VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Veterans Health Administration

Review of Alleged Unauthorized Commitments for Prosthetic Purchases at the Network Contracting Office 3

June 12, 2017
15-03678-210

ACRONYMS

DAS	Deputy Assistant Secretary
eCMS	Electronic Contract Management System
FAR	Federal Acquisition Regulation
FPDS	Federal Procurement Data System
FY	Fiscal Year
IFCAP	Integrated Funds Distribution Control Point, Accounting and Procurement System
NCO	Network Contracting Office
OAL	Office of Acquisition and Logistics
OIG	Office of Inspector General
PCPM	Purchase Card Program Manager
SAO	Service Area Office
VA	Department of Veterans Affairs
VISN	Veterans Integrated Service Network
VHA	Veterans Health Administration

Highlights: Review of Alleged Unauthorized Commitments for Prosthetic Purchases at VHA's NCO 3

Why We Did This Review

In May 2015, members of Congress Kathleen Rice and Mike Coffman requested the VA Office of Inspector General (OIG) review allegations that a supervisor at a VA facility in Bronx, NY, made unauthorized commitments in fiscal years 2011 and 2012, totaling more than $50 million, by splitting prosthetic purchases in increments below $25,000. Initial examination of these transactions gave the appearance that fraud might have been committed, along with the possibility that these purchases might need to be ratified. Moreover, Congresswoman Rice asked the OIG to assess VA's claim that related procurement records were destroyed during Hurricane Sandy in October 2012.

What We Found

We did not substantiate that the Purchase Card Program Manager (PCPM) made more than $50 million in unauthorized commitments by splitting prosthetic purchases. We determined that the Network Contracting Office (NCO) 3 PCPM erroneously reported approximately $54.4 million of prosthetic purchases in Federal Procurement Data System (FPDS) during FYs 2011 and 2012. FPDS is a reporting system intended to provide transparency in Federal contracting and purchasing but is not used to obligate or expend funds. This erroneous reporting included the alleged split purchases under review.

The PCPM erroneously reported contract purchases because NCO 3 was not meeting a performance metric that measured acquisitions on contracts. This occurred because the NCO3 Contract Manager did not provide oversight or ensure implementation of the required segregation of duties for FPDS reporting. This erroneous reporting of prosthetic purchases was eventually removed from FPDS, in 2013. In the course of our review, we did identify 11 unauthorized commitments totaling about $457,000 for prosthetic purchases that exceeded the warrants of the purchasers. The facility was unable to provide documentation of compliance with VA policy showing that these payments had been made by purchase cardholders in accordance with their warrant authority. The unauthorized commitments must now be ratified.

We did not substantiate VA's claim that procurement records for prosthetic purchases at NCO 3 were destroyed during Hurricane Sandy. We determined that, in fact, all the prosthetic procurement files had been stored on the 14th floor of the medical center, and not in an area affected by the hurricane.

What We Recommended

We recommended that the Executive Director, Service Area Office (SAO) East submit a ratification request for unauthorized commitments and consult with Regional Counsel to determine if the Executive Director should take actions related to erroneous reporting. We also recommended that the Executive Director conduct a review of Network Contracting Office operations to ensure internal controls, such as segregation of duties, are monitored and enforced.

Agency Comments

The Acting Under Secretary for Health responded to the recommendations addressed to Executive Director, SAO East and concurred with recommendations. We were provided sufficient evidence to close recommendations 2 and 3 and will follow up on the implementation of the corrective actions for recommendation 1.

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INTRODUCTION

Allegations

In May 2015, members of Congress Kathleen Rice and Mike Coffman requested that the VA Office of Inspector General (OIG) review allegations that a supervisor at a VA facility in Bronx, NY, had made unauthorized commitments totaling more than $50 million by splitting purchases for prosthetics in increments below $25,000. Congresswoman Rice also asked the OIG to determine whether VA's claim that the related procurement records had been destroyed during Hurricane Sandy[1] had any merit.

Background

The allegations originated in September 2012 with a request from Congressman Bill Johnson, Chairman of the House Committee on Veterans' Affairs, Subcommittee on Oversight and Investigations. He requested that VA conduct a comprehensive review of Veterans Integrated Service Network (VISN) 3 purchases—which totaled approximately $54.4 million in fiscal years 2011 and 2012—to determine compliance with the Federal Acquisition Regulation (FAR). Many of the procurement transactions reported in the Federal Procurement Data System (FPDS)[2] appeared to be split purchases, including many transactions with the same vendor, the same date, and in the same amounts below $25,000. For example, the FPDS data provided listed 971 transactions, each for $24,900, with many of them recorded on the same day and to the same vendor.

