

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

***Operating Budget Data***

(\$ in Thousands)

	<b><u>FY 05</u></b>	<b><u>FY 06</u></b>	<b><u>FY 07</u></b>	<b><u>FY 06-07</u></b>	<b><u>% Change</u></b>
	<b><u>Actual</u></b>	<b><u>Working</u></b>	<b><u>Allowance</u></b>	<b><u>Change</u></b>	<b><u>Prior Year</u></b>
General Fund	\$79,152	\$78,082	\$82,726	\$4,644	5.9%
Special Fund	19,235	17,864	18,228	364	2.0%
Federal Fund	28,791	32,783	31,692	-1,091	-3.3%
Reimbursable Fund	<u>3,600</u>	<u>3,363</u>	<u>3,363</u>	<u>0</u>	
<b>Total Funds</b>	<b>\$130,779</b>	<b>\$132,092</b>	<b>\$136,009</b>	<b>\$3,917</b>	<b>3.0%</b>

- The fiscal 2007 allowance funds several initiatives, including program expansion as determined by locally determined priorities, new long-term residential slots, as well as a provider cost-of-living adjustment.
- Federal Substance Abuse Prevention and Treatment block grant funds are declining. This may result in some scaling back of the proposed initiatives or other treatment reductions.

***Personnel Data***

	<b><u>FY 05</u></b>	<b><u>FY 06</u></b>	<b><u>FY 07</u></b>	<b><u>FY 06-07</u></b>
	<b><u>Actual</u></b>	<b><u>Working</u></b>	<b><u>Allowance</u></b>	<b><u>Change</u></b>
Regular Positions	49.50	49.50	64.00	14.50
Contractual FTEs	<u>2.20</u>	<u>3.17</u>	<u>3.17</u>	<u>0.00</u>
<b>Total Personnel</b>	<b>51.70</b>	<b>52.67</b>	<b>67.17</b>	<b>14.50</b>

***Vacancy Data: Regular Positions***

Turnover, Excluding New Positions	3.78	5.90%
Positions Vacant as of 12/31/05	6.50	13.10%

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

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- The 14.5 new positions reflected in the fiscal 2007 allowance are positions being converted from a Bureau of Governmental Research contract. These positions are expected to be created by the Board of Public Works in the near future.

## ***Analysis in Brief***

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### **Major Trends**

***Prevention Programming:*** The Alcohol and Drug Abuse Administration (ADAA) has strengthened prevention programming by requiring certain programs to be model evidence-based programs as approved by the federal Substance Abuse and Mental Health Service Administration. A variety of data point to prevention programs being successful and effective.

***Treatment Programming:*** Different data suggest that programs funded by ADAA have positive outcomes, although there is considerable variety between programs.

### **Issues**

***ADAA Develops Performance-based Contracts for Certain Statewide Treatment Services:*** After some considerable discussion, ADAA has recently awarded contracts for the delivery of residential services for patients in the criminal justice system and to pregnant and postpartum women with children. They are also in the process of issuing a contract for the delivery of services to patients with co-occurring disorders. Each contract contains incentives if certain performance measures are attained.

***Revisiting a 2003 Joint Chairmen’s Report Response:*** Twice in recent years, including as recently in 2003, the legislature has expressed interest in how locally awarded substance abuse treatment and prevention dollars are allocated to each jurisdiction and has asked ADAA to develop an alternative formula for funding allocations. However, the allocation methodology has not changed, not least because changing the current methodology could hurt some jurisdictions while benefiting others.

### **Recommended Actions**

	<b><u>Funds</u></b>
1. Reduce contractual employment spending to fiscal 2005.	\$ 40,000
2. Delete funding for "Get the Message" program.	54,000
3. Reduce funding for prior year grant activity.	550,000

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4.	Reduce funding for program expansion set by locally determined priorities to reflect savings by deferring the start of the initiative for three months.	695,000
5.	Adopt narrative requesting the allocation of locally awarded funds.	
	<b>Total Reductions</b>	<b>\$ 1,339,000</b>

## **Updates**

*The Integration of Child Welfare and Substance Abuse Treatment Act:* Budget bill language added in the 2005 session restricted funding for an independent evaluation of the program developed under this Act. That evaluation is moving forward.

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***Operating Budget Analysis***

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**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 all 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, Acts 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 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**

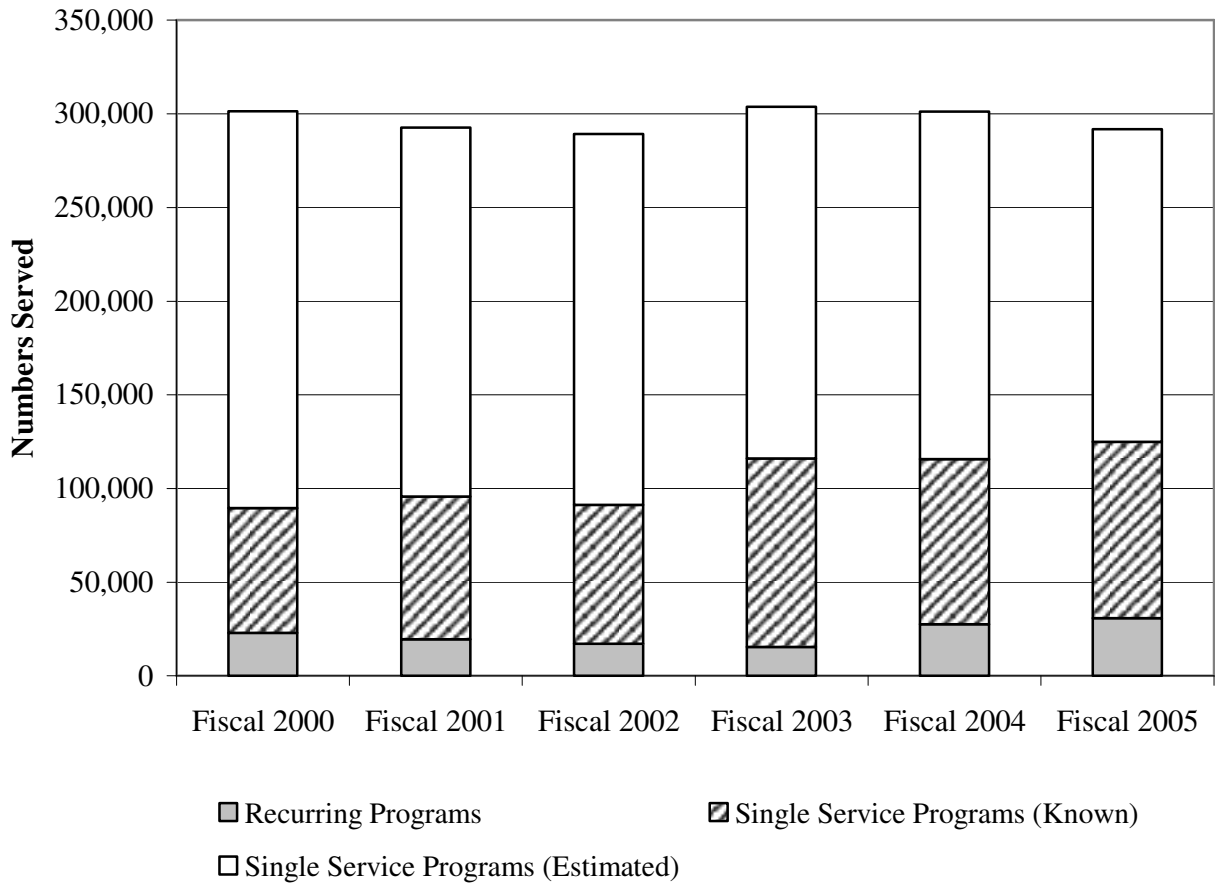
**Prevention Programming**

ADAA prevention services are provided through two types of programming:

- Recurring prevention programming, i.e., programming with the same group of individuals for a minimum of six separate occasions and programming that is an approved Substance Abuse and Mental Health Services Administration (SAMHSA) model.
- Single service programs such as presentations, speaking engagements, training, etc. that are provided to the same group on less than a six separate occasions. Participant numbers are either known or estimated.

