to reiterate with all other certifying officials within the facility VA Policy regarding their responsibilities as certifying officials. The facility will leverage the Financial Quality Assurance program to monitor compliance and hold individuals accountable for payment policy and regulatory violations.

6. Consult with Office of General Counsel and Office of Acquisitions, Logistics and Construction to determine whether a bona fide needs or other appropriations law violation occurred and, if any violations did occur, take appropriate remedial and preventive actions to address them.

Healthcare system concurred.

Target date for completion: March 31, 2025

Plan: Correction action plan for #5 applies to preventive action to address future violations. Additionally, on December 2, 2024 the facility has submitted an OGC Request for Legal Support Services for bona fide needs or appropriation law potential violation review and any additional appropriate remedial actions.

7. Ensure cardholders comply with prior approval, segregation of duties, and record retention requirements as required by VA Financial Policy, volume 16, chapter 1B, “Government Purchase Card for Micro-Purchases.”

Healthcare system concurred.

Target date for completion: March 31, 2025

Plan: Cardholders, Approving Officials, and their responsible Service will maintain a standardized record-keeping system of purchase card documentation to ensure record retention and to enable more timely review and prevention of prior approval and segregation of duty violations. Services will ensure Cardholders and Approving Officials have performance plans incorporating purchase card duties that include knowledge of and complying with valid prior approval, segregation of duty, and record retention requirements. In addition to required purchase card training, additional facility purchase card training for Cardholders, Approving Officials, and responsible Services. Monthly, quarterly, and annual auditing of sampled purchase card transactions and purchase card documentation will be performed to identify non-compliance for corrective action by Cardholder, Approving Official, and responsible Service. Specific non-compliance will be reported immediately to responsible parties to include A/OPC for corrective action and monitored as part of facility reporting. Progressive actions from education to loss of purchasing card use will be dependent on continuing compliance/non-compliance.

8. Ensure cardholders and approving officials are aware of the requirement to review purchases and determine when it is in the best interest of the government to use strategic sourcing.

Healthcare system concurred.

Target date for completion: March 31, 2025

Plan: Cardholders, Approving Officials, and their responsible Service will maintain a standardized record-keeping system of purchase card documentation to enable more timely review and analysis for strategic sourcing. Services will verify regular review of routine and recurring purchases including follow-up in support of strategic sourcing. Cardholders and Approving Officials will have performance plans incorporating strategic sourcing duties.

9. Develop and implement a plan to ensure data accuracy and reliability in the Generic Inventory Package and ensure processes are in place to monitor performance metrics in accordance with Veterans Health Administration policy.

Healthcare system concurred.

Target date for completion: January 31, 2025

Plan: The Tampa VA Supply Chain Management team has a chartered Inventory Accuracy project established with System Redesign that began in July 2024. The scope of the project is to address the data accuracy issues in Generic Inventory Package (GIP). Specifically, the project is looking to achieve a minimum of 95% medical supply inventory accuracy rate, ensure an inventory scan rate of 75%, while increasing stock availability and decreasing long supply within the HCS. As of 11/25/2024, the MSPV DOSH is in compliance with the governing directive at 28.45 DOSH (max 30 DOSH). Non-MSPV DOSH is at 48.5% which is 3 days above the requirement, working to decrease. We will continue to utilize the Supply Chain Common Operating Picture (SCCOP) and Supply Chain Data & Informatics Office (SCDIO) tools to monitor improvements and develop sustainability.

10. Develop and maintain an effective standardized training program for new and current inventory staff and monitor the staff's knowledge and skill level.

Healthcare system concurred.

Target date for completion: October 1, 2025

Plan: A FY25 training plan for the Inventory Management Specialist (EX) assigned to SCM was prepared and communicated to staff at the beginning of FY25. This training plan identified the critical Knowledge, Skills, and Abilities (KSAs) needed to maintain an accurate medical supply inventory (see attached). Successful completion of this training will be annotated in the employees' competency folder and reviewed quarterly.

Recommendations 11-12 (Director of the VA Tampa Healthcare System and the Strategic Acquisition Center associate executive director)

11. Ensure that the Medical Surgical Prime Vendor facility-level contracting officer's representatives and ordering officers are appointed and delegated properly and perform all required duties according to the scope and limitation of the designee's authority.

Healthcare system concurred.

Target date for completion: November 20, 2024

Plan: On 10/30/2024, the Chief Supply Chain Officer at the Tampa VA Medical Center reached out to the Strategic Acquisition Center's Medical Surgical Prime Vendor (MSPV) Contracting Officer to discuss the appointment of the COR and the ordering officer delegations. The SAC representative provided confirmation that all staff members within SCM were compliant with the MSPV program. A facility readiness dashboard was created in Power BI to monitor the MSPV program activities and the Service has an internal process to monitor staff OOD designations.

12. In coordination with the Strategic Acquisition Center, submit ratifications for any Medical Surgical Prime Vendor unauthorized commitments in accordance with the Federal Acquisition Regulation.

Healthcare system concurred.

Target date for completion: October 30, 2024

Plan: On 10/30/2024, the Chief Supply Chain Officer at the Tampa VA reached out to the Strategic Acquisition Center's Medical Surgical Prime Vendor Contracting Officer (MSPV) to discuss the need to submit a ratification for any MSPV unauthorized commitments made during the audit period of 12/2022 – 12/2023. The SAC noted that the facility implemented internal policies and procedures to address these findings and to mitigate against future occurs. With all the accounting and payment issues being resolved, no requirement to submit a ratification.

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

OIG Contact and Staff Acknowledgments

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