In July 2013, the VA Secretary responded to the Chairman's letter and acknowledged that VA was not compliant with FAR Part 13, *Simplified Acquisition Procedures*, for the reported purchases but claimed that contract files were not available. Based on the findings, the Deputy Assistant Secretary (DAS), Office of Acquisition and Logistics (OAL), issued a memo instructing the Veterans Health Administration (VHA) to comply with FAR contracting requirements and requested the removal of approximately $55 million in transactions from FPDS because of a lack of contractual documentation to support these purchases. The removal of these data was completed by September 2013. These purchases resurfaced when the issue was raised again in a May 2015 hearing[3] during which the DAS cited VISN 3 as an example of purchase card abuse. This, in turn, prompted Congresswoman Rice's request.

[1] In late October 2012, Hurricane Sandy devastated portions of the Mid-Atlantic and Northeastern United States.
[2] FPDS provides a comprehensive web-based tool for agencies to report contract actions as required by the Federal Funding Accountability and Transparency Act of 2006 (Pub. L. 109-282).
[3] On May 14, 2015, the Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs, held a hearing on Waste, Fraud and Abuse related to VA's Purchase Card Program.

RESULTS AND RECOMMENDATIONS

Finding 1 Procurement Purchases Erroneously Recorded in the Federal Procurement Data System

We did not substantiate the allegation that the Purchase Card Program Manager (PCPM) made unauthorized commitments[4] totaling more than $50 million by splitting purchases for prosthetics in increments below $25,000. We determined that the PCPM at the Network Contracting Office 3 (NCO)[5] erroneously reported in FPDS, during FYs 2011 and 2012, about $54.4 million of prosthetic purchases, including those that were allegedly split. The PCPM mistakenly reported contract purchases because NCO 3 was not meeting a performance metric, namely, that 95 percent of purchases above the micro-purchase limit were either matched to contracts in FPDS or qualified for FPDS reporting exemptions. This occurred because the NCO 3 Contract Manager did not provide oversight or implement the required segregation of duties to reduce the risk of error, misuse, or fraud. Although the erroneous purchase data were eventually removed in September 2013, the misreporting of procurements by NCO 3 harms the public trust that VA is properly executing its duties.

In the course of our review, we identified 11 payments totaling approximately $457,000 for prosthetic purchases that exceeded the warrants of the purchasers. These payments were both unauthorized commitments and improper payments. The facility was unable to provide documentation of compliance with VA policy[6] showing that these payments were made by purchase cardholders in accordance with their warrant authority. Approving officials are responsible for monitoring cardholder compliance with purchase limits.

Prosthetics Procurement Policy

Title 38 United States Code (U.S.C.) § 8123, *Procurement of Prosthetics Appliances*, gives VA special authority to procure prosthetics without regard to any other provision of law. VHA Directive 2003-037, dated July 16, 2003,[7] imposed limitations on purchasing agents who acquire prosthetic devices under a basic level warrant of $25,000, which could be increased up to $100,000 with approval from the Head of Contract Authority.

[4] FAR, 1.6. Unauthorized commitment is an agreement that is not binding solely because the Government representative who made it lacked the authority to enter into that agreement on behalf of the Government. Contracting officers have authority to enter into, administer, or terminate contracts and make related determinations and findings.
[5] NCO 3 merged into NCO 2 on August 8, 2016.
[6] VA Financial Policies and Procedures, Volume XVI
[7] VHA Directive 2003-037 was effective for prosthetic purchases made in FYs 2011 and 2012.

However, purchasing agents were allowed to use a special procurement authority under four circumstances. These are: (1) when the patient's medical needs cannot be met through the use of a required source of supply, or (2) documentation supports that the required product or service does not meet the medical requirements, or (3) medical evidence supports that the delivery time does not meet the patient's medical needs, or (4) a medical emergency exists supported by medical evidence. However, this authority has no documentation requirements for purchases not made from a required source of supply and does not specify the documentation required under the remaining three circumstances of medical need. In January 2013, the DAS OAL issued a memo stating that open-market procurement of prosthetics priced at $25,000 or more be placed by contracting officers because of concerns that contracts were not executed for acquisitions above the micro-purchase threshold.

In March 2014, VHA Directive 1081[8] made some significant changes to the procedures for procuring prosthetic appliances and sensory aids. Notably, the directive requires that all procurement actions above the micro-purchase limit be performed by a warranted contracting officer. The directive also establishes the circumstances under which other than full and open competition can be used and mandates the use of the Electronic Contract Management System (eCMS) to document and retain procurement details and justifications.

Federal Procurement Data System

FPDS is a procurement reporting system intended to provide transparency in Federal contracting and purchasing, as required by the Federal Funding Accountability and Transparency Act of 2006. The system provides a web-based tool for Federal agencies to report contract actions, as required by Federal law, including all unclassified contract actions exceeding the micro-purchase threshold ($3,000). FPDS data are used to assess the impact of Federal procurement on the nation's economy[9]. FPDS is not used to obligate or expend funds.

