Department of Veterans Affairs
Office of Inspector General

Evaluation of the Department of Veterans Affairs Government Purchase Card Program

Improved controls continue to be needed to detect fraud and improper uses of purchase cards.

Report No. 02-01481-135 **April 26, 2004**

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

Introduction

The Office of Inspector General (OIG) evaluated the Department of Veterans Affairs (VA) Government Purchase Card Program to determine the effectiveness of internal controls to prevent and detect fraudulent, improper, or questionable purchases. The evaluation was conducted utilizing the results of investigations, hotlines, and Combined Assessment Program (CAP) reviews performed at VA medical facilities and VA regional offices (VAROs). The evaluation also included separate data mining analyses of purchase card transactions at five VA facilities. In Fiscal Year (FY) 2003, VA issued approximately 31,800 purchase cards to cardholders who made 3.2 million transactions valued at about $1.7 billion. In addition, VA earned approximately $18.2 million in rebates in FY 2003 from the purchase card contractor based on purchase card sales volume.

Evaluation Results

The OIG issued an audit report on VA's Government Purchase Card Program on February 12, 1999 (Report Number 9R3-E99-037). The audit showed that management controls were not effectively implemented to ensure the integrity of the Government Purchase Card Program and maximum benefits were not being realized. Since this audit, the OIG issued 83 reports during the period March 31, 1999, through September 30, 2003, which have continued to identify internal control weaknesses in the Government Purchase Card Program. Over these years, the OIG reported numerous instances of improper and questionable uses of the purchase cards, including some instances of fraudulent activity. We identified internal controls that need to be fully implemented to provide management greater assurance that purchase cards are used properly. Areas needing improvement included: (a) closer supervision and better training of cardholders and approving officials, (b) timely reconciliation of purchase card transactions by cardholders, (c) timely and thorough certifications of transactions by approving officials to ensure competitive prices are obtained and preferred purchasing sources are used, (d) preventing improper purchases, and (e) avoiding split purchases.

In addition, facility managers needed to conduct effective focused audits to provide greater assurance that: (a) duties are appropriately segregated, (b) cardholders and approving officials are properly trained, (c) the span of control for approving officials is appropriate, and (d) questionable transactions are identified and validated. Appendix D, page 17, lists the 83 reports summarized in this report and Appendix E, page 23, provides a matrix of the internal control weaknesses by report number. VA management needs to strengthen internal controls and provide greater oversight to ensure that VA policy and the Federal Acquisition Regulation (FAR) are effectively implemented in order to prevent and detect fraudulent, improper, and questionable uses of the purchase cards.

Recommendations

We recommended that the Under Secretary for Health and the Under Secretary for Benefits, in coordination with the Assistant Secretary for Management: (a) direct VA facility managers to conduct quarterly focused reviews of their Government Purchase Card Programs to provide greater assurance that controls are properly implemented, cardholders and approving officials are properly trained, and the span of control for approving officials is monitored to prevent and detect fraudulent, improper, or questionable purchases, and (b) develop and implement procedures and checklists for approving officials to use in monitoring cardholders' use of purchase cards. Actions need to be taken to ensure that purchases are for official Government use, purchases are legal and proper and the items and services have been received, purchases are made within authorized spending limits, purchases are not improperly split to circumvent cardholder limits, the FAR and VA procurement policy are followed, and supporting documentation is maintained for all purchases.

We also recommended that the Assistant Secretary for Management: (a) update VA Directive 4080 to include span of control criteria for approving officials, and (b) ensure facilities implement internal controls, the FAR, and VA policy. In addition to required monthly audits of randomly selected samples of facility purchase card transactions, focused audits of questionable transactions that can be identified through data mining analyses should be periodically conducted.

Under Secretary for Health, Under Secretary for Benefits, and Assistant Secretary for Management Comments

The Under Secretary for Health, the Under Secretary for Benefits, and the Assistant Secretary for Management agreed with the findings and recommendations and provided acceptable improvement plans. (See Appendixes F, G, and H, pages 26-35, for the full text of their comments.) We will follow up on the planned actions until they are completed.

(original signed by:)

MICHAEL L. STALEY
Assistant Inspector General
for Auditing

Results and Recommendations

Improved Controls Continue To Be Needed to Detect Fraud and Improper Uses of Purchase Cards

We evaluated the effectiveness of internal controls over VA's Government Purchase Card Program, which were developed to prevent and detect fraudulent, improper, or questionable purchases. The evaluation was conducted utilizing the results of investigations, hotlines, and CAP reviews performed at VA medical facilities and VAROs. The evaluation also included a separate data mining analysis of purchase card transactions at five VA facilities.

The OIG issued an audit report on VA's Government Purchase Card Program on February 12, 1999.[1] The audit showed that management controls were not effectively implemented to ensure the integrity of the Purchase Card Program and maximum benefits were not being realized. Since this audit, we issued 83 reports during the period March 31, 1999, through September 30, 2003, which continued to identify weaknesses in internal controls over the Government Purchase Card Program (See Appendix D, page 17).

Over these years, we reported numerous instances of improper and questionable uses of purchase cards, including some instances of fraudulent activity. The deficiencies we identified are similar to issues posted on the President's Council on Integrity and Efficiency (PCIE) website, which highlights a number of OIGs' reports on procurement card procedural and internal control deficiencies throughout the Federal system. These reports can be found at www.ignet.gov.

We concluded that inappropriate uses of purchase cards at VA facilities continue to occur because facility management has yet to fully implement policies and procedures prescribed by VA and comply with the FAR.

VA management needs to strengthen internal controls and provide greater management oversight to ensure that VA policies and the requirements of the FAR are effectively implemented in order to prevent and detect fraudulent, improper, and questionable uses of purchase cards.

Purchase Card Fraud

The OIG Office of Investigations continues to receive allegations involving purchase card fraud. Generally, individuals were able to commit purchase card fraud because internal controls were not effectively implemented (i.e., approving officials did not ensure that purchases were legal and proper and that items had been received and were for official Government use).

[1] Audit of the Department of Veterans Affairs Purchase Card Program, Report Number 9R3-E99-037, dated February 12, 1999.

The following table summarizes the details associated with five purchase card fraud cases that illustrate the effect of poor internal controls:

Table 1: Summary Details of Five Purchase Card Fraud Cases

Items Purchased	VA Facility	Total Amount	Program Participants Involved
Computers, Televisions, and Stereos	National Cemetery	$200,000	Purchase Cardholder
Computers and Peripheral Equipment	Medical Center	$178,000	Purchase Cardholder
Diamond Ring, Televisions, DVD and CD Players	Medical Center	$45,000	Purchase Cardholder
Various Merchandise	Medical Center	$8,000	Purchase Cardholder
Items for Personal Use	Medical Center	$4,900	Purchase Cardholder

Details of fraudulent activity follow:

- A former VA employee pleaded guilty to theft of Government property. The individual admitted that, while employed by VA, she used a Government purchase card to buy over $200,000 worth of computers, televisions, stereos, and other items which she either then sold to friends and associates, or kept for personal use. The employee forged her supervisor's signature to approve the bills and also falsified the receipts. The VA OIG and the Federal Bureau of Investigations conducted a joint investigation and recorded the employee on videotape shopping at local computer stores and selling the equipment in front of her house.

- A VA employee and an associate (a non-VA employee) pleaded guilty to theft of Government funds. The employee oversaw all administrative matters for a VA medical center Surgical Service and had authority to procure items for the service using a Government purchase card. The employee fraudulently purchased approximately $178,000 worth of laptop computers and peripheral equipment using the Government purchase card and the associate bought $170,000 worth of the items from the employee. The associate then sold the computers and peripheral equipment to various pawnshops.

- Five former VA employees were indicted after a Federal grand jury returned a 125-count indictment charging each individual with false statements for their alleged role in a conspiracy to defraud VA. An OIG investigation determined that each individual used a Government purchase card to purchase items for their own use during a 3-year period from July 2000 through 2002. The illegal purchases included a diamond ring, televisions, DVD and CD players, karaoke machines, clothing, and power tools. After making the purchases, the individuals submitted fraudulent purchase orders to VA in an effort to obscure the crimes. The total loss to VA exceeded $45,000.

- A VA employee was charged with larceny, theft, and unauthorized use of a Government purchase card. A joint VA OIG and VA police investigation disclosed that the employee misused the purchase card by making unauthorized purchases totaling more than $8,000. The employee was authorized to use a purchase card for gas and services related to the use of an assigned Government vehicle.

