

VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS



# Veterans Health Administration

*Review of  
Alleged Irregular Use  
of Purchase Cards  
by the Engineering Service  
at the Carl Vinson VA  
Medical Center  
in Dublin, Georgia*

June 27, 2017  
15-01227-249

# ACRONYMS

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

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## Highlights: Review of Alleged Irregular Use of Purchase Cards by VHA's Engineering Service at the Carl Vinson VAMC in Dublin, GA

### Why We Did This Review

The Office of Inspector General conducted this review in response to allegations that Dublin VA Medical Center (VAMC) purchase cardholders split purchases and made duplicate payments to Ryland Contracting Incorporated and Sterilizer Technical Specialists.

### What We Found

We substantiated the allegation that VAMC Dublin cardholders in Engineering Service made unauthorized commitments by splitting purchases and exceeding micro-purchase limits. Of 130 sampled purchases made from October 2012 through March 2015, 23 were split purchases that avoided the \$3,000 limit for supplies and 14 were purchases that exceeded the \$2,500 limit for services.

This was not prevented because approving officials did not adequately monitor cardholders to ensure compliance with VA policy. As a result, of 5,100 purchase card transactions totaling about \$7.1 million, we estimated about 100 transactions totaling about \$240,000 (3.4 percent) were unauthorized commitments and improper payments.

We did not substantiate the allegation that cardholders made duplicate payments to Ryland Contracting Incorporated and Sterilizer Technical Specialists. However, we found cardholders inappropriately made 91 micro-purchases for services received from these vendors without establishing contracts.

This was not prevented because approving officials did not adequately review cardholder transactions to identify service purchases exceeding Veterans Health Administration's (VHA) \$5,000 threshold for establishing contracts during a fiscal year. As a result, cardholders purchased and received services totaling about \$218,000 that avoided Federal competition requirements.

### What We Recommended

We recommended the Veterans Integrated Service Network 7 Director review transactions for unauthorized commitments, submit ratification requests, emphasize the importance of monitoring cardholders, provide training, and ensure approving officials do not exceed the limit of assigned cardholders. In addition, we recommended the Director ensure contracts are established in accordance with VHA policy and take appropriate administrative action for each cardholder who made unauthorized commitments.

### Agency Comments

The Acting Deputy Director concurred with Recommendations 1–4 and 6 and concurred in part with Recommendations 5 and 7. We will follow up on implementation of the planned corrective actions.

A handwritten signature in blue ink that reads "Larry M. Reinkemeyer".

**LARRY M. REINKEMEYER**  
Assistant Inspector General  
for Audits and Evaluations

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## INTRODUCTION

### **Allegations**

In August 2014, the VA's Office of Inspector General (OIG) Hotline Division received an allegation of purchase card irregularities at the Carl Vinson VA Medical Center (VAMC), Dublin GA. The medical facility is located in Veterans Integrated Service Network (VISN) 7. Specifically, the complainant alleged purchase cardholders made unauthorized commitments by splitting purchases and making duplicate payments to Ryland Contracting Incorporated and Sterilizer Technical Specialists.

The Government Charge Card Abuse Prevention Act of 2012 requires the OIG conduct audits of purchase card transactions to identify improper use of purchase cards. Accordingly, we also reviewed purchases to determine whether cardholders exceeded Federal Acquisition Regulation (FAR) micro-purchase limits and Veterans Health Administration's (VHA) \$5,000 limit for recurring purchases of services during a fiscal year without contracts.

### **Purchase Card Program**

The General Services Administration's SmartPay2 Program provides purchase cards to Federal agencies through contracts negotiated with contractor banks. VA reported making approximately 6.7 million purchase card transactions totaling about \$4.0 billion during FY 2015.

### **Federal Acquisition Regulation**

The FAR generally defines a micro-purchase as an acquisition at or below \$3,000 for supplies; \$2,500 for services; and \$2,000 for construction.<sup>1</sup> Generally, VA policies allow only warranted individuals to make purchases above micro-purchase limits.<sup>2</sup> Unauthorized commitments are agreements that are not binding solely because the Government representative who made them lacked the authority to enter into that agreement.

### **Prior Reports**

In April 2014, OIG's *Audit of Engineering Service Purchase Card Practices at the Ralph H. Johnson VA Medical Center, Charleston, South Carolina*, (April 17, 2014, Report No. 13-02267-124) reported cardholders made unauthorized commitments. In response to the report's recommendations, the VISN 7 Director agreed to ensure VAMC Charleston identified unauthorized commitments and submitted appropriate ratification actions.

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<sup>1</sup>FAR Subpart 2.1. Note: In October 2015, the micro-purchase limit for supplies increased to \$3,500.

<sup>2</sup>VA Financial Policies and Procedures, *Government Purchase Card Program*, Volume XVI.

## RESULTS AND RECOMMENDATIONS

### Finding 1 VAMC Dublin Engineering Service Purchase Cardholders Made Unauthorized Commitments

#### What We Found

We substantiated the allegation that VAMC Dublin Engineering Service purchase cardholders made unauthorized commitments. For 37 of 130 sampled cardholder purchase card transactions made from October 2012 through March 2015, the transactions were unauthorized commitments that avoided Federal contracting competition requirements and resulted in improper payments. Of the 37 unauthorized commitments, 23 involved split purchases to avoid the \$3,000 micro-purchase limit for supplies, and 14 involved purchases that exceeded the \$2,500 micro-purchase limit for services.

