

**M00F02**  
**Community and Family Health Administration**  
**Department of Health and Mental Hygiene**

***Operating Budget Data***

(\$ in Thousands)

	<b>FY 07</b>	<b>FY 08</b>	<b>FY 09</b>	<b>FY 08-09</b>	<b>% Change</b>
	<b><u>Actual</u></b>	<b><u>Working</u></b>	<b><u>Allowance</u></b>	<b><u>Change</u></b>	<b><u>Prior Year</u></b>
General Fund	\$123,138	\$117,082	\$126,415	\$9,333	8.0%
Special Fund	51,881	45,042	45,153	112	0.2%
Federal Fund	140,645	137,091	147,455	10,364	7.6%
Reimbursable Fund	<u>527</u>	<u>645</u>	<u>809</u>	<u>164</u>	<u>25.4%</u>
<b>Total Funds</b>	<b>\$316,191</b>	<b>\$299,860</b>	<b>\$319,832</b>	<b>\$19,972</b>	<b>6.7%</b>

- The Family Health Administration received a federal fund deficiency appropriation in the amount of \$12.9 million for the Women, Infant, and Children Food Program (WIC) due to increased participation and the higher cost of food.
- The fiscal 2009 allowance increases by almost \$20.0 million, but the actual change in costs is masked by one-time health insurance savings and Other Post Employment Benefits (OPEB). Absent health insurance and OPEB funding which distort year-to-year comparisons, the underlying fiscal 2009 budget change for the Community and Family Health Administrations is increasing by \$18.5 million, or 6.2%.
- General funds are increasing \$9.3 million with the major changes as follows: the transfer of the grant for the Montebello Rehabilitation Center to the Family Health Administration (\$3.0 million), new oral health initiatives (\$2.1 million), increase in core funding to the local health departments (\$1.8 million), and infant mortality funding for the Office of Minority Health (\$1.0 million).
- Federal funds are increasing by a net of \$10.4 million. Federal funds for WIC are increasing \$14.0 million, and this is offset by a \$3.8 million decrease in federal funding for the Office of Preparedness and Response.

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

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## ***Personnel Data***

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	<b><u>FY 07 Actual</u></b>	<b><u>FY 08 Working</u></b>	<b><u>FY 09 Allowance</u></b>	<b><u>FY 08-09 Change</u></b>
Regular Positions	350.70	345.70	340.40	-5.30
Contractual FTEs	<u>11.75</u>	<u>11.17</u>	<u>10.50</u>	<u>-0.67</u>
<b>Total Personnel</b>	<b>362.45</b>	<b>356.87</b>	<b>350.90</b>	<b>-5.97</b>

### ***Vacancy Data: Regular Positions***

Turnover, Excluding New Positions	19.74	5.80%
Positions Vacant as of 01/01/08	34.00	9.84%

- The positions for agencies included in the Community and Family Health Administrations budget analysis are decreasing by 5.3 regular positions and 0.7 contractual positions. The Family Health Administration’s regular positions are decreasing by 2.0, the Office of Preparedness and Response regular positions are decreasing by 2.0, and the Community Health Administration’s regular positions are decreasing by 1.3 regular positions. All 5.3 regular positions were abolished at the Board of Public Works (BPW) meeting January 30, 2008.
- The vacancy rate as of January 1, 2008 was 9.8%, which is more than the budgeted turnover of 5.8%. After the BPW abolitions, the vacancy rate for the Community and Family Health Administration dropped to 8.4%

## ***Analysis in Brief***

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### **Major Trends**

***The Family Health Administration:*** Since fiscal 2002, the Office of Oral Health has significantly increased the number of services provided to children in community-based and clinical settings. Following the national trend, Maryland’s overall infant mortality rate increased from 2002 through 2003 but declined to 7.3 deaths per 1,000 live births in 2005. However, in 2006, the overall infant mortality rate increased, while the African American infant mortality rate remained level.

***Community Health Administration:*** The infection rate of primary and secondary syphilis decreased 3.6% in 2006, but Maryland continues to have a syphilis rate significantly higher than the national average. The problem remains pronounced in Baltimore City, although the syphilis rate there dropped 18.4% from 2005 to 2006.

***Cigarette Restitution Fund Program:*** The number of cancer screenings spiked in fiscal 2003, and since then the number of cancer screenings provided has decreased due to decreased funding for the activity. The proportion of Marylanders smoking has decreased significantly from 2001 through 2006 in all age groups surveyed.

***Office of Preparedness and Response:*** The Office of Preparedness and Response continues to work towards the goals of training, complying with federal regulations, developing preparedness plans, and conducting functional exercises. In a national assessment of public health preparedness, Maryland ranked average among the 50 states by receiving a passing grade in 8 of the 10 indicators.

## **Issues**

***Access to Dental Care:*** In response to last year's tragic death of the 12-year-old youth who had an untreated tooth infection, numerous actions were taken to address the issue of dental access in Maryland. First, during the 2007 regular session, the General Assembly passed a bill establishing the Oral Health Safety Net Program. Then, over the summer, the Department of Health and Mental Hygiene formed a Dental Action Committee.

***Failure to Meet the Centers for Disease Control and Prevention Recommended Tobacco Prevention Spending:*** A report found that states have made progress in funding for tobacco prevention activities, but most states (including Maryland) still fail to fund tobacco prevention programs at the minimum levels recommended by the Centers for Disease Control and Prevention (CDC). Expenditures in the State increased in fiscal 2007 and went above 50% of the CDC recommended lower spending limit. However, the CDC revised the recommended limits in fiscal 2008, which decreases the State's spending to below 50% of the lower spending limit.

***Stockpile of Antivirals:*** The federal government has offered states a subsidized price to purchase antiviral drugs to develop stockpiles. The Office of Preparedness and Response has purchased 36% of the antivirals available to Maryland under the federal offer, and the office has until June 29, 2008, to purchase the remaining antiviral treatment doses.

***Local Health Department Funding Formula:*** The 2007 *Joint Chairmen's Report* directed the Department of Health and Mental Hygiene and the Maryland Association of County Health Officers to examine the Targeted Local Health Formula. The committees were concerned with how State funding for State employees in the local health departments is provided through the Core Local Health Funding Formula.