Unauthorized Commitments

VA policy[10] allows purchase cardholders to make purchases only within the limits of their delegated warrant authority. When purchase cardholders exceed the limitations placed on their purchasing authority, they make unauthorized commitments. When unauthorized commitments are identified they must be ratified, which is the act of approving an unauthorized commitment, if appropriate, by an official who has the authority to perform

[8] VHA Directive 1081 rescinded VHA Directive 2003-037 and established new rules for the procurement of prosthetics.
[9] FAR, Subpart 4.6.
[10] VA Financial Policies and Procedures, Volume XVI

the action.[11] Unauthorized commitments are also considered improper payments because the payments should not have been made under statutory requirements.

Improper Payments

The Office of Management and Budget Circular A-123, Appendix C, *Requirements for Effective Estimation and Remediation of Improper Payments*, defines an improper payment as follows:

> *An improper payment is any payment that should not have been made or that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements.*

$54.4 Million of Transactions Reported in FPDS for FYs 2011 and 2012

We analyzed 1,859 transactions for prosthetic purchases totaling $54.4 million made during FYs 2011 and 2012. The analyzed data was an extract from FPDS that was provided to us by the House Committee on Veterans' Affairs, Subcommittee on Oversight and Investigations. We used this extract, and not data directly from FPDS because, in June 2013, the DAS OAL issued a memo instructing VHA to remove the transactions from FPDS due to a lack of contractual documentation. By September 2013, VHA had removed the data. We conducted this analysis to determine the circumstances leading up to the entry of the $54.4 million of purchases into FPDS and what occurred after the discrepancies were discovered.

Of the 1,859 transactions listed on the extract, 1,790 were under $25,000, and most appeared to be split purchases as a way to keep the reported amount below the $25,000 threshold. For example, we identified 571 transactions (30.7 percent) valued at $24,500 each. Table 1 shows our analysis of the 1,859 transactions by amount, number of transactions, and calculated total dollars reported in FPDS.

[11] FAR, 1.602-3 *Ratification of Unauthorized Commitments*. Ratification, as used in this subsection, means the act of approving an unauthorized commitment by an official who has the authority to do so.

Table 1. FYs 2011 and 2012 Transactions Reported in FPDS

Amount of Transactions	Number of Transactions	Percentage of Total Transactions	Total Dollars Reported	Percentage of Total Dollars
$24,500	571	30.7%	$13,989,500	25.7%
$24,800	126	6.8%	$3,124,800	5.7%
$24,900	971	52.2%	$24,177,900	44.4%
$24,980	60	3.2%	$1,498,800	2.8%
Other Amounts under $25,000	62	3.3%	$1,525,918	2.8%
Subtotal	**1,790**	96.3%	**$44,316,918**	81.4%
Amounts over $25,000	69	3.7%	$10,118,824	18.6%
Total Transactions Reported	**1,859**	100.0%	**$54,435,742**	100.0%

Source of Data: House Committee on Veterans' Affairs, Subcommittee on Oversight and Investigations, Schedule of FY2011 and 2012 Contract Purchases in FPDS, received June 17, 2015

FPDS Transactions Did Not Match IFCAP

The PCPM matched nearly 3,411 purchase order transactions totaling approximately $25.9 million in the Integrated Funds Distribution Control Point, Accounting and Procurement System (IFCAP) to 1,859 transactions totaling approximately $54.4 million in FPDS. These 3,411 IFCAP transactions were reported in a VHA Procurement and Logistics application, which the PCPM used to match purchase order transactions to contracts in FPDS. Since FPDS is used to report contract actions, and not to obligate or expend funds, we compared the FPDS data with the purchase order transactions in IFCAP to find the corresponding obligation or expenditure. IFCAP is VA's accounting system and automates the creation, approval, forwarding, monitoring, and payment of requests for supplies and services.

We determined that 1,834 (approximately $51.1 million) of the 1,859 FPDS transactions did not have corresponding IFCAP transactions. Specifically, 1,204 transactions had no record of funds obligated or expended, 627 transactions had some significant dollar amount variances reported, and three transactions had reporting errors in vendor names, which made us question the accuracy of the reported FPDS transactions. For example, in FY 2012, the reported purchases for one vendor totaled $954,000 in FPDS compared to the purchases shown in IFCAP of $95,400. The balance of 25 FPDS transactions totaling approximately $3.3 million matched 433 of 3,411 IFCAP purchase transactions. However, our tests showed that purchases were not made on contracts and therefore should not have been reported in FPDS.

Table 2 shows our analysis of the 1,859 FPDS transactions compared to amounts reported in IFCAP.

