

M00F02
Community and Family Health Administrations
Department of Health and Mental Hygiene

Operating Budget Data

(\$ in Thousands)

	<u>FY 05</u> <u>Actual</u>	<u>FY 06</u> <u>Working</u>	<u>FY 07</u> <u>Allowance</u>	<u>FY 06-07</u> <u>Change</u>	<u>% Change</u> <u>Prior Year</u>
General Fund	\$111,699	\$117,993	\$116,080	-\$1,912	-1.6%
Special Fund	41,472	29,787	48,639	18,853	63.3%
Federal Fund	120,850	124,761	124,074	-687	-0.6%
Reimbursable Fund	<u>452</u>	<u>243</u>	<u>497</u>	<u>254</u>	<u>104.6%</u>
Total Funds	\$274,474	\$272,783	\$289,290	\$16,507	6.1%

- The allowance exceeds the fiscal 2006 working appropriation by \$16.5 million, or 6.1%. The increase is largely due to a \$17.8 million increase in Cigarette Restitution Funds.
- The budget includes a \$3.0 million increase to provide ambulatory health care to legal immigrant pregnant women and children; and an additional \$2.0 million to provide case management and direct care services to uninsured low-income pregnant women and children.
- In fiscal 2007, the Maryland Primary Care program, administered by the Family Health Administration, will be discontinued, and enrollees will begin receiving services under the new Adult Primary Care Program administered by Medicaid. The transfer of the program results in a \$7.3 million general fund reduction in the Family Health Administration budget.
- The allowance provides a \$3.8 million fiscal 2006 general fund deficiency appropriation to provide funds for biomedical research performed by the academic health centers addressing cancer and other tobacco related diseases.

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

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Personnel Data

	<u>FY 05 Actual</u>	<u>FY 06 Working</u>	<u>FY 07 Allowance</u>	<u>FY 06-07 Change</u>
Regular Positions	345.70	350.70	342.70	-8.00
Contractual FTEs	<u>10.17</u>	<u>16.64</u>	<u>17.33</u>	<u>0.69</u>
Total Personnel	355.87	367.34	360.03	-7.31

Vacancy Data: Regular Positions

Turnover, Excluding New Positions	21.32	6.22%
Positions Vacant as of 12/31/05	29.00	8.27%

- The 2007 allowance has eight fewer positions than fiscal 2006. Six positions are abolished and two positions are transferred to Medicaid to administer the new Adult Primary Care Program. Abolished positions include an administrator, an epidemiologist, and four Chronic Disease Control positions due to a reduction in federal funds.
- The budgeted turnover rate for the Community and Family Health Administration is 6.22%. To meet this turnover rate, the department on average requires 21.32 vacancies. Currently, the department has 29 vacant positions. The allowance abolishes 1 of those positions.

Analysis in Brief

Major Trends

Syphilis Rates Exceed National Averages: The State continues to have one of the highest rates of primary and secondary syphilis in the nation, driven by increases in infection among men.

Infant Mortality Rates Increase: Between fiscal 2001 and 2004, the infant mortality rate for all races increased from 7.9 to 8.5 per 1,000 live births. The increase is due to a number of reasons including a decline in community-based perinatal care reflecting fiscal constraints and a reduction in the number of obstetricians available to meet community needs.

Issues

Is Maryland Prepared for a Pandemic Influenza?: Recent worldwide concern about avian influenza now affecting birds in Asia and Europe has raised concerns about how prepared Maryland is to respond to an outbreak of pandemic influenza. Maryland's Pandemic Influenza Preparedness Plan, developed in 1999 and last updated in fiscal 2002, guides State actions and identifies federal actions in the event of a human pandemic outbreak. **The Community Health Administration should be prepared to discuss the status of the State's pandemic preparedness efforts, including the status of surge capacity and the development of vaccine and antiviral supply, distribution, and mass immunization strategies. Furthermore, the department should be prepared to comment on what needs remain and how they will be addressed.**

Breast and Cervical Cancer Screening Program Costs: The department has submitted a report describing the costs of breast and cervical cancer screening services in Baltimore City. **The Family Health Administration should comment on the differences between the services provided and program costs.**

Recommended Actions

	<u>Funds</u>
1. Add budget language that prohibits the expenditure of funds until legal proceeding related to the 2006 Master Settlement Agreement payment are concluded.	
2. Reduce funding for contractual employees.	\$ 110,232
Total Reductions	\$ 110,232

M00F02 – DHMH – Community and Family Health Administrations

M00F02
Community and Family Health Administrations
Department of Health and Mental Hygiene

Operating Budget Analysis

Program Description

As of July 1, 2001, the Community and Public Health Administration was divided into two separate administrations – the Community Health Administration and the Family Health Administration.

The Community Health Administration seeks to protect the health of the community by preventing and controlling infectious diseases, investigating disease outbreaks and environmental health issues, and protecting the health and general welfare of the public from foods, substances, and consumer products which may cause injury or illness.

The Family Health Administration promotes public health by ensuring the availability of quality primary, preventive, and specialty health care services, with special attention to at-risk and vulnerable populations. Charges include control of chronic diseases, injury prevention, public health education, and promotion of healthy behaviors.

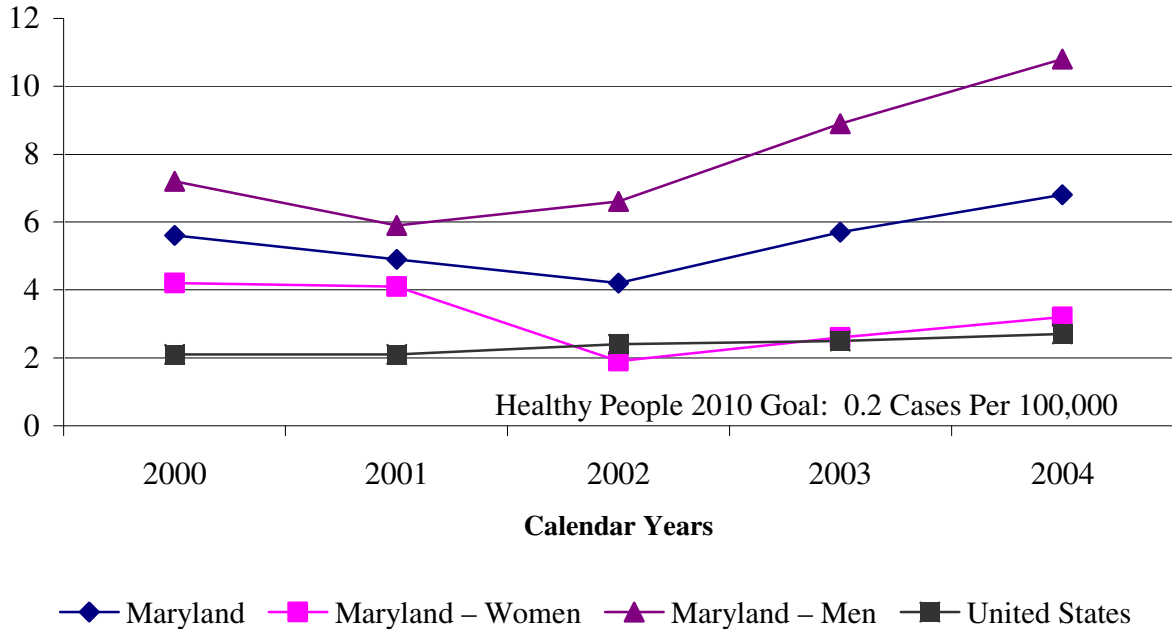
Performance Analysis: Managing for Results