As shown in **Exhibit 1**, ADAA prevention programming served just under 300,000 clients in fiscal 2005. While the trend in numbers served in prevention programs is actually falling, this decline is due to a fall in the estimated population served in single service programs. More importantly, numbers served in recurring prevention programming grew between fiscal 2003 and 2005 after four successive years of declines. As important is that ADAA now requires these programs to be model evidence-based programs as approved by the federal SAMHSA. As of fiscal 2006, all recurring prevention programs utilize these model programs.

**Exhibit 1**  
**ADAA Prevention Programming**  
**Clients Served**  
**Fiscal 2000 – 2005**



Source: Alcohol and Drug Abuse Administration

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ADAA groups prevention strategies according to the definitions used by SAMHSA's Center for Substance Abuse and Prevention:

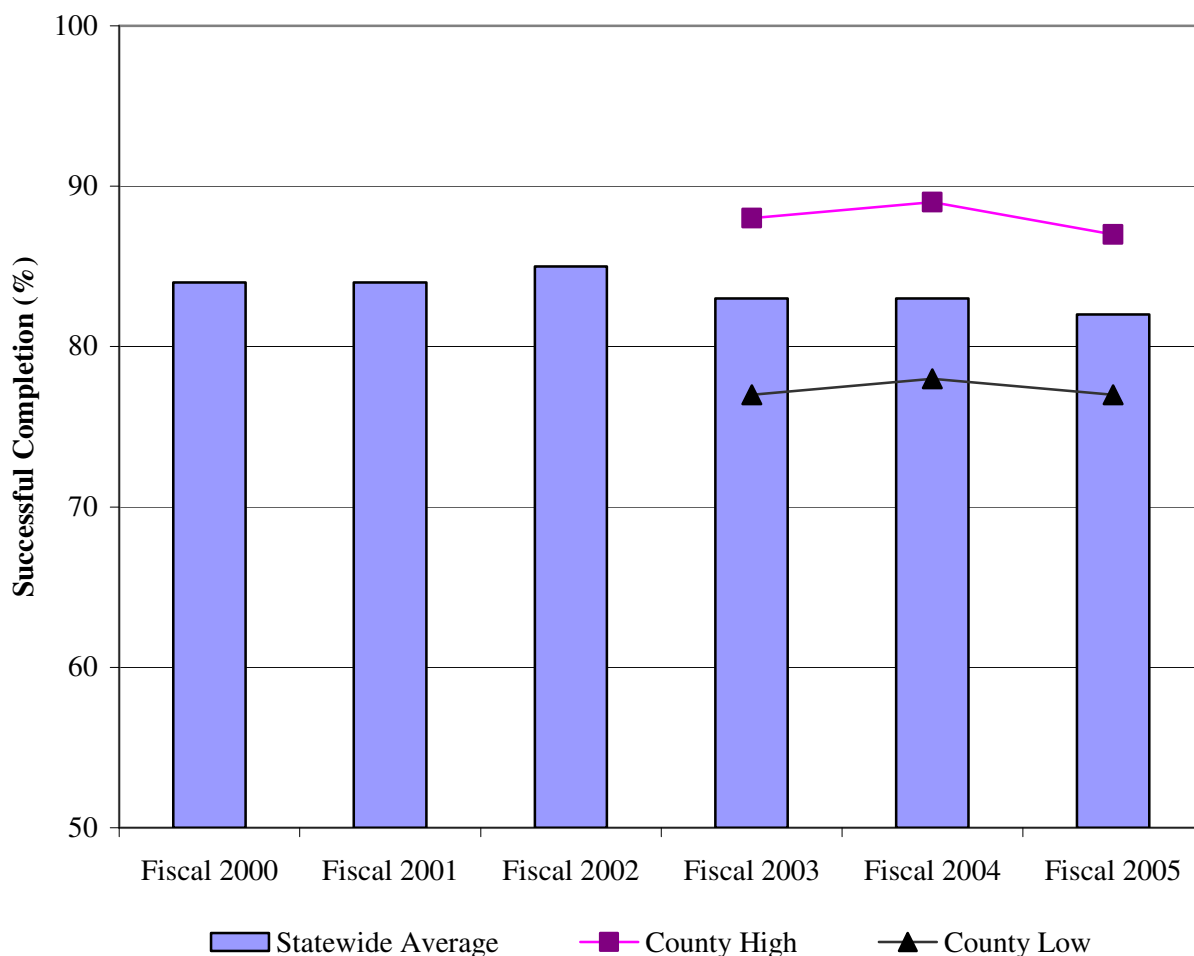
- Information dissemination (characterized as one-way information dissemination e.g., health fairs and media campaigns);
- Education (involves two-way communication e.g., education programs for youth and pre-school prevention programs);
- Alternatives (involves targeting populations in activities excluding substance abuse e.g., community drop-in centers and community service activities);
- Community-based process (e.g., community coalition and network building);
- Environment (establishes or changes written and unwritten community standards e.g., changing codes, ordinances, regulations, and legislation); and
- Problem ID and Referral (classifies those involved in illegal or age inappropriate use of tobacco and alcohol and first use of illicit drugs e.g., driving under the influence/driving while intoxicated (DUI/DWI) programs).

Not surprisingly, in fiscal 2005, over half of the people served in prevention programming were served through information dissemination activities, with a quarter served through alternative strategies.

As shown in **Exhibit 2**, ADAA reports that in fiscal 2005, 82% of participants in recurring prevention programs successfully completed the program. That represents the lowest successful completion rate since a high of 85% was reached in fiscal 2002. As also shown in this exhibit, the variation among programs in terms of successful completion varies from county to county. In fiscal 2005, for example, the successful completion rate varied from 87% in Queen Anne's County to 77% in Allegany County. However, it should be noted that ADAA does not utilize a universal definition of what is considered a "successful completion," preferring to allow each program to determine success based on the particular nature of that program, thereby preventing direct comparisons of outcomes. Success could include, for example, completion of pre- and post-programming tests and a minimum level of session attendance.

Further insight into the efficacy of prevention programming in Maryland can be gained from data in the Maryland Adolescent Survey compiled by the Maryland State Department of Education. These data are pertinent since the majority of persons served by prevention programming in Maryland are school-aged children and parents. While self-reported survey data have shortcomings,

**Exhibit 2**  
**ADAA – Recurring Prevention Programs**  
**Successful Completion Rate**  
**Fiscal 2000 – 2005**



Source: Alcohol and Drug Abuse Administration

as shown in **Exhibit 3** the long- and short-term trends in terms of use of cigarettes, alcohol, and any drug other than tobacco and alcohol in the past 12 months are almost universally positive. Perhaps the only negative is the apparent worsening trends between the 2002 and 2004 survey in all three areas for 6<sup>th</sup> graders.

**Exhibit 3**  
**Maryland Adolescent Survey**  
**Percentage of Students Reporting Substance Abuse in the Last 12 Months by Grade**

	<u>6th Grade</u>	<u>8th Grade</u>	<u>10th Grade</u>	<u>12th Grade</u>
<b>Cigarettes</b>				
2004 Survey	2.7%	10.3%	17.3%	26.8%
2002 Survey	2.3%	11.5%	19.3%	26.8%
2001 Survey	4.2%	17.0%	23.5%	31.7%
1998 Survey	6.4%	22.9%	31.9%	36.1%
<b>Alcohol (Any Form)</b>				
2004 Survey	9.0%	27.0%	47.7%	63.0%
2002 Survey	8.0%	27.1%	51.2%	63.3%
2001 Survey	11.4%	34.9%	53.1%	65.5%
1998 Survey	12.9%	36.1%	56.5%	65.6%
<b>Any Drug (Other Than Alcohol/Tobacco)</b>				
2004 Survey	5.8%	16.5%	29.2%	39.4%
2002 Survey	5.1%	16.4%	31.9%	40.4%
2001 Survey	6.5%	21.3%	34.2%	42.9%
1998 Survey	6.9%	21.0%	36.2%	41.1%

