

VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS



# Veterans Health Administration

*Audit of  
Engineering Service Purchase  
Card Practices  
at the Ralph H. Johnson  
VA Medical Center,  
Charleston, South Carolina*

April 17, 2014  
13-02267-124

## ACRONYMS AND ABBREVIATIONS

FAR	Federal Acquisition Regulation
OIG	Office of Inspector General
VAMC	Veterans Affairs Medical Center
VISN	Veterans Integrated Service Network
VHA	Veterans Health Administration

**To Report Suspected Wrongdoing in VA Programs and Operations:**

**Telephone: 1-800-488-8244**

**Email: [vaoighotline@va.gov](mailto:vaoighotline@va.gov)**

**(Hotline Information: <http://www.va.gov/oig/hotline>)**



# Report Highlights: Audit of VHA's Engineering Service Purchase Card Practices at VAMC Charleston, SC

## Why We Did This Audit

VA's Office of Inspector General Hotline Division received an allegation that Engineering Service employees at the Ralph H. Johnson, VA Medical Center (VAMC), Charleston, SC, were splitting purchases to circumvent the \$3,000 micro-purchase limit. We expanded the scope of the audit to determine the extent Engineering Service employees inappropriately used purchase cards from October 2011 through May 2013.

## What We Found

We substantiated the allegation that Charleston VAMC Engineering Service employees split purchases and identified improper purchase card payments. Of 139 sampled purchases Engineering Services made during the period of October 2011 through May 2013, 40 were unauthorized commitments totaling \$83,100 that avoided competition requirements. The 40 unauthorized commitments included 35 purchases valued at about \$69,300 that cardholders split and 5 purchases valued at about \$13,800 that exceeded the micro-purchase limit for services.

Engineering Service employees also made 33 purchases that we could not determine whether payment was proper because of insufficient documentation. The value of these improper payments was about \$55,000.

This occurred because of ineffective oversight of cardholder transactions and inadequate cardholder and approving official

purchase card training. As a result, we estimated that Charleston VAMC's Engineering Service cardholders made about \$274,000 of unauthorized commitments and approximately \$372,000 of purchases that lacked sufficient documentation.

## What We Recommended

We recommended the Veterans Integrated Service Network (VISN) 7 Director review Charleston VAMC Engineering Service's purchase card transactions for unauthorized commitments and purchases lacking sufficient documentation and process necessary ratification and payment recovery actions. Additionally, we recommended the VISN 7 Director improve purchase card practices by implementing monitoring mechanisms that ensure improved oversight and providing sufficient training.

## Agency Comments

The VISN 7 Director concurred with the recommendations and provided an acceptable action plan.

A handwritten signature in blue ink that reads "Linda A. Halliday".

**LINDA A. HALLIDAY**  
Assistant Inspector General  
for Audits and Evaluations

# TABLE OF CONTENTS

Introduction.....	1	
Results and Recommendations .....	2	
Finding	Charleston VAMC Engineering Service Employees Made Unauthorized Commitments and Improper Payments.....	2
	Recommendations .....	7
Appendix A	Background .....	10
Appendix B	Scope and Methodology .....	11
Appendix C	Statistical Sampling Methodology .....	13
Appendix D	Potential Monetary Benefits in Accordance With Inspector General Act Amendments.....	15
Appendix E	Veterans Integrated Service Network 7 Director Comments .....	16
Appendix F	Office of Inspector General Contact and Staff Acknowledgments .....	21
Appendix G	Report Distribution.....	22

## INTRODUCTION

- Allegation*** In April 2013, the VA's Office of Inspector General (OIG) Hotline Division received an allegation that Engineering Service employees at the Ralph H. Johnson VA Medical Center (VAMC), Charleston, SC, were splitting purchases to circumvent the \$3,000 micro-purchase limit. We expanded the scope of the audit to determine the extent Charleston VAMC Engineering Service employees inappropriately used purchase cards.
- Purchase Card Program*** The General Services Administration's SmartPay2 program provides purchase cards to Federal agencies through contracts negotiated with contractor banks. Purchase cards provide Federal agencies with a purchase and payment tool that implements simplified acquisition procedures, which streamline the procurement process by allowing for quick ordering and paying of supplies and services.
- Micro-Purchases*** VA Financial Policies and Procedures, for Government Purchase Card use, require cardholders to use the Government purchase card for all micro-purchases. The Federal Acquisition Regulation (FAR) defines a micro-purchase as an acquisition of supplies using simplified acquisition procedures, where the aggregate amount does not exceed \$3,000. FAR establishes lower micro-purchase thresholds of \$2,500 for acquisitions of services subject to the Service Contract Act and \$2,000 for construction-related acquisitions subject to the Davis-Bacon Act.
- Responsible VA Program Offices*** VA's Office of Finance provides VA purchase card policy and procedures. VA's Office of Acquisition and Logistics is responsible for developing and assessing compliance with procurement policy and procedures. The Veterans Health Administration's (VHA) Procurement and Logistics Office is responsible for oversight of VHA's Purchase Card Program. During 2013, VA reported making over 5.8 million purchase card transactions valued at \$3.5 billion.
- Charleston VAMC Engineering Service*** Charleston VAMC's Engineering Service is responsible for construction projects and for improving, maintaining, and operating the VAMC's physical plant and equipment. Engineering Service consists of several sections, including construction management and maintenance and operations. These sections are responsible for providing various services, such as maintaining electrical, mechanical, and boiler plant operations.
- Other Information***
- Appendix A provides additional background information.
  - Appendix B outlines the audit scope and methodology.
  - Appendix C details the audit statistical sampling methodology.