This was not prevented because approving officials did not adequately monitor cardholder purchases to ensure compliance with VA policy. Further, one approving official was assigned 16 cardholders without obtaining the required approval from the facility director. VHA Handbook 1730.1 states approval officials should be assigned no more than 10 cardholders to ensure they can adequately monitor each cardholder's purchases. As a result, of 5,100 purchase card transactions totaling about \$7.1 million, we estimated approximately 100 transactions totaling about \$240,000 (3.4 percent) were unauthorized commitments. The 100 unauthorized commitments we identified were also improper payments.

#### Criteria

VA's Office of Acquisition, Logistics, and Construction must authorize and validate warrants issued to contracting officers. To become warranted, individuals must receive initial and recurring training to meet statutory requirements for Federal Acquisition Certification in Contracting. Warranted individuals are required to ensure the award of fair and reasonable priced contracts.

VA policy allows only purchase cardholders who have warrants to make purchases above micro-purchase limits.<sup>3</sup> When purchase cardholders exceed their micro-purchase limits, they make unauthorized commitments. The FAR allows for ratifications, which means the act of approving an unauthorized commitment by an official who has the authority to do so.<sup>4</sup>

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<sup>3</sup> VA Financial Policies and Procedures, Volume XVI and VHA Handbook 1730.01, *Use and Management of the Government Purchase Card Program*. (Rescinded April 2017)

<sup>4</sup>FAR, Subpart 1.6.

**Split  
Purchases**

We identified 23 split purchases made by unwarranted Engineering Service cardholders that circumvented the \$3,000 micro-purchase limit. The value of the 23 split purchases totaled about \$48,000. Split purchases occurred when cardholders made multiple charges on the same day, with the same vendor, for one purchase in order to circumvent the micro-purchase limits and competition requirements. The FAR states cardholders may not split a transaction to avoid the requirement to obtain competitive bids for purchases over the micro-purchase limit or to avoid other established purchase limits.<sup>5</sup> In addition, VHA policy prohibits split purchases, which are also considered unauthorized commitments.<sup>6</sup>

Examples 1 and 2 highlight how cardholders split purchases to circumvent competition requirements and the \$3,000 micro-purchase limit:

**Example 1**

In March 2014, an Engineering Service cardholder circumvented the \$3,000 micro-purchase limit by splitting an order of about \$5,800 into two purchases. The cardholder purchased 16 hospital bed cables for approximately \$2,900 and another 16 cables for about \$2,900 from the same vendor in two separate orders about 22 minutes apart. This was not prevented because approving officials did not adequately monitor cardholders to ensure compliance with VA policy.

**Example 2**

In January 2015, another Engineering Service cardholder split an order for about \$5,600 into three purchases. The cardholder purchased one copier rental for about \$2,500, another copier rental for approximately \$1,500, and a third copier rental for \$1,600 from the same vendor in three separate orders within four minutes.

VISN 7 Senior Management agreed the unwarranted Engineering Service cardholders split purchases.

**Purchases  
Outside the  
Micro-Purchase  
Limit**

We identified 14 purchases for services above the \$2,500 micro-purchase limit that were made by unwarranted Engineering Service cardholders. The value of these purchases totaled about \$40,000. The FAR and VHA Handbook 1730.01 establish a \$2,500 micro-purchase limit for unwarranted cardholders purchasing services.<sup>7</sup> The Service Contract Labor Standards provide an exemption to this limit for services where the primary purpose is to maintain, calibrate, or repair medical apparatus or equipment.<sup>8</sup> When

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<sup>5</sup>FAR, Subparts 2.1, 13.1, and 22.10.

<sup>6</sup>VA Financial Policies and Procedures, Volume XVI; and VHA Directive 1730.01, *Use and Management of the Government Purchase Card*.

<sup>7</sup>FAR, Subpart 2.1.

<sup>8</sup>Section 6707, Title 41, United States Code, Service Contract Labor Standards and Section 4.123, Title 29, United States Code, Administrative limitations, variations, tolerances, and exemptions Pg. 2-3/3.

unwarranted cardholders exceed the \$2,500 micro-purchase limit for services, they also make unauthorized commitments.

Cardholders made 14 service purchases to relocate furniture and medical equipment to various VAMC Dublin and community based outpatient clinic locations. Example 3 highlights how cardholders' purchases exceeded the established purchasing limit for acquiring services that do not meet the Service Contract Labor Standards exemption:

**Example 3**

In July 2014, a cardholder purchased services to relocate medical refrigerators from VAMC Dublin to the Albany, GA, community based outpatient clinic for approximately \$2,900. In August 2014, the same cardholder made two other purchases for about \$2,800 each, to have additional equipment relocated to the Albany outpatient clinic and to have other equipment relocated from the Albany outpatient clinic to VAMC Dublin. All three purchases exceeded the \$2,500 micro-purchase limit for services and did not qualify for the Service Contract Labor Standards exemption. The cardholder believed the micro-purchase limit was \$3,000 for these purchases instead of \$2,500.

The Purchase Card Coordinator agreed the 14 purchases made by unwarranted Engineering Service cardholders exceeded the micro-purchase limit.

