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

Operating Budget Data

($ in Thousands)

	FY 08 Actual	FY 09 Working	FY 10 Allowance	FY 09-10 Change	% Change Prior Year
General Fund	$86,791	$94,318	$95,890	$1,572	1.7%
Contingent & Back of Bill Reductions	0	0	-18	-18	
Adjusted General Fund	**$86,791**	**$94,318**	**$95,872**	**$1,554**	**1.6%**
Special Fund	17,535	17,952	17,918	-34	-0.2%
Adjusted Special Fund	**$17,535**	**$17,952**	**$17,918**	**-$34**	**-0.2%**
Federal Fund	32,160	32,313	31,943	-370	-1.1%
Contingent & Back of Bill Reductions	0	0	-5	-5	
Adjusted Federal Fund	**$32,160**	**$32,313**	**$31,937**	**-$376**	**-1.2%**
Reimbursable Fund	3,985	4,108	4,937	828	20.2%
Adjusted Reimbursable Fund	**$3,985**	**$4,108**	**$4,937**	**$828**	**20.2%**
Adjusted Grand Total	**$140,470**	**$148,691**	**$150,665**	**$1,973**	**1.3%**

- The fiscal 2010 budget for the Alcohol and Drug Abuse Administration (ADAA) includes just over $1.2 million in funding to support a 0.9% provider rate adjustment.

- After adjusting the fiscal 2009 working appropriation for additional drug court treatment funds, the fiscal 2010 budget for treatment aside from the rate adjustment falls slightly. Similarly, funding for statewide prevention activities is also lower in fiscal 2010 compared to fiscal 2009.

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

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Personnel Data

	FY 08 Actual	FY 09 Working	FY 10 Allowance	FY 09-10 Change
Regular Positions	62.00	60.00	60.00	0.00
Contractual FTEs	2.41	5.00	5.00	0.00
Total Personnel	**64.41**	**65.00**	**65.00**	**0.00**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	2.40	4.00%
Positions and Percentage Vacant as of 12/31/08	4.50	7.50%

- There is no change to ADAA's fiscal 2010 regular and contractual personnel complement. However, ADAA is adding support through a contract with the University of Maryland.

Analysis in Brief

Major Trends

Prevention: Exposure to prevention activities increased in fiscal 2008 compared to fiscal 2007. In national comparative data, Maryland's prevention outcomes show greater exposure than the national average to prevention messages among youths surveyed. However, first use of alcohol was reported at a slightly earlier age than the national average.

Treatment: Treatment outcomes remain positive. In national comparative data, Maryland's treatment outcomes are generally better than the national average.

Court-involved Processing: Clearance to admission times show improvement following the addition of funding in the fiscal 2009 budget for more residential beds.

Issues

The Delivery of Substance Abuse Treatment: ADAA is only one of many State agencies that fund substance abuse treatment. Within the Department of Health and Mental Hygiene, the opportunity exists to maximize federal fund attainment and add more money into the substance abuse treatment environment by expanding substance abuse treatment service to the Primary Adult Care Program. This expansion could be achieved in fiscal 2010 through existing State dollars used to fund treatment grant awards.

Utilization of Grant Dollars, Allocation Methodology, and the 2008 Needs Assessment: Following up from an issue raised in the fiscal 2009 budget analysis, ADAA has developed an action plan to minimize grant fund underutilization. That action plan also hints at potential changes to individual grant awards using utilization rather than the prior year award as the basis for funding. At this point, the recently completed needs assessment is not part of the allocation equation.

Recommended Actions

1. Add language transferring funds from the Alcohol and Drug Abuse Administration to the Medical Care Programs Administration to expand substance abuse treatment coverage to the Primary Adult Care Program and enhance rates for Medicaid substance abuse services.

Updates

Evaluation of the Pilot Project to Integrate Child Welfare and Drug Treatment Services: Chapter 551 of 2000 established a program whereby qualified addiction specialists were placed in child welfare offices in two jurisdictions: Prince George's County and Baltimore City. The legislature first asked for an evaluation of the efficacy of this program in fiscal 2004, but an evaluation was not submitted until 2008. While the program is certainly referring clients to treatment, in almost half of the cases reviewed, those referred did not subsequently enter treatment.

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 to private and nonprofit providers and local health departments. Maryland's community-based addictions treatment programs include primary and emergency care; intermediate care facilities; halfway houses; long-term programs; and outpatient care. The State also funds prevention programs.

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. ADAA has indicated that these local plans will be key in determining specific program activities in each jurisdiction.

Performance Analysis: Managing for Results

Prevention

ADAA prevention services are provided through two types of programming:

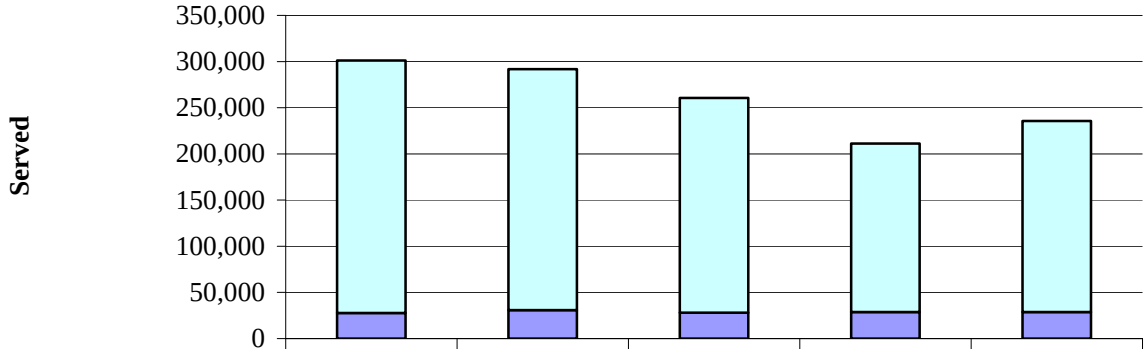
- Recurring prevention programming, *i.e.*, with the same group of individuals for a minimum of six separate occasions and with programming that is an approved Substance Abuse and Mental Health Services Administration (SAMHSA) model. In fiscal 2008, a total of 453 recurring prevention programs were offered across the State.

- Single service programs such as presentations, speaking engagements, training, etc., that are provided to the same group on less than six separate occasions. Participant numbers are either known or estimated. In fiscal 2008, 1,498 single service prevention activities were offered in Maryland.

As shown in **Exhibit 1**, ADAA prevention programming served almost 236,000 clients in fiscal 2008. Interestingly, while this number was higher than in fiscal 2007, and certainly reversed a trend from prior years, the number of recurring prevention programs offered was actually lower, and the number of single-service activities barely increased. Still, this increased participation is welcome and certainly reflects the additional funding provided for prevention programming in the fiscal 2008 budget.

It should also be noted that most of the growth in prevention program participation was through single service activities and not the more sophisticated programming requirements of recurring prevention programs (*i.e.*, programming consistent with SAMHSA evidence-based practice models). ADAA had hoped that as providers establish an infrastructure to provide model programming, more people would be served in recurring prevention programs and that additional funding fiscal 2008 would help in that regard. The data suggests that it did not.

Exhibit 1
ADAA – Prevention Programming
Clients Served and Funding Levels
Fiscal 2004-2008

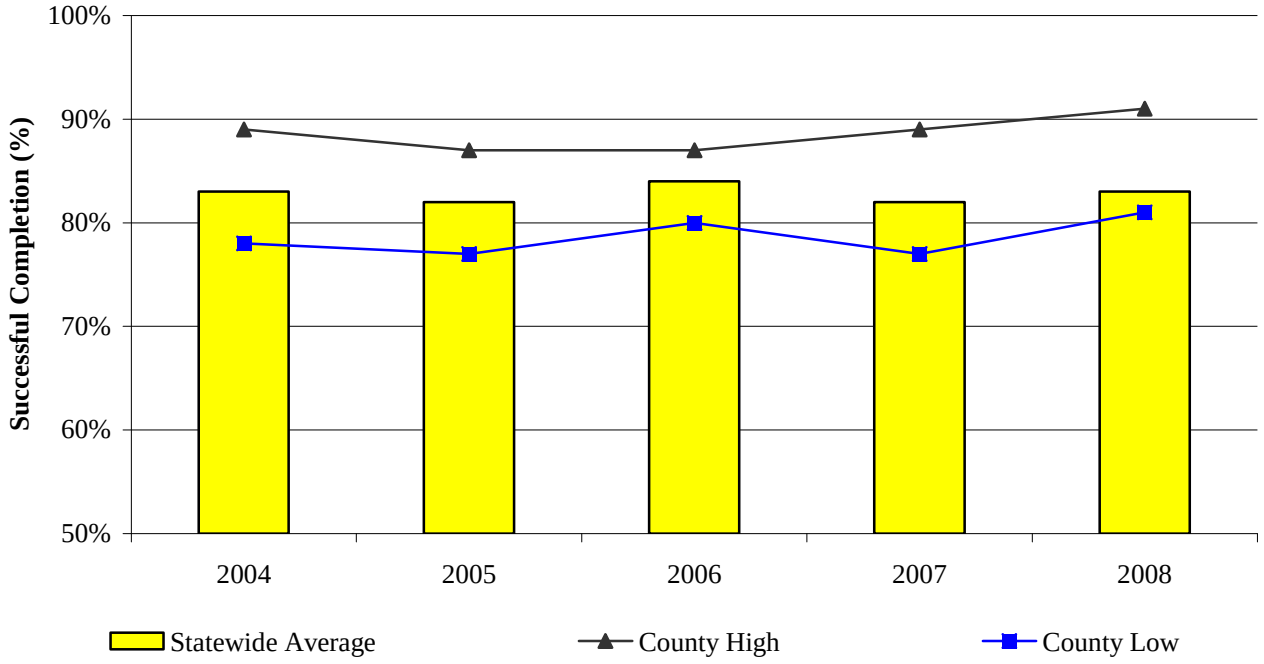


	2004	2005	2006	2007	2008
Prevention Funding ($ in Millions)	$5.159	$5.127	$4.974	$4.877	$6.093
Single Service Programs	273,479	260,974	232,566	182,472	206,810
Recurring Programs	27,734	30,879	27,988	28,762	28,812

Source: Alcohol and Drug Abuse Administration

As shown in **Exhibit 2**, ADAA reports that in fiscal 2008, 83% of participants in recurring prevention programs successfully completed the program, slightly higher than in fiscal 2007. As also shown in this exhibit, there is variation by county among programs in terms of successful completion. In fiscal 2008, for example, the successful completion rate varied from 91% in Allegany County to 81% in Anne Arundel County. But across all of the programs, the general trend is one of higher levels of completion. 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 – Recurring Prevention Programs
Successful Completion Rate
Fiscal 2004-2008

