

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

Operating Budget Data

(\$ in Thousands)

	FY 06	FY 07	FY 08	FY 07-08	% Change
	<u>Actual</u>	<u>Working</u>	<u>Allowance</u>	<u>Change</u>	<u>Prior Year</u>
General Fund	\$78,082	\$84,881	\$90,746	\$5,865	6.9%
Special Fund	17,792	17,639	17,748	109	0.6%
Federal Fund	32,648	31,678	31,441	-237	-0.7%
Reimbursable Fund	<u>3,363</u>	<u>3,363</u>	<u>3,363</u>	<u>0</u>	<u>0.0%</u>
Total Funds	\$131,885	\$137,561	\$143,298	\$5,736	4.2%

- The fiscal 2008 allowance for the Alcohol and Drug Abuse Administration (ADAA) is just over \$5.7 million above the fiscal 2007 working appropriation. After adjusting for one-time savings in employee and retiree health costs, this growth is actually slightly higher at \$5.9 million, or 4.3%.
- Funding increases for prevention and treatment. However, this expansion is not uniform with support for statewide residential contracts falling by \$1.2 million.

Personnel Data

	FY 06	FY 07	FY 08	FY 07-08
	<u>Actual</u>	<u>Working</u>	<u>Allowance</u>	<u>Change</u>
Regular Positions	64.00	65.00	64.00	-1.00
Contractual FTEs	<u>2.39</u>	<u>3.17</u>	<u>4.50</u>	<u>1.33</u>
Total Personnel	66.39	68.17	68.50	0.33

Vacancy Data: Regular Positions

Turnover, Excluding New Positions	3.84	6.00%
Positions Vacant as of 12/31/06	9.50	14.62%

- The fiscal 2008 allowance abolishes one regular full-time equivalent position.

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

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Analysis in Brief

Major Trends

Prevention: Participation in prevention programming fell for the second year in a row in fiscal 2006. However, more people successfully completed the programming.

Treatment: Admissions to ADAA-funded treatment programming also fell between fiscal 2005 and 2006. However, completion rates and other outcomes are positive.

Issues

The Allocation of Local Prevention and Treatment Dollars: The Development of a New Funding Formula and How to Implement It: ADAA grants local prevention and treatment dollars using a patchwork quilt of allocation methodologies. In fiscal 2007 budget deliberations, the legislature adopted budget bill language withholding funds pending the development of a formula to apply to all prevention and treatment funding. A workgroup has been tackling this issue and has requested more time to complete the task as well as clarification from the legislature on the task itself.

ADAA and Performance-based Contracting: ADAA has aggressively infused performance into its contracts and grant awards. However, additional attention needs to be paid to contract monitoring.

Recommended Actions

	<u>Funds</u>
1. Add language restricting funds for the expansion of buprenorphine treatment to specified purposes.	
2. Add language withholding funds pending the development of a formula for the allocation of local prevention and treatment grant awards.	
3. Reduce funds for the expansion of buprenorphine treatment.	\$ 400,000
4. Reduce funds for a University of Maryland contract position by reclassifying an existing vacant position for that function.	88,000
Total Reductions	\$ 488,000

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 finally moving forward.

M00K – DHMH – Alcohol and Drug Abuse Administration

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

Operating Budget Analysis

Program Description

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

ADAA maintains an integrated statewide service delivery system through a variety of treatment and prevention modalities that provide financial and geographic access to 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 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

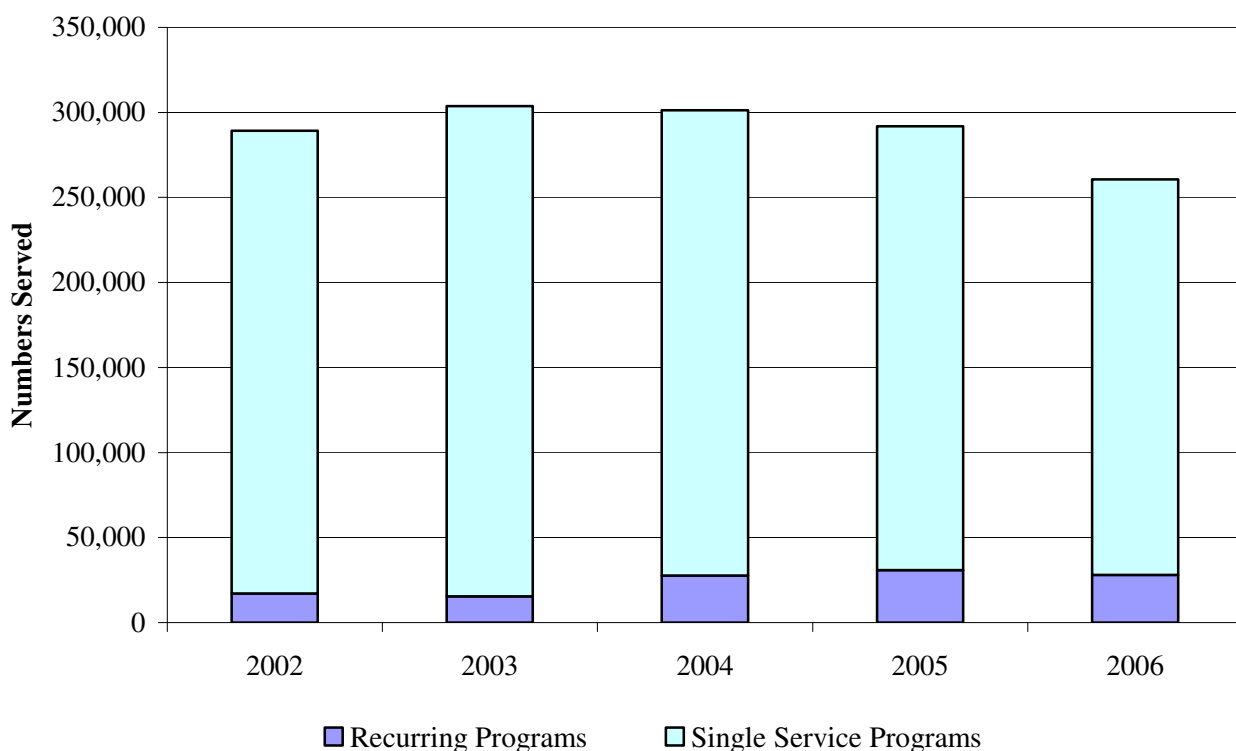
Prevention

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 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 six separate occasions. Participant numbers are either known or estimated.

As shown in **Exhibit 1**, ADAA prevention programming served just over 260,000 clients in fiscal 2006. This is the second year in a row that total numbers served fall. More importantly, numbers served in recurring prevention programming also fell between fiscal 2005 and 2006. ADAA attributes this decline to tight resources, staffing vacancies, and more sophisticated programming requirements.

