VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

# Department of Veterans Affairs

*Independent Review of VA's FY 2013 Detailed Accounting Submission to the Office of National Drug Control Policy*

**February 10, 2014**
**14-00258-66**

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**Department of Veterans Affairs**

# Memorandum

**Date:** February 3, 2014

**From:** Assistant Inspector General for Audits and Evaluations (52)

**Subj:** Final Report: *Independent Review of VA's Fiscal Year 2013 Detailed Accounting Submission to the Office of National Drug Control Policy*

**To:** Chief Financial Officer, Veterans Health Administration (10A3)

1. The Office of Inspector General is required to review the Department of Veterans Affairs' (VA) Fiscal Year 2013 Detailed Accounting Submission (Submission) to the Director, Office of National Drug Control Policy (ONDCP), pursuant to ONDCP Circular: *Accounting of Drug Control Funding and Performance Summary* (Circular), dated January 18, 2013, and as authorized by 21 U.S.C. §1703(d)(7).* The Submission is the responsibility of VA's management and is included in this report as an Attachment.

2. We reviewed VA's management's assertions, as required by the Circular, concerning its drug methodology, reprogrammings and transfers, and fund control notices. The assertions are found in the Submission on page 11 of this report.

3. We conducted our review in accordance with attestation standards established by the American Institute of Certified Public Accountants, and the applicable standards contained in *Government Auditing Standards,* issued by the Comptroller General of the United States. An attestation review is substantially less in scope than an examination. The objective of an examination is the expression of an opinion on the assertions in the Submission. Accordingly, we do not express such an opinion.

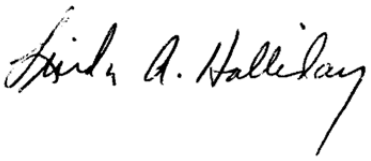
4. Our report, *Audit of VA's Consolidated Financial Statements for Fiscal Years 2013 and 2012* (Report No. 13-01316-22, dated November 27, 2013), identified one material weakness, information technology security controls, which is a repeat condition. A material weakness is a significant deficiency, or combination of significant deficiencies, that results in more than a remote likelihood that a material misstatement of the financial statements will not be prevented or detected. A significant deficiency is a control deficiency, or combination of control deficiencies, that adversely affects the entity's ability to initiate, authorize, record, process, or report financial data reliably in accordance with generally accepted accounting principles such that there is more than a remote likelihood that a misstatement of the entity's financial statements that is more than inconsequential will not be prevented or detected.

5. Based upon our review, except for the effects, if any, of the material weakness discussed in paragraph four, nothing came to our attention that caused us to believe that management's

*To view the Circular, please visit http://www.whitehouse.gov/sites/default/files/docs/2013_circular-accounting_of_drug_control_funding_and_performance_summary.pdf.

assertions included in the accompanying Submission of this report are not fairly stated in all material respects based on the criteria set forth in the Circular.

6. We provided you our draft report for comment. You concurred with our report without further comments.



LINDA A. HALLIDAY

Attachment

**Department of Veteran Affairs**

# Memorandum

**Date:** January 15, 2014

**From:** Chief Financial Officer, Veterans Health Administration
Associate Chief Financial Officer, Veterans Health Administration
Director of Budget Services, Veterans Health Administration

**Subj:** Management Representation Letter for the Independent Review of VA's Fiscal Year 2013 Detailed Accounting Submission to the Office of National Drug Control Policy (Project Number 2014-00258-R1-0030)

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

1. We are providing this letter in connection with your attestation review of our Detailed Accounting Submission to the Director, Office of National Drug Control Policy (ONDCP).

2. We confirm, to the best of our knowledge and belief, that the following representations made to you during your attestation review are accurate and pertain to the fiscal year ending on September 30, 2013.

3. We confirm that we are responsible for and have made available to you the following:

4. The Table of Drug Control Obligations and related assertions;

    a. b. All financial records and related data relevant to the Detailed Accounting Submission; and,

    b. c. Communications from the Office of National Drug Control Policy and other oversight bodies concerning the Detailed Accounting Submission.

5. No reprogramming or transfer of funds from drug related resources, as identified in the Fiscal Year 2013 financial plan, occurred in Fiscal Year 2013.

6. We understand your review was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants, and applicable standards contained in Government Auditing Standards, issued by the Comptroller General of the United States. A review is substantially less in scope than an examination and accordingly, you will not express an opinion on the Table of Drug Control Obligations and related disclosures.

7. No events have occurred subsequent to September 30, 2013, that would have an effect on the Detailed Accounting Submission.