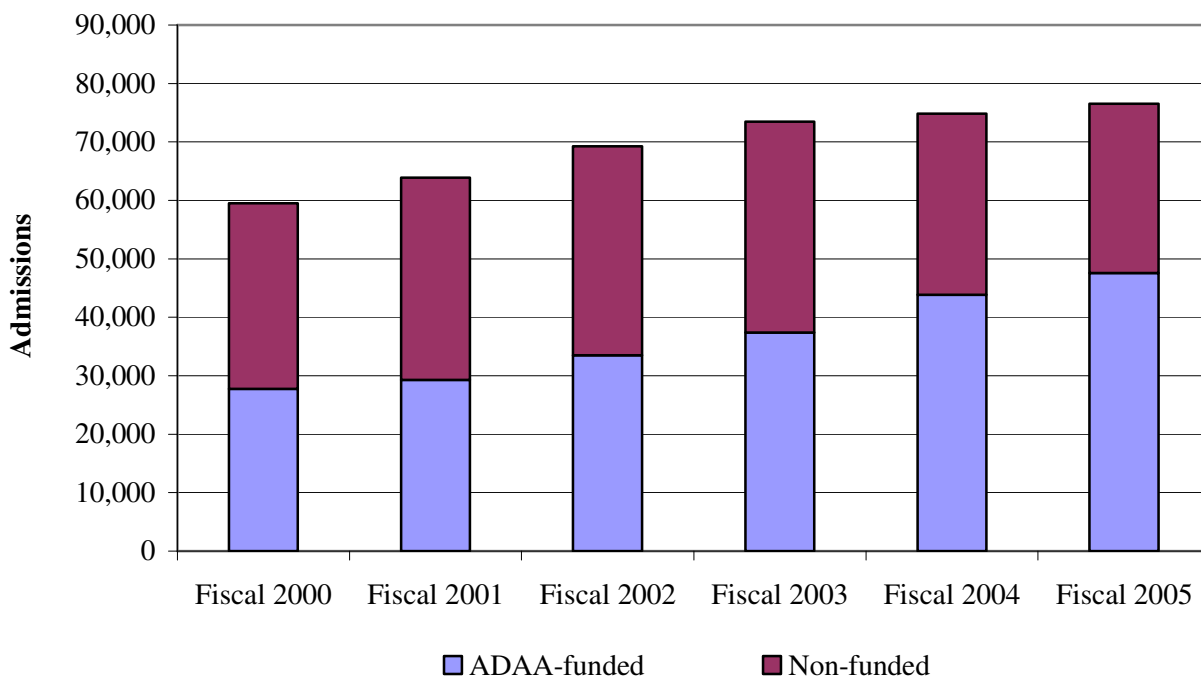
Source: Maryland State Department of Education

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### **Treatment Programming**

As shown in **Exhibit 4**, admissions to treatment services increased steadily between fiscal 2000 and 2005, driven by an increase in admissions to treatment services funded through ADAA. Indeed, total admissions to non-ADAA funded programs fell by almost 3,000 over the period while admissions to ADAA funded programs increased by almost 20,000. (ADAA collects, as required under statute, data from both ADAA-funded and non-funded programs. Non-funded programs as a rule serve more individuals with health insurance and higher incomes than similar ADAA-funded programs.) Significant ADAA funding increases over the period in question were the primary driver of this trend.

**Exhibit 4**  
**Admissions to Certified Alcohol and Drug Abuse Treatment Programs**  
**Fiscal 2000 – 2005**

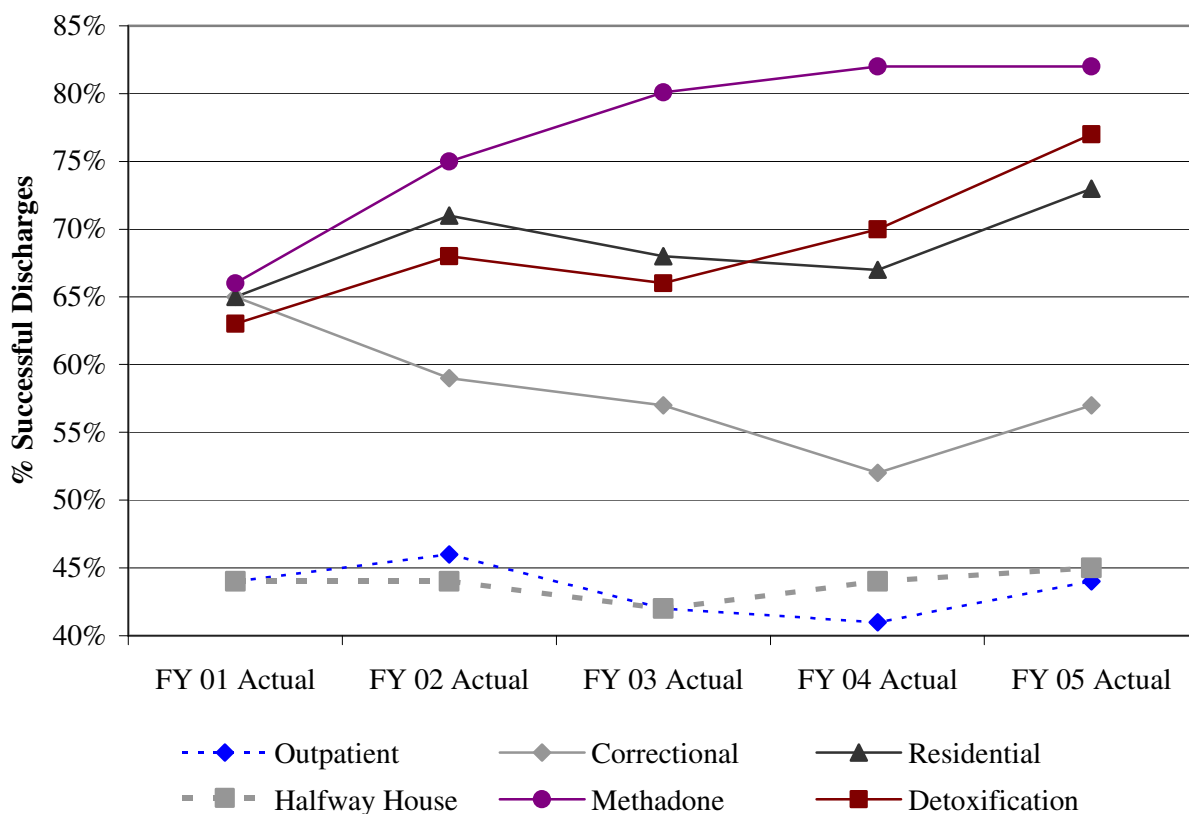


Source: Alcohol and Drug Abuse Administration

In terms of outcomes, **Exhibit 5** notes the percentage of clients discharged from a variety of ADA-funded treatment modalities that have been discharged with a successful treatment record. Treatment modalities include:

- **Outpatient Treatment:** These services are provided in a non-residential setting. Distinctions are made between outpatient (less than nine hours a week per patient) and intensive outpatient services (more than nine hours per week).
- **Correctional Treatment:** This is treatment available to incarcerated individuals on site at a prison or detention center.
- **Residential Treatment:** These services are provided in a residential setting, with addiction programming often combined with other clinical services.

**Exhibit 5**  
**Clients Discharged with a Successful Treatment Record**  
**ADAA-funded Treatment**  
**Fiscal 2001 – 2005**



Source: Alcohol and Drug Abuse Administration

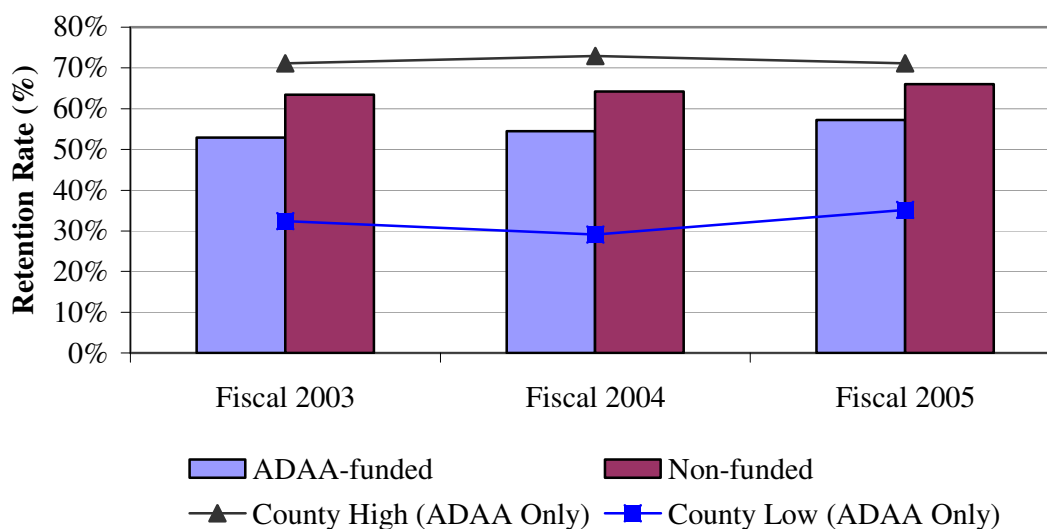
- **Halfway Houses:** These facilities combine outpatient level treatment in a residential setting.
- **Methadone Maintenance Programs:** These programs provide medication assisted treatment specific to opioid addiction.
- **Detoxification Treatment:** This treatment service typically precedes a client placement into another treatment modality.