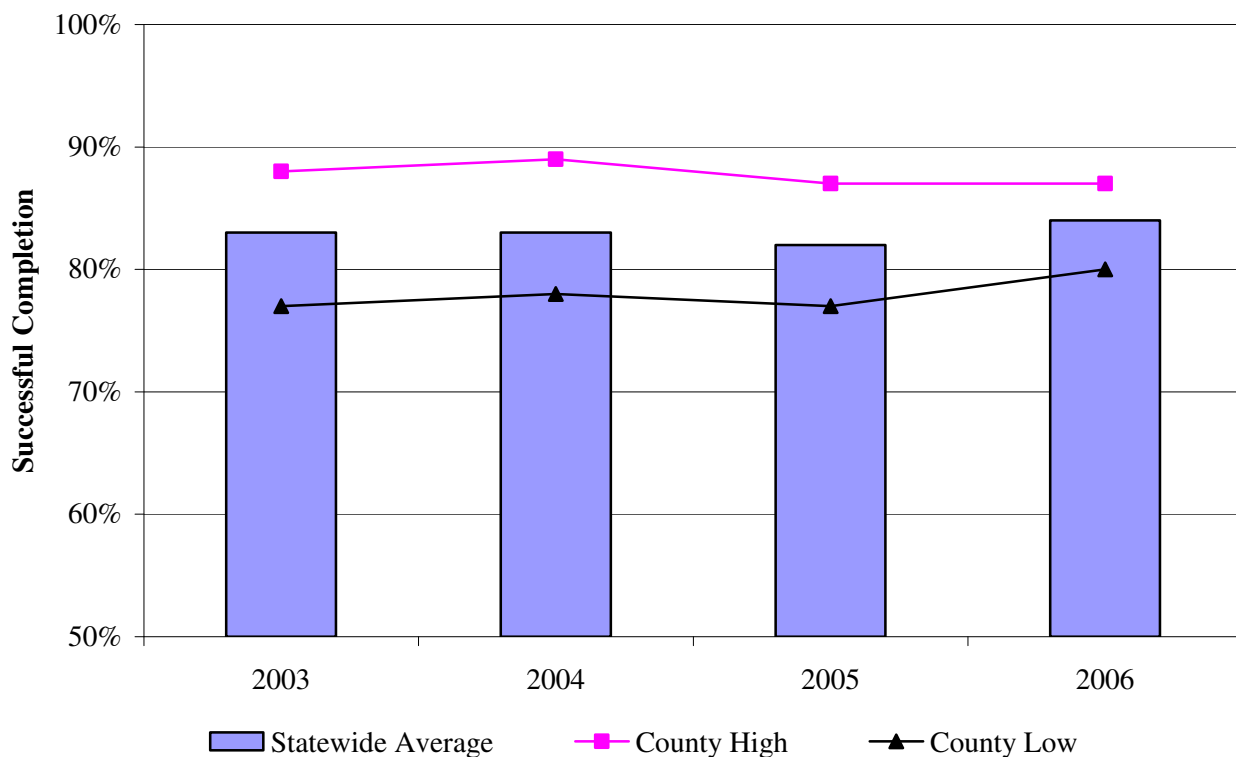
Exhibit 1
ADAA – Prevention Programming
Clients Served
Fiscal 2002-2006



Source: Alcohol and Drug Abuse Administration

As shown in **Exhibit 2**, ADAA reports that in fiscal 2006, 84% of participants in recurring prevention programs successfully completed the program, slightly up on fiscal 2005. As also shown in this exhibit, there is variation by county among programs in terms of successful completion. In fiscal 2006, for example, the successful completion rate varied from 87% in Washington County to 80% in Prince George’s County. However, since programming varies from one jurisdiction to the next, there is no universal definition of what is considered a “successful completion.”

Exhibit 2
ADAA – Recurring Prevention Programs
Successful Completion Rate
Fiscal 2003-2006

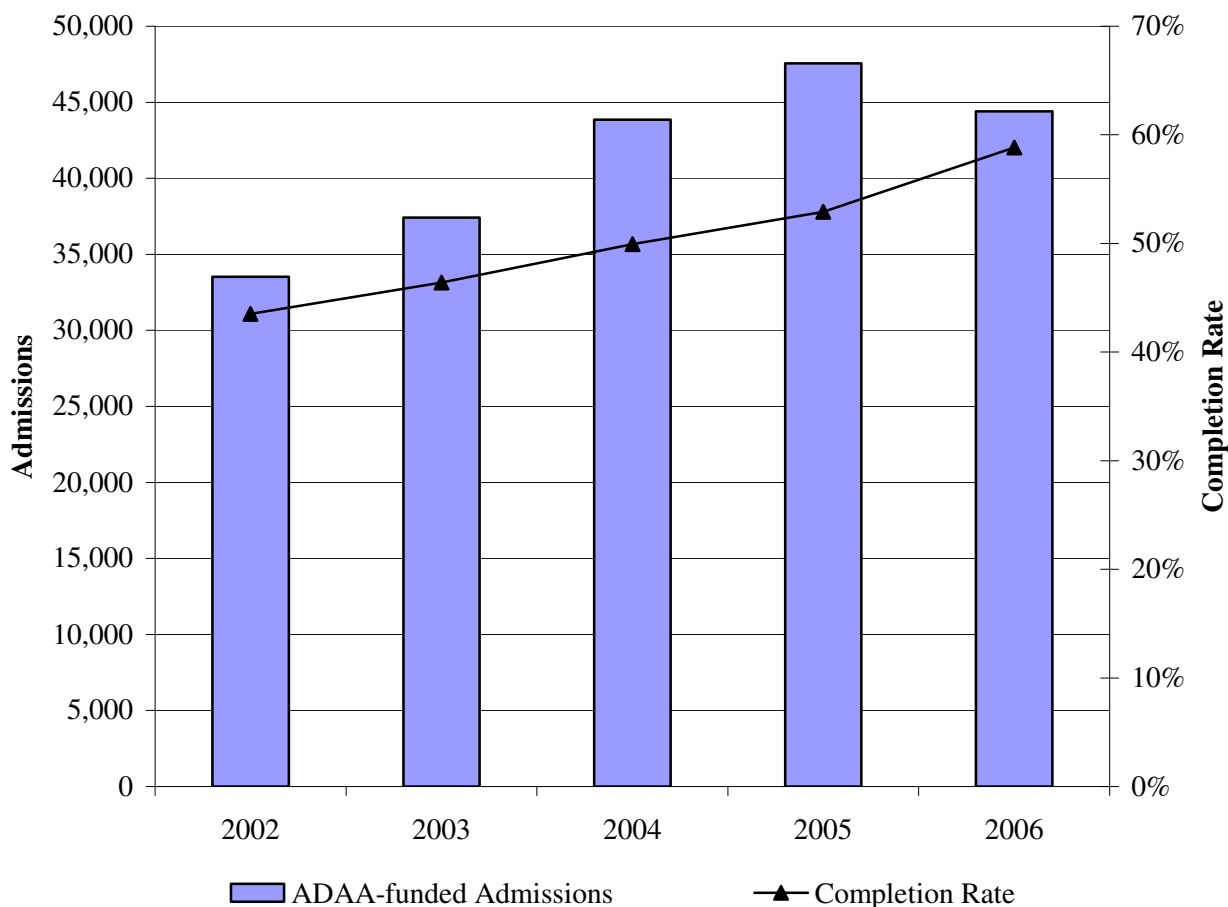


Source: Alcohol and Drug Abuse Administration

Treatment

As shown in **Exhibit 3**, admissions to ADAA-funded treatment services increased steadily between fiscal 2002 and 2005 before falling in fiscal 2006. However, completion rates (program completion and discharge without the need for further treatment or program completion with appropriate referral to the next level of treatment) have risen steadily over the past five years.