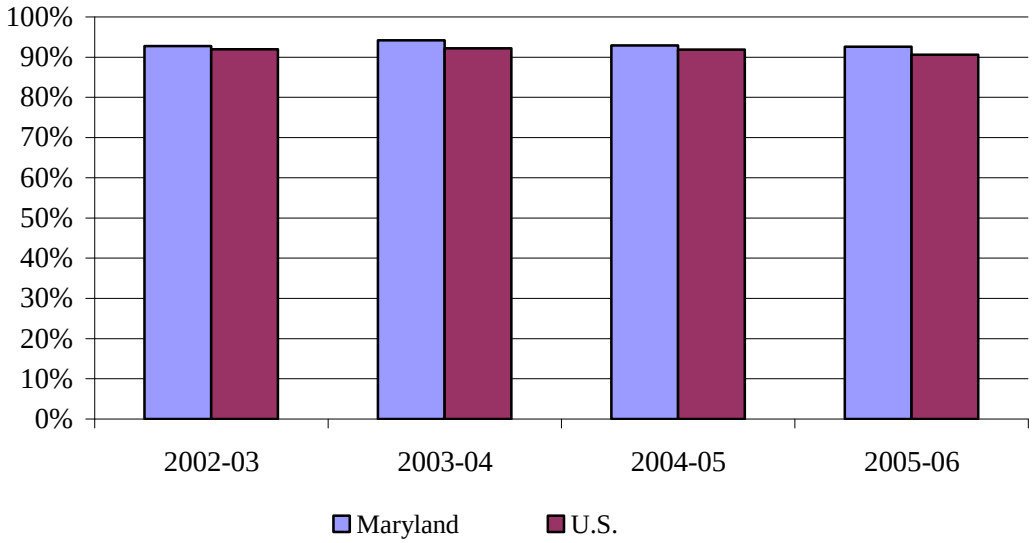


Source: Alcohol and Drug Abuse Administration

At the national level, the federal SAMHSA through its National Outcomes Measures (NOMS) initiative compiles a variety of state-by-state data around a series of domains concerning the treatment and prevention of substance abuse and the treatment of mental illness. Picking just two of the measures relating to prevention of substance abuse, **Exhibit 3** shows that, based on survey data, 92.6% of Maryland youth (aged 12 to 17) indicate exposure to prevention messages. While the trend among Maryland youth is actually downwards in terms of exposure, it is still slightly higher than the national average**.**

Exhibit 4 presents data on the average age of first use of alcohol. Again, this data is drawn from self-reported survey data of youth 12-17 years old, and again the Maryland data closely tracks the national average. However, Maryland youth surveyed report first use of alcohol at a slightly younger age than the national average, and that age has remained relatively unchanged over the period shown, while the national average shows evidence of a slight deferment of first alcohol use.

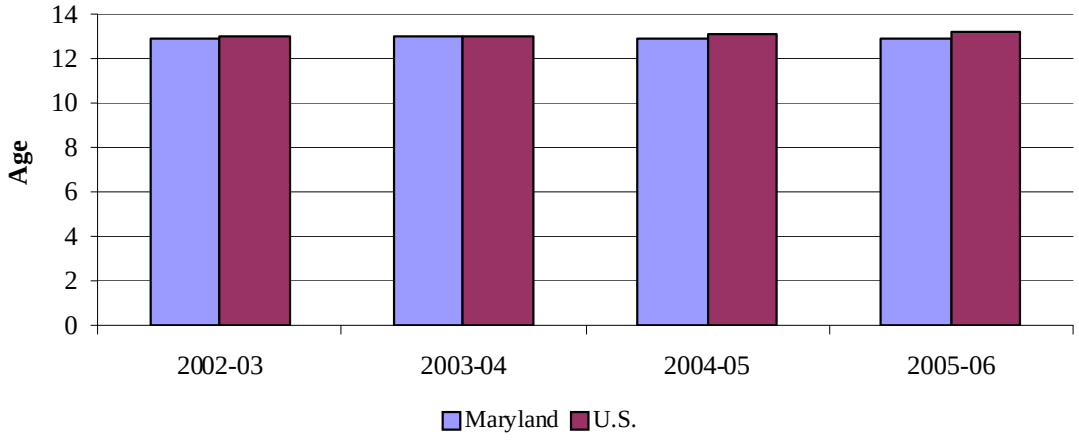
Exhibit 3
NOMS: Youth Exposure to Prevention Messages
Calendar 2002-3 to 2005-6



NOMS: National Outcomes Measures

Source: Substance Abuse and Mental Health Services Administration

Exhibit 4
NOMS: Average Age of First Use of Alcohol
Calendar 2002-03 to 2005-06



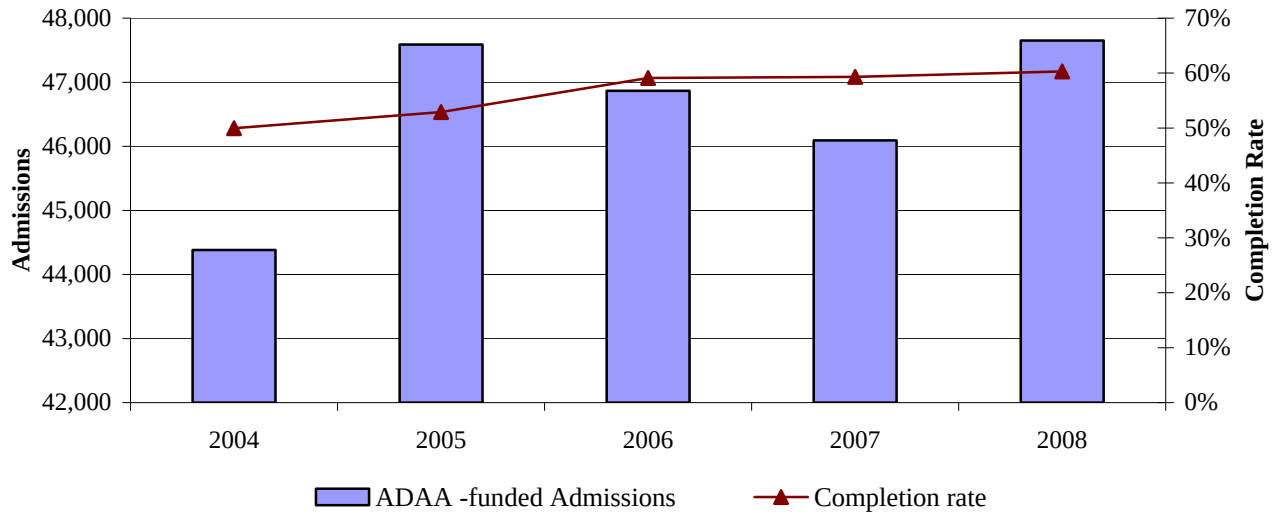
NOMS: National Outcomes Measures

Source: Substance Abuse and Mental Health Services Administration

Treatment

As shown in **Exhibit 5**, after falling between fiscal 2006 and 2007, admissions to ADAA-funded treatment services increased by 3% between fiscal 2007 and 2008. Completion rates (program completion and discharge without the need for further treatment or program completion with appropriate referral to the next level of treatment) continued the steady rise seen in prior years.

Exhibit 5
Admissions to ADAA-funded Treatment Programs and Completion Rates
Fiscal 2004-2008

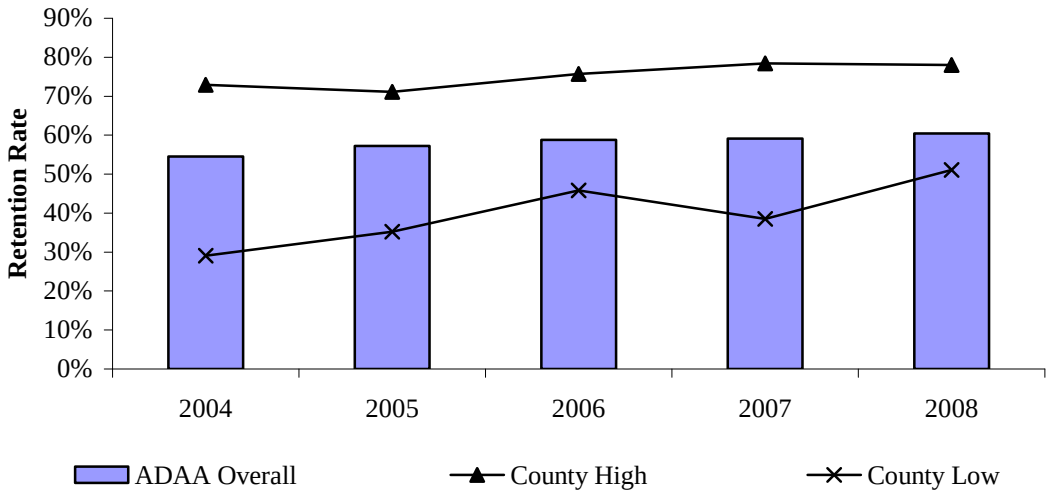


Source: Alcohol and Drug Abuse Administration

In terms of outcomes, a key outcome measure is 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 6**, the gradual improvement in the retention rate beyond 90 days in ADAA-funded Level I (outpatient) programs continued in fiscal 2008.

At the same time, while there was less variation between programs in fiscal 2008 than in the prior year, marked variation remains. For fiscal 2008, the highest retention rate for ADAA-funded programs is 78% (Washington County), while the lowest retention rate is just above 51% (Baltimore City). Interestingly, the jurisdiction with the highest retention rate in fiscal 2007 (St. Mary's County) fell to just below the statewide average in fiscal 2008. What explains these variances and changes from year-to-year? At this time, ADAA is unable to offer a comprehensive answer, although the administration notes that focus on this particular outcome has not been uniform across all jurisdictions while others are adopting evidence-based practices that play close attention to retention.

Exhibit 6
Level I Retention Rates
Percent Retained More Than 90 Days
Fiscal 2004-2008



Source: Alcohol and Drug Abuse Administration

Retention in program is one of two measures used by ADAA in its Pay for Performance Outpatient Incentive Pilot program which began in fiscal 2007. Under this program, ADAA pays an incentive bonus to jurisdictions ranging from $15,000 to $30,000, depending on the number of clinics in a jurisdiction, and based on certain results. Specifically, incentives are paid if for ADAA-funded outpatient enrollees (excluding adolescents and jail-based populations):

- there is retention of 65% or more of enrollees for a period of at least 90 days; and
- those enrollees have a successful completion rate of 50% or higher.

Jurisdictions that meet both standards receive a 100% performance payment; for one standard a 50% performance payment is made.