A successful treatment record is considered to be program completion and discharge without the need for further treatment or program completion with appropriate referral to the next level of treatment. As shown in the exhibit, for each of the treatment modalities, with the exception of methadone maintenance programs where the trend is flat, there is improvement between fiscal 2004 and 2005. Importantly, trends in residential, correctional, and outpatient programming that had been moving in the wrong direction since fiscal 2002, were reversed between fiscal 2004 and 2005.

ADAA indicates that it is too early to definitively state what is driving these trends. However, it points to standardization of programming, the adoption of patient placement criteria, the development, collection and dissemination of data to provide feedback to clinicians and programs, and the use of simple benchmarks as grant conditions for jurisdictions as possible factors.

Another key outcome measure is retention rate within a program. ADAA notes that there is strong evidence linking retention rates with successful outcomes. In outpatient treatment, for example, keeping a person in a program for longer 90 days is considered an important benchmark. As shown in **Exhibit 6**, for fiscal 2003 to 2005, the retention rate beyond 90 days in both ADAA-funded and ADAA non-funded Level I (outpatient) programs, has gradually improved. Interestingly, there is wide variation among programs. As noted in the same exhibit, the highest retention rates by county for ADAA-funded programs only were over 70%, while the lowest retention rates were 35% and below.

**Exhibit 6**  
**Level I Retention Rates**  
**(Percent Retained More Than 90 Days)**  
**Fiscal 2003 – 2005**



Source: Alcohol and Drug Abuse Administration

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Finally, it is obviously important that clients not only complete programs, but that during the course of treatment, other outcomes improve. For example, that:

- clients have 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 7**, for ADAA-funded treatment programs, outcomes for fiscal 2003 through 2005 are positive:

- In terms of substance abuse, clients are abusing at a lower rate on discharge than admission. In fiscal 2005 for example, just over two-thirds of clients were abusing substances at admission, while less than half were doing so at discharge, a 27% decline.
- More clients were employed at discharge than at admission, a 20% increase in fiscal 2005 for example.
- The rate of criminal justice involvement drops significantly. Over half of the clients had some criminal justice involvement in the two years prior to admission in terms of arrests, but less than 20% are arrested during treatment.

At this point there are no national benchmarks with which to compare Maryland outcomes, although SAMHSA new National Outcomes Measures initiative could lay the groundwork for providing them in the future.

## **Governor's Proposed Budget**

As shown in **Exhibit 8**, the Governor's fiscal 2007 allowance for ADAA increases by almost \$4 million, or 3%. Major changes are detailed below.

### **Personnel Expenses and Administration**

The fiscal 2007 allowance indicates an increase of 14.5 full-time equivalent (FTE) regular positions over the fiscal 2006 working appropriation. All of these positions were formerly supported under a Bureau of Governmental Research contract. However, there is no concomitant increase in personnel funding. This is due to the fiscal 2006 working appropriation already reflecting the creation of these positions. ADAA anticipates that the positions will be created by the Board of Public Works (BPW) on February 15, 2006.

**Exhibit 7**  
**ADAA-funded Programs – Selected Outcomes**

	Substance Abuse			Employed			Criminal Justice Involvement (Arrest Rate Per Patient)		
	<u>At Admission</u>	<u>At Discharge</u>	<u>% Change</u>	<u>At Admission</u>	<u>At Discharge</u>	<u>% Change</u>	<u>Two Years Prior to Admission</u>	<u>During Treatment</u>	<u>% Change</u>
Fiscal 2003	71.0%	48.7%	-31%	30.8%	35.7%	16%	0.581%	0.205%	-65%
Fiscal 2004	69.0%	51.5%	-25%	29.9%	36.1%	21%	0.558%	0.160%	-71%
Fiscal 2005	68.3%	49.9%	-27%	32.1%	38.6%	20%	0.590%	0.156%	-74%

Source: Alcohol and Drug Abuse Administration

**Exhibit 8**  
**Governor's Proposed Budget**  
**DHMH – Alcohol and Drug Abuse Administration**  
**(\$ in Thousands)**

<b>How Much It Grows:</b>	<b>General Fund</b>	<b>Special Fund</b>	<b>Federal Fund</b>	<b>Reimb. Fund</b>	<b>Total</b>
2006 Working Appropriation	\$78,082	\$17,864	\$32,783	\$3,363	\$132,092
2007 Governor's Allowance	<u>82,726</u>	<u>18,228</u>	<u>31,692</u>	<u>3,363</u>	<u>136,009</u>
Amount Change	\$4,644	\$364	-\$1,091	\$0	\$3,917
Percent Change	5.9%	2.0%	-3.3%		3.0%

**Where It Goes:**

<b>Personnel Expenses</b>	<b>\$297</b>	
Fiscal 2007 employee and retiree health insurance .....		\$82
Understatement of fiscal 2006 employee and retiree health insurance expenditures .....		75
Employee increments .....		74
Retirement contributions .....		39
Workers' compensation premium assessment .....		33
Other fringe benefit adjustments .....		-6
<b>Administration</b>	<b>\$271</b>	
National Outcome Measures Incentive Initiative (federal funds).....		350
Training (alignment to most recent actual spending) .....		-79
<b>Prevention</b>	<b>\$ 54</b>	
Get The Message prevention initiative .....		54
<b>Treatment Services</b>	<b>\$3,298</b>	
Expansion of programming as determined by local plans (and potential backfilling of federal block grant reduction).....		2,778
Increase in residential treatment (primarily through statewide contracts).....		1,000
1% provider cost-of-living adjustment .....		600
Prior year grant activity .....		550
Reduction in federal fund support due to a reduction in available block grant funds .....		-1,276
Reduction in general funds for treatment to backfill reductions elsewhere due to a reduction in available federal block grant funds.....		-244
Available Maryland Substance Abuse Fund revenues .....		-110
<b>Other</b>		-3
<b>Total</b>		<b>\$3,917</b>

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

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The largest increase in the administration area is a federal fund grant to encourage states to participate in the adoption of, and adherence to, National Outcome Measures. The \$350,000 represents the maximum award available for an individual state participant. The award includes \$200,000 for the development of prevention data elements, and \$150,000 to bring ADAA into full compliance with treatment outcomes (ADAA already voluntarily reports 6 of the 10 required measures).

### **Prevention**

There is \$54,000 to support a “Get the Message” life skills and basketball skills prevention program designed to educate and influence the decision making of youth and young adults to not use illicit drugs and other addictive substances. Interestingly, as noted above, ADAA has been moving to require many of its prevention programs to use model evidence-based programs as approved by SAMHSA. This program is not such a program.

### **Treatment**

The allowance includes three separate treatment initiatives, all supported by general funds:

- Just under \$2.8 million to support an expansion of programming as determined by local plans. As required under 2004 legislation, each county is required to submit a local plan. At the time of writing, all jurisdictions except for Prince George’s County had a finalized local plan. Those plans include specific local funding enhancement requests, for example additional staff, additional residential treatment slots, and additional training for current local health department staff. According to ADAA, requests from these local plans exceed the amount available.

