

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

Operating Budget Data

(\$ in Thousands)

	<u>FY 11</u> <u>Actual</u>	<u>FY 12</u> <u>Working</u>	<u>FY 13</u> <u>Allowance</u>	<u>FY 12-13</u> <u>Change</u>	<u>% Change</u> <u>Prior Year</u>
General Fund	\$85,198	\$82,994	\$87,876	\$4,882	5.9%
Adjusted General Fund	\$85,198	\$82,994	\$87,876	\$4,882	5.9%
Special Fund	22,950	23,192	24,814	1,622	7.0%
Adjusted Special Fund	\$22,950	\$23,192	\$24,814	\$1,622	7.0%
Federal Fund	27,398	38,442	39,791	1,349	3.5%
Adjusted Federal Fund	\$27,398	\$38,442	\$39,791	\$1,349	3.5%
Reimbursable Fund	5,559	5,697	6,232	535	9.4%
Adjusted Reimbursable Fund	\$5,559	\$5,697	\$6,232	\$535	9.4%
Adjusted Grand Total	\$141,105	\$150,325	\$158,713	\$8,388	5.6%

- Although the Alcohol and Drug Abuse Administration (ADAA) budget increases by almost \$8.4 million, 5.6%, the amount of funding ultimately available to the administration will be lowered by the transfer of almost \$16.1 million in general funds to the Primary Adult Care (PAC) program to fund substance abuse treatment for PAC recipients.
- After allowing for the transfer of PAC funds, the funding available to ADAA is up a more modest \$1.6 million, 1.1%, and represents an increase in problem gambling funding.

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

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Personnel Data

	<u>FY 11 Actual</u>	<u>FY 12 Working</u>	<u>FY 13 Allowance</u>	<u>FY 12-13 Change</u>
Regular Positions	64.50	68.50	68.50	0.00
Contractual FTEs	<u>3.51</u>	<u>8.67</u>	<u>6.77</u>	<u>-1.90</u>
Total Personnel	68.01	77.17	75.27	-1.90

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	3.43	5.00%
Positions and Percentage Vacant as of 12/31/11	15.00	21.90%

- ADAA has no new regular positions in the fiscal 2013 budget, although the personnel budget reflects the staffing-up of the Prescription Drug Monitoring Program created in the 2011 session.

Analysis in Brief

Major Trends

Prevention Indicators Show Change in Program Emphasis: The available prevention data shows declining utilization of prevention programs traditionally funded by ADAA as it switches funding to “environmental strategies.” ADAA needs to incorporate this shift into its presentation of prevention data.

Treatment Admission Continues to Rise: Admission to ADAA-funded treatment continues to rise, although completion rates show only modest improvement from fiscal 2010 to 2011.

Issues

Integration of Behavioral Health Care: The current provision of behavioral health services is fragmented. A 2011 interim consultant’s report commissioned by the Department of Health and Mental Hygiene (DHMH) recommended significant changes to the delivery of those services. Although the department demurred on any final decision at this point, it is committed to a process to propose legislative changes in the 2013 session for implementation in 2014.

Expansion of the PAC Program and the Impact on Substance Abuse Grant Funding: Data suggests that the expansion of substance abuse treatment to the PAC population has resulted in more overall spending on publically funded substance abuse treatment. However, some outstanding concerns linger.

Fiscal 2011 Closeout Audit: The fiscal 2011 close-out audit conducted by the Office of Legislative Audits indicated that ADAA contravened budget law by charging \$3.9 million in unspent federal funds to general funds. As important is why ADAA, given tight budgets, had \$3.9 million in unspent general funds available to accommodate this accounting maneuver.

Problem Gambling Prevalence: Baseline data from a recent study on problem gambling prevalence is outlined.

Recommended Actions

	<u>Funds</u>	<u>Positions</u>
1. Delete long-term vacant positions.	\$ 158,011	3.0
2. Reduce administrative expenses by \$100,000.	100,000	
Total Reductions	\$ 258,011	3.0

Updates

Non-opioid Pharmacotherapies for Alcohol Dependence: The efficacy of non-opioid pharmacotherapies for alcohol dependence is briefly reviewed, as is current State funding of this treatment modality.

Recovery Homes: Chapter 255 of 2011 required DHMH to identify standards for best practices in recovery homes. An update on the department's response to that requirement is provided.

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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.

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

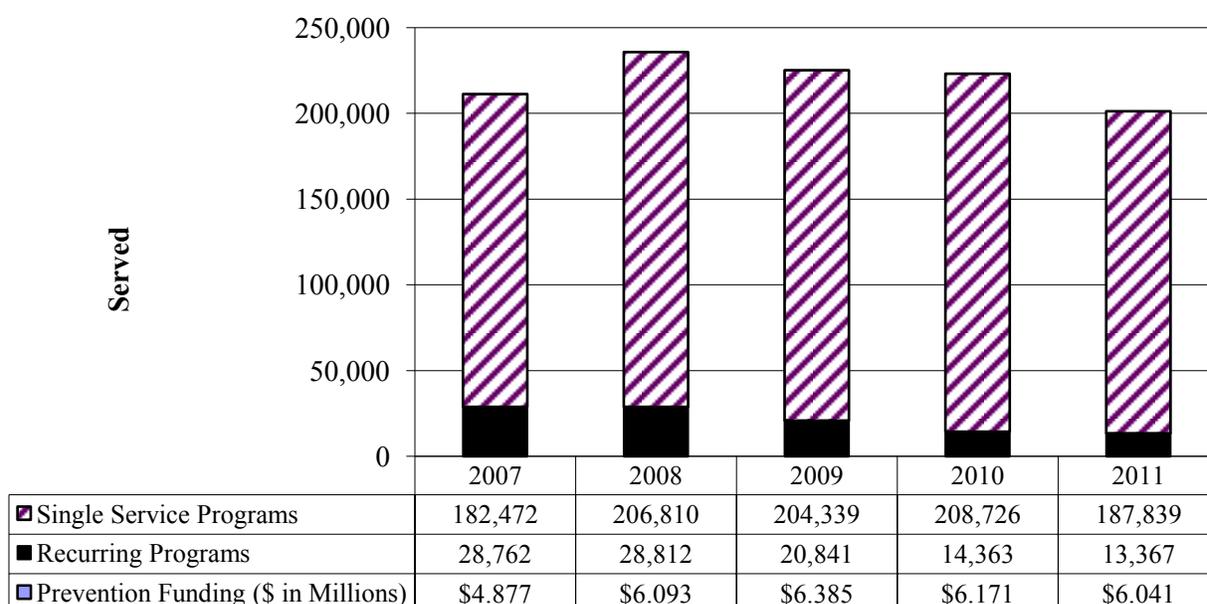
Prevention

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) evidence-based model. In fiscal 2011, a total of 362 recurring prevention programs were offered across the State, a drop of 13 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 2011, 1,235 single service prevention activities were offered in Maryland, a drop of 168 from the prior year.

As shown in **Exhibit 1**, ADAA prevention programming served just over 201,000 in fiscal 2011, far lower than the 223,000 served in fiscal 2010. Recurring programs, which saw a significant drop in people served from fiscal 2009 to 2010, fell by almost another 1,000 people served in fiscal 2011. The number of participants in recurring programs in fiscal 2011 is some 57% below the level served in fiscal 2005. The drop in the number of participants served in single service programs is even more dramatic, almost 21,000, or 10%, from fiscal 2010 to 2011.

**Exhibit 1
ADAA-funded Prevention Programs
Served by Program
Fiscal 2007-2011**



ADAA: Alcohol and Drug Abuse Administration

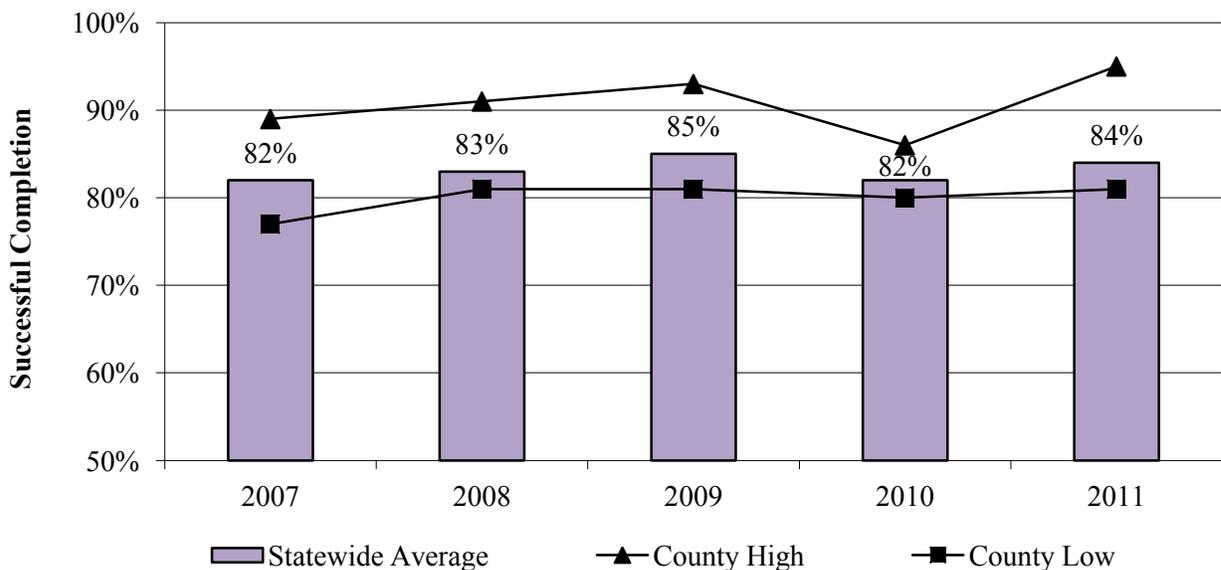
Source: Alcohol and Drug Abuse Administration