As shown in **Exhibit 7**, in fiscal 2008 18 jurisdictions received a performance payment, up from 11 in fiscal 2007. Of these, 12 jurisdictions received a 100% payment (up from 6 jurisdictions in fiscal 2007) with 6 receiving a 50% payment (up from 5 in fiscal 2007). Observations about the fiscal 2008 incentives include:

- Changes in the group designations for the number of clinics had 2 primary effects. The middle group is now defined 3-7, rather than 3-6, a change which impacted Baltimore County. A significant number of jurisdictions that fell into the 3-6 clinic category in

Exhibit 7
Outpatient Incentive Pilot
Fiscal 2008

	No. of Clinics	65% Retention at Least 90 Days	50% Completion
Allegany	1-2	68.6	63.3
Carroll	1-2	78.1	62.8
Charles	1-2	77.7	63.0
Dorchester	1-2	68.0	58.6
Frederick	1-2	69.6	50.7
Harford	1-2	64.8	51.3
Queen Anne's	1-2	71.1	54.7
Somerset	1-2	78.0	63.6
Talbot	1-2	68.1	58.1
Washington	1-2	83.7	69.0
Wicomico	1-2	72.8	53.9
Baltimore	3-7	64.7	51.9
Caroline	1-2	74.4	37.2
Cecil	1-2	67.6	42.9
Garrett	1-2	61.0	53.4
Kent	1-2	61.6	50.2
St. Mary's	1-2	62.1	54.4
Montgomery	3-7	75.7	47.0
Statewide Average		**60.4**	**51.5**

Note: See text for fuller explanation. Jurisdictions below the line did not meet both performance standards and received only a 50% payment. The shaded data indicates the performance measure that was not met. Jurisdictions not listed did not receive an incentive program.

Source: Alcohol and Drug Abuse Administration

fiscal 2007 are now listed as 1-2 clinics. This change reflects that in fiscal 2007 not all jurisdictions were using the State of Maryland Automated Record Tracking (SMART) system which meant every location was counted as a separate clinic (*i.e.*, an agency with three separate locations was counted as being 3 clinics). In fiscal 2008, this has been resolved and has resulted in a change in categorization.

- It appears that the jurisdictions with enrollees in 3 or more outpatient clinics in a jurisdiction find it more difficult to attain the performance standards, and neither of the jurisdictions (Anne Arundel County and Baltimore City) with enrollees in 8 or more clinics attained any award in fiscal 2008. Only 3 of the jurisdictions with enrollees in 1-2 clinics failed to attain any award. Conversely, all but one of the jurisdictions (Baltimore County) receiving the

100% award are jurisdictions with enrollees in 1-2 clinics. While providing a larger bonus for jurisdictions with more clinics is a nod to the understanding that this difficulty might arise, it is unclear if there are other factors influencing jurisdictional performance which inhibit the attainment of the performance goals.

- Two jurisdictions, Baltimore and Harford counties, are listed as attaining the 65% retention standard, although the data shows them at slightly below this mark. ADAA indicated that they rounded up so that the jurisdictions met the standard.

- Two jurisdictions, Caroline and Cecil counties, have a wide divergence between their retention rates (in both cases they exceed the 65% mark), and completion rates (only two jurisdiction have lower completion rates). This discrepancy has been attributed to the limited options beyond outpatient care often available in some jurisdictions. Thus, care is being provided, but perhaps not at the appropriate level for many individuals.

ADAA is also persisting with a pay for performance model in its statewide residential contracts. Using similar types of benchmarks, in calendar 2007, ADAA paid incentives totaling $106,476.

It is obviously important that clients are not only retained in (and successfully complete) programs, but that during the course of treatment, other outcomes improve. For example, relevant outcomes include:

- clients that have a declining incidence of substance abuse;

- clients are able to obtain employment; and

- clients have less involvement in the criminal justice system.

As shown in **Exhibit 8**, for ADAA-funded treatment programs, outcomes for fiscal 2004 through 2008 are positive:

- Clients are abusing at a lower rate on discharge than admission.

- More clients were employed at discharge than at admission. Although the employment rate at discharge has fallen from a high of 38.6% in fiscal 2005, the total gain in employment in fiscal 2008 between admission and discharge was the largest in the period shown. However, this is as much due to employment at admission being the lowest in the period shown. It might be expected that in a weakening economy that employment at admission will be lower. It will be interesting to see in that same economy if the improvement in employment levels at discharge can be maintained.

Exhibit 8
ADAA-funded Programs – Selected Outcomes
% of Total Patient Population

	Substance Abuse			Employed			Criminal Justice Involvement (Patient Arrests)		
	At Admission	At Discharge	Absolute Change	At Admission	At Discharge	Absolute Change	30 Days Prior to Admission	30 Days Prior to Discharge	Absolute Change
Fiscal 2004	69.0%	51.5%	-17.5%	29.9%	36.1%	6.2%			
Fiscal 2005	68.3%	49.9%	-18.4%	32.1%	38.6%	6.5%			
Fiscal 2006	68.5%	40.9%	-27.6%	32.1%	38.0%	5.9%	8.6%	2.4%	-6.2%
Fiscal 2007	69.4%	37.2%	-32.2%	30.6%	37.5%	6.9%	8.6%	2.5%	-6.3%
Fiscal 2008	69.9%	32.7%	-37.2%	29.2%	37.1%	7.9%	8.6%	2.8%	-5.8%

ADAA: Alcohol and Drug Abuse Administration

Source: Alcohol and Drug Abuse Administration

- Criminal justice involvement (comparing arrests 30 days prior to admission and discharge) also shows improvement, although not as stark as in prior years.

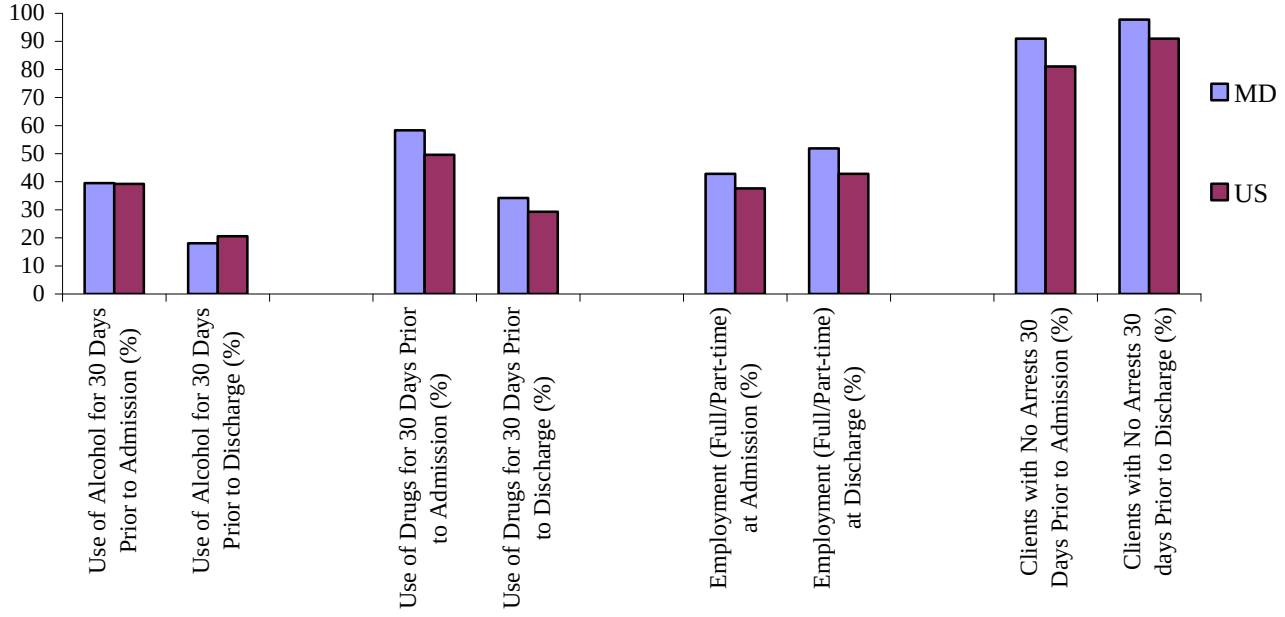
Again, comparative treatment data is available through the National Outcomes Measures program. While the reported data on the SAMHSA web site for Maryland is slightly different than that reported by ADAA in Exhibit 8, the data shown in **Exhibit 9** illustrates that Maryland generally outperforms the national average:

- Clients in Maryland have higher levels of abstinence from alcohol at program discharge and a greater level of improvement. While clients in Maryland have slightly higher use of drugs at discharge than the national average, the improvement between admission and discharge is greater in Maryland.
- Clients in Maryland show higher levels of employment at discharge, and the increase in employment levels are greater than the national average.
- Clients in Maryland have fewer arrests 30 days prior to discharge compared to the national average although improvement between admission and discharge among Maryland clients is lower. However, this is perhaps more a reflection of the higher overall criminal justice involvement of clients at admission nationally rather than any issue with Maryland programming.

Exhibit 9

NOMS: Various Treatment Outcomes for All Treatment Types

Most Recent Available Data



NOMS: National Outcomes Measures

Source: Substance Abuse and Mental Health Services Administration

Court-involved Processing

Under current law, the courts may order the Department of Health and Mental Hygeine (DHMH) to conduct evaluations of criminal defendants to determine if they are in need of, and could benefit from, treatment. Additionally, the courts may commit a defendant to DHMH for treatment (in outpatient or residential settings) if the defendant agrees to that treatment as a condition of release, after conviction, or at another time (Sections 8-505 and 8-507 of the Health-General article).

