VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Veterans Health Administration

Independent Review of VA's FY 2017 Detailed Accounting Submission to the Office of National Drug Control Policy

March 26, 2018
18-00836-147

ACRONYMS

FY	Fiscal Year
OIG	Office of Inspector General
ONDCP	Office of National Drug Control Policy
VA	Department of Veterans Affairs

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Department of Veterans Affairs

Memorandum

Date: March 26, 2018

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

Subj: Final Report: *Independent Review of VA's Fiscal Year 2017 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 2017 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. § 1704(d)(A).[1] 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, application of methodology, reprogrammings or transfers, and fund control notices. The assertions are found in the Submission on page 10 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 *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 Financial Statements for Fiscal Years 2017 and 2016* (Report No. 17-01219-24, dated November 15, 2017) included six material weaknesses, five of which were repeat weaknesses from the FY 2016 audit, plus one that was elevated from a significant deficiency:

- information technology security controls;
- compensation, pension, burial, and education actuarial estimates;
- community care obligations, reconciliations, and accrued expenses;
- financial reporting;
- Chief Financial Officer organizational structure; and

[1] To view the Circular, please visit https://obamawhitehouse.archives.gov/sites/default/files/docs/2013_circular-accounting_of_drug_control_funding_and_performance_summary.pdf.

- loan guarantee liability; this was elevated to a material weakness from a significant deficiency in the prior fiscal year audit report.

We also identified a significant deficiency related to Procurement, Undelivered Orders, Accrued Expenses, and Reconciliations, which was also reported as a significant deficiency in FY 2016. 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 weaknesses discussed in paragraph four, nothing came to our attention that caused us to believe that management's 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. This report is intended for the information and use of the ONDCP in meeting its statutory obligation to provide the U.S. Congress an accounting of VA's FY 2017 Detailed Accounting Submission. As a result, this report is not intended to be used for any other purpose.

7. We provided the Veterans Health Administration our draft report for review and comment. The Acting Chief of Staff concurred with our report without further comments.

LARRY M. REINKEMEYER

Attachments

VA's Management Representation Letter

Department of Veterans Affairs Memorandum

Date: January 5, 2018

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 FY 2017 Detailed Accounting Submission to the Office of National Drug Control Policy (Project Number 2017-00836-BA-0031)

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

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).

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, 2017.

1. We confirm that we are responsible for and have made available to you the following:
    a. The Table of Drug Control Obligations and related assertions;
    b. All financial records and related data relevant to the Detailed Accounting Submission; and,
    c. Communications from the Office of National Drug Control Policy and other oversight bodies concerning the Detailed Accounting Submission.

2. No reprogramming or transfer of funds from drug related resources, as identified in the Fiscal Year 2017 financial plan, occurred in Fiscal Year 2017.

3. We understand your review will be 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.

4. No events have occurred subsequent to September 30, 2017, that would have an effect on the Detailed Accounting Submission.

(original signed by:)

Mark Yow
Chief Financial Officer (10A3)
Veterans Health Administration

(original signed by:)

Ed Bernard
Associate VHA Chief Financial Officer
Resource Management (10A3B)

(original signed by:)

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

cc: Veterans Health Administration Audit Liaison (10B5)

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

Attachment

Statement of Disclosures and Assertions for FY 2017 Drug Control Obligations Submitted to Office of National Drug Control Policy (ONDCP) for Fiscal Year Ending September 30, 2017

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), which is the designated Managerial Cost Accounting (MCA) System of the Department of Veterans Affairs.

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.

DEPARTMENT OF VETERANS AFFAIRS
VETERANS HEALTH ADMINISTRATION
Annual Reporting of FY 2017 Drug Control Funds

DETAILED ACCOUNTING SUBMISSION

A. Table of FY 2017 Drug Control Obligations

(In Millions)

Description	FY 2017 Actual
Drug Resources by Budget Decision Unit:	
Medical Care	$733.877
Medical & Prosthetic Research	$16.559
Total	$750.436
Drug Resources by Drug Control Function:	
Treatment	$733.877
Research & Development	$16.559
Total	$750.436

1. Drug Control Methodology

The Table of FY 2017 Drug Control Obligations (above) and the Resource Summary (page 9) showing obligations and FTE (Full-Time Equivalent) for Substance Use Disorder treatment in VHA are based on specific patient encounters. This includes all inpatient and outpatient episodes of care either 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 traditional outpatient Medical Care in the Community (MCC) and Provider Agreements (PA), it is the Provider Payment file. For Third Party Agreements (TPA) Choice, it is the expedited payments from the Office of Community Care (OCC) which also resides in the Corporate Data Warehouse (CDW).