- A former VA employee pleaded guilty to criminal information charging him with theft of Government funds. The guilty plea was the result of a joint investigation by the VA OIG and VA police, which disclosed that over an 8-month period the employee used a Government purchase card to buy more than $4,900 worth of items for personal use. The employee resigned from his position after receiving a notice of proposed removal.

Improper and Questionable Purchase Card Transactions

Since the OIG audit was published in 1999, we continued to report numerous instances of improper and questionable uses of purchase cards. Additionally, data mining analyses of purchase card transactions at five VA facilities identified potentially fraudulent, improper, and questionable purchases. Through data mining, we searched for suspicious transactions and patterns of activity. (See Appendix B, page 13, for details and data mining criteria.) Our data mining identified 1,445 high risk transactions totaling $3,207,028, from a universe of 99,167 purchase card transactions valued at $60,958,012. A review of these high risk transactions identified 458 improper or questionable transactions (32 percent) totaling $1,127,748 that did not comply with the FAR, VA policy, or were not adequately supported by documentation. Improper purchases are those items or services that are not permitted to be procured by law, the FAR, or VA policy. Questionable transactions are those transactions that appear to be improper as a result of applying data mining criteria and subsequently found not to be supported by documentation. The table below provides a breakdown of the 458 exceptions.

Table 2: Summary of Exceptions

Noncompetitive Procurements	(71)	$604,209
Lack of Supporting Documentation	(121)	$196,036
Split Transactions	(84)	$165,474
Lack of Verification of Charges	(3)	$68,428
Unauthorized Transactions	(25)	$46,350
Inappropriate Transactions	(148)	$39,430
Unrecorded Property	(6)	$7,821
Total Exceptions	(458)	$1,127,748

The following paragraphs provide examples of improper and questionable transactions identified through our data mining analyses and CAP reviews.

Improper Purchase Card Transactions

We identified the following types of improper purchase card transactions: (a) purchases over $2,500 for which cardholders did not comply with the FAR to include obtaining most advantageous prices, (b) split purchases in which the cardholders circumvented the micro-purchase limit, (c) purchases of prohibited items, and (d) other purchasing deficiencies.

Noncompetitive Procurements. The FAR requires purchasing officials to ensure prices paid are most advantageous to the Government. VA procurement policy requires that VA facilities purchase supplies from preferred purchasing sources. This policy enables VA to achieve substantial price discounts associated with national level contracts and minimize open market purchases.

The results of our hotline and CAP reviews showed that cardholders did not follow the FAR or VA policy at 15 of 83 facilities. We also found through our data mining analyses that cardholders did not obtain the most advantageous prices or justify sole source procurements for 71 procurements valued at $604,209. Examples of these improper transactions involved the following purchases of medical, surgical, and prosthetic supplies.

Medical/Surgical Supplies. Our data mining analyses at a medical facility disclosed that cardholders did not obtain prices from preferred purchasing sources for medical and surgical supplies such as prosthetic hip and knee implants and accompanying components. For a 20-month period ending May 31, 2002, two purchase cardholders placed 45 orders totaling $265,970 for hip and knee implants and accompanying components. Cardholders purchased these implants on the open market from vendors selected by physicians. The cardholders claimed they were unaware that they were required by the FAR to obtain prices most advantageous to the Government and had not sought prices from preferred purchasing sources.

We obtained data from the VA National Acquisition Center that showed that Federal Supply Schedule (FSS) vendors offered comparable items at lower prices. For example, in February and October 2001, cardholders purchased hip and knee implants with accompanying components on the open market for $10,751 and $6,613, respectively. The prices for comparable prosthetic hip and knee implants and accompanying components from a FSS vendor would have been $6,534 and $4,070, respectively. As a result, the medical facility paid $4,217 (64.5 percent) more on the open market for each hip implant and $2,543 (62.5 percent) more for each knee implant. If the cardholders had used the FSS vendor for the 45 orders, the facility could have saved an estimated $162,000.

Prosthetic Supplies. At another medical facility, data mining results showed that cardholders did not obtain supplies from sources whose prices were most advantageous to the Government, as required by the FAR. In addition, cardholders did not consider obtaining supplies from preferred purchasing sources. For the 17-month period ending February 28, 2002, cardholders made 17 open market purchases for prosthetic supplies totaling $281,739. The prosthetic supplies included cochlear implants, primary and voice prosthesis, wheelchairs, electric beds, and canes.

The cardholders, who were also contracting officers, did not explore other available sources of supply such as FSS vendors, did not do best value determinations, and did not attempt to negotiate prices advantageous to VA with the open market vendors. In addition, the cardholders had not maintained documentation to justify these sole source purchases.

On a medical center CAP review, allegations were made that a physician received compensation from a vendor that sold prosthetic implants. Allegedly, the physician directed contracting officials to purchase prosthetic implants from a vendor on the open market versus purchasing the items from FSS sources. For the 20-month period ending May 31, 2000, the cardholder made 38 purchases from this vendor totaling $76,222. Our analysis of these purchases disclosed that the medical facility may have paid up to 40 percent (approximately $30,500) more for this vendor's products over comparable products if purchased from FSS sources.

Split Purchases. Another type of improper transaction we identified was a split purchase. A split purchase occurs when a cardholder splits a procurement into more than one transaction to circumvent the FAR requirement to obtain competitive prices for purchases over the $2,500 micro-purchase limit or to avoid exceeding the established $2,500 single purchase limit. Our hotline and CAP reviews found that cardholders at 19 of 83 facilities split purchases. In addition, our data mining analysis identified 84 split transactions valued at $165,474. Examples of the split purchases follow:

- Data mining results at a medical facility disclosed that a cardholder improperly split 19 purchases of office furniture and supplies into 65 separate transactions, totaling $107,391. As a result, the cardholder did not subject the procurements to competitive pricing and may have paid more for the items than needed.

- A medical center CAP review identified that a cardholder improperly paid a vendor $7,368 to renovate a medical facility conference room. The cardholder split the purchase into three transactions of $2,483, $2,425, and $2,460 to circumvent the $2,500 single purchase limit and to avoid obtaining competitive prices. Both the cardholder and approving official were aware of the FAR requirement and VA policy, but chose not to comply with the requirements.

Purchases of Prohibited Items. VA policy prohibits the use of a purchase card for certain goods and services. We found during our hotline and CAP reviews that purchase cards were used to purchase prohibited items at 23 of 83 facilities. Our data mining analyses identified 133 prohibited purchases valued at $22,243. Examples of the prohibited purchases follow:

- Our data mining results showed that a cardholder routinely allowed her approving official to make purchases with her Government purchase card. The approving official in the Surgical Healthcare Group improperly used the card and made 132 purchases for surgical supplies totaling $21,475. VA policy states that cardholders are not allowed to let others use their cards. In addition, the approving official also reconciled and approved these transactions, which violates VA policy and sound internal control practices.

- Data mining results also disclosed that a cardholder used the purchase card to improperly purchase $768 of food for an employee Christmas party. VA policy states that the purchase card can only be used for official Government purchases and prohibits procurement of personal goods. A VA physician directed the cardholder to use the purchase card to cater an employee Christmas party. Improper use of the card should result in its cancellation, disciplinary action, or issuance of a bill collection. As a result of our review, the facility established an accounts receivable for the physician.

- A medical facility CAP review identified that cardholders improperly used their purchase cards for vehicle maintenance and food for an employee Christmas party. We found that $340 was improperly billed to a purchase card, rather than the Government Fleet Card, for maintenance on two General Services Administration (GSA) vehicles that were used by the VA Security Service.

Other Purchasing Deficiencies. An additional type of improper purchase card transaction is when cardholders do not comply with the FAR or VA policy. Our data mining analyses identified 49 transactions valued at $139,786 where items acquired using purchase cards did not comply with the FAR or VA policy. For example, our data mining results at a medical facility showed that a cardholder and approving official did not verify the accuracy of charges to a purchase card and dispute erroneous charges, as required. The cardholder purchased three defibrillators and accompanying components from an FSS vendor at a cost of $68,428. The cardholder did not ensure that prices charged for the items were accurate and consistent with FSS contract prices. As a result, the medical facility overpaid the vendor by $13,428. In response to our inquiry, the vendor issued a credit to the facility for $13,428.