Primary/Secondary Syphilis

The Community Health Administration is charged with preventing and controlling transmission of infectious diseases, including sexually transmitted diseases (STDs). The administration has developed initiatives to reduce their spread, with an emphasis on populations at risk, such as economically disadvantaged and incarcerated populations. Syphilis continues to be a major concern in the State, with the rate of infection in Maryland second highest in the nation. In addition to its primary effects, syphilis presents public health concerns for its role in facilitating transmission of the human immunodeficiency virus (HIV). Syphilis also causes fetal death in 40% of pregnant women with the disease.

Syphilis rates in Maryland are displayed in **Exhibit 1**. In 2004 the Community Health Administration reported a statewide rate of 6.8 cases per 100,000 population, more than twice the national rate of 2.7 cases. Infection rates, in Maryland and nationwide, are increasing, driven by increased infection rates among men. These increases are associated with infection with HIV and high-risk sexual behavior, specifically, among men who have sex with men. The problem is pronounced in Baltimore City, where the rate of syphilis among men is 33.2 cases per 100,000 population, accounting for 55% of all reported Maryland cases.

**Exhibit 1
Rates of Primary/Secondary Syphilis
Cases Per 100,000 Population
Calendar 2000 – 2004**



Source: Department of Health and Mental Hygiene; Centers for Disease Control and Prevention

The Community Health Administration has attempted to address the problem through a contract with the Department of Public Safety and Correctional Services for syphilis testing at the Baltimore City Booking and Intake Center. Other actions taken include increased technical assistance to local health departments and Baltimore City through local and regional meetings, annual updates, and training sessions. Additionally, the Community Health Administration is partnering with the Baltimore City Health Department to analyze risk factors specific to Baltimore City and to strategize additional interventions. Preliminary calendar 2005 data show a decrease in statewide syphilis rates from 6.8 to 5.5 cases per 100,000.

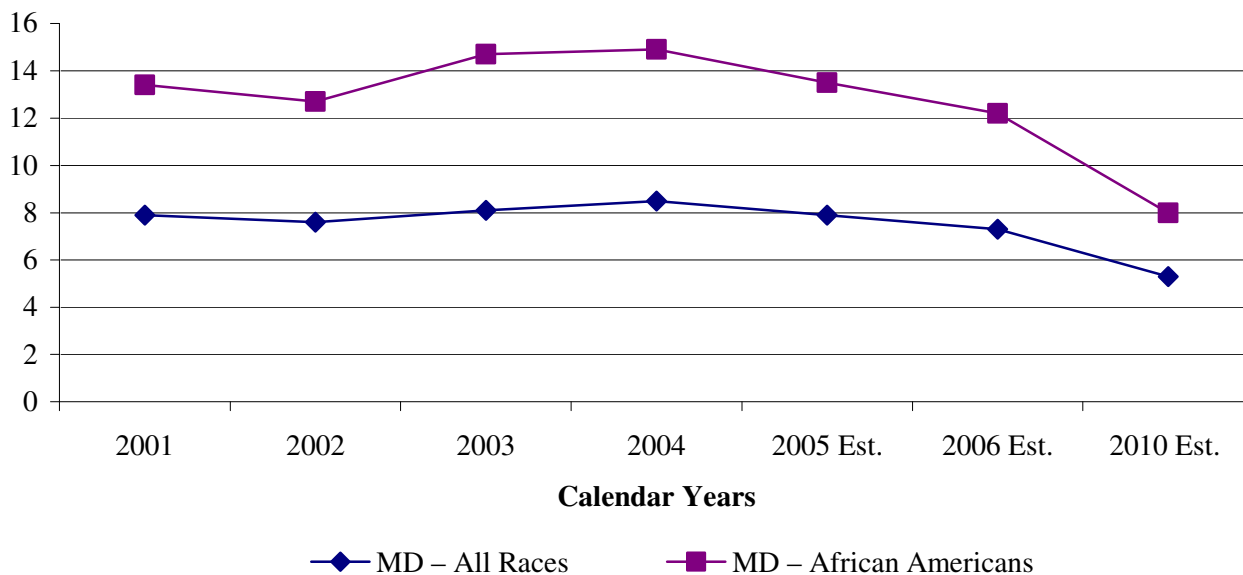
Infant Mortality Rates

The Maternal and Perinatal Health Program within the Family Health Administration is charged with reducing infant mortality and promoting the health and well-being of all women and children. Infant mortality rates are used to indicate the total health of populations in the United States and internationally. During the second half of the twentieth century, infant mortality rates in the United States fell from 29.2 to 6.9 per 1000 live births, a decline of 76%. Over this period, infant

mortality rates declined for all races; however, rates for African American infants have consistently been higher than rates for white infants. Mirroring the national trend, Maryland’s infant mortality rate decreased 22% during the 1990s due to improved access to preconception, prenatal, and family planning services. Also contributing to the decline was the development of hospital perinatal standards, high risk consultation, and community-based perinatal health improvements.

In 2002 the United States infant mortality rate increased for the first time since 1958. According to the National Center for Health Statistics, infant mortality rates were the highest among mothers who smoke, had no prenatal care, were teenagers, were unmarried, and had less education. As shown in **Exhibit 2**, Maryland’s infant mortality rate for all races increased from 7.9 to 8.5 per 1000 live births, respectively from 2001 to 2004. Following national trends, Maryland’s African American infant mortality rate has consistently been higher than other races. Increased mortality rates are attributable to a number of reasons including a decline in community-based perinatal care reflecting fiscal constraints and a reduction in the number of obstetricians available to meet community needs. Rising malpractice premiums have resulted in some providers limiting their practice to higher paying clients.

Exhibit 2
Maryland Infant Mortality⁽¹⁾ Rates
Calendar 2001 – 2010
Cases Per 1,000 Live Births



⁽¹⁾ Death during the first year of life.