**Improper Payments**

The 37 unauthorized commitments we identified were also improper payments. The Office of Management and Budget Circular A-123, Appendix C, *Requirements for Effective Measurement and Remediation of Improper Payments*, includes the following definition:

*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.*

These purchases should not have been made because cardholders exceeded their authority and did not have the legal authority to make the purchases. Only warranted contracting officers or delegated officials have the authority to bind VA to purchases that exceed micro-purchase limits.

**Reasons for Unauthorized Commitments**

Engineering Service staff made unauthorized commitments and improper payments because approving officials did not adequately monitor cardholder purchases to prevent split purchases and transactions that exceeded the \$2,500 micro-purchase limit for services. Further, one approving official exceeded the number of cardholders that can be adequately monitored.

*Purchase Card  
Monitoring Was  
Not Adequate*

Approving officials did not adequately monitor cardholder transactions to prevent split purchases and those purchases that exceeded the micro-purchase limit. Approving officials are responsible for monitoring cardholders' purchases to ensure compliance with FAR and VA purchase card rules and regulations and for recommending disciplinary actions when needed. Approving officials did not disapprove cardholder transactions that were not in compliance with VA policy.

Approving officials need to receive focused training on monitoring purchase card transactions to ensure cardholders adequately comply with FAR and VA purchase card rules and regulations and report noncompliance to supervisors. VHA policy states splitting purchases, procuring supplies and services without proper authority, and making purchases exceeding established dollar limits are grounds for revocation or suspension of cardholder privileges.

*Approving  
Official  
Exceeded the  
Limit of  
Assigned  
Cardholders*

The approving official for three cardholders who made split purchases and two other cardholders who exceeded the \$2,500 micro-purchase limit for services was the approving official for 16 cardholders. Purchase cardholders under this approving official made 23 of the 37 purchases that were split or exceeded the micro-purchase limit.

VHA Handbook 1730.1 states approving officials should be assigned no more than 10 cardholders to ensure they can adequately monitor each cardholder's purchases. The number of cardholders assigned to approving officials can be more than 10 upon written approval from the facility director or VISN director. This Engineering Service approving official was responsible for reviewing and approving purchases for 16 cardholders. The approving official had not received approval from the facility director or VISN director prior to being assigned more than 10 cardholders.

*Effects of  
Inappropriate  
Purchase  
Card Use*

Of 5,100 purchase card transactions totaling about \$7.1 million made from October 2012 through March 2015, we identified 14 purchases exceeding authorized limits and estimated 89 additional split transactions. Combined, they represent over 100 transactions totaling about \$240,000 of unauthorized commitments (3.4 percent). The cardholders who made these unauthorized commitments circumvented the FAR's system of checks and balances in performing procurement functions.

**Conclusion**

We substantiated the allegation that VAMC Dublin Engineering Service cardholders made unauthorized commitments by splitting purchases and exceeding the micro-purchase limit for services from October 2012 through March 2015. VAMC Dublin approving officials did not adequately monitor purchase card transactions that led to the misuse of purchase cards. In addition, VAMC Dublin employees did not protect the Government's interests when obtaining supplies and services without the benefits of ensuring competitive procurement practices. VA employees have a fundamental responsibility to be effective stewards of taxpayer resources and

to safeguard those resources against unauthorized commitments and improper payments.

## **Recommendations**

1. We recommended the Veterans Integrated Service Network 7 Director review VA Medical Center Dublin's micro-purchase card transactions made by Engineering Service cardholders from October 2012 through March 2017 to identify unauthorized commitments.
2. We recommended the Veterans Integrated Service Network 7 Director submit ratification requests for unauthorized commitments identified in this report and Veterans Integrated Service Network 7 to the Veterans Health Administration's Head of Contracting Activity.
3. We recommended the Veterans Integrated Service Network 7 Director issue a memo to the VA Medical Center Dublin Director emphasizing the importance of approving officials monitoring cardholder purchases for adherence to Government charge card requirements in Federal and VA regulations and VA policies and the consequences of failing to adhere to these requirements.
4. We recommended the Veterans Integrated Service Network 7 Director require VA Medical Center Dublin Engineering Service cardholders and approving officials to receive focused training on not splitting purchases, procuring supplies and services without proper authority, and making purchases exceeding established dollar limits.
5. We recommended the Veterans Integrated Service Network 7 Director require VA Medical Center Dublin to establish an oversight mechanism to ensure approving officials without the required approval are assigned no more than 10 cardholders each.
6. We recommended the Veterans Integrated Service Network 7 Director take appropriate administrative action for each cardholder who made unauthorized commitments.

### **Management Comments**

The Acting Deputy Director, VA Southeast Network, concurred in whole or in part with our findings and recommendations 1–6 as noted below. For Recommendation 1, the Acting Deputy Director concurred and reported the facility completed an analysis that identified 58 unauthorized commitments. For Recommendation 2, the Acting Deputy Director concurred and reported the head of the contracting activity has approved 26 of 58 unauthorized commitments and work on ratifying the remaining 32 unauthorized commitments is ongoing.

For Recommendation 3, the Acting Deputy Director concurred and reported the VISN 7 Network Director issued a memo to the medical center director citing requirements to adhere to Federal and VA regulations and VA policies. For Recommendation 4, the Acting Deputy Director concurred and reported facility purchase card holders have been provided training on the Government Purchase Card Program and the ratification process.