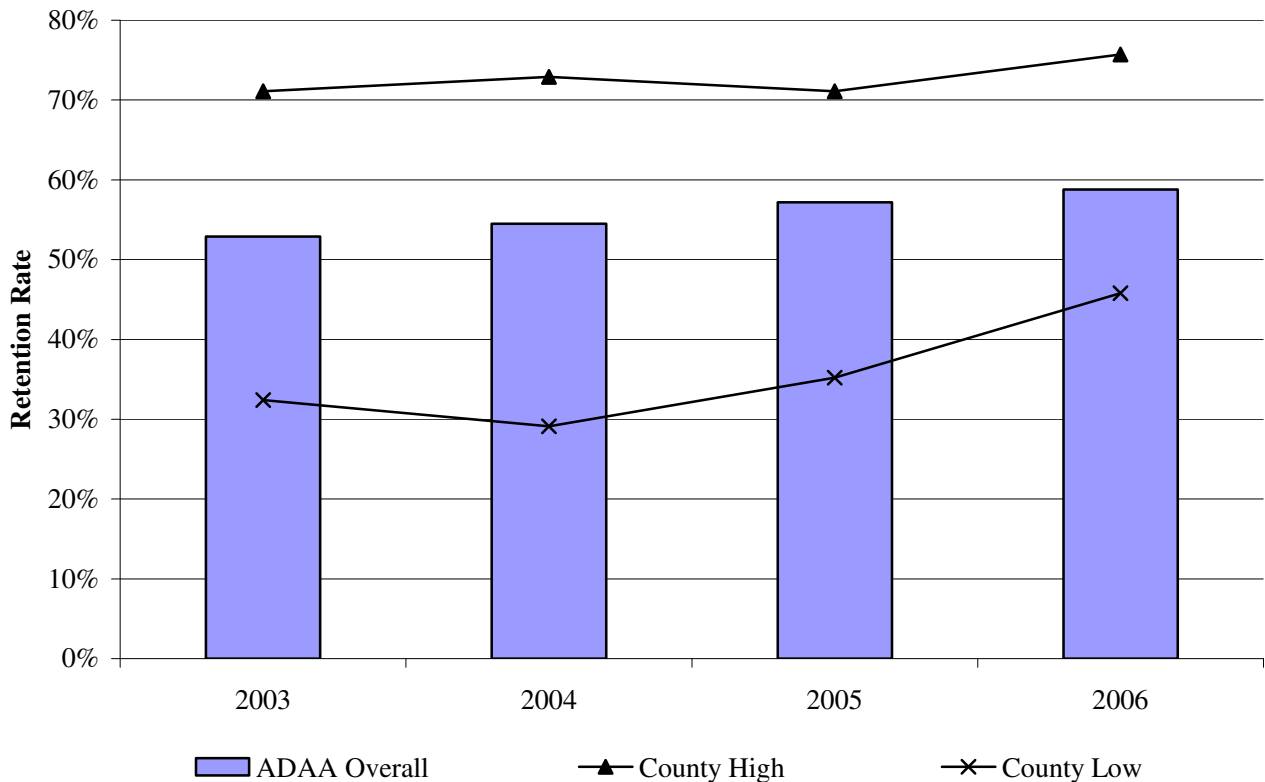
**Exhibit 3
Admissions to ADAA-funded Treatment Programs and Completion Rates
Fiscal 2002-2006**



Source: Alcohol and Drug Abuse Administration

In terms of outcomes, a 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 than 90 days is considered an important benchmark. As shown in **Exhibit 4**, for fiscal 2003 to 2006, the retention rate beyond 90 days in ADAA-funded Level I (outpatient) programs, has gradually improved. There remains wide variation among programs. As noted in the same exhibit, the highest retention rates for ADAA-funded programs are over 75% (Allegany and Washington counties), while the lowest retention rates are 45% (Wicomico County). However, as also shown in the exhibit, this variation is actually shrinking.

Exhibit 4
Level I Retention Rates
Percent Retained More Than 90 Days
Fiscal 2003-2006



Source: Alcohol and Drug Abuse Administration

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 5**, for ADAA-funded treatment programs, outcomes for fiscal 2003 through 2006 are positive: clients are abusing at a lower rate on discharge than admission; more clients were employed at discharge than at admission; and the rate of criminal justice involvement drops significantly.

Exhibit 5
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%
Fiscal 2006	66.5%	45.9%	-31%	33.9%	40.3%	19%	0.693%	0.144%	-79%

Source: Alcohol and Drug Abuse Administration

Governor’s Proposed Budget

The Governor’s fiscal 2008 allowance for ADAA is just over \$5.7 million, or 4.2% above the fiscal 2007 working appropriation. This growth is little changed after adjusting for the one-time savings in employee and retiree health insurance expenditures, with growth of \$5.9 million, 4.3%. Specific changes are detailed in **Exhibit 6** and are discussed below.

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

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
2007 Working Appropriation	\$84,881	\$17,639	\$31,678	\$3,363	\$137,561
2008 Governor’s Allowance	<u>90,746</u>	<u>17,748</u>	<u>31,441</u>	<u>3,363</u>	<u>143,298</u>
Amount Change	\$5,865	\$109	-\$237	\$0	\$5,736
Percent Change	6.9%	0.6%	-0.7%		4.2%

Where It Goes:

Personnel Expenses	-\$26	
Increments and other compensation.....		\$162
Retirement contributions.....		67
Workers’ compensation assessment		50
Turnover adjustments		-25
Abolished position (one full-time equivalent)		-40
Employee health insurance		-72
Retiree health insurance one-time savings.....		-168
Administration	\$221	
Contract with the University of Maryland, College Park for the Executive Director of the State Alcohol and Drug Abuse Council.....		130
Other outside contracts		46
Contractual employment.....		45
Prevention	\$631	
Prevention funding (federal funds).....		631
Treatment	\$4,800	
Expansion of buprenorphine treatment.....		5,000
Annualization of January 1, 2007 treatment expansion as determined through local planning process		1,000

Where It Goes:

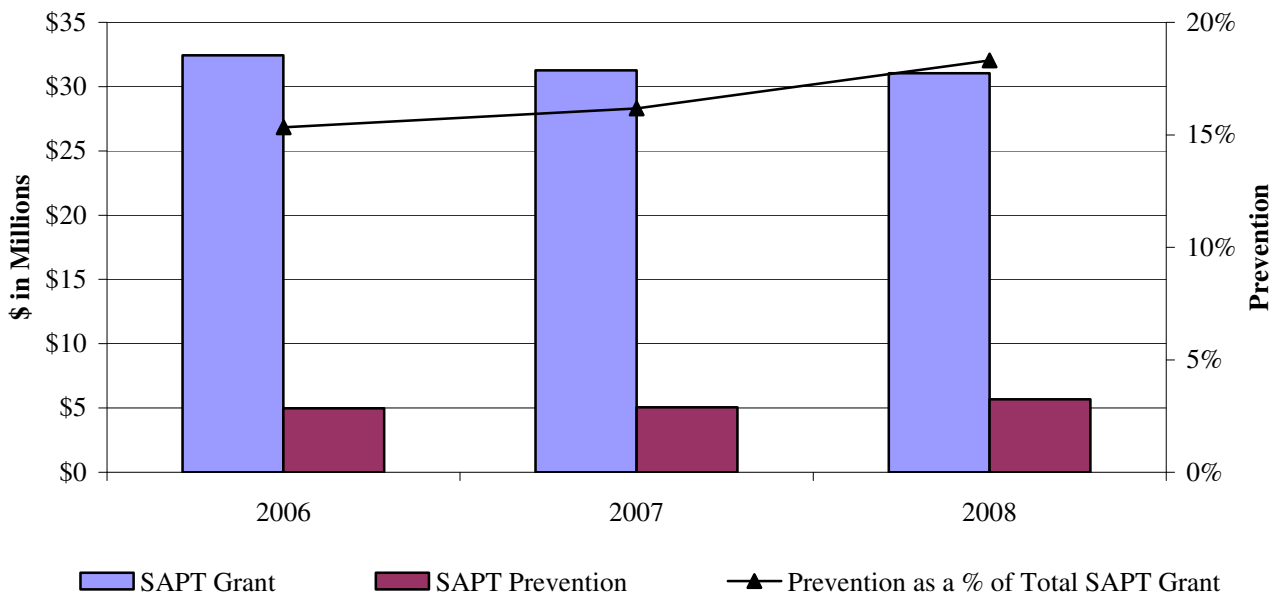
Statewide treatment contracts	-1,200
Prior Year Grant Activity	\$100
Estimate of prior year grant settlements	100
Other	10
Total	\$5,736

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

Prevention

Funding for prevention activities increases by \$631,000 to just under \$5.7 million. All of this funding is derived from federal Substance Abuse Prevention and Treatment (SAPT) Block Grant funds. SAPT funds may be used at the discretion of the State, but one of the requirements is that no less than 20% of the funds shall be spent on prevention programming. As shown in **Exhibit 7**, while the percentage of the SAPT grant allocated to prevention funding in fiscal 2008 is at its highest in the past three years, at 18.3% it is still \$525,000 below the 20% threshold.