Source: Department of Health and Mental Hygiene

The fiscal 2007 allowance includes an additional \$2.0 million to fund the Babies Born Healthy Initiative and a \$3.0 million enhancement to fund the Immigrant Health Initiative. Funding for both programs will be dedicated to providing direct care to uninsured pregnant women and children. Basic prevention strategies including perinatal, postnatal, and preconception/family planning will be offered through the local health departments. The department's goal is to reduce the infant mortality rate to no more than 5.3 per 1,000 live births for all races and 8.0 per 1,000 live births for African Americans by 2010. **The department should comment on its plans to reduce the infant mortality rate.**

Fiscal 2006 Actions

Proposed Deficiency

The 2005 budget reconciliation legislation authorized additional Cigarette Restitution Funds (CRF) of \$6.7 million in fiscal 2006 to provide the academic health centers with a level of funding close to the fiscal 2005 appropriation of \$15.3 million. The proposed fiscal 2007 allowance includes a fiscal 2006 general fund deficiency appropriation (rather than CRF) of \$3.8 million for the centers, resulting in a total fiscal 2006 appropriation \$2.9 million below the authorized level. The deficiency appropriation provides \$3.2 million to the University of Maryland Medical Group (UMMG) and \$0.6 million to the Johns Hopkins Institutions (JHI). The increased funding will allow UMMG to support recently recruited research faculty members, maintain the telemedicine infrastructure, and reinstate the pilot faculty research program. JHI will use the deficiency appropriation to award additional grants in fiscal 2006. Including the deficiency appropriation, the fiscal 2007 allowance for the centers increases \$3.9 million, or 34% over the fiscal 2006 working appropriation.

The 2005 budget reconciliation legislation also included a provision mandating minimum spending of \$15.4 million in CRF to support the statewide academic health centers beginning in fiscal 2007. This level of funding is consistent with the level of funding provided in fiscal 2005. As shown in **Exhibit 3**, the Governor's proposed budget includes \$15.4 million as required by State law.

Governor's Proposed Budget

The allowance for the Community and Family Health Administrations increases \$16.5 million, detailed in **Exhibits 4** and **5**. Funding for the Community Health Administration increases \$1.5 million, primarily due to increased funding for core public health services. Funding for the Family Health Administration increases \$15.0 million, mainly due to a \$17.8 million increase in CRF.

Exhibit 3
Fiscal 2006 General Fund Deficiency Appropriation and
Statewide Academic Health Center Grants
Fiscal 2005 – 2007
(\$ in Millions)

	<u>FY 2005</u>	<u>FY 2006</u>	<u>FY 2007</u>
Statewide Academic Health Centers			
UMMG	\$12.9	\$6.5	\$12.9
JHI	2.4	1.2	2.5
Subtotal	\$15.3	\$7.7	\$15.4
Deficiency Appropriation			
UMMG		\$3.2	
JHI		0.6	
Subtotal		\$3.8	
Total	\$15.3	\$11.5	\$15.4

Source: Maryland Operating Budget; Department of Health and Mental Hygiene

Exhibit 4
Distribution of Funding by Administration
Fiscal 2005 – 2007

	<u>FY 05</u> <u>Actual</u>	<u>FY 06</u> <u>Working</u> <u>Appropriation</u>	<u>FY 07</u> <u>Allowance</u>	<u>FY 06-07</u> <u>Difference</u>	<u>%</u> <u>Change</u>
Administration	\$1,162,503	\$1,178,727	\$1,222,064	\$43,337	4%
Community Health Services	39,293,524	38,163,482	38,372,557	209,075	1%
Core Public Health	65,370,984	66,351,987	67,584,607	1,232,620	2%
Subtotal	\$105,827,011	\$105,694,196	\$107,179,228	\$1,485,032	1%
Administration	\$2,098,501	\$2,274,605	\$2,358,158	\$83,553	4%
Family Health Services	95,485,600	102,664,108	97,756,770	-4,907,338	-5%
Prevention and Disease Control	29,896,338	32,436,024	34,513,887	2,077,863	6%
Cigarette Restitution Funds	41,166,355	29,714,145	47,482,294	17,768,149	60%
Subtotal	\$168,646,794	\$167,088,882	\$182,111,109	\$15,022,227	9%
Total	\$274,473,805	\$272,783,078	\$289,290,337	\$16,507,259	6%

Source: Maryland Operating Budget; Department of Legislative Services

Exhibit 5
Governor's Proposed Budget
DHMH – Community and Family Health Administrations
(\$ in Thousands)

How Much It Grows:	<u>General</u> <u>Fund</u>	<u>Special</u> <u>Fund</u>	<u>Federal</u> <u>Fund</u>	<u>Reimb.</u> <u>Fund</u>	<u>Total</u>
2006 Working Appropriation	\$117,993	\$29,787	\$124,761	\$243	\$272,783
2007 Governor's Allowance	<u>116,080</u>	<u>48,639</u>	<u>124,074</u>	<u>497</u>	<u>289,290</u>
Amount Change	-\$1,912	\$18,853	-\$687	\$254	\$16,507
Percent Change	-1.6%	63.3%	-0.6%	104.6%	6.1%

Where It Goes:

Personnel Expenses

Fiscal 2006 understated healthcare base	\$645
Increments and other compensation	503
Employee and retiree health insurance	478
Contributions to employee retirement system	197
Turnover adjustments	177
Reduction of eight positions	-573
Other fringe benefit adjustments	-24

Other Community Health Administration Changes

Core public health funds for local health departments	1,233
Grants to local health departments for public health preparedness	437
Refugee health screening	279
Sexually transmitted disease intervention activities through the local health departments	99
Preparedness planning for hospitals	-293
Vaccine medications, based in fiscal 2005 actual expenditures	-191
Grants for immunization activities	-199
Public health training grants	-141
Surveillance and investigation of Pfiesteria and harmful algal blooms	-135
Tuberculosis surveillance, testing, and treatment	-113
Medical reserve activation system to respond in the event of an emergency	-45

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Where It Goes:

Other Family Health Administrative Changes

Immigrant health services.....	3,000
Babies Born Healthy Initiative	2,000
Colorectal Cancer Screening Demonstration Project	675
Maryland cancer fund – income tax checkoff	562
Spinal Cord Injury research grants	500
Child abuse and neglect centers of excellence per Chapter 334, Act of 2005.....	225
Breast and cervical cancer screening and treatment	205
Comprehensive cancer control plan.....	147
Public Health Injury Surveillance and Prevention Program.....	120
Transfer of Maryland Primary Care Program to Medicaid.....	-7,377
Federal funds for the Women, Infants, and Children Food Program (WIC) Supplemental Nutrition Program.....	-1,594
Prince George's County Hospital Center grant.....	-1,320
Cardiovascular disease prevention	-224
Children's medical services, based on three average of actual costs	-107

Other Cigarette Restitution Fund Program Changes

Grants to academic health centers for cancer and related programs.....	6,721
Tobacco – local public health	5,130
Tobacco statewide public health.....	2,377
Tobacco surveillance activities.....	1,900
Tobacco-related disease research at the University of Maryland	1,005
Administration.....	305
Management	283
Surveillance and evaluation.....	47

Other Changes

Contractual personnel	74
Other changes	-277
Medical equipment	-127
Personnel computers.....	-34
Motor vehicle.....	-27
Department of Budget and Management paid telecommunications	-16

Total **\$16,507**

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

Personnel Expenses

Personnel expenses in the Community and Family Health Administrations are expected to increase \$1.4 million in fiscal 2007. The increase is largely due to a \$1.1 million increase in health care costs, reflecting higher premiums and an understated fiscal 2006 base. The inclusion of increments further increases personnel expenditures by \$0.5 million. Additional increases include \$0.2 million to recognize a higher turnover rate and \$0.2 million for employee retirement. Increases are offset by the transfer of two positions to Medicaid to administer the Adult Primary Care program and the abolition of six positions.