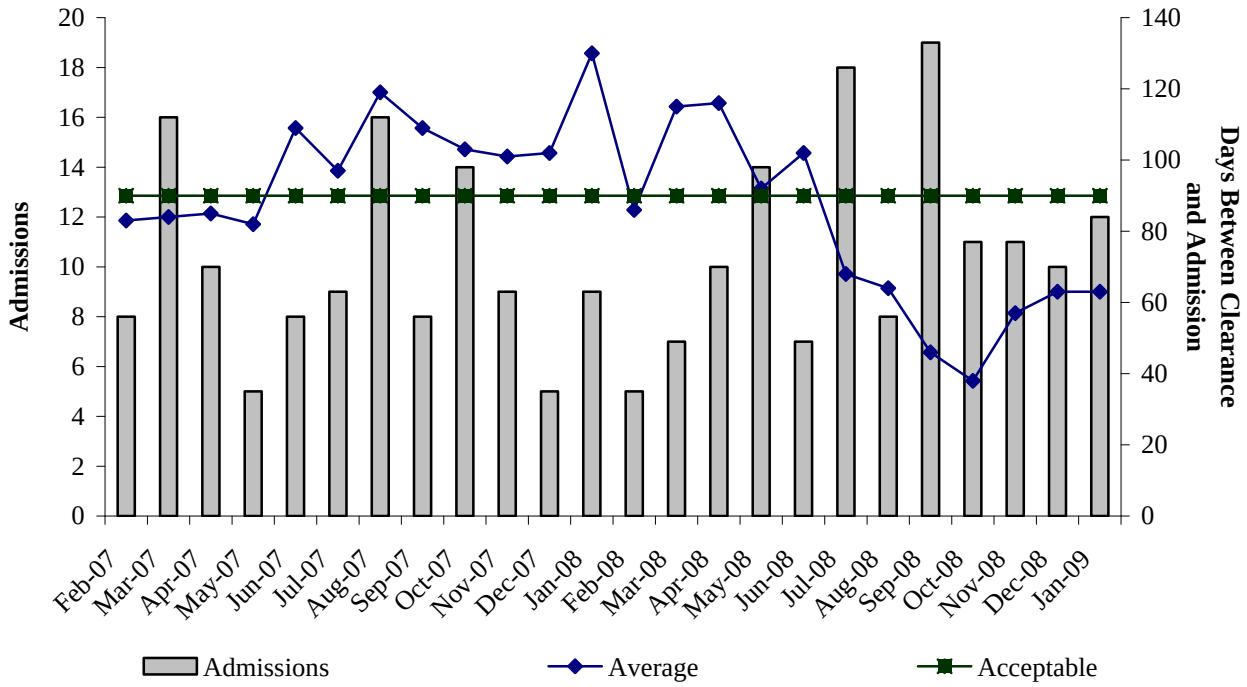
Although the statute notes that the department shall provide services required, it is generally considered that this service provision is subject to the availability of funds provided for in the budget. Certainly a review of the legislative history associated with these provisions would indicate that. In other words, this section is not "treatment on demand" for all individuals that the courts find have an alcohol and drug dependency and are suitable for, and agree to, commitment to the department.

In recent years, there have been various times when ADAA has found itself in contempt of court for another provision of the same statute, namely the facilitation of "prompt treatment of a defendant" which the courts have generally considered to be 90 days from clearance to admission. In particular, the courts have been frustrated by the lack of residential treatment slots for individuals under Section 8-507.

ADAA re-bid its three statewide residential contracts in calendar 2005 and 2006 and expanded the number of residential slots that could serve this population. The existing contracts for women and children (46 beds) and co-occurring disorders (70 beds) are not exclusively for court-involved individuals although generally serve such clients. The third, and largest, contract is exclusively for court-ordered individuals (120 beds). Additional statewide beds for the court-involved population also exist under new programming developed in Carroll County in fiscal 2009 (6 beds).

At the beginning of calendar 2008, delays in the placement of individuals under Section 8-507 were noted, and additional funding for co-occurring residential slots was included in the fiscal 2009 budget. As shown in **Exhibit 10**, which presents data only for individuals with co-occurring disorders who require level III.3 (residential) treatment, the time taken from a defendant being cleared for service under Section 8-507 and admission to the program has fallen. Data for all court-ordered placements indicates a similar decline in the average time between clearance and admission beginning in mid-2008, with the average days between clearance and admission at 61 days for the 12-month period beginning February 2008.

Exhibit 10
Clearance to Admission Times for Co-occurring Level III.3 Treatment
February 2007–January 2009



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

Fiscal 2009 Actions

Impact of Cost Containment

To date, ADAA's fiscal 2009 legislative appropriation has been reduced by just over $1 million in cost containment actions. A small amount of this cost containment related to reductions in personnel expenditures from deleting funding for Other Post Employment Benefits as well as reducing budgeted funding for health insurance costs based on the use of statewide health insurance balances. The largest cost containment action concerned the fiscal 2009 provider rate adjustment which was lowered from 2.7 to 2.0%. This 2.0% increase still represented a 0.5% increase over that originally provided in the fiscal 2009 budget. This additional increase was supported by overattained fiscal 2008 lottery revenues.

Planned fiscal 2009 budget reductions not yet reflected in the working appropriation include an estimated $41,450 in general funds for employee furloughs.

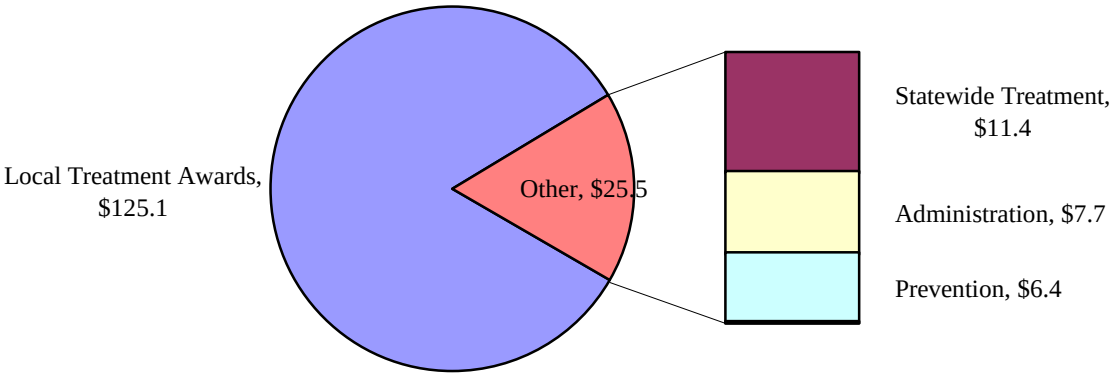
Proposed Budget

As shown in **Exhibit 11**, the fiscal 2010 budget for ADAA is just over $150.6 million. Based on preliminary information provided by ADAA, that funding is allocated as follows:

- $125.1 million (83%) awarded to local jurisdictions for substance abuse treatment;
- $11.4 million (8%) dedicated to a variety of statewide treatment contracts and programming;
- $6.4 million (4%) for local and statewide prevention programming and for ongoing support of NOMS, the bulk of this again awarded to local jurisdictions; and
- $7.7 million (5%) for administration and oversight of the system, including the operation and maintenance of the administration's data-reporting systems.

Final fiscal 2010 awards to local jurisdictions will not be made until after budget deliberations. However, **Appendix 2** provides a preliminary estimate of fiscal 2010 local prevention and treatment grants based on available data.

Exhibit 11
ADAA – How the Money Gets Spent
Fiscal 2010 Allowance
($ in Millions)



Note: Beginning in fiscal 2010, prevention funding includes the support of NOMS.

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

Additional detail on the ADAA budget is provided in **Exhibit 12**. The fiscal 2010 budget of just over $150.6 million is almost $2.0 million, 1.3%, above the fiscal 2009 working appropriation. Key changes include:

- **Personnel:** Increments and other compensation increases by $68,000. This reflects annualization of fiscal 2009 increments and annualization of fiscal 2009 reclassfications.

- **Administration:** Administration costs fall by $246,000. This reduction is driven by the expiration of two federal grants to support outcomes measurement efforts. However, the drop is somewhat artificial in that funding for NOMS is being moved from administration to prevention where it will be supported with other federal Substance Abuse Prevention and Treatment (SAPT) block grant funding. Within administration, there are some programmatic increases, including support for a special projects manager for grant evaluation design capability. Funded through SAPT block grant funds, this position is a contract with the University of Maryland, School of Nursing to provide assistance with grant writing and monitoring, SAPT block grant management, policy and procedure development, and medication-assisted treatment. The specific person to be utilized under this contract has been working with ADAA on the buprenorphine initiative in fiscal 2009, specifically the area of physician training and the evaluation of that training.

- **Prevention:** Funding for prevention increases by $56,000. As noted above, spending on NOMS is reflected in prevention spending for the first time in fiscal 2010. There is also funding for a small 0.9% provider rate adjustment. However, based on the budget allocation for prevention activities, these increases are offset by a reduction in statewide prevention grants of $200,000.

  It should also be noted that, as proposed, the fiscal 2010 budget meets the requirement that at least 20% of SAPT block grant is spent on prevention activities.

- **Treatment:** Treatment funding increases by just over $1.8 million. Of this amount $1.2 million is funding for the 0.9% provider rate adjustment. Funding for treatment associated with drug courts also increases by $783,000 (reimbursable funds from the Judiciary). However, this increase is an artifact of budgeting in that higher treatment funding levels are not yet reflected in the fiscal 2009 working appropriation. DHMH will process the reimbursable fund budget amendment adding fiscal 2009 funds once an executed Memorandum of Understanding is received from the Office of Problem Solving Courts. With that amendment, fiscal 2010 support for this particular treatment area will be level-funded.

  Based on the budget allocation for treatment activities, once these increases are taken into account, there is another $111,000 in as of yet non-specific reductions to treatment grants. This is driven largely by a drop in the available SAPT block grant.

Exhibit 12
Proposed Budget
DHMH – Alcohol and Drug Abuse Administration
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
2009 Working Appropriation	$94,318	$17,952	$32,313	$4,108	$148,691
2010 Allowance	95,890	17,918	31,943	4,937	150,688
Amount Change	$1,572	-$34	-$370	$828	$1,997
Percent Change	1.7%	-0.2%	-1.1%	20.2%	1.3%
Contingent Reduction	-$18	$0	-$5	$0	-$23
Adjusted Change	$1,554	-$34	-$376	$828	$1,973
Adjusted Percent Change	1.6%	-0.2%	-1.2%	20.2%	1.3%

Where It Goes:

Personnel Expenses	**$308**	
Workers' compensation premium assessment		$111
Employee and retiree health insurance		89
Increments and other compensation		68
Turnover		61
Retirement contributions		43
Other fringe benefit adjustments		3
Deferred compensation contingent reduction		-22
Other Post Employment Benefits		-45
Administration	**-$246**	
Special projects manager (federal funds)		46
Support services for substance abuse screening of temporary cash assistance applicants (reimbursable funds)		43
In-state travel (alignment to most recent actual)		15
State Outcomes Measurement and Management System (federal funds)		-150
NOMS (federal funds)		-200
Prevention	**$56**	
NOMS		200
Prevention grants provider rate adjustment		56
Statewide prevention grants		-200

Treatment	**$1,841**	
Treatment grants provider rate adjustment		1,169
Funding for treatment associated with Drug Courts (reimbursable funds)		783
Other funding for treatment grants (special and federal funds)		-111
Other		14
Total		**$1,973**

NOMS: National Outcomes Measures

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

SAPT Block Grant Availability

The slight drop in SAPT block grant funding for treatment reflects an assumption of no additional block grant attainment in fiscal 2010 over 2009 and higher use of the block grant for other programming, namely NOMS. At this time, despite calls from advocacy groups, the federal stimulus package does not contain any additional SAPT block grant funding.

Based on anticipated fiscal 2009 and 2010 SAPT attainment and expenditures, as shown in **Exhibit 13**, ADAA again plans for no fiscal 2010 year-end fund balance. Further, as currently anticipated, ADAA is only setting-aside 20% of the anticipated fiscal 2010 attainment for the subsequent year, below the 25% reserve level that is standard practice for federal grants.