Exhibit 7
Prevention Funding and the Federal Substance Abuse Prevention and Treatment Block Grant
Fiscal 2006-2008

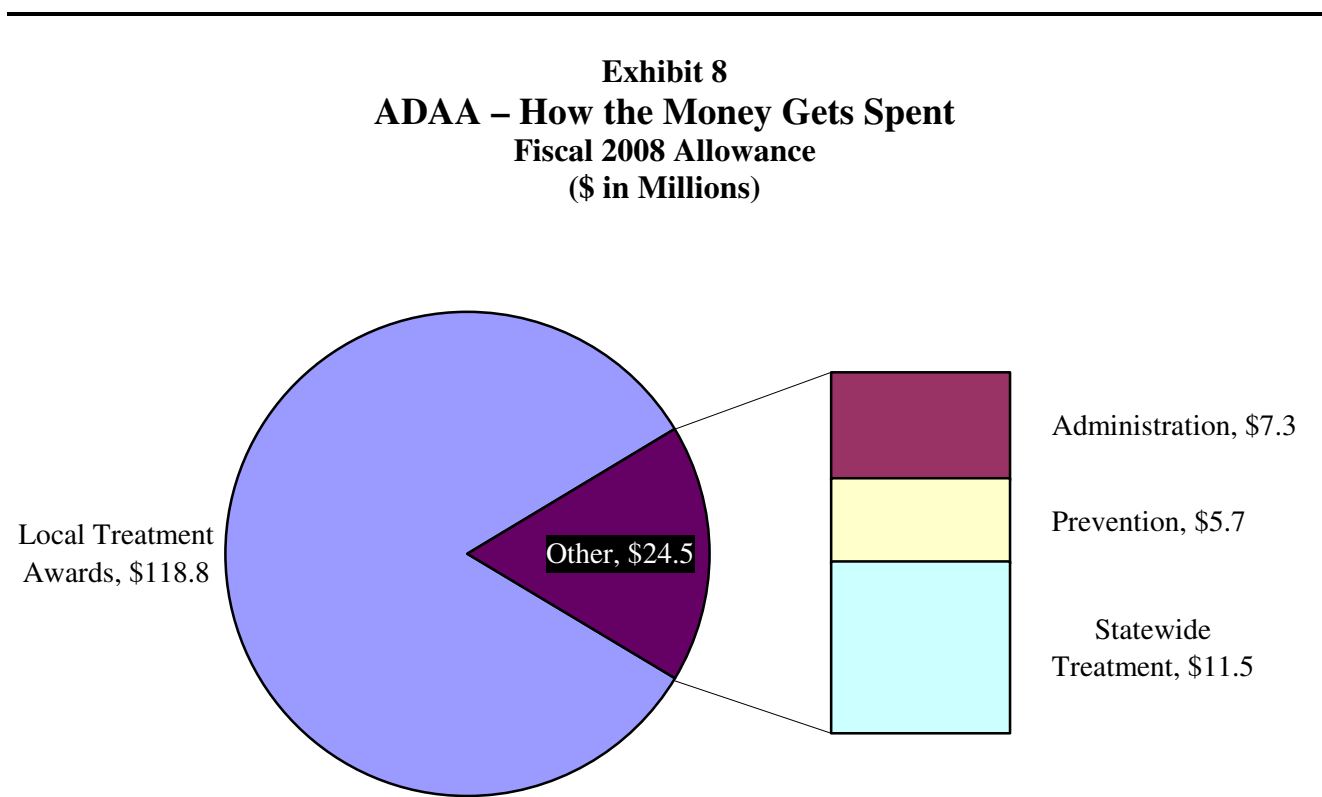


Source: Alcohol and Drug Abuse Administration

According to ADAA, it had previously been including as “prevention” activities, expenditures on early intervention programming. However, after clarification from the federal government, it appears that such expenditures cannot be included as prevention. To date, ADAA has not been challenged by the federal government on the fact that it has not been complying with the SAPT prevention funding requirement. ADAA indicates that it intends to reach the 20% limit by fiscal 2009. However, ADAA is facing another federal review of SAPT expenditures in May 2007, and it is unclear if this proposal will be acceptable to the federal government.

Treatment

Even with the increase in prevention funding proposed in the fiscal 2008 allowance, as shown in **Exhibit 8** it is treatment funding, and specifically treatment funding provided to local jurisdictions, that dominates the ADAA budget.



Source: Alcohol and Drug Abuse Administration

The fiscal 2008 allowance shows a \$4.8 million increase in treatment funding over the fiscal 2007 working appropriation. The funding increase is derived as follows:

- **A \$5 million increase to expand the use of buprenorphine.** Buprenorphine, like methadone, is used in substitution maintenance therapy for opioid dependence. Such therapy

involves the substitution of heroin or other opioid drugs with a pharmacologically related therapy that has the capacity to prevent the emergence of withdrawal symptoms, reduces craving, is long-lasting to reduce the frequency of administration, and can be administered in a manner that reduces the risk of infections associated with the use of illicitly used opioids.

According to the World Health Organization, substitution maintenance therapy is one of the most effective therapies for opioid dependence. Evidence from clinical trials, longitudinal studies, and program evaluations link such therapy to substantial reductions in illicit opioid use, criminal activity, deaths due to overdose, and behaviors with a high risk of Human Immunodeficiency Virus (HIV) transmission.

Buprenorphine is considered less likely than methadone to result in an opioid overdose condition and is considered to be as effective as methadone at adequate doses in terms of the reduction of illicit opioid use and resulting improvement in psychosocial functioning. However, buprenorphine may be associated with lower rates of retention in treatment compared to methadone. Buprenorphine is also expensive (as much as \$400 per month compared to \$30 per month for methadone).

According to ADAA, the proposed \$5 million for buprenorphine is intended to develop a wider statewide infrastructure for the administration of buprenorphine. According to SAMHSA, in Maryland there are currently 209 physicians and 22 treatment programs where buprenorphine may be administered (and under federal law, an individual physician may serve no more than 100 patients with this therapy although appropriately registered treatment programs are not subject to patient limits). ADAA anticipates that \$4 million of the funding will be distributed locally either to individual jurisdictions or regional groupings of jurisdictions based on the estimated unmet need for the treatment of opiate addiction. It is likely that the bulk of the funding will go to Baltimore City. The remaining \$1 million is anticipated to be used for such things as the education of physicians, the purchase of buprenorphine to fill gaps in local budgets for medications, and improving information systems.

From a policy standpoint, the issue with this proposal is that it represents the substantial expansion of funding to address one particular form of addiction and for one particular therapy and seems to run counter to the policy direction established in the 2004 legislation creating the local drug and alcohol abuse planning process. Under that legislation, the focus has been on the development of local prevention and treatment plans and allowing the localities to determine local priorities. For example, according to ADAA, only two local strategic plans mention buprenorphine.