Emergency Response

Within the Department of Health and Mental Hygiene (DHMH), the Community Health Administration has assumed primary responsibility for coordination of emergency preparedness and response. In fiscal 2007 the administration is anticipating \$20.1 million for these programs, a reduction of less than 1%. The largest reduction occurs in the Maryland Bioterrorism Hospital Preparedness program, which provides grants to develop and enhance response capabilities within hospitals and other locations. Grant funds are expected to decrease \$0.3 million in fiscal 2007. Funding for public health training grants is also expected to decrease \$0.1 million. These reductions are partially offset by a \$0.4 million increase to support preparedness planning among the State's 24 local health departments. This action will increase the amount available to local units for public health emergency planning and assessment.

Other Community Health Administration Initiatives

Independent of core public health funds, nearly 78% of the Community Health Administration budget derives from federal contracts and grant programs. There are several changes in these programs in fiscal 2007.

- Funds for sexually transmitted disease control are expected to grow \$0.1 million in the fiscal 2007 allowance, increasing the funds available for disease intervention activities at the local health departments.
- Funds for immunization and outreach efforts at the local health departments and the University of Maryland are expected to decrease \$0.2 million in fiscal 2007.
- Tuberculosis surveillance, testing, and treatment funds decrease \$0.1 million. The decline will result in across-the-board reductions for disease intervention at the local health departments.
- Funds for surveillance and investigation of Pfiesteria and harmful algal blooms decrease \$0.1 million, reducing the amount available for research projects and surveillance support primarily at the University of Maryland.

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Reimbursable funds for refugee health screening services are expected to increase \$0.3 million in fiscal 2007. The Maryland Office of New Americans in the Department of Human Resources (DHR) provides financial support for this program through an annual agreement with DHMH. Reimbursable funds are provided to DHMH to reimburse local health departments for specific health services provided to new refugees. Approximately 1,700 refugees will be served in fiscal 2007.

The fiscal 2007 allowance also includes \$1.2 million in general funds to increase the amount of core public health funds from \$66.4 to \$67.6 million. The statutory formula for increasing core public health funds would indicate an increase of \$1.8 million in fiscal 2007; however, previous increases have exceeded the amount required. The amount of general funds in the fiscal 2007 allowance still exceeds required base funding by \$4.4 million.

Immigrant Health Initiative

The fiscal 2007 allowance includes a \$3.0 million general fund enhancement to provide ambulatory care to legal immigrant pregnant women and children. The initiative will provide \$2.5 million in grants to local health departments for partnerships with local and regional providers. Funds will be allocated to the counties with the greatest immigrant health needs. The remaining funds will be used to provide specialty case services for legal immigrants under the Children's Medical Service (CMS) fee-for-service reimbursement program. CMS is the payer of last resort for uninsured and underinsured Maryland children with chronic illnesses having family incomes below 200% of Federal Poverty Level.

Babies Born Healthy Initiative

The fiscal 2007 allowance includes an additional \$2.0 million to fund the Babies Born Healthy Initiative. Funding will be dedicated to providing direct care services, such as prenatal, preconception/family planning, and postnatal care for uninsured, low-income pregnant women and children. Some of the funding will also be used to expand the Medicaid Healthy Start program, which provides home visitation and case management to high risk, hard-to-reach, low-income pregnant women and children. The additional funding will provide approximately 10,000 services to 3,000 pregnant women and infants. Services will be provided primarily through the local health departments. Allocations to the health departments will be based on indicators of risk, such as the number of low birthweight births by jurisdiction. Funding will also support quality initiatives and upgrades to the electronic birth registration system. The initiative is supported with a combination of general funds (\$1.5 million) and federal funds (\$0.5 million).

Child Abuse and Neglect Centers of Excellence Initiative

Chapter 334, Acts of 2005 (SB 782) established the Child Abuse and Neglect Centers of Excellence within DHMH. The allowance includes \$0.2 million in general funds to establish local or regional centers of pediatric expertise to assist in the accurate diagnosis of child abuse and neglect.

Local or regional pediatricians will be recruited for advanced clinical training and, after training, will serve as ongoing local resources for community providers.

Other Family Health Administration Initiatives

Many of the changes in the Family Health Administration are the result of changes to federal grants and contracts. These changes include:

- Funding for the WIC Supplemental Nutrition Program decreases \$1.6 million in the fiscal 2007 allowance. The program, which is almost entirely federally funded, provides nutrition and education services to low-income women, pregnant and postpartum, and their young children. The decrease will not have an impact on services, as the fiscal 2006 working appropriation reflects overstated food costs.
- Funds for the Chronic Disease Program, supported with the Preventative Health and Health Services block grant, decrease \$0.2 million in fiscal 2007. The anticipated impact of the reduction is fewer resources for State oversight and federal program coordination in the area of cardiovascular disease prevention.
- Funds for the National Comprehensive Cancer Control Program, which supports ongoing community-based projects related to colorectal, breast, cervical, skin, or other cancer areas, increases \$0.1 million in fiscal 2007. The amount of the increase is overstated, as a budget amendment to recognize fiscal 2006 funds has not yet been processed.
- The Centers for Disease Control and Prevention (CDC) will provide an additional \$0.2 million to screen uninsured, underserved, and low-income women for breast and cervical cancer. The amount of the increase is overstated, as a budget amendment to recognize fiscal 2006 funds has not yet been processed.
- The CDC will provide \$0.7 million to implement a Colorectal Cancer Screening Demonstration Program. The program will screen approximately 300 individuals for colorectal cancer in fiscal 2007.
- The fiscal 2007 allowance includes \$0.1 million to prevent injuries and violence and to monitor and detect fatal and non-fatal injuries, including traumatic brain injury. The project is funded from August 2005 through 2010 and will culminate in the production of a comprehensive injury report.

Changes to general and special fund programs include:

- A \$1.3 million general fund grant was included in the fiscal 2006 budget to support critical operational needs at the Prince George's Hospital Center. Release of funds is contingent upon

the receipt of a report prepared jointly by the county executive and county council detailing a plan to restructure the health system and to pursue a possible transfer of control to a not-for-profit Maryland-based academic health system. The report has not been received.