However, it should also be noted that some of the increased general funds may be used to backfill for reductions elsewhere. For example, special fund revenues into the Maryland Substance Abuse Fund from court-imposed fees were supposed to support the administrative costs of the local drug and alcohol abuse councils. Those revenues have failed to materialize and ADAA has indicated that it may use general funds to support those councils. Similar backfilling may occur for lower than anticipated federal fund revenues (discussed further below).

- \$1 million for the expansion of residential treatment slots supported through statewide contracts. ADAA anticipates an additional 65 slots through statewide contracts (see Issue 1 for additional discussion).
- \$600,000 to provide a 1% cost-of-living adjustment (COLA) for provider grants and contracts. No COLA has been provided for these grants and contracts since fiscal 2002. Prior to fiscal 2003, increases in grant and contracts awards were tied (if somewhat loosely) to COLAs received by State employees. The rationale for this link was that many of these grants and contracts are made to local health departments who actually deliver services locally.

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Most local health department employees are in the State personnel management system and receive the same COLAs and benefits as State employees.

The increase in treatment funding represented by the three initiatives is, however, partially offset by other treatment reductions. As noted below, federal funds available for treatment fall. Similarly, special fund revenues into the Maryland Substance Abuse fund have not met expectations. Again, federal funds that had been supporting information technology contracts have been reduced, necessitating reductions in treatment funds. When the initiatives and reductions are considered together, funding for treatment services increases by just under \$3.3 million.

### **Federal Fund Availability**

Just under one-quarter of ADAA's budget is derived from the federal Substance Abuse Prevention and Treatment (SAPT) Block Grant. The SAPT block grant comes with a series of strings, including that at least 20% of the funds be spent for the education/counseling of persons not in treatment (i.e. prevention programming) as well as certain set-asides for pregnant women and women with dependant children. ADAA has provided the Department of Legislative Services (DLS) with the detailed information on how those various requirements are satisfied in the allowance.

However, the fiscal 2007 allowance is built on a drop of over \$1.4 million in SAPT funds. As noted above in Exhibit 8, much of that reduction comes in treatment funds. At the time of writing, ADAA did not have any specific plans as to how it was going to address this reduction except to indicate that it did not intend to reduce awards to local health departments. While using new general funds to backfill this reduction is one option, another is to review other awards of these dollars. For example, ADAA indicated that it will be meeting with Department of Juvenile Service (DJS) officials to review the \$973,000 transferred to DJS annually. Specifically, ADAA intends to discuss with DJS the need for the development of outcome measure to satisfy new federal requirements.

In addition, since the development of the fiscal 2007 allowance, the latest federal SAPT allocation has been finalized, and it represents an additional reduction to the available funds. When coupled with anticipated but not budgeted increases in federally funded salaries and fringe benefits, a further \$324,000 in SAPT funds is now unavailable.

**ADAA should be prepared to brief the committees on the specific reductions that can be anticipated given the anticipated and unanticipated reductions in federal SAPT funds available for fiscal 2007.**

## ***Issues***

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### **1. ADAA Develops Performance-based Contracts for Certain Statewide Treatment Services**

#### **Background**

Most of ADAA's treatment and prevention budget is awarded to local jurisdictions that either deliver those services directly or contract out for them. However, ADAA directly manages contracts for a number of treatment services including long-term residential slots. ADAA recently issued an Invitation for Bids (IFBs) for three different services:

- statewide long-term residential substance abuse for patients with co-occurring disorders;
- statewide therapeutic community substance abuse treatment for patients in the criminal justice system; and
- statewide long-term residential substance abuse treatment for pregnant and postpartum women and their children.

The procurement process for these contracts was not without controversy. Indeed, all three procurements were subject to bid protests. Major items of concern expressed about these three procurements included:

- the procurement method used by ADAA (the IFB rather than the Request for Proposals method);
- the specification requirements contained in the IFBs;
- transition/continuity of care issues;
- pricing;
- the incorporation of written questions and answers into the IFBs; and
- judicial requirements.

Ultimately, two of the bid protests (for therapeutic services to patients in the criminal justice system and to pregnant and postpartum women and their children) were withdrawn prior to a Board of Contract Appeals hearing, and the contracts were on the February 1, 2006, BPW agenda. The third contract, treatment for persons with co-occurring disorders, was withdrawn by ADAA. ADAA

issued a new IFB on January 24, 2006, and intends to go to BPW with this contract in March and hopes to have all three contracts in place April 1, 2006.

### Slot Expansion

As shown in **Exhibit 9**, under the new contracts, based on new contract pricing and combined with additional funds available in the fiscal 2007 allowance, ADAA anticipates:

- increasing the total number of statewide contracted residential slots by 65; and
- changing the mix of contracts, away from predominantly level III.5 slots (high intensity residential treatment providing recovery services in combination with intense clinical services) to a broader balance of level III.5 and level III.3 slots (medium intensity residential treatment with less intensive clinical services).

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### Exhibit 9 ADAA Statewide Residential Services Contracts

	<u>Women and Children</u>	<u>Criminal Justice</u>	<u>Co-occurring Disorders</u>
<b>Current Contracts</b>			
Level III.3 Slots	18	–	–
Level III.5 Slots	24	79	20
<b>New Contracts (IFBs)</b>			
Level III.3 Slots	46	–	50
Level III.5 Slots	–	110	–
<b>Additional Slots to Be Provided</b>	<b>4</b>	<b>31</b>	<b>30</b>

Source: Alcohol and Drug Abuse Administration

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### Adding Performance Incentives

The two contracts that went to BPW on February 1, 2006, and the IFB for services to clients with co-occurring disorders all contain performance incentives. Specifically, an additional 5% will be paid following the completion of each calendar year of the contract if certain performance

measures are met. While the IFBs note that additional performance measures can be used to determine if a contractor is fulfilling the terms of the contract, the two specifically stated are that:

- at least 50% of the programs discharges in a contract term will be for “completed treatment”; and
- at least 50% of the patients will remain in treatment for a minimum of 210 days.

According to ADAA, these are the only two performance measures that will be used initially to determine eligibility for the 5% performance bonus. Meeting one measure will result in a 2.5% bonus; meeting both will yield the full 5%.

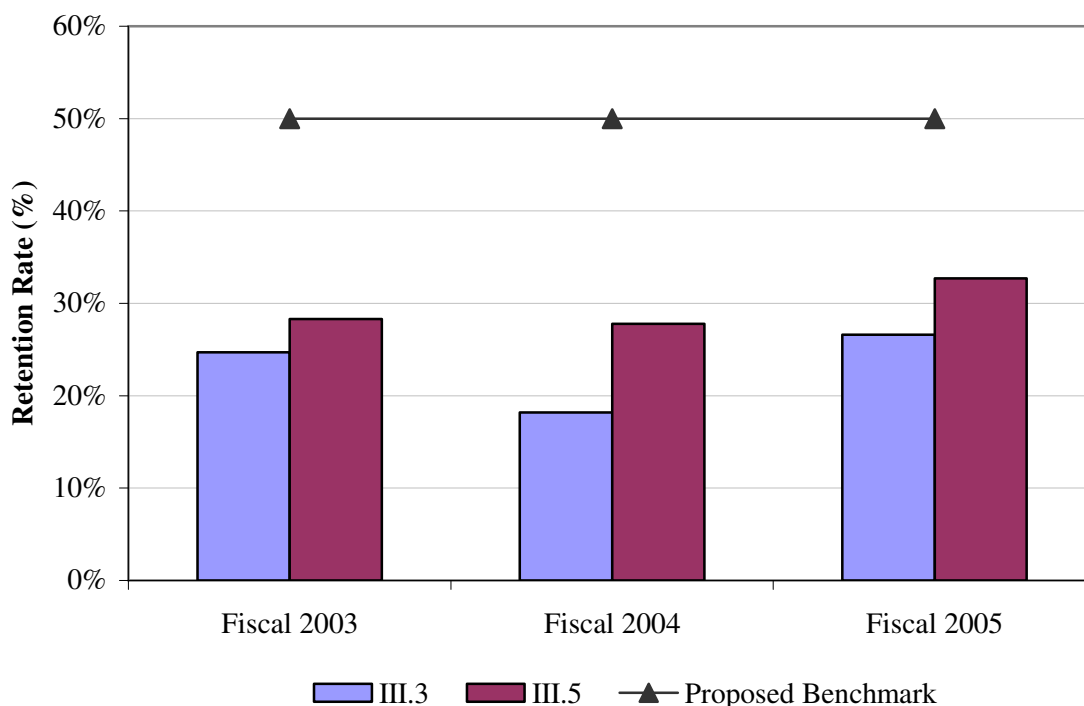
Meeting the first benchmark, having at least 50% of the program discharges completing treatment, may not be that difficult a hurdle to overcome. As noted earlier in Exhibit 5, in fiscal 2005 over 70% of clients in residential treatment were discharged with a successful treatment record (which is comparable to “completed treatment”). However, as shown in **Exhibit 10**, using data specifically for statewide ADAA-funded level III.3 and III.5 services, meeting the second benchmark related to patient retention within a program for 210 days may be considerably more challenging. Notwithstanding the challenge that meeting this benchmark represents to contractors, ADAA contends that the evidence points to this length of retention in a program as being critical to success.

