Revising the Department of Veterans Affairs drug treatment budget

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Author's Note: I believe that the substantive contents of this memo are all available in the public record, but any opinions expressed should be considered my responsibility and not necessarily reflective of official opinions of the VA or of the ONDCP.

This memo explains how the Department of Veterans Affairs (VA) calculates its portion of the U.S. President's budget for the National Drug Control Strategy. I state at the outset that most readers, even readers with an interest in the addiction treatment field, will consider what follows tedious reading. My intended audience is the very small group of U.S. drug policy wonks who follow the minutiae of federal drug budgeting. I was inspired to write this memo because in the past few years I have heard or read policy analyses of the VA drug budgeting process that were not cognizant of how the formula has changed (e.g., Boyum & Reuter, 2005; Walsh, 2004). As VA is a significant portion of the U.S. federal budget for drug treatment, incorrect assumptions about the VA drug budget can lead to false conclusions about more contentious issues, for example the relative federal investment in demand reduction versus supply reduction programs. I therefore hope this memo will be useful to the work of U.S. drug policy budget analysts, including newly arrived VA and ONDCP staff and political appointees who wish to understand how the budget has evolved over prior administrations.

In the late 1980s, Congress passed several anti-drug abuse acts that among other things created an Office of National Drug Control Policy in the White House and significantly expanded the VA's role in treating drug abuse. As part of coordinating federal drug policy, ONDCP was charged with drawing up an annual budget of what each federal agency contributed to drug control. This naturally lead the ONDCP to want a budget line from the VA, which Congress had just awarded about 90M recurring dollars to significantly expand substance abuse services for veterans.

The original VA drug budget formula was developed and agreed to by ONDCP, OMB and VA. This formula included the costs of VA drug abuse-related research and drug-free workplace programs, which together have averaged between 0.5 to 2% of the budget each year and will therefore not be discussed further here. The more critical aspects of the formula were the two components of services for drug using VA patients. The first component was called "specialized drug treatment" and the second was called "other related medical treatment". The first component is relatively straightforward and

is calculated as follows: The total amount of money VA expends in accounts covering specialized substance abuse treatment is pulled from its national databases and then multiplied by the proportion of patients in those programs who had a diagnosed illicit drug problem. For the sake of example, if the VA spent $100M on specialized substance abuse treatment and 70% of these patients had an illicit drug abuse or dependence diagnosis (the rest being alcohol only), the specialized drug treatment spending for that year would be $100M X 70% = $70M. There have been important technocratic improvements in the calculation of this part of the budget over the years, but its basic logic and approach are the same today as when it was first developed.

The "other related medical treatment" component is more complex and has historically been more controversial. To describe it, it is necessary first to comment that most medical record systems, including VAs, offer treating clinicians the option of listing multiple diagnosis in order of importance to the present treatment, i.e., a primary diagnosis, a secondary diagnosis and so forth. In VA records, there is space for up to 10 diagnoses although few patients have that many. In VA drug budget lingo, diagnosis appearing anywhere from third to tenth have been called "associated" diagnoses.

The original VA drug treatment budget included 4 components (see Table 1). As described above, component #1, the costs of specialized drug treatment programs, has always been and still is in the budget. The changes in components #2-4 are the subject of this memo. The inclusion of these costs in the VA drug budget was criticized by a team at RAND in independent articles (Murphy, 1994) and later in a detailed report commissioned by the ONDCP (Murphy, Davis, Liston, Thaler & Webb, 2000). That ONDCP requested such a report in the first place reflected concerns within the organization about the drug budget, so RAND was not alone in its skepticism. The nub of RAND's criticism (which others made as well) was that the "other related medical treatment costs" led to a dramatic overstatement of VA's contribution to drug treatment.

There is no disputing that the initial formula included costs that were not incurred in specialty drug treatment programs, because the formula was explicitly designed to do just that (Hence we are not dealing here with a technocratic criticism). The logic behind including other related costs was based on a reality that no one, including critics of the budget formula, disputed: Untreated drug abuse results in extensive health care costs to many providers, including VA. But whether such costs should be included in a drug treatment budget is much debated. For example, the Clinton Administration ONDCP publicly embraced the goal of treating the consequences of drug use (which would seem to support counting other related costs) whereas the G.W. Bush administration has focused on reduction of drug use per se (which would seem to support not counting such costs).

In 2000, ONDCP and the VA had a series of meetings and correspondence focused on revising the VA drug budget in light of the RAND report. Because key individuals in both agencies were convinced of the need for some changes in the formula, the exchanges were cordial and consensus was achieved. In what was perhaps the last official drug policy decision of the Clinton administration, ONDCP formally

communicated in an letter to VA on December 19, 2000 what had been worked out in the meetings: Costs in component #3 and #4 should be dropped from the VA drug treatment budget. Costs in component #2 (medical costs for untreated individuals who had a primary drug abuse diagnoses) were debated during the 2000 meetings and ultimately retained, on the theory that these costs reflect treatment of drug abuse occurring in other settings, such as psychiatry programs and primary care practices.