All encounters have an associated diagnosis. 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. A list of Diagnosis groups is shown in the following table.

Diagnosis Code	Description (ICD10 – DSM-5)
F11xx	Opioid Related Disorders
F12xx	Cannabis Related Disorders
F13xx	Sedative Hypnotic/Anxiolytic Related Disorders
F14xx	Cocaine Related Disorders
F15xx	Other Stimulant Related Disorders
F16xx	Hallucinogen Related Disorders
F19xx	Other Psychoactive Substance Related Disorders

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 VHA provided services is calculated by the Decision Support System (DSS), which is the designated Managerial Cost Accounting (MCA) System of the Department of Veterans Affairs. MCA cost data is used at all levels of the VA for important functions, such as cost recovery (billing), budgeting and resource allocation. Additionally, the system contains a rich repository of clinical information, which is used to promote a more proactive approach to the care of high risk (i.e., diabetes and acute coronary patients) and high cost patients. VA MCA data is also used to calculate and measure the productivity of physicians and other care providers.

The basic unit of MCA cost is the product. For VHA a product can range from a prescription fill made through a mail-out pharmacy, to an outpatient dental exam, to a bed-day of care in an Intensive Care Unit. Every product that is delivered is fully costed. This means that all direct labor, direct supply and associated indirect costs (to include local and national overhead costs) are applied. Once they are fully costed, products are then assigned to the applicable patient encounter.

MCA costs are the basis for the obligations displayed in the ONDCP report. The Allocation Resource Center (ARC) develops ARC cost, which is computed by taking the MCA cost and removing the non-patient specific costs, such as Operating costs for Headquarters, VISN Support, National Programs, and Capital and State Home costs, and adding in the FEE payments.

For budget purposes, ARC costs are transformed into obligations to account for the entire VHA Budget. It is a multi-step methodology that is implemented to compute obligations.

- The ARC costs are divided into their appropriations using cost centers identified in their Monthly Program Cost Report (MPCR), which is a MCA Account Level Budget (ALB) based report that accounts for all the costs that comprise the MCA system.
- A facility specific ratio of obligations to ARC cost for non-capital costs is created and multiplied by the expenditures to create medical center specific obligations.
- Assign the medical center capital obligations to VHA services proportional to cost.
- Aggregate the national overhead obligations by cost center into their appropriations and assign them to patient services proportional to cost.
- Balance the final obligations nationally to the SF133 Report on Budget Execution total proportionately.

MEDICAL CARE

Year in Review

VA provides two types of 24-hour-a-day care to patients having particularly severe substance use disorders (SUD). 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.

In FY 2017, VHA provided services by mental health clinicians in a variety of outpatient settings to 199,903 patients with any diagnosis of a drug use disorder. Of these, 32 percent used cocaine, 30 percent used opioids, and 49 percent used cannabis. Nearly 88 percent had co-existing psychiatric diagnoses. (These categories are not mutually exclusive.)

VHA has continued to improve service delivery and efficiency by integrating services for mental health disorders, including SUD, into primary care settings. Veterans from Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn/Operation Inherent Resolve (OEF/OIF/OND/OIR) and Veterans from other eras are served in primary care teams (Patient Aligned Care Teams; PACTs) that have co-located mental health staff to identify and address potential mental health needs. Secondary prevention services include diagnosis and assessment of possible substance use disorders in patients presenting medical problems that suggest elevated risk of substance use disorders (e.g. treatment for Hepatitis C).

VA continues to pursue a comprehensive strategy to promote safe prescribing of opioids when indicated for effective pain management. The purpose of the Opioid Safety Initiative is to ensure pain management is addressed thoughtfully, compassionately, and safely. Based on comparisons of national data between the quarter beginning in July 2012 and the quarter ending in September 2017, several aspects of the Opioid Safety Initiative have begun to show positive results. Despite an increase of 157,923 veterans who were dispensed any medication from a VA pharmacy, 192,742 fewer veterans were on long-term opioids, and 82,285 fewer veterans received opioid and benzodiazepine medications together. There has been an increase in the percentage of veterans on opioid therapy who have had at least one urine drug screen from 37 percent to 88 percent. The average dose of selected opioids has continued to decline as 33,565 fewer patients were receiving daily doses greater than or equal to 100 milligrams of morphine equivalent, demonstrating that prescribing and consumption behaviors are changing.