In both cases, beginning in fiscal 2011, there was a change in program focus from individual-based programming to population-based programming/activities. This change in focus, direction from SAMHSA, is intended to create a community level change. This change is expected to continue with the ADAA’s charge (under the broad direction of national drug policies) that jurisdictions 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.

This emphasis is consistent with goals in Maryland’s State Health Improvement Process (SHIP). The only concern with this shift is that it moves funding away from programs that are supposed to be evidence-based, *i.e.*, that there is some evidence that they are successful. It is unclear how evidence-based the environmental strategies are. **ADAA should be prepared to indicate how they are ensuring that the environmental strategies being pursued at the local level are evidence-based. ADAA should also update its annual prevention report to reflect its change in focus, including outcomes on local environmental strategies and, at the very least, incorporate the SHIP data. ADAA should also look to develop some prevention measure in its Managing for Results submission. Currently, there is no measure relating to prevention even though one of the vision statements for ADAA concerns community capacity to discourage substance abuse.**

As shown in **Exhibit 2**, ADAA reports that in fiscal 2011, 84% of participants in recurring prevention programs successfully completed the program, slightly higher than in fiscal 2010. As also shown in this exhibit, there is variation by county among programs in terms of successful completion. In fiscal 2011, for example, the successful completion rate varied from 95% in Cecil County to 81% in Baltimore City. 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 2007-2011



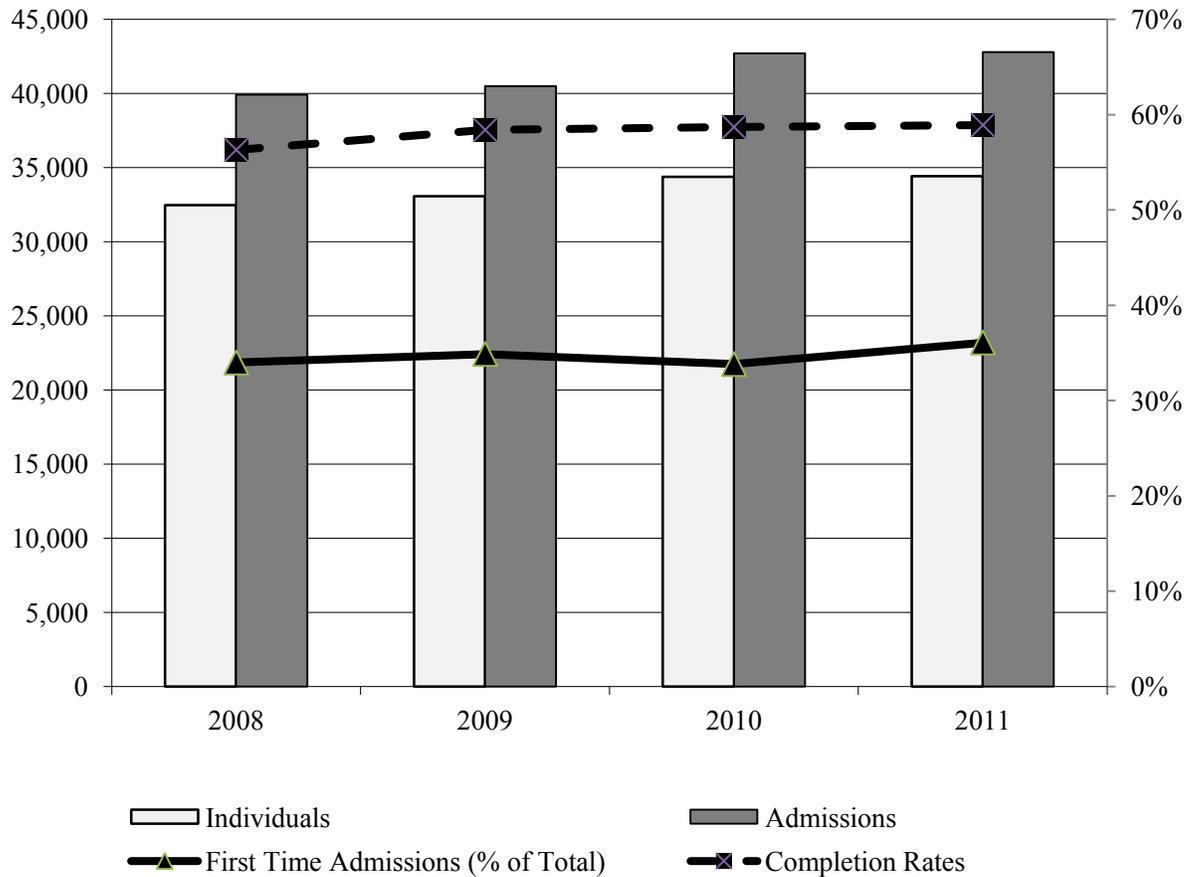
ADAA: Alcohol and Drug Abuse Administration

Source: Alcohol and Drug Abuse Administration

Treatment

As shown in **Exhibit 3**, ADAA-funded admissions have risen from just under 40,000 in fiscal 2008 to almost 43,000 in fiscal 2011, with the number of individuals served likewise increasing from just under 32,500 to just under 34,500 in the same period. First time admissions are also slightly up over the period. 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 show a slight increase over the period, up to 58.9% in fiscal 2011.

Exhibit 3
ADAA-funded Treatment Programs – Various Data
Fiscal 2008-2011

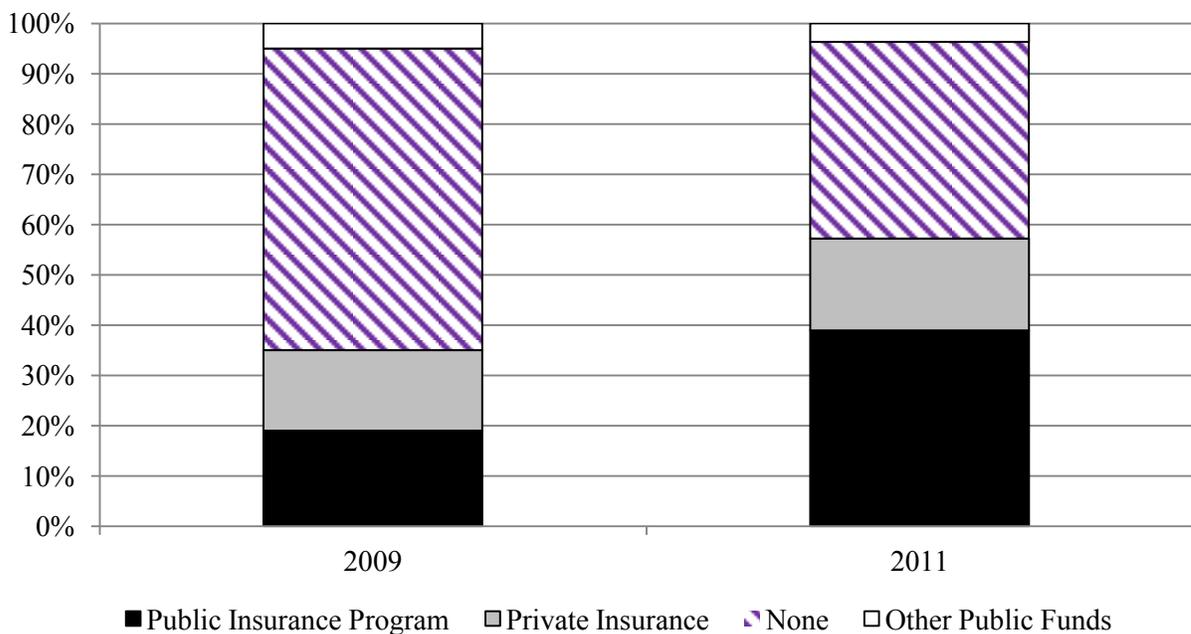


ADAA: Alcohol and Drug Abuse Administration

Source: Alcohol and Drug Abuse Administration

Exhibit 4 details the health insurance status for those admitted to ADAA-funded treatment programs. As shown in the exhibit, the expansion of substance abuse services to the Primary Adult Care (PAC) program dramatically impacted this data (for a more detailed discussion of the PAC substance abuse expansion see Issue 2). Specifically, in fiscal 2009, only 19% of admissions were in public insurance programs (Medicaid and Medicare) compared to 39% in fiscal 2011. Of this growth, 63% is attributed to the expansion of services to the PAC program, with 37% due to the growth in Medicaid overall because of the recession.