## **Recommended Actions**

	<u><b>Funds</b></u>
1. Reduce general fund support for the Women, Infant, and Children Food Program.	\$ 185,000
2. Add language to restrict \$1.0 million in new funding for the Office of Minority Health and Health Disparities to reduce infant mortality to be used to expand the Babies Born Healthy program.	
3. Delete general funds to reduce adult health disparities from the Office of Minority Health and Health Disparities.	250,000
4. Reduce funding in the Office of Oral Health for equipment and construction.	950,000
<b>Total Reductions</b>	<b>\$ 1,385,000</b>

## **Updates**

***Maryland Cancer Fund:*** Fiscal 2007 was the third year funds were collected by the Maryland Cancer Fund, which is administered by the Family Health Administration. However, the fund has yet to award grants and holds a fund balance of \$1.4 million.

**M00F02**  
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***Operating Budget Analysis***

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**Program Description**

The Community Health and Family Health Administrations consist of four separate public health entities: the Community Health Administration (CHA), the Family Health Administration (FHA), the Cigarette Restitution Fund Program, and the Office of Preparedness and Response (OPR).

CHA 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. Also, CHA works to assure that the Core Public Health Functions and Essential Public Health Services are provided to every community.

FHA 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.

The Cigarette Restitution Fund Program receives a majority of its funding from payments made under the Master Settlement Agreement (MSA). Through the MSA, the settling tobacco manufacturers will pay the litigating parties, which are 46 states, 5 territories, and the District of Columbia, approximately \$206 billion over the next 25 years and beyond. By statute, the Cigarette Restitution Funds (CRF) must be appropriated to eight health- and tobacco-related priorities, and the CRF program administers a few of these programs: the Tobacco Use Prevention and Cessation Program; the Cancer Prevention, Education, Screening, and Treatment program; and the Minority Outreach and Technical Assistance program.

OPR oversees programs focused on enhancing the public health preparedness activities for the State and local jurisdictions. The key aspects of the work conducted under the leadership of OPR are interagency collaboration and preparedness for public health emergencies. The projects in OPR are federally funded through two federal grants focused in four areas: (1) the Centers for Disease Control and Prevention's (CDC) Public Health Preparedness and Response for Bioterrorism grant; (2) CDC Pandemic Influenza Grant; (3) CDC Cities Readiness Initiative funding; and (4) the Health Resources and Services Administration's National Bioterrorism Hospital Preparedness Program.

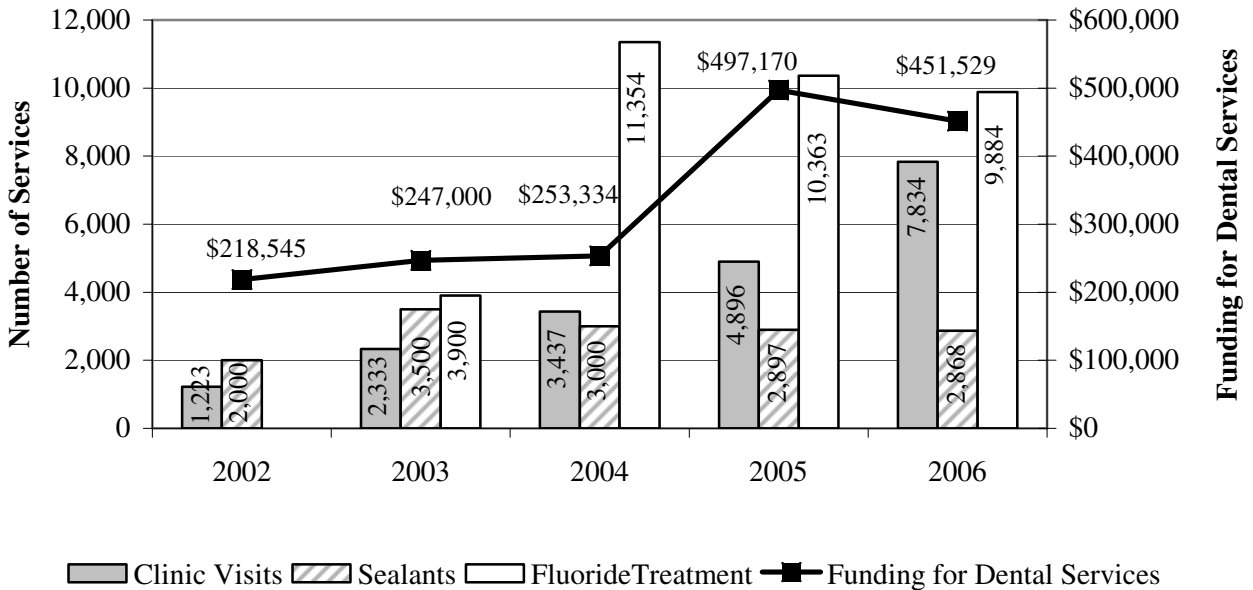
**Performance Analysis: Managing for Results**

**Family Health Administration**

**Oral Health Services**

Since fiscal 2002, the Office of Oral Health has significantly increased oral health services provided to children. **Exhibit 1** shows that since fiscal 2002 the number of services has increased over 500% while the funding has increased just over 100%. While both dental services and funding have increased over this period, the 500% increase in dental services is misleading because in fiscal 2002 the Office of Oral Health was still working with clinical dental programs and the local health departments (LHDs) to establish a process of data collection. As of fiscal 2005, the Office of Oral Health considers the data collection process to be functional. The Office of Oral Health has indicated that refining the data collection process will be a priority.

**Exhibit 1  
Dental Services to Children and Funding  
Calendar 2002-2006**



Source: Department of Health and Mental Hygiene

In Exhibit 1, the fluoride treatments and sealants are defined as services provided in non-clinical settings, such as schools or community-based programs. The clinical visits encompass comprehensive dental services provided in a clinical setting, including exams, x-rays, cleanings, fluoride treatments, sealants, fillings, root canals therapy, and extractions.

Even though the funding and the number of services have increased, the need for additional oral health services is evident. The recently released *Survey of the Oral Health of Maryland School Children: 2005-06* found that only 30% of Maryland kindergarten and third grade students have dental sealants and 33% of that same group has untreated dental disease. The fiscal 2009 allowance addresses these issues by significantly increasing the funding for dental services to children, so it is expected that all of the data in Exhibit 1 will increase over the next few years.

