

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEASURING DRUG ABUSE
TREATMENT COSTS**

MANAGEMENT ADVISORY REPORT



NOVEMBER 1992

OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services' (HHS) programs as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by three OIG operating components: the Office of Audit Services, the Office of Investigations, and the Office of Evaluation and Inspections. The OIG also informs the Secretary of HHS of program and management problems and recommends courses to correct them.

OFFICE OF AUDIT SERVICES

The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the Department.

OFFICE OF INVESTIGATIONS

The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil money penalties. The OI also oversees State Medicaid fraud control units which investigate and prosecute fraud and patient abuse in the Medicaid program.

OFFICE OF EVALUATION AND INSPECTIONS

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The findings and recommendations contained in these inspection reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.

OEI's Atlanta Regional Office staff prepared this report under the direction of Jesse J. Flowers, Regional Inspector General, and Chris Koehler, Deputy Regional Inspector General. Principal OEI staff included:

ATLANTA

Jim Wilson
Jacqueline Watkins
Betty Apt

HEADQUARTERS

Ruth Folchman

To obtain a copy of this report, call the Atlanta Regional Office at (404) 331-4108.

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEASURING DRUG ABUSE
TREATMENT COSTS**

MANAGEMENT ADVISORY REPORT



NOVEMBER 1992 OEI-04-91-00430

EXECUTIVE SUMMARY

PURPOSE

To show how effectively the Alcohol, Drug Abuse and Mental Health Administration measures costs for drug abuse treatment.

BACKGROUND

Public funding of drug abuse treatment programs is largely the responsibility of individual localities and States. Most Federal funding for drug abuse treatment has been provided by the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA). At the time of our review, ADAMHA was undergoing an extensive reorganization, and effective October 1, 1992, was replaced by the Substance Abuse and Mental Health Services Administration (SAMHSA). ADAMHA reorganized to better distinguish its dual service and research missions by focusing on treatment and services through SAMHSA and shifting research activities to the National Institutes of Health (NIH). **Throughout the report, we will refer to ADAMHA instead of SAMSHA since the review was conducted prior to the effective date of the reorganization.**

In 1981, ADAMHA changed its primary funding method from categorical grants to block grants. The funds were provided through the Alcohol, Drug Abuse and Mental Health services (ADMS) block grant program. Block grants allowed States greater flexibility and required less reporting than categorical grants. Under the block grant program, States were not required to furnish data such as costs of drug abuse treatment. With the recent reorganization, the block grant will be split into two separate grants: one for mental health services and one for substance abuse treatment and prevention services.

Reliable cost data is needed so that decision-makers can plan effective treatment programs. Accordingly, Federal legislation was passed in 1988 which increased ADAMHA's data collection requirements and States' block grant reporting requirements to correct ADAMHA's lack of drug abuse treatment cost data.

FINDINGS

ADAMHA is required to collect drug abuse treatment costs.

The Anti-Drug Abuse Act of 1988 (P.L. 100-690) amended title V of the Public Health Service Act to require ADAMHA to collect costs on different drug abuse treatment modalities.

ADAMHA's data collection system does not provide reliable data for measuring drug abuse treatment costs.

ADAMHA's three major sources of data on drug abuse treatment - the State Alcohol and Drug Abuse Profile (SADAP), the National Drug Abuse and Alcoholism Treatment Unit Survey (NDATUS) and Drug Abuse Services Research Survey (DSRS) - are flawed in their cost reporting and limit the completeness, accuracy and relevancy of cost data. The data sources do not distinguish between reimbursement and costs, include indirect costs and relate cost data to services provided.

RECOMMENDATIONS

Ultimately, ADAMHA should obtain precise costs on the various drug treatment programs it supports. Without such cost data, the Department's ability to assess, plan and budget effective treatment programs is limited. However, ADAMHA has not required States and localities to furnish drug abuse treatment cost data. Accordingly, we recommend that ADAMHA:

- 1. Aggressively continue to incrementally build a system for measuring drug abuse treatment costs.**

Such data is essential for planning and budgeting effective drug abuse treatment services. To assure that reliable, useable cost data is available, ADAMHA should, as part of its ongoing efforts to establish and clearly define appropriate drug abuse treatment protocols:

- a) identify in accordance with commonly accepted accounting principles, all indirect and direct cost components of various drug abuse treatment protocols;
- b) develop cost standards for the different types of drug abuse treatment protocols;
- c) identify and use alternative methods for obtaining reliable drug abuse treatment costs;
- d) aggregate and summarize provider cost data to establish ranges and baselines; and
- e) periodically verify cost data collected to assure its reliability (the cost of such validation could be limited through use of sampling techniques).