Exhibit 4
ADAA-funded Treatment Program Admissions – Health Insurance Status
Fiscal 2009 and 2011

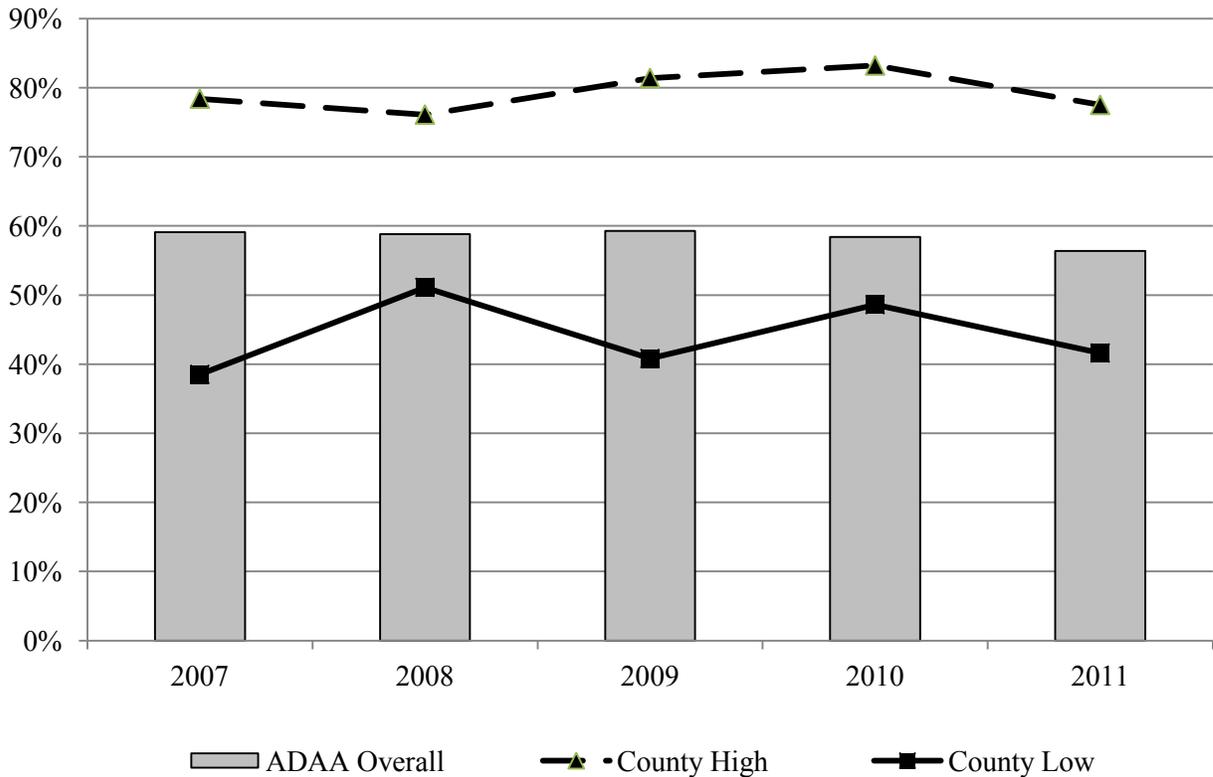


ADAA: Alcohol and Drug Abuse Administration

Source: Alcohol and Drug Abuse Administration

In terms of outcomes, 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 5**, 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.

**Exhibit 5
Level I Retention Rates
Retained More Than 90 Days
Fiscal 2007-2011**



ADAA: Alcohol and Drug Abuse Administration

Source: Alcohol and Drug Abuse Administration

There continues to be a wide variation between programs in fiscal 2011. For fiscal 2011, the highest retention rate for ADAA-funded programs is 77.5% (Caroline County), while the lowest retention rate is 41.6% (Queen Anne’s County). The agency has historically attributed this gap in retention rates to a difference in reporting practices between jurisdictions. If this is still the case, the agency should seek to standardize data reporting.

It should be noted that ADAA was once in the forefront in the health department and even statewide in its use of contract incentives linked to outcomes. Most notably it experimented with incentive payments to jurisdictions which, for example, had retention rates above certain levels. ADAA reports that it no longer makes these incentive payments because of lack of funds.

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Additional outcome data drawn from treatment programming is shown in **Exhibit 6**. 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 period shown in the exhibit, fiscal 2003 to 2011, there has been a fairly consistent decline in those reporting substance use 30 days prior to discharge. This number had been increasing in recent years but fell to its lowest point in the period shown in fiscal 2011.
- Data on employment is somewhat mixed. Between fiscal 2006 and 2010, there was a steady relative growth in employment at discharge among people admitted to treatment compared to employment levels at admissions. This relative change fell slightly in fiscal 2011 but was still at a reasonably high level. Unfortunately, reflective of the employment situation at large, fewer people were employed at admission in fiscal 2010 and 2011 compared to earlier years.

Exhibit 6
ADAA-funded Treatment Programs
Various Treatment Outcomes for All Treatment Types
Fiscal 2003-2011

Fiscal Year	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
2003	71.0%	48.7%	-31.4%	30.8%	35.7%	15.9%			
2004	69.0%	51.5%	-25.4%	29.9%	36.1%	20.7%			
2005	68.3%	49.9%	-26.9%	32.1%	38.6%	20.2%			
2006	68.5%	40.9%	-40.3%	32.1%	38.0%	18.4%	8.6%	2.4%	-72.1%
2007	69.4%	37.2%	-46.4%	30.6%	37.5%	22.5%	8.8%	2.5%	-71.6%
2008	70.2%	33.0%	-53.0%	29.1%	37.2%	27.5%	8.7%	2.8%	-68.0%
2009	71.1%	33.1%	-53.4%	27.7%	35.7%	29.1%	8.7%	2.8%	-68.0%
2010	73.9%	34.8%	-53.0%	24.2%	32.0%	32.1%	8.4%	2.4%	-71.6%
2011	74.7%	32.7%	-56.3%	24.2%	31.6%	30.6%	8.1%	2.8%	-65.1%

ADAA: Alcohol and Drug Abuse Administration

Source: Alcohol and Drug Abuse Administration

- The relative change in the level of criminal justice involvement 30 days prior to treatment compared to 30 days prior to discharge showed the lowest level of improvement in fiscal 2011 of the period for which data is shown. However, this was due to the relatively low level of criminal justice involvement at admission rather than any dramatic change in the level of involvement at discharge.

Court-involved Processing

Under current law, the courts may order the Department of Health and Mental Hygiene (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 the services required, it is generally considered that this service provision is subject to the availability of funds provided 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 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. However, recent data indicates that the time between a defendant being cleared for services under Section 8-507 and admission to the program has fallen considerably to an average of 32 days in the last six months.

Fiscal 2012 Budget Actions

Section 47 of the fiscal 2012 budget bill required the Governor to abolish 450 positions as of January 1, 2012. ADAA lost 1 federally funded position under this provision.

Proposed Budget

As shown in **Exhibit 7**, the fiscal 2013 allowance for ADAA increases by just under \$8.4 million, or 5.6%. However, the funding to be transferred to the Medical Care Programs Administration to support substance abuse treatment in the PAC program also increases by almost \$6.8 million. If this increase is discounted, the growth in ADAA’s budget is more modest, just over \$1.6 million, or 1.1%.