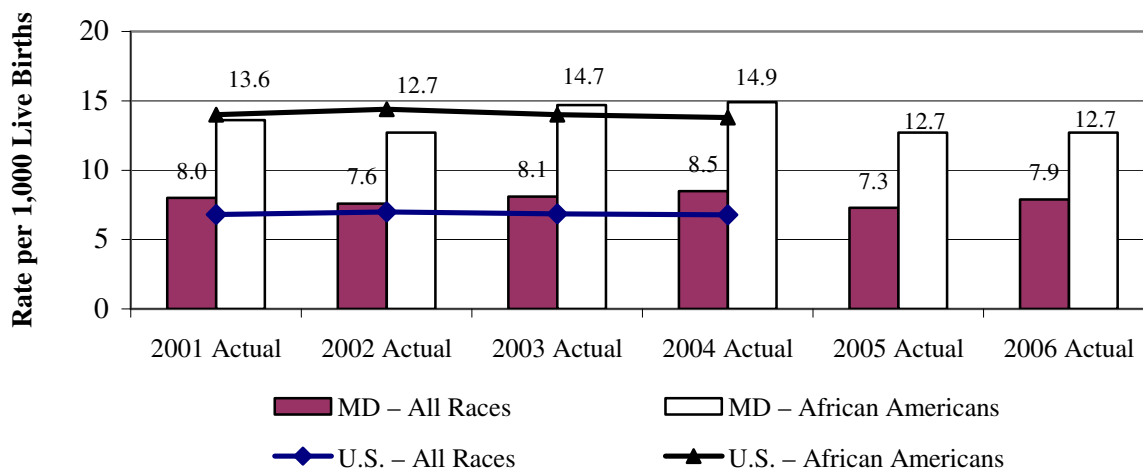
### **Infant Mortality Rates**

The Center for Maternal and Child Health within FHA 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 non-Hispanic black infants have consistently been higher than rates for all other races and ethnicities. Mirroring the national trend, Maryland's infant mortality rate decreased 23% 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 smoked, had no prenatal care, were teenagers, were unmarried, and had less education. Following the national trend, Maryland's overall infant mortality rate increased from 2002 through 2004 but declined to 7.3 deaths per 1,000 live births in 2005. However, as shown in **Exhibit 2**, the overall infant mortality rate increased to 7.9 deaths per 1,000 live births in 2006.

Following national trends, Maryland's African American infant mortality rate has consistently been higher than other races, but the infant mortality rate among African Americans remained level from 2005 to 2006, while the overall infant mortality rate increased.

**Exhibit 2**  
**Maryland vs. U.S. Average for Infant Mortality<sup>1</sup> Rates**  
**Calendar 2001-2006**  
**Cases Per 1,000 Live Births**



<sup>1</sup> Death during the first year of life.

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

Prenatal care during the first trimester helps to identify and prevent medical, genetic, or environmental risk factors that might increase the possibility of a premature or low-birth weight baby. In **Exhibit 3**, there is data showing prenatal rates by race and compared to national rates of prenatal care. In total, Maryland ranks just about average with 82.3% of mothers receiving prenatal care, but there is a distinct disparity by race with white mothers ranking higher than others in the proportion receiving prenatal care. African American mothers rank about average, and Hispanic mothers rank below average with only 64.1% receiving prenatal care.

In 2006, the percentage of women receiving prenatal care decreased slightly to 80.4%. It had been expected that the proportion of women receiving prenatal care would increase in 2006 because FHA had received new funding for the Babies Born Healthy and Immigrant Health initiatives. Funding for both programs was dedicated to providing direct care to uninsured pregnant women and children. Through these initiatives, basic prevention strategies including perinatal, postnatal, and preconception/family planning were expanded primarily at the local health departments.

**Exhibit 3**  
**Prenatal Care Rates by Race and**  
**Compared to National Rates**  
**Calendar 2004**

	<u>All Races</u>	<u>White</u>	<u>Black</u>	<u>Hispanic</u>
Maryland's %	82.3%	90.2%	74.7%	64.1%
State Ranking	23	11	23	35

Note: National data are only available through calendar 2004.

Source: National Center for Health Statistics; Centers for Disease Control and Prevention

As shown in **Exhibit 4**, the Immigrant Health initiative was eliminated in fiscal 2008 and the funding was shifted to the Medical Care Programs Administration. While the Babies Born Healthy program funding increased in fiscal 2008, the allowance decreases the program's funding by \$500,000 in fiscal 2009. The fiscal 2009 allowance allocates \$1.0 million to the Office of Minority Health and Health Disparities to reduce infant mortality.

**Exhibit 4**  
**Funding for Prenatal Services**  
**Fiscal 2001-2009**

	<u>2001</u>	<u>2002</u>	<u>2003</u>	<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008 Working</u> <u>Appropriation</u>	<u>2009</u> <u>Allowance</u>
Maternal Health	\$2.6	\$2.6	\$3.3	\$3.2	\$3.6	\$2.8	\$2.9	\$3.0	\$3.1
Babies Born Healthy	-	-	-	-	-	-	1.3	2.9	2.4
Immigrant Health	-	-	-	-	-	-	3.0	-	-
Office of Minority Health	-	-	-	-	-	-	-	-	1.0
<b>Total Infant Mortality Funding</b>	<b>\$2.6</b>	<b>\$2.6</b>	<b>\$3.3</b>	<b>\$3.2</b>	<b>\$3.6</b>	<b>\$2.8</b>	<b>\$7.2</b>	<b>\$6.0</b>	<b>\$6.5</b>