## RESULTS AND RECOMMENDATIONS

### **Finding Charleston VAMC Engineering Service Employees Made Unauthorized Commitments and Improper Payments**

We substantiated the allegation that Charleston VAMC Engineering Service employees split purchases inappropriately and identified improper purchase card payments. Of 139 sampled purchases made by Engineering Service cardholders from October 2011 through May 2013, 40 were unauthorized commitments totaling \$83,100 that avoided competition requirements. The 40 unauthorized commitments included 35 purchases valued at about \$69,300 that cardholders split and 5 purchases valued at about \$13,800 that exceeded the micro-purchase limit for services. Engineering Service employees also made 33 purchases that we could not determine whether payment was proper because of insufficient documentation. The value of these improper payments was about \$55,000. This occurred because of ineffective oversight of cardholder transactions and inadequate cardholder and approving official purchase card training.

As a result, we estimated that Charleston VAMC's Engineering Service cardholders made about \$274,000 of unauthorized commitments and approximately \$372,000 of purchases that lacked sufficient documentation. Before estimating the combined sample results, we projected that Engineering Service made \$660,000 inappropriate purchases or about 20 percent of the approximately \$3.4 million micro-purchases made from October 2011 through May 2013.<sup>1</sup>

#### ***Inappropriate Purchase Card Use***

Out of 139 purchases reviewed, Charleston VAMC Engineering Service made 40 unauthorized commitments totaling \$86,100 that avoided competition requirements. The 40 unauthorized commitments included 35 purchases valued at about \$69,300 that cardholders split and 5 purchases valued at about \$13,800 that exceeded the micro-purchase limit for services. When requests for services exceed single purchase limits, VA requires cardholders to forward procurement requests to warranted contracting officers who have spending limits above the micro-purchase threshold.

The split purchases and those purchases that exceeded the micro-purchase limit for services were unauthorized commitments. When cardholders, who are only authorized to make micro-purchases, split or fragment an order to avoid exceeding the micro-purchase limit, they make unauthorized

---

<sup>1</sup> The \$660,000 is the lower limit of the combined totals and does not equal the sum of the lower limit estimates for the separate projections of \$274,000 and \$372,000. This is because these are three independent sample estimates. See Appendix C for a description of statistical estimates.

commitments. The VAMC had not requested ratification for any of the identified unauthorized commitments.

**Unauthorized Commitments**

Unauthorized commitments are agreements that are not binding solely because the Government representative who made them lacked the authority to enter into that agreement on behalf of the Government. VA policies prohibit employees from making unauthorized commitments because unauthorized commitments circumvent FAR and eliminate an important system of checks and balances in performing procurement functions.

FAR allows Federal agencies to perform ratification actions for unauthorized commitments. Ratification is the act of approving an unauthorized commitment by an official who has the authority to perform the action. VHA's Head of Contracting Activity has authority to ratify unauthorized commitments made by employees at VA medical facilities. The Head of Contracting Activity must deny requests for ratification of expenditures that violate public law or are an unauthorized use of appropriated funds.

**Split Purchases**

We identified 35 split purchases made by 8 Engineering Service cardholders that circumvented their \$3,000 micro-purchase limit. The value of the 35 split purchases was about \$69,300. Split purchases occur when cardholders make multiple charges to the same vendor for one purchase in order to circumvent single purchase limits. FAR states that cardholders may not split a transaction to avoid the requirement to obtain competitive bids for purchases over the micro-purchase threshold or to avoid established purchase limits. In addition, VHA and the Charleston medical facility policies prohibit cardholders from splitting purchases to circumvent their single purchase limits.