2. **As a condition of grant award, require that drug abuse treatment research and demonstration grantees who perform clinical effectiveness studies use Federal standards for collecting treatment cost data.**

ADAMHA's Office for Treatment Improvement, the National Institute on Drug Abuse, and others are aware of the problems created by lack of reliable drug abuse treatment costs and they have remedial initiatives underway.

COMMENTS

We did not receive written comments from the Public Health Service (PHS). However, in commenting orally, ADAMHA staff agreed with the findings, but stressed that grantees lack capacity to capture cost data. We did receive written comments from the Assistant Secretary for Planning and Evaluation and the Counsel to the Secretary for Drug Abuse and Policy. They agreed that ADAMHA should continue efforts to improve measurement of drug abuse treatment costs. However, the Counsel to the Secretary did not believe that all grantees performing clinical effectiveness studies should be required to collect treatment cost data. We have clarified that we are not recommending this, but rather that those who do collect cost data should use Federal standards.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

INTRODUCTION 1

FINDINGS 5

 ADAMHA's Requirements for Data Collection 5

 ADAMHA's Data Collection System 5

RECOMMENDATIONS 7

ENDNOTES 9

APPENDIX A: COMMENTS ON DRAFT REPORT A-1

INTRODUCTION

PURPOSE

To show how effectively the Alcohol, Drug Abuse and Mental Health Administration measures costs for drug abuse treatment.

BACKGROUND

Evolution of Drug Treatment Programs

Drug abuse treatment programs have evolved with changes in types of drugs used, composition of drug abuser populations, and definitions of drug abuse and addiction.

In the early 1900s, drug abuse treatment was directed largely at cocaine and opium abusers with most treatment provided in medical settings. Between 1910 and 1920, public perception of drug abuse shifted from treatment of drug abuse as an illness to punishment of drug abuse as a crime. Enactment of the Harrison Narcotic Act in 1914 signalled a change in approach to treatment of addiction by attempting to control the sale of drugs defined as narcotic. The U.S. Supreme Court decisions in 1914 and 1916 restricted physicians' authority to prescribe heroin for addicts. By 1923, the last public maintenance clinics for heroin addicts had closed. Thereafter, little change occurred until the 1960s.

Throughout the 1950s and 1960s, drug addiction incidence increased. During the 1960s, treatment practices changed and medical treatment again became the predominant method of coping with drug abuse. For example, the Public Health Service opened treatment hospitals for heroin addicts in Kentucky and Texas. Most treatment programs that began in the 1960s focused on abusers who used only heroin.

In the 1970s, methadone maintenance and therapeutic treatment communities were used successfully for heroin addicts. However, as drugs such as cocaine and amphetamines were recognized to cause dependency, a new approach to treatment was adopted -- outpatient drug-free programs with emphasis on individual counseling. As a result, Federal, State and local government funding increased. Private funding for drug abuse treatment also increased in the late 1970s and 1980s as coverage became available by private health insurance programs¹.

From the 1980s to the present, Federal funding has increased both for treatment and prevention (enforcement and education). Private funding, along with State and local governments, continued to pay for most drug abuse treatment. In recent years, private coverage has begun to decline as insurance cost containment programs reduced coverage allowances for drug abuse treatment.

Generally Accepted Drug Abuse Treatment Modalities

Modalities can be defined as treatment setting and/or medical protocol used in treating drug dependency. Drug abuse treatment is now classified into four general modalities²:

- ▶ Methadone Maintenance,
- ▶ Outpatient non-methadone (drug-free) treatment,
- ▶ Residential therapeutic communities (TC), and
- ▶ Chemical Dependency (CD) units.

In addition, some professionals consider drug detoxification to be a modality because it is generally the first step in the treatment process and it requires resources.

However, some controversy exists over whether detoxification should be considered a distinct modality. For example, a September 1990 Institute of Medicine study, Treating Drug Problems, argued that detoxification is not a treatment modality. The study noted that, "Detoxification is seldom effective in itself as a modality for bringing about recovery from dependence, although it can be used as a gateway to other treatment modalities. Detoxification episodes are often hospital based and may begin with an emergency treatment of an overdose. However, clinicians generally advocate that, because of the narrow and short-term focus and very poor outcomes in terms of relapse to drug dependence, detoxification not be considered a modality of treatment in the same sense as methadone, TCs, outpatient nonmethadone, and CD programs."

