M00K
Alcohol and Drug Abuse Administration
Department of Health and Mental Hygiene

Operating Budget Data

($ in Thousands)

	FY 12 Actual	FY 13 Working	FY 14 Allowance	FY 13-14 Change	% Change Prior Year
General Fund	$82,359	$87,654	$88,091	$437	0.5%
Contingent & Back of Bill Reductions	0	0	-5	-5	
Adjusted General Fund	**$82,359**	**$87,654**	**$88,086**	**$432**	**0.5%**
Special Fund	21,333	24,831	24,530	-301	-1.2%
Adjusted Special Fund	**$21,333**	**$24,831**	**$24,530**	**-$301**	**-1.2%**
Federal Fund	38,442	39,746	35,378	-4,368	-11.0%
Contingent & Back of Bill Reductions	0	0	-3	-3	
Adjusted Federal Fund	**$38,442**	**$39,746**	**$35,375**	**-$4,371**	**-11.0%**
Reimbursable Fund	5,663	6,232	6,016	-216	-3.5%
Adjusted Reimbursable Fund	**$5,663**	**$6,232**	**$6,016**	**-$216**	**-3.5%**
Adjusted Grand Total	**$147,798**	**$158,463**	**$154,007**	**-$4,456**	**-2.8%**

- The fiscal 2014 budget for the Alcohol and Drug Abuse Administration (ADAA) is almost $4.5 million (2.8%) below the fiscal 2013 working appropriation. The decline is driven by a lower availability of federal Substance Abuse Prevention and Treatment block grant funds.

- The budget continues to change the emphasis for substance abuse funding away from the traditional funding for treatment slots and into recovery support services. Local treatment funding declines by almost $6.4 million from fiscal 2013 to 2014.

Note: Numbers may not sum to total due to rounding.

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Personnel Data

	FY 12 Actual	FY 13 Working	FY 14 Allowance	FY 13-14 Change
Regular Positions	68.50	65.50	65.50	0.00
Contractual FTEs	6.64	6.77	7.08	0.31
Total Personnel	**75.14**	**72.27**	**72.58**	**0.31**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions		8.09	12.35%
Positions and Percentage Vacant as of 12/31/12		10.50	16.03%

- The fiscal 2014 budget includes an assumption of $350,000 in personnel savings as a result of a proposed merger of ADAA with the Mental Hygiene Administration.

Analysis in Brief

Major Trends

Prevention: Recurring prevention programming declined between fiscal 2011 and 2012, both in terms of the number of programs offered and people served. Single service programs grew slightly in the same time period in terms of the number of activities but saw a dramatic jump in terms of participation.

Treatment: The number of State-supported treatment admissions and unique individuals admitted to treatment fell slightly between fiscal 2011 and 2012. However, more people are in treatment on a daily basis. Data on employment among those admitted to treatment remains discouraging, especially in certain jurisdictions such as Baltimore City.

Issues

Integration of Behavioral Health Care: Choosing a Model for a Service Delivery and Financing System: In the 2012 interim, the Department of Health and Mental Hygiene continued the process for the potential development of a new service delivery and financing system for behavioral health services. Discussion in the 2012 interim primarily centered on which system model to adopt. At the time of writing, no final choice of model had been made.

Recommended Actions

1. Add language concerning the choice of a new behavioral health service delivery and financing system.

2. Add language requesting a report on the fiscal 2014 allocation of substance abuse treatment funding.

3. Adopt narrative requesting the Alcohol and Drug Abuse Administration to include prevention data in its annual Managing for Results submission.

4. Adopt narrative concerning the development of outcomes for, and an evaluation of, recovery support services in Maryland.

Updates

Expansion of Substance Abuse Services in the Primary Adult Care Program and the Impact on Substance Abuse Grant Funding: The inclusion of a substance abuse benefit in the Primary Adult Care (PAC) program supported with funds previously allocated to local treatment grants has widened access to substance abuse treatment services. However, some jurisdictions appear to be more aggressive in either linking substance abuse treatment recipients to the PAC program or ensuring that PAC recipients receiving treatment have that treatment paid for with PAC program funding.

Fiscal 2012 Closeout Actions in ADAA: A review of fiscal 2012 closeout actions in ADAA reveals that the administration was better able to utilize its grant funding compared to fiscal 2011.

Non-opioid Pharmacotherapies for Alcohol Dependence: Update to January 2012 Report: Pilot projects to evaluate the efficacy of non-opioid pharmacotherapies for alcohol dependence are currently underway in the Medicaid program and in the Department of Public Safety and Correctional Services. No outcome data is yet available from either project.

M00K
Alcohol and Drug Abuse Administration
Department of Health and Mental Hygiene

Operating Budget Analysis

Program Description

The Alcohol and Drug Abuse Administration (ADAA) develops and operates unified programs for substance abuse research, training, prevention, and rehabilitation in cooperation with federal, State, local, and private agencies. ADAA's mission is to provide access to a quality and effective substance abuse prevention, intervention, and treatment service system for the citizens of Maryland.

ADAA maintains an integrated statewide service delivery system through a variety of treatment and prevention modalities that provide financial and geographic access to Marylanders who need help with drug and alcohol addiction. Treatment is funded through grants and contracts with private and nonprofit providers and local health departments. Maryland's community-based addiction treatment programs include primary and emergency care; intermediate care facilities; halfway houses; long-term residential programs; and outpatient care. The State also funds prevention programs and recovery support services. Initial fiscal 2013 funding allocations for treatment and prevention are provided in **Appendix 3**.

Chapters 237 and 238 of 2004 formalized a local planning role for drug and alcohol abuse services. That legislation requires each county to have a local drug and alcohol abuse council and for each council to develop a local plan that includes the plans, strategies, and priorities of the county in meeting identified needs of both the general public and the criminal justice system for alcohol and drug abuse evaluation, prevention, and treatment services.

Performance Analysis: Managing for Results

1. Prevention

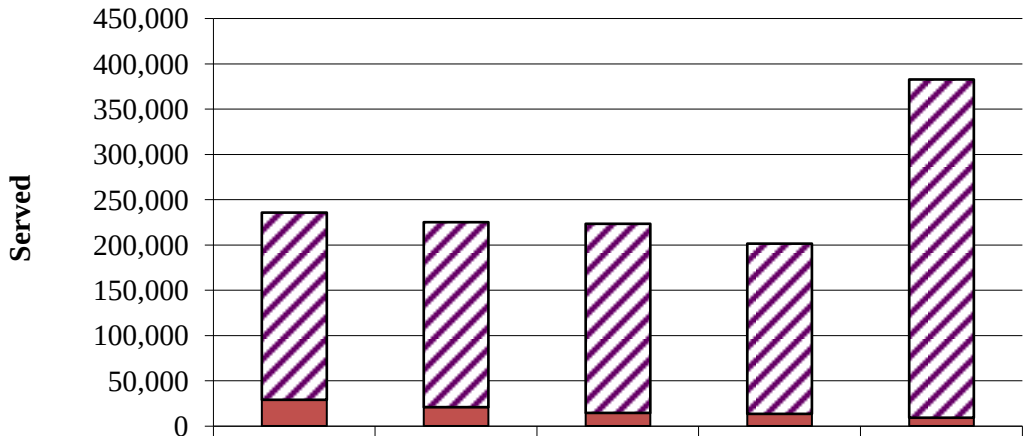
ADAA prevention services are provided through two types of programming:

- Recurring prevention programming, *i.e.*, with the same group of individuals for a minimum of four separate occasions and with programming that is an approved Substance Abuse and Mental Health Services Administration evidence-based model. In fiscal 2012, a total of 328 recurring prevention programs were offered across the State, a drop of 34 from the prior year.

- Single service programs such as presentations, speaking engagements, training, *etc*., that are provided to the same group on less than four separate occasions. Participant numbers are either known or estimated. In fiscal 2012, 1,253 single service prevention activities were offered in Maryland, an increase of 18 from the prior year.

As shown in **Exhibit 1**, ADAA reports prevention programming serving almost 383,000 participants in fiscal 2012, far above the 201,000 served in fiscal 2011. Recurring programs continue to see a drop in people served, down almost 4,300 (32%) between fiscal 2011 and 2012. Conversely, the number of participants served in single service programs, which fell steeply between fiscal 2010 and 2011, essentially doubled between fiscal 2011 and 2012.

Exhibit 1
ADAA-funded Prevention Programs
Served by Program
Fiscal 2008-2012



	2008	2009	2010	2011	2012
Single Service Programs	206,810	204,339	208,726	187,839	373,515
Recurring Programs	28,812	20,841	14,363	13,367	9,080
Prevention Funding ($ in Millions)	$6.093	$6.385	$6.179	$6.277	$7.730

ADAA: Alcohol and Drug Abuse Administration

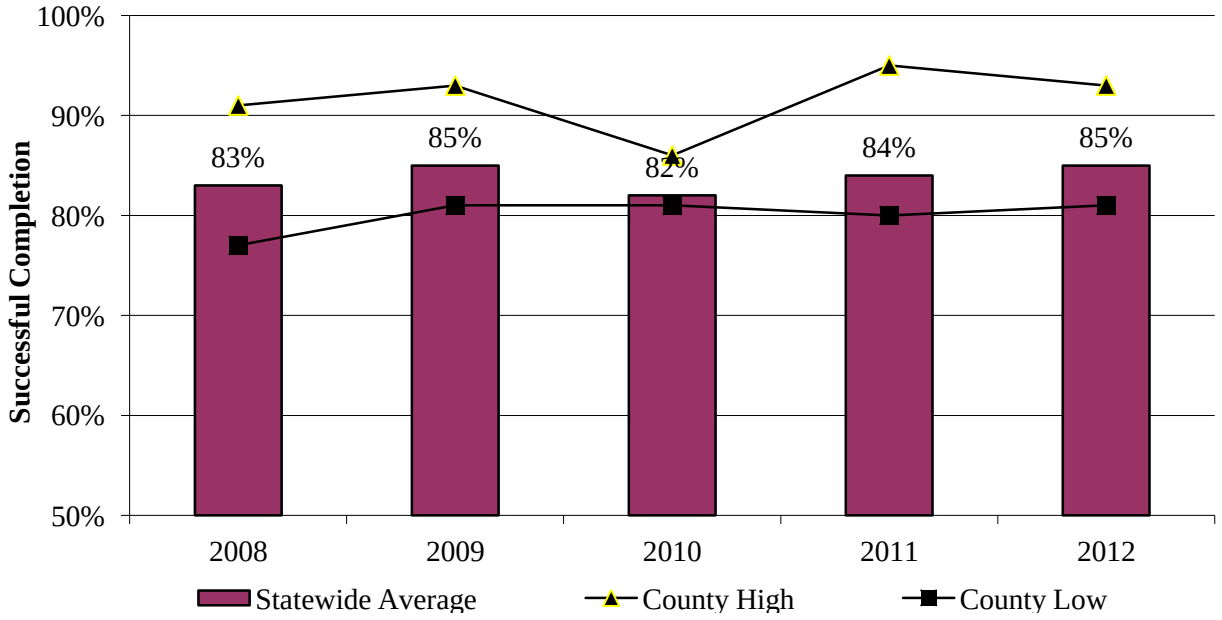
Note: Funding includes prevention block grant funds and beginning in fiscal 2010 Strategic Prevention Framework Grant funds.

Source: Alcohol and Drug Abuse Administration

Beginning in fiscal 2011, there was a change in program focus from individual-based programming to population-based programming/activities. Under the broad direction of national drug policies, jurisdictions must spend 50% of their prevention award on "environmental strategies," *i.e.*, the establishment of, or changes to, written and unwritten community standards, codes, and attitudes influencing the incidence and prevalence of the abuse of alcohol, tobacco, and other drugs. Activities include public policy efforts; changing environmental codes, ordinances, regulations, and legislation; and preventing underage alcohol sales and the sale of tobacco and tobacco products. Environmental strategies tend to be primarily single service activities, limiting the funding available for recurring services, hence the decline in that programming. Conversely, the broader reach of environmental programming, including mass media campaigns, boosts exposure to single service activities.

