



DEPARTMENT OF VETERANS AFFAIRS  
**OFFICE OF INSPECTOR GENERAL**

*Office of Audits and Evaluations*

DEPARTMENT OF VETERANS AFFAIRS

Independent Review of VA's  
Fiscal Year 2018 Detailed  
Accounting Submission to  
the Office of National Drug  
Control Policy

AUDIT

REPORT #19-00224-87

MARCH 19, 2019



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## Abbreviations

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



DEPARTMENT OF VETERANS AFFAIRS  
**OFFICE OF INSPECTOR GENERAL**  
WASHINGTON, DC 20001



**Date:** March 19, 2019

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

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

**Subject:** Final Report: *Independent Review of VA's Fiscal Year 2018 Detailed Accounting Submission to the Office of National Drug Control Policy*

1. The VA Office of Inspector General (OIG) reviewed the Department of Veterans Affairs' (VA) Fiscal Year 2018 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 May 8, 2018, and as authorized by 21 U.S.C. §1703(d)(7).<sup>1</sup> The submission is the responsibility of VA's management and is included in this report as an attachment.

2. The OIG 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 pages 12 and 13 of this report.

3. The OIG conducted its review in accordance with attestation standards established by the American Institute of Certified Public Accountants and by 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. Specifically, the objective of an examination is the expression of an opinion on the assertions in the submission. Accordingly, the OIG does not express such an opinion.

4. The OIG's report, *Audit of VA's Financial Statements for Fiscal Years 2018 and 2017* (Report No. 18-01642-09, dated November 26, 2018) included five material weaknesses, all of which were repeat weaknesses from prior fiscal years (FYs). They are defined as

- Community care obligations, reconciliations, and accrued expenses;
- Financial systems and reporting;
- Information technology security controls;
- Compensation, pension, burial, and education actuarial estimates; and

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<sup>1</sup> The circular is available at <https://www.whitehouse.gov/wp-content/uploads/2018/09/2018-Accounting-and-Performance-Summary-Circular.pdf>.

- Entity-level controls, including Chief Financial Officer organizational structure.

The report also identified two significant deficiencies. One deficiency, *loan guarantee liability*, was reported as a material weakness in FY 2017 and as a significant deficiency in FY 2016; the other, *procurement, undelivered orders, accrued expenses, and reconciliations*, has been reported as a significant deficiency since FY 2016. A material weakness is a deficiency, or combination of deficiencies, in internal control over financial reporting, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented or detected and corrected in a timely basis. A significant deficiency is deficiency, or combination of deficiencies, in internal control over financial reporting. This type of deficiency is less severe than a material weakness yet important enough to merit attention by those charged with governance.

5. Based upon the OIG's review, except for the effects, if any, of the material weaknesses discussed in paragraph four, nothing came to the OIG's attention that caused it 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 2018 Detailed Accounting Submission. As a result, this report is not intended to be used for any other purpose.

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



LARRY M. REINKEMEYER  
Assistant Inspector General  
for Audits and Evaluations

Attachments

## VA's Management Representation Letter

### Department of Veterans Affairs Memorandum

Date: December 27, 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 2018 Detailed Accounting Submission to the Office of National Drug Control Policy (Project Number 2019-00224-BA-0002)

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, 2018.

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 2018 financial plan, occurred in Fiscal Year 2018.
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, 2018, that would have an effect on the Detailed Accounting Submission.

*(original signed by:)*

Charles Stepanek  
Acting, Director of Budget Services  
Resource Management (10A3B)

*(original signed by:)*

Rachel A. Mitchell  
Deputy Chief Financial Officer  
Veterans Health Administration

*(original signed by Rachel Mitchell:)*

Laura Duke  
Chief Financial Officer (10A3)  
Veterans Health Administration

cc: Veterans Health Administration Audit Liaison (10B5)

## **Attachment**

### **Statement of Disclosures and Assertions for FY 2018 Drug Control Obligations Submitted to Office of National Drug Control Policy (ONDCP) for Fiscal Year Ending September 30, 2018**

In accordance with ONDCP's Circular, Accounting of Drug Control Funding and Performance, dated May 08, 2018, 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.