Engineering Service cardholders made these purchases with the same vendor on the same day for dollar amounts sometimes just under established spending limits only minutes apart. The following examples highlight how a cardholder circumvented competition requirements and the \$3,000 micro-purchase limit:

**Example 1**

In May 2013, an Engineering Service cardholder circumvented a \$3,000 single purchase limit by splitting a \$5,483 order into two purchases. The cardholder purchased key sets for \$2,800 and locks sets for \$2,683 from the same vendor in two separate orders just 7 minutes apart.

**Example 2**

Another cardholder continued this practice by splitting a \$5,927 order into two purchases in May 2013. The cardholder purchased sign holder frames for \$2,999 and slot holders with magnets for \$2,928 from the same vendor in two separate orders just 2 minutes apart.

*Purchases Exceeded Micro-Purchase Limit for Services*

Engineering Service cardholders, who did not have warrants, made unauthorized commitments totaling about \$13,800 by completing five purchases that exceeded the FAR \$2,500 micro-purchase limit for acquisition of services subject to the Service Contract Act. Services covered by the Act include operation, maintenance, or logistic support of a Federal facility. The following examples highlight how cardholders exceeded the established purchasing limit for acquiring services:

**Example 3**

In February 2012, a cardholder purchased storage of patient waiting room furniture for \$2,555 and purchased storage and delivery of furniture for \$2,838. Both of these purchases exceeded the FAR \$2,500 purchase limit for services.

**Example 4**

Engineering Service continued this purchasing practice when another cardholder purchased artwork services for \$2,999 in March 2013.

Contracting officers have authority to bind VA to contracts that exceed the \$2,500 limit for acquiring services. FAR contracting procedures are designed to maximize competition and obtain needed goods and services at fair and reasonable prices.

**Lack of Sufficient Documentation**

Of Charleston VAMC Engineering Service's 139 purchase card transactions, 33 transactions lacked sufficient documentation to determine whether payment was proper. These 33 transactions were valued at about \$55,000. Acceptable documentation includes packing slips, receipts, and any other documents showing that goods or services were reasonably priced, received, and for official use. The Office of Management and Budget Circular A-123, Appendix C, *Requirements for Effective Measurement and Remediation of Improper Payments*, defines an improper payment as follows.

*An improper payment is any payment that should not have been made or that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements. Incorrect amounts are overpayments or underpayments that are made to eligible recipients (including inappropriate denials of payment or service, any payment that does not account for credit for applicable discounts, payments that are for the incorrect amount, and duplicate payments). An improper payment also includes any payment that was made to an ineligible recipient or for an ineligible good or service or payments for goods or services not received (except for such payments authorized by law). When an agency's review is unable to discern whether a payment was proper as a result of insufficient or lack of documentation, this payment must also be considered an improper payment.*

The U.S. Government Accountability Office's *Standards for Internal Control in the Federal Government* states that appropriate documentation of transactions and other significant events need to be clearly documented and be readily available. The following example highlights how a cardholder did not maintain sufficient supporting documentation:

**Example 5**

In May 2012, a cardholder made three purchases of \$500, \$1,200, and \$2,500 totaling \$4,200 for maintenance and repairs. Although Engineering Service staff maintained the purchase orders, they could not provide documentation, such as invoices, to show the VAMC received the maintenance and repairs.

Cardholders also did not consistently determine if vendors were eligible to provide goods and services. VHA policy requires cardholders to document General Service Administration's Excluded Parties List System or System for Award Management searches to confirm whether the Federal government had debarred vendors that VHA was considering to use. The following example highlights how a cardholder did not maintain sufficient documentation for debarment searches.

**Example 6**

In August 2012, December 2012, and January 2013, a cardholder made purchases for paint, supplies, and demolition that totaled \$4,835 from three vendors. The cardholder did not maintain sufficient documentation showing searches for debarred vendors. Documentation inadequacies included not showing the date of the debarment search, the search was before the purchase, and the name of the vendor that was searched.

We verified the Federal government had not debarred the three vendors in this example. Cardholders must maintain invoices and debarment search results to show that payments for goods and services were reasonably priced and purchased from eligible vendors. Without these documents, Charleston VAMC management is unable to discern whether payments were proper.

**Reasons for Inappropriate Purchase Card Use**

Engineering Service cardholders made unauthorized commitments and a number of purchases lacked sufficient documentation. These actions occurred because of insufficient oversight of cardholder transactions and inadequate purchase card training.