- **\$1 million for the annualization of fiscal 2007 treatment expansion to address priorities as determined by the local planning process.** The fiscal 2007 budget included \$1 million in funding added during the supplemental budget process to expand treatment as determined by those local prevention and treatment plans. ADAA ultimately awarded those funds effective January 1, 2007, with the intent of localities being allowed to fully spend funds in the second half of fiscal 2007 and thus requiring an additional \$1 million to annualize the cost of that expansion.

- **However, to accommodate the buprenorphine initiative, prevention expansion, and the annualization of treatment activity at the local level, the fiscal 2008 allowance requires a reduction in statewide treatment funding of \$1.2 million.** The fiscal 2007 working appropriation includes just under \$12.7 million to fund three different statewide treatment contracts: long-term residential substance abuse for patients with co-occurring disorders; therapeutic community substance abuse treatment for patients in the criminal justice system; and long-term residential substance abuse treatment for pregnant and postpartum women and their children. These three contracts, awarded after a lengthy and contentious procurement process, were considered by ADAA to be important for a number of reasons but not least because they provided significant expansion of treatment slots, especially for those with criminal justice involvement and co-occurring disorders.

At this time, it is not clear what impact a potential reduction of \$1.2 million would have on statewide treatment slots. However, the Judiciary, for example, has been very vocal in calling for additional treatment slots for those with criminal justice involvement and the additional slots provided in fiscal 2007 were long in development. ADAA indicates that it may receive \$500,000 under the federal High Intensity Drug Trafficking Areas program to partially offset this reduction. However, absent this and other funding, it will need to appropriately lower admissions to the statewide residential programs

Budget Summary

As presented, the fiscal 2008 allowance offers expansion of prevention and treatment but also potentially difficult choices:

- Prevention funding increases but still falls short of federal requirements.
- Treatment funding increases but only at the cost of a potentially significant reduction in statewide treatment funding and also at the expense of other locally determined priorities.
- There is no funding provided for a provider cost-of-living adjustment (COLA) (unlike that available in the mental health and developmental disabilities budgets for example). This at a time when, like other health providers, staffing issues are a growing concern.
- There is no funding to complete a new needs assessment, a concern raised by the recent work of the formula workgroup (discussed further below).

In order to address other funding priorities, an alternative use of the \$5 million for expansion of buprenorphine treatment is proposed in **Exhibit 9**.

Exhibit 9
ADAA – Use of Buprenorphine Expansion Funding
An Alternative

2% provider COLA	\$2,625,000
Back-filling of cut in statewide residential treatment	1,200,000
Increase general fund support for base treatment expenditures to allow additional federal funds to support prevention activities as required by federal grant requirements	525,000
Needs assessment study	250,000
Subtotal	\$4,600,000
Remainder	\$400,000

COLA: cost-of-living adjustment

Source: Department of Legislative Services

At the very least, the State should quickly come into compliance with federal requirements regarding the use of SAPT grant funding for prevention and level-fund statewide residential contracts. An argument may also be made for the need to maintain a strong prevention and treatment infrastructure and provide a 2% cost-of-living adjustment to providers.

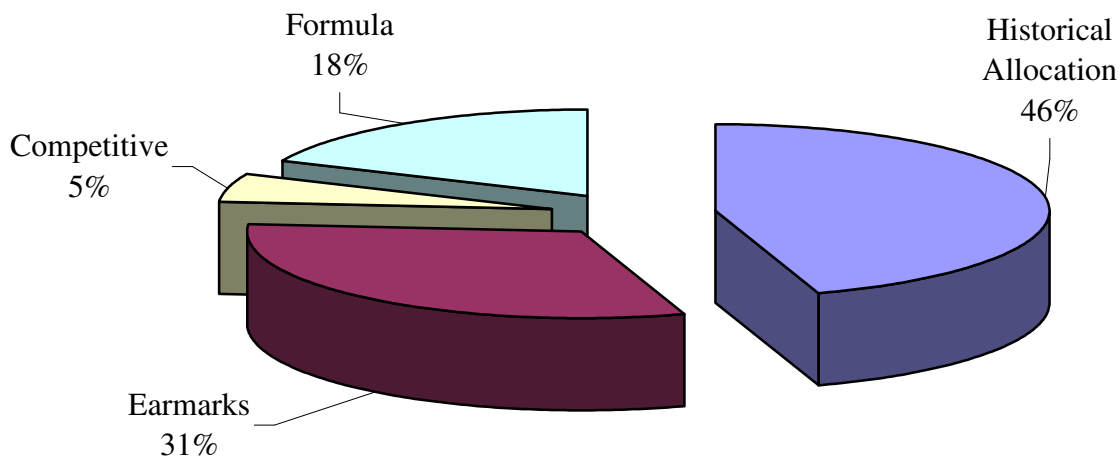
As a starting point for discussion, the Department of Legislative Services (DLS) recommends budget bill language restricting \$4.6 million in funds for buprenorphine treatment expansion to the purposes proposed in Exhibit 9 and cutting the remaining \$400,000. To the extent that these recommendations are not adopted, the committees may wish to consider whether to restrict funding for locally determined treatment priorities. That would allow jurisdictions like Baltimore City, where the expansion of buprenorphine therapy has been identified as a strategic priority, to expand that therapy, while other jurisdictions may choose different priorities.

Issues

1. The Allocation of Local Prevention and Treatment Dollars: The Development of a New Funding Formula and How to Implement It

As noted above, the bulk of ADAA’s funding is granted to local jurisdictions for prevention and treatment. The granting of that funding to those jurisdictions, however, remains the result of a patchwork quilt of allocation methodologies. As shown in **Exhibit 10**, for fiscal 2008, it is anticipated that:

Exhibit 10
ADAA – Local Prevention and Treatment Grants
How the Money Gets Allocated
Fiscal 2008 Allowance



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

- 46% of the awards to be made in fiscal 2008 will be allocated based on historic allocation levels. How those local allocation levels evolved is not documented, but historical accident, local influence, local interest, and funding availability are probably all involved.
- 31% of the funding is based on earmarking that is dedicated to a particular activity or jurisdiction. Typically this earmarking has been driven by legislative direction, for example, Chapter 367 of 1997 (Senate Bill 512) that established a Drug Affected Babies program, and

Chapter 551 of 2000 (House Bill 7) that was intended to improve the provision of substance abuse treatment services to parents in the child welfare system. The most recent additions to this category would be funding added in fiscal 2007 directed to treatment associated with drug courts and the proposed expansion of buprenorphine therapy in fiscal 2008. Indeed, these latter earmarks account for a significant rise in the share of local prevention and treatment funding that is in fact dedicated to a specific purpose.

- 5% of the funding will be awarded competitively through the Substance Abuse Treatment Outcomes Partnership Fund created by Chapter 675 of 2000 (House Bill 1205).
- 18% of the funding will be awarded by formula that consists of three variables: HIV incidence; drug and driving while intoxicated (DWI) arrests; and estimates of treatment need.

The Development of a New Formula and How to Implement It

In fiscal 2007 budget deliberations, the legislature added budget bill language requesting the Maryland State Drug and Alcohol Abuse Council to develop a formula for the allocation of all prevention and treatment funding granted to local jurisdictions for implementation in fiscal 2010. That formula was to be developed by February 1, 2007, and take into consideration:

- The need to equitably fund prevention and treatment services in all jurisdictions.
- The need to hold jurisdictions harmless in the implementation of any new formula as the application of any formula to the **total** funding granted to local jurisdictions would inevitably mean that some jurisdictions would gain funds at the expense of others.
- The need to account for regionally based treatment provided by a single jurisdiction.
- A funding schedule to fully implement the formula by fiscal 2010.