Federal Agencies Active In Drug Abuse Treatment

Within the Department of Health and Human Services, at the time of our review, the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) had responsibility for policy development and funding of State treatment programs. Effective October 1, 1992, ADAMHA was replaced by the Substance Abuse and Mental Health Services Administration (SAMHSA). The creation of SAMHSA was an attempt to address concerns that the institutes within ADAMHA had shifted their focus over the years from services development to biomedical research. SAMHSA will focus on treatment and services for people who are mentally ill or chemically dependent and will comprise three agencies: the Center for Substance Abuse Treatment--formerly the Office of Treatment Improvement (OTI), the Center for Substance Abuse--formerly the Office of Substance Abuse Prevention (OSAP), and a newly created Center for Mental Health Services. Research activities formerly conducted by ADAMHA's three research institutes were transferred to the National Institutes of Health (NIH). Throughout this report, we have referred to ADAMHA instead of SAMSHA since the review was conducted prior to the effective date of the reorganization.

Also within the Department, the Drug Abuse Policy Office is located in the Office of the Secretary, increasing the visibility and policy attention given to drug abuse. The Assistant Secretaries for both Planning and Evaluation, and Management and Budget work closely together in providing oversight and policy direction in program expenditures.

One other Federal agency plays an important policy role for drug abuse treatment. The White House Office of National Drug Control Policy (ONDCP) was created by the 1988 Anti-Drug Abuse Act and granted statutory authority to develop an annual National Drug Control Strategy.

Public Funding for Drug Abuse Treatment Programs

Public funding of drug abuse treatment programs is largely the responsibility of localities and individual States. In recent years, Federal roles in drug abuse treatment have been expanding. Most Federal funds for drug abuse treatment have been provided by ADAMHA through the Alcohol, Drug Abuse, and Mental Health Services (ADMS) block grant program. With the ADAMHA reorganization, the ADMS block grant was split into two grants: one for mental health services and one for substance abuse treatment and prevention services. The reorganization also modified the formula under which each state's block grant allotment is determined providing that, through Fiscal Year 1994, no state may receive less than its Fiscal Year 1991 block grant allocation. Federal funding to States has increased significantly, representing about 20 percent of total funding for drug abuse treatment. The ADAMHA expenditures for Fiscal Year 1991 were approximately \$638 million for drug abuse treatment³.

Until 1981, ADAMHA's primary mechanism for funding drug abuse treatment was through categorical grants for drug abuse treatment. The categorical grant program allowed the Federal government to influence the design, implementation, and data collection methodologies for State and local drug abuse treatment programs. With the Omnibus Budget Reconciliation Act of 1981, the Congress consolidated all categorical treatment grants under the ADMS block grant program. The intent of the block grant program was to enable States to design their own treatment programs and allocate funds accordingly. Subsequent to development of the block grant program, a number of drug abuse treatment discretionary grant programs have been developed and targeted on special populations and needs. Conversion from categorical grants to block grants allowed the States greater flexibility, but reduced Federal access to drug abuse treatment data.

METHODOLOGY

We reviewed principal data collection surveys sponsored by ADAMHA to assess how well they satisfied certain criteria including cost, timeliness, completeness and verification. Our primary concern was to determine whether reliable data for establishing estimates on the costs of drug abuse treatment were present in the current principal surveys.

Drug abuse treatment costs, for purposes of this report, are defined as direct and indirect costs related to clinical treatment of drug abusers. This report does not consider other costs such as those related to diminished productivity or social impact of drug abuse.

In addition to reviewing existing data bases, we interviewed principal staff in ADAMHA's Office for Treatment Improvement and the National Institute on Drug Abuse.

Our review was conducted in accordance with the *Interim Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

ADAMHA is Required to Collect Drug Abuse Treatment Costs.

The Anti-Drug Abuse Act of 1988 (P.L. 100-690) amended title V of the Public Health Service Act to require the Administrator of ADAMHA to collect costs on different treatment modalities⁴. The Act requires:

ADAMHA to consult with States and appropriate national organizations to develop uniform criteria for collecting drug abuse treatment cost data⁵;

States to provide ADAMHA cost data required as a condition for receiving their block grants⁶;

ADAMHA to support research on comparable costs and efficacy of different treatment modalities⁷; and

ADAMHA to collect data each year on the national incidence and prevalence of the various forms of substance abuse⁸.