Exhibit 7
Proposed Budget
DHMH – Alcohol and Drug Abuse Administration
(\$ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
2012 Working Appropriation	\$82,994	\$23,192	\$38,442	\$5,697	\$150,325
2013 Allowance	<u>87,876</u>	<u>24,814</u>	<u>39,791</u>	<u>6,232</u>	<u>158,713</u>
Amount Change	\$4,882	\$1,622	\$1,349	\$535	\$8,388
Percent Change	5.9%	7.0%	3.5%	9.4%	5.6%
Contingent Reduction	\$0	\$0	\$0	\$0	\$0
Adjusted Change	\$4,882	\$1,622	\$1,349	\$535	\$8,388
Adjusted Percent Change	5.9%	7.0%	3.5%	9.4%	5.6%

Where It Goes:

Personnel Expenses	\$271	
Employee and retiree health insurance.....		\$167
Regular earnings.....		156
Retirement contributions.....		84
Other fringe benefit adjustments.....		14
Removal of the fiscal 2012 one-time \$750 bonus.....		-41
Workers' compensation assessment.....		-53
Turnover adjustment.....		-56
Administration	\$351	
Prescription Drug Monitoring Program, nonpersonnel costs.....		299
State of Maryland Automated Record Tracking ongoing enhancement and development.....		52
Prevention	\$50	
Strategic prevention network (federal funds).....		112
Substance Abuse Prevention and Treatment Block Grant (federal funds).....		-62
Treatment	\$6,160	
Transfer of funds to PAC.....		6,765
Statewide contracts.....		135
Access to Recovery grant (federal funds).....		-54
Treatment grants (after PAC transfer).....		-687

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Where It Goes:

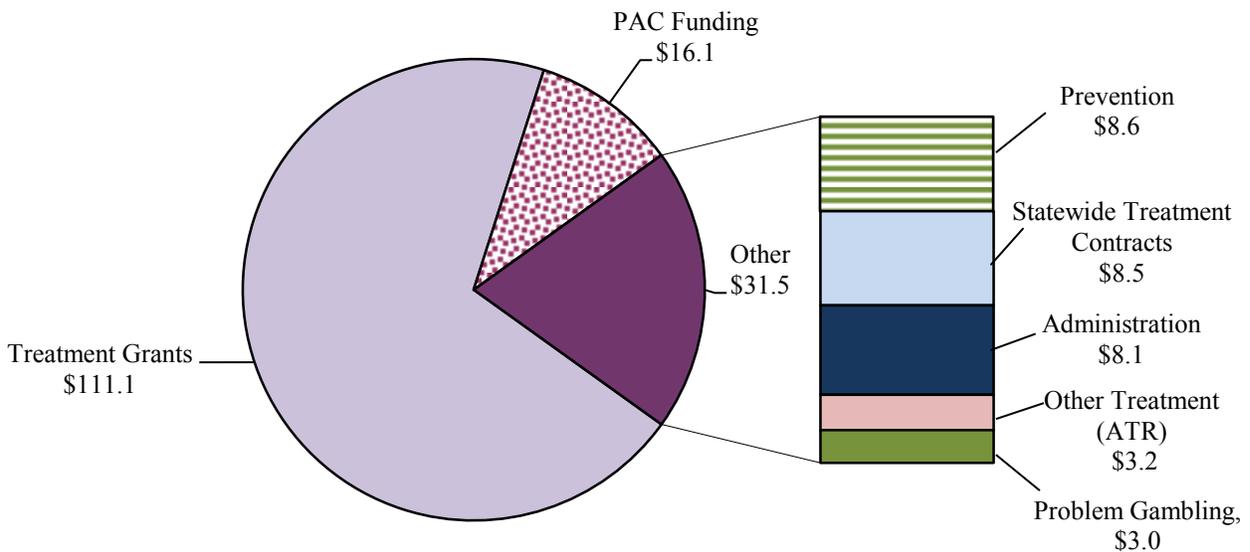
Problem Gambling	\$1,625
Center of Excellence for Problem Gambling	1,625
Other	-69
Total	\$8,388

PAC: Primary Adult Care

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

Exhibit 8 provides a broad overview of how the ADAA budget will be spent. Treatment grants account for the bulk of total funding at just over \$111 million, 70%. Funding that will be transferred to the PAC program amounts to just over \$16 million, 10%, with the remainder split between statewide contracts, prevention activities, administration, and other programming.

Exhibit 8
ADAA Fiscal 2013 Budget – Broad Spending Categories
 (\$ in Millions)



ADAA: Alcohol and Drug Abuse Administration
 ATR: Access to Recovery
 PAC: Primary Adult Care

Source: Alcohol and Drug Abuse Administration

Personnel

Personnel expenses increase by \$271,000 driven by increases in health insurance costs and regular earnings. The increase in regular earnings is primarily a result of the staffing-up of the Prescription Drug Monitoring Program. This program, aimed at stemming problems of prescription drug abuse and diversion, was created by Chapter 166 of 2011. During the 2011 interim, the Board of Public Works created positions for this program, although expenditures associated with the program are currently only reflected in fiscal 2013.

Prevention

There is a small increase in prevention funding. Funding available through the Strategic Prevention Network increases by \$112,000, while prevention grant funding through the Substance Abuse Prevention and Treatment Block Grant falls by \$62,000.

Treatment

Fiscal 2013 provides almost \$6.2 million in additional funds for treatment over fiscal 2012. However, the funding that will be transferred to support the PAC program increases by almost \$6.8 million, to a total of just over \$16.1 million, all general funds. After considering the small increase in the budget to support statewide contracts for residential programming, the funding for local treatment grants falls by \$687,000. Funding allocations for fiscal 2013 for local awards are not finalized until after the budget. However, as a point of reference, **Appendix 2** provides initial allocations for total prevention and treatment spending by jurisdictions in fiscal 2012.

In addition to the funding available at the local level for treatment falling, ADAA's fiscal 2013 budget proposes to continue the re-purposing of local treatment awards away from simply the purchase of treatment slots to a Recovery Oriented System of Care (ROSC). ROSC has a number of elements that are not included in the current system including:

- 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.

ROSC builds on the approach developed under the Access to Recovery federal grant. The outcomes to measure success will include variants on those traditionally used – retention in multiple treatment services over a length of time and successful linkage between various types of treatment and recovery support services.

The fiscal 2013 budget envisages \$5.3 million in new spending on ROSC elements other than simple treatment slots for a total of \$9.6 million. This is up from just over \$4.3 million in the fiscal 2012 budget.

It should also be noted that ADAA intends to rebid its statewide residential contracts and merge the existing three contracts into two. Currently, ADAA utilizes 38 Level III.3 (clinically managed medium-intensity) beds for women and children, 55 Level III.5 (clinically managed high-intensity beds for court-involved individuals), and another 68 beds for Level III.3 court-ordered individuals (110 beds). ADAA plans to merge the two court-involved contracts and anticipates an increase in Level III.5 beds for court-involved individuals as a result.

Problem Gambling Funding

There is an additional \$1.625 million in funding anticipated to be available from the Problem Gambling Fund for a total of almost \$3 million. ADAA has indicated that rather than allocate funding available for problem gambling prevention and treatment directly to the local jurisdictions (the practice for much of the ADAA substance abuse prevention and treatment budget), it will instead develop a Center of Excellence on Problem Gambling to manage the multiple prevention, treatment, and other activities associated with gambling. This is a model utilized in three other centers: Yale University and the University of Minnesota, which were established in 2009 with funding from the National Center for Responsible Gaming, a group funded primarily by the gaming industry; and the University of Denver, which is funded by the Colorado Division of Behavioral Health.

ADAA is currently preparing a request for proposals (RFP) for the establishment of a Center of Excellence on Problem Gambling in Maryland. It is anticipated that it will be based in a university setting and thus take advantage of related research activities. The center will also be required to develop, publish, and execute a comprehensive gambling treatment and prevention plan for Maryland. The plan will include among other things the operation of a 24/7 assistance hotline; development of appropriate statewide training; dissemination of gambling-related materials to clinicians, treatment professionals, and the general public; and determining funding levels needed to support clinical treatment services in the community while maximizing the existing substance abuse delivery system.

It can be argued that treatment interventions for gambling disorders are the same or very similar to those used with substance abuse interventions. Indeed, as noted in the prevalence study prepared for ADAA in the 2011 interim (see Issue 4 for additional details), many problem/pathological gamblers also present with substance abuse and mental health disorders. Thus, the existing treatment network should be able to readily handle any new clients with a primary issue of problem gambling. However, ADAA wants to develop a gambling plan to ensure that providers are indeed able to handle those presenting with primarily gambling-related issues, to recommend changes and training to ensure that providers are able to handle these individuals, as well as allocate funding.

Funding for problem gambling services varies considerably among states. The most recent survey undertaken by the Association of Problem Gambling Service Administrators (APGSA) indicated 37 states allocate public funds toward problem gambling service delivery. As shown in **Exhibit 9**, nearly 60% of states dedicated less than \$1 million for problem gambling services in fiscal 2010. It should be noted, however, that due to the current economic climate, many states have since experienced a decrease in funding for problem gambling services. On a per-capita basis, the average amount of funding dedicated to problem gambling services was \$0.34 in fiscal 2010. Among the states identified in APGSA’s survey, per capita spending on problem gambling ranges from less than \$.01 (Maryland) to \$1.36 (Iowa). Obviously, beginning in fiscal 2012 and now continuing into fiscal 2013, Maryland is making more funding available for problem gambling, although as noted above, how the funding will be specifically spent remains unanswered.