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

**Elevated Blood Lead**

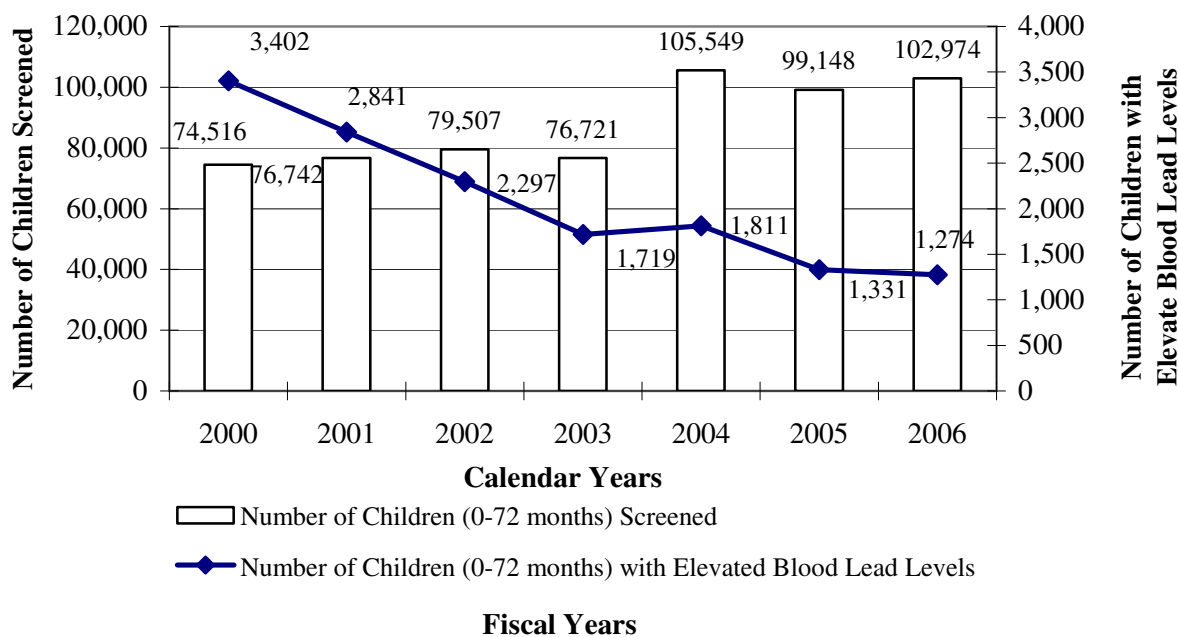
The CDC has a national goal to eliminate the blood lead levels of greater than 10 microgram per deciliter (*ug/dL*) in children younger than the age of six by the year 2010. It has been clinically proven that blood lead levels greater than 70 *ug/dL* can cause severe neurological problems (*i.e.*, seizures, coma, and death). Also, studies have linked blood lead levels as low as 10 *ug/dL* with decreased intelligence and other adverse neurodevelopmental effects.

Common sources of lead exposure include house dust contaminated with lead paint, soil contaminated with lead paint, and industrial or motor vehicle emissions. Nationally, elevated blood lead levels are more prevalent with children living in houses built before 1946. Also, income is a factor in the prevalence of elevated blood lead levels in children with the following breakdown:

- low-income – 16.4% prevalence;
- middle-income – 4.1% prevalence; and
- high-income – 0.9% prevalence.

FHA has indicated a goal of having the number of children with elevated blood lead levels (greater than 10  $\mu\text{g}/\text{dL}$ ) will be no more than 230 by calendar 2010. As shown in **Exhibit 5**, since 2000, the number of children with elevated blood lead levels has been significantly above the 2010 goal. However, the number of children with elevated blood lead levels has decreased over 60% since 2000, while the number of screenings provided increased by almost 40%.

**Exhibit 5  
Screenings and Results for Elevated Blood Lead Levels  
In Children under the Age of Six**



	<u>2000</u>	<u>2001</u>	<u>2002</u>	<u>2003</u>	<u>2004</u>	<u>2005</u>	<u>2006</u>
Funding for Blood Lead Screenings (in millions)	\$0.7	\$1.2	\$1.3	\$1.3	\$1.3	\$1.3	\$1.6

Source: Department of Health and Mental Hygiene

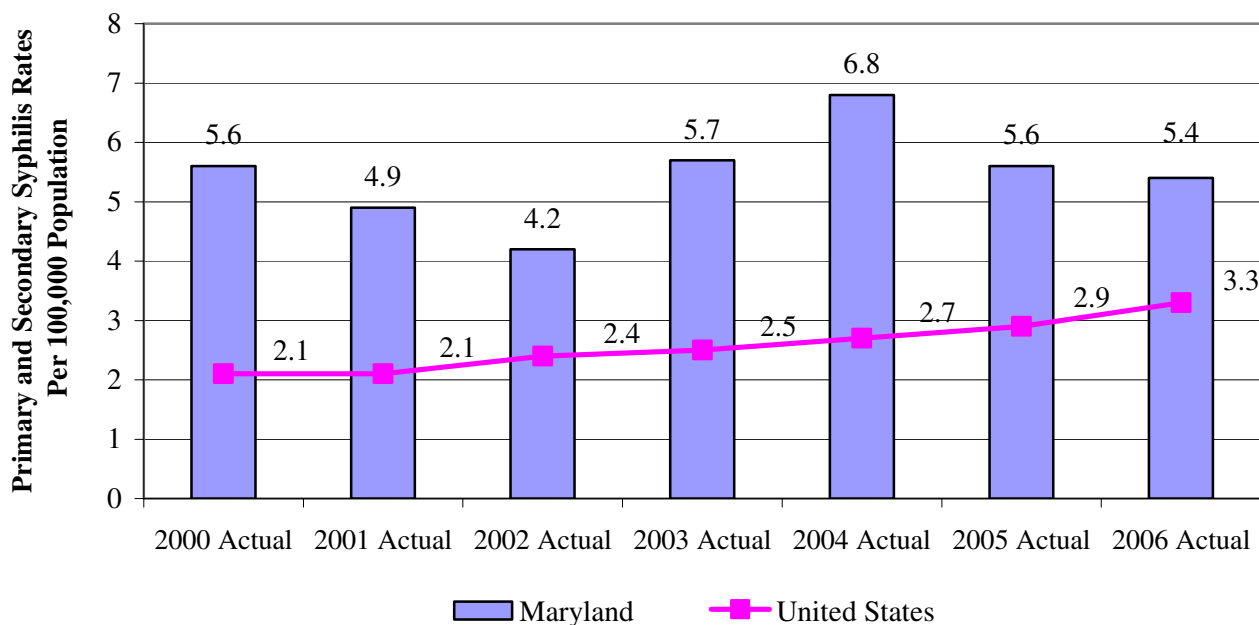
## Community Health Administration

### Syphilis

CHA is charged with preventing and controlling the transmission of infectious diseases, including sexually transmitted diseases (STDs). The administration has developed initiatives to reduce the spread of STDs, 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 fifth highest in the nation (as of the most recent national comparison which was conducted with data from 2006). 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 compared to the national average are displayed in **Exhibit 6**. In 2006, the CDC reported a statewide infection rate of primary and secondary syphilis in Maryland of 5.4 cases per 100,000 population, a 3.6% decrease over the 2005 rate. Despite the decline, the syphilis rate is still significantly higher than the national rate of 3.3 cases per 100,000. Increased infection rates are associated with HIV infection and high-risk sexual behavior, specifically, among men who have sex with men.