As shown in **Exhibit 2**, ADAA reports that in fiscal 2012, 85% of participants in recurring prevention programs successfully completed the program, slightly higher than in fiscal 2011. As also shown in this exhibit, there is variation by county among programs in terms of successful completion. In fiscal 2012, for example, the successful completion rate varied from 93% in Charles County to 81% in Somerset County. It should be noted that since programming varies from one jurisdiction to the next, there is no universal definition of what is considered a "successful completion."

Exhibit 2
ADAA-funded Recurring Prevention Programs
Successful Completion Rates (%)
Fiscal 2008-2012



ADAA: Alcohol and Drug Abuse Administration

Source: Alcohol and Drug Abuse Administration

Finally, as noted in the fiscal 2013 analysis, ADAA does not have a prevention outcome in its Managing for Results (MFR) submission, although it produces plentiful data on prevention activities. ADAA indicated last year that it would review its MFR measures, but there is no prevention data in the fiscal 2014 budget submission. **The Department of Legislative Services (DLS) recommends narrative requesting the development of an MFR key goal, objectives, and performance measures consistent with the agency's mission.**

2. Treatment

As shown in **Exhibit 3**, State-funded admissions have risen from just under 40,000 in fiscal 2008 to just over 45,000 in fiscal 2012, with the number of unique individuals admitted to treatment likewise increasing from just over 32,600 to just under 35,600 in the same period. Admissions and unique individuals admitted fell marginally from fiscal 2011 to 2012. ADAA attributes this recent drop to an increase in length of stay within a treatment episode which has increased the average daily active patients but reduced the ability to accept admissions. The administration also indicates that preliminary data for fiscal 2013 indicates that admissions are once again rising.

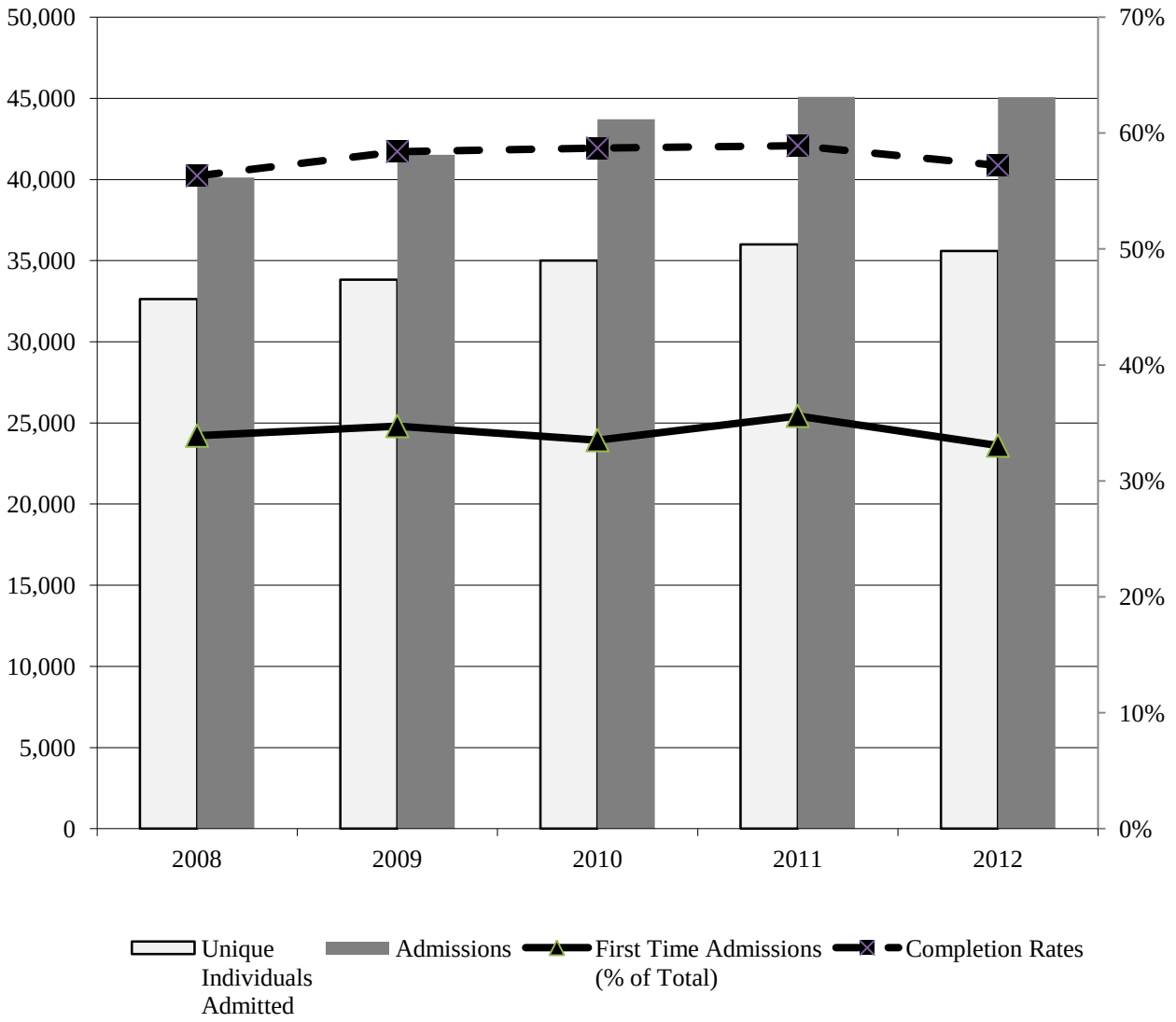
First time admissions as a percentage of total admissions are relatively constant over the five-year period, ranging between 34-36% of total admissions. Completion rates (program completion and discharge without the need for further treatment or program completion with appropriate referral to the next level of treatment) also vary little from year-to-year, although the gradual upward trend in completion rates between fiscal 2008 and 2011 reversed itself between fiscal 2011 and 2012.

In terms of outcomes, traditionally a key outcome measure is the retention rate within a program. Research, as well as Maryland experience, demonstrates a strong relationship between retention rates and successful outcomes. In outpatient treatment, for example, keeping a person in a program for longer than 90 days is considered an important benchmark. As shown in **Exhibit 4**, the gradual improvement in the retention rate beyond 90 days in ADAA-funded Level I (outpatient) programs that had dated back to fiscal 2003 stopped in fiscal 2009 and has fallen since that time including a slight decline from 56.4% in fiscal 2011 to 56.1% in fiscal 2012.

There continues to be a wide variation between programs in fiscal 2012. For fiscal 2012, the highest retention rate for State-supported programs is 75.7% (Kent County), while the lowest retention rate is 39.7% (Queen Anne's County which also had the lowest rate in fiscal 2011).

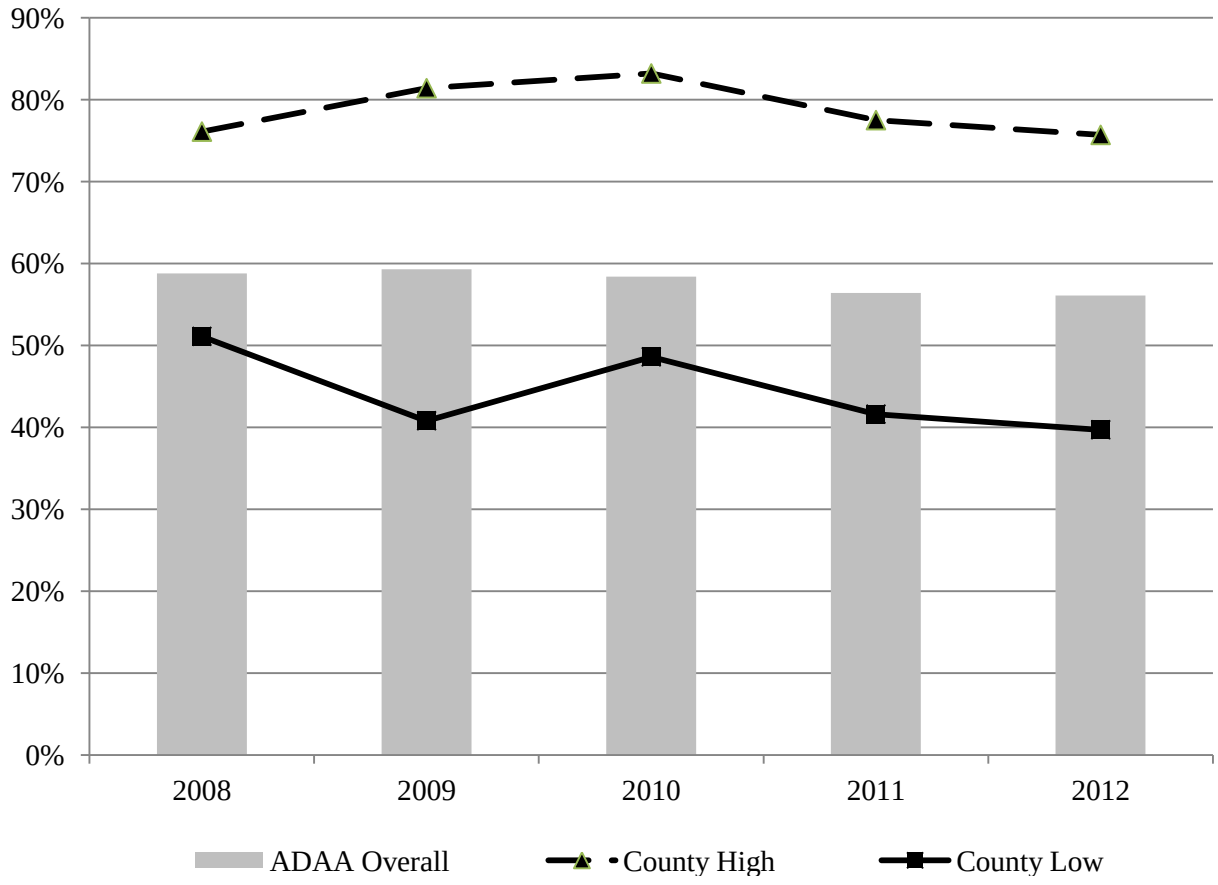
It should be noted that ADAA is moving toward measuring retention by episode of care which could include treatment in multiple levels of care (residential, outpatient, etc.). Once there is sufficient longitudinal data to present, this will offer a more complete picture of the treatment model ADAA is developing.

Exhibit 3
State-funded Treatment Programs – Various Data
Fiscal 2008-2012



Source: Department of Legislative Services; Alcohol and Drug Abuse Administration

Exhibit 4
Level I Retention Rates
Retained More Than 90 Days
Fiscal 2008-2012



ADAA: Alcohol and Drug Abuse Administration

Source: Alcohol and Drug Abuse Administration

Additional outcome data drawn from treatment programming is shown in **Exhibit 5.** As shown in the exhibit:

- There has been a slow but steady increase in the percentage of admissions to State-supported treatment programs among individuals who had used substances 30 days prior to admission to treatment. Over the same period shown in the exhibit, up until fiscal 2012, there had been a fairly consistent decline in those reporting substance use 30 days prior to discharge. However, between fiscal 2011 and 2012 this number increased to 39.8%.

Exhibit 5
State-funded Treatment Programs
Various Treatment Outcomes for Most Treatment Types
Fiscal 2008-2012

	Substance Abuse			Employed			Criminal Justice Involvement (Arrested in Prior 30 Days, % of Patients)		
	30 Days Prior to Admission	30 Days Prior to Discharge	% Change	At Admission	At Discharge	% Change	Prior to Admission	Prior to Discharge	% Change
Fiscal 2008	77.4%	44.9%	-42.0%	30.4%	40.4%	32.9%	8.7%	3.0%	-65.5%
Fiscal 2009	78.0%	40.0%	-48.7%	27.1%	35.2%	29.9%	8.0%	3.2%	-60.0%
Fiscal 2010	78.3%	38.7%	-50.6%	24.3%	32.0%	31.7%	8.4%	2.9%	-65.5%
Fiscal 2011	78.5%	37.4%	-52.4%	23.5%	30.9%	31.5%	8.0%	3.4%	-57.5%
Fiscal 2012	78.5%	39.8%	-49.3%	22.6%	30.0%	32.7%	8.5%	3.5%	-58.8%

Note: Data on substance abuse usage excludes persons reported as being in a controlled environment 30 days prior to treatment and detoxification patients; data on employment and criminal justice involvement excludes patients in short-term residential placements and detoxification.