ADAMHA's Data Collection System Does Not Provide Reliable Data for Measuring Drug Abuse Treatment Costs.

Presently, ADAMHA has three major sources for data collection on drug abuse treatment. We reviewed the reports from each source. The reports provide important data, but each is flawed with regard to cost reporting. Specifically, as shown below, the reports do not include costs of drug abuse treatment.

State Alcohol and Drug Abuse Profile: Congressional amendments to the ADMS block grant program in 1984 required the Department, in consultation with national interest groups, to develop model data collection criteria and formats to obtain national-level data on services provided, number and types of clients served, and total funding⁹.

To develop and maintain the required data, the National Institute on Drug Abuse (NIDA) provides funds to the National Association of State Alcohol and Drug Abuse Directors, Inc. (NASADAD) for collecting and analyzing drug abuse treatment data. This system is widely known by its acronym, SADAP. States submit data on a voluntary basis. The data, however, is not verified and costs of drug abuse treatment are not obtained.

National Drug Abuse and Alcoholism Treatment Unit Survey: In addition to information provided by SADAP, NIDA collects other drug abuse treatment data through the National Drug Abuse and Alcohol Treatment Survey (NDATUS). NIDA initiated the survey in 1974 and has repeated it intermittently since then. The National Drug Abuse Treatment Survey collects data on both private and public drug abuse treatment providers. It represents the most comprehensive collection of data from the census of drug abuse treatment providers, but it does not collect cost data -- it collects data on program funding. Further, NDATUS does not include all providers and does not verify the data.

Drug Abuse Services Research Survey: As a condition for continued funding of NDATUS for Fiscal Year 1990, the Office of Management and Budget and Office of National Drug Control Policy directed NIDA to undertake a separate and additional data collection effort -- the Drug Abuse Services Research Survey (DSRS)¹⁰. The NIDA's Financing and Services Research Branch gathered a range of data on provider services, clients in treatment, type of treatment staff, revenue, etc. This data collection effort was completed in April 1991. DSRS surveyed a substantial number of providers of drug abuse treatment services, but captured limited aggregate costs and revenue data by modality. NIDA staff told us that requested information was not generally available on costs of treatment by modality at the provider level. NIDA's data would be enhanced substantially by national reporting standards for collecting costs of treatment.

In addition to the specific limitations of the data systems discussed above, there are two general problems with existing cost data.

Costs Are Understated. In most cases, when financial data is collected, it reflects program funding or reimbursement, rather than treatment costs. For example, some States reimburse local programs and counties at less than 100 percent of their actual costs of treatment. Furthermore, States do not always include indirect costs in drug abuse treatment allocation, resulting in further understating actual costs.

Funding Data Do Not Relate To Services. Most cost information collected is not specifically related to the factors that affect costs, including the setting, type and intensity of services provided. Unless cost data is directly associated with treatment modality and level of services provided, it has limited utility to policy makers.

RECOMMENDATIONS

Ultimately, ADAMHA should obtain precise costs on the various drug treatment programs it supports. Without such cost data, the Department's ability to assess, plan and budget effective treatment programs is limited. However, ADAMHA has not required States and localities to furnish drug abuse treatment cost data. Accordingly, we recommend that ADAMHA:

1. **Aggressively continue to incrementally build a system for measuring drug abuse treatment costs.**

Such data is essential for planning and budgeting effective drug abuse treatment services. To assure that reliable, useable cost data is available, ADAMHA should, as part of its ongoing efforts to establish and clearly define appropriate drug abuse treatment protocols:

- a) identify in accordance with commonly accepted accounting principles, all indirect and direct cost components of various drug abuse treatment protocols;
- b) develop cost standards for the different types of drug abuse treatment protocols;
- c) identify and use methods for obtaining reliable drug abuse treatment costs, such as:
 - performing case-studies of providers with focus on units of service related to types of drug abuse and related costs;
 - obtaining actual verified costs on a significant sample of providers for treatment of various types of drug abuse and types of services;
 - identifying, analyzing and verifying the validity of existing drug treatment data collection systems to determine if such systems collect cost data and meet standards to be developed by ADAMHA;
 - studying possible use of Medicaid data to measure drug abuse treatment costs since Medicaid is an entitlement program and cost data is a program requirement; and
 - identifying private insurers and Health Maintenance Organizations who have drug abuse treatment cost data which they are willing to share with ADAMHA.