**Exhibit 6**  
**Rates of Primary/Secondary Syphilis**  
**Cases Per 100,000 Population**  
**Calendar 2000-2006**



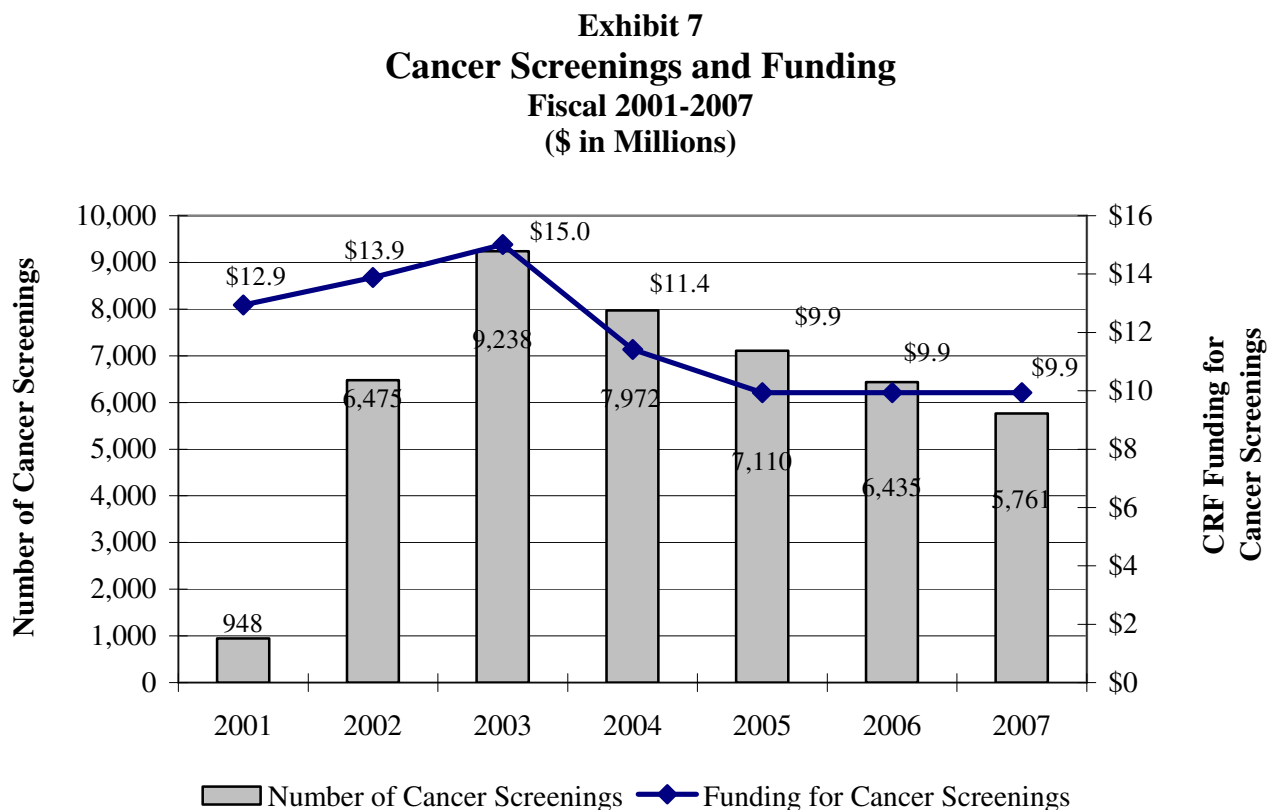
Source: Department of Health and Mental Hygiene; Centers for Disease Control and Prevention

The problem is pronounced in Baltimore City, where the rate of syphilis is 24.9 cases per 100,000 population, accounting for 53% of all reported Maryland cases. However, the calendar 2006 syphilis data is significantly better than the calendar 2005 data, which was 30.5 cases per 100,000 population, and 62% of all the syphilis cases in the State.

## Cigarette Restitution Fund Program

### Cancer Prevention, Education, Screening, and Treatment

One of the main functions of the Cancer Prevention, Education, Screening, and Treatment Program is to fund community-based programs that prevent, detect, and treat cancer. **Exhibit 7** shows the number of cancer screenings funded by the Cancer Prevention, Screening, and Treatment Program from fiscal 2001 through 2007. In fiscal 2003, the number of cancer screenings spiked at a total of 9,238 screenings, and since then, the number of screenings provided has decreased due to decreased funding levels.



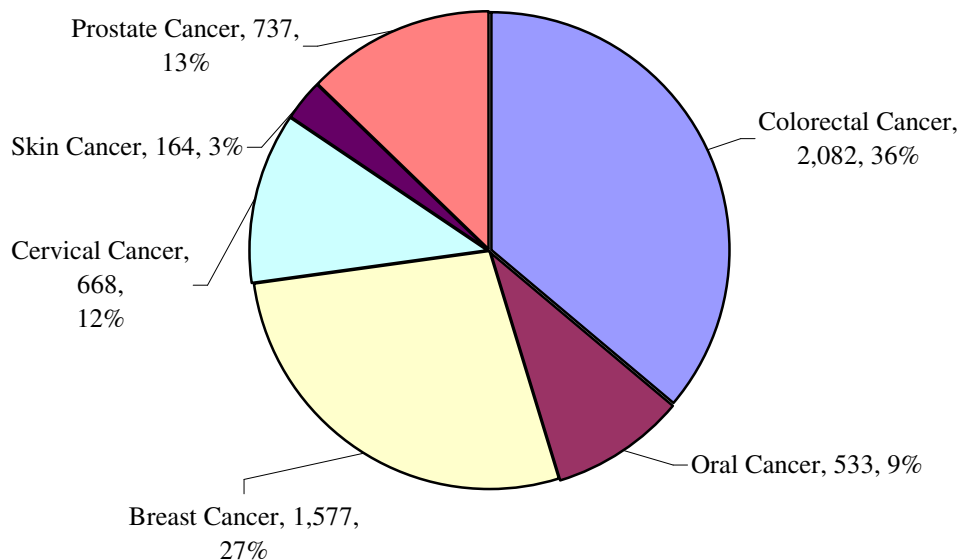
CRF: Cigarette Restitution Fund

Source: Department of Health and Mental Hygiene

The Cancer Prevention, Education, Screening, and Treatment Program provides a number of different types of cancer screenings. **Exhibit 8** shows the number of cancer screenings provided in fiscal 2007 by type.