Exhibit 13
SAPT Block Grant Availability
Fiscal 2008-2011

	2008	2009	2010	2011
Beginning Balance/Prior Year Reserve	$10,156,334	$8,723,148	$7,614,862	$6,526,780
Attainment	31,744,186	31,869,681	31,869,681	
Subtotal	**$41,900,520**	**$40,592,829**	**$39,484,543**	
Reserved for Subsequent Year	-7,967,420	-7,614,862	-6,256,780	
Transferred Out	-1,325,110	-1,088,082	-1,088,082	
Expenditures	-31,852,262	-31,889,885	-31,869,681	
Ending Balance	**$755,728**	**$0**	**$0**	

SAPT: Substance Abuse Prevention and Treatment

Source: Department of Health and Mental Hygiene

Issues

1. The Delivery of Substance Abuse Treatment

At just over $125 million, ADAA's treatment budget is bigger than that of any other State agency but is only one component of the publicly funded substance abuse treatment system. Other major players in terms of funding include the Mental Hygiene Administration (MHA) (which treats the co-occurring mental ill/substance abusing population) and Medicaid. Agencies with smaller treatment budgets, such as the Department of Juvenile Services (DJS) and Public Safety and Correctional Services, are nonetheless central to any discussion of the substance abuse treatment system given the populations they serve.

Indeed, in substance abuse treatment, the notion of a publicly funded system should not be envisaged as a single entity, but rather as a collection of diverse subsystems. In addition to the multitude of agencies funding substance abuse treatment is the proliferation of ways that this funding is administered. For example:

- ADAA delivers treatment primarily through a grant-based system, with grants made to local jurisdictions that in turn contract for services or in some cases deliver services directly. These local grants are supplemented by statewide contracts for certain residential services, services primarily directed to court-involved individuals.

- Medicaid delivers treatment via managed care organizations, which have their own contractual arrangements with providers, and a fee-for-service system.

- agencies such as DJS provide treatment through contracts with other entities/organizations as well as providing direct treatment services in its facilities.

Medicaid, Primary Adult Care and the Alcohol and Drug Abuse Administration Treatment Grant Awards

The picture gets more confusing when looking at how different populations are served. Consider, for example, the Medicaid and primary adult care (PAC) populations. **Exhibit 14** details coverage of substance abuse services under Medicaid.

Exhibit 14
Coverage of Substance Abuse Services Under Maryland Medicaid

Service	Medicaid Coverage	PAC Coverage	Expected PAC Coverage Under Health Care Expansion
Ambulatory detox	Yes	No	Was fiscal 2010
Outpatient	Yes	No	Was fiscal 2010
Intensive outpatient	Partial: children and pregnant women only	No	Never for non-pregnant adults
Partial hospitalization	Yes	No	Fiscal 2011
Inpatient detox	Yes	No	Fiscal 2012
Methadone maintenance	Yes	No	Fiscal 2010
Residential treatment	Partial: children only (federal rules)	No	Not for adults
Long-term residential treatment	No (federal rules)	No	No
Buprenorphine (medication)	Yes	Yes	Yes

PAC: Primary Adult Care

Source: Department of Health and Mental Hygiene

As shown in the exhibit, under the current Medicaid program, while most substance abuse services are covered, some are not because of federal rules, and some only for certain populations. Coverage under the PAC program is limited only to accessing Buprenorphine (the drug itself), but not the counseling and other services that accompanies the use of that treatment. Even under the recently enacted health care expansion legislation, while the PAC population would eventually have access to the same range of substance abuse services as those offered to Medicaid recipients, some service gaps would remain. Further, as proposed, the fiscal 2010 budget delays the expansion.

How are those gaps filled? One of the roles of the ADAA treatment grant awards is to be a gap-filler. What data ADAA collects on income (and this data is incomplete) indicates that a substantial amount of clients served in ADAA-funded treatment programs are probably eligible for Medicaid or PAC. In fiscal 2006, for example, for those admissions where income information was known, over half reported having family incomes of below $10,000.

That ADAA grant awards fill the gaps in treatment for these two populations is reasonable. However, if grant awards are utilized to cover substance abuse treatment for individuals in PAC, the

State appears to be missing an opportunity to maximize federal funds by instead expanding treatment coverage to the PAC program. DHMH estimates that extending substance abuse services to the PAC population would cost just over $5.4 million ($2.7 million general funds/$2.7 million federal funds).

Complicating this issue is the fact that the current reimbursement levels both within Medicaid (Management Care Organization and fee-for-service) and between Medicaid and ADAA can be widely different for the same services. Reimbursement under the treatment grants tend to be higher than under Medicaid fee-for-service or the MCOs. This:

- creates a disincentive for providers to bill Medicaid versus using available treatment grant dollars. Thus, for Medicaid MCO clients, the State can be effectively paying for services twice (through the MCO capitation rate and the treatment grant) or for non-MCO Medicaid clients paying for services through the ADAA treatment grant and not drawing down the federal match.

- creates resistance to extending substance abuse treatment benefits to PAC clients because providers would be often providing the same services that they are currently giving to the same client but at a lower reimbursement level.

DHMH estimates it would cost just over $7.9 million ($3.95 million general funds/$3.95 million federal funds) to implement a fair and equitable rate structure that would bring Medicaid rates up to those offered through the grant system.

Funding Medicaid Substance Abuse Services for PAC Clients

As it currently stands, there is no funding in the fiscal 2010 budget to begin expansion of substance abuse treatment services to PAC clients or to eliminate the rate reimbursement discrepancies between the Medicaid and ADAA programs. As shown in **Exhibit 15,** one way to move forward with such an expansion and improve the rate reimbursement structure while at the same time increasing federal fund attainment thereby increasing overall spending on substance abuse treatment is to transfer funding from the ADAA treatment grants to Medicaid. The almost $6.7 million reduction in treatment grant support would translate into almost $13.4 million in total spending on substance abuse.

Further, the impact of any reduction to treatment grants is somewhat mitigated in that the movement of PAC clients from the grant system concomitantly reduces demand on that system. Further, to the extent that removing the disincentive created by low Medicaid/MCO reimbursement rates results in clients currently served via treatment grants appropriately shift back to Medicaid, there is another potential reduction of demand for services under the grant system. In effect, the actual impact on slots funded by treatment grants is likely lower than the $6.7 million noted in Exhibit 15.

Concerns around such a proposal center include:

- Whether all providers have sufficiently sophisticated business operations to deal with the billing and claims requirements of Medicaid. However, since expansion of substance abuse treatment to PAC is currently part of the eventual health care expansion agenda, this concern will need to be addressed at some point.

Exhibit 15
Cost/Benefit of Expanding Substance Abuse Benefits to PAC and Reforming Substance Abuse Treatment Reimbursement Rates

Reductions to Treatment Grants	
Expanding Substance Abuse Services to PAC	-$2,726,460
General Fund Cost Of Equalizing Substance Abuse Treatment Rates	-3,960,375
Total Reductions to Treatment Grants	**-$6,686,835**
Total Spending on Substance Abuse Treatment	
Total Expenditures on Substance Abuse to PAC Clients	$5,452,920
Total Expenditures on Substance Abuse through Higher Rates	7,920,749
Total Spending On Substance Abuse Treatment	**$13,373,669**
Offsets to Treatment Grant Reduction	
Services currently provided to PAC recipients	*Positive but unknown*
Services currently provided to MCO clients but not billed to the MCOs	*Positive but unknown*
Services currently provided to Fee-for-service Medicaid clients but not billed to Medicaid	*Positive but unknown*

MCO: Managed Care Organization
PAC: Primary Adult Care

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

- If this prioritization of funds runs counter to the local planning and priority concept that supposedly underpins ADAA-funded treatment activity. However, in truth, the past two budgets have moved away from this concept to prioritize funding for specific populations (for example, the court-involved) and forms of treatment (for example, buprenorphine).

- How would treatment grants be reduced. Perhaps the most appropriate way would be to reduce funding proportional to the populations served in PAC (for the funding related to the expansion of substance abuse treatment services to PAC) and Medicaid and PAC combined (for the funding related to the overall adjustment of reimbursement rates). **Exhibit 16** illustrates the impact to each jurisdiction's treatment grant of such a proposal.

Given the ability to draw down federal funds and to pump additional dollars into the substance abuse treatment system by providing substance abuse treatment services to the PAC population, and understanding that such a move can only be properly accomplished by improving Medicaid reimbursement rates, the Department of Legislative Services (DLS) recommends that language be added to the budget restricting funding of treatment grants for that purpose.

Exhibit 16

Allocation of the Reduction in Treatment Grants Required to Expand Substance Abuse Benefits to PAC and Reforming Substance Abuse Treatment Reimbursement Rates

	Funding for SA Treatment to PAC Based on PAC Populations	Funding for Rate Reimbursement Increases Based on MA Populations	Total Reduction
Allegany	$94,610	$76,457	$171,067
Anne Arundel	114,990	221,592	336,582
Baltimore County	249,745	466,304	716,049
Calvert	18,799	43,192	61,991
Caroline	16,691	37,012	53,702
Carroll	20,556	59,225	79,780
Cecil	33,908	73,393	107,301
Charles	34,699	77,229	111,928
Dorchester	25,651	41,536	67,186
Frederick	59,735	102,067	161,802
Garrett	24,070	33,857	57,927
Harford	82,838	117,452	200,290
Howard	37,510	96,603	134,113
Kent	8,872	16,072	24,945
Montgomery	137,215	458,840	596,054
Prince George's	181,840	574,208	756,048
Queen Anne's	9,224	24,579	33,803
St. Mary's	28,198	63,134	91,333
Somerset	13,265	27,801	41,066
Talbot	12,913	24,049	36,963
Washington	57,627	115,700	173,327
Wicomico	37,774	98,191	135,965
Worcester	20,117	37,130	57,247
Baltimore City	1,405,615	1,074,752	2,480,367
Total	**$2,726,460**	**$3,960,375**	**$6,686,835**

MA: Medicaid
PAC Primary Adult Care
SA: Substance Abuse

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

A Different Service Delivery Model for Substance Abuse Treatment

The overlapping and somewhat imperfect service delivery system that is evident with regard to the delivery of substance abuse treatment services in Medicaid, PAC, and through the ADAA treatment grants has prompted some discussion of the need for a significant overhaul of the way that the State delivers substance abuse services. Numerous possibilities could be considered including:

- carving substance abuse services out of Medicaid and using an Administrative Services Organization (ASO) model similar to that currently used in MHA while preserving set-asides for court-involved individuals;

- combining substance abuse and mental health services into a single fee-for-service system using the existing MHA ASO model while continuing existing grants and contracts for non-fee-for-service services;

- combining substance abuse and mental health services under a behavioral managed care organization; and

- carving all behavioral health services back under the MCOs.