For Recommendation 5, the Acting Deputy Director concurred in part with our finding and recommendation. The Acting Deputy Director reported the criteria listed in VHA Handbook 1730.01 have been rescinded as of April 4, 2017. VA Financial Policy, Volume XVI, is the current criteria allowing 25 cardholders to each approving official. The Acting Deputy Director reported the facility gives consideration to the volume and complexity of purchases when evaluating cardholder to approving official ratios.

For Recommendation 6, the Acting Deputy Director concurred and reported the facility delegated responsibility for any disciplinary and adverse actions to the supervisor with appropriate authority. In addition, facility leadership will ensure proper supervisory training will be provided. The VISN 7 Network Director will receive an update of initial proposed actions to be taken within 30 days of the initial submission response to the OIG. The facility will provide a response with the final determination of those actions within 30 days of determination.

**OIG  
Response**

The Acting Deputy Director's comments and corrective actions are responsive for Recommendations 1–4 and 6. For Recommendation 5, the Acting Deputy Director concurred in part and the proposed action meets the intent of our recommendation. We will monitor VHA's implementation of the planned actions and close all recommendations when we receive sufficient evidence demonstrating completion. Appendix E provides the full text of the Acting Deputy Director's comments.

## **Finding 2 VAMC Dublin Cardholders Did Not Make Duplicate Payments to Vendors**

### **What We Found**

We did not substantiate the allegation that VAMC Dublin Environmental Management Service (EMS) and Engineering Service cardholders made duplicate payments to Ryland Contracting Incorporated and Sterilizer Technical Specialists. From October 2012 through March 2015, all 77 cardholder payments to Ryland Contracting Incorporated were for distinct services and all 14 cardholder payments to Sterilizer Technical Specialists were purchased services for distinct pieces of equipment.

While we did not substantiate the allegation, we found six VAMC Dublin cardholders inappropriately made a total of 91 purchases from Ryland Contracting and Sterilizer Technical Specialists from October 2012 through March 2015 without following VHA's purchase card procedures to establish contracts. These 91 purchases were also improper payments. This was not prevented because the EMS Director and Engineering Service's Administrative Officer, who were also approving officials, did not adequately review cardholder purchases transactions to identify service purchases exceeding VHA's \$5,000 threshold for establishing contracts during a fiscal year. As a result, VAMC Dublin cardholders purchased and received services totaling about \$218,000 that avoided Federal competition requirements.

### **Criteria**

VA policy requires cardholders to pay fair and reasonable prices for supplies and services.<sup>9</sup> VHA Handbook 1730.01 states facilities need to establish contracts for services when appropriate. Specifically, facilities need to negotiate indefinite-delivery/indefinite-quantity contracts for services that can reasonably be expected to exceed \$5,000 during a fiscal year.

VHA standard operating procedures require VAMC facilities to request the services through the Network Contracting Activities. VAMC requesting departments are required to prepare and submit a purchase request to the contracting office. Purchase requests must include:

- Justification for the purchase (if required)
- Sources for the desired supplies or services
- Statements of work
- Cost estimates

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<sup>9</sup>VA Financial Policies and Procedures, Volume XVI.

The VAMC service should also identify an individual to act as the Contracting Officer's Technical Representative to monitor contractor quality and performance.<sup>10</sup>

**Duplicate  
Payments Not  
Identified**

We did not identify duplicate purchase orders to Ryland Contracting Incorporated or Sterilizer Technical Specialists. From October 2012 through March 2015, VAMC Dublin Engineering Service and EMS cardholders made a total of 77 purchases from Ryland Contracting Incorporated. The purchases ranged from \$300 to \$2,950. The purchases were for services such as moving furniture; cleaning floors, walls, baseboards, and kitchen areas; and moving medical equipment to and from a community based outpatient clinic. None of the invoices for these services included the same description of service for the same time period. Therefore, we concluded VAMC Dublin cardholders did not make duplicate payments to Ryland Contracting.

From October 2012 through March 2015, VAMC Dublin employees made a total of 16 purchases for preventative equipment maintenance and other services from Sterilizer Technical Specialists. The 16 purchases included 14 purchases paid by credit card and two purchases paid by certified invoice. The 14 purchases ranged from just over \$1,900 to about \$3,000. It was alleged that cardholders made purchases from Sterilizer Technical Specialists for work that was also paid by certified invoice. The 14 purchases were not for the same equipment maintenance services that were paid by the two certified invoice payments. Therefore, we concluded VAMC Dublin cardholders did not make duplicate payments to Sterilizer Technical Specialists.

**Contracting  
Requirements  
Not Followed**

From October 2012 through March 2015, six VAMC Dublin cardholders, including five Engineering Service cardholders and one EMS cardholder, made 91 purchase card transactions for services totaling about \$218,000 from Ryland Contracting Incorporated and Sterilizer Technical Specialists without following VHA's contracting requirements.<sup>11</sup> Specifically, the EMS Director and the Engineering Service Administrative Officer, who were also approving officials, did not provide the Network Contracting Office statements of work, justifications, and other documentation needed to establish contracts for procuring services exceeding \$5,000 during a fiscal year.

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<sup>10</sup>VHA Standard Operating Procedure 160-10-01.