VHA is steadily expanding the availability of opioid agonist treatment for veterans with opioid use disorder (OUD). VA monitors the percentage of patients with OUD who receive medication-assisted treatment (35 percent during FY 2017) as part of the Psychotropic Drug Safety Initiative (PDSI). PDSI is a nationwide psychopharmacology quality improvement (QI) program that supports facility-level QI through: quarterly quality metrics, clinical decision support tools, technical assistance for QI strategic implementation, and a virtual learning collaborative. Compared to FY 2016, during FY 2017, 11 percent more unique Veterans received treatment with buprenorphine (total of 14,660) and the number of prescribers increased by 12 percent (to 1,150). In FY 2017, evidence-based medication-assisted treatment (MAT) for opioid use disorder, including office-based treatment with buprenorphine, was accessible to patients seen at 100 percent of VA Medical Centers. Including VA Medical Centers, Community-Based Outpatient Clinics, and other sites of care separate from the medical centers, over 550 total sites of service provided at least some MAT. VA operates federally regulated opioid treatment programs that can provide methadone maintenance on-site at 32 larger urban locations, and at a growing number of VHA facilities that maintain contractual arrangements or arrange non-VA care for providing these services through community-based licensed opioid treatment programs.

Programs to end Homelessness among veterans have 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. 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. All VA medical centers have at least one designated Veterans Justice Outreach (VJO) Specialist.

During FY 2017, VHA continued implementation of clinical symptom monitoring using the Brief Addiction Monitor that transmits responses to the national database. The Brief Addiction Monitor assists substance use disorder specialty care clinicians in initial treatment planning and monitoring the progress of patients while they are receiving care for a substance use disorder. This also serves as a basis for giving feedback to enhance each patient's 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 Brief Addiction Monitor assesses self-reported substance use in the prior 30 days, which includes the use of any illicit and non-prescribed drugs, as well as specific substances.

VHA has supplemented its current suite of internal indicators of substance use disorder care processes using administrative data related to a patient reported outcome measure derived from the Brief Addiction Monitor: abstinence from drug use at follow-up in a substance use disorder specialty treatment population. During the first three quarters of FY 2017 (allowing time for follow-up assessment during Quarter 4), VHA substance use disorder specialty outpatient programs assessed self-reported abstinence among 2,620 veterans with substance use disorder diagnoses documented at admission. Among the veterans who remained engaged in care and were reassessed 30 to 90 days after admission, 80 percent reported abstinence from drugs during the previous 30 days. Over 7,555 veterans were assessed at the beginning of substance use disorder specialty care during the 4th quarter of FY 2017.

The accompanying Department of Veterans Affairs Resource Summary (page 9) 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.

Specialized Treatment Costs (Dollars in Millions**)**

Specialized Treatment	VHA Obligations	Care in the Community Obligations	Total Obligations	FTE
Inpatient	$176.470	$19.295	$195.765	831
Outpatient	$292.889	$21.621	$314.510	1287
Residential Rehabilitation & Treatment	$223.602	$0.000	223.602	1181
Total	**$692.961**	**$40.917**	**$733.877**	**3,299**

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 VHA invests in research helps aid efforts to improve the prevention, diagnosis and treatment of substance use disorders, while improving the effectiveness, efficiency, accessibility and quality of Veterans' health care.

Specialized Function	Obligations (Millions)	Drug Control Related Percent	FTE
Research & Development	$16.559	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 unmodified opinion on VA's FY 2017 consolidated financial statements. They identified six material weaknesses and one significant deficiency. The material weaknesses relate to: a) Compensation, Pension, Burial and Education Actuarial Estimates (partial repeat); b) Community Care Obligations, Reconciliations and Accrued Expenses (repeat); c) Financial Reporting (repeat); d) Loan Guarantee Liability (repeat); e) CFO Organizational Structure (repeat); and f) Information Technology Security Controls (repeat). The significant deficiency relates to: Procurement, Undelivered Orders, Accrued Expenses, and Reconciliations (repeat).

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 2017 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, 2013.

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.

(original signed by:) *1/5/2018*

Mark Yow
Chief Financial Officer (10A3)
Veterans Health Administration

Date

(original signed by:) *1/4/2018*

Ed Bernard
Associate VHA Chief Financial Officer
Resource Management (10A3B)

Date

(original signed by:) *1/4/2018*

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

Date

Department of Veterans Affairs Resource Summary Obligations (In Millions)	2017 Actual
Medical Care:	
Specialized Treatment	
Inpatient	$195.765
Residential Rehabilitation & Treatment	$223.602
Outpatient	$314.510
Specialized Treatment	$733.877
Medical & Prosthetics Research:	
Research & Development	$16.559
Drug Control Resources by Function & Decision Unit Total	$750.436
Drug Control Resources Personnel Summary	
Total FTE	3,299
Total Enacted Appropriations	$183,564.000
Drug Control Percentage	0.41%

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

Appendix A OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Murray Leigh, Director Tesia Basso Nathan Fong D. Stephen Nose

Appendix B Report Distribution

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