## **Conclusion**

ADAA’s new and proposed statewide residential treatment services contracts represent an important step forward in injecting outcomes and performance into contracts. However, it is to be hoped that this is just the first step forward. These performance measures apply only to a small amount of the treatment services funded by ADAA. For example, nine jurisdictions funded level III.3 treatment slots with ADAA funds in fiscal 2005, and only one jurisdiction met the 50% retention minimum. Further, while ADAA does require grant recipients to meet the Managing for Results measures, it does not currently require contracts issued by those grant recipients to include similar performance incentives.

**ADAA should be prepared to discuss what other performance measures it might add to the statewide contracts and a possible time frame for requiring similar performance incentives to be added into other contracts supported by ADAA grants.**

**Exhibit 10**  
**Retention Rates for Selected Treatment Modalities**  
**Statewide Services Only**  
**Fiscal 2003 – 2005**



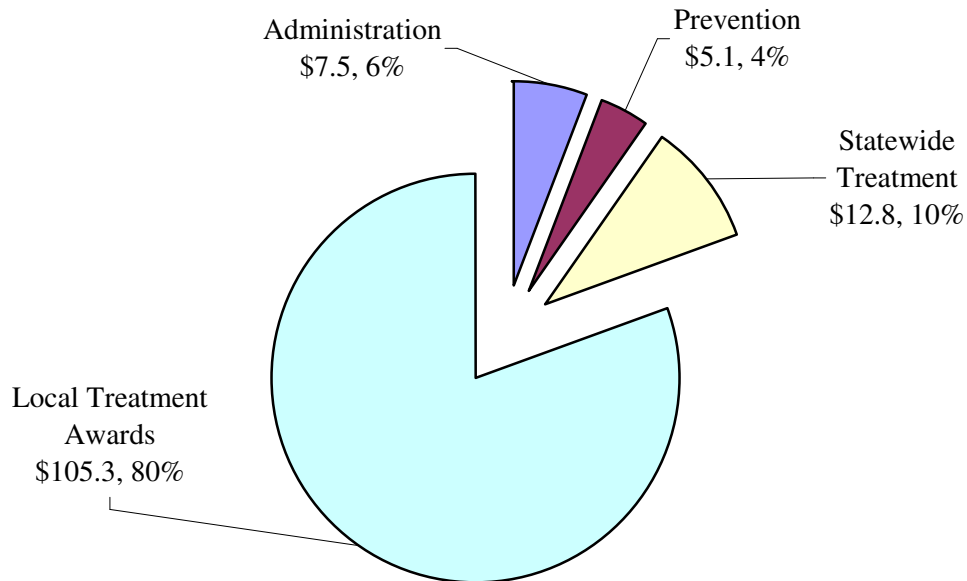
Source: Alcohol and Drug Abuse Administration

## 2. Revisiting a 2003 *Joint Chairmen's Report* Response

### Background

As shown in **Exhibit 11**, using the most recent actual data for fiscal 2005, 90% of ADAA's budget is spent on treatment services, with 80% being awarded to local jurisdictions. How that funding is allocated to the local jurisdictions, however, is based on a variety of factors. The allocation of local dollars was the basis for a 2003 *Joint Chairmen's Report* (JCR) request. Specifically, ADAA was required to submit a report on how substance abuse prevention and treatment funds are allocated and to recommend a formula for how future allocations might be made.

**Exhibit 11**  
**ADAA – Allocation of Fiscal 2005 Funding**  
**(\$ in Millions)**



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

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The subsequent report detailed that funding was allocated using a variety of methodologies:

- Almost half of the funding (49% of the awards to be made in fiscal 2004) was allocated based on historic allocation levels. How those local allocation levels evolved was not documented, but historical accident, local influence, local interest, and funding availability were probably all involved.
- Just over 25% of the funding was based on legislative direction, for example, Chapter 367, Acts of 1997 (Senate Bill 512) that established a Drug Affected Babies program, and Chapter 551, Acts of 2000 (House Bill 7) that was intended to improve the provision of substance abuse treatment services to parents in the child welfare system.
- 6% of the funding was awarded competitively through the Substance Abuse Treatment Outcomes Partnership Fund created by Chapter 675, Acts of 2000 (House Bill 1205).
- Just under 20% of the funding was awarded by formula.

The fiscal 2007 allowance adds another wrinkle to this funding distribution process in that ADAA intends to distribute just under \$2.8 million in new funds for treatment services based on locally determined priorities as established in local plans. The specifics of the funding allocation have yet to be determined by ADAA.

### **Revisiting the Formula Allocation Model**

While the policy of having local jurisdictions through local plans (developed under the technical guidance and oversight of ADAA) set local priorities for treatment appears a rational way for determining what treatment services should be provided with locally awarded dollars, the way those dollars are allocated appears less rational. This concern about the allocation of dollars was recognized in the 2003 JCR request as well as in a 2001 request for a formula to distribute additional funding made available in that year's budget.

Indeed, the 2003 JCR report utilized the same formula as previously submitted to the legislature in 2001 in its discussion as to how locally awarded dollars should be allocated. That formula was based on three variables:

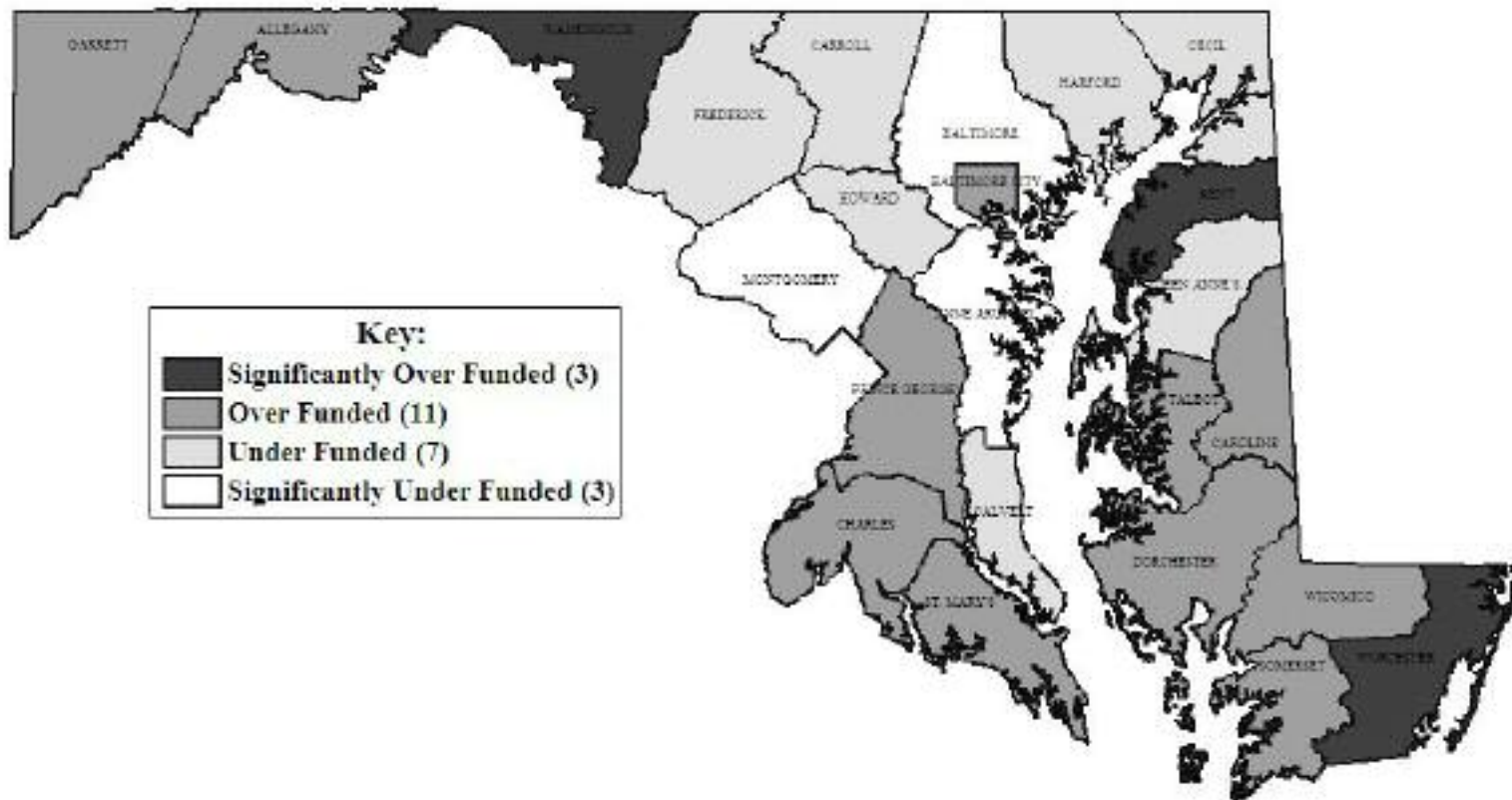
- HIV incidence;
- drug and DWI arrests; and
- estimates of treatment need.