Questionable Purchase Card Transactions

Transactions Not Supported by Documentation. Questionable transactions include those where the cardholders made recurring purchases from the same vendors and did not maintain appropriate supporting documentation such as packing slips, invoices, and sales slips. The results showed that cardholders did not obtain documentation supporting 121 (26 percent) of 458 transactions valued at $196,036. Without appropriate documentation to support a transaction there is insufficient evidence to determine the validity of the transaction.

- Our data mining results showed that a cardholder made 26 separate purchases (ranging from $2,400 to $2,500) valued at $63,809 from 2 vendors for minor maintenance and repair projects. The pattern of recurring purchases just under the single purchase limit of $2,500 from these two vendors gave the appearance of purchase splitting or possible collusion among the cardholder, approving official, and vendors. The vendors did not provide documentation such as bids and invoices to describe the actual work performed and labor and material costs.

- A medical facility CAP review identified that cardholders were not retaining appropriate supporting documentation. Cardholders were unable to provide supporting

documentation for 14 (23 percent) of 60 purchase card transactions in our judgment sample. The 14 transactions totaled $18,022, including charges of $809 from a restaurant and $443 for photographic supplies. The appropriateness of the purchases cannot be verified without supporting documentation detailing the descriptions, quantities, and prices of the items or services purchased. Approving officials, as well as the program coordinator, had not ensured that the cardholder maintained documentation or that supplies and services were authorized and appropriate for official Government use.

- On a VARO CAP review, our analysis of a judgment sample of purchase card transactions disclosed questionable purchases made by two cardholders. The 2 cardholders could not provide documentation justifying $18,749 in purchases, which represented 10 purchases from vendors such as Circuit City, Craftmaster Hardware, and other specialty retail stores. Further, six of the transactions at $2,500 each were made at Craftmaster Hardware on consecutive days at the end of the fiscal year. The cardholder stated she had no recollection of the items purchased.

Internal Controls Needing Implementation

Improper and questionable purchases continued to be identified because VA facility managers did not implement internal controls to ensure compliance with procurement regulations. We identified opportunities to provide management with greater assurance that purchase cards are used properly. Areas needing improvement to strengthen facility internal controls included: (a) closer supervision and better training of cardholders and approving officials, (b) timely reconciliation's of purchase card transactions by cardholders, (c) timely and thorough certifications of transactions by approving officials to ensure competitive prices are obtained and preferred purchasing sources are used, (d) preventing improper purchases, and (e) avoiding split purchases. In addition, facility managers need to conduct more effective focused audits to provide greater assurance that: (a) duties are appropriately segregated, (b) cardholders and approving officials are properly trained, (c) the span of control for approving officials is appropriate, and (d) questionable transactions are identified and validated. Appendix D, page 17, lists the 83 reports summarized in this report and Appendix E, page 23, provides a matrix of the internal control weaknesses by report number. Internal control weaknesses relating to non-competitive procurements, split purchases, and improper purchase card uses are included in the results of data mining previously discussed. Weaknesses in internal controls included the following.

Account Reconciliations and Certifications. VA facility managers needed to ensure that cardholders and approving officials performed timely account reconciliations and certifications. The reconciliation process involves matching payment charges from the purchase card program contractor to the purchase card order. VHA policy requires cardholders to reconcile 75 percent of payments within 10 days, 95 percent within 17 days, and 100 percent within 30 days. Further, approving officials are required to certify all reconciled payment charges within 14 days of receipt from the cardholder. The certification process requires approving officials to ensure that purchases are necessary to accomplish the mission of the agency, are legal and proper, and that

goods and services have been received. Purchase card transactions were not timely reconciled and certified at 52 (63 percent) of 83 facilities.

Segregation of Duties. VA facility managers needed to ensure that the duties of purchase card program officials were segregated to reduce the risk of irregularities or fraud. VA policy and sound internal control practices prohibit any one individual from controlling all the key aspects of a transaction. A common deficiency identified at VA facilities was that the program coordinator, cardholder, approving official, billing officer, or dispute officer performed overlapping duties. Segregation of duties was not in place at 27 (33 percent) of 83 facilities.

Monthly and Quarterly Audits. VA facility managers needed to strengthen monthly audits and ensure that quarterly audits of cardholders' and approving officials' activities were conducted to enhance compliance with the FAR and VA policy. Monthly audits are conducted to ensure that purchases are appropriate and used for VA purposes only, are timely reconciled and certified, are within cardholder spending limits, and are supported by appropriate documentation. The VA Financial Services Center selects a monthly statistical sample of purchase card transactions from a nationwide universe for review by each VA facility. Generally, we found that monthly audits were being conducted. However, we noted that on an individual facility basis as few as two or three transactions were selected for review monthly. Because of the small number of transactions selected for review at each facility, the effectiveness of these reviews in ensuring compliance with the FAR and VA policy is questionable. In addition, VA policy requires VA facilities to conduct quarterly audits of cardholders and approving officials not reviewed in the monthly audits of purchase card transactions. We found that quarterly audits were not conducted at 22 (27 percent) of 83 facilities. We believe that program oversight can be improved by increasing the number of transactions sampled monthly at each facility and by monitoring the performance of quarterly audits.

Training and Warrants. VA facility managers needed to ensure that purchase cardholders and approving officials were properly trained to carry out their purchase card responsibilities. Purchase cardholders who make purchases above $2,500 are required to complete a 40-hour training course on procurement policies and procedures, and obtain contracting officer warrants that allow them to spend up to, but not exceed, specific higher dollar amounts. Purchase cardholders and approving officials were not properly trained and warranted at 26 (31 percent) of 83 facilities.

Purchase Card Cancellation. VA facility managers needed to ensure that purchase cards were canceled and retrieved from employees who terminated employment. VA policy provides that the program coordinator is responsible for cancellation of purchase card accounts. Purchase cards were not canceled for employees who terminated employment at 12 (14 percent) of 83 facilities.

Approving Officials Span of Control

The span of control of approving officials needs to be established. In November 2003, the General Accounting Office (GAO) issued a guide on *Auditing and Investigating the Internal Control of Government Purchase Card Programs*. In addition to the types of internal control issues discussed in this report, GAO identified the span of control of approving officials as an important internal control element of a Government Purchase Card Program. Span of control refers to the review responsibilities assigned to approving officials for purchase card transactions for one or more cardholders.

VA policy does not provide guidance to VA facility managers regarding the span of control for approving officials. We reviewed the span of control at 11 medical facilities and found overall ratios of cardholders to approving officials ranged from a low of 1.8 to a high of 4.3, which we considered reasonable. However, at two of these medical facilities, we found that the span of control for two approving officials was excessive. At a medical facility, an approving official had responsibility for monitoring 41 cardholders. The cardholders made 1,167 purchases totaling approximately $1.2 million. At the second medical facility, an approving official, who was also a contracting official, was responsible for 19 cardholders who had a total of 367 purchase cards.

In response to a 2002 GAO evaluation, the Department of Defense Purchase Card Program Management Office issued policy guidance that approving officials should normally be responsible for five to seven cardholders. In our opinion, VA should establish similar policy guidance to ensure that the VA facility approving official span of control is not excessive and is monitored on a periodic basis.

Conclusion

VA management needs to implement effective internal controls over the Government Purchase Card Program. Since our audit in 1999, we frequently reported weaknesses in internal controls in our investigations, hotlines, and CAP reviews. The results of our data mining further confirmed the need to strengthen internal controls and enhance program oversight. VA management needs to strengthen internal controls and provide greater management oversight to ensure that the FAR an VA policy are effectively implemented in order to prevent and detect fraudulent, improper, and questionable uses of purchase cards.

Recommendation 1

We recommended that the Under Secretary for Health and the Under Secretary for Benefits, in coordination with the Assistant Secretary for Management:

a. Direct VA facility managers to conduct quarterly focused reviews of their Government Purchase Card Programs to provide greater assurance that: controls are properly

implemented; cardholders and approving officials are properly trained; and the span of control for approving officials is monitored to prevent and detect fraudulent, improper, or questionable purchases.

b. Develop and implement procedures and checklists for approving officials to use in monitoring cardholders' uses of purchase cards to ensure that: purchases are for Government business only; purchases are legal and proper and the items and services have been received; purchases made are within authorized spending limits, purchases are not improperly split to circumvent cardholder limits; the FAR and VA procurement policy are followed; and supporting documentation is maintained for all purchases.