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**Exhibit 8**  
**Cancer Screenings by Type**  
**Fiscal 2007**



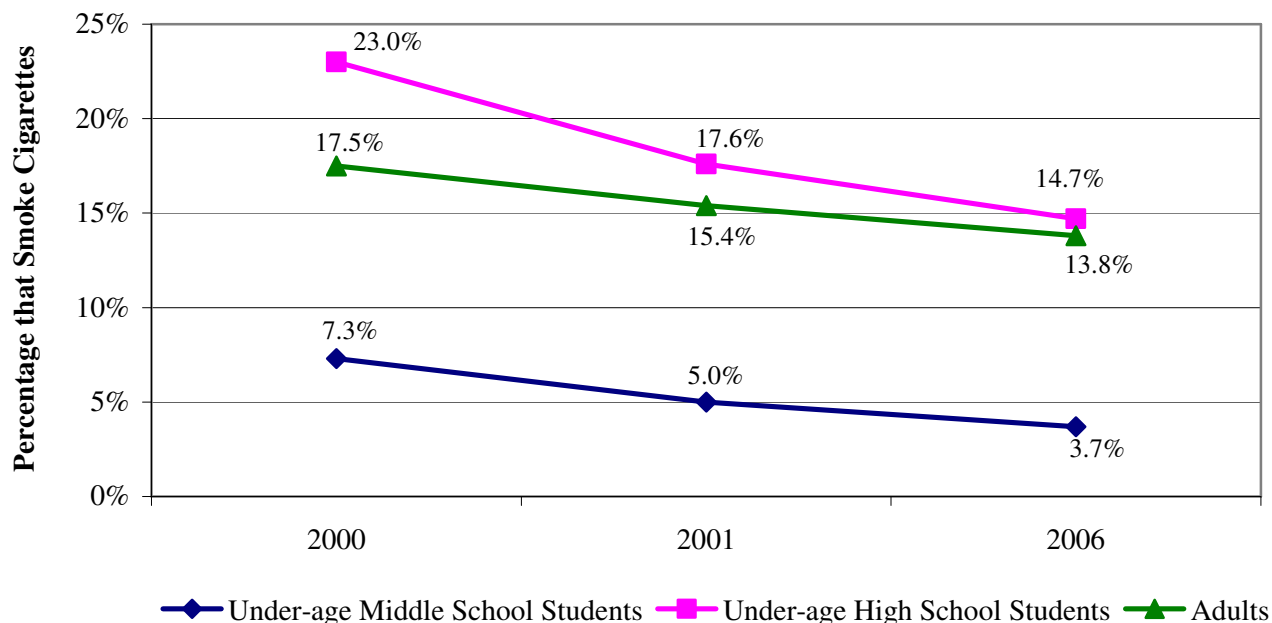
Source: Department of Health and Mental Hygiene

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### **Tobacco Use Prevention and Cessation Program**

The mission of the Tobacco Use Prevention and Cessation Program is to reduce the use of tobacco products and to reduce the burden of tobacco related morbidity and mortality in the State. The program delivers comprehensive smoking cessation assistance to smokers seeking assistance in quitting smoking and tobacco use prevention services directed at youth and young adults. To measure the effectiveness of the services, the program conducts a biennial county-level youth and tobacco survey, and the results are shown in **Exhibit 9**. The data show a distinct decrease in the proportion of smokers in Maryland from calendar 2000 to 2006.

**Exhibit 9  
Proportion of Marylanders Smoking  
Calendar 2000-2006**



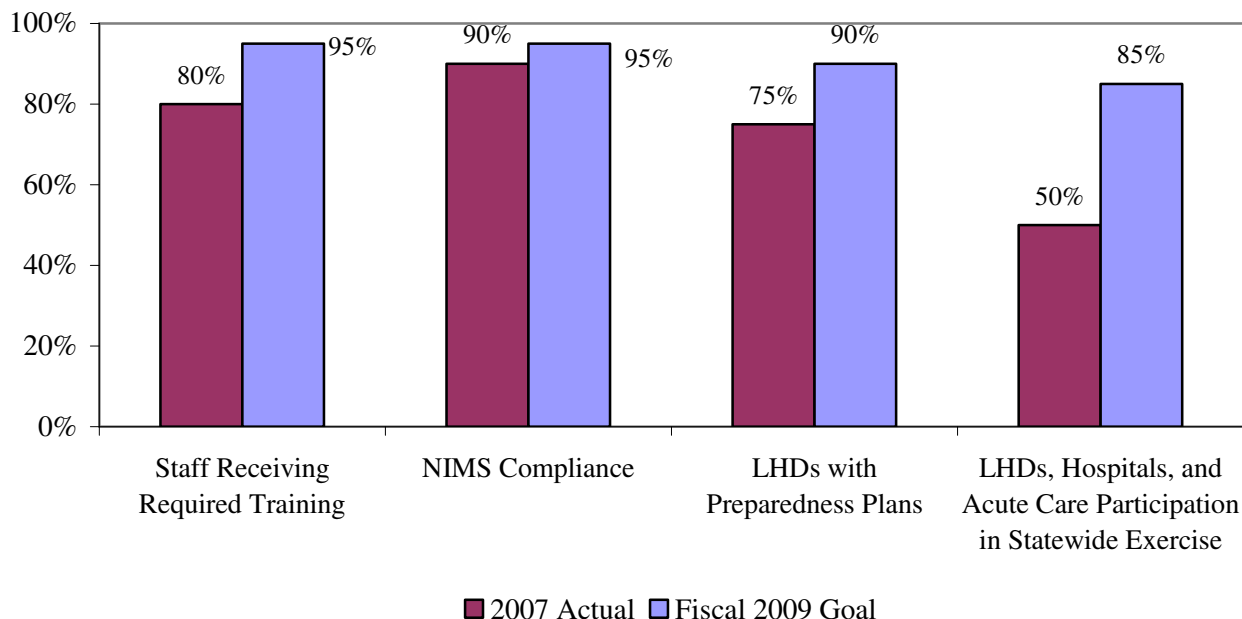
Note: There is no data for calendar 2004 due to lack of funding.