Table 2. Comparison of FYs 2011 and 2012 Transactions Reported in FPDS to IFCAP
(Dollars Estimated in Millions)

Description	Number of Transactions in FPDS	Total Dollars Reported in FPDS	Total Dollars Reported in IFCAP	Variance
Reported in FPDS - No obligations or expenditures reported in IFCAP	1,204	$29.9	-	$29.9
Reported in FPDS - amounts reported in FPDS do not match IFCAP	627	$20.9	$22.3	($1.4)
Reporting errors - FPDS vendor names do not match IFCAP	3	.3	.3	0
Subtotal	**1,834**	**$51.1**	**$22.6**	**$28.5**
Reported in FPDS - Amounts match IFCAP	25	$3.3	$3.3	-
Total	**1,859**	**$54.4**	**$25.9**	**$28.5**

Source of Data: FPDS- House Committee on Veterans' Affairs, Subcommittee on Oversight and Investigations, Investigative Counsel, Schedule of FY2011 and 2012 Contract Purchases in FPDS, received June 17, 2015; and IFCAP data from VHA Procurement and Logistics Office

FPDS Transactions Matched IFCAP

We tracked 25 FPDS transactions, totaling approximately $3.3 million, to 433 purchase orders in IFCAP. The 25 transactions represented 24 different vendors. We requested procurement documentation, including references to contract numbers, for a sample of 28 of 433 prosthetic purchase orders, which totaled approximately $685,000, to determine if they were contract purchases. The Chief of Patient Services, VISN 2 South Prosthetics, reported that only one of the 28 transactions was purchased on a contract. VA directives allow prosthetic purchases to be made on the open market due to medical necessity, but these 27 non-contract purchases should not have been reported in FPDS.

Unauthorized Commitment

We performed further reviews to determine if the 28 purchases were made in accordance with the purchasing agent's warrant authority. We identified 11 unauthorized commitments totaling approximately $457,000 in which purchasing agents made purchases in excess of their warrant authority.

In Recommendation 1, we address the need to ratify the unauthorized commitments.

Cause of Erroneous Reporting

The approximately $54.4 million in erroneous reporting to FPDS occurred because of the PCPM's perceived workload issues and pressures to improve NCO 3's performance metrics. A lack of supervision by the NCO 3 Contract Manager, as well as the failure to segregate duties, allowed the PCPM to make improper entries in FPDS.

The PCPM has the responsibility to ensure that the Purchase Card Program complies with the FAR. The PCPM reviews the IFCAP purchase card

transactions above a $3,000 limit and has the additional responsibility to match them to an appropriate contract. Once the purchases are matched to the corresponding contract, the PCPM enters the information into FPDS. If the purchase is not compliant with the FAR, it is the PCPM's responsibility to bring this to the attention of management. As an internal control, the FAR requires a warranted contracting officer to verify entries to ensure the accuracy of the information entered into FPDS. In this case, this was not done; instead, this task was delegated to the PCPM, who was not a warranted contracting officer.

Data Integration Issues

During FY 2011, data integration problems within the automated-matching process used to match purchase orders from the IFCAP system to contracts for reporting into FPDS required a manual intervention. VA needed to manually match some purchase orders over $3,000 to contracts in FPDS. This process required research by the PCPM to determine whether a purchase was made on a contract. During the next fiscal year, VA eliminated the need to manually match purchase orders to FPDS when the IFCAP data feed was terminated in early FY 2012 and replaced by an automated data feed to FPDS from the eCMS.

Erroneous Entries Improved Performance Metrics

When we interviewed the PCPM, he told us that he knowingly entered inaccurate data in FPDS. He explained that because of his workload, he made entries into FPDS without researching whether the purchase was made pursuant to a contract. He also admitted combining purchase orders under a fictitious amount below $25,000, which gave the appearance of a split purchase. When asked why FPDS transactions were predominantly in increments below $25,000, he told us that he entered amounts below $25,000, in the belief that a warranted contracting officer would have to process transactions in excess of $25,000 in the eCMS.

He further said he wanted to improve NCO 3's performance metrics because NCO 3 was not meeting its metric that 95 percent of purchases above the micro-purchase limit ($3,000) either were matched to contracts in FPDS or met FPDS reporting exemptions. VA established this performance metric in a VHA Procurement and Logistics application to improve reporting purchases on contracts and ensure that they were accurately reported in FPDS. We asked the PCPM if he agreed with our conclusions that matching purchase orders was done to meet performance metrics even though they were not matched to contracts in FPDS; he replied that he did. As a result of the erroneous matching in FY 2011, the PCPM improved NCO 3's performance metric from 62 percent to 91 percent by erroneously reporting purchases made on contracts. Not only did this action give the incorrect appearance that VA was improving on this metric, it also obscured the fact that purchases were not made on a contract.

We address in Recommendation 2 the need to determine what actions, if any, should be taken in regard to the erroneous reporting.

Lack of Segregation of Duties and Oversight

The PCPM was able to erroneously report prosthetic purchases in FPDS because of the lack of oversight, the lack of segregation of duties, and failure to ensure that a warranted contracting officer verified the entries in FPDS. We found that the PCPM signed for both making the entry and the verification that purchase orders were matched to contracts in 61 percent of the cases. We asked the NCO 3 Contract Manager what oversight was performed to ensure that reporting in FPDS was accurate. The supervisor said that she did not review the PCPM's reporting in FPDS. Instead, she relied upon his representations that the reporting was accurate. The NCO 3 Contract Manager further failed to ensure segregation of duties and verification by a warranted contracting officer that the entries were accurate, as required.[12]

The U.S. Government Accountability Office's *Standards for Internal Control in the Federal Government* requires that management divides or segregates key duties and responsibilities among different people to reduce the risk of error, misuse, or fraud. This includes separating the responsibilities for authorizing transactions, processing and recording them, reviewing the transactions, and handling any related assets so that no one individual controls all key aspects of a transaction or event. In particular, segregation of duties can address and manage the risk of management override, which circumvents existing control activities and increases fraud risk.