Under Secretary for Health Comments

Agree. VHA's Financial Assistance Office (FAO) formed a purchase card task force to devise strategies to improve work performance, eliminate recurring OIG deficiency assessments, improve the accuracy of accounting records, and reduce vulnerability for waste, fraud, and abuse. Specific steps are being taken by the specially designated purchase card management task force to upgrade and streamline current reporting mechanisms, provide comprehensive, nationally-based training guides, and offer personalized consultant assistance to those facilities identified as being in non-compliance with requirements.

The FAO plans to update the Government Purchase Card Handbook to specify minimal sampling and quality review requirements, including training specifications, and require approving officials to document their reviews and certify to the Chief Financial Officer that the reviews were completed. The FAO purchase card task force has been working since early 2003 to identify best practices at field facilities and to develop administrative tools to assist approving officials and cardholders to improve oversight controls. In coordination with the Office of Logistics, handbook revisions and appropriate checklists and guidelines will be designed to assist the approving officials to monitor compliance of individual cardholders in meeting procurement requirements. The target completion date for this action is May 2004. (See Appendix F, pages 26-30, for the full text of the Under Secretary's comments.)

Office of Inspector General Comments

The Under Secretary for Health agreed with the findings and recommendations and provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Under Secretary for Benefits Comments

Agree. The Under Secretary for Benefits will release the draft copy of the handbook and letter directing quarterly reviews. The completion date for this action was the week of January 20, 2004. Further, emphasis on strengthening internal controls and management oversight of the purchase card program will be provided at the next Directors' Conference. Purchase card

program reviews will continue to be performed during field operation site surveys. In addition, specialized training on the purchase card program was provided at the Financial Management and Budget Training Conference in March 2004. The purchase card program will be emphasized at the monthly Finance conference telephone calls. (See Appendix G, pages 31-32, for the full text of the Under Secretary's comments.)

Office of Inspector General Comments

The Under Secretary for Benefits agreed with the findings and recommendations and provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Recommendation 2

We recommended that the Assistant Secretary for Management:

a. Update VA Directive 4080 to include span of control criteria for approving officials.

b. Enhance the effectiveness of oversight of the Government Purchase Card Program to ensure facilities implement internal controls, the FAR, and VA policy. In addition to required monthly audits of randomly selected small samples of facility purchase card transactions, focused audits of questionable transactions that can be identified through data mining analyses should be periodically conducted.

Assistant Secretary for Management Comments

Agree. The Office of Finance will update VA Handbook 4080 to include a requirement to set up a reasonable ratio of cardholders to approving officials. This action will be completed in FY 2004. The Management Quality Assurance Service (MQAS) within the planned Office of Business Oversight will perform focused audits of questionable transactions identified through data mining. MQAS will work closely with the Financial Services Center to obtain purchase card transaction data that MQAS will data mine monthly. MQAS will perform focused audits of identified questionable transactions monthly. These audits will include coverage of purchase card internal controls and compliance with the FAR and VA policy. The implementation date for this action is FY 2005. (See Appendix H, pages 33-35, for the full text of the Assistant Secretary's comments.)

Office of Inspector General Comments

The Assistant Secretary for Management agreed with the findings and recommendations and provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Appendix A

Background

The Federal Government adopted the use of purchase cards in the early 1980s. Purchase cards are internationally accepted credit cards available to all Federal agencies under a GSA contract and are to be used for small purchases of up to $25,000. GSA awarded the first Government-wide purchase card contract in 1989. In 1993, the Vice President's National Performance Review identified the purchase card as a major acquisition reform, and recommended that all Federal agencies increase their use of the cards to streamline the Federal procurement process. In 1995, the FAR designated the purchase card as the preferred method to pay for micro-purchases (those under $2,500).

VA began using purchase cards in October 1994. VA's use of purchase cards is mandatory for all micro-purchases. Purchase cards must also be used, to the maximum extent possible, for all purchases up to the simplified acquisition threshold ($100,000) where appropriate warranting has been completed. Since FY 1995, VA-wide use of purchase cards has grown considerably, as illustrated by the three graphs at the bottom of this page. However, more recently the number of cards issued nationwide declined by approximately 7 percent from a high in FY 2000 of 34,200 cards to approximately 31,800 cards in FY 2003 (Figure 1). The number and value of purchase card transactions has grown considerably since FY 1995; from about 20,000 transactions valued at $4.5 million to over 3.2 million transactions valued in excess of $1.7 billion in FY 2003 (Figures 2 and 3). In FY 2003, VA earned approximately $18.2 million in rebates from the purchase card contractor based on purchase card sales volume.

Figure 1: Purchase Cards Issued (Thousands)

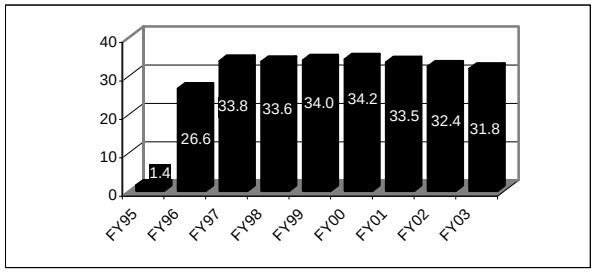


Figure 2: Purchase Card Transactions (Millions)

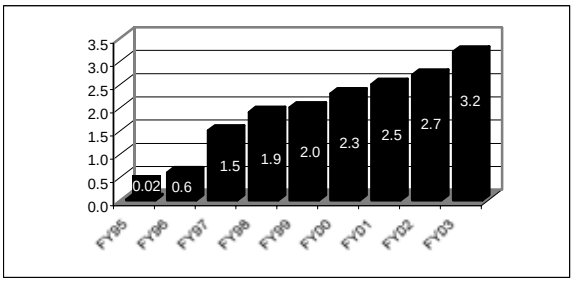
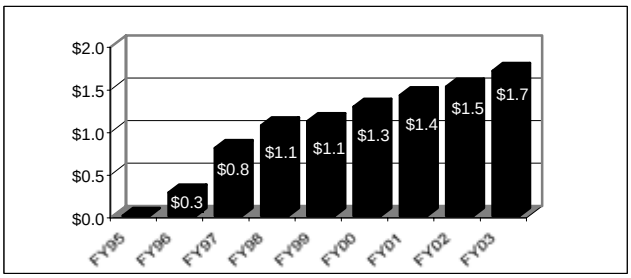


Figure 3: Purchase Card Transaction Volume (Billions)



Appendix B

Objectives, Scope, and Methodology

Objectives

We evaluated the effectiveness of internal controls over VA's Government Purchase Card Program to prevent and detect fraudulent, improper, or questionable purchases. The objectives of our evaluation were to report the following:

- Results of our purchase card program coverage on hotline and CAP reviews conducted during the period March 31, 1999, through September 30, 2003. We issued 83 reports that identified internal control weaknesses in the Government Purchase Card Program.
- Results of our data mining of purchase card activity for indications of potentially fraudulent, improper, or questionable purchases at five VA facilities.
- Results of purchase card fraud investigations conducted by the VA OIG Office of Investigations.

Scope and Methodology

We reviewed findings related to the Government Purchase Card Program from 80 CAP reviews and 3 hotline reports issued during the period March 31, 1999, through September 30, 2003. The 80 CAP reviews were conducted at 67 VA medical facilities and 13 VAROs. The purposes of CAP reviews are to evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical and benefits services. As part of the CAP reviews, we determined if Government Purchase Card Program internal controls ensured compliance with the FAR and VA policy and minimized vulnerability to fraud, waste, and abuse. In addition, we reviewed findings from three hotline reviews related to the Government Purchase Card Program. We interviewed key managers and staff at medical facilities and VAROs.

We also reviewed purchase card activity for indications of potentially fraudulent, improper, or questionable purchases using data mining techniques. We conducted data mining of purchase card transactions that focused on the following:

- Prohibited transactions (e.g., personal use or travel-related).
- Transactions just below the $2,500 micro-purchase limit.
- Numerous recurring transactions with the same vendor.
- Unusually high-dollar amount transactions.
- Transactions in even-dollar amounts.
- Transactions with specialty and department stores.
- Transactions made on holidays, weekends, and at the end of the fiscal year.

Appendix B

We conducted on-site evaluations at the following four medical facilities and one national cemetery as shown below.