- d) aggregate and summarize provider cost data to establish ranges and baselines; and
 - e) periodically verify cost data collected to assure its reliability (the cost of such validation could be limited through use of sampling techniques).
2. **As a condition of grant award, require that drug abuse treatment research and demonstration grantees who perform clinical effectiveness studies use Federal standards for collecting treatment cost data.**

ADAMHA's Office for Treatment Improvement, the National Institute on Drug Abuse, and others are aware of the problems created by lack of reliable drug treatment costs and they have remedial initiatives underway.

COMMENTS TO DRAFT MANAGEMENT ADVISORY REPORT

In meetings with ADAMHA staff, they generally agreed with the management advisory report. They expressed a desire that the report elaborate on their grantees present lack of capacity to capture and report cost data. Our limited review did not provide sufficient data for us to comment on grantees' capacity to collect data. While we understand the concern about capacity, we believe reliable program cost is information grantees need to plan effective operations.

The Assistant Secretary for Planning and Evaluation (ASPE), and the Counsel to the Secretary for Drug Abuse Policy commented on the draft management advisory report. Although we have not received written comments from ADAMHA, we have discussed the findings and recommendations with them.

The ASPE agreed with our recommendations, and asked about the reasonableness of using NDATUS data for budgeting purposes. Since the NDATUS does not collect cost data, we believe its use in developing budget estimates is limited. However, that issue was not included in the scope of our inspection.

The Counsel to the Secretary for Drug Abuse Policy concurred with our recommendation to incrementally build a system for measuring drug abuse treatment costs but did not agree about mandating the collection of cost data through clinical effectiveness studies. He suggested possible options for collecting treatment cost data which ADAMHA plans to include in future demonstration programs. We agree there are many other appropriate means of collecting data. We did not mean that all grantees should be required to collect such data but that those who do should use Federal standards.

ENDNOTES

1. Jaffe and Musto, 1987 in Hubbard, R. 1989 **DRUG ABUSE TREATMENT A National Study of Effectiveness**. Chapel Hill, N.C. : University of North Carolina Press, 3-5.
2. Gerstein and Harwood, et al. 1990. **TREATING DRUG PROBLEMS**. Committee for the Substance Abuse Coverage Study, Division of Health Care Services, INSTITUTE OF MEDICINE. Washington, D.C. : National Academy Press, 12.
3. Unpublished. Fiscal Year 1991 Department of Health and Human Services, Anti-Drug Abuse Spending. ADAMHA's Office for Treatment Improvement (OTI)- includes ADMS Block Grants, Waiting List Grants, Crisis Areas Grants, Treatment Improvement, OTI Management, Homeless Demonstration Grants and NIDA Research Demonstration Grants. Source is the Office of The Assistant Secretary for Management and Budget, Department of Health and Human Services.
4. Section 2052 of the Anti-Drug Abuse Act (P.L. 100-690) amended Part A of title V of the Public Health Act by adding a new section-- Section 509D. Section 509D (c)(G) refers to "costs of the different types of treatment modalities."
5. Section 2052 of the Anti-Drug Abuse Act amended Part A of title V of the Public Health Service Act to add Section 509D(d) which specifies "consultation with the States and with appropriate national organizations, the Administrator shall develop uniform criteria for the collection of data..."
6. Section 2034 of the Anti-Drug Abuse Act amended Section 1916(c) of the Public Health Service Act by adding sections (16)-(21). Section 1916(c)(2) specifies "The State agrees that the State will provide to the Secretary any data required by the Secretary pursuant to section 509D and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section."
7. Section 2012 of the Anti-Drug Abuse Act describes purposes of this Act. Section 2012(6) states as one of its purposes-- "to increase understanding about the extent of alcohol abuse and other forms of drug abuse by expanding data collection activities and supporting research on the comparative cost and efficacy of substance abuse prevention and treatment services."
8. Section 2052 of the Anti-Drug Abuse Act added Section 509D to the Public Health Service Act and specifies "Sec. 509D. (c)(2) Annual surveys shall be carried out in the collection of data under this section. Summaries and analyses of the data collected shall be made available to the public."
9. Kusserow, Richard P. 1989. **An Assessment of Data Collection for Alcohol, Drug Abuse, and Mental Health Services**. Washington, D.C. : Office of the Inspector General, 1-2.
10. Batten, et al., Bigel Institute for Health Policy, Brandeis University, 1991. **DRUG SERVICES RESEARCH SURVEY, Phase I Final Report: Non-Correctional Facilities**, NIDA Contract Number 271-90-8319/1.