- Chapter 392, Acts of 2004 established the Maryland Cancer Fund within DHMH to be used to provide grants for cancer research, prevention, and treatment. The fiscal 2007 allowance includes a \$0.6 million increase in special funds financed by the Cancer Fund checkoff on individual income tax returns.
- Chapter 513, Acts of 2000 established the State Board of Spinal Cord Injury Research, funded by the insurance premium tax. The fund supports basic, preclinical, and clinical spinal cord research with a long-term goal of restoring neurological function in individuals with spinal cord injuries. Between fiscal 2002 and 2005, the Spinal Cord Injury Trust Fund received \$1.0 million annually from the tax. During this time, grants totaling approximately \$1.0 million were distributed, leaving the fund with a \$3.0 million fund balance. Cost containment actions taken in the 2004 budget reconciliation legislation transferred \$2.6 million of the fund's balance to the general fund and transferred the remaining balance to the Department of Aging. As a result, no grants were awarded in fiscal 2005. Beginning in fiscal 2006, the budget reconciliation legislation also reduced the funding allocation from the insurance premium tax to \$0.5 million annually. In fiscal 2006, no funding is included in the budget for this program; however, the department plans to process a budget amendment to recognize the fund's fiscal 2006 allocation from the tax. In fiscal 2007 the program is funded at \$0.5 million.
- In fiscal 2007 the Maryland Primary Care program will be discontinued, and 8,000 enrollees will receive services under the new Primary Adult Care Program administered by Medicaid. The transfer of the program results in a \$7.3 million general fund reduction in the Family Health Administration budget.

Cigarette Restitution Funds

CRF program spending increases \$17.8 million (\$14 million after accounting for the proposed general fund deficiency appropriation) in the Governor's proposed budget. Changes to the program are detailed in **Exhibit 6**. The largest increase occurs among the academic health centers – UMMG and JHI – and will increase the amount of funding for cancer research at the two institutions by \$7.7 million (\$3.9 million after accounting for the proposed general fund deficiency appropriation). Funding for local public health increases \$5.1 million over the fiscal 2006 working appropriation, an increase of 74%. The additional funding will increase the amount of grants available for tobacco use prevention and cessation activities at the local level. The allowance also provides \$1.9 million to conduct a tobacco survey and \$2.3 million to support statewide public health tobacco prevention activities, including \$1.1 million to support a telephone quit line. The CDC awarded the department a supplemental grant in federal fiscal 2005 and 2006 to establish the framework for a telephone-based quit line in Maryland. The grant was part of a nationwide effort by the CDC to establish quit lines in every state.

Exhibit 6
Change in Cigarette Restitution Fund Program Spending
Fiscal 2005 – 2007

	<u>FY 05</u> <u>Actual</u>	<u>FY 06</u> <u>Working</u> <u>Appropriation</u>	<u>FY 07</u> <u>Allowance</u>	<u>FY 06-07</u> <u>Difference</u>	<u>%</u> <u>Change</u>
Cancer Prevention, Education, Screening, and Treatment					
Statewide academic health centers	\$15,349,000	\$7,674,500	\$15,400,000	\$7,725,500	101%
Local public health	7,504,089	7,504,090	7,504,090	0	0%
Baltimore City public health	2,446,000	2,446,000	2,446,000	0	0%
Surveillance and evaluation	1,635,888	1,240,908	1,288,359	47,451	4%
Administration	983,271	697,346	995,804	298,458	43%
Database development	385,000	385,000	385,000	0	0%
Statewide public health	111,798	111,798	111,798	0	0%
Subtotal	\$28,415,046	\$20,059,642	\$28,131,051	\$8,071,409	40%
Tobacco Use Prevention and Cessation					
Administration	\$390,516	\$332,439	\$768,135	\$435,696	131%
Countermarketing	1,000,000	500,000	500,000	0	0%
Local public health	6,943,223	6,960,000	12,090,000	5,130,000	74%
Statewide public health	1,020,916	1,088,652	3,465,489	2,376,837	218%
Surveillance and evaluation	500,000	0	1,900,000	1,900,000	100%
Other tobacco cessation	0	428,725	0	-428,725	-100%
Subtotal	\$9,854,655	\$9,309,816	\$18,723,624	\$9,413,808	101%
Management	372,501	344,687	627,619	282,932	82%
Breast and Cervical Cancer Program	2,524,153	0	0	0	0%
Subtotal	\$41,166,355	\$29,714,145	\$47,482,294	\$17,768,149	60%
Deficiency appropriation – general funds		\$3,837,250			
Total	\$41,166,355	\$33,551,395	\$47,482,294	\$13,930,899	42%

Source: Maryland Operating Budget Fiscal 2007

Issues

1. Is Maryland Prepared for a Pandemic Influenza?

Background

Recent worldwide concern about avian influenza (AI), now affecting birds in Asia and Europe, has raised concerns about how prepared Maryland is to respond to an outbreak of pandemic influenza. AI normally infects birds; however, the virus can infect other animals including humans. According to the World Health Organization, since 2003, there have been 169 total human cases detected and 91 deaths. Most human AI infections result from direct contact with infected birds or bird parts. AI has not yet shown an ability to transmit easily between humans; however, there is concern that it might acquire this capability. If rapid human to human transmission is detected, AI could have the potential to cause a worldwide pandemic influenza.

Maryland's Status

In response to a 2004 AI outbreak in poultry on the Eastern Shore of Maryland and in Delaware, a task force of poultry and human health experts (including DHMH and the Maryland Department of Agriculture (MDA)) mobilized to develop procedures and practical guidance related to infection prevention and control. The resulting document, Interim Guidance for Implementation of Centers for Disease Control and Occupational Safety and Health Administration Avian Influenza Recommendations, provides practical guidance related to human AI infection prevention and control. In addition, DHMH has developed a pandemic influenza preparedness strategic plan to guide State actions and identify federal actions in the event of a human AI outbreak. The plan is currently being updated from the fifth version that was last updated in April 2002.

Major aspects of the State's plan include early detection/surveillance; vaccination and antiviral use; and other prevention and infection control measures. During the initial stages of a pandemic it is unlikely that a vaccine will be widely available. Pandemic vaccines cannot be accurately developed until the strain responsible for the pandemic is identified. Even after identification, it may take months to develop, test, and produce a vaccine. According to DHMH, local health departments have developed the capacity to distribute vaccines and antiviral medications quickly in crisis; however, it is possible that vaccines may not be available immediately, but rather, in small amounts distributed over several months. Lacking a vaccine, antiviral medications might play a limited role in treatment and, potentially, prevention of pandemic influenza; however current supplies are insufficient to play a major role. DHMH maintains a limited supply of antiviral medications for small scale uses. The Maryland Institute for Emergency Medical Services Systems (MIEMSS), in conjunction with DHMH, has developed a system to quickly inventory supplies of antiviral medications at healthcare facilities in Maryland and assist with redistribution.

Several State agencies, in partnership with the federal government, local jurisdictions, and the agricultural sector, are involved in efforts to address AI and pandemic influenza. State agency responsibilities are summarized in **Exhibit 7**.

Exhibit 7
State Avian and Pandemic Influenza Prevention and Control Efforts

State Agency

Responsibility

Department of Health and Mental Hygiene	Lead State agency for the development and implementation of State pandemic influenza preparedness plan. DHMH Secretary has overall direction and control of health-related personnel and resources committed to control an influenza pandemic at the State level.
Maryland Department of Agriculture	Lead State agency for preventing and controlling poultry AI outbreaks in Maryland.
Department of Natural Resources	Tests waterfowl and water birds for AI.
Maryland Emergency Management Agency	Operates emergency operations center and coordinates media communication and damage and needs assessments.
MIEMSS	Coordinates and monitors statewide emergency medical services, public safety, and commercial ambulance services in pandemic situation

Note: Other State agencies are important for pandemic influenza planning and response, e.g., the Department of Business and Economic Development assisting business planning and response.