Facilities Visited, Samples, and Universe of Purchase Card Transactions

Facility	Sample		Universe	
	Transactions	Amount	Transactions	Amount
VAMC Washington, DC[2]	417	$1,113,628	23,458	$15,867,037
Long Beach Healthcare System, CA[3]	384	718,555	33,978	15,472,814
VAMC Bronx, NY[4]	408	996,372	15,809	15,210,944
VAMC Hines, IL[5]	194	369,873	16,072	11,383,484
Baltimore National Cemetery, MD[6]	42	8,600	9,850	3,023,733
Total	1,445	$3,207,028	99,167	$60,958,012

From a universe of 99,167 purchase card transactions valued at $60,958,012, we identified 1,445 questionable transactions totaling $3,207,028 for further review. Based on an analysis of the questionable transactions, we identified 458 transactions (32 percent) totaling $1,127,748 that did not comply with VA policies or the FAR.

For the purchase card issues summarized from CAP review reports, the reviews were conducted in accordance with OIG standard operating procedures. Our additional analyses were conducted in accordance with generally accepted government auditing standards for independence, professional judgment, and competence; fieldwork standards for planning, supervision, and evidence; and reporting standards for performance audits.

[2] Review period October 1, 2000, to May 31, 2002
[3] Review period October 1, 2000, to February 28, 2002
[4] Review period October 1, 2000, to February 28, 2002
[5] Review period October 1, 2000, to May 31, 2002
[6] Review period January 1, 2002, to March 31, 2002

Appendix C

Government Purchase Card Program Responsibilities

VA has organized its implementation of the Government Purchase Card Program around the relationships of seven positions. Each position has a critical role in ensuring the integrity of the process. A description of each position follows.

Program Coordinator. A program coordinator's responsibilities include: (a) implementing the program to include contract compliance with the purchase card contractor's rules and regulations, (b) ensuring that appropriate training has been provided to cardholders, approving officials, and alternate approving officials, (c) retrieving and canceling all cards of any employee who either terminates employment or violates Government purchase card procedures, (d) performing a joint review of cardholders and approving officials in conjunction with the fiscal officer and head of the contracting authority, and (e) distributing cards to cardholders with activation instructions. The program coordinator cannot be a cardholder or an approving official.

Cardholder. A cardholder's responsibilities include: (a) obtaining training on proper use of the purchase card, (b) complying with the FAR and VA policy, (c) verifying the availability of funds prior to making purchases, (d) complying with single and monthly purchase card limits, (e) reconciling payment charges within specified timeframes, (f) ensuring receipt of goods ordered, (g) providing applicable documentation to the approving official to enable certification of payments, and (h) safeguarding the Government purchase card.

Approving Official. An approving official's responsibilities include: (a) recommending individuals as cardholders and recommending single purchase and monthly purchase limits in conjunction with the program coordinator, the billing officer, and the head of the contracting activity, (b) monitoring use of the Government purchase cards by cardholders to ensure purchases are within guidelines, (c) certifying all transactions made by cardholders and ensuring appropriate documentation is maintained, (d) ensuring Federal, VA, and local acquisition regulations are followed, (e) certifying all procurements are legal and proper, and ensuring all items are received, and (f) certifying reconciled payment charges within specified timeframes.

Dispute Officer. A dispute officer's responsibilities include coordinating and monitoring disputed procurements, credits, and billing errors. The dispute officer will assist when a dispute cannot be handled in the normal method using the "Government Cardholder Dispute Form".

Billing Officer. A billing officer's responsibilities include ensuring that single and monthly purchase limits are within fund control limits. The billing officer has final certifying authority on the legitimacy of any procured item and also collects amounts from the cardholder for any inappropriate procurement. In addition, the billing officer ensures rebates are credited to the correct appropriation.

Fiscal Officer. A fiscal officer's responsibilities include: (a) ensuring the VA Financial Services Center's random monthly quality reviews are completed, verifying that the review results are accurate, and ensuring cardholders do not complete the reviews, (b) providing training to cardholders on correct costing and reconciliation procedures, and receipts record maintenance, and (c) performing the joint review of cardholders and approving officials to ensure compliance with applicable VA policy and procedures including the FAR, in conjunction with program coordinators and the head of contracting activity.

Head of Contracting Activity. A head of the contracting activity's responsibilities include: (a) auditing cardholders and approving officials for compliance with applicable VA policy and procedures including the FAR, in conjunction with program coordinators and the fiscal officer, in order to ensure procurement integrity, (b) appointing contracting officers and cardholders, and (c) delegating micro-purchase authority to cardholders.

Appendix D

Reports Identifying Internal Control Weaknesses

1. Report No. 03-01144-170, Combined Assessment Program Review of the VA Hudson Valley Health Care System Montrose, New York, August 26, 2003.

2. Report No. 03-03214-163, Combined Assessment Program Review of the VA Medical Center Butler, Pennsylvania, August 21, 2003.

3. Report No. 03-01674-155, Combined Assessment Program Review of the VA Regional Office St. Louis, Missouri, August 14, 2003.

4. Report No. 03-01404-161, Combined Assessment Program Review of the VA Medical Center Asheville, North Carolina, August 14, 2003.

5. Report No. 02-03264-148, Combined Assessment Program Review of the VA Medical Center New Orleans, Louisiana, August 7, 2003.

6. Report No. 03-00821-141, Combined Assessment Program Review of the Edith Nourse Rogers Veterans Hospital Bedford, Massachusetts, July 31, 2003.

7. Report No. 03-00752-143, Combined Assessment Program Review of the VA Medical Center Augusta, Georgia, July 31, 2003.

8. Report No. 03-00700-140, Combined Assessment Program Review of the VA Medical Center Bay Pines, Florida, July 29, 2003.

9. Report No. 03-00988-135, Combined Assessment Program Review of the VA Sierra Nevada Health Care System Reno, Nevada, July 18, 2003.

10. Report No. 03-01396-131, Combined Assessment Program Review of the Overton Brooks VA Medical Center Shreveport, Louisiana, July 17, 2003.

11. Report No. 03-00287-130, Combined Assessment Program Review of the VA Regional Office Los Angeles, California, July 16, 2003.

12. Report No. 02-02172-129, Combined Assessment Program Review of the Washington, DC VA Medical Center, July 14, 2003.

13. Report No. 03-01387-126, Combined Assessment Program Review of the VA Medical Center Iron Mountain, Michigan, July 14, 2003.

14. Report No. 03-00759-125, Combined Assessment Program Review of the VA Regional Office St. Paul, Minnesota, July 10, 2003.

15. Report No. 03-00758-117, Combined Assessment Program Review of the VA Regional Office Chicago, Illinois, June 27, 2003.

16. Report No. 03-01379-115, Combined Assessment Program Review of the Houston VA Medical Center Houston, Texas, June 19, 2003.

17. Report No. 03-01049-109, Combined Assessment Program Review of the VA Regional Office Muskogee, Oklahoma, June 5, 2003.

18. Report No. 03-00760-102, Combined Assessment Program Review of the VA Medical Center Marion, Illinois, May 27, 2003.

19. Report No. 02-03094-101, Combined Assessment Program Review of the James A. Haley VA Medical Center Tampa, Florida, May 22, 2003.

20. Report No. 02-00987-96, Combined Assessment Program Review of the San Francisco VA Medical Center San Francisco, California, May 20, 2003.

21. Report No. 02-02171-89, Combined Assessment Program Review of North Chicago VA Medical Center North Chicago, Illinois, April 30, 2003.

22. Report No. 03-00699-83, Combined Assessment Program Review of the VA Roseburg Healthcare System Roseburg, Oregon, April 22, 2003.

23. Report No. 02-02856-76, Evaluation of Alleged Government Purchase Card Misuse and Conflicts of Interest in Facilities Management Service at the VA San Diego Healthcare System, March 20, 2003.

24. Report No. 02-01273-55, Combined Assessment Program Review of the VA Medical Center West Palm Beach, Florida, February 3, 2003.

25. Report No. 02-01430-50, Combined Assessment Program Review of the Chalmers P. Wylie VA Outpatient Clinic Columbus, Ohio, January 23, 2003.

26. Report No. 01-02641-40, Combined Assessment Program Review of the Northern Arizona VA Health Care System Prescott, Arizona, December 26, 2002.

27. Report No. 02-01432-39, Combined Assessment Program Review of the VA Medical Center Birmingham, Alabama, December 24, 2002.

28. Report No. 02-00868-15, Combined Assessment Program Review of the VA Medical Center San Juan, Puerto Rico, November 13, 2002.