APPENDIX A

COMMENTS ON DRAFT REPORT



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

JUN 11 1992

IG	<input checked="" type="checkbox"/>
PDIG	<input checked="" type="checkbox"/>
DIG-AS	<input checked="" type="checkbox"/>
DIG-EI	<input checked="" type="checkbox"/>
DIG-OI	<input checked="" type="checkbox"/>
AIG-MP	<input checked="" type="checkbox"/>
OGC/IG	<input checked="" type="checkbox"/>
EX SEC	<input checked="" type="checkbox"/>
DATE SENT	6/11/92

TO: Richard P. Kusserow
Inspector General

FROM: Assistant Secretary for
Planning and Evaluation

SUBJECT: OIG Management Advisory Report: "Measuring Drug Abuse
Treatment Costs," OEI-04091-00430

Thank you for the opportunity to review the above named draft management report. I think that the report helps to highlight the limitations of the existing financial data on drug abuse treatment available to the Alcohol, Drug Abuse and Mental Health Administration's (ADAMHA), and provides constructive suggestions for how to begin to improve our information.

It will take some time, however, to improve the financial data available on drug treatment costs. Consequently, it would be helpful from a policy perspective if the report could include a discussion of how the existing National Drug and Alcohol Treatment Utilization Survey (NDATUS) data available on funding sources can be used to develop budget estimates. As you are aware, we currently use this data to develop the estimates for the costs of drug treatment slots. It would be helpful to understand the reasonableness of such use and the limitations of the data for budgeting purposes. In addition, if you have suggestions for ways we can improve our estimating process using the existing available data sources this would also be of assistance.

If you have any questions, please call Elise Smith at 245-1870.



Martin H. Gerry

cc: Emilie Baebel

1992 JUN 16 AM 10:52

OFFICE OF INSPECTOR GENERAL



DEPARTMENT OF HEALTH & HUMAN SERVICES

Counsel to the Secretary
for Drug Abuse Policy

Washington, D.C. 20201

July 30, 1992

MEMORANDUM TO RICHARD P. KUSSEROW
INSPECTOR GENERAL

FROM: MARK BARNES
COUNSEL TO THE SECRETARY
FOR DRUG ABUSE POLICY

SUBJECT: OIG Management Advisory Report: "Measuring Drug Abuse
Treatment Costs", OEI-04-91-00430

I have reviewed the above-mentioned draft report and concur in part with your recommendations. I do not, however, concur with your second recommendation which seems to indicate that all grantees performing clinical effectiveness studies must collect treatment cost data. I suggest that we not mandate the collection of treatment cost data through clinical effectiveness studies. There are many more appropriate vehicles for the collection of treatment cost data.

With regard to the section on findings, I suggest that you include a short reference to the Services Research Outcome Study (SROS), a follow-up component to the Drug Abuse Services Research Survey. It is my understanding that SROS will collect cost data on treatment services. Additionally, I recommend that you consider mentioning the ADMS block grant forms as an additional possible source of cost information. Although the States are not currently required to complete the more detailed set of forms, some States have agreed to comply on a voluntary basis. For these States, the Office of Treatment Improvement has been able to collect some pertinent cost information.

Thank you for the opportunity to review this report. If you have any questions, please contact either Sarah Vogelsberg or myself at (202) 690-6641.

IG	<input checked="" type="checkbox"/>	_____
PDIG	<input checked="" type="checkbox"/>	_____
DIG-AS	<input type="checkbox"/>	_____
DIG-EI	<input checked="" type="checkbox"/>	_____
DIG-OI	<input type="checkbox"/>	_____
AIG-MP	<input checked="" type="checkbox"/>	_____
OGC/IG	<input type="checkbox"/>	_____
EX SEC	<input checked="" type="checkbox"/>	_____
DATE SENT		8/3

RECEIVED
OFFICE OF THE INSPECTOR GENERAL
AUG 1 1992
11 11 1992