<sup>11</sup>Of these 91 purchases, 14 exceeded the \$2,500 micro purchase limit for services. Therefore, the 14 purchases with a total value of about \$40,000 were also unauthorized commitments and included in the 37 purchases discussed in the Finding 1 section of this report.

**Purchases  
From Ryland  
Contracting  
Incorporated**

The EMS and Engineering Service officials approved 77 cardholder purchases from Ryland Contracting Incorporated for services totaling about \$180,000 without ensuring cardholders followed VHA Handbook 1730.01 to establish indefinite-delivery/indefinite-quantity contracts for recurring services expected to exceed \$5,000 during a fiscal year. Purchased services included assembling and moving office furniture, cleaning floors, assembling and installing beds, and moving medical equipment from VAMC Dublin to a community based outpatient clinic. For example, during FY 2014, an EMS cardholder made 19 purchases of \$2,500 each totaling \$47,500 from Ryland Contracting Incorporated without a negotiated contract.

By not requesting the Network Contracting Office to establish a contract for these services, EMS and Engineering Service cardholders and approving officials bypassed VHA's contracting requirements. Therefore, cardholders circumvented the requirements designed to maximize competition and ensure procurement of supplies and services at fair and reasonable prices.

**Purchases  
From Sterilizer  
Technical  
Specialists**

An Engineering Service official approved 14 cardholder purchases with Sterilizer Technical Specialists totaling about \$39,000 without ensuring cardholders followed VHA Handbook 1730.01 to establish indefinite-delivery/indefinite-quantity contracts for recurring services expected to exceed \$5,000 during a fiscal year. Engineering Service cardholders used Sterilizer Technical Specialists to perform services such as repairing and maintaining defibrillators, beds, bed scales, and other medical equipment. For example, from October 2013 through July 2014, one Engineering Service cardholder made nine purchases, ranging from about \$1,900 to about \$3,000, to Sterilizer Technical Specialists for various medical equipment maintenance and repair services. The nine purchases totaled about \$24,000.

The approving official for the Engineering Service cardholder reported she was aware of VHA Handbook 1730.01 requiring the negotiation of indefinite-delivery and/or indefinite-quantity contracts for services expected to exceed \$5,000 during a fiscal year. However, the approving official did not review service requirements and monitor purchase card transactions to ensure indefinite-delivery/indefinite-quantity contracts were negotiated. The approving official stated she did not review the annual volume of purchases but instead focused on ensuring individual purchases were within micro-purchase limits and satisfied a legitimate business need.

**Improper  
Payments**

The 91 purchases for services totaling about \$218,000 from Ryland Contracting Incorporated and Sterilizer Technical Specialists were improper payments. The purchases should not have been made because the cardholders did not comply with VHA Handbook 1730.01 requiring the negotiation of indefinite-delivery/indefinite-quantity contracts for services expected to exceed \$5,000 during a fiscal year. The Office of Management and Budget Circular A-123, Appendix C, *Requirements for Effective Measurement and*

*Remediation of Improper Payments* includes the following definition of improper payments:

*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.*

**Reason  
Vendor  
Contracts Not  
Established**

VAMC Dublin cardholders did not comply with contracting requirements because the EMS Director and Engineering Service's Administrative Officer, who were also approving officials, did not adequately review cardholder purchases. Specifically, they did not identify cumulative service purchases from vendors that would exceed VHA's \$5,000 threshold for establishing contracts during a fiscal year. Although approving officials stated they were aware of VHA's contract requirements for services, they continued to approve the use of purchase cards to procure services instead of requesting the Network Contracting Office to negotiate prices and establish contracts.

**Effects of Not  
Establishing  
Vendor  
Contracts**

VAMC Dublin cardholders purchased services totaling about \$218,000 without meeting Federal competition requirements. In addition, cardholders did not initiate efforts to establish contracts that were expected to be in the best interest of the Government.

**Conclusion**

We did not substantiate the allegation VAMC Dublin EMS and Engineering Service cardholders made duplicate payments to Ryland Contracting Incorporated or Sterilizer Technical Specialists. However, VAMC Dublin cardholders inappropriately made 91 micro-purchases totaling about \$218,000 for services from these vendors without following VHA contracting requirements. These purchases were also improper payments. It is essential VAMC Dublin management establishes effective controls to ensure indefinite-delivery/indefinite-quantity contracts are negotiated for services. Ensuring VAMC Dublin appropriately requests the VISN 7 Network Contracting Office to negotiate needed contracts will meet competition requirements and provide reasonable assurance of fair and reasonable prices for services.

**Recommendation**

7. We recommended the Veterans Integrated Service Network 7 Director require VA Medical Center Dublin to establish an oversight mechanism to ensure approving officials adequately review cardholder purchases of recurring services from vendors expected to exceed \$5,000 during a fiscal year to ensure contracts are established in accordance with Veterans Health Administration policy.

**Management  
Comments**

The Acting Deputy Director, VA Southeast Network, concurred in part with our finding and recommendation. The Acting Deputy Director reported the criteria listed in VHA Handbook 1730.01 have been rescinded as of

April 4, 2017. The facility stated it is confident that non-severable services exceeding the micro-purchase threshold will not be purchased with the card. In addition, the Acting Deputy Director reported the VA Office of Internal Controls audit team has made refinements to identify split purchases and other unauthorized commitments. Additionally, the VISN Purchase Card Manager and Purchase Card Coordinator conduct reviews of the entire purchase history for every cardholder when selecting transactions for their audit.