29. Report No. 02-01760-06, Combined Assessment Program Review of the Bronx VA Medical Center Bronx, New York, October 18, 2002.

30. Report No. 02-01933-3, Combined Assessment Program Review of the VA Medical Center Lexington, Kentucky, October 16, 2002.

31. Report No. 02-00988-170, Combined Assessment Program Review of the VA Loma Linda Healthcare System, September 30, 2002.

32. Report No. 02-01766-171, Combined Assessment Program Review of the VA Regional Office Denver, Colorado, September 30, 2002.

33. Report No. 01-01518-166, Combined Assessment Program Review of the VA Medical Center Fayetteville, North Carolina, September 20, 2002.

34. Report No. 02-01929-156, Combined Assessment Program Review of the VA Regional Office Roanoke, Virginia, September 3, 2002.

35. Report No. 02-01259-148, Combined Assessment Program Review of the VA Regional Office, Newark, New Jersey, August 6, 2002.

36. Report No. 02-01159-145, Combined Assessment Program Review of the William S. Middleton Memorial Veterans Hospital Madison, Wisconsin, August 5, 2002.

37. Report No. 02-01171-108, Combined Assessment Program Review of the VA Long Beach Healthcare System, July 31, 2002.

38. Report No. 01-02120-20, Combined Assessment Program Review of the John J. Pershing VA Medical Center Poplar Buff, Missouri, July 22, 2002.

39. Report No. 01-01073-140, Combined Assessment Program Review of the VA Connecticut Healthcare System, July 19, 2002.

40. Report No. 01-00223-136, Combined Assessment Program Review of the James H. Quillen VA Medical Center, July 16, 2002.

41. Report No. 01-02122-133, Combined Assessment Program Review of the Central Arkansas Veterans Healthcare System, July 10, 2002.

42. Report No. 00-01219-134, Combined Assessment Program Review of the VA Medical & Regional Office Center Fargo, North Dakota, July 10, 2002.

43. Report No. 01-02639-115, Combined Assessment Program Review of the VA Regional Office Manchester, New Hampshire, June 12, 2002.

44. Report No. 00-02083-52, Combined Assessment Program Review of the Central Alabama Veterans Health Care System, May 31, 2002.

45. Report No. 01-01518-30, Combined Assessment Program Review of the VA Medical Center, Durham, North Carolina, April 4, 2002.

46. Report No. 00-02097-46, Combined Assessment Program Review of the VA Medical Center Minneapolis, Minnesota, January 29, 2002.

47. Report No. 01-00686-44, Combined Assessment Program Review of the VA Medical Center Louisville, Kentucky, January 24, 2002.

48. Report No. 01-02123-43, Combined Assessment Program Review of the Samuel S. Stratton VA Medical Center Albany, New York, January 17, 2002.

49. Report No. 01-01515-40, Combined Assessment Program Review of the Kansas City VA Medical Center, January 2, 2002.

50. Report No. 01-01253-14, Combined Assessment Program Review of the VA Boston Healthcare System, October 31, 2001.

51. Report No. 01-01254-10, Combined Assessment Program Review of the Spark M. Matsunaga VA Medical and Regional Office Center Honolulu, Hawaii, October 9, 2001.

52. Report No. 01-00788-108, Combined Assessment Program Review of the VA Tennessee Valley Healthcare System, August 8, 2001.

53. Report No. 00-02096-125, Combined Assessment Program Review of the Royal C. Johnson Memorial VA Medical and Regional Office Center Sioux Falls, South Dakota, July 24, 2001.

54. Report No. 01-00685-120, Combined Assessment Program Review VA New Jersey Health Care System, July 24, 2001.

55. Report No. 00-02066-51, Combined Assessment Program Review of the Harry S. Truman Memorial Veterans' Hospital Columbia, Missouri, July 10, 2001.

56. Report No. 01-00079-104, Combined Assessment Program Review of the Oklahoma City Veterans Affairs Medical Center, July 2, 2001.

57. Report No. 00-02811-89, Combined Assessment Program Review of the South Texas Veterans Health Care System, June 29, 2001.

58. Report No. 01-00507-79, Combined Assessment Program Review of the Ralph H. Johnson VA Medical Center Charleston, South Carolina, June 27, 2001.

59. Report No. 00-00709-88, Combined Assessment Program Review of the Richard L. Roudebush VA Medical Center Indianapolis, Indiana, May 31, 2001.

60. Report No. 00-02860-67, Combined Assessment Program Review of the VA Medical Center Manchester, New Hampshire, April 11, 2001.

61. Report No. 01-00071-59, Combined Assessment Program Review of the VA Puget Sound Health Care System, March 16, 2001.

62. Report No. 00-02679-41, Combined Assessment Program Review of the Hunter Holmes McGuire VA Medical Center Richmond, Virginia, February 22, 2001.

63. Report No. 00-02974-35, Combined Assessment Program Review of the VA Medical Center Miami, Florida, January 31, 2001.

64. Report No. 99-01685-10, Review of Selected Construction Contracts, Purchase Card Activities, and Vehicle Administration at the Veterans Affairs Medical Center Clarksburg, West Virginia, January 25, 2001.

65. Report No. 00-02285-19, Review of Hotline Complaint: Misuse of Government Purchase Card, December 6, 2000.

66. Report No. 00-02022-17, Combined Assessment Program Review of the VA Pittsburgh Healthcare System, November 30, 2000.

67. Report No. 00-01230-120, Combined Assessment Program Review of the VA Western New York Healthcare System, September 25, 2000.

68. Report No. 00-01065-117, Combined Assessment Program Review of the VA North Texas Health Care System, September 8, 2000.

69. Report No. 00-01225-109, Combined Assessment Program Review of the VA Medical Center Hampton, Virginia, August 31, 2000.

70. Report No. 00-01202-107, Combined Assessment Program Review of the William Jennings Bryan Dorn Veterans' Hospital Columbia, South Carolina, August 18, 2000.

71. Report No. 00-01223-104, Combined Assessment Program Review of the VA New York Harbor Healthcare System, August 3, 2000.

72. Report No. 00-00933-88, Combined Assessment Program Review of the VA Gulf Coast Veterans Health Care System Biloxi/Gulfport, Mississippi, June 19, 2000.

73. Report No. 00-01062-84, Combined Assessment Program Review of the VA Medical and Regional Office Center White River Junction, Vermont, June 5, 2000.

74. Report No. 00-00473-63, Combined Assessment Program Review of the VA Medical Center Denver, Colorado, May 4, 2000.

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75. Report No. 00-00025-37, Combined Assessment Program Review of the Department of Veterans Affairs Medical Center Omaha, Nebraska, April 3, 2000.

76. Report No. 00-00358-44, Combined Assessment Program Review of the Carl Vinson VA Medical Center Dublin, Georgia, March 20, 2000.

77. Report No. 99-00161-24, Combined Assessment Program Review VAMC Philadelphia, Pennsylvania, December 30, 1999.

78. Report No. 99-00173-18, Combined Assessment Program Review of the Edward Hines, Jr. VA Hospital Hines, Illinois, November 22, 1999.

79. Report No. 99-00684-8, Combined Assessment Program Review of the Department of Veterans Affairs Medical Center St. Louis, Missouri, October 28, 1999.

80. Report No. 9IG-CAP-504, Combined Assessment Program Review of the Louis Stokes Cleveland VA Medical Center Cleveland, Ohio, September 24, 1999.

81. Report No. 91G-CAP-503, Combined Assessment Program Review of the Southern Nevada Veterans Healthcare System, June 30, 1999.

82. Report No. 91G-CAP-502, Combined Assessment Program Review of the North Florida and South Georgia Veterans Health System, April 22, 1999.