**Exhibit 12** applies the same formula to the fiscal 2006 working appropriation locally funded allocations based on the most recently available data and distinguishes between those jurisdictions that are over funded (less than one standard deviation from the mean) or significantly over funded (more than one standard deviation from the mean) in their allocations relative to the formula compared to those jurisdictions who receive less funding than they would otherwise receive under the formula (dollar changes are shown in **Appendix 5**).

As shown in the exhibit, three jurisdictions (Montgomery, Baltimore, and Anne Arundel counties) receive significantly less under current allocations than they would under the formula, while three (Worcester, Kent, and Washington counties) receive significantly more. However, it is important to note that:

- Although the formula indicates that jurisdictions may receive more or less funding under the formula than under current allocations, all jurisdictions demonstrated more need for treatment than is currently available.
- The formula is just one formula. If other variables are considered (or excluded), the formula allocation could change significantly. For example, removing DWI arrests from the formula made relatively little difference to allocations except for one jurisdiction, Baltimore City, which would move from “over funded” to “under funded.”

**Exhibit 12**  
**Allocation of Locally Awarded Substance Abuse Treatment and Prevention**  
**Funding by Formula Relative to Actual Allocation**  
**Fiscal 2006**



Source: Department of Legislative Services

## **Conclusion**

While ADAA is increasingly integrating data into its decision making, the allocation of funding to local jurisdictions is still primarily based on history and legislative direction. ADAA in theory can change the historical allocations at any time. In practice, changing the current allocation strategy is clearly difficult if the result is that some jurisdictions lose a significant amount of funding. If a funding formula can be agreed upon by all jurisdictions, implementation could be done prospectively, thereby holding jurisdictions harmless; phased in over a number of years; or phased in over a number of years with a lower minimum funding level.

**DLS recommends that committee narrative be adopted requesting ADAA to work with the local drug and alcohol abuse councils on the development of a funding formula for the distribution of locally awarded substance abuse treatment and prevention funding, a strategy and timetable for implementing that formula, and the funding changes required for implementation.**

## *Recommended Actions*

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	<b><u>Amount Reduction</u></b>	
1. Reduce contractual employment spending to fiscal 2005 actual.	\$ 40,000	SF
2. Delete funding for "Get the Message" program. The program is inconsistent with the Alcohol and Drug Abuse Administration's efforts to use model prevention programs as approved by the federal Substance Abuse and Mental Health Services Administration.	54,000	GF
3. Reduce funding for prior year grant activity. The Alcohol and Drug Abuse Administration (ADAA) is required to estimate grant and contract settlements and to budget for settlements that it may make in a separate sub-program. In prior years, settlement activity was substantial because of ADAA's practice of over-awarding funds on the basis that not all funds would be spent. This practice has since ended, and closer attention is being paid to grant awards. This in turn should limit the amount of settlement activity. The reduction is based on ADAA's fiscal 2006 estimate of settlement activity. If settlement activity is higher, ADAA may process a budget amendment accordingly.	550,000	SF
4. Reduce funding for program expansion set by locally determined priorities by deferring the start of the initiative for three months to reflect start-up delays. This action generates one-time savings in fiscal 2007 but assumes full funding in fiscal 2008.	695,000	GF
5. Adopt the following narrative:		

**Allocation of Locally Awarded Funds:** The committees understand that the dollars currently available to local jurisdictions do not satisfy needs in any particular jurisdiction. However, they are concerned that the allocation of locally awarded substance abuse treatment and prevention dollars are not adequately correlated to specific levels of need in each local jurisdiction. The committees request the Alcohol and Drug Abuse Administration (ADAA),

*M00K – DHMH – Alcohol and Drug Abuse Administration*

in cooperation with local drug and alcohol abuse councils, to develop a funding formula for the distribution of locally awarded substance abuse treatment and prevention funding, a strategy and timetable for implementing that formula, and the funding changes required to support implementation.

<b>Information Request</b>	<b>Author</b>	<b>Due Date</b>
Allocation of locally awarded funds	ADAA	December 1, 2006
<b>Total Reductions</b>		<b>\$ 1,339,000</b>
<b>Total General Fund Reductions</b>		<b>\$ 749,000</b>
<b>Total Special Fund Reductions</b>		<b>\$ 590,000</b>

## ***Updates***

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### **1. The Integration of Child Welfare and Substance Abuse Treatment Act**

The Integration of Child Welfare and Substance Abuse Treatment Act, established in Chapter 551, Acts of 2000 was designed to improve the provision of substance abuse treatment services to parents in the child welfare system. The program – operated jointly by the Department of Human Resources and the Department of Health and Mental Hygiene – places addictions specialists in social service offices to assess the treatment needs of parents with children entering out-of-home placements.

The Act called for a comprehensive statewide program with addictions specialists placed in all child welfare offices. With funding significantly below the amounts intended in the legislation, the departments implemented the program on a trial basis in fiscal 2002 with the hiring of seven addictions specialists in Baltimore City and two addictions specialists in Prince George's County. Funding has remained relatively stable since that time at \$2.3 million, which provides for addictions counselors, assessment, and substance abuse treatment in the two targeted jurisdictions.

Chapter 551 also required an independent results-based evaluation by December 2004. However, the funding required to perform the evaluation was deleted in 2003.

Budget bill language added in the 2005 session restricted \$250,000 in funds intended for this program for an independent evaluation of the program. According to ADAA, a research committee has developed the necessary research protocol, and meetings have occurred between ADAA and the appropriate local departments of social services. ADAA intends to move forward with an evaluation conducted by the University of Maryland.