Exhibit 9
Funding Levels for Problem Gambling Services
Fiscal 2010

Less than \$1.0 million	Arkansas, Delaware, Georgia, Illinois, Kansas, Maryland , Maine, Missouri, Mississippi, North Dakota, New Jersey, New Mexico, Nevada, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Vermont, Washington, and Wisconsin
\$1.01 million – 2.0 million	Arizona, Colorado, Connecticut, Massachusetts, Minnesota, North Carolina, Nebraska, and West Virginia
\$2.01 million – 3.0 million	Louisiana and Michigan
\$3.01 million – 4.0 million	Iowa
\$4.01 million – 5.0 million	New York and Oregon
\$5.01 million – 6.0 million	Pennsylvania
\$6.01 million +	California

Source: Association of Problem Gambling Service Administrators

ADAA envisages the Center of Excellence contract being awarded so that the center is operational in June 2012. In the meantime, it has indicated that it intends to use the bulk of the \$1 million in problem-gambling funding available in fiscal 2012 (exclusive of the \$100,000 to fund the 24-hotline for compulsive and problem gamblers) for substance abuse treatment, efforts to increase public awareness, training and prevention, and for a limited amount of start-up expenses. It should be noted that this is less than the amount originally appropriated and is based on the most recent estimates of available funding. **The Department of Legislative Services (DLS) recommends that ADAA follow through with its plan to spend funding in a planned way through the Center of Excellence. Thus, DLS recommends that \$950,000 of the fiscal 2012 appropriation for problem gambling be allowed to revert to the Problem Gambling fund and Budget**

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Reconciliation and Financing Act language be added to transfer those funds to the Educational Trust Fund. A corresponding \$950,000 reduction in general fund support for education will be included in the Aid to Education analysis.

Issues

1. Integration of Behavioral Health 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. However, all too often, not only are behavioral health services delivered in separate systems, so too are those systems poorly integrated with other medical care. For public health programs, such as Medicaid, this lack of integration is particularly disconcerting given that a small number of individuals in this program disproportionately consume a large percentage of overall spending. Many of these individuals have multiple chronic conditions, frequently including behavioral health problems.

2011 Interim Study

During the 2011 interim, a consultant working for the department released a report detailing options for the integration of behavioral health care. The report noted issues with the current delivery system that have also been noted in the past.

- Poor alignment of benefit design and management was considered the most glaring limitation of the current system, specifically the 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 was evident.
- Uncoordinated care management including multiple service authorization entities and no meaningful coordinated care determination systems was also present.
- There was a lack of performance risk. With the exception of the modest value-based purchasing program for managed care organizations (MCO), no element of the system currently has any financial incentive around performance. Payment is for volume not outcomes.
- Integrated care management across the systems is lacking.

The study reviewed a variety of models and systems operating in other states but ultimately made two recommendations:

- Provide a Medicaid behavioral health benefit managed by health plans through a “protected carve-in” selected with an emphasis on performance. Under this proposal, a health plan would receive a separate, dedicated behavioral health capitated rate that can only be spent on behavioral health treatment and recovery support. Contractual requirements would specify certain levels of behavioral health staffing in clinical leadership. Contracts would also have performance risk and require the provision of data elements including penetration rates, expenditure levels, and authorization denials.

The report argued that this option had the advantage of accelerating integration while at the same time protecting the behavioral health benefit and allowing the testing of the notion that health plans can manage behavioral health as effectively as medical care. It places risk for general health and behavioral health outcomes in one management system and would have one integrated network. The same health plans could also manage services for the uninsured (even after Medicaid expansion and the availability of subsidies through the Exchange) as they currently do for the PAC populations.

- The second option would be the development of a Behavioral Health Plan, a risk-based contract for the management of the existing Medicaid behavioral health benefit and the State/block grant-funded benefit. This option retains the current “carve-out” approach for mental health services and would extend it to all behavioral health services. Again, such a plan would bear both insurance and performance risk. The report did note some disadvantages with this approach: it is an approach from the 1990s when states first began the use of risk arrangements for behavioral health; it does not combine accountability for medical and behavioral health benefits in the same management system; it will require workarounds to build incentives for integration and, as such, will require alignment of two separate contracts and contracting processes; and it can only be considered an interim step to full financial and benefits integration. The consultant’s report clearly did not favor this option.

It should be emphasized that both solutions are not mutually exclusive of other efforts to improve service delivery, for example, through patient-centered medical homes and chronic care medical homes. Indeed, Maryland is already moving forward with the patient-centered medical home model and includes homes within the MCO system (the development of Chronic Care medical homes is proposed in the fiscal 2013 Medicaid budget).

The report’s conclusions were that the State should opt for a new system to coincide with the expansion of Medicaid on January 1, 2014. In the interim, it proposed adding performance risk to the Administrative Services Organization (ASO) contract with the September 2012 renewal and increasing risk in MCO contracts and adding performance standards to be shared by both; conducting more data analysis including but not limited to Medicaid data on utilization of behavioral health in primary settings, expenditure patterns for primary and specialty behavioral health services, and expenditure data generally; adding the development of health homes as a contractual obligation for MCOs and the ASO and attaching risk to this requirement; and aligning contracting and certification requirements. To this list might usefully be added how to measure performance in any system that emerges.

Next Steps

While the department acknowledged the flaws of the current delivery system, it concluded that it was not prepared at the current time to choose one option over another. Rather, the Secretary indicated that the department would develop a detailed integration plan to define:

- the potential mechanisms to align incentives across medical, mental health, and substance abuse treatment;
- what models of care in Maryland need supports;
- incentives required to deploy those models of care;
- how to measure the health care and financial outcomes of a new system; and
- the capacity of various entities to play the roles required in a new system.

The department envisages one agency to oversee the financing of medical, substance abuse and mental health services, namely the Medicaid program. Thus, the Deputy Secretary for Health Care Financing will lead the planning team to review financing and integration options. A draft proposal to integrate care based on the consultant's report will be developed by September 30, 2012, with a view to legislation in the 2013 session ahead of implementation in calendar 2014.

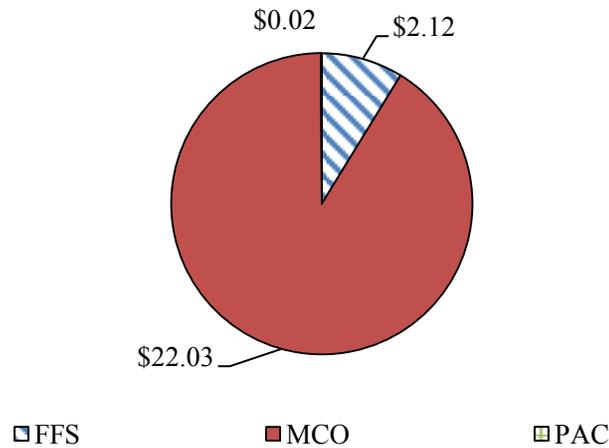
2. Expansion of the PAC Program and Impact on Substance Abuse Grant Funding

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 subsequent years, and including the proposed fiscal 2013 budget, the program has continued to be supported by transfers from the ADAA grant program, reducing the funding available for treatment grants.

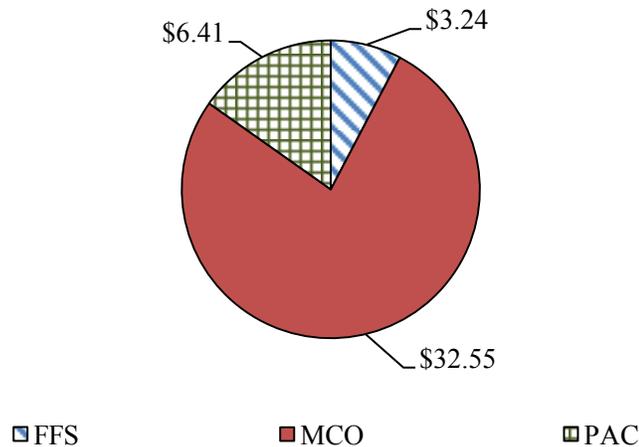
In the 2011 interim, the department released a report assessing the impact of the expansion of substance abuse treatment services to PAC. Between fiscal 2009 and 2010, total spending on outpatient substance abuse treatment increased from \$24.2 million to \$42.2 million, or 75%, a period reflecting only six months of the new PAC benefit and reimbursement rates. As shown in **Exhibit 10**, this increase was most noticeable with the emergence of the PAC program as the second largest source of Medicaid substance abuse expenditures. The remaining growth was attributable to a mix of rate increases and growth in Medicaid enrollment generally.

Exhibits 10
Medicaid Outpatient Substance Abuse Expenditures
Fiscal 2009 and 2010
(\$ in Millions)

2009



2010



FFS: fee-for-service
MCO: managed care organization
PAC: Primary Adult Care

Note: Expenditures are generally for nonpharmacy payments only. While Methadone treatment is a bundled payment that includes a payment for Methadone, Buprenorphine costs, for example, would be excluded. According to the department, pharmacy expenditures related to substance abuse treatment typically amount to an additional 23% of total substance abuse expenditures.