Source: Alcohol and Drug Abuse Administration

There is a fairly significant disparity in this data by individual jurisdiction. Substance abuse within 30 days at admission ranges from a low of 45.7% in Carroll County to 90.5% in Kent County. Substance abuse, within 30 days prior to discharge, ranges from a low of 14.3% in Frederick County to 57.9% in Baltimore City. The percentage change between use prior to admissions and discharge is most evident in Frederick County (83.1%) while Harford County sees only a 27.5% change.

According to ADAA, jurisdictional differences can be attributed to such things as variation in reporting standards; variation between providers on reporting of substance use prior to treatment; and differences in the mix of levels of care being reported.

- Data on employment remains somewhat discouraging. Although in fiscal 2012 the change in employment status at admission and discharge is at its highest level since fiscal 2008, a smaller percentage of people were employed both at admission to treatment and at discharge, reflective of the employment situation at large.

  The jurisdictional data makes for even grimmer reading in certain areas of the State. Baltimore City, for example, although it records a 77.1% increase in employment status between admission and discharge (second only to Frederick County), has only 8.8% of persons employed at admission and 15.5% at discharge. Talbot County has both the highest level of employment at admission (44.1%) and discharge (53.6%). Here again, variation across subdivisions relates to such things as patient mix (*i.e.*, the degree to which they might serve adolescents or indigents), local economic factors, and the levels of care offered (with many residential programs, for example, integrating employment into program goals and developing relationships in the community around job placement).

- The relative change in the level of criminal justice involvement 30 days prior to treatment compared to 30 days prior to discharge showed a small level of improvement between fiscal 2011 and 2012. However, this was due more to the relative rise in criminal justice involvement at admission rather than any dramatic change in the level of involvement at discharge.

  Again, the differences by jurisdiction can be quite wide. Talbot County (18.0%) had the highest percentage of individuals who were arrested 30 days prior to admission compared to Caroline County with only 4.1%. In terms of persons arrested 30 days prior to discharge, Charles County had only 0.5% of clients arrested compared to 8.2% in Kent County which actually saw more people arrested within 30 days prior to discharge than prior to admission. However, the number of individuals arrested prior to admission and discharge in Kent County is too small to draw any conclusions from that data.

Proposed Budget

The fiscal 2014 Governor's allowance for the Alcohol and Drug Abuse Administration is almost $4.5 million (2.8%) below that of the fiscal 2013 working appropriation (see **Exhibit 6)**.

Exhibit 6
Proposed Budget
DHMH – Alcohol and Drug Abuse Administration
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
2013 Working Appropriation	$87,654	$24,831	$39,746	$6,232	$158,463
2014 Allowance	88,091	24,530	35,378	6,016	154,014
Amount Change	$437	-$301	-$4,368	-$216	-$4,449
Percent Change	0.5%	-1.2%	-11.0%	-3.5%	-2.8%
Contingent Reduction	-$5	$0	-$3	$0	-$7
Adjusted Change	$432	-$301	-$4,371	-$216	-$4,456
Adjusted Percent Change	0.5%	-1.2%	-11.0%	-3.5%	-2.8%

Where It Goes:

Personnel Expenses	**-$28**	
Retirement contributions		$118
Regular salaries		113
Employee and retiree health insurance		50
Annualization of fiscal 2013 2% cost-of-living adjustment		39
Workers' compensation premium assessment		20
Other fringe benefit adjustments		8
Turnover adjustments (includes savings from future reorganization)		-375
Administration	**$687**	
Prescription Drug Monitoring Program		512
State of Maryland Automated Record Tracking (SMART)		181
Various training activities (principle increase concerns sexual health and recovery supported with reimbursable funds)		44
Recovery Oriented Systems of Care administration (federal funds)		-50
Prevention	**$87**	
Strategic Prevention Framework activities (federal funds)		87
Problem Gambling	**-$149**	
Problem gambling activities		-149

Where It Goes:

Treatment	**-$5,009**
Recovery Support Services	5,100
Transfer of funds to Medicaid to support substance abuse services in the Primary Adult Care program	-3,739
Local treatment grants	-6,370
Other	-44
Total	**-$4,456**

Note: Numbers may not sum to total due to rounding.

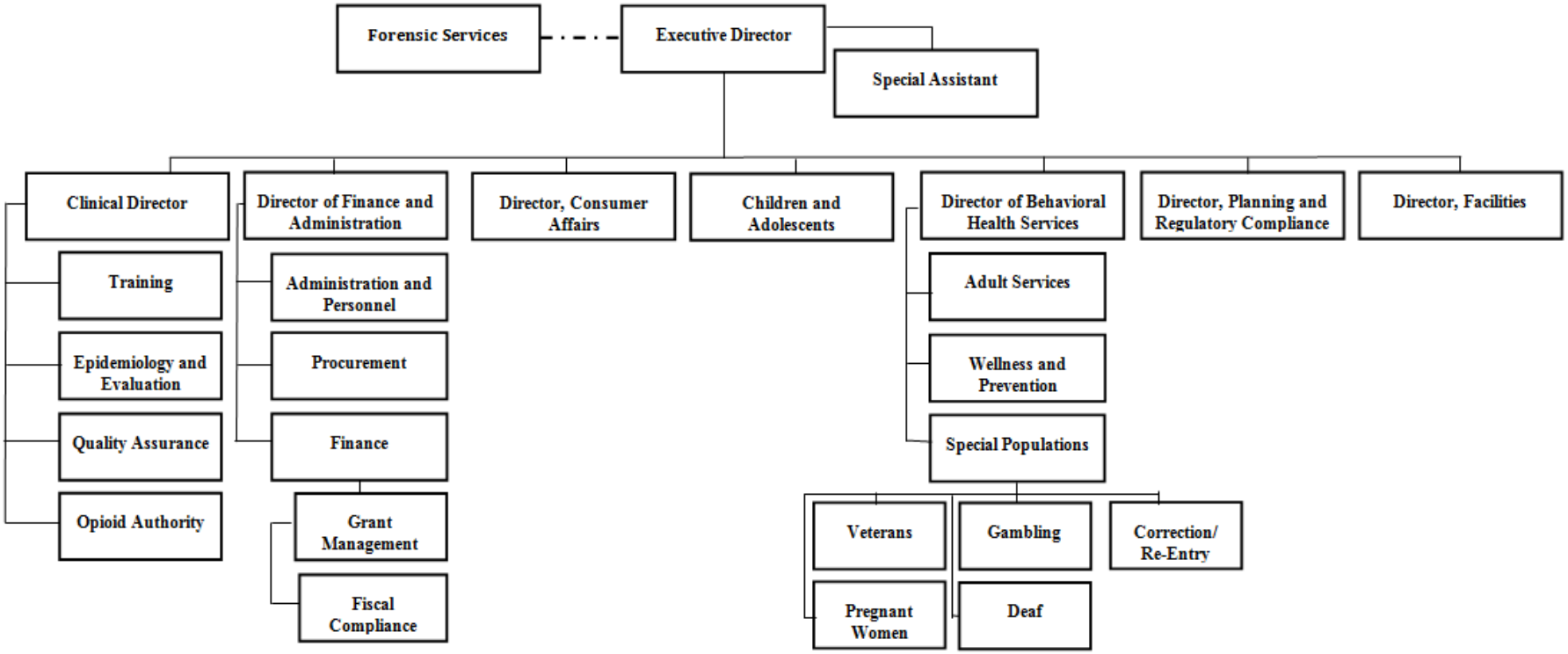
Personnel Expenses

Personnel expenses in the 2014 budget are $28,000 below the fiscal 2013 working appropriation. Large increases include $118,000 in retirement contributions (due to underattaining investment returns, adjusting actuarial assumptions, and increasing the reinvestment of savings achieved in the 2011 pension) and $113,000 for regular salaries above and beyond the funding need for annualization of the fiscal 2013 cost-of-living adjustment (COLA) due to higher salary needs based on fiscal 2013 reclassifications and funding for new hires above budgeted fiscal 2013 levels.

Offsetting these and other smaller increases is an increase in turnover. According to the department, ADAA's budget includes the recognition of $350,000 in savings from a proposed reorganization of ADAA and the Mental Hygiene Administration (MHA) into a single administration (see **Exhibit 7**). Savings of $150,000 are also identified in the MHA budget. It should be noted that this reorganization is not final and no specific positions have been identified for cost savings. The department has indicated that when that decision is made, three positions from either ADAA or MHA will be transferred to the Laboratories Administration. That budget has increased personnel funding for fiscal 2014 budget but not additional positions. This funding is for the expansion of inspection activities. It is also not known at this point if the reorganization will involve additional positions beyond these three.

Exhibit 7

Proposed Organizational Structure for a Combined Alcohol and Drug Abuse and Mental Hygiene Administration



Source: Department of Health and Mental Hygiene

Administration

Two major administrative increases are in the Prescription Drug Monitoring Program ($512,000) and funding for the State of Maryland Automated Record Tracking (SMART), $181,000.

The Prescription Drug Monitoring Program (PDMP) was established under Chapter 166 of 2011. The intent of the program is to create an electronic database of controlled dangerous substance (CDS) prescription information and provide healthcare providers with real-time access to this information in order to improve patient care. The data can also be used for appropriate investigations into CDS diversion, healthcare fraud, and improper professional practice. Funding for the program in fiscal 2012 and 2013 was exclusively through federal grants

In July 2012, the department submitted a report to the General Assembly that included a number of recommendations for program design and implementation, regulations, and legislation. Focusing on program design and implementation and funding, the recommendations included:

- integration of the PDMP within the statewide Health Information Exchange (HIE) to the greatest extent possible;
- development of a system that allows for real-time data collection for dispensers of CDS;
- ensure accuracy of dispenser reports and the ability to identify unique patients in any database;
- require disclosure requests from law enforcement, licensing boards, other units of the department, patients, and researchers to be individually processed; and
- work to remove legal barriers to interoperability with PDMPs operating in other states.

In terms of funding, the report noted that the decision to develop an electronic database through a contract with the Chesapeake Regional Information System for our Patients to implement the database within the HIE made it difficult to estimate the total cost needed for implementation. The report also noted that this decision might result in higher costs up-front compared to developing a stand-alone database but could result in cost savings (as well as programmatic benefits) in the long-term. In any event, the estimate of procuring a data collection vendor and adapting the HIE infrastructure would be between $1 million and $2 million. While there is some federal grant funding available to offset these costs, additional general fund support is required.

As noted above, the fiscal 2014 budget includes an additional $512,000 in general fund support for PDMP information technology (IT) development (along with $300,000 in federal funds) to begin this integrated database development.

SMART is the major IT support system for ADAA hosted by the Institute for Government Service and Research at the University of Maryland, College Park. Funding supports secure hosting, training, end-user and systems support, and general maintenance and support. Funding will also be used to develop new modules and enhancements for recovery support services, gambling treatment, and HIV services as well as interfacing with other systems. The increase in funding for SMART – $181,000 – represents the consolidation of various contracts into one specific program.