**Strengthened Oversight Is Necessary**

Four Engineering Service approving officials did not use VHA's required checklist to monitor cardholders' use of purchase cards. The checklist provides a methodical procedure for approving officials to review purchases for inappropriate practices, such as split purchases, illegitimate expenditure of funds, spending that exceeds purchase card limits, and documenting that vendors used are not debarred. Additionally, the VAMC's oversight

procedures did not include sufficient analysis of purchase card data to identify purchase card risks and abuses. The VAMC Purchase Coordinator did not use two available VA financial system reports that identify potential split purchases—History of Transactions Report and Fiscal Daily Review Report.

*Improved  
Training Is  
Needed*

Six of 14 Charleston VAMC Engineering Service cardholders and 3 of 5 approving officials had not completed required refresher training every 2 years. Adequate training is essential for cardholders and approving officials to perform their duties effectively. VHA policy requires purchase cardholders and approving officials to take online purchase card training prior to issuance of purchase cards. The policy also requires refresher training every 2 years for both purchase cardholders and approving officials.

After discussions with Charleston VAMC management during our site visit, the facility initiated a purchase card training plan. The plan includes face-to-face training for all new cardholders at the time of card delivery. However, the plan did not address the required refresher training. Thus, the VAMC Director needs to ensure Engineering Service cardholders complete the required refresher training every 2 years.

*Effects of  
Inappropriate  
Purchase Card  
Use*

We estimated that Charleston VAMC's Engineering Service cardholders made about \$274,000 of unauthorized commitments and approximately \$372,000 of purchases that lacked sufficient documentation. Before estimating the combined the sample results, we project that Engineering Service made \$660,000 inappropriate purchases or about 20 percent of the approximately \$3.4 million micro-purchases made from October 2011 through May 2013.

**Conclusion**

We substantiated the allegation that Charleston VAMC Engineering Service employees split purchases, exceeded the micro-purchase card limit for acquiring services, and lacked sufficient documentation to support that card payments were proper. Charleston VAMC's weak purchase card controls created an environment vulnerable to misusing purchase cards and to the ineffectiveness of an important system of procurement checks and balances.

The VAMC needs to address the identified purchase card program control weaknesses to ensure cardholders protect the Government's interests when obtaining goods and services. Correcting the issues identified will require a strong, sustained commitment from Charleston VAMC management to improve training for cardholders and strengthen oversight over Engineering Service's use of purchase cards.

## Recommendations

1. We recommended the Veterans Integrated Service Network 7 Director use data mining and detailed reviews of high risk transactions to review Charleston VA Medical Center Engineering Service's micro-purchase card transactions made from October 2011 through December 2013 to identify unauthorized commitments, and submit ratification requests for the unauthorized commitments identified by the Office of Inspector General and by Veterans Integrated Service Network 7 to the Veterans Health Administration Head of Contracting Activity.
2. We recommended the Veterans Integrated Service Network 7 Director use data mining and detailed reviews of high-risk transactions to review Charleston VA Medical Center Engineering Service's micro-purchase card transactions made from October 2011 through December 2013 for purchases lacking sufficient documentation and take steps to recover identified inappropriate payments.
3. We recommended the Veterans Integrated Service Network 7 Director develop monitoring mechanisms to ensure Charleston VA Medical Center Engineering Service approving officials consistently use Veterans Health Administration's required Approving Official Checklist to identify split purchases, purchases that exceed the micro-purchase limit for services, and purchases without sufficient documentation.
4. We recommended the Veterans Integrated Service Network 7 Director ensure Charleston VA Medical Center Engineering Service's purchase cardholders and approving officials receive required refresher training every 2 years.

### **Management Comments and OIG Response**

The Veterans Integrated Service Network (VISN) 7 Director concurred with our recommendations and provided corrective action plans that will address our recommendations by September 2014. We will monitor VISN 7's progress and follow up on implementation of planned corrective actions until all actions are completed. Following is a summary of our response to areas where we disagreed with the positions taken by the VISN 7 Director. See Appendix E for the full text of the VISN 7 Director's comments.

**Management Comment:** The VISN 7 Director stated the Charleston VAMC leadership team raised concerns regarding the sampling methodology and the accuracy of projections based on the sample size. The Charleston VAMC leadership team asserted the sample size used in our audit was very small among the "other purchases." The total purchases that met the sampling criteria was 139 out of the universe of 3,543 indicates that approximately 4 percent sample. They noted we determined that 35 purchases or just 1 percent of the total universe failed to comply with

regulations. They contended that in most statistical reviews, the margin of error is defined as within +/-1-5 percent.

They also stated our report did not provide clarity regarding resampling of cancelled orders, and whether the random sample was selected all at once or whether several random samples were selected. They felt their concerns related to the sampling methodology and evidence provided in their comments do not support the estimated dollar amounts in our report.