**VETERANS HEALTH ADMINISTRATION**  
Annual Reporting of FY 2018 Drug Control Funds

DETAILED ACCOUNTING SUBMISSION

**A. Table of FY 2018 Drug Control Obligations**

(In Millions)	
Description	FY 2018 Actual
<b>Drug Resources by Budget Decision Unit:</b>	
Medical Care.....	\$751.771
Medical & Prosthetic Research.....	\$15.651
Total.....	\$767.422
<b>Drug Resources by Drug Control Function:</b>	
Treatment.....	\$751.771
Research & Development.....	\$15.651
Total.....	\$767.422

1. Drug Control Methodology

The obligation tables for the FY 2018 Drug Control Obligations (above) and the Resource Summary (page 12) showing obligations and FTE (Full-Time Equivalent) for substance use disorder (SUD) treatment in Veterans Health Administration (VHA) are based on specific patient encounters. The specific patient encounters include 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) that are stored in the Corporate Data Warehouse (CDW).

All patient 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 a substance use disorder treatment and which type of substance use disorder. A list of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) and International Statistical Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis groups used for substance use disorders are shown in the following table:

2 of 12

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 Managerial Cost Accounting (MCA) System of the Department of Veterans Affairs (VA). 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, Veterans Integrated Service Network (VISN) Support, National Programs, and Capital and State Home costs, and adding in the community care 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**

In FY 2018, VHA provided services by mental health clinicians in a variety of outpatient settings to 211,735 patients with any diagnosis of a drug use disorder. Of these, 31 percent used cocaine, 29 percent used opioids, and 51 percent used cannabis. Nearly 89 percent had co-existing psychiatric diagnoses. (These categories are not mutually exclusive.)

VHA continues 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 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 stabilization in numerous inpatient medical and general mental health units throughout the VA system. Outpatient detoxification or induction onto medication is available for patients who are medically stable and who have sufficient social support systems to monitor their status.

VHA offers care in Residential Rehabilitation Treatment Programs to Veterans with a range of mental health concerns. Although many of these programs are designated as “Substance Abuse Residential Rehabilitation Treatment Programs” and focus primarily on substance use disorder services, in FY 2018, 93.6 percent of all Residential Rehabilitation Treatment Programs patients had a substance use disorder present for the fiscal year during which they received residential treatment.

Most Veterans with substance use disorders are treated in outpatient programs. Standard outpatient programs typically treat patients one or two hours per session and patients are generally seen once or twice a week. Intensive substance use disorder outpatient programs provide at least three hours of service per day and patients attend three or more days per week.

Considering the frequent co-occurrence of substance use disorders with post-traumatic stress disorder, VHA has also assigned a substance use disorder specialist to each of its hospital-level post-traumatic stress disorder services or teams. The staff person is an integral member of the post-traumatic stress disorder clinical services team and works to integrate substance use disorder care with all other aspects of post-traumatic stress disorder-related care. Among the specialists' responsibilities are identification and treatment of Veterans with co-occurring substance use disorder and post-traumatic stress disorder. Specialists also promote preventive services for Veterans with post-traumatic stress disorder who are at risk for developing a substance use disorder.

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 substance use disorders 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.

In communities where justice programs relevant to Veterans exist (Veterans courts, drug courts, mental health courts, and police crisis intervention teams), VA has taken the initiative in building working relationships to ensure that eligible justice-involved Veterans get needed care. In communities where no such programs exist, VA has reached out to potential justice system partners (judges, prosecutors, police, and jail administrators) to connect eligible justice-involved Veterans with needed VA services including addiction treatment. VJO Specialists currently serve Veterans in 551 Veterans Treatment Courts and other Veteran-focused courts, with more planned. In communities without Veterans Treatment Courts, VA medical centers have established relationships with a range of justice system and community partners, including police and sheriffs' departments, local jail administrators, judges, prosecutors, public defenders, probation officers, and community mental health providers.

### **Opioid Safety Initiative**

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 2018, several aspects of the Opioid Safety Initiative have begun to show positive results. Despite an increase of 219,673 veterans who were dispensed any medication from a VA pharmacy, 234,492 fewer veterans were on long-term opioids, and 93,586 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 91 percent. The average dose of selected opioids has continued to decline as 40,584 fewer patients were receiving daily doses greater than or equal to 100 milligrams of morphine equivalent, demonstrating that prescribing and consumption behaviors are changing.

Chronic pain is a national public health problem as outlined in the 2011 study by the Institute of Medicine (IOM). At least 100 million Americans suffer from some form of chronic pain. The IOM study describes in detail many concerns of pain management, including system-wide deficits in the training of our Nation's health care professionals in pain management and substance use disorders prevention and management, and the problems caused by a fragmented health care system. The over-use and misuse of opioids for pain management in the United States is a consequence of a health care system that until recently was less than fully prepared to respond to these challenges.