Source: Pandemic Influenza Preparedness Plan for Maryland (Version 5); Department of Health and Mental Hygiene

Remaining Needs

The Community Health Administration is working on revisions to the State plan to incorporate lessons learned during two recent table top exercises and a gap analysis generated by comparing Maryland’s plan with the recently released federal plan. For example, specific guidance is needed by educational authorities for the development of thresholds and triggers for school closure and reopening along with the need for school systems to develop pandemic planning elements integrated within their overall planning for emergencies. Other needs identified by the gap analysis include, the development of operational plans to manage prolonged periods of community isolation and quarantine; and the need to enhance business continuity of operations planning. The administration advises that several areas still need to be addressed, including but not limited to:

- continued enhancement of local public health and healthcare system capacity;

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- education of decision makers on the potential impact of a pandemic influenza, and on the decisions that may be required to control transmission and reduce mortality;
- a review of existing legal authority and capacity to issue and enforce public health directives during a pandemic;
- governmentwide planning for continuation of operations and maintenance of essential services;
- support for research and development of new vaccines and medications; and
- support for business and other private sector pandemic-related contingency planning.

In January 2006 the federal government announced additional funding of \$100 million to accelerate and intensify current planning efforts for pandemic influenza. Maryland's share of the new funding is anticipated to be \$1.8 million. Federal guidance on applying for these planning funds is expected shortly. The department is also expecting additional federal funding in fiscal 2007 for pandemic influenza planning, although it is too early to anticipate the award amount. These additional federal funds constitute one-time funding (both to be funded from federal fiscal 2006 funds) and will likely be used to conduct State and local pandemic influenza planning exercises with a focus on practical, community-based procedures that could prevent or delay the spread of pandemic influenza, and to facilitate conversion of strategic plans into operational plans. All 50 states and territories are expected to receive a portion of the new funding. **The Community Health Administration should be prepared to discuss the status of the State's pandemic preparedness efforts, including the status of surge capacity and the development of vaccine and antiviral supply, distribution, and mass immunization strategies. Furthermore, the department should be prepared to comment on what needs remain and how they will be addressed.**

2. Breast and Cervical Cancer Screening Program Costs

Committee narrative included in the 2005 *Joint Chairmen's Report* directed DHMH in consultation with UMMG to provide a report on the costs of breast and cervical cancer screening services in Baltimore City. The report was to include a comparison of costs between UMMG and the Medstar Health breast and cervical cancer screening programs. The report due November 1, 2005, has not been submitted to the committees. However, an unofficial report was submitted to legislative staff in January 2006.

UMMG and Medstar both offer breast and cervical cancer screening services in Baltimore City. As shown in **Exhibit 8**, the sources of funds and services provided, varies significantly between the programs. UMMG, funded with CRF, screens Baltimore City residents at least 40 years of age with family incomes at or below 250% of the federal poverty level. By law, the program is required to provide necessary treatment or linkages to treatment for uninsured individuals diagnosed with cancer as part of the program. Medstar Health, a nonprofit health care organization provides breast and cervical cancer screening services to low-income, uninsured Maryland residents.

Exhibit 8
Baltimore City Breast and Cervical Cancer Programs

<u>Program</u>	<u>Source of Funds</u>	<u>Services</u>
UMMG	CRF	Screening, diagnosis, treatment, case management, coalition building, community education, outreach, and data entry.
Medstar	State and federal funds	Screening, follow-up case management, and data entry.

Source: Department of Health and Mental Hygiene

Although both programs screen for breast and cervical cancer, the programs are structured differently and have different reporting requirements. Several key differences include:

- UMMG must abide by CRF statute which requires the establishment and maintenance of a Baltimore City Cancer Coalition. Medstar Health does not have this requirement. Maintaining the coalition requires staff time to survey cancer coalition members and prepare progress reports;
- UMMG provides services such as public education; Medstar has very limited funding for outreach;
- UMMG hosts a survivor network and support group, Medstar does not;
- UMMG is a non-hospital based program with linkages to the Federally Qualified Health Centers; Medstar provides services through two Baltimore City hospitals; and
- UMMG provides funds for treatment as required by statute, Medstar does not.

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The fiscal 2005 and 2006 budgets for UMMG and Medstar’s breast and cervical cancer programs are shown in **Exhibits 9** and **10**. The budgets support clinical services, as well as direct and indirect operating expenses. UMMG’s budget is approximately 30% higher than Medstar’s budget, reflecting a larger staff. Both programs provide breast and cervical cancer screening services; however, UMMG also provides community education, outreach, case management, and data entry. Additionally, the CRF statute requires extensive reporting requirements not included in Medstar’s grant application. These additional services and reporting requirements necessitate a larger staff reducing funds available for screening.

Exhibit 9
UMMG and Medstar Health Budgets
Fiscal 2005
(\$ in Thousands)

	UMMG – 14 FTEs		Medstar Health – 6.5 FTEs	
	<u>Funding</u>	<u>Percent</u>	<u>Funding</u>	<u>Percent</u>
Personnel	\$674	55.3%	\$348	37.5%
Clinical costs ⁽¹⁾	404	33.2%	537	58.3%
Operating costs	110	9.0%	23	2.5%
Indirect costs	30	2.5%	13	1.4%
Total Budget	\$1,218	100%	\$921	100%
Women Screened	1,100		1,370	
Average Cost Per Screening	\$956		\$672	
Total Cost²	\$1,052		\$921	

FTE = full-time equivalent

⁽¹⁾ Clinical costs include screening, diagnosis and treatment at UMMG, and screening costs only at Medstar Health.

⁽²⁾ UMMG budget does not include \$166,417 budgeted for treatment in fiscal 2005.

Source: Department of Health and Mental Hygiene

Exhibit 10
UMMG and Medstar Health Budgets
Fiscal 2006
(\$ in Thousands)

	UMMG – 14 FTEs		Medstar Health – 6.5 FTEs	
	<u>Funding</u>	<u>Percent</u>	<u>Funding</u>	<u>Percent</u>
Personnel	\$678	55.7%	\$357	36.8%
Clinical costs ⁽¹⁾	\$417	34.2%	562	57.9%
Operating costs	93	7.6%	31	3.2%
Indirect costs	30	2.5%	21	2.2%
Total Budget	\$1,218	100%	\$971	100%
Women Screened	1,700		1,500	
Average Cost Per Screening	\$628		\$647	
Total Cost⁽²⁾	\$1,068		\$971	

⁽¹⁾ Clinical costs include screening, diagnosis and treatment costs at UMMG, and screening costs only at Medstar Health.