Source: Department of Health and Mental Hygiene

**Office of Preparedness and Response**

The main functions of OPR are to provide public health and emergency response training; ensure hospitals and local health departments are in compliance with federal regulations; develop and implement preparedness plans; and conduct functional exercises. **Exhibit 10** shows the office's performance in those areas in fiscal 2007 juxtaposed to the fiscal 2009 goals.

**Exhibit 10**  
**Office of Preparedness and Response**  
**Fiscal 2007 Actual Versus Fiscal 2009 Goal**



LHD: Local Health Department  
 NIMS: National Incident Management System

Source: Department of Health and Mental Hygiene

One of OPR’s goals is to maintain and improve the technical expertise in public health preparedness and emergency response through providing state-of-the-art annual training and educational opportunities for the Department of Health and Mental Hygiene (DHMH) and LHD staff. LHDs are required to have the capability to field a Public Health Response Team (PHRT). Training for PHRT members requires Incident Command System, National Incident Management System (NIMS), and other response training as approved by DHMH. As shown in Exhibit 10, OPR has provided the required training to 80% of the staff in fiscal 2007.

Another goal for OPR is to expand compliance with NIMS for the State, LHDs, and hospitals because NIMS compliance is federally mandated. NIMS provides a consistent nationwide method for federal, state, and local governments to work together to prepare for, respond to, and recover from domestic incidents, regardless of cause, size, or complexity. As shown in Exhibit 10, 90% of the LHDs and hospitals were NIMS compliant in fiscal 2007.

The federal government requires states to have a number of preparedness plans in place, such as Strategic National Stockpile (SNS) Distribution Plan, Statewide Evacuation Plan, Pandemic Influenza Plan, and Isolation and Quarantine Plan. Also, each LHD is required to develop a preparedness plan to address current and emerging public health threats specific to their jurisdiction. As shown in Exhibit 10, 75% of the LHDs had completed and approved preparedness related operational plans in fiscal 2007.

OPR is required to conduct regular exercises and drills in coordination with LHDs that are designed to test and assess the strengths and weaknesses of the State's public health preparedness. Specifically, OPR and LHDs are required to exercise at least some components of their respective public health preparedness plan and the Pandemic Influenza Plan annually. As shown in Exhibit 10, 50% of the LHDs and hospitals participated in statewide functional exercises in fiscal 2007.

### **Maryland's Public Health Preparedness Compared with Other States**

The Trust for America's Health, a nonprofit organization dedicated to disease prevention, issued a December 2007 report titled *Ready or Not? Protecting the Public's Health from Disease, Disaster, and Bioterrorism*. The report assessed readiness in each of the 50 states according to 10 indicators of emergency response capabilities. This is the fifth year in a row that this report has been released, but each year the Trust for America's Health has assessed different aspects of public health preparedness.

The general findings from the 2007 report were that while important progress has been made, critical areas of the nation's emergency health preparedness effort still require attention. Maryland ranked average among the 50 states by receiving a passing grade on 8 of the 10 indicators.

One of the two indicators that Maryland failed was whether the State has an adequate plan to distribute emergency vaccines, antidotes, and medical supplies from SNS. This is something that has been rated in four out of the five years, and in all four years Maryland did not receive points. In the 2007 report, Maryland was only 1 of 10 states that did not receive a passing grade for this indicator. SNS has a national repository of antibiotics, chemical antidotes, antitoxins, various pharmaceuticals, and other medical supplies and equipment to be used in the event of a terrorist attack or major national disaster. The stockpile is kept at undisclosed locations throughout the country that can be delivered anywhere within the United States in 12 hours.

The other indicator that Maryland did not pass was regarding laws that extend liability shields to healthcare volunteers in a public health emergency. Maryland was 1 of 21 states that failed this indicator. Lack of such protections has been identified as a key impediment to recruiting sufficient volunteers to respond to major health emergencies.

Maryland did show some progress in the 2007 report by receiving a passing grade for the first time for an indicator that has been measured all five years the report has been conducted. The Trust for America's Health determined that Maryland does have sufficient laboratory capabilities to test for a biological threat.

## **Fiscal 2008 Actions**

### **Proposed Deficiency**

FHA received a federal fund deficiency appropriation in the amount of \$12.9 million for the Women, Infant, and Children Food Program (WIC) due to increased participation and the higher cost of food. WIC provides healthy supplemental foods and nutrition counseling for income eligible pregnant, postpartum, and breast-feeding women, as well as children under the age of five years with medical and nutritional risk factors. The enrollment for this program is about 18% higher than had been estimated for fiscal 2008. Also, the average monthly food cost per participant is about 13% higher than assumed in the fiscal 2008 legislative appropriation.

### **Impact of Cost Containment**

The Administration withdrew \$3.8 million in special funds from the CRF as shown in **Exhibit 11**. This is an 8% across-the-board reduction for the services in the CRF Program. This addresses potential shortfalls in funding to CRF due to legal issues for payments by participating manufacturers based on market share increases by non-participating manufacturers (NPM) and whether the State is diligently enforcing its qualifying statute. A portion of the tobacco settlement payments are being placed in escrow pending the resolution of this issue, but until it is settled, Maryland will not receive the full settlement amount. The withdrawn appropriations align CRF spending with the expected loss related to the NPM adjustment.