The VHA has identified and broadly responded to the many challenges of pain management through policies supporting clinical monitoring, education and training of health professionals and teams, and expansion of clinical resources and programs. VA's Pain Management Directive defines and describes policy expectations and responsibilities for the overall National Pain Management Strategy and Stepped Care pain model, which is evidence-based and has been adopted by the Department of Defense (DoD) as well. Our approach to managing opioid over-use fits into this plan, and the VA has employed broad strategies to address the opioid epidemic: education, pain management, risk mitigation, and addiction treatment. First, the VA addressed the problem of clinically inappropriate high-dose prescribing of opioids through the VA's national program, the Opioid Safety Initiative (OSI); Second, VA developed an effective system of interdisciplinary, patient-aligned pain management with the competency to provide safe and effective pain control and quality of life for Veterans for the remainder of their lives.

To further strengthen OSI and keep this trend moving in the right direction, VA has deployed state-of-the-art tools to help protect Veteran patients using high doses of opioids or with medical risk factors that put them at an increased risk of complications from opioid medications.

These tools, referred to as the Opioid Therapy Risk Report (OTRR) and the Stratification Tool for Opioid Risk Mitigation (STORM), are available to all staff in the VHA. These tools include information about the dosages of narcotics and other sedative medications, significant medical problems that could contribute to an adverse reaction and monitoring data to aid in the review and management of complex patients.

The Opioid Therapy Risk Report allows VA providers to review all pertinent clinical data related to pain treatment in one place, providing a comprehensive Veteran-centered and more efficient level of management not previously available to primary care providers. The Stratification Tool for Opioid Risk Mitigation allows VA providers to view information about risk factors for opioid overdose, suicide-related events and other harms along with potential risk mitigation strategies.

Additionally, VHA has formalized a system-wide Academic Detailing program that is in process of being implemented throughout the organization. Academic Detailing provides specialty teams to visit facilities and provide on-site support and education to providers to further enhance pain management efforts. The Academic Detailing program is another important step to improve mental health and pain management medication therapy across all VAMCs. As of September 30, 2018, specially trained VA pharmacists had over 32,000 outreach visits with VA prescribers about opioid safety, opioid overdose and naloxone distribution, and opioid use disorder.

As VA continues its efforts to address opioid over-use, complementary and integrative medicine treatments are an important component to VA's Pain Management Strategy. VA currently offers many complementary and integrative medicine treatments, many of which may be useful in chronic pain. These treatments include acupressure, acupuncture, biofeedback, chiropractic services, exercise, heated pool therapy, hypnosis/hypnotherapy, massage therapy,

meditation, occupational therapy, physical therapy, recreational therapy, relaxation, tai chi, transcutaneous electrical nerve stimulation, yoga and other services.

VA has several other programs that are complementary to the Opioid Safety Initiative and include:

- ❖ Overdose Education and Naloxone Distribution (OEND): As of September 30, 2018, over 204,000 naloxone prescriptions were dispensed to Veterans.
- ❖ State Prescription Drug Monitoring Programs (PDMP): 48 States, District of Columbia, and Puerto Rico are activated for VA data transmission. From Quarter 3, Fiscal Year 2013 (ending in June 2013) to Quarter 4, Fiscal Year 2018 (ending September 2018), VA providers have documented over 3.8 million queries to State Prescription Drug Monitoring Programs to help guide treatment decisions.
- ❖ Substance Use Disorder: Medication Assisted Treatment (MAT) is available to Veterans receiving care in VA.
- ❖ Medication Take-Back Program: VA offers free medication take back services to Veterans through mail-back envelopes and on-site receptacles compliant with Drug Enforcement Administration (DEA) regulations. As of September 30, 2018, Veterans have returned over 99 tons (the equivalent of 31 elephants) of unwanted or unneeded medication using these services.

VHA is steadily expanding the availability of medication treatment for veterans with opioid use disorder (OUD). VA monitors the percentage of patients with OUD who receive medication-assisted treatment (34.8 percent during the 4th quarter of FY2018) 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 2017, during FY 2018, 11 percent more unique Veterans received treatment with buprenorphine (total of 16,313) and the number of prescribers increased by 15 percent (to 1,327). In FY 2018, evidence-based medication-assisted treatment (MAT) for opioid use disorder, including office-based treatment with buprenorphine and extended-release injectable naltrexone, 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 630 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 care through community-based licensed opioid treatment programs.