We address the need to ensure proper segregation of duties in Recommendation 3.

VA Actions Taken

VA made system and policy changes that lessened the opportunity that inaccurate reporting in FPDS would reoccur.

- In January 2013, the DAS OAL issued instructions to limit the procurement of non-electronic goods through contract purchasing, an activity primarily performed by Prosthetics purchasing agents, thereby reducing the need for manual matching for reporting into FPDS.
- In March 2014, VHA Directive 1081 required that VA transfer the authority to purchase prosthetic appliances and sensory aids from the Prosthetics staff to warranted contracting officers when procurement amounts are above the micro-purchase threshold.

Furthermore, an OAL analyst reported that VA completed the transition of contract reporting in FPDS from IFCAP to the eCMS in October 2011, thereby removing the need for manual matching. We confirmed that no transactions from IFCAP are currently being manually matched.

[12] FAR Subpart 4.604(b)(1) and (2) assigns responsibility to warranted contracting officers for completeness and accuracy of reporting in FPDS.

Conclusion

Based on our interviews and analytical tests, we did not substantiate the allegation that a supervisor made unauthorized commitments totaling more than $50 million by splitting prosthetic purchases in increments below $25,000. For 11 purchases totaling approximately $457,000, we found that purchasing agents exceeded warrant authorities of $25,000 and $30,000. These purchases were unauthorized commitments and must be ratified to ensure that fraud, waste, and abuse of Government resources did not occur. VA employees have a fundamental responsibility to be effective stewards of taxpayer resources and to safeguard those resources against improper payments.

We determined the PCPM erroneously reported approximately $54.4 million of contracted purchases in FPDS during FYs 2011 and 2012. These transactions gave the appearance of purchase card abuse, which was the reason these transactions were brought to the attention of the House Committee on Veterans' Affairs, Subcommittee on Oversight and Investigations at the hearing in May 2015. The transactions were reported as purchases made for the same vendor on the same day, which gave the impression that the facility was making split purchases. Although the erroneous purchase data were removed in September 2013, the misreporting of procurements by NCO 3 harms the public trust that VA is properly executing its duties.

Recommendations

1. We recommended the Director of Contracting, NCO 2, submit a ratification request for the unauthorized commitments identified in this report to the Head of Contracting Activity–Executive Director, Service Area Office East.

2. We recommended the Executive Director, Service Area Office East, consult with Regional Counsel to determine what actions, if any, should be taken based on information contained in this report and related to erroneous reporting.

3. We recommended the Executive Director, Service Area Office East, conduct a review of Network Contracting Office operations to ensure internal controls, such as segregation of duties, are monitored and enforced.

Management Response

In response to our draft report, the Acting-Under Secretary for Health concurred with recommendations 1 and 2. For recommendation 1, the Acting Under Secretary for Health reported that NCO 2 will submit a request for ratification for unauthorized commitments identified in the report to the Executive Director, SAO East. The targeted completion date for this action is July 2017. For recommendation 2, the Acting Under Secretary for Health reported that appropriate steps to hold staff responsible for the erroneous

reporting had been taken. The supervisor was removed from his or her supervisory role and no longer works for the SAO East. For recommendation 3, the Acting Under Secretary for Health concurred in principle since VHA has implemented a new initiative throughout the entire VHA Contracting organization related to GAO High Risk Area 2 (inadequate oversight and accountability).

SAO East's continuous monitoring of all NCO operations will ensure adequate oversight and accountability of NCO internal controls across the organization and was not specific to NCO 2. The Acting USH reported that SAO East had completed a review of NCO operations to ensure that segregation of duties is monitored and enforced for VHA contracting actions. In addition, VHA removed warrants from prosthetics purchasing agents that were not contracting officers, reduced purchase card limits to the micro-purchases threshold, and realigned prosthetics purchasing staff under contracting. There have been technical enhancements to the interface between eCMS and FPDS to ensure that only contract actions awarded by a warranted contracting officer are reported in accordance with the FAR. Further, there are monthly monitors of contract actions reported in FPDS to ensure that only transactions entered in eCMS are reported in FPDS.