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

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The report also projected fiscal 2012 total Medicaid and ADAA grant expenditures in comparison to fiscal 2009. Specifically, Medicaid expenditures are expected to grow from \$24.2 million in fiscal 2009 to \$65.5 million in fiscal 2012. Conversely, ADAA grant funds for treatment will fall. However, this still nets to an increase of funding for substance abuse treatment of over \$26.0 million. As shown in **Exhibit 11**, the jurisdictional impact varies:

- All but four jurisdictions project to have more expenditures on substance abuse treatment in fiscal 2012 compared to fiscal 2009. The increases range from 0.3% in Montgomery County to 65.4% in Kent County (a figure inflated by the recently available grant funding for residential treatment at the Whitsitt Center resulting from the closure of the Upper Shore Community Mental Health Center).
- Two other jurisdictions (Baltimore and Harford counties) project increases of over 50.0%.
- Four jurisdictions project to have an overall reduction in funding for substance abuse treatment: Talbot (16.0%), Prince George's (8.0%), St. Mary's (6.0%), and Worcester (5.0%).
- Of those jurisdictions projected to see a decline in funding for substance abuse treatment, perhaps the most unexpected is Prince George's County. Based on current PAC enrollment, the projected number of unique users of outpatient substance abuse services who are also PAC enrollees in Prince George's County is remarkably low (less than 4.0%) compared to 41.0% in Anne Arundel County and 23.0% statewide (see **Exhibit 12**). A similar observation can be made for Talbot and St. Mary's counties, although less so for Worcester County.
- The data from Prince George's County is of particular concern because in the recent comprehensive needs assessment for drug treatment (2008), Prince George's County was identified as the jurisdiction most in need of developing treatment slots. At that time, the county was identified as having a shortage of residential beds and trained counselors.
- All jurisdictions received technical assistance regarding billing, collections, and changes needed for businesses to sustain a fee-for-service business. Prince George's was among four jurisdictions that received additional targeted technical assistance. How they actually fare in fiscal 2012 versus the projections will be followed up once the data is available.

Exhibit 11
Substance Abuse Treatment Expenditures by Jurisdiction
Difference Between Fiscal 2009 and 2012

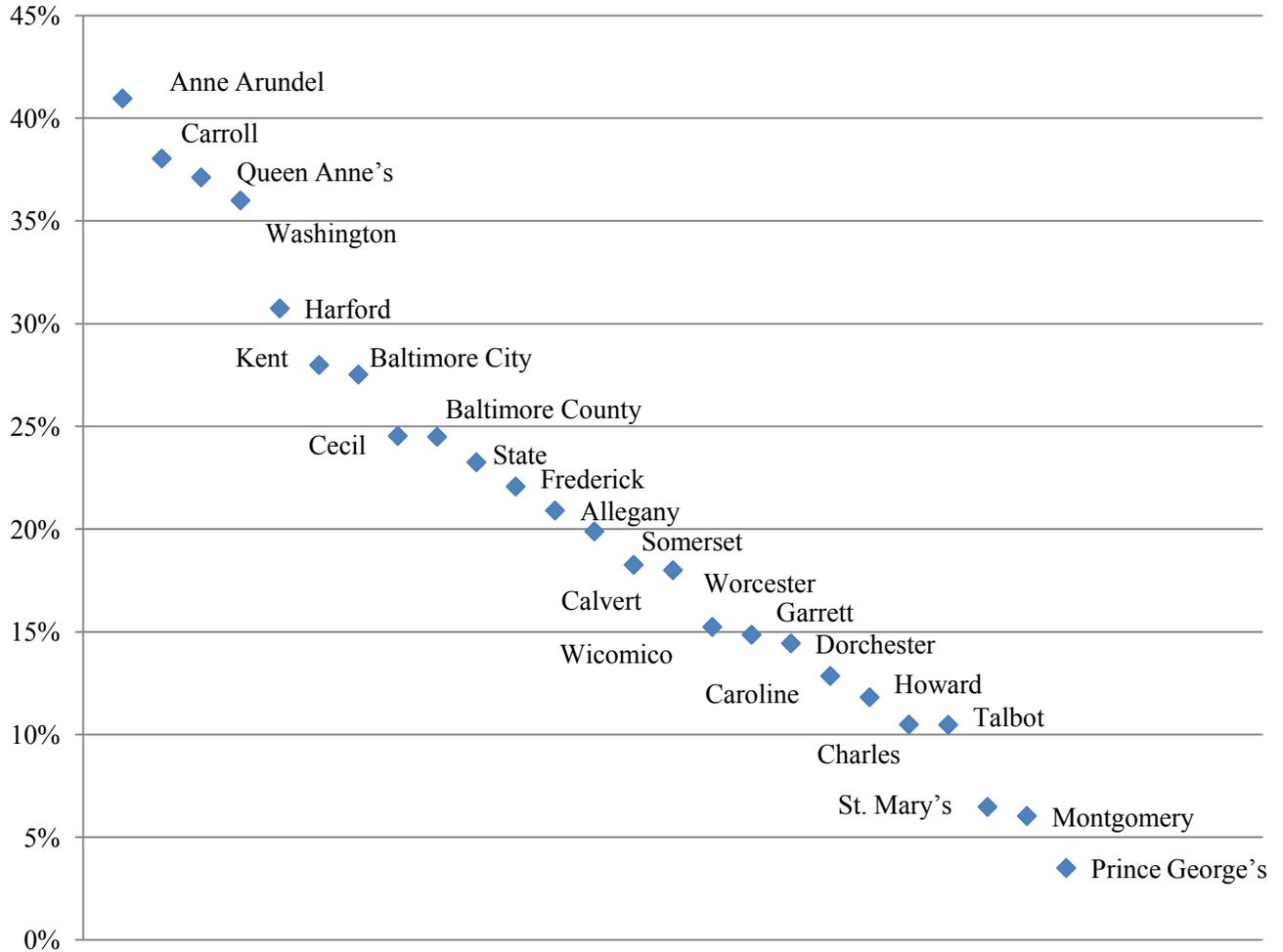
	<u>Medicaid Expenditures 2009 v. 2012</u>	<u>ADAA Grants 2009 v. 2012</u>	<u>Net Difference</u>	<u>% Change</u>
Allegany	\$976,179	-\$578,800	\$397,379	7.43%
Anne Arundel	3,066,443	-718,807	2,347,636	40.93%
Baltimore City	21,791,037	-7,828,482	13,962,555	26.04%
Baltimore County	6,436,167	-1,464,798	4,971,369	56.80%
Calvert	168,012	-112,910	55,102	7.02%
Caroline	160,280	-70,509	89,771	15.85%
Carroll	881,353	-475,000	406,353	12.01%
Cecil	912,489	-171,456	741,033	44.58%
Charles	266,839	-255,082	11,757	0.57%
Dorchester	276,470	-248,925	27,545	1.61%
Frederick	603,617	-394,606	209,011	9.16%
Garrett	126,872	-76,001	50,871	8.93%
Harford	1,244,326	-177,044	1,067,282	55.72%
Howard	377,118	-92,548	284,570	18.99%
Kent	84,945	1,074,895	1,159,840	65.37%
Montgomery	655,408	-641,804	13,604	0.34%
Prince George's	457,496	-1,155,864	-698,368	-8.34%
Queen Anne's	151,026	-134,223	16,803	2.34%
Somerset	78,613	28,538	107,151	15.87%
St. Mary's	68,619	-233,295	-164,676	-6.24%
Talbot	15,080	-143,154	-128,074	-16.01%
Washington	1,290,292	-506,781	783,511	25.08%
Wicomico	1,054,709	-599,816	454,893	20.44%
Worcester	215,873	-343,263	-127,390	-4.91%
Total	\$41,359,263	-\$15,319,735	\$26,039,528	22.29%

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Note: Medicaid expenditures are generally for nonpharmacy payments only.

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

Exhibit 12
Projected 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 certainly supports 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, a policy decision aimed at maximizing the use of State funding, improving access to substance abuse services, and increasing the total funding available to the substance abuse treatment system and providers.

However, concern remains 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 15.2% of encounters (42,226) and 10.6% in fiscal 2010 (47,508). The extent of unpaid encounters in fiscal 2010, for example, in the HealthChoice program ranged from a low of 0.2% by Maryland Physicians Care to a high of 28.6% by United Healthcare and in the PAC program from 0.7% by Maryland Physicians Care to 28.6% again by United Healthcare. Advocates were concerned that this represented a significant number of encounters for which providers were not paid. The department noted that there are a number of legitimate reasons why payments may not be made for encounters including duplicate encounters and nonpayment as a result of coordination of benefits. However, the department indicated it would be following up on this issue.