A workgroup of the Maryland State Drug and Alcohol Abuse Council was established to undertake this formula revision, working closely with a consultant. On February 1, 2007, the council submitted the workgroup's report to date and recommended extending the deadline for the development of a formula until December 1, 2007. The request for an extension is certainly not related to a lack of effort on the part of the workgroup but rather the difficulty in resolving a number of key questions including:

- **The implementation of a hold harmless provision.** Under virtually any scenario, it is hard to imagine that the implementation of any formula will not result in sharp redistributions of funding (generally, those redistributions are at the expense of Baltimore City and rural jurisdictions). Such redistributions would have a detrimental impact on the service delivery infrastructure that has developed under current funding streams. It was generally agreed that this should be avoided, and no jurisdiction would lose funds under any new formula.

Thus the question then becomes whether to:

- Establish the current fiscal year funding as “Base Funding” and applying a new formula to any new generally available funding so that in any given year all jurisdictions get new funding above their base (although as shown in the current fiscal 2008 budget discussion, most of the new treatment funding is in fact earmarked and will, by necessity, be distributed utilizing a different methodology again). This has the advantage of providing some funding increases to all jurisdictions over the base while preserving current service capacity, but the disadvantage of institutionalizing real or perceived funding inequities that have developed over time.
- Establish the current fiscal year funding as “Base Funding” and determining what base funding would be if totally allocated by formula and providing any new generally available funding only to those jurisdictions receiving funding below what they would otherwise receive under a total formula allocation. This preserves the current service capacity and more aggressively attacks past funding inequities, but given the availability of funding would likely result in some jurisdictions receiving no additional funding for some considerable period.
- Adopt a hybrid approach whereby the current fiscal year is established as “Base Funding” and any new generally available funding is distributed in two ways: first a percentage across-the-board adjustment to adequately maintain current service; and then allocating the remainder by formula.
- Do nothing until sufficient new funding is appropriated in a single year to be able to fully implement a new formula without reducing any existing allocation. Since this would, depending on the formula, require \$20 million to \$25 million (unlikely) and also require numerous jurisdictions to willingly forego a slice of that \$20 million to \$25 million (perhaps more unlikely), it effectively means preserving the status quo.

That the hold harmless provision is perhaps the most important issue for the group is reflected in the request to the legislature to clarify what it meant by hold harmless. Clearly, achieving what might be considered a more equitable funding allocation poses significant challenges in terms of preserving current service capacity.

- **What variables to include in any formula.** Much discussion has taken place over what variables to include in any formula including the complexity of any formula, the quality of available data, the relative weight of variables, and the use of variable clusters. One particular variable that has come under scrutiny is one currently used by ADAA in its existing formula – estimated need.

ADAA accepts that the current estimated need variable, while developed utilizing a generally accepted methodology is flawed. Consequently, the workgroup is reluctant to use it in any formula (notwithstanding that absent a new formula it remains in the existing formula). The

current variable is based on a needs assessment undertaken in 1998 and updated in 2002 and is used because it is an affordable means of calculating the prevalence of alcohol and substance abuse problems in each jurisdiction and thus the need for prevention and treatment services. It would appear to make sense that prevalence of alcohol and substance abuse problems would be an important variable in any formula allocating prevention and treatment funds. However, reviewing studies and study costs done elsewhere indicates that such needs assessments are not cheap. **Thus, as noted above in Exhibit 9, DLS recommends restricting \$250,000 for the development of a needs assessment.**

- **How to overcome the “rural” factor.** Specifically there is an argument that service provision in rural jurisdictions is more expensive (because the cost of doing business may be greater and requires greater planning) and disproportionately falls upon the public sector because of an absence of private providers.
- **How to incorporate the regional provision of treatment.** Some jurisdictions pool resources to support treatment options (for example, residential treatment, intensive outpatient treatment, medication-assisted treatment, and medically supervised withdrawal) that could not be sustained by a single jurisdiction. It is unclear how best to recognize these pooled dollars in a formula arrangement.
- **How court-ordered commitments should be funded.** A concern specifically voiced by the Judiciary is how to equitably account for court-ordered evaluations and treatment (including the so-called 8-505 and 8-507 placements ordered pursuant to those sections of the Health General Article). While some of these evaluations and treatment are captured in statewide funding dollars, it is clear that as the Judiciary looks to expand treatment as an alternative to incarceration there needs to be some consideration of how services provided to this population play into funding allocations. For example, is it simply part of a jurisdiction’s overall treatment need and funded as part of local strategic planning process, or should funding for this population be considered separate and apart from those local plans?
- **How to deal with prevention services.** It was generally agreed that a separate formula would apply for the allocation of prevention funding. However, the concern was that the paucity of prevention dollars could result in reallocations that would prevent even the most basic prevention infrastructure. For example, it was expressed that any reallocation of prevention dollars had to result in the funding of at least one prevention services coordinator in each jurisdiction.

Summary

In summary, the workgroup is continuing to evaluate formula variables and trying to resolve the various issues that arose in the past six months. However, the group has specifically asked for guidance from the legislature about the hold harmless provision *i.e.*, how is any new formula to be applied?

In DLS's judgment, fully resolving the inequities that result from historical funding patterns and the past earmarking of funds cannot easily be resolved without significant infusions of new funding, infusions which at this time appear unlikely. Simply reallocating funding based on a new formula without regard to current funding levels or even holding jurisdictions harmless until the redistributive impact of a new formula is felt (which would likely mean a slow drawn-out decline in service capability in those jurisdictions receiving no new funding) would have a detrimental impact on current service capacity. Degrading service capacity in some areas to provide new capacity elsewhere does not make tremendous sense given that there is apparent consensus that every jurisdiction has unmet need.

Thus, DLS recommends adding budget bill language withholding funds until the formula workgroup completes its task and develops a new formula to be applied only to any new funding for the expansion of prevention and treatment services and to implement that formula beginning in fiscal 2009. This leaves open the question of how new funding is presented in the ADAA budget, allowing the opportunity for distinguishing between across-the-board adjustments and funding for the expansion of services. The workgroup should also strive to resolve other funding questions raised in the recently submitted report, including how to treat the funding of court-ordered evaluations and commitments. In the unlikely event that ADAA receives a significant amount of new funding in the near-term, it is reasonable to revisit the idea of applying a new formula to all prevention and treatment funds.

2. ADAA and Performance-based Contracting

In recent years, at all levels of government, greater emphasis has been placed on the effectiveness of government programs. In Maryland, this emphasis is best reflected in the Managing for Results (MFR) process. A natural adjunct of MFR with its development of performance goals and the measurement of outcomes is the concept of performance-based contracting.

Performance-based contracting means different things to different people. However, at its core, performance-based contracting is intended to change the behavior of contractors (and by extension, the agencies overseeing those contracts and contractors) to focus more on performance. Supporters of performance-based contracts point to such potential benefits as the encouragement of contractors to be innovative, increased emphasis on better outcomes and lower costs, and increased accountability (on the part of the contracting agency as well as the contractor). Skeptics note that performance-based contracts are best used for contracts that are well-defined, have accepted metrics, and have a reasonably predicted time-frame for achieving the desired outcomes, something often absent.

For ADAA, DLS reviewed both the statewide residential contracts as well as the local grant prevention and treatment awards to assess the extent to which they contain performance elements:

- ADAA has been actively pursuing the integration of performance into its grants and contracts. In the three statewide residential contracts, for example, performance revolves around completion of treatment and retention in treatment. Grant awards are linked to ADAA's MFR.