OIG Response

The Acting Under Secretary for Health's comments, and actions taken by the Executive Director, SAO East are responsive to our recommendations. The Executive Director, SAO East provided an acceptable action plan for recommendation 1 and sufficient documentation to close recommendations 2 and 3

Finding 2 Prosthetic Procurement Records Not Destroyed During Hurricane Sandy

We did not find VA's claim that procurement records for prosthetic purchases at NCO 3 were destroyed during Hurricane Sandy to have merit. The Chief of Network 3 Prosthetics stated that all of the prosthetic procurement files had been stored on the 14th floor of the VA New York Harbor Health System, Manhattan Campus, and not in an area affected by the hurricane. We requested and received 18 of 20 FY 2011 procurement files for purchases that occurred before Hurricane Sandy hit the Northeast in late October 2012. We did not receive two procurement files because the purchases had been canceled.

Claim That Prosthetic Files Were Destroyed

During the investigation by OAL, following Congressman Johnson's September 2012 letter, the NCO 3 contract manager sent an email to the Associate Deputy Assistant Secretary for Office of Procurement Policy, Systems and Oversight, OAL. In the email, dated January 2013 and discussing the records for prosthetic purchases, the manager stated, "…all VISN 3 Prosthetics files are located at Manhattan campus. Any files that are older than 1 year were stored in the basement of the medical center and were totally destroyed." This email was used as the basis for the request by Congresswoman Rice for the OIG to determine the merit of the statement. We interviewed the NCO 3 Contract Manager, who could not recall who had told her that the procurement files were located in the basement and destroyed.

Prosthetic Records Stored on 14th Floor

The Chief of Network 3 Prosthetics stated that prosthetic records were not stored in the basement of the VA New York Harbor Health System Manhattan Campus, which suffered damages from Hurricane Sandy. In fact, the prosthetic purchasing agents were located on the 14th floor—where all the records were maintained. Again, we reviewed 18 FY 2011 procurement files as evidence that the files were not destroyed in Hurricane Sandy. The purchase orders and invoices listed items that included stair lifts, prosthetic aids, and supplies.

Conclusion

Based on our interviews and tests, we did not find VA's claim to have merit; namely, that procurement records for prosthetic purchases at NCO 3 were destroyed during Hurricane Sandy. Because we did not substantiate this allegation, we are making no recommendations.

Appendix A Scope and Methodology

Scope

We conducted our review from June 2015 through February 2017. Our review focused on NCO 3's recording of 1,859 procurement actions in FPDS totaling about $54.4 million for FYs 2011 and 2012.

Methodology

We conducted site visits at the James J. Peters VA Medical Center, Bronx, NY, and VA New York Harbor Healthcare System (Manhattan Campus). We interviewed VA Procurement officials, including management and staff from OAL, VHA Procurement and Logistics Office, VISN 3, Service Area Office East, and NCO 3. We reviewed data and documents related to the business processes used to accumulate and report procurement actions reported in FPDS.

We obtained and reviewed spreadsheets, IFCAP data, FPDS–NG manuals and other documentation related to NCO 3's recording of 1,859 procurement actions in FPDS totaling about $54.4 million for FYs 2011 and 2012. We performed analytical tests to determine the accuracy of FPDS data compared to VA's accounting systems. IFCAP manually matched data was summarized by Procurement Instrument Identification Number and compared to amounts reported in FPDS. In our assessment of proper segregation of duties, we reviewed the U.S. Government Accountability Office's *Standards for Internal Control in the Federal Government.* For contract reporting into FPDS, we reviewed FAR 4.604, Contract Reporting Responsibilities, which requires that a contracting officer review and certify FPDS entries to ensure accuracy.

To assess the allegation of unauthorized commitments by splitting payments, we reviewed a sample of 28 of 433 purchases totaling, respectively, approximately $685,000 of $3.3 million that matched what was reported in FPDS. Our sample was selected for all prosthetic transactions greater than the basic warrant level authority of $25,000 and for transactions made for the same vendor and same day that exceeded $25,000. We reviewed documentation provided by the facility to assess if the sample of prosthetic purchases were reportable in FPDS and to test for unauthorized commitments. We requested contract award numbers to verify that purchases made on contract were reported in FPDS. We reviewed purchasing agents' warrants and compared that to the sample of procurements made by purchasing agents to determine if VA was compliant with FAR 1-602.1, regarding delegated limits of authority. We reviewed compliance with FAR 13.003(c)(2)(ii), which prohibits cardholders from splitting a transaction to avoid any requirements that apply to purchases exceeding the micro-purchase threshold.

To assess compliance with law and directives, we reviewed VA compliance with Title 38 United States Code (U.S.C.) § 8123, *Procurement of Prosthetics Appliances*, which provides VA with special authority to exempt

procurement of prosthetics from the FAR. Specifically, the Secretary may procure prosthetic appliances and necessary services required in the fitting, supplying, and training and use of prosthetic appliances by purchase, manufacture, contract, or in such other manner as the Secretary may determine to be proper, without regard to any other provision of law.