Problem Gambling Fund

There is a $149,000 decline in the funding available for problem gambling activities based on anticipated revenues into the Problem Gambling Fund. The fund supports the newly created Center of Excellence on Problem Gambling at the University of Maryland, School of Medicine as well as funding for local treatment grants. The center is charged with a variety of tasks including:

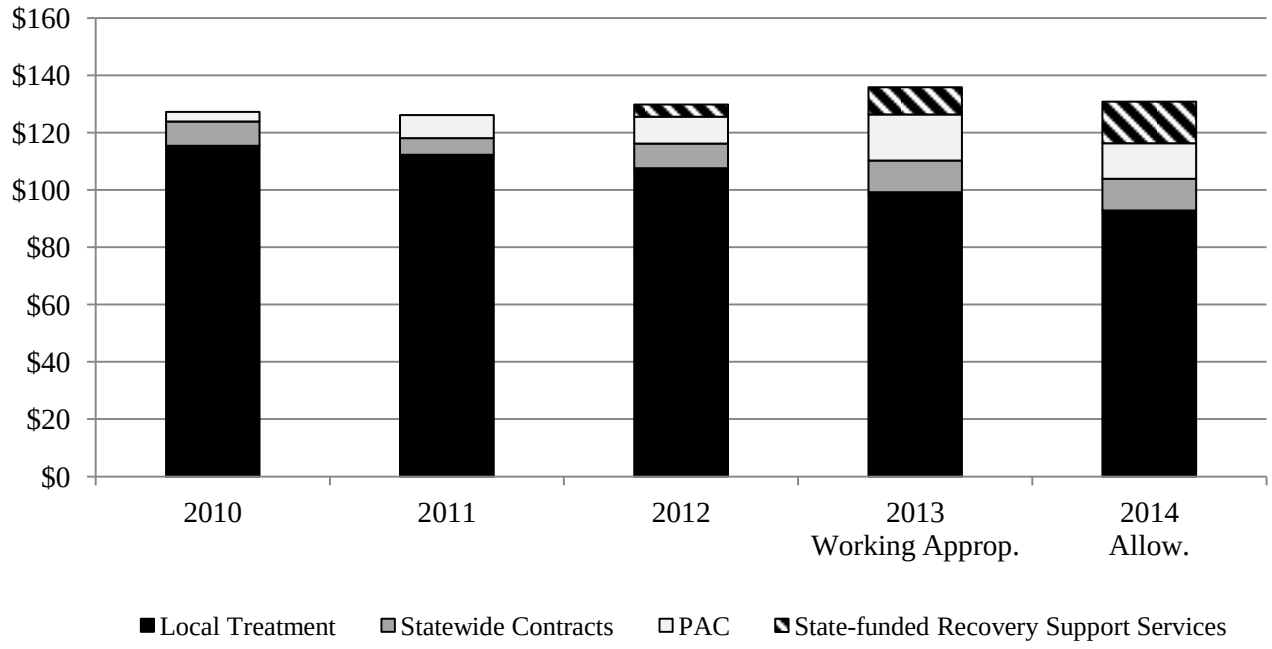
- contracting with the National Council on Problem Gambling to provide 24/7 toll-free hotline and referral services;
- developing referral policies and procedures for referral and placement of hotline callers to appropriate providers;
- publicizing and providing training and education; and
- developing awareness of problem gambling and publicizing the availability of treatment resources.

The center is responsible for developing the funding allocations for treatment funding, anticipated at $360,000 in fiscal 2013 and just under $1.2 million in fiscal 2014.

Treatment

The fiscal 2014 budget earmarks an additional $5.1 million for recovery support services, bringing total support for these services to over $14.0 million. As shown in **Exhibit 8**, the growth in recovery support service funding has been dramatic. Recovery support services include increased involvement of peers as recovery coaches; the availability of services beyond treatment to include recovery housing, recovery community centers, and supported employment programs; emphasis on outreach and engagement strategies (for example, transportation and child care services) to encourage early intervention and retention in care; and focus on continuing care recovery monitoring, more assertive linkage of patients to services, and where necessary, lowering the threshold for re-engagement with treatment services.

Exhibit 8
ADAA-funded Treatment
Fiscal 2010-2014
($ in Millions)



ADAA: Alcohol and Drug Abuse Administration
PAC: Primary Adult Care

Note: Excludes funding from the Problem Gambling Fund.

Source: Alcohol and Drug Abuse Administration

ADAA is developing a client outcome measure to collect data every six months for individuals engaged in recovery support services. The initial data collection is focused on patients receiving care coordination with a plan to expand use to other recovery support services. Success is measured by looking at those leaving residential treatment who access recovery support services compared to those who do not. It is anticipated that better outcomes will be seen in terms of connections to another level of care, employment, living situation, and subsequent utilization of more intensive services.

Given the focus on recovery support services, DLS recommends narrative requesting ADAA to report on the methodology it intends to use to measure success, the time-line for developing outcomes, and preliminary results from the services developed under the federal Access to Recovery grants and State funding.

As also illustrated in Exhibit 8, funding for traditional local treatment grants has declined significantly in recent years. This decline is due not only to this changing focus of treatment funding to recovery support services but also:

- the transfer of funds from ADAA to Medicaid to support substance abuse services through the Primary Adult Care (PAC) program; and

- A fiscal 2013 increase in funding for statewide treatment contracts, specifically increasing residential service slots from 46 to 62 for pregnant women/women with children thereby eliminating what had been a lengthy waiting list.

As noted in Exhibit 6, local treatment grants fall by almost $6.4 million between fiscal 2013 and 2014. This drop is due primarily to the increase in funding for recovery support services. In addition, there is a drop, over $4.9 million, in the availability of federal Substance Abuse Prevention and Treatment Block Grant funding. The drop in block grant funding is due to a combination of:

- a lower anticipated fund balance to begin fiscal 2014. Specifically, fiscal 2013's opening fund balance was artificially high due to an accounting action taken at the end of fiscal 2012 (see Update 2 for additional detail);

- a slightly lower expectation of attainment; and

- the transfer of a higher amount of attained funds to other programs, specifically an increase to almost $1.6 million for substance-abuse related HIV prevention programs in the Prevention and Health Promotion Administration. A certain amount of block grant funds are intended to support this activity and the transfer is intended to improve the delivery of HIV prevention activities by consolidating the funding.

Funding required to support the PAC program actually falls by just over $3.7 million, reflecting the anticipated ending of that program on January 1, 2014, because of expansion of the Medicaid program provided for under the Affordable Care Act. However, savings from the PAC program transfer do not offset the loss of federal funds for treatment and the expansion of recovery support services.

The Administration argues that a drop in treatment funding will be offset by a drop in demand for local treatment services by individuals who are currently uninsured as more individuals are able to access health insurance through the Maryland Health Benefit Exchange (MHBE) and the expansion of Medicaid up to 138% federal poverty level. Specifically:

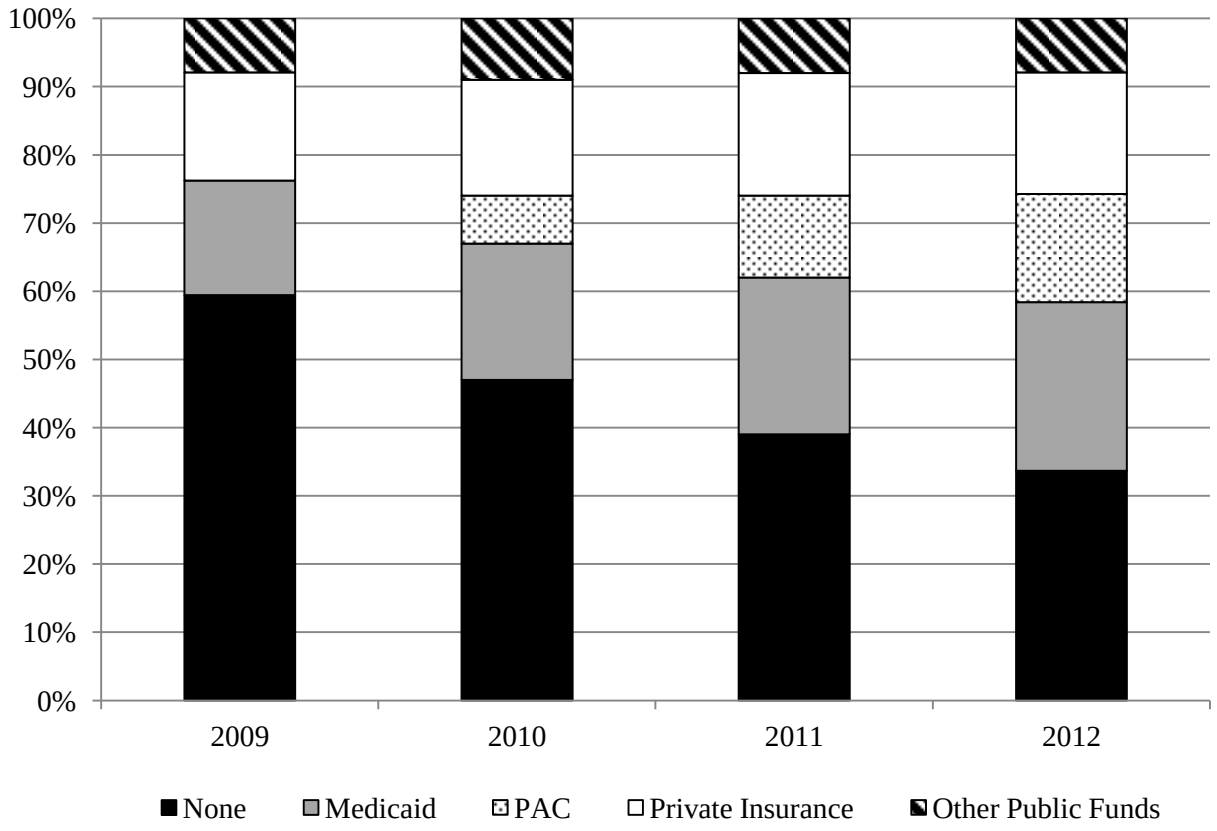
- individuals that become Medicaid-eligible will have Medicaid-eligible substance abuse services (although this does not include the full spectrum of substance abuse services) covered through Medicaid thereby freeing up some dollars for other individuals/non-Medicaid-eligible services;

- individuals covered through PAC will receive the full range of substance abuse services allowed under Medicaid; and

- individuals accessing insurance through MHBE may also no longer need public support.

It is unclear the extent to which Medicaid expansion and MHBE enrollment will reduce demand for State-funded admissions. As shown in **Exhibit 9,** which details the health insurance status for those admitted to ADAA-funded treatment programs, the expansion of substance abuse services to the PAC program, in combination with the recent growth in Medicaid enrollment because of the economic downturn, has already significantly reduced the number of uninsured admissions in State-supported treatment.

Exhibit 9
State-funded Treatment Program Admissions – Health Insurance Status
Fiscal 2009-2012

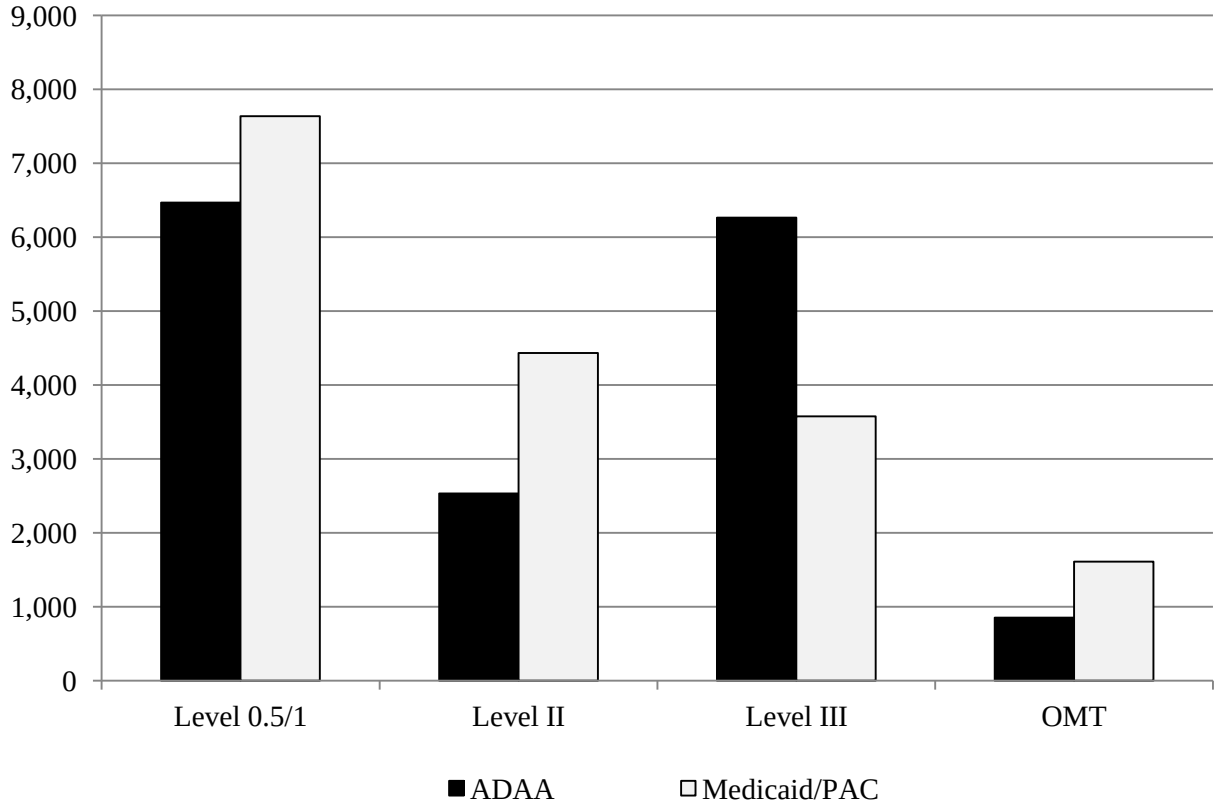


PAC: Primary Adult Care

Source: Alcohol and Drug Abuse Administration

ADAA did provide additional data for fiscal 2012 on health coverage and payment. **Exhibit 10** illustrates the primary source of payment by individual reported at discharge. This data also gives a sense of where potential savings could come from under expanded Medicaid coverage and MHBE enrollment although because the data lists payment source by the level of care at discharge, that source could reflect multiple levels of care in a treatment episode. As shown in the exhibit, ADAA funding will likely continue to dominate funding for Level III (residential) services, while savings may be possible in other levels of care. However, again it is impossible to know the extent to which savings will be generated.