Signature: _____
Kathleen M. Turco, M.B.A
Chief Financial Officer (10A3)
Veterans Health Administration

Signature: _____
for Mark W. Yow
Associate VHA Chief Financial Officer
Resource Management Office (10A3B)

Signature: _____
Calvin L. Seay, Jr.
Director of Budget Services
Resource Management Office (10A3B)

Attachment

cc: Veterans Health Administration Audit Liaison (10B5)

## Attachment

**Statement of Disclosures and Assertions for FY 2013 Drug Control Expenditures Submitted to Office of National Drug Control Policy (ONDCP) for FY Ending September 30, 2013**

In accordance with ONDCP's Circular, Drug Control Accounting, dated January 18, 2013, the Veterans Health Administration asserts that the VHA system of accounting, use of obligations, and systems of internal controls provide reasonable assurance that:

Obligations are based upon the actual expenditures as reported by the Decision Support System (DSS).

The methodology used to calculate obligations of budgetary resources is reasonable and accurate in all material respects and as described herein was the actual methodology used to generate the costs.

Accounting changes are as shown in the disclosures that follow.

**Attachment**

DEPARTMENT OF VETERANS AFFAIRS
VETERANS HEALTH ADMINISTRATION
Annual Reporting of FY 2013 Drug Control Funds

DETAILED ACCOUNTING SUBMISSION

## A. Table of FY 2013 Drug Control Obligations

| Description | FY 2013 Final *(in Millions)* |
|---|---|
| Drug Resources by Budget Decision Unit: | |
| Medical Care | $634.658 |
| Medical & Prosthetic Research | $24.233 |
| **Total** | **$658.891** |
| Drug Resources by Drug Control Function: | |
| Treatment | $634.658 |
| Research & Development | $24.233 |
| **Total** | **$658.891** |

1. Drug Control Methodology

The Table of FY 2013 Drug Control Obligations (above) and the Resource Summary (page 8) showing obligations and FTE (Full-Time Equivalent) for Substance Abuse treatment in VHA are based on specific patient encounters. This is for all inpatient and outpatient episodes of care whether provided by VHA staff or purchased in the community. The source data for VHA inpatient care is the Patient Treatment File (PTF). For Outpatient Care it is the National Patient Care Database Encounter file (SEFILE). For contract care it is either the PTF or the hospital payment file. For outpatient FEE Care it is the Provider Payment file.

All of these data sources have a diagnosis associated with the encounter. The primary diagnosis is considered the reason the patient is being treated and is used to determine whether the treatment provided is substance abuse treatment and which type of substance abuse. Below is a list of Diagnosis groups used.

| Diagnosis Code | Description |
|---|---|
| 292.xx | Drug Induced Mental Disorders |
| 304.xx | Drug Dependence |
| 305.xx | Nondependent Abuse of Drugs (excluding 305.0 – Alcohol Abuse and 305.1 – Tobacco Use Disorder) |

**Attachment**

It should be noted that Prescriptions and Lab tests do not have linkages to a specific diagnosis and are not included in the report.

The cost of the VHA provided services is assigned through the Decision Support System (DSS) management cost accounting system and is based on the products consumed by producing departments. Every product is valued and assigned a cost. All the cost of all the products a patient uses are rolled up. A national data extract of patients at the encounter level is created and is the source of the cost. An additional extract at the encounter level also splits out the DSS intermediate product department, (NDE IPD). The cost of the contracted care comes from the Inpatient (Hospital) and Outpatient (FEE) payment systems. The DSS costs and payments are expenditures. These expenditure costs are modified to reflect full VHA obligations.

The FTE calculation is based on the DSS staff mapping to DSS Departments which are the production units. As we noted above, all the products are accumulated to an encounter. The DSS NDE IPD extracts show the cost of the encounter by department and the cost by three cost categories; Variable Direct, Fixed Direct and Fixed Indirect. All the costs, including the fixed costs, from all the departments are included in the cost calculation; however, there are no FTE numbers in the extract.

The Monthly Program Cost Report (MPCR) is a secondary DSS cost report which allows for the calculation of FTE at a detailed level. The DSS Department costs and FTE are aggregated to the service level, the clinic stop and the treating specialty. The portion of the DSS Department's costs and FTE can be assigned to these levels based on the DSS IPD extract. The FTE calculation assumes that a proportionate amount of each DSS Department's FTE is associated with each dollar assigned. The FTE calculation only uses the Direct Care Departments costs. The average Direct FTE/Cost is calculated for each Clinic stop and Treating specialty at each medical center/CBOC. The service specific FTE/dollars are multiplied by the cost of the service providing substance abuse care. The result is the FTE.

MEDICAL CARE

Year in Review

According to the 2012 *Drug and Alcohol Program Survey* (DAPS), at the start of FY 2013, 56 percent of VA facilities were able to offer 24-hour Substance Use Disorder (SUD) care on-site, 41 percent of facilities offered intensive outpatient services as their highest intensity of SUD care, and 82 facilities (59%) reported offering stand-alone intensive outpatient treatment that was not a component of a 24-hour care program. In FY 2012, 97 percent of facilities offered either 24-hour care or intensive outpatient programming on site. All VA facilities currently provide SUD services within a specialty setting, as well as in general mental health settings.