Before March 2014, VA procured VA prosthetic purchases under VHA Directive 2003-037, July 16, 2003, which put limits on purchase authority under Title 38 U.S.C. § 8123, but allowed exceptions under a special procurement authority once prosthetic purchasing agents passed training requirements and were awarded a basic warrant authority of $25,000. Specifically, the delegated use of the special procurement authority by VA prosthetic purchasing staff must only be exercised under four circumstances. These are: (1) when the patient's medical needs cannot be met through the use of a required source of supply, or (2) documentation supports that the required product or service does not meet the medical requirements, or (3) medical evidence supports that the delivery time does not meet the patient's medical needs, or (4) a medical emergency exists supported by medical evidence. However, this authority had no documentation requirements for purchases not made from a required source of supply and did not specify the documentation required under the remaining three circumstances of medical need.

In March 2014, VHA Directive 1081 made some significant changes to the procurement of prosthetic appliances and sensory aids procedures. The changes included requiring that a warranted contracting officer conduct the procurement and that justification of purchases made using other than full and open competition be maintained in the eCMS.

To assess the allegation regarding destruction of prosthetic records, we conducted an onsite visit at the Manhattan campus where we interviewed the Chief of Network 3 Prosthetics. We reviewed a sample of 18 prosthetic procurement records that originated at least one year before Hurricane Sandy in October 2012.

Data Reliability

We used computer-processed IFCAP data for FYs 2011 and 2012 from VA's Corporate Data Warehouse (CDW) during the review. To test the reliability of the computer-processed data, we traced a sample of 46 IFCAP transactions and compared purchase order numbers, vendor names, and dollar amounts, with hard-copy source documentation, such as purchase orders and vendor invoices to verify the completeness and accuracy of the data. We determined the IFCAP data were sufficiently reliable for the purposes of this report.

Data Limitations

We compared the FPDS data we received through the House Committee on Veterans' Affairs, Subcommittee on Oversight and Investigation on June 17, 2015 with the data from the original allegations in September 2012. We confirmed that the transactions were the same. However, we were unable to determine the reliability of the FPDS data from the source because the data had been deleted in FPDS as previously reported due to identified inaccuracies.

Government Standards

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

Appendix B Potential Monetary Benefits in Accordance With Inspector General Act Amendments

Recommendations	Explanation of Benefits	Better Use of Funds	Questioned Costs
1	Prosthetic purchase card transaction made without appropriate warrant authority	$0	$457,000
	Total	**$0**	**$457,000**

Appendix C Management Comments

Department of Veterans Affairs Memorandum

Date: April 17, 2017

From: Acting Under Secretary for Health (10)

Subj: OIG Draft Report Review of Alleged Unauthorized Commitments for Prosthetic Purchases at VA Network Contracting Office 3 (VAIQ 7785253)

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

1. Thank you for the opportunity to review the Office of Inspector General (OIG) draft report, Review of Alleged Unauthorized Commitments for Prosthetic Purchases at Department of Veterans Affairs (VA) Network Contracting Office 3. I concur with the draft report content and findings. I concur with recommendations 1 and 2 and concur in principle with recommendation 3. I provide the attached action plan to address recommendation 1 and provide a summary of completed actions for recommendations 2 and 3.

2. The Veterans Health Administration (VHA) takes the issues identified in the draft report very seriously and instituted a national initiative to prevent similar occurrences in the future. VHA's Office of Procurement and Logistics (P&LO) started implementing national improvements in 2014. All prosthetics purchase card holders are now aligned under VA Central Office P&LO. With this centralization, P&LO can identify erroneous purchases and direct the Service Area Office (SAO) to take appropriate corrective action.

3. SAO East reviewed the issues raised by OIG for underlying causes. SAO East found that human error due to training deficiencies was the primary cause and that staff did not deliberately intend to make improper purchases. SAO East properly trained all prosthetics purchase card holders in the contracting systems and reporting requirements and removed the individual in question from a supervisory role.

4. SAO East reconciled the actual purchase card orders to remove the mistakenly reported items and entered accurate information. Any actions that could not be specifically reconciled are resolved via the ratification process. Current processes and SAO East oversight preclude the likelihood of this mistake happening in the future. Any reporting of transactions that circumvent established systems is immediately flagged by the SAO office for resolution.

5. On another note, during the course of OIG's review, SAO East merged Network Contracting Offices (NCO) 2 and 3. The NCO merger resulted in standardized processes and best practices being incorporated into a more streamlined organization, with greater accountability and effectiveness. SAO East further used this merger to proactively address the leadership and supervisory concerns OIG identified in this report. New leadership improved training, basic management, and contracting practices in addition to providing stability and improved accountability. This new leadership demonstrated improved performance on procurements metrics (procurement lead time, timely processing of requirements, adherence to procurement regulations, and continuous training of procurement staff).

6. If you have any questions, please email Karen Rasmussen, M.D., Director, Management Review Service at VHA10E1DMRSAction@va.gov.

(original signed by:)

Poonam Alaigh, M.D.

Attachment

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

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

OIG Draft Report: Review of Alleged Unauthorized Commitments for Prosthetic Purchases at VA Network Contracting Office 3

Date of Draft Report: March 22, 2017

Recommendations/ Actions	Status	Completion Date

Recommendation 1: We recommend the Director of Contracting, NCO 2 submit a ratification request for the unauthorized commitments identified in this report to the cognizant Head of Contracting Activity – Executive Director, Service Area Office East.