Certainly, with the establishment of a new Deputy Secretariat for behavioral health, DHMH is perhaps in a stronger position to focus on the current substance abuse service delivery model and to see how it might be improved.

2. Utilization of Grant Dollars, Allocation Methodology, and the 2008 Needs Assessment

During fiscal 2009 budget deliberations, data was presented that in any given year a significant amount of funds provided for local prevention and treatment grant awards are unutilized by the grant recipients. This underutilization typically represents a small percentage of total statewide awards, between 2 and 3%, with some jurisdictions spending a significantly smaller percentage of their awards and others utilizing all of the awards.

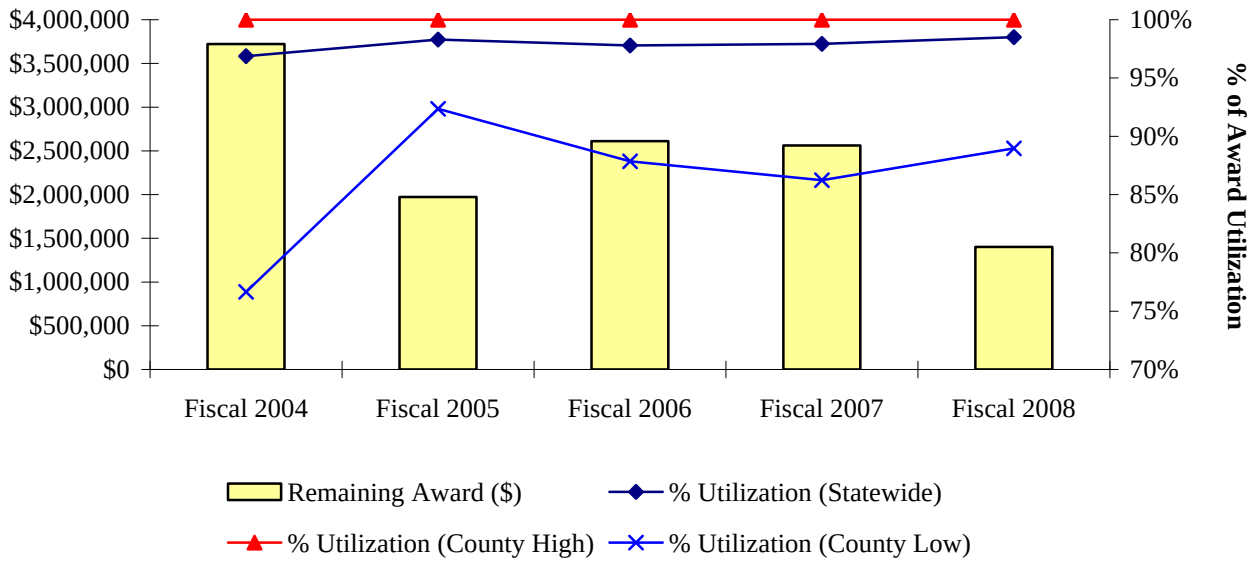
Fiscal 2008 grant award reconciliations are ongoing. Based on current information, as shown in **Exhibit 17**, of the 17 jurisdictions for which data is reported, unexpended awards total just over $1.4 million. This figure can be expected to grow if history is any guide as two of the jurisdictions for which data is not available (Frederick and Prince George's counties) often leave significant dollars unspent at the end of the fiscal year. Further, as detailed in **Appendix 1**, significant general fund transfers out of ADAA into other areas of DHMH as well as federal fund cancellations at fiscal 2008 close-out also indicate that the underutilized grant award numbers will grow.

Why Are Grant Awards Underutilized?

Budget language was added in the 2008 session withholding funds pending the submission of a report asking ADAA to take action to maximize the utilization of local prevention and treatment grant awards. In its report back to the budget committees, ADAA summarized the various issues facing local jurisdictions which resulted in grant underutilization:

- problems with hiring staff are almost universally expressed throughout the State;

Exhibit 17
Award Utilization
Fiscal 2004-2008



Note: Fiscal 2008 data is incomplete.

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

- hiring freezes, including in some jurisdictions where hiring freezes apply to all positions regardless of the fund source of origin;
- collection levels may be higher than anticipated resulting in less need to use grant funds (ADAA funds are considered funds of last resort);
- problems with contract authorizations and contract amendments;
- fear of over-expenditures; and
- particular to supplemental awards, jurisdictions reported issues getting local approval to spend supplemental awards and also being able to amend previously awarded contracts to accommodate the additional funding.

ADAA Actions to Minimize Under-utilization of Grant Awards

A grant-based system inevitably invites conservative budgeting, and arguably an overall 97 to 98% utilization rate statewide reflects close to the maximum level of utilization that might be expected. However, there remains significant variation between jurisdictions. Indeed, DLS noted in its 2009 analysis that because grant awards are based on the level of the prior year award rather than

having any relation to actual expenditures, ADAA might want to consider using a three-year award utilization history when making future allocations. For the moment, ADAA intends to:

- heighten its financial monitoring and oversight of spending and encourage jurisdictions that appear to be underutilizing grant awards to voluntarily reduce those awards at an earlier point in the fiscal year (at no future penalty to that jurisdiction) so that funds can be used elsewhere;

- beginning in fiscal 2010, if an individual jurisdiction's award appears too high based on three-year utilization trends, the award will be reduced;

- improve communication of grant underutilization data to the jurisdictions; and

- after completion of first quarter expenditure reports, ADAA will monitor reports on a monthly basis.

Based on the report submitted by ADAA, DLS recommends releasing the fiscal 2009 withheld funds. Absent any indication to the contrary, DLS will prepare a letter to that effect after the ADAA budget hearings.

Allocation Methodology and the Needs Assessment

Despite indications from ADAA that it will consider changing a jurisdiction's grant allocation on a case-by-case basis if those funds are consistently underutilized, the question of whether the grant awards are appropriately allocated remains an open question. This is a longstanding debate that despite numerous studies and workgroup reports has not been resolved. As noted in last year's analysis, the latest work in this area was delivered to the State Drug and Alcohol Abuse Council in December 2007. The recommendation of the workgroup was to base any increases in funding off of the current base and to allocate of new funds for prevention and treatment services as follows:

- Prior to any expansion of services, to allocate an amount sufficient to provide a 2% inflationary adjustment based on prevention and treatment funding levels.

- Of the remaining funds,

    - 80% should be allocated to treatment as follows: 95% allocated among all jurisdictions by formula based on a jurisdiction's substance abuse prevalence and the population below 200% of the Federal Poverty Level (FPL); and 5% split equally between federally designated rural jurisdictions.

    - The remaining 20% should be allocated to prevention as follows: 95% allocated by formula among all jurisdictions based on a jurisdiction's total population and the population below 200% of FPL; and 5% split equally between federally designated rural jurisdictions.

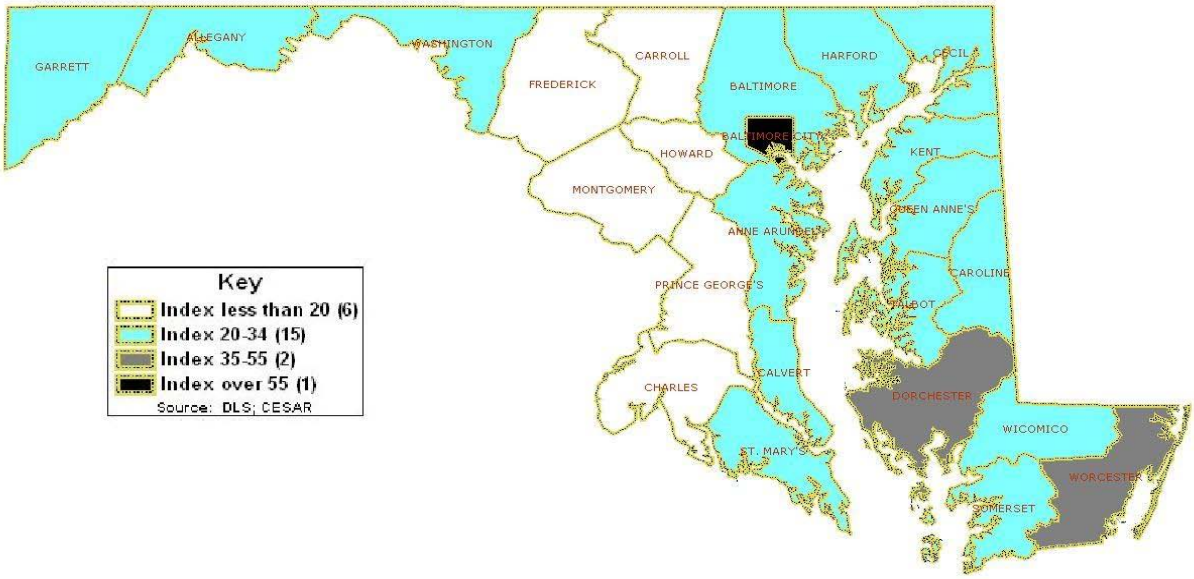
The State Drug and Alcohol Abuse Council postponed any action on the workgroup report to await the results of the needs assessment being undertaken as a result of Chapter 82 of 2007. ADAA contracted with researchers at Harvard University and CESAR for this needs assessment, and a final report was delivered during the 2008 interim and presented to the council. The researchers revised the needs assessment based on updated data and have re-submitted it to the department. However, the council has yet to consider its findings.

The needs assessment utilized available data to develop a substance need index as a measure of substance abuse problems. The index was based on:

- mortality data (focusing on underlying or contributing diagnosis of explicit-mention drug or alcohol disorders);
- hospital discharge data (based on individuals admitted to hospitals to receive treatment for drug or alcohol abuse or dependence or treatment for a medical complication or condition stemming from substance abuse); and
- arrest data for drug- and alcohol-related crimes.

The resulting index was scaled from 0 to 100, with 0 representing a jurisdiction with no substance abuse deaths, hospitalization, or drug- and alcohol-related arrests and 100 representing where a jurisdiction has the highest observable rates in all three indicators. As shown in **Exhibit 18**, results were somewhat predictable, with Baltimore City having by far the highest index score, 91. Perhaps more surprising are the relatively high index scores on the Eastern Shore.