⁽²⁾ UMMG budget does not include \$150,000 for treatment in fiscal 2006

Source: Department of Health and Mental Hygiene

Exhibits 9 and 10 also show the number of women screened by the programs and the average cost per patient. UMMG is projecting to increase the number of women screened from 1,100 in fiscal 2005 to 1,700 in fiscal 2006 despite budgeting approximately the same amount of funds for clinical costs in both years. Part of the increase is due to a decrease in Medicare fees allowing for additional screenings. However, without an increase in the amount of funds budgeted for clinical care, it is unclear how the program will screen an additional 600 women in fiscal 2006. Medstar’s program is also projecting to increase the number of women screened; however, the increase is less substantial.

In fiscal 2005, UMMG diagnosed 12 breast cancers and 1 cervical abnormally among the clients it served. Using the fiscal 2005 treatment budget of \$166,417, UMMG provided cancer therapy to five patients. Of the remaining cancer patients identified, five were referred to the Family Health Administration’s general fund treatment program, and three used other forms of insurance.

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During the first eight months of fiscal 2006, nine new cases of cancer have been detected among the women screened. The fiscal 2006 treatment budget of \$150,000 is providing cancer therapy services to six of the cancer patients identified. The remaining three patients will likely be referred to the Family Health Administration's general fund treatment program. **The Family Health Administration should comment on the differences between the services provided and program costs. The administration should also comment on how the UMMG's breast and cervical cancer screening program will screen an additional 600 women in fiscal 2006 despite approximately the same clinical budget as fiscal 2005.**

Recommended Actions

1. Add the following language:

Section XX. AND BE IT FURTHER ENACTED, That \$26,000,000 of the special fund appropriation for M00Q01.03 from the Cigarette Restitution Fund may not be expended until the Department of Budget and Management and the State’s Office of the Attorney General submit a letter to the budget committees certifying that the legal proceedings related to the 2006 Master Settlement Agreement payment will not result in revenues received by the Cigarette Restitute Fund during 2006 falling below \$153,478,000. The budget committees shall have 45 days to review and comment on the letter from the date the letter was received by the committees.

Explanation: This language prohibits the expenditure of \$26.0 million of Cigarette Restitution Funds appropriated in the Medicaid budget. Recent actions by participating manufacturers threaten to reduce the 2006 Master Settlement Agreement (MSA) payment to the states. The MSA authorizes manufacturers that lose a certain share of the market to adjust the MSA payment by withholding three times the amount of their losses. This adjustment known as a “Non-Participating Manufacture” (NPM) adjustment has the potential to reduce payments under the MSA by \$1.1 billion, or 18%, of which Maryland’s share is approximately \$26.0 million. An arbitrator will issue a final decision on March 27, 2006, on whether the MSA was a significant factor contributing to the loss of market share. If the arbitrator finds that the MSA was not a significant factor, there will be no NPM adjustment and Maryland will be entitled to receive its full 2006 MSA payment. If the arbitrator finds that the MSA was a significant factor, \$1.1 billion may be withheld from the 2006 MSA payment. The MSA provides that the NPM adjustment will apply to all states unless a state has enacted and is diligently enforcing its Qualifying Statute. Diligent enforcement of the Qualifying Statute will be determined on a state-by-state basis, through a court proceeding. If Maryland is found to have diligently enforced its Qualifying Statue, there will be no NPM adjustment and Maryland’s 2006 MSA payment will not be affected; however, if it is determined that Maryland has not diligently enforced the statue, the State will be allocated a portion of the entire NPM adjustment. If one state wins on diligent enforcement, that state’s share of the NPM adjustment will be reallocated to those states that are found not to have diligently enforced. Consequently, it is possible that Maryland’s share of the NPM adjustment could exceed \$26 million.

The language also requires the Department of Budget and Management (DBM) and the State’s Office of the Attorney General to submit a letter to the committees notifying the committees of the conclusion of the proceedings. The budget committees will have 45 days to review and comment prior to the release of funds.

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Information Request	Authors	Due Date
Letter notifying the committees of the conclusion of the legal proceedings	DBM Attorney General	45 days prior to release of funds

	<u>Amount Reduction</u>	
2. Reduce funding for contractual employees. The allowance of \$800,784 for contractual salaries exceeds the actual fiscal 2005 spending by \$225,324. In each of the last three years, the administration has received more than \$2.5 million to hire contractual employees and spent less than \$1.8 million for that purpose. The reduction still allows for a 20% increase over actual fiscal 2005 spending.	\$ 40,103	GF
	\$ 5,450	SF
	\$ 64,679	FF
Total Reductions	\$ 110,232	
Total General Fund Reductions	\$ 40,103	
Total Special Fund Reductions	\$ 5,450	
Total Federal Fund Reductions	\$ 64,679	

Current and Prior Year Budgets

Current and Prior Year Budgets Community and Family Health Administrations (\$ in Thousands)

	<u>General Fund</u>	<u>Special Fund</u>	<u>Federal Fund</u>	<u>Reimb. Fund</u>	<u>Total</u>
Fiscal 2005					
Legislative Appropriation	\$112,438	\$40,840	\$116,309	\$218	\$269,805
Deficiency Appropriation	0	0	0	0	0
Budget Amendments	-739	1,125	11,623	385	12,394
Cost Containment	0	0	0	0	0
Reversions and Cancellations	0	-493	-7,082	-151	-7,726
Actual Expenditures	\$111,699	\$41,472	\$120,850	\$452	\$274,473
Fiscal 2006					
Legislative Appropriation	\$117,103	\$29,787	\$123,794	\$243	\$270,927
Budget Amendments	890	0	967	0	1,857
Working Appropriation	\$117,993	\$29,787	\$124,761	\$243	\$272,783

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

Fiscal 2005

The general fund appropriation decreased \$0.7 million. Of that amount, \$1.6 million was reduced to cover operating deficits in other units of the department; funds were primarily available due to decreased expenditures for inpatient hospital and physician services. Funds were further reduced \$0.1 million due to the transfer of the Institutional Review Board from the Community Health Administration to the Office of the Inspector General. These decreases were offset by a \$0.4 million increase to cover maternal health contracts and medicine; a \$0.2 million increase to recognize the transfer of five positions from several departmental units to the Family Health Administration; a \$0.1 million increase to recognize the fiscal 2005 cost-of-living adjustment (COLA); a \$0.1 million increase related to the transfer of emergency preparedness funding from another unit of DHMH and a \$0.1 million increase to accurately reflect health insurance costs.

The special fund appropriation increased \$1.0 million as a result of a deficiency appropriation for a comprehensive evaluation of the CRF cancer and tobacco programs. Funds were further increased \$0.1 million for prior year human service contracts and COLA for 29 positions supported with CRF. Funds were cancelled primarily due to less American Legacy Grant spending than appropriated and reduced CRF salary expense.

The federal fund appropriation increased \$11.6 million as a result of higher-than-anticipated federal fund attainment. Significant increases were made in the following areas:

- \$5.5 million for the WIC Supplemental Nutrition Program;
- \$1.6 million for Pfiesteria research and surveillance;
- \$1.2 million to support local infrastructure for bio-defense planning and preparedness;
- \$1.0 million for breast and cervical cancer outreach, education, screening, and follow-up services;
- \$0.8 million to improve pregnancy outcomes;
- \$0.7 million to provide family planning services;
- \$0.4 million related to the transfer of emergency preparedness funding from another unit of DHMH; and
- \$0.3 million for local injury prevention programs and evaluation activity.