**OIG Response:** We stratified our sample into three strata and the final sample sizes within each stratum were sufficient to support the projections of the full population used in our report. We believe it is not appropriate to judge sample size based on the percent of the population. In accordance with accepted sampling procedures, a sample size of 30 is required for almost any population to ensure that the sampling distribution is normal and our sample of 139 purchases significantly exceeded the minimum requirement.

Cancelled orders did not affect our sample because we replaced these orders with the next random order. We selected only one random sample within each stratum. Our analyses fully accounted for the complexity of the sample design in the estimation. In addition, we used an estimation methodology that employs “replication” to correctly account for the complexity of the sample design to compute conservative estimates of the variance for sample projections.

**Management Comment:** The VISN 7 Director stated VHA’s “Handbook 1730.01 defines Split or Fragmented Orders as “orders in which the cardholder modifies the requirement by splitting or fragmenting the requested supplies or item quantity into multiple purchases to circumvent their micro-purchase limit or warrant authority limit.”” He asserted that many of the purchases we identified as “split” involved different tasks such as different activities of work that did not require a duty to combine them by the purchase card clerk. He further stated that there is no official definition of duty to combine referenced in the handbook, directive, or training.

**OIG Response:** We reiterate that Charleston VAMC Engineering Service employees inappropriately split purchases. Engineering Service cardholders made these purchases with the same vendor on the same day for dollar amounts sometimes just under established spending limits only minutes apart. Regardless of whether or not the purchases involved different activities of work, when practicable, FAR requires agencies to procure supplies in quantities that will result in the total cost and unit cost most advantageous to the Government. Consequently, when supplies or services are needed for different activities of work, and the combined orders will exceed cardholder micro-purchase limits, cardholders should request their contracting office to procure the supplies or services. This will help ensure compliance with FAR acquisition and competition requirements designed to

ensure Federal agencies procure supplies and services at costs that are fair, reasonable, and most advantageous to the Government.

**Management Comment:** The VISN 7 Director stated there is no VHA Directive requirement mandating that approving officials consistently use a checklist for every purchase order.

**OIG Response:** The VISN7 Director is incorrect. VHA's *Procurement and Logistics Office Standard Operating Procedure Purchase Card Program #002, Implementation and Monitoring of the Approving Official Checklist*, approved June 25, 2010, requires approving and alternate officials to use the checklist as a guide for every transaction they approve.

## Appendix A Background

### **Oversight Responsibilities**

The Veterans Integrated Service Network 7 Head of Contracting Activity is responsible for coordinating the implementation and oversight of purchase card practices throughout the network.

### **Facility Overview**

The Charleston VAMC reported serving over 53,000 veterans in 22 counties. The VAMC provides medical, surgical, and psychiatric inpatient care, as well as outpatient primary and mental health care. Annually, the VAMC also reported providing more than 659,000 outpatient visits and approximately 4,300 inpatient stays.

### **Engineering Service Workforce**

As of June 2013, the Charleston VAMC Engineering Service had 73 employees. Engineering Service had 14 cardholders with 22 purchase cards and 5 approving officials. All cardholders had micro-purchase card single purchase limits of \$3,000 with monthly limits ranging from \$17,000 to \$300,000.

### **Purchase Card Requirements**

Purchase cards reduce administrative costs for the acquisition of supplies and services, streamline payment procedures, and improve management controls by providing procedural checks and feedback. The *Office of Management and Budget Circular A-123, Appendix B, Improving the Management of Government Charge Card Programs* provides Government-wide charge card program requirements and guidance, standard minimum requirements, and suggested best practices. In addition, the *Government Charge Card Abuse Prevention Act of 2012* requires Federal agencies to review Government purchase cards practices to prevent abuse of purchase card use and establishes penalties for misuse of purchase cards.

## **Appendix B Scope and Methodology**

### **Scope**

We conducted our audit from May 2013 through February 2014. The audit focused on a universe of about 4,000 micro-purchases, which totaled about \$3.4 million. The purchases were made from October 2011 through May 2013. We used VA's Veterans Health Information Systems and Technology Architecture to identify these purchases.

We interviewed VHA's National Purchase Card Manager and the Veterans Integrated Service Network 7's Purchase Card Coordinator. In addition, we interviewed Charleston VAMC senior officials and managers; the Purchase Card Coordinator; fiscal, contracting, and logistics officials; and Engineering Service managers, cardholders, and approving officials who participated in the process of making the sampled purchases. We conducted onsite audit work during two Charleston VAMC site visits in June 2013.