83. Report No. 91G-CAP-501, Combined Assessment Program Review VAMC Martinsburg, West Virginia, March 31, 1999.

Appendix E

Matrix of Internal Control Weaknesses

Report Number	Account Reconciliations and Certifications	Acquisition Regulations	Split Purchases	Improper Purchase Card Use	Monthly and Quarterly Audits	Segregation of Duties	Training and Warrants	Purchase Card Cancellation
1. 03-01144-170	X	X				X		
2. 03-03214-163	X		X	X	X	X		
3. 03-01674-155	X							
4. 03-01404-161	X				X	X		
5. 02-03264-148	X		X	X	X			
6. 03-00821-141	X			X				
7. 03-00752-143								
8. 03-00700-140					X		X	X
9. 03-00988-135	X					X		
10. 03-01396-131					X			
11. 03-00287-130	X		X					
12. 02-02172-129		X		X	X	X	X	X
13. 03-01387-126	X							
14. 03-00759-125							X	
15. 03-00758-117							X	
16. 03-01379-115							X	
17. 03-01049-109	X					X		
18. 03-00760-102	X				X	X	X	
19. 02-03094-101	X				X			
20. 02-00987-96						X		
21. 02-02171-89	X		X		X			X
22. 03-00699-83	X			X		X		
23. 02-02856-76			X	X				
24. 02-01273-55	X						X	
25. 02-01430-50						X	X	
26. 01-02641-40	X		X					
27. 02-01432-39	X							
28. 02-00868-15	X		X		X		X	X
29. 02-01760-06		X						
30. 02-01933-3	X		X				X	
31. 02-00988-170	X					X	X	X
32. 02-01766-171			X			X	X	
33. 01-01518-166	X				X	X	X	
34. 02-01929-156					X	X		
35. 02-01259-148	X	X	X	X	X	X	X	X

Appendix E

Report Number	Account Reconciliations and Certifications	Acquisition Regulations	Split Purchases	Improper Purchase Card Use	Monthly and Quarterly Audits	Segregation of Duties	Training and Warrants	Purchase Card Cancellation
36. 02-01159-145					X	X	X	
37. 02-01171-108				X				
38. 01-02120-20							X	
39. 01-01073-140			X				X	
40. 01-00223-136			X			X		
41. 01-02122-133	X			X				
42. 00-01219-134	X				X			
43. 01-02639-115		X			X	X	X	X
44. 00-02083-52	X							
45. 01-01518-30	X			X	X	X	X	
46. 00-02097-46	X							
47. 01-00686-44	X							
48. 01-02123-43		X		X	X			X
49. 01-01515-40	X		X					
50. 01-01253-14		X		X		X	X	
51. 01-01254-10		X				X	X	
52. 01-00788-108	X			X				
53. 00-02096-125	X	X			X			
54. 01-00685-120		X					X	
55. 00-02066-51	X					X		
56. 01-00079-104	X		X					
57. 00-02811-89	X							
58. 01-00507-79	X			X			X	
59. 00-00709-88			X	X	X			
60. 00-02860-67			X					
61. 01-00071-59	X			X				X
62. 00-02679-41	X	X		X				X
63. 00-02974-35	X							
64. 99-01685-10	X	X	X	X	X	X	X	
65. 00-02285-19			X					
66. 00-02022-17		X						
67. 00-01230-120		X					X	
68. 00-01065-117	X							
69. 00-01225-109	X					X		
70. 00-01202-107	X						X	
71. 00-01223-104	X	X	X					
72. 00-00933-88	X							
73. 00-01062-84				X				
74. 00-00473-63						X		

Appendix E

Report Number	Account Reconciliations and Certifications	Acquisition Regulations	Split Purchases	Improper Purchase Card Use	Monthly and Quarterly Audits	Segregation of Duties	Training and Warrants	Purchase Card Cancellation
75. 00-00025-37	X			X		X		X
76. 00-00358-44	X							
77. 99-00161-24	X					X		
78. 99-00173-18	X			X	X			
79. 99-00684-8				X				X
80. 91G-CAP-504	X							
81. 91G-CAP-503	X							
82. 91G-CAP-502	X							
83. 91G-CAP-501	X			X				

Appendix F

Under Secretary for Health Comments

Department of Veterans Affairs **Memorandum**

Date: February 12, 2004

From: Under Secretary for Health (10/10B5)

Subject: **Draft Report - Evaluation of the Department of Veterans Affairs Government Purchase Card Program (Project No. 2002-01481-R1-0092)**

To: Assistant Inspector General for Auditing (52)

1. VHA program managers agree with the findings and recommendations of the referenced report, and our plan of corrective action is attached. We are already addressing most of the issues you raise, and to better clarify the broad scope of our program efforts, I believe that several points of background detail are useful. VHA has established unusually high efficiency goals in administering the purchase card program, and our record of preventing large-scale purchase card abuse, and of acting promptly to contain individual misuse, is recognized within the federal community as being one of the most effective. This is particularly reflected in our prime vendor system for pharmaceuticals and medical supplies. VHA cardholders spend more than $1.5 billion annually and make more than a quarter of a million purchases each month. Within such a vast operational scope, anecdotal instances of insufficient documentation and lack of full compliance with our 100 percent timeliness goals are not unexpected. Nevertheless, we continue to strive for ongoing improvement, and in the past year have accelerated efforts to systematically pinpoint and rectify the root causes of purchase card administrative gaps

2. As a foundation for our improvement plan, VHA's Financial Assistance Office (FAO) formed a task force in January 2003 to devise strategies to improve work performance, eliminate recurring OIG deficiency assessments, improve the accuracy of accounting records and reduce vulnerability for waste, fraud and abuse. The task force, which is comprised of special work groups with representation from Central Office, network and facility staff, has developed a three-pronged approach that once fully implemented, should fully address the issues identified by OIG, as well as other improvement opportunities.

3. The first element of the plan is aimed at improving work performance as measured by purchase card and financial indicator reports. Based on current monthly productivity reports that we utilize, 32 stations were identified as

being untimely in completing purchase card reconciliations and certifications. The involved work group agreed to provide personal on-site consultation to these outlier facilities, utilizing program staff from other facilities within the networks with effectively managed purchase card operations. Through this diffusion of "best practices," 21 of the problem facilities have already shown reportable improvement. The remaining 11 stations will be visited by June 2004.

4. Another goal of the plan is to improve program reports to better enable both facility and VACO oversight of purchase card management effectiveness. One of the work groups reviewed all 46 existing reports, and recommended that that number be significantly reduced to approximately 21 without compromising administrative efficiency. Twelve of the reports are now undergoing modification and four new reports will be developed to allow VACO managers to monitor VA/Citibank data compatibility, reconciliation inquiries, separation of duties and purchase card exceptions. The FAO is also working in close coordination with the Deputy Under Secretary for Health for Operations and Management to resolve other reporting weaknesses, particularly in relation to the limited capability provided in the existing IFCAP (Integrated Funds Control, Accounting, and Procurement) system, which now captures purchase card reporting data. This system is expected to eventually be replaced by the CoreFLS (Core Financial Logistics System). As an interim measure, however, we are exploring the feasibility of incorporating needed IT modifications to 1) capture prior fiscal year accruals in the Monthly Accrual Report; 2) provide a more accurate Headquarters Report by eliminating the possibility of manual adjustments to reconciled items; and, 3) enable "shadowing" capability for facility program coordinators that will allow them to see from their own monitors what the cardholders and approving officials are inputting, as well as enable them to communicate directly with the users and approving officials.

5. Training is another area of focused attention by the task force. Although facility managers regularly report that key staff are receiving required training, we are aware that these efforts are often inconsistent and lacking uniformity throughout the system. To provide a more standardized approach, individualized training guides have been designed for program coordinators, cardholders, approving officials, involved fiscal staff, and dispute officials. An audit guide is also under review. It is anticipated that all of the training tools will be approved and ready for final distribution before the end of this fiscal year. Field staff are encouraged to access and comment on these draft documents, which are posted on the FAO website. In addition, periodic refresher training is now mandated (VA Directive and Handbook 4080, dated April 4, 2003) within two years of initial training. Although we have not yet reached our goal of 100 percent compliance with the refresher training by January 1 of this year, our first quarter FY 2004 report showed that more than 88 percent of cardholders and approving officials have received the required training, with 92 facilities meeting the full goal. Facility Fiscal Officers, Logistics Officers and purchase card coordinators will soon be required to jointly certify training completion.

6. We are pleased to note that current financial reports suggest that our efforts are resulting in improved performance. For example, in fiscal year 2002, when VHA processed more than 2.65 million transactions, 3.8 percent of those transactions exceeded 30 days to reconcile and 1.3 percent took more than 14 days to approve. In contrast, fiscal year 2003 data report more than 3.2 million transactions, of which only 2.1 percent took more than 30 days to process and 0.9 percent more than 14 days to approve completed orders.

7. In summary, VHA is committed to systematically implementing necessary solutions to address identified gaps in purchase card program management, including training requirements, and will coordinate actions with other departmental offices to assure ongoing improvement. As our action plan notes, facility fiscal and logistics managers are already conducting monthly and quarterly reviews of the program, and efforts are being made to expedite these reporting processes through IT enhancements. We appreciate the efforts of your auditors in helping us to prioritize our targeted actions and we will continue to share our progress with you with regular status updates in the coming months. If additional information is required, please contact Margaret M. Seleski, Director, Management Review and Administration Service (10B5), at 273-8360.