Exhibit 10
Primary Source of Payment by Individual Reported at Discharge by ASAM Level of Care
Fiscal 2012



ADAA: Alcohol and Drug Abuse Administration
ASAM: American Society of Addiction Medicine
OMT: opioid maintenance therapy
PAC: Primary Adult Care

Note: Multiple levels of care may have been involved in the episode.

Source: Department of Legislative Services; Alcohol and Drug Abuse Administration

In addition to the uncertainty about the extent of savings, there is also the issue of how the reduction in treatment funds will be allocated and also how localities will in turn allocate funds between different modes of treatment. The latter issue is important because many recipients of local treatment funding (local health departments) are also providers. That may influence the decisions made at the local level about the allocation of funding even though, as noted above, local grant funding is more likely to be needed for residential treatment than for other modes of treatment. DLS recommends adding budget bill language requesting information on both the allocation of fiscal 2014 treatment funds by jurisdiction and how those funds will be used at the local level.

Finally, it should be noted that there is no provider rate adjustment assumed for substance abuse treatment providers. These providers were not included in Chapters 497 and 498 of 2010 which covers other community providers in the mental health and developmental disabilities fields, and no accommodation is made for an increase.

Federal Substance Abuse Prevention and Treatment Block Grant Maintenance of Effort Requirements

The federal substance abuse block grant includes a maintenance of effort (MOE) requirement. Specifically, the principal receiving agency must maintain an aggregate level of State expenditures on authorized activities at least equal to the average level of expenditures in the prior two years. A waiver can be obtained on a fiscal year by fiscal year basis based on certain extraordinary economic conditions. For each of the past two years Maryland has sought, and been given, a waiver. The waiver was requested because of the drop in general fund support for substance abuse treatment activities that qualify as a match. The administration indicates it will be seeking another waiver for the fiscal 2012 block grant award. Absent receiving a waiver, the federal government has the option of cutting the block grant by the equivalent amount that the State falls short of the MOE requirement.

Issues

1. Integration of Behavioral Health Care: Choosing a Model for a Service Delivery and Financing System

Background: Why Integrate Care?

It has long been understood that there is a high prevalence of co-occurring substance abuse and mental health conditions. Lifetime prevalence of co-occurring disorders among individuals seeking substance abuse treatment has been estimated from 25.0 to over 50.0%. National surveys reveal 51.4% of those surveyed with a lifetime substance abuse disorder also reported a lifetime mental health disorder, and 50.9% of those with a mental health disorder reported having a substance abuse disorder.

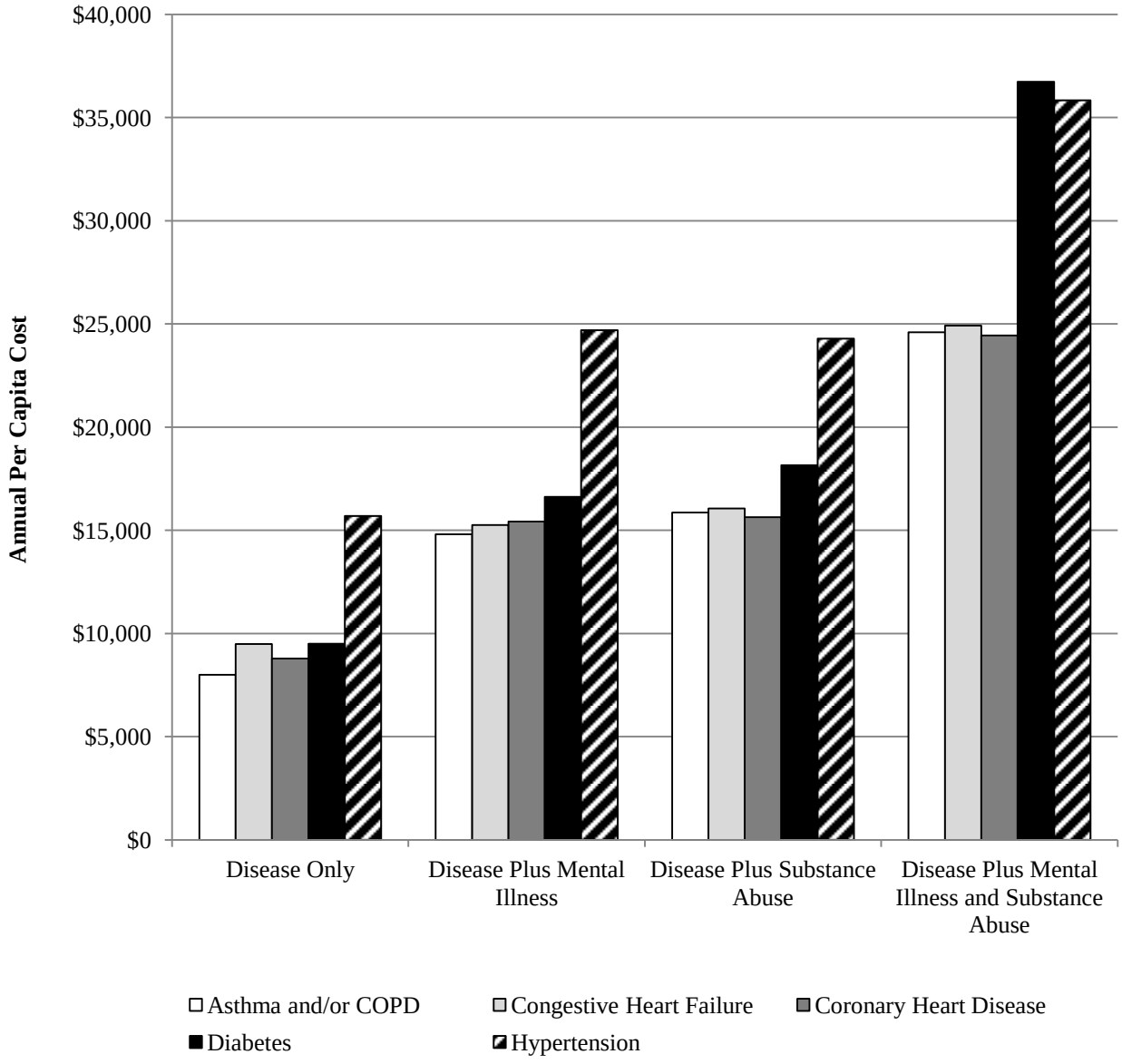
In addition, the impact on the cost of treatment of individuals with co-morbid somatic and behavioral health issues is striking. A shown in **Exhibit 11,** the cost of treatment for individuals with a chronic somatic problem roughly doubles if that problem is combined with either mental illness or substance abuse problems, and increases three- to four-fold when combined with both mental illness and substance abuse problems.

Concerns with the Current System

All too often, not only are behavioral health services delivered in separate systems, those systems are poorly integrated with other medical care. A consultant report released in 2011 observed the Maryland system's fragmentation of the behavioral health service system between mental health and substance abuse disorders and the lack of connection (and coordination of benefits) with general medical services; fragmentation of purchasing and financing with multiple, disparate public funding sources, purchasers, and payers; uncoordinated care management including multiple service authorization entities; and a lack of performance risk with payment for volume not outcomes.

Exhibit 12 attempts to illustrate the complexity of the current payment and service system by detailing how funding for behavioral health services can be provided. This exhibit focuses on the system as it applies to the Medicaid HealthChoice population. Enrollees in the Medicaid fee-for-service system would look similar in terms of interactions but with slightly different funding streams. The complexity can be attributed to different agency responsibilities, different types of funding streams (*e.g.*, grants, contracts, fee-for-service, and capitation which encourage different provider behaviors), different choices of service delivery (carved-in versus carved-out), the treatment of the under/uninsured, and the various types of services that are offered within a program (**Exhibit 13**, for example, details what is and what is not covered under Medicaid and PAC).

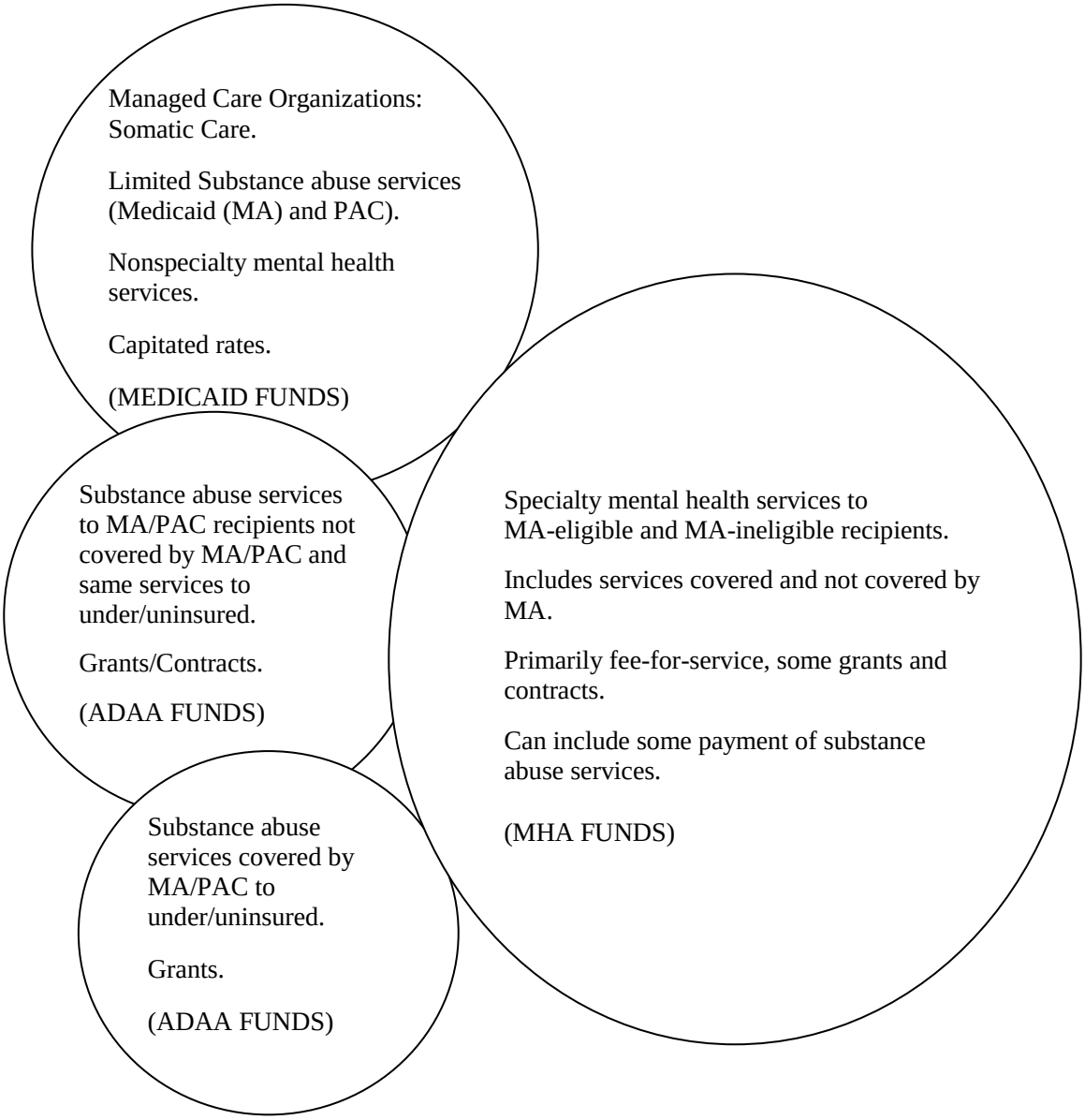
Exhibit 11
Impact of Behavioral Health Comorbidities on Per Capita Costs Among Medicaid-only Beneficiaries with Disabilities



COPD: chronic obstructive pulmonary disease

Source: Center for Health Care Strategies, *Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services for Medicaid Populations*

Exhibit 12
Maryland's Behavioral Health Service System



ADAA: Alcohol and Drug Abuse Administration
MHA: Mental Hygiene Administration
PAC: Primary Adult Care

Note: For illustrative purposes, this exhibit attempts to illustrate the connection for the HealthChoice program. Other Medicaid recipients receive services through fee-for-service Medicaid which would have similar connections but a different payment structure for Medicaid-reimbursed services.