### **Methodology**

To accomplish the audit objective, we reviewed applicable Federal regulations and VHA policies, procedures, and handbooks related to purchase card management. We also audited 139 sampled purchases from the universe of about 4,000 purchases—132 selected statistically and 7 selected non-statistically. When appropriate, we also contacted vendors. For each of the 139 sampled purchases, we reviewed purchase orders, invoices, and other available supporting documentation. Appendix C provides details on the statistical sampling methodology and projections.

### **Fraud Assessment**

The audit team assessed the risk of fraud, violations of legal and regulatory requirements, and abuse. The audit team exercised due diligence in staying alert to any fraud indicators by taking actions, such as:

- Soliciting the OIG's Office of Investigations for indicators
- Reviewing prices, assessing appropriate reconciliations and certifications of purchase orders, and verifying VAMC Charleston used purchases of goods or services for legitimate Government needs

We did not identify any instances of fraud during this audit.

### **Data Reliability**

We used computer-processed data from VA's Veterans Health Information Systems and Technology Architecture during the audit. To test the reliability of this data, we compared the computer-processed data with hard-copy documentation, such as purchase orders and vendor invoices. We determined the Veterans Health Information Systems and Technology Architecture data were sufficiently reliable for the audit objective.

We also used computer-processed data from VA's Talent Management System to validate cardholder and approving officials purchase card training.

To test the reliability of these data, we compared the computer-processed data with training certificates. Based on this assessment, we determined the data from the Talent Management System were sufficient for the purposes of our audit.

**Government  
Standards**

Our assessment of internal controls focused on those controls related to our audit objective. We conducted this performance audit in accordance with generally accepted government auditing standards. These standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions on our audit objective.

## Appendix C Statistical Sampling Methodology

### Approach

To evaluate the allegation that Charleston VAMC Engineering Service employees split purchases and to identify additional inappropriate use of purchase cards, we reviewed a representative sample of purchase card transactions below the \$3,000 micro-purchase threshold. We used statistical sampling to quantify the extent of inappropriate purchases that cardholders could have made with a purchase card and to project potential monetary benefits.

### Universe

The universe included about 4,000 purchases below the \$3,000 micro-purchase threshold made by Charleston VAMC Engineering Service cardholders from October 2011 through May 2013. The total for these purchases was approximately \$3.4 million.

### Sampling Design

From the universe, we selected a sample of 139 transactions that had a total value of about \$227,000. Of the 139 sampled transactions, we selected 132 statistically and 7 non-statistically. We added the seven non-statistically sampled transactions to the projections because they were treated as a certainty stratum. While the seven transactions were included in the overall projections, they did not represent any other transactions in the universe.

We stratified the universe of transactions into three strata. The first stratum included purchases that cardholders made on the same day, with the same vendor, where the total dollar amount of the purchases exceeded the \$3,000 micro-purchase limit. The second stratum included the remaining purchases from the universe, except for the seven non-statistical purchases. The third stratum included these seven purchases. Table 1 provides the number of reviewed purchases for the three strata.

**Table 1. Purchases Reviewed by Strata**

Strata	Reviewed Purchases	Universe
1. Potential Split Purchases	95	409
2. Other Purchases	37	3,543
Sub-total	132	3,952
3. Non-Statistical	7	7
<b>Total</b>	<b>139</b>	<b>3,959</b>

*Source: VA OIG statistical sampling of Charleston VAMC purchases*

### Weights

We computed sampling weights as a product of the inverse of the probability of selection at each stage of sampling. We used these weights to compute universe estimates from the sample findings.

**Projections and Margins of Error**

We used WesVar software to calculate the weighted universe estimates and associated sampling errors. WesVar employs replication methodology to calculate margins of error and confidence intervals that correctly account for the complexity of the sample design.

Margins of error and confidence intervals are indicators of the estimates' precision. If we repeated this audit with multiple samples, the confidence intervals would differ for each sample, but would include the true universe value 90 percent of the time. For example, we are 90 percent confident the true universe of micro-purchases that were potentially unauthorized commitments is between \$274,000 and \$446,000. For each estimate, we used the lower limit of the 90 percent confidence interval. Table 2 shows the audit projections and number of sampled Charleston VAMC Engineering Service transactions for the attributes described.