## *Current and Prior Year Budgets*

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

	<b><u>General Fund</u></b>	<b><u>Special Fund</u></b>	<b><u>Federal Fund</u></b>	<b><u>Reimb. Fund</u></b>	<b><u>Total</u></b>
<b>Fiscal 2005</b>					
Legislative Appropriation	\$79,408	\$17,811	\$32,804	\$3,422	\$133,445
Deficiency Appropriation	0	0	0	0	0
Budget Amendments	-256	1,772	0	240	1,756
Reversions and Cancellations	0	-347	-4,013	-62	-4,422
<b>Actual Expenditures</b>	<b>\$79,152</b>	<b>\$19,235</b>	<b>\$28,791</b>	<b>\$3,600</b>	<b>\$130,779</b>
<b>Fiscal 2006</b>					
Legislative Appropriation	\$78,050	\$17,864	\$32,783	\$3,363	\$132,059
Budget Amendments	33	0	0	0	33
<b>Working Appropriation</b>	<b>\$78,082</b>	<b>\$17,864</b>	<b>\$32,783</b>	<b>\$3,363</b>	<b>\$132,092</b>

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

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## **Fiscal 2005**

The fiscal 2005 legislative appropriation for ADAA was reduced by just under \$2.7 million as follows:

- Budget amendments increased the legislative appropriation by just under \$1.8 million. This increase consisted of:
  - General fund budget amendments reducing the legislative appropriation by \$256,000. Specifically, a \$32,000 increase representing the share of the fiscal 2005 COLA originally budgeted in the Department of Budget and Management (DBM) for ADAA was more than offset by a reduction of \$267,000 related to salary realignments following the elimination of positions in the department at the beginning of fiscal 2005 as well as to facilitate salary increases in the Office of the Chief Medical Examiner and \$21,000 in savings from unspent health insurance funds.
  - Special fund budget amendments increasing the legislative appropriation by almost \$1.8 million. All of this increase derived from prior year grant recoveries used to offset the same amount of increased costs in other prior year grant awards.
  - \$240,000 in reimbursable fund budget amendments.
- Special, federal, and reimbursable fund cancellations more than offset the increase to the legislative appropriation from budget amendments, totaling over \$4.4 million. Of this, over \$4 million was federal fund cancellations. The federal fund cancellation relates to an overestimate of the amount of federal Substance Abuse Block Grant to be received by the State. Both the fiscal 2005 and 2006 budgets assumed a level of federal funding that did not occur. As a result, fiscal 2005 federal fund expenses had to be reduced by \$2 million, and a further \$2 million was reserved for fiscal 2006 to offset the overstatement in attainment in that year's budget.

## **Fiscal 2006**

To date, the fiscal 2006 legislative appropriation has been increased by \$33,000, all general funds. This increase represents ADAA's share of the fiscal 2006 COLA originally budgeted in DBM.

## ***Audit Findings***

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Audit Period for Last Audit:	April 12, 2000 – January 22, 2003
Issue Date:	July 2003
Number of Findings:	3
Number of Repeat Findings:	2
% of Repeat Findings:	67%
Rating: (if applicable)	n/a

***Finding 1:*** ADAA did not adequately monitor substance abuse treatment grants to ensure appropriate services were rendered by providers.

***Finding 2:*** **ADAA did not evaluate the success and effectiveness of the State’s privately funded alcohol and drug abuse treatment programs as required by law.**

***Finding 3:*** **ADAA had not established adequate control over collections.**

\*Bold denotes item repeated in full or part from preceding audit report.

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

<u>Object/Fund</u>	<u>FY05 Actual</u>	<u>FY06 Working Appropriation</u>	<u>FY07 Allowance</u>	<u>FY06 - FY07 Amount Change</u>	<u>Percent Change</u>
<b>Positions</b>					
01 Regular	49.50	49.50	64.00	14.50	29.3%
02 Contractual	2.20	3.17	3.17	0	0%
<b>Total Positions</b>	<b>51.70</b>	<b>52.67</b>	<b>67.17</b>	<b>14.50</b>	<b>27.5%</b>
<b>Objects</b>					
01 Salaries and Wages	\$ 3,002,112	\$ 3,990,543	\$ 4,287,674	\$ 297,131	7.4%
02 Technical & Spec Fees	70,478	104,390	105,151	761	0.7%
03 Communication	20,538	22,474	22,505	31	0.1%
04 Travel	62,762	80,321	83,035	2,714	3.4%
07 Motor Vehicles	3,126	4,260	3,092	-1,168	-27.4%
08 Contractual Services	127,503,109	127,815,957	131,435,503	3,619,546	2.8%
09 Supplies & Materials	48,198	55,834	53,685	-2,149	-3.8%
10 Equip - Replacement	47,339	0	0	0	0.0%
13 Fixed Charges	21,041	18,117	18,122	5	0%
<b>Total Objects</b>	<b>\$ 130,778,703</b>	<b>\$ 132,091,896</b>	<b>\$ 136,008,767</b>	<b>\$ 3,916,871</b>	<b>3.0%</b>
<b>Funds</b>					
01 General Fund	\$ 79,152,431	\$ 78,082,179	\$ 82,725,893	\$ 4,643,714	5.9%
03 Special Fund	19,235,484	17,864,122	18,228,136	364,014	2.0%
05 Federal Fund	28,791,016	32,782,500	31,691,643	-1,090,857	-3.3%
09 Reimbursable Fund	3,599,772	3,363,095	3,363,095	0	0%
<b>Total Funds</b>	<b>\$ 130,778,703</b>	<b>\$ 132,091,896</b>	<b>\$ 136,008,767</b>	<b>\$ 3,916,871</b>	<b>3.0%</b>

Note: The fiscal 2006 appropriation does not include deficiencies, and the fiscal 2007 allowance does not reflect contingent reductions.

**Fiscal Summary**  
**DHMH – Alcohol and Drug Abuse Administration**

<u>Program/Unit</u>	<u>FY05 Actual</u>	<u>FY06 Wrk Approp</u>	<u>FY07 Allowance</u>	<u>Change</u>	<u>FY06 - FY07 % Change</u>
02 Alcohol And Drug Abuse Administration	\$ 130,778,703	\$ 132,091,896	\$ 136,008,767	\$ 3,916,871	3.0%
<b>Total Expenditures</b>	<b>\$ 130,778,703</b>	<b>\$ 132,091,896</b>	<b>\$ 136,008,767</b>	<b>\$ 3,916,871</b>	<b>3.0%</b>
General Fund	\$ 79,152,431	\$ 78,082,179	\$ 82,725,893	\$ 4,643,714	5.9%
Special Fund	19,235,484	17,864,122	18,228,136	364,014	2.0%
Federal Fund	28,791,016	32,782,500	31,691,643	-1,090,857	-3.3%
<b>Total Appropriations</b>	<b>\$ 127,178,931</b>	<b>\$ 128,728,801</b>	<b>\$ 132,645,672</b>	<b>\$ 3,916,871</b>	<b>3.0%</b>
Reimbursable Fund	\$ 3,599,772	\$ 3,363,095	\$ 3,363,095	\$ 0	0%
<b>Total Funds</b>	<b>\$ 130,778,703</b>	<b>\$ 132,091,896</b>	<b>\$ 136,008,767</b>	<b>\$ 3,916,871</b>	<b>3.0%</b>

Note: The fiscal 2006 appropriation does not include deficiencies, and the fiscal 2007 allowance does not reflect contingent reductions.

**Allocation of Locally Awarded Substance Abuse Treatment and Prevention  
Funding by Formula Relative to Actual Allocation  
Fiscal 2006**

	<b>Fiscal 2006 Working Appropriation <u>Funding Allocation</u></b>	<b>Formula <u>Funding</u></b>	<b>Variance Formula v. <u>Allocation</u></b>
Allegany	\$2,362,756	\$1,078,460	-\$1,284,296
Anne Arundel	4,821,491	7,500,833	2,679,342
Baltimore	7,435,398	10,737,626	3,302,228
Calvert	1,162,131	1,574,619	412,488
Caroline	633,774	534,192	-99,582
Carroll	1,767,628	1,905,019	137,391
Cecil	1,400,736	1,639,677	238,941
Charles	2,305,735	2,171,764	-133,971
Dorchester	1,987,771	753,429	-1,234,342
Frederick	2,593,029	2,884,787	291,758
Garrett	1,087,120	462,568	-624,552
Harford	2,095,246	3,130,534	1,035,288
Howard	1,780,466	2,507,011	726,545
Kent	1,974,999	484,184	-1,490,815
Montgomery	4,971,312	8,516,027	3,544,715
Prince George's	11,400,622	10,729,777	-670,845
Queen Anne's	847,576	848,839	1,263
Somerset	1,077,933	480,818	-597,115
St. Mary's	2,798,750	1,540,034	-1,258,716
Talbot	941,422	710,775	-230,647
Washington	3,867,216	2,044,846	-1,822,370
Wicomico	2,228,034	1,883,840	-344,194
Worcester	3,087,225	1,512,628	-1,574,597
Baltimore City	47,260,068	46,256,150	-1,003,918