Dropping components #3 and #4 from the VA drug budget had a significant impact. The VA drug budget had under the old formula been projected to be nearly $1.2B in FY2001; instead actual spending for that year under the new formula was around half that amount ($573M). Specialized drug abuse treatment programs' share of the VA drug budget approximately doubled under the revised formula, from about one quarter to one half of the total. This was by any standard a major change in drug budgeting. But as explained below it was not the end of the story.

After Congress significantly expanded eligibility for VA services, the number of veterans using VA health care services increased at a historic pace beginning in the late 1990s. Among the hundreds of thousands of new VA patients each year during this period, some of course had drug problems. For those patients whose drug problems were diagnosed as primary, all medical care costs were counted in the VA drug budget whether they received drug treatment or not, because Component #2 was still part of the budget formula. Even though only a small minority of VA patients have serious drug problems, the growth of enrollment was so fast during this period (VA health care system enrollment doubled in only six years) that the VA drug budget began increasing rapidly despite the fact that the 2000 formula revision had removed many "other medical treatment" costs from consideration. Specifically, the VA drug budget went from $573M in 2001 to $765M only three years later. Had the original formula been in effect, growth would have been even more startling (somewhere on the order of $200M/year), but the revised formula number was still rising at a notable pace.

Such rapid growth in a budget number might have raised eyebrows in any era, but it drew particular attention in the early years of the new millennium because VA was substantially reducing its specialty services for substance abuse patients. Indeed, a Secretary and an Undersecretary of Health had publicly identified declines in substance abuse treatment as a serious problem and made a substantial financial commitment to reverse the trend. This raised an awkward question: "If the drug treatment programs are shrinking why is the drug treatment budget number soaring"?[1] Concerns about the revised formula were increased when analysis by the VA Program Evaluation and Resource Center presented to VA leadership and ONDCP showed that a large proportion of the medical costs included in Component #2 were, contrary to what some had expected, occurring in parts of the system where it seemed impossible that treatment of drug abuse or dependence per se was a primary focus, such as dentistry, nutrition and oncology.

VA and ONDCP therefore agreed to remove Component #2 from the VA drug budget. The official letter communicating this decision was sent on September 7, 2004,

and a recalculation of the budget for that year showed a substantial impact: the $765M figure was reduced to $411M. In testifying during the following budget cycle (February 10, 2005) to the Committee on Government Reform, Subcommittee on Criminal Justice, Drug Policy and Human Resources, ONDCP Director Walters stated that he considered the change in the VA drug budget a major improvement that would better track VA's efforts to provide treatment to drug addicted veterans. Naturally, subsequent administrations may have different drug policy goals and request that the VA drug budget be changed again to reflect them (including for example returning to an inclusion of components #2-#4), but Director Walters' comments would seem to indicate that the VA drug treatment budget formula will stay in its current form for the remainder of the current administration.

To summarize, the VA drug budget indeed included a large amount of "other related medical treatment" in its original form. Most of these costs were removed in 2000; the remainder was removed in 2004. The VA drug treatment budget today only includes costs incurred in specialty drug treatment programs.

Notes

1 Of course this much-asked question had a rational answer, namely that the formula was intended to capture some costs occurring outside of specialized treatment programs. However, what the frequency of the question showed was that many sincere people *thought* the formula only included specialized drug treatment programs, which tends to support a comment in the RAND analysis (Murphy et al., 2000), namely that federal drug budget numbers are often presented or understood to mean something they do not.

References

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Table 1: The components of the VA drug treatment budget

(1) All medical costs for patients treated in a specialized drug program, no matter whether their drug diagnosis was primary, secondary or associated. For example if a patient with diagnoses of heroin dependence and major depressive disorder was treated in a methadone program that provided him group counseling, individual psychotherapy, and a course of vocational rehabilitation all of these costs would be scored in the drug budget regardless of whether the treating clinician judged that the heroin dependence or the depression was the primary diagnosis. *(These costs are still scored in the budget)*

(2) All medical costs for patients with a primary drug diagnosis who were not treated in a specialized drug abuse program. For example if the patient in example 1 above had refused a referral to the methadone program, every cost he incurred in the VA medical system for the rest of the year would be counted even though he never received specialized drug treatment. (*These costs were dropped as of 2005)*.

(3) 50% of medical costs for patients with a secondary drug diagnosis who were not treated in a specialized drug abuse program. For example if a patient treated for a primary diagnosis of emphysema had a secondary diagnosis of marijuana dependence that went untreated, half of all medical costs in VA for the year would be counted as related costs *(These costs were dropped as of 2000).*

(4) 25% of medical costs for patients with an associated drug diagnosis who were not treated in a specialized drug abuse program. For example if a patient had AIDS as a primary diagnosis, endocarditis as a secondary diagnosis, and heroin dependence as an associated diagnosis, and he never received specialized treatment for the heroin dependence, 25% of all the costs of VA care he utilized that year would be scored (*These costs were dropped as of 2000).*