**Table 2. Projections of Inappropriate Purchases Card Use for Charleston VAMC Engineering Service (October 2011–May 2013)**

Description	Estimated	Margin of Error	90% Confidence Interval Lower Limit	90% Confidence Interval Upper Limit	Sample Transactions With Condition
Unauthorized Commitments Value	\$360,000	\$85,600	\$274,000	\$446,000	<b>40</b>
Unauthorized Commitments Percent	11%	3%	8%	14%	
Lacked Sufficient Supporting Documentation Value	\$768,000	\$396,000	\$372,000	\$1,200,000	<b>33</b>
Lacked Sufficient Supporting Documentation Percent	23%	11%	11%	34%	
Combined Value	\$1,100,000	\$400,000	\$660,000	\$1,500,000	<b>65</b>
Combined Percent	32%	11%	20%	43%	

Source: VA OIG statistical analysis of Charleston VAMC purchases

Note: Numbers are rounded for report presentation. Also, the lower limit of the combined total does not equal the sum of the two lower limits for unauthorized commitments and purchases that lacked sufficient supporting documentation. This is because these are three independent sample estimates.

## Appendix D Potential Monetary Benefits in Accordance With Inspector General Act Amendments

Recommendation	Explanation of Benefits	Better Use of Funds	Questioned Costs
1	Reviewing Charleston VAMC, Engineering Service purchase card transactions for unauthorized commitments and performing ratification actions.	\$0	\$274,000
2	Reviewing Charleston VAMC, Engineering Service purchase card transactions for purchases lacking sufficient documentation and pursuing recovery for inappropriate payments.	\$0	\$372,000
<b>Total</b>		<b>\$0</b>	<b>\$660,000<sup>2</sup></b>

<sup>2</sup> The questioned costs are based on the lower limit of a 90 percent confidence interval. As illustrated in Table 2, the lower limit of the combined total does not equal the sum of the two lower limits for unauthorized commitments and purchases that lacked sufficient supporting documentation. This is because these are three independent sample estimates.

## Appendix E Veterans Integrated Service Network 7 Director Comments

### Department of Veterans Affairs

### Memorandum

**Date:** March 27, 2014

**From:** Network Director, VA Southeast Network (10N7)

**Subj:** Draft Report, Audit of VHA's Purchase Card Practices, Ralph H. Johnson VA Medical Center, Charleston, SC., Project Number 2013-02668-R3-0136

**To:** VA OIG - Office of Audits and Evaluations

1. I have reviewed the draft report of the Assistant Inspector General for Audits and Evaluations for Ralph H. Johnson VA Medical Center Engineering Service. Although we concur with the recommendations, we do not agree with all of the findings. Specifically, we are not in agreement with the number of purchases that were cited as being inappropriate or split purchases.
2. In addition, I am aware that the Charleston leadership team raised concerns regarding the sampling methodology and the accuracy of projections based on the sample size. The sample size used in this audit was very small among the "Other Purchases." The total purchases that met the sampling criteria was 139 out of the universe of 3543 indicates that approximately 4 percent sample. You determined that 35 purchases or just 1% of the total universe failed to comply with regulations. In most statistical reviews the margin of error is defined as within +/-1-5 %. The 35 purchases identified as deficient certainly would fall within that typical range of error.
3. We also contend that this was not a large enough sample to be a representative sample of the all purchases. The report did not provide clarity regarding resampling of cancelled orders, and it is not clear if this is accounted for in subsequent analyses. The total population of purchase orders becomes unclear when cancelled orders are re-sampled. In addition, it is also unclear whether the random sample was selected all at once or whether several random samples were selected. If several random samples were selected, it is unclear whether analyses fully accounted for the sampling strategy employed. This concern related to sampling methodology and evidence provided in this response does not support the estimated dollar amounts in the draft report.

4. VISN 7 and our facilities continuously strive to improve our outcomes, efficiency and accuracy, therefore we appreciate any opportunity to exam our performance. I appreciate the opportunity to review the draft report and provide supporting documentation. Please contact Dr. Robin Hindsman with any questions 678-924-5723.



Charles E. Sepich, FACHE

Attachment

**VETERANS INTEGRATED SERVICE NETWORK 7  
Action Plan**

**OIG Draft Report, Audit of Engineering Service Purchase Card Practices,  
Ralph H. Johnson VA Medical Center, Charleston, SC**

**Date of Draft Report: February 19, 2014**

<b>Recommendations/ Actions</b>	<b>Status</b>	<b>Completion Date</b>
-------------------------------------	---------------	----------------------------

**Recommendation 1: We recommend the Veterans Integrated Service Network 7 Director use data mining and detailed reviews of high risk transactions to review Charleston VA Medical Center Engineering Service’s micro-purchase card transactions made from October 2011 through December 2013 to identify unauthorized commitments, and submit ratification requests for the unauthorized commitments identified by the Office of Inspector General and by Veterans Integrated Service Network 7 to the Veterans Health Administration Head of Contracting Activity.**

Concur - with Stipulations

In process

September 30, 2014

We will use data mining to review the Charleston VA Medical Center Engineering Service’s high risk transactions for a Reasonable Sample from October 2011 through December 2013 and submit ratification requests for any unauthorized commitments to Contracting. The methodology for defining the specific targeted purchases to be reviewed is yet to be developed. We are looking for a process that has sufficient specificity to provide only those records that require review. We propose that we review further with the OIG the timeframe for which this type of review would be relevant.