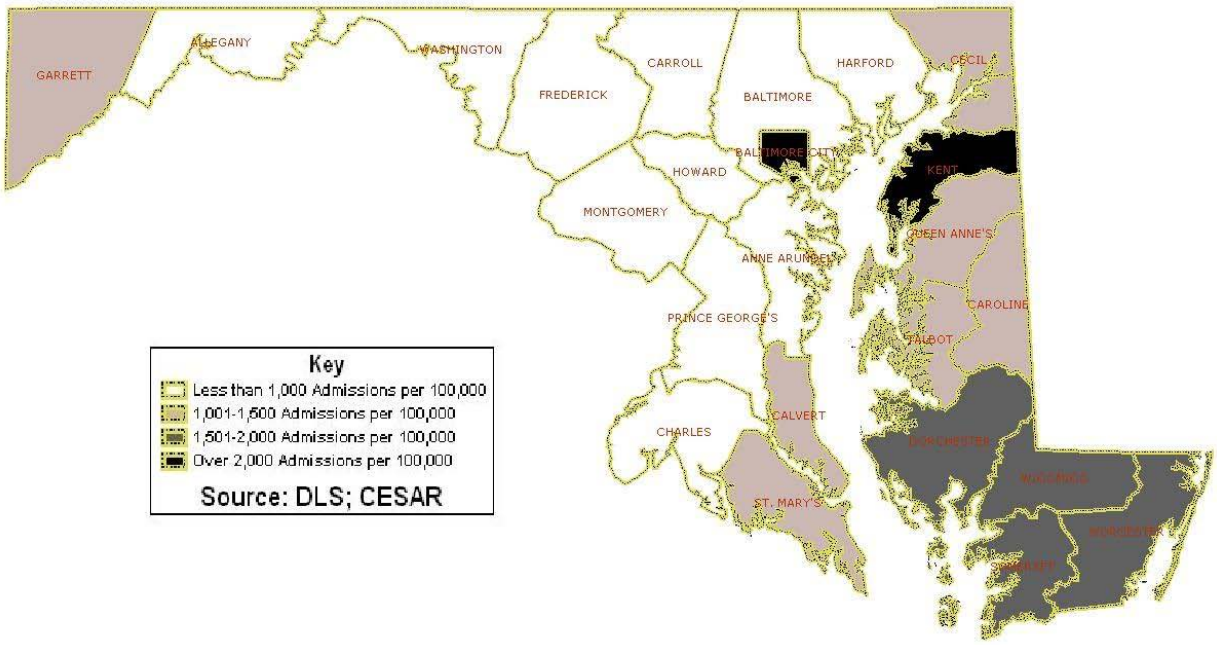
Exhibit 18
Maryland Substance Abuse Need Index



Source: Department of Legislative Services; Center for Substance Abuse Research

To estimate how well substance abuse needs are being met, the needs assessment plotted substance abuse admission rates. This was done for both ADDA-funded and non-funded treatment slots. **Exhibit 19** details admission rates just for ADAA-funded slots.

Exhibit 19
Publicly Funded Alcohol and Drug Treatment Admissions
(Admission Rates Per 100,000 Population)



Source: Department of Legislative Services; Center for Substance Abuse Research

Even just looking at Exhibits 18 and 19 it is possible to observe that treatment admissions match up quite well to the substance abuse need index. Statistical analysis in the needs assessment confirms the impression that most services are in the right places. However, some treatment gaps are identified. These gaps occur both in jurisdictions with moderate-to-high need (Allegany, Baltimore, Cecil, and Worcester counties and Baltimore City) but also in jurisdictions identified as having relatively low levels of need and low admission rates (Prince George's, Howard, Montgomery, Harford, Frederick, Anne Arundel, and Carroll counties). The needs assessment quantifies these gaps, while at the same time establishing a caveat for the estimated treatment gap in Baltimore City because of the size of the treatment need in Baltimore City.

Thus, the needs assessment offers a potential road map for ADAA to use to guide future funding of treatment. As noted above, however, it remains unclear how the administration intends to use the research with which it has been provided.

Recommended Actions

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

   , provided that $6,686,835 of this appropriation made for the purpose of providing treatment grants to local jurisdictions, may not be expended for that purpose but instead may be transferred by budget amendment to the Medical Care Programs Administration, program M00Q01.03 Medical Care Provider Reimbursements, to be used only for adding Medicaid substance abuse service coverage to the Primary Adult Care Program and enhancing Medicaid reimbursement rates for substance abuse services. In reducing local treatment grant awards, the Department of Health and Mental Hygiene shall allocate the reduction based on local enrollment in the Medicaid and Primary Adult Care Program. Funds not expended for this restricted purpose may not be transferred by budget amendment or otherwise to any other purpose, and shall revert to the general fund.

   Explanation: The language authorizes the transfer of funds from the Alcohol and Drug Abuse Administration to the Medical Care Programs Administration to expand coverage of substance abuse treatment services to the Primary Adult Care Program and enhance rates for Medicaid substance abuse services. This action maximizes federal fund attainment and increases the total amount of funding in the substance abuse system.

Updates

1. Evaluation of the Pilot Project to Integrate Child Welfare and Drug Treatment Services

Background

Chapter 551 of 2000 established a program whereby qualified addiction specialists were placed in child welfare offices in two jurisdictions – Prince George's County and Baltimore City. Those specialists were tasked with screening, assessing, and referring cases to needed substance abuse treatment. The legislation also instituted a process for reciprocal reporting on case outcomes as well as mandated cross-training for personnel in each system.

The impetus for this program was well-established research that demonstrates that substance abuse and child maltreatment are closely linked and often cyclical – child abuse increases the risk of subsequent substance abuse in adulthood, and parental substance abuse is a precipitating factor in 40 to 80% of confirmed child abuse and neglect cases.

Funding was first provided in ADAA for this program in fiscal 2002 and has remained constant in recent years at just over $2.3 million, all general funds. This ADAA funding is used to purchase substance abuse treatment services.

Evaluation Requests

The legislature first asked for an evaluation of the efficacy of this program in fiscal 2004. That evaluation was not conducted due to a lack of funds. Subsequently, in the 2005 session, the legislature restricted funding to complete an independent evaluation of the program. That evaluation was conducted by the Center for Substance Abuse Research at the University of Maryland, College Park and was finally submitted during the 2008 session, but not in time to be considered by the budget committees.

Evaluation Results

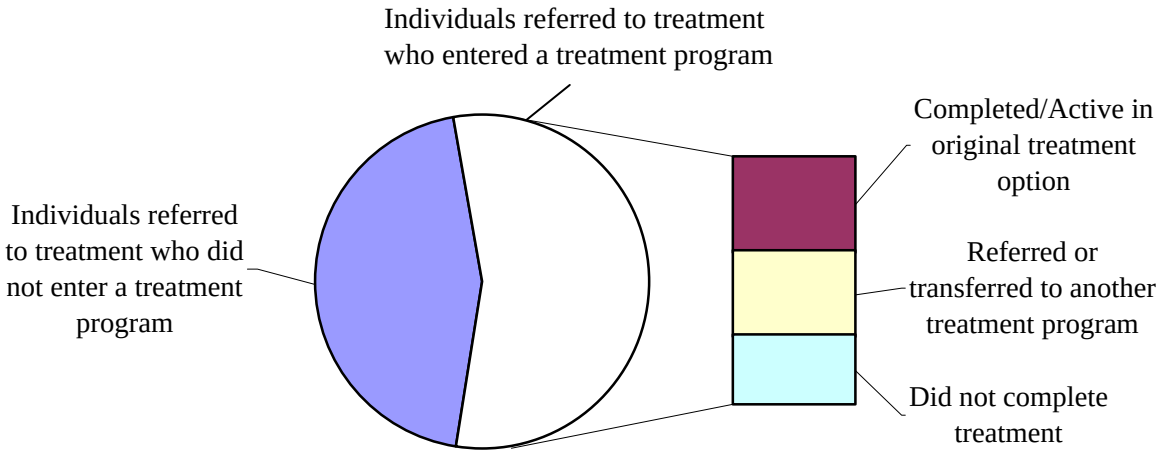
The evaluation consisted of two parts – a review of administrative records for all program participants (213) assessed as needing drug treatment in Baltimore City in calendar 2006; and telephone surveys with program staff to assess program implementation issues.

Exhibit 20 details the results of the administrative record review. As shown, for this sample of program participants, almost half (45%) of those identified by Child Protective Services (CPS) and referred to treatment by an addiction specialist had not received treatment after one year of follow-up. As the evaluation notes, there are many reasons why an individual identified by the program as in need of substance services would not show up for treatment:

- lack of transportation;
- lack of child care;
- lack of confidence in treatment; and
- concern about the potential loss of their children.

However, the report concludes that since these individuals have come to the attention of authorities for child abuse and neglect as well as being identified with substance abuse services, a more concerted effort needs to be made to ensure that they attend needed services.

Exhibit 20
Record Review of Participants in the Baltimore City Child Welfare and Drug Treatment Integration Pilot Project
Calendar 2006



Source: Center for Substance Abuse Research; Department of Legislative Services

For those that did enter treatment:

- 40% had completed or were still in treatment with the original treatment provider;
- 34% had been referred or transferred on to another treatment program, although no data was available as to whether an actual admission occurred or what the outcome of this additional treatment was; and
- 26% did not complete treatment.

The survey interviews with staff identified four areas of improvement in the administration of the program:

- The tool used as the primary method of screening for alcohol and drug problems among parents in the child welfare system may be inadequate. The report recommended an alternative instrument. However, the original screening tool continues to be used, although it is being supplemented with other assessment/screening tools.
- To facilitate case processing, a timeline should be developed for key events that occur between entry into the child welfare system, initial assessment by addiction specialists, entry into treatment, and discharge from treatment.
- More in-service cross-training of CPS caseworkers and addictions specialists is needed.
- Follow-up protocols were not standardized.

Evaluation Follow-up

Evaluation results were shared with ADAA and the Department of Human Resources (DHR) in 2007, and a workgroup was established consisting of staff from DHR, ADAA, the Baltimore City and Prince George's County Departments of Social Services, Prince George's County Health Department, and Baltimore Substance Abuse Services. That workgroup focused on two of the recommendations: improvement of cross-training and improvement of case follow-up.

In terms of cross-training, ADAA met with the University of Maryland, Baltimore Child Welfare Academy to discuss the development of a cross-training curriculum. Training on addictions is already incorporated into the training program for new social worker hires, and it was agreed that ADAA would develop an appropriate child welfare curriculum for addictions staff. That curriculum has been developed but follow-up actions by DHR remain pending.

One of the ways that was considered to improve case follow-up was to use a shared database to track shared clients. ADAA encouraged DHR to utilize the existing SMART application, ADAA's automated record tracking system. However, DHR declined and chose to continue a paper-based system when they discovered SMART was a web-based application.

Conclusion

A follow-up to this evaluation noted an increase in the number of individuals admitted for substance abuse treatment in fiscal 2008 although no data was provided as to outcomes for those admitted. While this at least indicates that the program is making referrals, it is nonetheless disheartening that the suggestions to improve the program made in the initial evaluation and in subsequent follow-up appear not to have been acted upon. The available information appears to indicate that these efforts founder because of a lack of action on the part of DHR.