**OIG  
Response**

The Acting Deputy Director concurred in part and the proposed action meets the intent of the recommendation. We will monitor VHA's implementation of the planned action and close the recommendation when we receive sufficient evidence demonstrating completion. Appendix E provides the full text of the Acting Deputy Director's comments.

## Appendix A Background

### **Facility Overview**

VAMC Dublin reported serving 40,000 veterans in 52 counties. The VAMC provides services, which include medical, surgical, and psychiatric inpatient care, as well as outpatient primary and mental health care. In FY 2014, the VAMC reported providing almost 296,000 outpatient visits and approximately 88,000 inpatient bed days.

### **Engineering Service and EMS Cardholders**

VAMC Dublin's Engineering Service is responsible for construction projects and for improving, maintaining, and operating the VAMC's physical plant and equipment. EMS provides a full range of services, including waste handling, bed cleaning, and pest management. VAMC Dublin Engineering Service cardholders had single purchase limits of \$3,000 with monthly purchase limits ranging from \$50,000 to \$250,000. VAMC Dublin's EMS cardholder had a single purchase limit of \$3,000 and a monthly purchase limit of \$18,000.

### **Purchase Card Requirements**

The objectives of the Purchase Card Program are to 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 provides Government-wide charge card program requirements and guidance, standard minimum requirements, and suggested best practices.<sup>12</sup>

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<sup>12</sup>Office of Management and Budget Circular A-123, Appendix B Revised, *Improving the Management of Government Charge Card Programs*.

## Appendix B Scope and Methodology

### **Scope and Methodology**

We conducted our review from April 2015 through April 2017. We focused on about 5,100 purchase card transactions at or below \$3,000 made by VAMC Dublin Engineering Service and EMS employees from October 2012 through March 2015 with a total value of about \$7.1 million. From this population, we reviewed a statistical sample of 115 transactions with a total value of about \$229,000 that were possible split purchases exceeding the \$3,000 micro-purchase limit. We also reviewed 15 sampled transactions with a total value of about \$43,000 we identified using data mining to determine if the purchases exceeded the \$2,500 services micro-purchase limit. When determining split transactions, we discarded transactions by the same cardholder with four or more hours between sequential purchases. We also discarded transactions between multiple cardholders when two or more hours lapsed between sequential purchases.

The scope of our review did not include determining whether VAMC Dublin had a legitimate need for purchased supplies and services. We interviewed VISN 7's Director of Contracting and the Purchase Card Manager and VAMC Dublin Purchase Card Coordinator, cardholders, and approving officials involved with the sampled purchases. We conducted a review at VAMC Dublin in May 2015. We reviewed applicable Federal regulations, VA and VHA policies, procedures, directives, and handbooks related to purchase cards, unauthorized commitments, and an Office of Management and Budget circular related to improper payments.

To determine whether cardholders exceeded VHA's \$5,000 limit during a fiscal year that would require facilities to negotiate contracts, we performed data mining and identified 91 transactions with a total value of about \$218,000 to review. For each of these 91 transactions, we reviewed purchase orders, invoices, and other available supporting documentation. When appropriate, we also contacted vendors and interviewed VAMC Dublin staff.

### **Fraud Assessment**

The review team assessed the risk of fraud, violations of legal and regulatory requirements, and abuse. The review team exercised due diligence in staying alert to fraud indicators by taking actions, such as soliciting the OIG's Office of Investigations for indicators and reviewing prices, assessing appropriate reconciliations and certifications of purchase orders. We did not identify any instances of fraud during this review.

### **Data Reliability**

We used computer-processed data from VA's Veterans Health Information Systems and Technology Architecture. To test the reliability of the computer-processed data, we reviewed and compared names, purchase order numbers, dollar amounts, and dates with source hard-copy documentation, such as purchase orders and vendor invoices to verify the completeness and accuracy of the data. We determined the Veterans Health Information

Systems and Technology Architecture data were sufficiently reliable for the review objective.

**Government  
Standards**

We conducted this review in accordance with the Council of Inspectors General on Integrity and Efficiency's *Quality Standards for Inspections and Evaluations*.

## Appendix C Statistical Sampling Methodology

### Approach

To evaluate the allegation that VAMC Dublin Engineering Service cardholders made unauthorized commitments by splitting purchases, we reviewed a representative sample of purchase card transactions at or below the \$3,000 micro-purchase limit. We used stratified statistical sampling to quantify the extent of inappropriate purchases cardholders could have made with a purchase card and to project potential monetary benefits. We also reviewed a non-statistical sample of purchase card transactions to determine whether VAMC Dublin made double payments to contractors and cardholders complied with VHA's fiscal year purchase card limit for procuring services.

### Population

The population included about 5,100 purchases at or below the \$3,000 micro-purchase limit made by VAMC Dublin Engineering Service cardholders from October 2012 through March 2015. The total for these purchases was about \$7.1 million.

### Sampling Design

We used data mining to review the population of 5,100 micro-purchases to identify a universe of 440 with a total value of about \$951,000 that were possible split 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. From this universe, we statistically selected a sample of 115 transactions with a total value of about \$229,000. Table 1 summarizes the stratified universe of micro-purchase transactions we identified using statistical sampling.