*Stipulations: The audit found that 35 purchase card orders or approximately 1 percent of purchase card practices were deficient. It’s our contention that this is an insufficient number to be an accurate representative sample of the total purchases from 2011-2013. It’s our intention to use a Vista fileman routine to identify high risk transactions transaction within this two year time frame and review than 15% of these purchases and make needed ratifications.*

Comments: VHA Handbook 1730.01 defines Split or Fragmented Orders as “orders in which the cardholder modifies the requirement by splitting or fragmenting the requested supplies or item quantity into multiple purchases to circumvent their micro-purchase limit or warrant authority limit.” Many of the purchases identified as “split” involved different tasks such as different activities of work that did not require a duty to combine them by the purchase card clerk. There is no official definition of duty to combine referenced in the handbook, directive or training.

**Recommendation 2: We recommend the Veterans Integrated Service Network 7 Director use data mining and detailed reviews of high risk transactions to review Charleston VA**

**Medical Center Engineering Service's micro-purchase card transactions made from October 2011 through December 2013 for purchases lacking sufficient documentation and take steps to recover identified inappropriate payments.**

Concur

In process

September 30, 2014

*Using the same data mining from recommendation #1 we will review supporting documentation of those purchases and take steps to recover inappropriate payments.*

Comments:

33 purchases were identified with insufficient documentation. We concurred with 11 of these in the findings.

**Recommendation 3: We recommend the Veterans Integrated Service Network 7 Director develop monitoring mechanisms to ensure Charleston VA Medical Center Engineering Service approving officials consistently use Veterans Health Administration's required Approving Official Checklist to identify split purchases, purchases that exceed the micro-purchase limit for services, and purchases without sufficient documentation.**

Concur- with Stipulations

In process

July 30, 2014

*Stipulations: There is no VHA Directive requirement mandating that approving officials (AOs) consistently use a checklist for every purchase order. Currently, the use of the checklist is recommended for training and guidance for new AOs as referenced in VHA's Procurement and Logistics Office Standard Operating Procedure Purchase Card Program #002 Implementation and Monitoring of the Approving Official Checklist.*

We do agree that retraining Charleston's AOs will improve their accuracy when reviewing purchase card orders. We will provide refresher education to each AO using the referenced checklist and require that each AO use the checklist on no less than 10 approvals per week for 30 days. Each AO will submit copies of their weekly checklist to the Facility and VISN Purchase Card Coordinators for review. The VISN Contracting Purchase Card Coordinator will also conduct a monthly audit of no less than five purchase card approvals per AO using the referenced checklist to document and track compliance.

**Recommendation 4: We recommend the Veterans Integrated Service Network 7 Director ensure Charleston VA Medical Center Engineering Service's purchase cardholders and approving officials receive required refresher training.**

Concur

Completed

The Facility and VISN 7 Purchase Card Coordinators will maintain a tracking database of the TMS Online Purchase Card Training completion dates and subsequent refresher due dates for all cardholders and approving officials. Required employees and supervisors will be notified at 60 days prior to expiration. All employees will be required to complete the required training no less than 30 days prior to expiration. Any employee who fails to complete this training will have their privileges revoked until the training has been completed.

## **Appendix F Office of Inspector General Contact and Staff Acknowledgments**

---

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
-------------	---

---

Acknowledgments	Kent Wrathall, Director Nick Dahl Michael Derick Benjamin Howe Rachel Stroup Al Tate Nelvy Viguera Butler Herman Woo
-----------------	---

## **Appendix G Report Distribution**

### **VA Distribution**

Office of the Secretary  
Veterans Health Administration  
Office of General Counsel  
Director, VA Veterans Integrated Service Network 7  
Director, Ralph H. Johnson, VA Medical Center, Charleston, SC

### **Non-VA Distribution**

House Committee on Veterans' Affairs  
House Appropriations Subcommittee on Military Construction, Veterans  
Affairs, and Related Agencies  
House Committee on Oversight and Government Reform  
Senate Committee on Veterans' Affairs  
Senate Appropriations Subcommittee on Military Construction, Veterans  
Affairs, and Related Agencies  
Senate Committee on Homeland Security and Governmental Affairs  
National Veterans Service Organizations  
Government Accountability Office  
Office of Management and Budget

**This report is available on our Web site at [www.va.gov/oig](http://www.va.gov/oig).**