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 2008					
Legislative Appropriation	$90,622	$17,748	$31,441	$3,363	$143,174
Deficiency Appropriation	0	0	0	0	0
Budget Amendments	-2,970	-57	1,639	780	-609
Cost Containment	-861	0	0	0	-861
Reversions and Cancellations	0	-156	-920	-158	-1,234
Actual Expenditures	**$86,791**	**$17,534**	**$32,160**	**$3,985**	**$140,470**
Fiscal 2009					
Legislative Appropriation	$93,811	$17,950	$32,321	$4,108	$148,190
Cost Containment	-1,054	-1	-8	0	-1,063
Budget Amendments	1,560	3	0	0	1,563
Working Appropriation	**$94,318**	**$17,952**	**$32,313**	**$4,108**	**$148,691**

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

Fiscal 2008

The fiscal 2008 actual spending for ADAA declined by just over $2.7 million compared to the fiscal 2008 legislative appropriation. The reduction was derived as follows:

- Budget amendments reduced the legislative appropriation by just over $600,000. This reduction consisted of:

    - A reduction of almost $3.0 million in general funds. This change was comprised of an almost $53,000 increase that represented ADAA's share of the fiscal 2008 cost-of-living adjustment (COLA) originally budgeted in the Department of Budget and Management and $9,000 as a result of the realignment of health insurance and telecommunication costs within DHMH that was more than offset by over $3.0 million transferred out of ADAA into other programs in DHMH as part of fiscal 2008 close-out. This transfer was based on lower than anticipated utilization of treatment grants (see above for a fuller discussion of this issue).

    - A small reduction of $57,000 in special funds.

    - An increase of over $1.6 million in federal funds representing an additional draw down of Substance Abuse Prevention and Treatment block grant to partially offset general funds transferred out of the program (although, as shown below, half of this funding was subsequently cancelled).

    - A $780,000 increase in reimbursable funds received from the Judiciary for treatment of drug court participants. This treatment will be provided through local health departments.

- Fiscal 2008 cost containment actions by the Board of Public Works (BPW) reduced ADAA's general fund appropriation by a further $861,000. The most significant reduction was $750,000 from the Governor's fiscal 2008 expansion of funding for buprenorphine. Other reductions were to various operational expenses spread throughout the budget.

- Cancellations further reduced the legislative appropriation by just over $1.2 million. The special fund cancellations related to lower than anticipated prior year grant expenditures, $109,000; and lower than anticipated expenditures for training and education, $47,000. The federal fund cancellations related to a variety of lower than budgeted expenditures in two grants: the Substance Abuse Prevention and Treatment Block Grant, $805,000; and the State Outcomes Measurement and Management System grant, $115,000. Reimbursable fund cancellations totaled $158,000.

Fiscal 2009

To date, the fiscal 2009 legislative appropriation has been increased by $501,000:

- As discussed above, fiscal 2009 cost containment taken by BPW in June and October 2008 resulted in a $1,054,000 reduction to ADAA's budget;

- This cost containment reduction was more than offset by an increase of just over $1.5 million in general funds to provide an additional 1.2% provider rate increase for ADAA grantees over and above the 1.5% increase originally provided in the fiscal 2009 appropriation. These funds were available as a result of overattainment in fiscal 2008 lottery revenues and legislation (Chapters 335 and 589 of 2008) directing those overattained funds to such an increase. However, as noted above, one of the October 2008 cost containment actions reduced that additional increase to 0.5%, or 2.0% in total. An additional $56,000 ($53,000 general funds, $3,000 special funds) was added to appropriation representing ADAA's share of the fiscal 2009 employee COLA.

Appendix 2

Preliminary Fiscal 2010 Prevention and Treatment Grant Allocations

	Prevention	Treatment	Total
Allegany	$228,145	$5,681,737	$5,909,882
Anne Arundel	283,679	5,458,056	5,741,736
Baltimore County	410,493	8,130,133	8,540,626
Calvert	80,190	1,035,976	1,116,166
Caroline	74,671	666,016	740,687
Carroll	91,382	3,978,629	4,070,011
Cecil	69,710	1,526,474	1,596,184
Charles	130,963	2,420,849	2,551,812
Dorchester	110,458	2,107,146	2,217,604
Frederick	363,633	2,636,635	3,000,268
Garrett	244,665	833,146	1,077,812
Harford	103,901	2,384,554	2,488,454
Howard	84,038	1,889,931	1,973,968
Kent	100,109	2,088,429	2,188,538
Montgomery	487,737	4,901,551	5,389,289
Prince George's	491,161	12,063,438	12,554,599
Queen Anne's	85,265	841,315	926,580
St. Mary's	95,551	3,440,482	3,536,033
Somerset	91,865	1,134,471	1,226,337
Talbot	100,430	953,779	1,054,209
Washington	239,971	3,844,425	4,084,397
Wicomico	347,862	2,288,680	2,636,542
Worcester	104,841	3,394,610	3,499,451
Baltimore City	1,002,974	51,437,851	52,440,826
Subtotal	***$5,423,696***	***$125,138,314***	***$130,562,010***
Statewide	817,114	11,399,232	12,216,346
Total	**$6,240,810**	**$136,537,546**	**$142,778,356**

Note: Statewide prevention excludes NOMS.

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

Object/Fund	FY08 Actual	FY09 Working Appropriation	FY10 Allowance	FY09 - FY10 Amount Change	Percent Change
Positions					
01 Regular	62.00	60.00	60.00	0	0%
02 Contractual	2.41	5.00	5.00	0	0%
Total Positions	**64.41**	**65.00**	**65.00**	**0**	**0%**
Objects					
01 Salaries and Wages	$ 4,130,515	$ 4,374,692	$ 4,704,602	$ 329,910	7.5%
02 Technical and Spec. Fees	76,773	123,467	123,979	512	0.4%
03 Communication	27,682	16,894	27,682	10,788	63.9%
04 Travel	91,867	79,406	94,251	14,845	18.7%
06 Fuel and Utilities	14	0	0	0	0.0%
07 Motor Vehicles	1,680	2,816	4,858	2,042	72.5%
08 Contractual Services	136,032,768	144,024,855	145,650,387	1,625,532	1.1%
09 Supplies and Materials	54,015	50,421	53,202	2,781	5.5%
10 Equipment – Replacement	18,125	0	0	0	0.0%
11 Equipment – Additional	2,636	0	0	0	0.0%
13 Fixed Charges	34,104	18,858	29,087	10,229	54.2%
Total Objects	**$ 140,470,179**	**$ 148,691,409**	**$ 150,688,048**	**$ 1,996,639**	**1.3%**
Funds					
01 General Fund	$ 86,791,014	$ 94,317,776	$ 95,890,118	$ 1,572,342	1.7%
03 Special Fund	17,534,565	17,952,311	17,918,455	-33,856	-0.2%
05 Federal Fund	32,159,848	32,312,955	31,942,751	-370,204	-1.1%
09 Reimbursable Fund	3,984,752	4,108,367	4,936,724	828,357	20.2%
Total Funds	**$ 140,470,179**	**$ 148,691,409**	**$ 150,688,048**	**$ 1,996,639**	**1.3%**

Note: The fiscal 2009 appropriation does not include deficiencies. The fiscal 2010 allowance does not include contingent reductions.

Fiscal Summary
DHMH – Alcohol and Drug Abuse Administration

Program/Unit	FY08 Actual	FY09 Wrk. Approp.	FY10 Allowance	Change	FY09 - FY10 % Change
K101 Executive Direction	$ 675,945	$ 704,023	$ 914,722	$ 210,699	29.9%
K102 Grants, Contracts and Management	795,240	793,421	779,784	-13,637	-1.7%
K103 Continuous Quality Improvement	524,524	690,249	708,240	17,991	2.6%
K104 Management Information Services	1,031,759	1,116,054	1,181,676	65,622	5.9%
K105 Education and Training	343,118	445,634	422,507	-23,127	-5.2%
K107 S.S.I. Drug and Alcohol	3,439	73,070	73,070	0	0%
K108 Criminal Justice	505,245	426,660	620,479	193,819	45.4%
K109 Policy, Planning and Development	200,000	200,000	0	-200,000	-100.0%
K110 Special Populations	58,037	150,000	0	-150,000	-100.0%
K111 Program Consultation	747,696	786,824	788,001	1,177	0.1%
K113 Administration and Operations	997,379	868,483	921,213	52,730	6.1%
K115 Adoption of Science-based Practices	46,110	0	0	0	0%
K117 Drug Abuse Target Cities Treatment	800,000	800,000	800,000	0	0%
K201 Prevention	6,092,647	6,385,144	6,385,144	0	0%
K202 Addictions Treatment Services (general fund)	72,541,140	77,881,851	79,106,724	1,224,873	1.6%
K203 SAPT Block Grant	24,380,375	24,013,846	23,836,882	-176,964	-0.7%
K204 Cigarette Restitution Funds (special fund)	17,059,612	17,048,197	17,058,197	10,000	0.1%
K206 Drug Treatment Court Commission of MD – reimbursable funds	1,655,134	1,745,272	2,528,728	783,456	44.9%
K219 Senate Bill 512 - Children In Need of Assistance Drug Affected Babies	1,691,374	1,656,599	1,656,599	0	0%
K220 Substance Abuse Treatment Outcomes Partnership Fund	6,146,825	6,433,718	6,433,718	0	0%
K221 House Bill 7 Integration of Child Welfare and Substance Abuse	2,332,412	2,322,364	2,322,364	0	0%
K225 Buprenorphine Funding	1,711,538	3,650,000	3,650,000	0	0%
K298 Grant Activity – Prior Fiscal Years	130,630	500,000	500,000	0	0%
Total Expenditures	**$ 140,470,179**	**$ 148,691,409**	**$ 150,688,048**	**$ 1,996,639**	**1.3%**
General Fund	$ 86,791,014	$ 94,317,776	$ 95,890,118	$ 1,572,342	1.7%
Special Fund	17,534,565	17,952,311	17,918,455	-33,856	-0.2%
Federal Fund	32,159,848	32,312,955	31,942,751	-370,204	-1.1%
Total Appropriations	**$ 136,485,427**	**$ 144,583,042**	**$ 145,751,324**	**$ 1,168,282**	**0.8%**
Reimbursable Fund	$ 3,984,752	$ 4,108,367	$ 4,936,724	$ 828,357	20.2%
Total Funds	**$ 140,470,179**	**$ 148,691,409**	**$ 150,688,048**	**$ 1,996,639**	**1.3%**

Note: The fiscal 2009 appropriation does not include deficiencies. The fiscal 2010 allowance does not include contingent reductions.