VHA Comments: Concur

This recommendation is related to Government Accountability Office (GAO) High Risk Area 2 (inadequate oversight and accountability). By properly submitting ratification requests for unauthorized commitments, the Veterans Health Administration (VHA) demonstrates ownership for this procedural breakdown and a commitment to resolve the problem.

The Director of Contracting, Network Contracting Office (NCO) 2 will work with the appropriate personnel to establish and submit a request for ratification for the unauthorized commitments identified in this report to the cognizant Head of Contracting Activity (Executive Director, Service Area Office East). It is important to note that in 2016, during the course of OIG's review, NCO 3 merged with NCO 2; NCO 3 no longer exists. The actions associated with this recommendation and relevant findings will be handled by NCO 2.

At completion of this action, The Director of Contracting, NCO 2 will provide OIG with evidence that the requested for ratification has been submitted and approved.

Status	Target Completion Date
In process	July 2017

Recommendation 2: We recommend the Executive Director, Service Area Office East (SAO East) consult with Regional Counsel to determine what actions, if any, should be taken based on information contained within this report related to erroneous reporting.

VHA Comments: Concur

This recommendation is related to Government Accountability Office (GAO) High Risk Area 2 (inadequate oversight and accountability). Service Area Office (SAO) East has taken the appropriate steps to hold staff accountable for erroneous reporting. The supervisor in question has been removed from their supervisory role and no longer works for the NCO. Additionally, SAO East relayed information of their informal review to the Regional Counsel in March 2017. Regional Counsel indicated that additional action regarding the Purchase Card Program Manager is not warranted. VHA submitted evidence of actions taken to OIG.

Status	Completion Date
Complete	March 27, 2017

Recommendation 3: We recommend the Executive Director, Service Area Office East conduct a review of Network Contracting Office operations to ensure internal controls, such as segregation of duties, are monitored and enforced.

VHA Comments: Concur in principle

VHA concurs in principle because VHA has instituted a national initiative which has been implemented throughout the entire VHA Contracting organization. The initiative is not specific to NCO 2.

This recommendation is related to GAO High Risk Area 2 (inadequate oversight and accountability). Service Area Office East's (SAO East) continuous monitoring of all NCO operations will ensure adequate oversight and accountability of NCO internal controls.

VHA initially established the Integrated Funds Distribution, Control Point Activity, Accounting and Procurement (IFCAP) to Electronic Contract Management System (eCMS)/FPDS metrics to ensure proper obligation, reporting and awarding of contracts was accomplished. Historically, this metric was important to ensure that not only contract awards were made in accordance with Federal Acquisition Regulations (FAR), but that they were also properly reported to FPDS. Subsequent to these issues being identified by VA OIG, VHA has taken actions to restrict all purchasing actions above the MicroPurchase threshold to properly certified and warranted contracting officers within the acquisition and Head of Contracting Activity (HCA) chain-of-command. In addition, several technical enhancements have been made to the contract writing system and its interface with FPDS to ensure all dollars reported to FPDS transfer through the eCMS system. Therefore, this measurement is no longer a formal performance metric. It remains in place solely to allow for oversight of proper awarding and reporting. Therefore, the issue of separation of duties is now a non-factor on the reporting of dollars awarded in eCMS, obligations recorded in IFCAP, or ultimately reported to FPDS.

Since the concerns regarding inaccurate reporting were first identified, SAO East has implemented additional controls to monitor actions properly awarded in eCMS and sent directly to FPDS via the automated interface from eCMS to FPDS. This ensures that the action was awarded by a warranted contracting officer and reported to FPDS as required by FAR 4.604. In addition, SAO East runs monthly reports from FPDS regarding the origin of every Completed Action Report (CAR) within FPDS to ensure no actions are directly entered into FPDS, but instead that all actions are via the direct interface from eCMS.

SAO East completed a review of the NCO operations subsequent to the initiation of this OIG review. To ensure segregation of duties are monitored and enforced, VHA Contracting implemented the following actions:

(1) Removed warrants from non-1102 employees,

(2) Realigned prosthetics purchasing staff under the Contracting organization,

(3) Reduced purchase card limits to the micro-purchase threshold, and

(4) Entered express reports into eCMS and directly reported to FDPS to provide accurate tracking and verification of contract files and actions.

Based on the reviews conducted, procedural changes established, and the reviews in place, SAO East has ensured actions cannot be directly entered into FPDS. VHA has submitted a screen shot of the current FY17 FPDS Origin of CAR report, a report of the review of NCO operations, and a copy of the briefing documents to OIG for evidence of compliance with this recommendation.

Status	Target Completion Date
Complete	March 28, 2017

Appendix D OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Anthony M. Leigh, Director Thomas Seluzicki Stephen Nose Kimberly Nikravesh

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