Finally, although it can be stated equivocally that the expansion of substance abuse treatment benefits to the PAC program put more funding into the substance abuse system as a whole, there still remains a lack of outcome data across the systems.

3. Fiscal 2011 Closeout Audit

In its statewide review of budget closeout transactions for fiscal 2011, the Office of Legislative Audits raised one finding against ADAA. Specifically, ADAA transferred approximately \$3.9 million that had originally been charged to federal fund appropriations under its Substance Abuse Prevention and Treatment (SAPT) block grant to its general funds appropriation. ADAA indicated that it did this because it had not expended all of its general fund appropriation. This clearly contravenes budget law which states that if expenditures can be charged to general or federal funds, federal funds should be charged first. In this instance, ADAA should have reverted \$3.9 million in general funds.

As shown in **Exhibit 13**, if ADAA had not taken this action, in fiscal 2011, it would not have been able to appropriately reserve SAPT block grant funds in fiscal 2012 and have an ending funding balance. Furthermore, it would not be able to meet its reserve requirements in fiscal 2013 while supporting the fiscal 2013 budget as provided by the Governor. However, DLS would suggest that this does not reflect prudent management of the SAPT block grant funds. Rather, it reflects somewhat optimistic forecasts of SAPT block grant funding compared to actual awards, and a tendency to over-rely on this funding source in recent years as an increased amount of funding was diverted from ADAA's budget to support substance abuse treatment in the PAC program.

Exhibit 13
Alcohol and Drug Abuse Administration
Substance Abuse Prevention and Treatment Block Grant
Fiscal 2011-2014

	<u>2011</u>	<u>2012</u>	<u>2013</u>	<u>2014</u>
Beginning Balance/Prior Year Reserve	\$10,002,882	\$14,003,098	\$11,274,686	\$7,786,230
Attainment	31,263,493	31,144,920	31,144,920	
Subtotal	\$41,266,375	\$45,148,018	\$42,419,606	
Reserved for Subsequent Year	-7,815,873	-7,786,230	-7,786,230	
Transferred Out	-603,012	-1,017,960	-665,445	
Expenditures	-26,660,265	-32,855,372	-33,967,931	
Ending Balance	\$6,187,225	\$3,488,456	\$0	

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

ADAA responds that it believes that because SAPT grants can be expended over a period of several years its action did not contradict budget law. However, the relevant law contains no exception for ADAA or the SAPT block grant.

In addition to contravening budget law, this transaction almost more importantly raises questions as to why ADAA was underspending its budget by such a significant amount, especially given increasing claims on its budget from the PAC program. Some years ago, DLS raised this issue of underspending in budget analyses, and ADAA appeared to have largely resolved this issue by closer monitoring of ongoing spending by its grantees. Clearly this did not occur in fiscal 2011. **ADAA should comment on the close-out finding, explain why it contravened budget law, and also explain why it significantly underspent its budget in fiscal 2011.**

4. Problem Gambling Prevalence

Chapter 4 of the 2007 special session, which provided for problem gambling prevention and treatment funding while at the same time establishing video lottery terminals in Maryland, also required a study on problem gambling prevalence. The report was submitted during the 2011 interim and provides baseline data for problem gambling in Maryland.

Gambling Prevalence Study

Problem gambling can be best understood as a continuum. At its most severe, a person can be considered a pathological gambler. Recognized as a mental disorder, pathological gambling involves continuous or periodic loss of control over gambling, a deepening involvement in gambling, and a continued involvement despite adverse consequences. Problem gamblers can be identified as individuals with substantial gambling-related difficulties, but those difficulties are not as severe as pathological gamblers, although gambling can compromise personal, family, or vocational pursuits. Further down the continuum are “at-risk” gamblers. In developing programs to address the issue of problem gambling across this broad continuum, the report notes that problem and at-risk gamblers are of as much concern as pathological gamblers because:

- problem and at-risk gamblers represent a much larger proportion of the population than pathological gamblers alone;
- there is potential for problem and at-risk gamblers to see their gambling-related difficulties increase over time; and
- the fact that the gambling habits of problem and at-risk gamblers can be more easily influenced by changes in social attitudes and public awareness.

The study also reviewed the research literature on the link between the availability of legal gambling opportunities and rates of problem and pathological gambling. The tentative conclusions drawn from that review include:

- The introduction and expansion of new forms of gambling, in particular electronic gaming machines, initially results in an increase in problem gambling especially among males and youth.
- Over time, problems can extend to groups that traditionally have low levels of gambling involvement such as women and older adults.
- Over time, in areas with prolonged increased availability of gambling opportunities, prevalence rates level off or decline, although it is unclear what to attribute this to.

The only prior research on the prevalence of problem and pathological gambling in Maryland was conducted as part of a larger study in 1989. At that time, 1.4% of respondents were identified as probable pathological gamblers, with an additional 2.4% identified as problem gamblers. These rates were consistent with rates in other East Coast states as well as California. Pathological and problem gamblers were more likely to be male, non-White, and non-high school graduates.

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The most recent prevalence study revealed the following:

- The prevalence of pathological gamblers was 1.5% (or 66,000 Maryland adults), slightly higher than identified in 1989, although problem gamblers were identified as only 1.9% of the population (84,000 adults), down from 2.4%. A further 9.0% of Marylanders (398,000 adults) were considered at-risk of becoming problem or pathological gamblers.
- Younger adults (18-29) were much more likely to be problem/pathological gamblers (6.8% of this age group).
- Males were much more likely to be problem/pathological gamblers than females (5.3 to 1.5%).
- Consistent with the 1989 study, non-White populations were more likely to be problem/pathological gamblers (4.9% for African Americans and 6.2% for other races, compared to 2.0% White).
- Pathological/problem gamblers are more prevalent among low income (below \$15,000) adults (15%) and non-high-school graduates (14.3%).
- There is some regional variation in pathological/problem gamblers:
 - 4.3% on the Eastern Shore;
 - 3.9% in Central Maryland (Baltimore City, and Baltimore, Harford, and Howard counties);
 - 3.2% in Southern Maryland (Anne Arundel, Calvert, Prince George's, Charles, and St. Mary's counties); and
 - 2.5% in Western Maryland (Allegany, Carroll, Frederick, Garrett, Montgomery, and Washington counties).

As shown in **Exhibit 14**, compared to other similar studies in other states and the nation, the lifetime prevalence of problem/pathological gamblers in Maryland is relatively high. However, it is important to note that these studies were conducted at different times, and changes in attitudes and accessibility to gambling over time may influence the differences.

Exhibit 14
Problem Gambling Prevalence
Various States

<u>Jurisdiction</u>	<u>Year of Study</u>	<u>Problem/Pathological Gamblers (%)</u>	<u>At-risk Gamblers (%)</u>
Nevada	2001	5.1	10.9
California	2006	3.7	9.5
Maryland	2010	3.4	9.0
Connecticut	2008	3.3	7.2
United States	1999	2.7	7.7
New Mexico	2005	2.2	6.4
Arizona	2002	2.1	11.0
Oregon	2000	2.1	7.7
Florida	2001	1.6	7.8
North Dakota	2000	1.5	5.2

Source: *Gambling Prevalence in Maryland: A Baseline Analysis* (May 2011)

Based on the data developed in prevalence study and using data from other research, it is estimated that the demand for gambling-related treatment is likely to initially be 3% of problem/pathological gamblers rising subsequently to 10%, *i.e.*, 2,000 to about 6,500. What is unclear is to what extent the number of pathological/problem gamblers will increase as legal gambling opportunities grow in Maryland. Many surrounding jurisdictions have already developed legal gambling options. Thus, it is unclear the extent to which easier access to legal gambling in Maryland will contribute to the growth in gambling problems.

The prevalence study concludes that a public health approach be implemented to counteract any further adverse effects from increased availability. Specifically:

- raising public awareness of the risks of excessive gambling;
- expanding treatment services for problem and pathological gamblers;
- strengthening regulatory, industry, and public health harm reduction measures; and
- undertaking periodic prevalence studies (as already required in statute).

Recommended Actions

	<u>Amount Reduction</u>		<u>Position Reduction</u>
1. Delete long-term vacant positions (018484, 047881, and 058838).	\$ 98,942 GF \$ 59,069 FF		3.0
2. Reduce administrative expenses by \$100,000.	100,000 GF		
Total Reductions	\$ 258,011		3.0
Total General Fund Reductions	\$ 198,942		
Total Federal Fund Reductions	\$ 59,069		

Updates

1. Non-opioid Pharmacotherapies for Alcohol Dependence

2011 *Joint Chairmen's Report* narrative 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 report was submitted in January 2012.

Naltrexone is a non-opioid pharmacotherapy first approved for the treatment of alcoholism in 1994. Such therapies are intended to block the pleasurable effects of alcohol and also reduce cravings. A new extended-release version of naltrexone, Vivitrol, was approved in 2006. Studies have found Vivitrol to have some benefit in reducing drinking days and heavy drinking days. Vivitrol has also shown benefits for individuals with opiate addiction. Other studies have also shown that treatment with Vivitrol may be cost-effective. It should also be noted that Vivitrol has a number of significant side effects including hepatitis and adverse psychiatric reactions.