### **Performance**

During FY 2018, 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 2018 (allowing time for follow-up assessment during Quarter 4), VHA substance use disorder specialty outpatient programs assessed self-reported abstinence among 3,337 veterans with drug use disorder diagnoses documented at admission. Among the veterans who remained engaged in care and were reassessed 30-90 days after admission, 79.3 percent reported abstinence from drugs during the previous 30 days, a level of performance that is essentially unchanged from the prior year and, despite not reaching our stretch goal of 88%, nonetheless represents a high level of performance success. Over 9,860 veterans were assessed at the beginning of substance use disorder specialty care during the 4th quarter of FY 2018.

The accompanying Department of Veterans Affairs Resource Summary (page 12) 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 May 08, 2018, (b) Budget Formulation, dated May 08, 2018, and (c) Budget Execution, dated May 08, 2018. 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)**

<b>Specialized Treatment</b>	<b>VHA Obligations</b>	<b>Care in the Community Obligations</b>	<b>Total Obligations</b>	<b>FTE</b>
Inpatient	\$180.276	\$26.544	\$206.820	845
Residential Rehabilitation & Treatment	\$299.347	\$18.180	\$317.527	1,302
Outpatient	\$227.425	\$0.000	\$227.425	1,236
<b>Total</b>	<b>\$707.047</b>	<b>\$44.724</b>	<b>\$751.771</b>	<b>3,383</b>

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 money 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.

In FY 2018, VHA exceeded targets for the numbers of studies relevant to substance use (28) or alcohol use (51) disorders and VA separately now reports opioid use disorder research with an FY 2018 baseline of 12 studies in progress. This distinction of a new category for opioid research aligns with heightened focus activity on management of opioid use and abuse. Multiple publications were released by VHA-funded researchers on these specific topics areas.

Specialized Function	Obligations (Millions)	Drug Control Related Percent	FTE
Research & Development	\$15.651	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 2018 consolidated financial statements. They identified five material weaknesses and two significant deficiencies. The material weaknesses relate to: (1) community care obligations, reconciliations, and accrued expenses; (2) financial systems and reporting; (3) information technology security controls; (4) compensation, pension, burial, and education actuarial estimates; and (5) entity level controls including chief financial officer organizational structure. The significant deficiencies relate to: (1) loan guarantee liability; and (2) procurement, undelivered orders, accrued expenses, and reconciliations.
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 2018 drug control obligations by function and budget decision unit is reasonable and accurate based on the criteria set forth in the ONDCP Circular dated May 08, 2018.
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 May 08, 2018.
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, dated May 08, 2018.

Subj: Statement of Disclosures and Assertions for FY 2018 Drug Control Obligations Submitted to Office of National Drug Control Policy (ONDCP) for Fiscal Year Ending September 30, 2018

*(original signed by Rachel Mitchell:)*

*1/26/2019*

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Laura Duke  
Chief Financial Officer  
VHA Office of Finance (10A3)

\_\_\_\_\_  
Date

*(original signed by:)*

*1/26/2019*

\_\_\_\_\_  
Rachel A Mitchell  
Deputy Chief Financial Officer  
VHA Office of Finance (10A3)

\_\_\_\_\_  
Date

*(original signed by:)*

*1/22/2019*

\_\_\_\_\_  
Charles Stepanek  
Management Analyst  
Resource Management (10A3B)

\_\_\_\_\_  
Date

Department of Veterans Affairs Resource Summary Obligations (In Millions)	
	2018 Actual
Medical Care:	
Specialized Treatment	
Inpatient.....	\$206.820
Residential Rehabilitation & Treatment.....	\$317.527
Outpatient.....	\$227.425
Specialized Treatment.....	\$751.771
Medical & Prosthetics Research:	
Research & Development.....	\$15.651
Drug Control Resources by Function & Decision Unit, Total....	\$767.422
Drug Control Resources Personnel Summary	
Total FTE.....	3,383
Total Enacted Appropriations.....	\$185,398.000
Drug Control Percentage.....	0.41%

❖ *Numbers may not add as a result of rounding*

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

## OIG Contact and Staff Acknowledgments

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<b>Contact</b>	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
<b>Review Team</b>	Murray Leigh, Director Tesia Basso D. Stephen Nose

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## Report Distribution

### VA Distribution

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