## Attachment

VA provides two types of 24-hour-a-day care to patients having particularly severe substance use disorders. VA offers 24-hour care in residential rehabilitation treatment programs for substance use disorders. Additionally, 24-hour care is provided for detoxification in numerous inpatient medical and general mental health units throughout the VA system. Outpatient detoxification is available for patients who are medically stable and who have sufficient social support systems to monitor their status. Most Veterans with substance use disorders are treated in outpatient programs. Intensive substance use disorder outpatient programs provide at least three hours of service per day to each patient, and patients attend them three or more days per week. Standard outpatient programs typically treat patients for an hour or two per treatment day and patients attend one or two days a week.

VA continues to expand the availability of opioid agonist treatment for Veterans with opioid use disorders. In FY 2013, evidence-based medication assisted treatment for opioid dependence, including buprenorphine, was available at 155 locations that served at least 10 patients and an additional 125 CBOCs or other locations that had at least some active buprenorphine treatment. VA operates methadone maintenance programs at 28 facilities and 25 VHA facilities maintain contractual arrangements for providing these services through community-based licensed opioid agonist treatment programs.

VHA has also expanded access to other SUD treatment services with continued special purpose funding for 406 SUD staff assigned to work in large community based outpatient clinics, mental health residential rehabilitation programs, intensive SUD outpatient programs and post traumatic stress disorder (PTSD) teams. Active monitoring is ongoing for replacing any positions that become vacant.

Consistent with principles of recovery, VA is setting the standard for a new and emerging health care profession, known as "Peer Specialists." As of November 5, 2013, VHA had hired 815 Peer Specialists and Peer Apprentices, exceeding the hiring goal set in President Obama's August 31, 2012, Executive Order aimed at improving access to mental health services for Veterans, service members and military families. Through the development of position descriptions that clearly outline the job duties of both Peer Specialists and Peer Support Assistants, certification of training requirements for both positions and consistently-defined, job-specific competencies, Peer Specialists and Peer Support Assistants are poised to provide a unique set of services to Veterans seeking care for mental health and substance use disorders.

VA continues to pursue a comprehensive strategy to promote safe prescribing of opioids when indicated for effective pain management. Among other efforts, VA has completed initial implementation of a national initiative that provides facilities with training on use of real-time data on opioid prescribing practices at the patient and provider level.

## Attachment

Consistent with the Clinical Practice Guideline on Management of Opioid Therapy for Chronic Pain that VA developed in collaboration with the Department of Defense, educational presentations for providers have addressed evidence on relative benefits and challenges of chronic opioid therapy, examples of strong models for changing practice behavior and lessons learned from sites regarding implementation strategies of the stepped care model of pain management.

The Homeless Programs continue to fund SUD specialists to support the Department of Housing and Urban Development – VA Supportive Housing (HUD-VASH) program. In addition, there are SUD Specialists working in Health Care for Homeless Veterans (HCHV) programs including 32 newly funded HCHV SUD Specialist positions added in FY 2012. These specialists emphasize early identification of SUD as a risk for maintaining permanent housing, promote engagement or re-engagement in SUD specialty care programs and serve as linkages between Homeless and SUD programs. As another effort to reduce homelessness and risk of homelessness, VHA has expanded outreach services to justice involved Veterans with funding for 172 full time Veterans Justice Outreach Specialists distributed across facilities based on need.

During FY 2013, VHA continued implementation of clinical symptom monitoring using the Brief Addiction Monitor (BAM) that transmits responses to the national data base with over 7,500 Veterans assessed at the beginning of a new episode of SUD specialty care during the 4th quarter of FY 2013. The BAM is designed to assist SUD specialty care clinicians in initial treatment planning and monitoring the progress of patients while they are receiving care for a substance use disorder, serving as a basis for giving feedback to them to enhance their motivation for change, and informing clinical decisions, such as the intensity of care required for the patient. In addition to items addressing risk and protective factors for recovery, the BAM assesses self-reported substance use in the prior 30 days including an item asking about days of any use of illicit or non-prescribed drugs as well as items on use of specific substances.

In FY 2013, VHA provided services to 129,361 patients with a primary drug use disorder diagnosis. Of these, 34 percent used cocaine, 30 percent used opioids and 27 percent used cannabis. Eighty percent had co-existing psychiatric diagnoses. (These categories are not mutually exclusive.)