In terms of current utilization of Vivitrol through the State budget:

- DPSCS currently has no funding in its budget to provide non-opioid pharmacotherapies for the treatment of alcoholism within the prison facilities. However, two studies are currently underway for the criminal justice population: one involving Division of Parole and Probation inmates residing in Gaudenzia treatment programs; and the second treating inmates at the Maryland Correctional Institute for Women and the Metropolitan Transition Center and covering opiate addiction or opiate and alcohol addiction. The latter study is being funded by the manufacturer of Vivitrol.
- Four jurisdictions are using or are planning to use Vivitrol for alcohol dependence supported through ADAA-funded treatment grants (Carroll, Montgomery, and Washington counties and Baltimore City).
- In Medicaid, MCOs are 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 Medicaid PAC, there are two main concerns about Vivitrol: because most of the cost-effectiveness around Vivitrol use is based on the avoidance of inpatient cost (not covered in the PAC program), the cost argument is not as persuasive; and because PAC enrollees can self-refer to any prescribing provider, including out-of-network providers that MCOs who provide PAC services might refuse to credential, the MCOs cannot engage the provider in any appropriate detailing or educational program. The Medicaid program's conclusion is that it would like additional information to inform its use of Vivitrol and is working with ADAA on the development of two model programs involving patients in residential programs for the treatment of alcohol abuse or the treatment of primary alcohol dependence in order to gain that information.

2. Recovery Homes

Chapter 255 of 2011 required DHMH to identify standards for best practices in recovery homes. Recovery housing is considered the basic service provided by recovery residences that include at a minimum recovery peer supports but can run to a residential program that also provides treatment. According to a report released in January 2012, DHMH does not regulate recovery housing, nor does it intend to because of concerns about violating the federal Fair Housing Act. It does, however, have housing standards governing quality, effectiveness, and efficiency. It developed these standards for both supportive (staffed) and recovery (peer-operated) housing as ADAA intended to encourage the use of grant dollars to include supportive and recovery housing as part of an overall continuum of care as well as through the Access to Recovery federal grant.

In terms of best practices, DHMH intends to support the development of a housing association that would be affiliated with the National Association of Recovery Residences which was formed in 2010 to identify evidence-based practices for recovery residences. Membership in the State association would be voluntary, but DHMH and other purchasers of recovery housing could (and in DHMH's case would) condition funding upon a provider's membership in that association. DHMH intends to develop an RFP for the establishment of a State association and award a contract in June 2012.

Current and Prior Year Budgets

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

	<u>General Fund</u>	<u>Special Fund</u>	<u>Federal Fund</u>	<u>Reimb. Fund</u>	<u>Total</u>
Fiscal 2011					
Legislative Appropriation	\$85,829	\$22,382	\$33,951	\$5,713	\$147,876
Deficiency Appropriation	0	200	3,308	0	3,508
Budget Amendments	-631	482	0	0	-149
Reversions and Cancellations	0	-114	-9,861	-154	-10,130
Actual Expenditures	\$85,198	\$22,950	\$27,398	\$5,559	\$141,105
Fiscal 2012					
Legislative Appropriation	\$82,967	\$23,191	\$38,430	\$5,697	\$150,285
Budget Amendments	27	1	13	0	41
Working Appropriation	\$82,994	\$23,192	\$38,442	\$5,697	\$150,325

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

Fiscal 2011

The fiscal 2011 legislative appropriation for ADAA was reduced by almost \$6.8 million. This decrease was derived as follows:

- Deficiency appropriations added just over \$3.5 million. These were derived from two separate actions:
 - \$200,000 in special funds to provide funds for addiction treatment services; and
 - just over \$3.3 million in a federal grant to provide access to nontraditional recovery services.
- Budget amendments marginally offset the increase derived from deficiency appropriations. Specifically:
 - General funds totaling \$631,000 were transferred out of ADAA to other agencies at close-out. Of this amount, \$318,000 reflected higher-than-budgeted levels of turnover, and \$253,000 was general funds originally budgeted for data collection that were available because ADAA was able to charge these expenses against federal funds.
 - Special funds were added to the appropriation, but in a lesser amount than the general fund reduction noted above. Specifically, \$482,000 in special funds were added due to a higher-than-anticipated level of prior year grant activity.
- The major source of the reduction to the legislative appropriation is cancellations, the most significant of which was almost \$9.9 million in federal funds. Federal fund cancellations included \$5.1 million in Substance Abuse Prevention and Treatment Block Grant funding, \$2.9 million in a recently awarded Access to Recovery grant, and \$1.9 million from a Substance Abuse and Mental Health Services Projects of Regional and National Significance grant.

Fiscal 2012

To date, the fiscal 2012 legislative appropriation for ADAA has been increased by \$41,000. All of this funding is to support the fiscal 2012 \$750 one-time bonus for State employees, funding originally budgeted in the Department of Budget and Management.

ADAA – Initial Fiscal 2012 Prevention and Treatment Awards

	<u>Prevention</u>	<u>Treatment</u>	<u>Total</u>
Allegany	\$201,734	\$5,089,748	\$5,291,482
Anne Arundel	345,917	4,693,235	5,039,152
Baltimore County	475,762	6,666,155	7,141,917
Calvert	146,813	863,667	1,010,480
Caroline	141,316	560,205	701,521
Carroll	157,959	3,536,470	3,694,429
Cecil	136,375	1,284,746	1,421,121
Charles	197,378	2,110,685	2,308,063
Dorchester	176,957	1,802,810	1,979,767
Frederick	317,205	2,140,115	2,457,320
Garrett	310,614	714,040	1,024,654
Harford	170,427	2,032,431	2,202,858
Howard	150,645	1,616,734	1,767,379
Kent	166,651	3,344,472	3,511,123
Montgomery	432,269	4,007,455	4,439,724
Prince George's	556,100	10,270,787	10,826,887
Queen Anne's	151,867	684,362	836,229
St. Mary's	162,112	3,070,986	3,233,098
Somerset	158,441	992,101	1,150,542
Talbot	166,970	823,208	990,178
Washington	305,940	3,026,575	3,332,515
Wicomico	404,559	1,822,668	2,227,227
Worcester	171,363	2,955,956	3,127,319
Baltimore City	1,065,815	42,517,993	43,583,808
Subtotal	\$6,671,189	\$106,627,604	\$113,298,793
Statewide	\$1,107,091	\$22,971,008	23,521,943
Total	\$7,778,280	\$129,598,612	\$137,376,892

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Note: Statewide treatment includes funding to be allocated for recovery housing, care coordination, and funding that will be transferred to Primary Adult Care.

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

<u>Object/Fund</u>	<u>FY 11 Actual</u>	<u>FY 12 Working Appropriation</u>	<u>FY 13 Allowance</u>	<u>FY 12 - FY 13 Amount Change</u>	<u>Percent Change</u>
Positions					
01 Regular	64.50	68.50	68.50	0.00	0%
02 Contractual	3.51	8.67	6.77	-1.90	-21.9%
Total Positions	68.01	77.17	75.27	-1.90	-2.5%
Objects					
01 Salaries and Wages	\$ 4,229,759	\$ 4,832,370	\$ 5,103,217	\$ 270,847	5.6%
02 Technical and Spec. Fees	83,759	173,475	146,939	-26,536	-15.3%
03 Communication	17,588	33,074	34,439	1,365	4.1%
04 Travel	80,022	104,786	117,629	12,843	12.3%
07 Motor Vehicles	1,263	3,712	3,069	-643	-17.3%
08 Contractual Services	136,530,948	145,075,228	153,198,718	8,123,490	5.6%
09 Supplies and Materials	68,301	48,552	55,015	6,463	13.3%
10 Equipment – Replacement	22,977	0	0	0	0.0%
11 Equipment – Additional	11,872	0	0	0	0.0%
13 Fixed Charges	58,565	54,144	54,019	-125	-0.2%
Total Objects	\$ 141,105,054	\$ 150,325,341	\$ 158,713,045	\$ 8,387,704	5.6%
Funds					
01 General Fund	\$ 85,197,560	\$ 82,994,224	\$ 87,875,851	\$ 4,881,627	5.9%
03 Special Fund	22,950,477	23,191,535	24,813,876	1,622,341	7.0%
05 Federal Fund	27,397,710	38,442,400	39,791,046	1,348,646	3.5%
09 Reimbursable Fund	5,559,307	5,697,182	6,232,272	535,090	9.4%
Total Funds	\$ 141,105,054	\$ 150,325,341	\$ 158,713,045	\$ 8,387,704	5.6%

Note: The fiscal 2012 appropriation does not include deficiencies.