(original signed by:)
Robert H. Roswell, M.D.

Attachment

OIG Draft Report: Evaluation of the Department of Veterans Affairs Government Purchase Card Program (Project No. 2002-01481-R1-0092)

VHA Action Plan

OIG Recommendation 1. We recommend that the Under Secretary for Health and the Under Secretary for Benefits, in coordination with the Assistant Secretary for Management:

a. Direct VA facility managers to conduct quarterly focused reviews of their Government Purchase Card Programs to provide greater assurance that: controls are properly implemented, cardholders and approving officials are properly trained, and the span of control for approving officials is monitored to prevent and detect fraudulent, improper or questionable purchases.

Concur

GOAL: To strengthen internal controls and provide greater management oversight of the purchase card program by requiring facilities to complete quarterly focused reviews of program effectiveness.

STRATEGY: Fiscal and Logistics managers are already required to conduct such quarterly reviews, as well as monthly productivity reports, summaries of which are provided to VHA's Financial Assistance Office (FAO) for review and follow-up action, if necessary. As detailed in our cover memo, specific steps are being taken by the specially designated purchase card management task force to upgrade and streamline current reporting mechanisms, provide comprehensive, nationally-based training guides, and offer personalized, consultant assistance to those facilities identified as being in non-compliance with requirements. The FAO plans to update the Government Purchase Card Handbook to specify minimal sampling and quality review requirements, including training specifications, and require approving officials to document their reviews and certify to the Chief Financial Officer (CFO) that the reviews were completed.

MEASURE: Certification by approving officials from all facilities to CFO that quarterly focused reviews are being completed; ongoing monitoring by Central Office program managers of required field reports, as well as CAP findings, show increased compliance with efficiency goals.

TARGET: 100 percent of facilities reported as being in full compliance with program requirements by first quarter of FY 2005.

STATUS: TBD

ACTUAL: Quarterly reviews are already being conducted, but Handbook guidance will be updated to better standardize minimal sampling and quality review requirements. Of the identified 32 stations being in non-compliance with established standards, 21 have documented improvement.

b. Develop and implement procedures and checklists for approving officials to use in monitoring cardholders' uses of purchase cards to ensure that: purchases are for Government use only, purchases made are within authorized spending limits, purchases are not improperly split to circumvent cardholder limits, the FAR and VA procurement policy are followed, and supporting documentation is maintained for all purchases.

Concur

GOAL: To provide approving officials with helpful administrative tools to assist them in monitoring cardholders' use of purchase cards.

STRATEGY: The VHA CFO's Fiscal Assistance Office purchase card task force has been working since early 2003 to identify best practices at field facilities and to develop administrative tools to assist approving officials and cardholders to improve oversight controls. In coordination with the Office of Logistics, handbook revisions and appropriate checklists and guidelines will be designed to assist the approving officials to monitor compliance of individual cardholders in meeting procurement requirements.

MEASURE: TBD

TARGET: TBD

STATUS: TBD

ACTUAL: Handbook revisions and checklist design are currently planned, with completion anticipated in May 2004.

Appendix G

Under Secretary for Benefits Comments

Department of Veterans Affairs **Memorandum**

Date: January 14, 2004

From: Under Secretary for Benefits (20)

Subject: **Draft Report - Evaluation of the Department of Veterans Affairs Government Purchase Card Program (Project No. 2002-01481-R1-0092)**

To: Assistant Inspector General for Auditing (52)

1. We have reviewed the Draft Report—Evaluation of the Department of Veterans Affairs Government Purchase Card Program (Project No. 2002-01481-R1-0092) and agree VBA management needs to strengthen internal controls and provide greater management oversight.

2. To comply with OIG's recommendations, VBA has drafted a handbook which will:

   a. Direct VBA facility managers to conduct quarterly focused reviews of their purchase card programs to provide greater assurance that controls are properly implemented, cardholders and approving officials are properly trained, and the span of control for approving officials is monitored to prevent and detect fraudulent, improper or questionable purchases.

   b. Address and implement procedures and checklists for approving officials to use in monitoring cardholders' use of purchase cards to ensure that: purchases are for Government business only; purchases are legal and proper and the items and services have been received; purchases are made within authorized spending limits; purchases are not improperly split to circumvent cardholder limits; the FAR and VA procurement policy are followed; and supporting documentation is maintained for all purchases.

3. VBA's implementation plan is as follows:

   a. During the week of January 20, 2004—Release the draft copy of the handbook and letter from the Under Secretary for Benefits directing quarterly reviews.

b. Provide emphasis on strengthening internal controls and management oversight of the purchase card program at the next Directors' Conference.

c. Continue to perform purchase card program reviews during field operation site surveys.

d. Provide specialized training on the purchase card program at the Financial Management and Budget Training Conference in March 2004.

e. Continue emphasis on the purchase card program at the monthly Finance Hotlines.

4. If you have any questions or need additional information, please contact Dee Fielding, VBA's OIG Liaison, at 273-7018.

(original signed by:)

Daniel L. Cooper

Appendix H

Assistant Secretary for Management Comments

Department of Veterans Affairs **Memorandum**

Date: January 12, 2004

From: Assistant Secretary for Management (004)

Subject: **Draft Report - Evaluation of the Department of Veterans Affairs Government Purchase Card Program (Project No. 2002-01481-R1-0092)**

To: Assistant Inspector General for Auditing (52)

Attached is the Office of Management's response to the OIG's recommendations regarding the evaluation of VA's government purchase card program. As you will note, we concur in the recommendations and accordingly submit implementation plans for the areas under jurisdiction of this office.

Please call me if you have any questions, or your staff may contact Mr. Ed Murray, Acting DAS for Finance, at 273-5504.

(original signed by:)

William H. Campbell

Attachment

Response to Recommendations from Office of Inspector General Draft Report: Evaluation of the Department of Veterans Affairs Government Purchase Card Program

OIG Recommendation 1. We recommend that the Under Secretary for Health and the Under Secretary for Benefits, in coordination with the Assistant Secretary for Management:

a. Direct VA facility managers to conduct quarterly focused reviews of their Government Purchase Card Programs to provide greater assurance that: controls are properly implemented, cardholders and approving officials are properly trained, and the span of control for approving officials is monitored to prevent and detect fraudulent, improper or questionable purchases.

Concur **Implementation Date: TBD***

b. Develop and implement procedures and checklists for approving officials to use in monitoring cardholders' uses of purchase cards to ensure that: purchases are for Government use only, purchases made are within authorized spending limits, purchases are not improperly split to circumvent cardholder limits, the FAR and VA procurement policy are followed, and supporting documentation is maintained for all purchases.

Concur **Implementation Date: TBD***

OIG Recommendation 2. We recommend that the Assistant Secretary for Management:

a. Update VA Directive 4080 to include span of control criteria for approving officials.

Concur **Implementation Date:** Fiscal Year 2004

The Office of Finance will update VA Handbook 4080 to include a requirement to set up a reasonable ratio of cardholders to approving officials.

b. Enhance the effectiveness of oversight of the Government Purchase Card Program to ensure facilities implement internal controls, the FAR, and VA policy. In addition to required monthly audits of randomly selected small samples of facility purchase card transactions, periodically conduct focused audits of questionable transactions that can be identified through data mining analyses.

Concur **Implementation Date:** Fiscal Year 2005

The Management Quality Assurance Service (MQAS) within the planned Office of Business Oversight will perform focused audits of questionable transactions identified through data mining. MQAS will work closely with the Financial Services Center to obtain purchase card transaction data that MQAS will data mine monthly. MQAS will perform focused audits of identified questionable transactions monthly. These audits will include coverage of purchase card internal controls and compliance with the FAR and VA policy.

*Implementation plan and target completion date must be provided by the VA administrations.

Appendix I

OIG Contact and Staff Acknowledgments

OIG Contact	Philip D. McDonald (781) 687-3140
Acknowledgments	Elizabeth MacLean Steven Rosenthal

Appendix J

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This report will be available in the near future on the OIG's Web site at http://www.va.gov/oig/52/reports/mainlist.htm. This report will remain on the OIG Web site for at least 2 fiscal years after it is issued.