The accompanying Department of Veterans Affairs Resource Summary (page 8) was prepared in accordance with the following Office of National Drug Control Policy (ONDCP) circulars (a) Accounting of Drug Control Funding and Performance Summary dated January 18, 2013, (b) Budget Formulation, dated January 18, 2013, and (c) Budget Execution, dated January 18, 2013. In accordance with the guidance provided in the Office of National Drug Control Policy's letter of September 7, 2004, VA's methodology only incorporates Specialized Treatment costs.

**Attachment**

| Specialized Treatment | Obligations *(in Millions)* | FTE |
|---|---|---|
| Inpatient | $158.676 | 706 |
| Residential Rehabilitation and Treatment | $210.426 | 1,133 |
| Outpatient | $265.556 | 1,089 |
| **Total** | **$634.658** | **2,928** |

VA does not track obligations by ONDCP function. In the absence of such capability, obligations by specialized treatment costs have been furnished, as indicated.

MEDICAL & PROSTHETIC RESEARCH

The dollars expended in VHA research help to acquire new knowledge to improve the prevention, diagnosis and treatment of disease, and generate new knowledge to improve the effectiveness, efficiency, accessibility and quality of Veterans' health care.

| Specialized Function | Obligations *(in Millions)* | Drug Control Related Percent | FTE |
|---|---|---|---|
| Research and Development | $24.233 | N/A | N/A |

2. Methodology Modifications – In accordance with the guidance provided in the Office of National Drug Control Policy's letter of September 7, 2004, VA's methodology only incorporates Specialized Treatment costs and no longer takes into consideration Other Related Treatment costs. Drug control methodology detailed in A.1 was the actual methodology used to generate the Resource Summary.

3. Material Weaknesses or Other Findings – CliftonLarsonAllen LLP provided an unqualified opinion on VA's FY 2013 consolidated financial statements. They identified one material weakness. The material weakness is a repeat condition from the prior year audit identified as Information Technology Security Controls. As a result of significant improvements made, in FY 2013, in closing out VHA's undelivered orders (UDOs) in a timely manner, the auditors removed the UDO significant deficiency. As such, the Department did not have any significant deficiency in FY 2013. There were no material weaknesses or other findings by independent sources, or other known weaknesses, which may materially affect the presentation of prior year drug-related obligations data.

**Attachment**

4. Reprogrammings or Transfers – There were no reprogramming of funds or transfers that adjusted drug control-related funding because drug control expenditures are reported on the basis of patients served in various VA clinical settings for specialized substance abuse treatment programs.

5. Other Disclosures – This budget accounts for drug control-related costs for VHA Medical Care and Research. It does not include all drug-related costs for the agency. VA incurs costs related to accounting and security of narcotics and other controlled substances and costs of law enforcement related to illegal drug activity; however, these costs are assumed to be relatively small and would not have a material effect on the reported costs.

**B. Assertions**

1. Drug Methodology – VA asserts that the methodology used to estimate FY 2013 drug control obligations by function and budget decision unit is reasonable and accurate based on the criteria set forth in the ONDCP Circular dated January 18, 2013.

2. Application of Methodology – The methodology described in Section A.1 above was used to prepare the estimates contained in this report.

3. Reprogrammings or Transfers – No changes were made to VA's Financial Plan that required ONDCP approval per the ONDCP Circular dated January 18, 20013.

4. Fund Control Notices – The data presented are associated with obligations against a financial plan that was based upon a methodology in accordance with all Fund Control Notices issued by the Director under 21 U.S.C., § 1703 (f) and Section 9 of the ONDCP Circular, Budget Execution.

**Attachment**

Edward B. Bernard
Acting Associate Chief Financial Officer
Resource Management Office (10A3B)

12/30/2013
Date

Calvin L. Seay, Jr.
Director of Budget Services
Resource Management Office (10A3B)

12/27/2013
Date

**Attachment**

| Department of Veterans Affairs<br>Resource Summary Obligations<br>*(in Millions)* | |
|---|---|
| | 2013<br>Final |
| Medical Care: | |
| Specialized Treatment | |
| Inpatient | $158.676 |
| Residential Rehabilitation and Treatment | $210.426 |
| Outpatient | $265.556 |
| Specialized Treatment | $634.658 |
| Medical & Prosthetics Research:<br>Research and Development | $24.233 |
| Drug Control Resources by Function and Decision Unit, Total | $658.891 |
| Drug Control Resources Personnel Summary | |
| Total FTE | 2,928 |
| Total Enacted Appropriations | $136,784.000 |
| Drug Control Percentage | 0.48% |

# Appendix A Office of Inspector General Contact and Staff Acknowledgments

| | |
|---|---|
| OIG Contact | For more information about this report, please contact the Office of Inspector General at (202) 461-4720. |
| Acknowledgments | Nick Dahl, Director<br>Irene J. Barnett<br>Jenna Lamy<br>Joseph Vivolo |

# Appendix B Report Distribution

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