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- Incentives are clearly linked to performance and are substantial in nature. In the three statewide residential contracts, for example, contractors may earn up to a 5% bonus if at least 50% of program discharges in a contract term complete treatment and at least 50% are retained for a minimum of 210 days (a 2.5% bonus is awarded for meeting one of the two performance benchmarks). To date, ADAA has paid out just over \$13,000 in bonuses and has an invoice for a second incentive payment of almost \$96,000.

For local grant awards, ADAA has developed incentive payments for ADAA-funded Level I outpatient services (treatment for patients who require less than nine hours of services weekly), again based on successful completion of treatment (50%) and program retention (65% of clients stay in the program for 90 days or longer). These goals are developed based on a jurisdiction's overall level of performance amongst all publicly funded programs. As shown in **Exhibit 11**, incentive levels vary by jurisdiction depending on the number of publicly funded programs in any one jurisdiction. Total incentive payments in fiscal 2007 could equal \$157,000 (which represents incentive funding for four months and would annualize to \$471,000, or 1.6% of total ADAA funding for Level I outpatient treatment) although ADAA expects awards to be nearer \$60,000.

Exhibit 11
ADAA – Outpatient Performance Incentives
Fiscal 2007

<u>Jurisdictions</u>	<u>Publicly Funded Outpatient Programs (#)</u>	<u>Potential Fiscal 2007 Prorated Incentive Payment</u>
Caroline, Cecil, Charles, Dorchester, Frederick, Garrett, Kent, Queen Annes, Talbot, Wicomico	1 to 2	\$5,000
Allegany, Calvert, Carroll, Harford, Howard, Montgomery, Somerset, St. Mary's, Washington, Worcester	3 to 6	\$6,667
Anne Arundel, Baltimore City, Baltimore, Prince George's	7+	\$10,000

Note: Performance awards are based on a prorated amount based on four months of data.

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

- The performance targets are well set in that they present providers/jurisdictions with a challenge, but a reasonable one. For example, for the statewide residential contracts, the successful completion goal of 50% was just about the average for those kinds of residential

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programs in fiscal 2006 (51%), while retention goals (50%) were actually above average (12-29% based on fiscal 2006 data).

For outpatient programs, the successful completion goal of 50% was slightly below the average successful completion rate in fiscal 2006 (54%). The retention goal of 65% was above the statewide average of 59%. Based on fiscal 2006 data, only nine jurisdictions would meet this goal.

- The contracts/grants awards do not contain penalties. However, ADAA did note that some jurisdictions (for example, Baltimore City and Baltimore and Montgomery counties) have changed providers that were not meeting overall MFR performance levels.
- Perhaps the biggest change this kind of effort to focus on performance presents to ADAA is the need for adequate grant and contract monitoring. ADAA has made it a real focus to be data driven. However, it obviously needs to verify that the data upon which these financial decisions are based are sound. A recent audit by the Office of Legislative Audits was critical on this point and serves to potentially undermine ADAA's data driven emphasis (see **Appendix 2** for additional details on the audit).

In summary, ADAA is moving more aggressively than perhaps any other agency to instill performance into its grants and contracts. The challenge for the administration is to ensure adequate oversight of those grants and contracts and also to ensure that the financial resources are available to meet its obligations. For example, offering incentives for performance in the statewide residential contracts becomes less of an issue to contractors if overall funding for those contracts has to fall by 10% in fiscal 2008 because funding is not available.

Recommended Actions

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

, provided that \$4,600,000 of this appropriation intended to expand the use of buprenorphine therapy may not be expended for that purpose and may only be used as follows:

- (1) \$2,625,000 to provide a 2 percent provider cost-of-living adjustment;
- (2) \$1,200,000 to support statewide residential contracts;
- (3) \$525,000 to back-fill for an equal amount of federal Substance Abuse and Prevention Treatment Block Grant treatment funding that is transferred to prevention activities; and
- (4) \$250,000 to support a comprehensive needs assessment.

Any funding not used as provided for above may not be transferred or expended for any other purpose but shall revert to the general fund.

Explanation: The proposed language restricts \$4.6 million in funding intended to expand treatment with buprenorphine to other specific purposes.

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

Further provided that \$100,000 of this appropriation may not be expended until the Maryland State Drug and Alcohol Abuse Council, in consultation with the local drug and alcohol abuse councils, develops a formula for the allocation of alcohol and drug abuse prevention and treatment funds distributed by the Alcohol and Drug Abuse Administration (ADAA) to local jurisdictions. It is the intent of the General Assembly that such a formula apply to all new ADAA prevention and treatment funding distributed to local jurisdictions for service expansion beginning in fiscal 2009.

In developing this formula, the council should also consider how best to:

- (1) fund services provided in rural jurisdictions;
- (2) account for the benefits that accrue from regional-based treatment provided by a single jurisdiction;
- (3) fund services provided for court-ordered commitments; and
- (4) fund prevention services.

The Maryland State Drug and Alcohol Abuse Council shall report to the budget committees by December 1, 2007, on the development of a funding formula. The committees shall have 45 days to review and comment.

Explanation: The language withholds funds pending the development of a new formula for the allocation of alcohol and drug abuse prevention and treatment grant awards to local jurisdictions by the Maryland State Drug and Alcohol Abuse Council. The language also clarifies budget bill language added during fiscal 2007 budget deliberations that the formula shall apply only to new funding for service expansion, but states the intent that the formula shall apply beginning in fiscal 2009 rather than fiscal 2010 as previously stated. The language also asks the council to consider various other issues as it develops the formula.

Information Request	Author	Due Date
Formula for the allocation of ADAA prevention and treatment funding to local jurisdictions	Maryland State Drug and Alcohol Abuse Council	December 1, 2007

		<u>Amount Reduction</u>	
3.	Reduce funds for the expansion of buprenorphine treatment.	\$ 400,000	GF
4.	Reduce funds for a University of Maryland contract position by reclassifying an existing vacant position for that function. The Executive Director of the State Drug and Alcohol Abuse Council is paid via a contract through the University of Maryland Public Safety Training and Technical Assistance Center housed at College Park. The Executive Director function is important to the work of the council and has grown in importance with the establishment of the local drug and alcohol abuse planning process which is in turn integral to the way that the Alcohol and Drug Abuse Administration (ADAA) administers its grant funding. However, ADAA has not been able to secure a regular position for this function. ADAA should take an existing vacant regular position (046192) and reclassify it to accommodate the Executive Director without loss of	88,000	GF

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salary or benefits. The reduction equals the salary and benefit value of that vacant position plus \$14,000 that is saved by not having to pay indirect costs to the University of Maryland.

Total General Fund Reductions **\$ 488,000**

Updates

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 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 (DHMH) – 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 the Institutional Review Boards of both DHMH and the University of Maryland (which will undertake the evaluation) approved the protocol in November and December of 2006, respectively, and the evaluation is finally underway.