Source: Department of Legislative Services

Exhibit 13
Coverage of Substance Abuse Services Under Maryland Medicaid

Service	Medicaid Coverage	PAC Coverage
Ambulatory detox	Yes	No
Outpatient	Yes	Yes, in community-based setting only, not rate-regulated settings
Intensive outpatient	Yes	Yes
Partial hospitalization	Yes, in hospital and facility settings only	No
Inpatient detox	Yes	No
Methadone maintenance	Yes	Yes, in community-based setting only, not rate-regulated settings
Residential treatment	Partial: children only (federal rules)	No
Buprenorphine (medication)	Yes	Yes

PAC: Primary Adult Care

Source: Department of Health and Mental Hygiene; Department of Legislative Services

The consultant's report made recommendations as to the system choices available to Maryland to improve the current service delivery and financing system. While acknowledging the flaws of the current system, the department concluded that at that time it was not prepared to choose one option over another.

Model Options

In the 2012 interim, the department established a process to deliberate on the choice of a service delivery and financing model of behavioral health services. The focus of these discussions is on services to the HealthChoice population. As shown in **Exhibit 14**, four model options were discussed drawing on experience from other jurisdictions.

Exhibit 14
Behavioral Health Integration: Options for Change

Model	Description	Example
Protected carve-in	All substance abuse/specialty mental health services would be delivered through managed care organizations (MCO). Protections could be put in place for behavioral health services. Examples of the kinds of protections that could be adopted included the amount of money spent on behavioral health and the ability to subcontract.	Tennessee
Behavioral health carve-out with performance risk	All substance abuse/specialty mental health services would be carved out from MCOs and delivered fee-for-service through an Administrative Services Organization (ASO) (the current Mental Hygiene Administration model). The ASO contract would include incentives/penalties for meeting set performance targets. Examples of targets include satisfaction levels, readmission rates, and financial goals.	Connecticut
Behavioral health carve-out with insurance risk	All substance abuse/specialty mental health services would be carved out from MCOs and delivered on a capitated basis through a behavioral health ASO/Behavioral Health Organization (BHO). The ASO/BHO contract would include specific goals around integration of care with somatic providers as well as performance targets. Examples of such targets include satisfaction levels, readmission rates, and financial goals.	Michigan
Population carve-out	Somatic and behavioral health services carved out for certain individuals (individuals with serious mental illness and or substance abuse problems) with delivery through a behavioral health MCO or health home model. Capitated payments with full insurance risk.	Maricopa County, Arizona (Phoenix)

Note: During the interim as the department held meetings on these various models, the ASO carve-out performance risk and insurance risk models were noted as two options of the same model. For the purposes of this discussion, they are noted as separate options given some of the distinct advantages and disadvantages of each option.

Source: Department of Legislative Services; Department of Health and Mental Hygiene

Models: Benefits and Challenges

Discussions during the 2012 interim centered on which model to pursue. Each of the models was presented as a broad blue print that could be followed, and the department outlined various Maryland-specific options that could be tailored for each model although none of those specific options were ever decided upon. With that limitation in mind, **Exhibit 15** summarizes the broad benefits and challenges that were voiced about each option.

Choosing a Model

Clearly all options have their strengths and weaknesses. Opinions have been divided as to the best financing model, often although not always only along system lines (*i.e.*, mental health, substance abuse, managed care organization (MCO)). The steering group leading the process initially recommended a risk-based carve out but subsequently chose the performance-based carve-out model. At the time of writing, the Secretary of the Department of Health and Mental Hygiene (DHMH) had yet to finalize the option to be pursued.

The research literature suggests that the key elements for integrated models of care can be introduced into any financing system, although some aspects may be easier to achieve in one model over another. These elements include:

- aligned financial incentives (rewarding quality and good outcomes and doing that across provider types);
- information exchange (including adequate and meaningful data collection);
- multidisciplinary care coordination teams; and
- competent provider networks.

How these elements are developed within the chosen model will form the next steps of this process. Other important questions that need to be addressed include:

- To what extent would current law governing provider rate adjustments need to be revisited? The current law does not treat substance abuse and mental health providers equally, neither does is comport with a system based on quality and performance.
- How will services to the uninsured be provided and funded?
- How will Medicaid-ineligible services (in both substance abuse and mental health) to Medicaid-eligible recipients be provided and funded? Regardless of system choice should these services and funding be better integrated?

Exhibit 15
Behavioral Health Integration Models: Benefits and Challenges

Model	Benefits	Challenges
Protected carve-in	• Organizationally most simple model for integrated somatic/behavioral health care • Clear alignment of financial incentives for overall patient health within one entity could facilitate appropriate investments and provider rewards • Consumer continuity • Avoids system struggles over payment responsibility based on diagnosis • Avoids need for diagnosis definition between systems • Increased budget certainty • Integration of behavioral health into a more rigorous rate-setting process • Allows for more benefit flexibility	• How to preserve access • Requires mental health providers to adapt to multiple managed care organization (MCO) clinical procedures and management practices • For the mental health system a need to possibly develop an alternative system for the uninsured and for state-funded only services • MCOs in Maryland do not have experience with specialty mental health care. If the MCOs were allowed to simply subcontract behavioral health services to another entity, some of the advantages of integration are undermined • Lack of transparency and consistency of data collection
Behavioral health carve-out with performance risk	• Reduces administrative burdens for providers, especially substance abuse providers that currently deal with multiple MCOs • Limiting model to a single ASO/BHO could avoid issues of access depending on authority of ASO/BHO to develop a network • Allows a more singular focus on the delivery of behavioral health services • Singular focus could facilitate better data collection • Easier to maintain existing funding systems for non-Medicaid eligible services and services to the uninsured • Coordination between a single BHO/ASO entity and providers in the Exchange and commercial insurers generally eases concerns about churn between coverage for this population	• Financial incentives split across systems requires more complex gain-sharing arrangements • Integration of care is potentially more cumbersome • Potentially more difficult early identification and prevention as early manifestation may be under a somatic MCO • Retains payment boundaries that can result in conflict over financial responsibility • Payment structure remains closest to one that rewards volume over quality • Performance data in the behavioral health system is far from consistent and applicable to all services • Inflexible payment rates and methods • Contracting with a single entity (rather than multiple MCOs) increases the risk at transition and diminishes choice and flexibility from a system perspective
Behavioral health carve-out with insurance risk	• Reduces administrative burdens for providers, especially substance abuse providers that currently deal with multiple MCOs	• Financial incentives split across systems requires more complex gain-sharing arrangements

Model	Benefits	Challenges
	• Limiting model to a single ASO/BHO could avoid issues of access depending on authority of ASO/BHO to develop a network • Allows a more singular focus on the delivery of behavioral health services • Singular focus could facilitate better data collection • Easier to maintain existing funding systems for non-Medicaid eligible services and services to the uninsured • Budget certainty • Potential for a more rigorous rate-setting process • Coordination between a single BHO/ASO entity and providers in the Exchange and commercial insurers generally eases concerns about churn between coverage for this population • Allows for more benefit flexibility • Potential for more flexible and responsive provider rate-setting to reward performance	• Integration of care is potentially more cumbersome • Potentially more difficult early identification and prevention as early manifestation may be under a somatic MCO • Retains payment boundaries that can result in conflict over financial responsibility • Contracting with a single entity (rather than multiple MCOs) increases the risk at transition and diminishes choice and flexibility from a system perspective
Population carve-out	• Shares many of the advantages of a protected carve-in • Benefits of integrated care should be enhanced for those within the model • Performance targets can be better tailored because of the narrower focus of population served • A more tailored system can more easily take up innovative treatment practices • Focus on more seriously ill population has the potential to yield the most savings, savings that can be easily identified and reinvested into the remaining system	• Shares many of the disadvantages of a protected carve-in • No real experience of this kind of model • Does little to promote early identification and prevention since a serious mental illness and/or substance abuse is the basis for participation • Risk of adverse selection • Stigma • Potential disincentives to patient recovery in order to retain payment base • Churn between systems

ASO/BHO: Administrative Services Organization/Behavioral Health Organization

Note: During the interim as the department held meetings on these various models, the ASO carve-out performance risk and insurance risk models were noted as two options of the same model. For the purposes of this discussion, they are noted as separate options given the distinct advantages and disadvantages of each option.

Source: Department of Legislative Services; Department of Health and Mental Hygiene

- What will be the role of local planning agencies in a new system, to what extent should they be provided with administrative funding by the State, and should local governments continue to directly provide services?

- How will programs that already exist outside of the current structure, such as the Baltimore capitation program, be treated?

- How will the existing carve-outs for a variety of substance abuse treatment options (drug courts, drug affected babies, Substance Abuse Treatment Outcomes Partnership Fund, grants, and so forth) be treated and is there a rationale for continuing the multiplicity of substance abuse treatment funding streams?

- How much performance risk should be built into contracts?

- How will robust and consistent outcome measures be developed?

Concomitant with the discussion over the service delivery and financing model, the department has, as noted above, also been deliberating on administrative integration, workforce issues, and regulatory integration. In terms of workforce, there is a recommendation that with certain exceptions (certain licensed professionals in solo or group practice and services that do not have accreditation standards such as driving while intoxicated education), treatment programs currently covered by mental health regulations and substance abuse regulations apply for and become accredited by a State-approved accrediting organization by July 1, 2015. Agencies will be required to be licensed by the State to operate as a behavioral health provider and accreditation will be part of that application process.

Accreditation is designed to strengthen the behavioral system by ensuring current practices are adopted by providers; eliminating the current system with dual sets of regulations; and changing the emphasis of the current oversight system from simply compliance to strengthening poorly performing programs. Accreditation is not without challenges, including understanding the different emphasis of accreditation versus compliance with regulatory standards; the need for resources to assist providers in preparing for accreditation; and dealing with the transition from regulatory compliance to accreditation.

At the time of writing, no final decision has been made on the workforce recommendation or the accompanying recommendation to integrate regulations so that providers only have to adhere to one set of regulatory standards.

Conclusion

Absent a decision not to move forward with any form of system integration (either in terms of service delivery and financing, workforce accreditation, integrated regulatory framework, or State administrative structure), continued movement reshaping the current delivery of behavioral health services can be anticipated for perhaps the next several years. DLS would anticipate that it would

take a minimum of 12 months to develop a framework to move forward with any system change, such as a Request for Proposals for an Administrative Services Organization/Behavioral Health Organization contract, with a lengthy review period after that. **DLS recommends that if the Secretary makes a decision to move ahead with integration, budget bill language be added so that the legislature can review the final proposal.**

Recommended Actions

1. Add the following language:

   Provided that $100,000 of the general fund appropriation of the Office of the Secretary made for the purpose of administration may not be expended until the Department of Health and Mental Hygiene (DHMH) submits a report to the budget committees detailing the Secretary of DHMH's final recommendation on a model for a behavioral health integrated service delivery and financing system.