**Table 1. Stratified Universe of Micro-Purchase Transactions  
(October 2012–March 2015)**

Type	Strata	Sampled Purchases	Universe	Amount
1-Split Purchase	From \$0 to \$1k	18	39	\$24,297
2-Split Purchase	From \$1,001 to \$2k	30	99	\$150,260
3-Split Purchase	Greater than \$2k	67	302	\$776,709
	<b>Total</b>	<b>115</b>	<b>440</b>	<b>\$951,266</b>

Source: VA OIG analysis of VAMC Dublin Engineering Service purchase card transactions.

### 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 review with multiple samples, the confidence intervals would differ for each sample, but would include the true universe value 90 percent of the time. For each estimate, we used the point estimate of the 90 percent confidence interval. Table 2 shows the projections and number of sampled VAMC Dublin Engineering Service transactions and the value of the transactions.

**Table 2. Projections of Inappropriate Purchases Card Use for VAMC Dublin Engineering Service (October 2012–March 2015)**

Description	Estimated	Margin of Error	90% Confidence Interval Lower Threshold	90% Confidence Interval Upper Threshold	Sample Transactions With Condition
Unauthorized Commitments	89	28	61	120	23
Value	\$200,000	\$69,400	\$131,000	\$270,000	23
Percent	21%	7%	14%	28%	

*Source: VA OIG statistical analysis of VAMC Dublin Engineering Service purchase card transactions.*

Note: Numbers are rounded for report presentation.

In addition, for 14 of the 15 sampled transactions using data mining, we found that cardholders made unauthorized commitments by inappropriately exceeding the \$2,500 micro-purchase limit for services. The value of these purchases was about \$40,000. Table 3 summarizes the unauthorized commitments we identified using statistical sampling and non-statistical data mining.

**Table 3. Unauthorized Commitments**

Sample Type	Transactions	Amount
1. Statistical	89	\$200,000
2. Non-Statistical	14	40,000
<b>Total</b>	<b>103</b>	<b>\$240,000</b>

*Source: VA OIG statistical sampling of VAMC Dublin Engineering Service purchase card transactions.*

Note: Numbers are rounded for report presentation.

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

Recommendations	Explanation of Benefits	Better Use of Funds	Questioned Costs
1 and 2	Reviewing VAMC Dublin Engineering Service purchase card transactions for unauthorized commitments and performing ratifications	\$0	\$240,000
7	Establishing a VAMC Dublin oversight mechanism to ensure approving officials monitor cardholder purchases from individual vendors that exceed \$5,000 during a fiscal year to ensure contracts are established	\$0	\$178,000 <sup>13</sup>
<b>Total</b>			<b>\$418,000<sup>14</sup></b>

<sup>13</sup>To calculate the \$178,000, we subtracted about \$40,000 from the \$218,000 value for the 91 purchase card transactions for services from individual vendors that exceeded \$5,000 during a fiscal year without contracts. The \$40,000 represents the total value for 14 of the 91 transactions that were also unauthorized commitments included in the \$240,000 questioned costs.

<sup>14</sup>The \$418,000 represents the total value of the estimated purchase card transactions that met the Office of Management and Budget Circular A-123, Appendix C's definition of improper payments and the definition of questioned costs defined in the Inspector General Act of 1978, as amended. (first step, Potential Monetary Benefits in Accordance With Inspector General Act Amendments (\$418,000= \$178,000 + \$240,000))

## Appendix E Management Comments

### Department of Veterans Affairs Memorandum

Date: May 19, 2017

From: Acting Deputy Director, VA Southeast Network (10N7)

Subj: OIG Draft Report – Review of Alleged Engineering Service Purchase Card Irregularities at VAMC  
Dublin, GA (Project Number 2015-01217-R3-0116)

To: Inspector General for Audits and Evaluations (52)

1. I have had the opportunity to review the OIG Draft Report – Review of Alleged Engineering Service Purchase Card Irregularities at VAMC Dublin, GA (Project Number 2015-01217-R3-0116).
2. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans. I concur with the implementation of recommendations 1 through 4 and 6 and concur, in part with recommendations 5 and 7.
3. If you have any questions or require further information, please contact Prudence Howard, VISN 7 Director of Contracting at (678) 924-5700.

*(original signed by)*

R. Shuron Hunter

Attachment

**Carl Vinson (Dublin) VA Medical Center**

**Review of Alleged Engineering Service Purchase Card Irregularities  
Draft Report Responses**

**Recommendation 1.** We recommended the Veterans Integrated Service Network 7 Director review VA Medical Center Dublin's micro-purchase card transactions made by Engineering Service cardholders from October 2012 through March 2017 to identify unauthorized commitments.

Concur

Target date for completion: April 11, 2017 (completed)

Facility response: The analysis was completed, and suspect purchases were identified for more detailed evaluation. There were a total of 86,315 transactions for the subject period for the facility. The first level analysis of transactions was completed by the OIG, and yielded 24 probable unauthorized commitments (UAC). The next level of analysis was completed by the VISN Purchase Card Manager and yielded 132 probable UAC's, for a total of 156. Each of the 156 probable UAC's were examined in extensive detail. Based upon the facts provided in the records, The VISN 7 Director of Contracting and the Purchase Card Program Manager were able to determine that 98 of the probable UAC's were not UAC's. The final net number of confirmed UAC's was 58.