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 2006					
Legislative Appropriation	\$78,050	\$17,864	\$32,783	\$3,363	\$132,059
Deficiency Appropriation	0	0	0	0	0
Budget Amendments	33	202	277	0	512
Reversions and Cancellations	0	-274	-412	0	-686
Actual Expenditures	\$78,082	\$17,792	\$32,648	\$3,363	\$131,885
Fiscal 2007					
Legislative Appropriation	\$84,832	\$17,635	\$31,678	\$3,363	\$137,508
Budget Amendments	50	4	0	0	54
Working Appropriation	\$84,881	\$17,639	\$31,678	\$3,363	\$137,561

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

Fiscal 2006

The fiscal 2006 legislative appropriation for ADAA was reduced by \$174,000 as follows:

- Budget amendments increased the legislative appropriation by \$512,000. This increase consisted of:
 - \$33,000 in general funds that represented ADAA’s share of the fiscal 2006 cost-of-living adjustment (COLA) originally budgeted in the Department of Budget and Management.
 - \$202,000 in special funds derived from prior year grant recoveries used to offset the same amount of increased costs in other prior year grant awards.
 - \$277,000 in federal funds for a variety of expenditures including a contract for \$100,000 to support substance abuse prevention data collection and reporting, \$75,000 to support ADAA’s efforts to meet the federal Substance Abuse and Mental Health Services Administration’s National Outcomes Measurement project; \$52,000 in available Substance Abuse Prevention and Treatment Block Grant funding to support substance abuse treatment services; and a National Institutes of Health grant for \$50,000 to support the adoption of science-based practices.
- Special and federal fund cancellations, totaling \$686,000, slightly offset the increase to the legislative appropriation from budget amendments. Special fund cancellations included \$171,000 in lower than anticipated training expenditures and \$100,000 in expenditures that were to be supported by revenues into the Maryland Substance Abuse Fund from court-imposed fees, revenues that failed to materialize. The bulk of the federal fund cancellation is lower than anticipated Substance Abuse Prevention and Treatment Block Grant expenditures.

Fiscal 2007

To date, the fiscal 2007 legislative appropriation has been increased by \$54,000. This entire amount (\$50,000 general funds, \$4,000 special funds) represents ADAA’s share of the fiscal 2007 State employee COLA.

Audit Findings

Audit Period for Last Audit:	January 23, 2003 – March 9, 2006
Issue Date:	December 2006
Number of Findings:	2
Number of Repeat Findings:	2
% of Repeat Findings:	100%
Rating: (if applicable)	n/a

Finding 1: ADAA did not adequately monitor substance abuse treatment grants to ensure appropriate services were rendered by providers. The Office of Legislative Audits recommended ADAA improve documentation comparing treatment slots funded to actual treatment provided; verify treatment data through routine field visits; ensure compliance by the vendor responsible for Baltimore City substance abuse grants; and ensure matching requirements under the Substance Abuse Treatment Outcomes Partnership grants are provided or waivers of this requirement are appropriately documented. DHMH concurred with the finding and the recommendations.

Finding 2: ADAA had not established adequate controls over cash receipts. DHMH concurred with the finding.

*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>FY06 Actual</u>	<u>FY07 Working Appropriation</u>	<u>FY08 Allowance</u>	<u>FY07-FY08 Amount Change</u>	<u>Percent Change</u>
Positions					
01 Regular	64.00	65.00	64.00	-1.00	-1.5%
02 Contractual	2.39	3.17	4.50	1.33	42.0%
Total Positions	66.39	68.17	68.50	0.33	0.5%
Objects					
01 Salaries and Wages	\$ 3,108,396	\$ 4,269,600	\$ 4,243,884	-\$ 25,716	-0.6%
02 Technical and Special Fees	73,492	65,051	109,827	44,776	68.8%
03 Communication	15,215	21,093	20,987	-106	-0.5%
04 Travel	85,612	94,035	92,118	-1,917	-2.0%
07 Motor Vehicles	4,335	3,342	3,049	-293	-8.8%
08 Contractual Services	128,452,237	133,036,961	138,757,587	5,720,626	4.3%
09 Supplies and Materials	59,694	53,204	52,110	-1,094	-2.1%
10 Equipment – Replacement	54,738	0	0	0	0.0%
11 Equipment – Additional	10,327	0	0	0	0.0%
13 Fixed Charges	21,202	18,122	18,184	62	0.3%
Total Objects	\$ 131,885,248	\$ 137,561,408	\$ 143,297,746	\$ 5,736,338	4.2%
Funds					
01 General Fund	\$ 78,082,179	\$ 84,881,077	\$ 90,746,072	\$ 5,864,995	6.9%
03 Special Fund	17,791,994	17,639,087	17,747,654	108,567	0.6%
05 Federal Fund	32,647,980	31,678,149	31,440,925	-237,224	-0.7%
09 Reimbursable Fund	3,363,095	3,363,095	3,363,095	0	0%
Total Funds	\$ 131,885,248	\$ 137,561,408	\$ 143,297,746	\$ 5,736,338	4.2%

Note: The fiscal 2007 appropriation does not include deficiencies, and the fiscal 2008 allowance does not reflect contingent reductions.

Fiscal Summary
DHMH – Alcohol and Drug Abuse Administration

<u>Program/Unit</u>	<u>FY06 Actual</u>	<u>FY07 Wrk Approp</u>	<u>FY08 Allowance</u>	<u>Change</u>	<u>FY07-FY08 % Change</u>
K101 Executive Direction	\$ 584,494	\$ 628,563	\$ 653,348	\$ 24,785	3.9%
K102 Grants, Contracts, and Management	718,525	799,174	779,398	-19,776	-2.5%
K103 Continuous Quality Improvement	417,515	589,064	665,146	76,082	12.9%
K104 Management Information Services	983,763	1,045,954	1,069,640	23,686	2.3%
K105 Education and Training	431,155	435,245	428,895	-6,350	-1.5%
K107 S.S.I. Drug and Alcohol	73,070	73,070	73,070	0	0%
K108 Criminal Justice	386,512	404,436	381,901	-22,535	-5.6%
K109 Policy, Planning, and Development	100,000	200,000	200,000	0	0%
K110 Special Populations	75,000	150,000	150,000	0	0%
K111 Program Consultation	767,505	891,286	853,710	-37,576	-4.2%
K113 Administration and Operations	1,592,309	795,595	971,936	176,341	22.2%
K115 M.A.T.C.	50,000	0	0	0	0%
K117 Drug Abuse Target Cities Treatment Im	724,276	800,000	800,000	0	0%
K201 SAPT Prevention (FF)	4,974,224	5,054,091	5,685,355	631,264	12.5%
K202 Addictions Treatment Services	65,719,508	73,290,010	73,862,630	572,620	0.8%
K203 SAPT Treatment (FF)	26,335,455	24,789,921	23,953,886	-836,035	-3.4%
K204 Cigarette Restitution Funds Treatment (SF)	17,054,368	17,002,318	17,056,150	53,832	0.3%
K219 SB 512 – Children In Need Of Assistance Drug Affected Babies Treatment	1,629,824	1,656,599	1,656,599	0	0%
K220 Substance Abuse Treatment Outcomes Partnership Fund	6,573,588	6,433,718	6,433,718	0	0%
K221 Hb7 Integration Of Child Welfare and Substance Abuse Treatment	2,285,893	2,322,364	2,322,364	0	0%
K224 Sdi – State Data Infrastructure Initiative	9,318	0	0	0	0%
K225 Buprenorphine	0	0	5,000,000	5,000,000	0%
K298 Grant Activity – Prior Fiscal Years	398,946	200,000	300,000	100,000	50.0%
Total Expenditures	\$ 131,885,248	\$ 137,561,408	\$ 143,297,746	\$ 5,736,338	4.2%
General Fund	\$ 78,082,179	\$ 84,881,077	\$ 90,746,072	\$ 5,864,995	6.9%
Special Fund	17,791,994	17,639,087	17,747,654	108,567	0.6%
Federal Fund	32,647,980	31,678,149	31,440,925	-237,224	-0.7%
Total Appropriations	\$ 128,522,153	\$ 134,198,313	\$ 139,934,651	\$ 5,736,338	4.3%
Reimbursable Fund	\$ 3,363,095	\$ 3,363,095	\$ 3,363,095	\$ 0	0%
Total Funds	\$ 131,885,248	\$ 137,561,408	\$ 143,297,746	\$ 5,736,338	4.2%

Note: The fiscal 2007 appropriation does not include deficiencies, and the fiscal 2008 allowance does not reflect contingent reductions.