   If the Secretary chooses to move forward with the implementation of a new model, the report shall:

   (1) detail how the new model will align financial incentives, promote information exchange, establish multidisciplinary care coordination teams, and competent provider networks;

   (2) outline how services to the uninsured and Medicaid-ineligible services to Medicaid recipients will be provided;

   (3) discuss the role of existing local planning agencies and State administrative support for those agencies;

   (4) outline how other existing programs that operate outside of the current Medicaid, mental health fee-for-service, and substance abuse grant programs will operate;

   (5) evaluate the outcome measures currently in place in the Medicaid, mental health, and substance abuse systems and detail how those measures need to be improved or expanded upon;

   (6) evaluate current rate-setting methodologies and determine what changes to those methodologies should be made;

   (7) discuss whether or to what extent the current array of statutorily created substance abuse treatment programs should be consolidated into a single block grant; and

   (8) add any other information the department wishes to include.

   Further provided that the department, simultaneous with the issuance of any request for proposals (RFP) to implement a new behavioral health service delivery and financing system shall submit the RFP to the budget committees.

The requested report shall be submitted on the earlier of December 1, 2013, or the issuance of an RFP to implement a new behavioral health service delivery and financing system. The committees shall have 45 days to review and comment only on the report. Funding withheld pending the receipt of the report may not be expended or transferred to any other purpose and shall revert to the General Fund if the report is not submitted.

Explanation: In the 2011 and 2012 interims, DHMH has been engaged in a process to develop a new behavioral health service delivery and financing system. A steering committee has recommended a system model, but no final decision has been made on implementation. The language requests DHMH to submit a report to the budget committees on implementation details for any model that is chosen including any RFP.

Information Request	**Author**	**Due Date**
Behavioral health integration	DHMH	December 1, 2013, or with the issuance of an RFP for the implementation of a new behavioral health service delivery and financing system if earlier

2. Add the following language to the general fund appropriation:

, provided that $100,000 of this appropriation made for the purpose of administration may not be expended until the Alcohol and Drug Abuse Administration (ADAA) submits a report to the budget committees detailing:

(1) final fiscal 2013 local treatment expenditures by the American Society of Addiction Medicine (ASAM) level of care;

(2) initial fiscal 2014 local treatment grant allocations by jurisdiction by ASAM level of care;

(3) any guidance provided by ADAA to local jurisdictions in determining how fiscal 2014 funding awards are to be allocated by ASAM level of care; and

(4) fiscal 2014 support for statewide treatment contracts.

The report shall be submitted to the budget committees by October 15, 2013. The committees shall have 45 days to review and comment upon receipt. Funding withheld pending the receipt of the report may not be expended or transferred to any other purpose and shall revert to the General Fund if the report is not submitted.

Explanation: The language requires ADAA to submit a report detailing the award of fiscal 2014 local treatment grants. Funding for these grants is significantly reduced in the fiscal 2014 budget.

Information Request	Author	Due Date
Local treatment grants	ADAA	October 15, 2013

3. Adopt the following narrative:

Substance Abuse Prevention: The committees request the Alcohol and Drug Abuse Administration (ADAA), consistent with its stated mission, to include in its annual Managing for Results (MFR) submission a key goal, objectives, and performance measures on substance abuse prevention.

Information Request	Author	Due Date
Substance abuse prevention	ADAA	With annual MFR submission

4. Adopt the following narrative:

Recovery Support Services: State funding for recovery support services (such as peer support, housing, supported employment, community centers, and outreach and engagement activities) has grown from zero in fiscal 2011 to over $14 million in fiscal 2014. The Alcohol and Drug Abuse Administration (ADAA) is currently developing outcome measures and a data collection methodology for these services. Given the rapid growth in funding for these services, the committees request that ADAA submit a report by November 15, 2013, that includes what outcome measures it intends to collect, a detailed data collection methodology, and a timeframe for implementation. To the extent that ADAA has any baseline data from either State-funded programs or the federally funded grant recovery supports program, it should be included in the report. The report should also include details of any evaluations done of the State or federally supported programs in Maryland or a plan to undertake such an evaluation and an appropriate key goal, objectives and performance measures to be included in ADAA's annual Managing for Results submission beginning in fiscal 2015.

Information Request	Author	Due Date
Recovery support services	ADAA	November 15, 2013

Updates

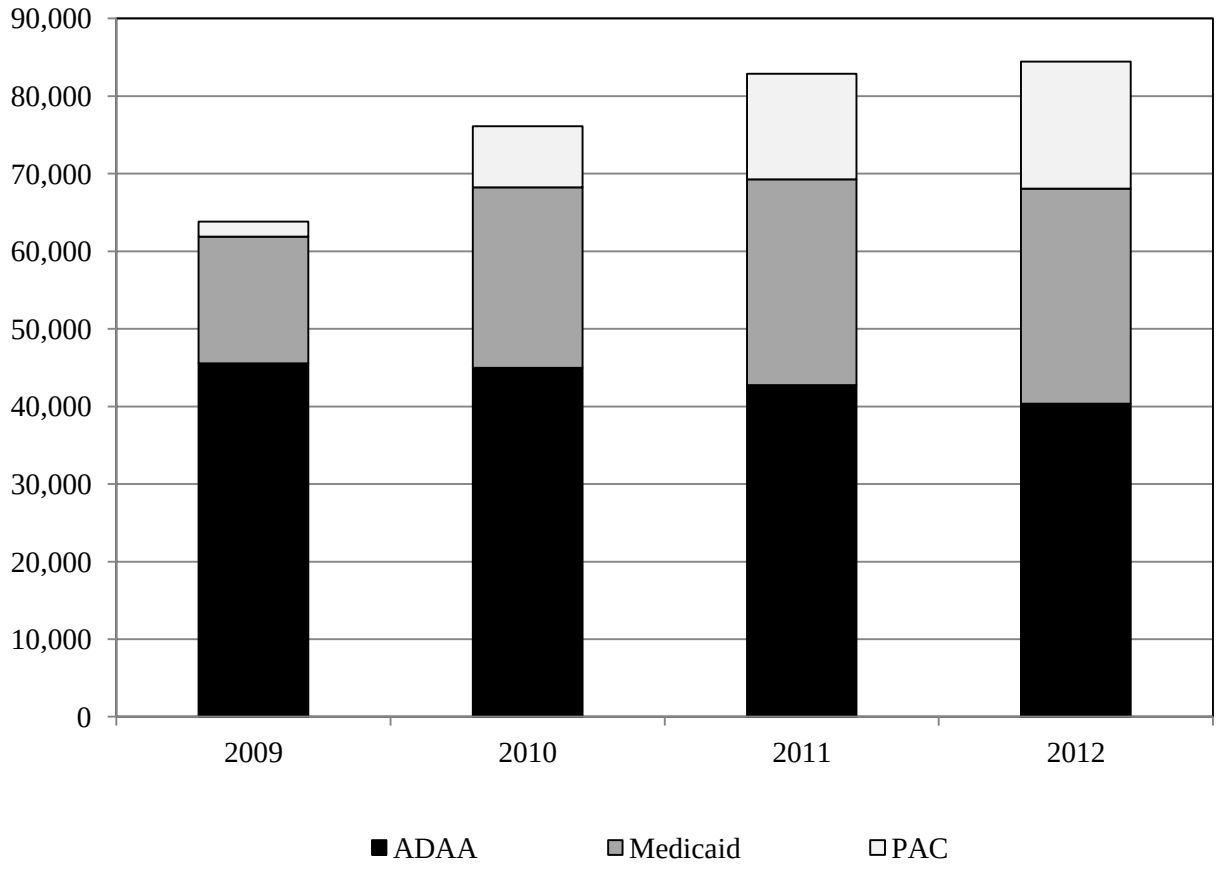
1. Expansion of Substance Abuse Services in the Primary Adult Care Program and the Impact on Substance Abuse Grant Funding

Chapter 332 of 2009 expanded the benefit package of the PAC program to include outpatient substance abuse treatment. Concurrent with other changes (increased service reimbursement rates to Medicaid providers and improving the ability of enrollees to self-refer for services), this represented a major expansion of substance abuse treatment in the State. Funding to support this expansion of services was derived from the existing State-funded only substance abuse treatment grant program in ADAA, matched with federal Medicaid dollars.

In the 2011 interim, the department released a report assessing the impact of the expansion of substance abuse treatment services to PAC. That report was discussed in the fiscal 2013 budget analysis for ADAA. The department released a subsequent update in June 2012. The report continues to reflect continued overall utilization of substance abuse services. As shown in **Exhibit 16**, the number of unique users of outpatient substance abuse services has grown by almost one-third between fiscal 2009 and 2012. While the loss of treatment funding in ADAA's budget to fund the PAC expansion resulted in a lower number of users through ADAA, that was more than offset by the growth in users through PAC.

As noted in the fiscal 2013 analysis, there remains a wide discrepancy in the take-up of services through the PAC program by jurisdiction. **Exhibit 17** updates data on the estimated number of PAC enrollees who are unique users of outpatient substance abuse services. The data for Prince George's County remains remarkably low (6%) compared to 42% in Anne Arundel County and 26% statewide. It should be remembered that all jurisdictions received technical assistance regarding billing, collections, and changes needed for businesses to sustain a fee-for-service business. Prince George's County was among four jurisdictions that received additional targeted technical assistance. Clearly more needs to be done in that jurisdiction.

Exhibit 16
Unique Users of Outpatient Substance Abuse Services
Fiscal 2009-2012

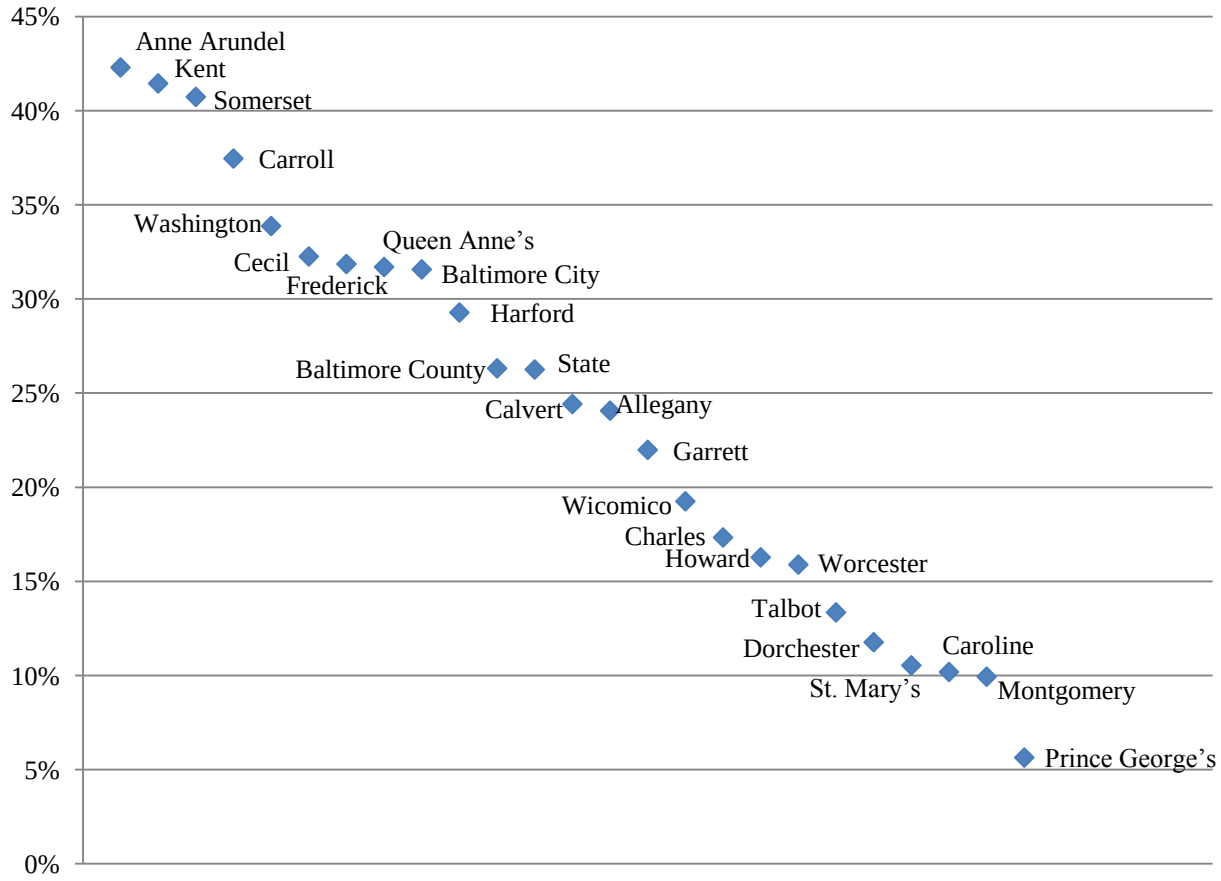


ADAA: Alcohol and Drug Abuse Administration
PAC: Primary Adult Care

Note: Fiscal 2009-2011 data are actuals; fiscal 2012 data was as estimated in June 2012.