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Smaller areas of increase totaling \$1.4 million include asthma control, abstinence education, oral health, and traumatic brain injury surveillance. These increases were offset by a \$1.4 million decrease due to the transfer of the WIC data management system to the Major Information Technology Development Fund. Funds were cancelled due to less federal funds expended than anticipated.

The reimbursable fund appropriation increased \$0.4 million as a result of funds from DHR to provide refugee health screenings. Funds were cancelled because the appropriation for refugee health screenings exceeded the cost.

Fiscal 2006

The fiscal 2006 appropriation was increased \$1.9 million to recognize the fiscal 2006 COLA (\$0.5 million) and the consolidation of various emergency preparedness functions the under Community Health Administration (\$1.3 million). Transferred units include:

- Bioterrorism Education and Training;
- Emergency Management;
- Demonstration project for Medical Reserve Corps; and
- Two PINs (021680 and 024194) transferred from Information Resources Management Administration and Executive Direction.

Audit Findings

Community Health Administration

Audit Period for Last Audit:	July 1, 2001 – February 2, 2005
Issue Date:	September 2005
Number of Findings:	2
Number of Repeat Findings:	2
% of Repeat Findings:	100%
Rating: (if applicable)	n/a

Finding 1: The Administration did not verify year-end expenditure entries reported by the local health departments at June 30, 2004, totaling approximately \$4.3 million.

Finding 2: One local health department reviewed did not comply with certain State regulations and internal control deficiencies were noted.

Family Health Administration

Audit Period for Last Audit:	July 1, 2001 – September 13, 2004
Issue Date:	November 2005
Number of Findings:	11
Number of Repeat Findings:	3
% of Repeat Findings:	27.3%
Rating: (if applicable)	n/a

Finding 1: The Family Health Administration did not adequately monitor the advertising contractor to ensure compliance with all significant contract provisions.

Finding 2: The Family Health Administration's advertising contract did not prohibit the contractor from awarding subcontracts to affiliated entities. Consequently, the contractor awarded a \$501,300 subcontract to an entity in which it had an equity interest.

Finding 3: The Family Health Administration did not have a process to ensure that audit findings were corrected by entities receiving CRF grants.

- Finding 4:** Formal regulations required by law for the Tobacco Use Prevention and Cessation Program and the Cancer Prevention, Education, Screening and Treatment Program were not established.
- Finding 5:** The Family Health Administration did not ensure that Program recipients applied for Medical Assistance benefits as required, and the State did not recover approximately \$53,000 because federal reimbursement was not requested timely.
- Finding 6:** Provider and patient information recorded in the automated payment system was not sufficiently controlled to prevent unauthorized disbursements.
- Finding 7:** Prior years' recoveries totaling approximately \$433,000 were not recorded as general fund revenue, as required.
- Finding 8:** The Family Health Administration did not have adequate recipient eligibility procedures.
- Finding 9:** The Family Health Administration did not maintain comprehensive program records and certain procedural and control deficiencies existed in the accounts receivable operations.
- Finding 10:** The Family Health Administration gave providers advance notice of the individuals whose medical records would be examined during on-site reviews.
- Finding 11:** The Family Health Administration did not obtain annual accountings from two grantees as required by the agreements. Additionally, the agreements with another grantee did not require annual accountings.

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

**Object/Fund Difference Report
DHMH – Community and Family Health Administrations**

<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>
Positions					
01 Regular	345.70	350.70	342.70	-8.00	-2.3%
02 Contractual	10.17	16.64	17.33	0.69	4.1%
Total Positions	355.87	367.34	360.03	-7.31	-2.0%
Objects					
01 Salaries and Wages	\$ 22,714,682	\$ 23,792,301	\$ 25,195,686	\$ 1,403,385	5.9%
02 Technical & Spec Fees	575,460	727,049	800,784	73,735	10.1%
03 Communication	675,661	464,720	448,646	-16,074	-3.5%
04 Travel	547,165	559,934	555,346	-4,588	-0.8%
07 Motor Vehicles	133,315	167,504	140,253	-27,251	-16.3%
08 Contractual Services	150,530,171	153,057,275	156,041,953	2,984,678	2.0%
09 Supplies & Materials	2,959,762	2,757,141	2,568,291	-188,850	-6.8%
10 Equip - Replacement	442,525	58,862	2,200	-56,662	-96.3%
11 Equip - Additional	936,456	234,263	112,068	-122,195	-52.2%
12 Grants, Subsidies, and Contributions	94,890,252	90,904,325	103,358,644	12,454,319	13.7%
13 Fixed Charges	68,356	59,704	66,466	6,762	11.3%
Total Objects	\$ 274,473,805	\$ 272,783,078	\$ 289,290,337	\$ 16,507,259	6.1%
Funds					
01 General Fund	\$ 111,699,152	\$ 117,992,580	\$ 116,080,155	-\$ 1,912,425	-1.6%
03 Special Fund	41,472,373	29,786,883	48,639,451	18,852,568	63.3%
05 Federal Fund	120,850,342	124,760,915	124,074,231	-686,684	-0.6%
09 Reimbursable Fund	451,938	242,700	496,500	253,800	104.6%
Total Funds	\$ 274,473,805	\$ 272,783,078	\$ 289,290,337	\$ 16,507,259	6.1%

Note: The fiscal 2006 appropriation does not include deficiencies.

Fiscal Summary
DHMH – Community and Family Health Administrations

<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>
03 Consumer Health Services	\$ 40,456,027	\$ 39,342,209	\$ 39,594,621	\$ 252,412	0.6%
07 Core Services	65,370,984	66,351,987	67,584,607	1,232,620	1.9%
02 Family Health Services and Primary Care	97,584,101	104,938,713	100,114,928	-4,823,785	-4.6%
06 Prevention and Disease Control	71,062,693	62,150,169	81,996,181	19,846,012	31.9%
Total Expenditures	\$ 274,473,805	\$ 272,783,078	\$ 289,290,337	\$ 16,507,259	6.1%
General Fund	\$ 111,699,152	\$ 117,992,580	\$ 116,080,155	-\$ 1,912,425	-1.6%
Special Fund	41,472,373	29,786,883	48,639,451	18,852,568	63.3%
Federal Fund	120,850,342	124,760,915	124,074,231	-686,684	-0.6%
Total Appropriations	\$ 274,021,867	\$ 272,540,378	\$ 288,793,837	\$ 16,253,459	6.0%
Reimbursable Fund	\$ 451,938	\$ 242,700	\$ 496,500	\$ 253,800	104.6%
Total Funds	\$ 274,473,805	\$ 272,783,078	\$ 289,290,337	\$ 16,507,259	6.1%

Note: The fiscal 2006 appropriation does not include deficiencies.