**Recommendation 2** We recommended the Veterans Integrated Service Network 7 Director submit ratification requests for unauthorized commitments identified in this report and Veterans Integrated Service Network 7 to the Veterans Health Administration's Head of Contracting Activity.

Concur

Target date for completion: August 16, 2017

Facility response: A total of 58 unauthorized commitments were identified. Twenty six (26) have been approved by the HCA, and 32 are in process for approval.

**Recommendation 3.** We recommended the Veterans Integrated Service Network 7 Director issue a memorandum to the VA Medical Center Dublin, GA Director emphasizing the importance of approving officials monitoring cardholder purchases for adherence to Government charge card requirements in Federal and VA regulations and VA policies and the consequences of failing to adhere to these requirements.

Concur

Target date for completion: May 22, 2017

Facility response: A memo was drafted and issued to the Dublin, Ga Medical Center Director from the Network 7 Director citing requirements for adherence to required Federal and VA regulations and VA policies.

**Recommendation 4.** We recommended the Veterans Integrated Service Network 7 Director require VA Medical Center Dublin Engineering Service cardholders and approving officials to receive focused training on not splitting purchases, procuring supplies and services without proper authority, and making purchases exceeding established dollar limits.

Concur

Target date for completion: June 2, 2016 (completed)

Facility response: On-site training provided by the VISN Purchase Card manager on June 2, 2016. Two sessions were provided, the first being specific to the GPC program, and the second being specific to the request for ratification process. The GPC training was comprehensive, lasting 2 hours. There were 62 attendees at the GPC training session and 42 attendees at the session on how to draft requests for ratification. Additionally, training is also offered the 3<sup>rd</sup> Tuesday of every month, both a morning and afternoon session.

**Recommendation 5.** We recommended the Veterans Integrated Service Network 7 Director require VA Medical Center Dublin to establish an oversight mechanism to ensure approving officials without the required approval are assigned no more than 10 cardholders each.

Concur, in part

Target date for completion: April 4, 2017 (completed)

Facility response: VHA Handbook 1730.01 was rescinded on the 4th of April 2017. The quantity of 10 cardholders was an arbitrary number. Ratios are managed within the standards specified in VA Financial Policy, Volume XVI, Chapter I, which is currently a 25:1 ratio, for non-prosthetics accounts and 40:1 for prosthetics. Consideration is given to the actual volume and complexity of purchases made by the cardholder group when evaluating business risk of cardholders to approving official ratios. Currently, there is one non-prosthetics business division approving official that has more than 10 cardholders assigned.

**Recommendation 6.** We recommended the Veterans Integrated Service Network 7 Director take appropriate administrative action for each cardholder who made unauthorized commitments.

Concur

Target date for completion: July 14, 2017

Facility Response: In accordance with VA Handbook 5021 Employee/Management Relations. The responsibility concerning disciplinary and adverse actions will be delegated to the supervisor with appropriate authority for the direction and discipline of each cardholder under their jurisdiction. In this case the supervisor for each cardholder who made the unauthorized commitment will be responsible for ensuring that appropriate administrative action is taken on each identified individual. Facility leadership will ensure proper supervisory training is provided to supervisors so they may determine appropriate administrative action to be taken prior to any proposed action.

The facility will provide an update to the VISN 7 Network Director within 30 days of initial submission response to the OIG on initial proposed actions to be taken for identified employees. The facility will provide a response with the final determination of actions taken on identified individuals within 30 days of final action determination.

**Recommendation 7** We recommended the Veterans Integrated Service Network 7 Director require VA Medical Center Dublin to establish an oversight mechanism to ensure approving officials adequately review cardholder purchases of recurring services from vendors expected to exceed \$5,000 during a fiscal year to ensure contracts are established in accordance with Veterans Health Administration policy.

Concur, in part

Target date for completion: April 4, 2017 (completed)

Facility response: The VHA Handbook 1730.01 was rescinded on the 4th April, 2017. The handbook mentioned the referenced \$5,000 annual limit (from a previous OIG investigation) for services, and the requirement that they be placed on contract. This is advice conflicts with both the Federal Acquisition Regulation and Department of Labor. As stated in 29 CFR § 4.141 - General criteria for measuring amount:

...the amount of the contract for purposes of application of the Act is not measured by the amount of an individual purchase order. In such cases, if the continuing services were procured through formal advertising, the contract term would typically be for one year, and the monthly purchase orders must be grouped together to determine whether the yearly amount may exceed \$2,500...

Based upon the training that has been provided, the process of ratifying dozens of transactions and the implementation of several IDIQ contracts for services, we are confident that non-severable services that exceed the micro-purchase threshold will not be purchased with the card. Further, since the OIG visit, the VA Office of Internal Controls audit team has made many refinements in their business tools to catch split purchases and other unauthorized commitments. The VISN Purchase Card Manager and purchase card coordinator personally reviews the entire purchase history for every cardholder when selecting transactions for their annual audit.

*For accessibility, the format of the original memo and attachment has been modified  
to fit in this document.*

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

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Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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Acknowledgments	Cherie Palmer, Director Earl Key Leon Roberts Michael Schiltz Nelvy Viguera Butler
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## **Appendix G Report Distribution**

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