Source: Department of Health and Mental Hygiene; Department of Legislative Services

Exhibit 17
Estimated Unique Users of Outpatient Substance Abuse Services Delivered Through the PAC Program as a Percentage of Total PAC Enrollment
Fiscal 2012



PAC: Primary Adult Care

Source: Department of Health and Mental Hygiene; Department of Legislative Services

The data presented in the updated report continues to support the policy decision to expand substance abuse services to the PAC enrollees even at the expense of funding previously allocated to substance abuse treatment through the ADAA grant program. Arguably this trade-off is maximizing the use of State funding (through collecting a federal match on dollars spent through the PAC program), improving access to substance abuse services, and increasing the total funding available to the substance abuse treatment system and providers.

However, it is also true that increased access for PAC recipients has resulted in less access through the ADAA grant funding. Further, it is apparent that some jurisdictions have been more adept at accessing these new funding opportunities than others. Concerns also linger about the number of encounters for substance abuse services via the MCOs either in HealthChoice or PAC for which no payment is subsequently made to the provider. In fiscal 2009, this amounted to 12.4% of encounters, 38,982, a number revised down from the original report. However, the department was reporting a 6.8% denial rate (although a higher number of claims 55,806) in fiscal 2011. The extent of denials continues to vary from MCO to MCO.

2. Fiscal 2012 Closeout Actions in ADAA

During the fiscal 2011 closeout audit, it was discovered that ADAA had underspent its local treatment grant funding by $3.9 million. The audit also revealed that the agency had taken certain accounting actions that resulted in the funding not reverting or being moved to another agency within DHMH that had deficiencies in fiscal 2011. While these actions preserved the funding for future years, they also contravened budget law.

Underspending of ADAA's grant funds had been a regular occurrence in the mid-2000s. However, ADAA began to resolve this problem by instituting more routine review of grant spending by local jurisdictions. It also put in place a policy of shifting funds from jurisdictions that were underspending during a fiscal year to other jurisdictions, normally to support one-time projects. ADAA never implemented a policy of actually reducing future allocations to jurisdictions based on prior year expenditures, but the enhanced scrutiny of treatment grant funding seemed to have worked in reducing significant underspending until fiscal 2011.

In fiscal 2012 closeout actions, ADAA transferred $711,000 in general funds to other parts of DHMH due to underspending of treatment grants. This represented approximately 0.7% of total local treatment grant funding, a significant improvement compared to fiscal 2011. ADAA reported that ultimately it needed to roll $323,000 in bills from fiscal 2012 into fiscal 2013 because the transfer effectively took more funding than ultimately proved available, making the actual underspending even less.

ADAA also reported that there was some re-allocation of funding during the fiscal year based on spending trends during the year. The largest re-allocation came from Baltimore City, $1.2 million due to issues with sub-vendors used by the city's substance abuse agency Baltimore Substance Abuse Systems, Inc. Funding was re-allocated to prevention activities, SMART, and one-time recovery support service projects.

3. Non-opioid Pharmacotherapies for Alcohol Dependence: Update to January 2012 Report

Committee narrative in the 2011 *Joint Chairmen's Report* requested ADAA and the Department of Public Safety and Correctional Services (DPSCS) to report to the budget committees on the current utilization of non-opioid pharmacotherapies to treat alcohol dependence and identify State and local funding for such therapies, estimate cost-effectiveness, and discuss plans to expand the use of such therapies especially in the inmate population. The subsequent report focused on the use of naltrexone, a non-opioid pharmacotherapy first approved for the treatment of alcoholism in 1994 and a new extended-release version of naltrexone, Vivitrol, approved in 2006. The report noted that studies have found Vivitrol to have some benefit in reducing drinking days and heavy drinking days, benefits for individuals with opiate addiction, and be cost-effective. However, Vivitrol also has a number of significant side effects including hepatitis and adverse psychiatric reactions.

The report noted that Vivitrol was being used/contemplated for use by four jurisdictions for alcohol dependence supported through ADAA-funded treatment grants (Carroll, Montgomery, and Washington counties and Baltimore City). In Medicaid, MCOs were willing to authorize Vivitrol when other treatments have not proven effective, but there has been limited interest in adding Vivitrol to the preferred drug list. In DPSCS it was noted that it was also developing a pilot study to provide Vivitrol to pre-release inmates.

In January 2013, updates were provided on the use of Vivitrol by both DHMH and DPSCS.

- DHMH selected Baltimore Substance Abuse Systems (BSAS) to pilot a program to see if expanded coverage for Vivitrol should be recommended in the Medicaid and PAC program. BSAS contracted with Mosaic to assist in the design of the pilot program and the program started treating patients in June 2012. Although a comprehensive set of outcome data is being reported, a summary of the first six months of the program was not available at the time of writing.

- DPSCS reported that they had screened 195 individuals for participation in its pilot study. However, as reported in January 2013, of those individuals who agreed to participate in the pilot, only 13 individuals had been deemed eligible. DPSCS is currently seeking additional volunteers to bring participation in the study up to 30. All 13 individuals currently in the study have received their first Vivitrol injection. Of these, 10 have been released and are eligible for six months of continued Vivitrol treatment in the community. At this point, no outcome data (re-arrest rates within six months of release) is available. DLS would note that while the data will be interesting to review, the small sample size may make any conclusions of limited value.

Appendix 1

Current and Prior Year Budgets

Current and Prior Year Budgets
DHMH – Alcohol and Drug Abuse Administration
($ in Thousands)

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2012					
Legislative Appropriation	$82,967	$23,191	$38,430	$5,697	$150,285
Deficiency Appropriation	0	0	0	0	0
Budget Amendments	-608	1	13	80	-514
Reversions and Cancellations	0	-1,859	0	-114	-1,973
Actual Expenditures	**$82,359**	**$21,333**	**$38,442**	**$5,663**	**$147,798**
Fiscal 2013					
Legislative Appropriation	$87,709	$24,814	$39,734	$6,232	$158,488
Budget Amendments	-54	17	12	0	-25
Working Appropriation	**$87,654**	**$24,831**	**$39,746**	**$6,232**	**$158,463**

Note: Numbers may not sum to total due to rounding.

Fiscal 2012

The fiscal 2012 legislative appropriation for ADAA was reduced by almost $2.5 million. This decrease was derived as follows:

- Budget amendments reduced the appropriation by $514,000. Specifically:
    - General funds were reduced by $608,000 derived from $711,000 transferred out of ADAA to other agencies at the fiscal year close-out based on lower than anticipated spending on substance abuse treatment contracts; and increases of $76,000 to support higher than anticipated health insurance and communications expenditures, and $27,000 for the fiscal 2012 one-time $750 bonus.
    - Special funds in the amount of $1,000 were added to the appropriation to support the fiscal 2012 one-time $750 bonus.
    - Federal funds in the amount of $13,000 were added to the appropriation to support the fiscal 2012 one-time $750 bonus.
    - Reimbursable funds totaling $80,000 were also added to the budget to allow ADAA to implement a Prescription Drug Monitoring Program.
- The major source of the reduction to the legislative appropriation is cancellations totaling almost $2.0 million, the most significant of which was almost $1.9 million in special funds. Special fund cancellations included $1.25 million in Problem Gambling Funds based on a start-up delay in the expenditure of those funds through a newly created Center for Problem Gambling Excellence, and $453,000 in Prior Year Grant Activity funding.

Fiscal 2013

To date, the fiscal 2013 legislative appropriation for ADAA has been reduced by $25,000. An increase of $29,000 ($17,000 in special funds and $12,000 in federal funds) to support the fiscal 2013 COLA was more than offset by the transfer of $54,000 in general funds to the Medical Care Programs Administration for a new Behavioral Health Unit.

Appendix 2

Audit Findings

Audit Period for Last Audit:	March 6, 2009 – July 14, 2011
Issue Date:	June 2012
Number of Findings:	1
Number of Repeat Findings:	0
% of Repeat Findings:	n/a
Rating: (if applicable)	n/a

Finding 1: Adequate controls were not established over cash receipts. The department concurred with the finding and corresponding recommendations.

Appendix 3

Initial Fiscal 2013 ADAA-Funded Prevention and Treatment Grant Allocations

	Prevention	Treatment	Total
Allegany	$168,258	$4,877,507	$5,045,765
Anne Arundel	312,441	5,016,645	5,329,086
Baltimore County	442,286	5,852,450	6,294,736
Calvert	113,337	940,018	1,053,355
Caroline	107,840	604,466	712,306
Carroll	124,483	3,505,699	3,630,182
Cecil	103,899	1,351,313	1,455,212
Charles	163,902	2,236,972	2,400,874
Dorchester	143,481	1,815,842	1,959,323
Frederick	283,729	2,565,414	2,849,143
Garrett	277,138	771,988	1,049,126
Harford	136,951	1,724,482	1,861,433
Howard	117,169	1,720,945	1,838,114
Kent	133,175	3,278,618	3,411,793
Montgomery	398,793	4,958,688	5,357,481
Prince George's	522,624	10,884,602	11,407,226
Queen Anne's	118,392	729,154	847,546
St. Mary's	164,623	3,607,033	3,771,656
Somerset	124,965	1,156,474	1,281,439
Talbot	133,494	913,205	1,046,699
Washington	272,464	3,183,352	3,455,816
Wicomico	371,084	1,732,934	2,104,018
Worcester	137,887	3,169,689	3,307,576
Baltimore City	1,032,339	39,018,204	40,050,543
College ATOD Centers	556,156	0	556,156
Subtotal	***$6,460,910***	***$105,615,694***	***$112,076,604***
Statewide	$869,106	$30,297,724	31,166,830
Total	**$7,330,016**	**$135,913,418**	**$143,243,434**

ADAA: Alcohol and Drug Abuse Administration
ATOD: Alcohol, Tobacco, and Other Drugs

Object/Fund Difference Report
DHMH – Alcohol and Drug Abuse Administration

Object/Fund	FY 12 Actual	FY 13 Working Appropriation	FY 14 Allowance	FY 13 - FY 14 Amount Change	Percent Change
Positions					
01 Regular	68.50	65.50	65.50	0.00	0%
02 Contractual	6.64	6.77	7.08	0.31	4.6%
Total Positions	**75.14**	**72.27**	**72.58**	**0.31**	**0.4%**
Objects					
01 Salaries and Wages	$ 4,594,204	$ 4,954,199	$ 4,933,976	-$ 20,223	-0.4%
02 Technical and Spec. Fees	131,746	146,939	134,361	-12,578	-8.6%
03 Communication	32,979	34,439	26,478	-7,961	-23.1%
04 Travel	132,844	117,629	130,264	12,635	10.7%
07 Motor Vehicles	2,242	3,069	2,801	-268	-8.7%
08 Contractual Services	142,782,015	153,097,637	148,716,009	-4,381,628	-2.9%
09 Supplies and Materials	31,765	55,015	44,968	-10,047	-18.3%
10 Equipment – Replacement	15,555	0	0	0	0.0%
11 Equipment – Additional	3,984	0	0	0	0.0%
13 Fixed Charges	70,267	54,019	25,378	-28,641	-53.0%
Total Objects	**$ 147,797,601**	**$ 158,462,946**	**$ 154,014,235**	**-$ 4,448,711**	**-2.8%**
Funds					
01 General Fund	$ 82,359,164	$ 87,654,226	$ 88,090,840	$ 436,614	0.5%
03 Special Fund	21,332,637	24,830,674	24,529,713	-300,961	-1.2%
05 Federal Fund	38,442,400	39,745,774	35,377,633	-4,368,141	-11.0%
09 Reimbursable Fund	5,663,400	6,232,272	6,016,049	-216,223	-3.5%
Total Funds	**$ 147,797,601**	**$ 158,462,946**	**$ 154,014,235**	**-$ 4,448,711**	**-2.8%**

Note: The fiscal 2013 appropriation does not include deficiencies. The fiscal 2014 allowance does not include contingent reductions.