**Exhibit 11  
Cigarette Restitution Fund Cost Containment  
Fiscal 2008**

	<b>Legislative Appropriation <u>2008</u></b>	<b>Board of Public Works <u>8% Reduction</u></b>	<b>Working Appropriation <u>2008</u></b>
<b>Cancer Prevention, Evaluation, Screening, and Treatment</b>			
Statewide Academic Health Center	\$15,400,000	-\$1,231,000	\$14,169,000
Local Public Health	7,504,090	-600,000	6,904,090
Baltimore City Public Health	2,446,000	-194,000	2,252,000
Surveillance and Evaluation	1,290,181	-103,000	1,187,181
Administration	736,822	-58,000	678,822
Cancer Screening Data Base	385,000	-30,000	355,000
Statewide Public Health	111,798	-8,000	103,798
<b>Total</b>	<b>\$27,873,891</b>	<b>-\$2,224,000</b>	<b>\$25,649,891</b>
<b>Tobacco Use Prevention and Cessation Program</b>			
Local Public Health	\$12,090,000	-\$967,000	\$11,123,000
Statewide Public Health	2,262,500	-181,000	2,081,500
Surveillance and Evaluation	1,900,000	-152,000	1,748,000
Minority Outreach and Technical Assistance	1,208,000	-96,000	1,112,000
Administration	682,333	-54,000	628,333
Counter-marketing	500,000	-40,000	460,000
<b>Total</b>	<b>\$18,642,833</b>	<b>-\$1,490,000</b>	<b>\$17,152,833</b>
DHMH Management Support	\$959,794	-\$76,000	\$883,794
<b>Totals</b>	<b>\$47,476,518</b>	<b>-\$3,790,000</b>	<b>\$43,686,518</b>

DHMH: Department of Health and Mental Hygiene

Source: Department of Health and Mental Hygiene

**Governor’s Proposed Budget**

The allowance for each agency included in the Community and Family Health Administration budget analysis is detailed in **Exhibit 12**, and the major changes in the fiscal 2009 allowance are shown in **Exhibit 13**.

**Exhibit 12**  
**Distribution of Funding by Administration**  
**Fiscal 2007-2009**

	<u>2007</u> <u>Actual</u>	<u>2008 Working</u> <u>Appropriation</u>	<u>2009</u> <u>Allowance</u>	<u>2008-09</u> <u>Difference</u>	<u>%</u> <u>Change</u>
<b>Community Health Administration</b>					
Administration	\$1,395,653	\$1,441,436	\$1,436,510	-\$4,926	0%
Community Health Services	20,025,083	17,121,403	17,665,965	544,562	3%
Core Public Health	68,160,951	71,484,283	73,253,355	1,769,072	2%
<b>Subtotal</b>	<b>\$89,581,687</b>	<b>\$90,047,122</b>	<b>\$92,355,830</b>	<b>\$2,308,708</b>	<b>3%</b>
<b>Family Health Administration</b>					
Administration	\$3,153,703	\$2,111,252	\$2,129,488	\$18,236	1%
Family Health Services	120,025,538	106,583,398	120,929,768	14,346,370	13%
Prevention and Disease Control	33,426,535	33,389,587	39,086,063	5,696,476	17%
<b>Subtotal</b>	<b>\$156,605,776</b>	<b>\$142,084,237</b>	<b>\$162,145,319</b>	<b>\$20,061,082</b>	<b>14%</b>
<b>Cigarette Restitution Fund Program</b>					
Cancer Prevention, Education, Screening, and Treatment	\$28,072,785	\$25,427,320	\$25,524,435	\$97,115	0%
Tobacco Use Prevention and Cessation	17,794,975	17,297,447	17,322,294	24,847	0%
Management Support	872,784	1,118,476	2,407,511	1,289,035	115%
<b>Subtotal</b>	<b>\$46,740,544</b>	<b>\$43,843,243</b>	<b>\$45,254,240</b>	<b>\$1,410,997</b>	<b>3%</b>
<b>Office of Preparedness and Response</b>					
Centers for Disease Control and Prevention funding	\$14,447,125	\$15,469,843	\$13,488,388	-\$1,981,455	-13%
Health Resources Services Administration funding	8,095,585	8,377,498	6,588,531	-1,788,967	-21%
Other grants	720,114	37,968	0	-37,968	0%
<b>Subtotal</b>	<b>\$23,262,824</b>	<b>\$23,885,309</b>	<b>\$20,076,919</b>	<b>-\$3,808,390</b>	<b>-16%</b>
<b>Total</b>	<b>\$316,190,831</b>	<b>\$299,859,911</b>	<b>\$319,832,308</b>	<b>\$19,972,397</b>	<b>7%</b>

Source: Governor's Budget Books; Department of Legislative Services

**Exhibit 13**  
**Governor’s Proposed Budget**  
**DHMH – Community and Family Health Administration**  
**(\$ in Thousands)**

<b>How Much It Grows:</b>	<b><u>General</u> <u>Fund</u></b>	<b><u>Special</u> <u>Fund</u></b>	<b><u>Federal</u> <u>Fund</u></b>	<b><u>Reimb.</u> <u>Fund</u></b>	<b><u>Total</u></b>
2008 Working Appropriation	\$117,082	\$45,042	\$137,091	\$645	\$299,860
2009 Governor’s Allowance	<u>126,415</u>	<u>45,153</u>	<u>147,455</u>	<u>809</u>	<u>319,832</u>
Amount Change	\$9,333	\$112	\$10,364	\$164	\$19,972
Percent Change	8.0%	0.2%	7.6%	25.4%	6.7%

**Where It Goes:**

**Personnel Expenses**

Reduce Other Post Employment Benefits liability .....	\$1,103
Employee and retiree health insurance .....	396
Salary increments and other compensations .....	26
Other fringe benefit adjustments.....	13
Abolished 5.3 positions.....	-363

**Family Health Administration**

Increase in federal funding for Women, Infants, and Children program.....	13,957
Grant to Montebello at Kernan transferred from the University of Maryland Medical System budget.....	3,055
Expand the dental public health infrastructure .....	1,400
School-based oral health services .....	700

**Community Health Administration**

Core funding distributed through the Targeted Local Health Formula to local health departments.....	1,769
Development of an environmental health tracking system.....	177
Reimbursable funds from the Department of Human Resources MONA – local health departments will be reimbursed for more of the costs incurred.....	154
Center for Disease Control and Prevention funding for a new tuberculosis study .....	96
Grant to Frederick County hepatitis clinic eliminated due to cost containment.....	-30
Eliminate contracts for Hepatitis C epidemiological data due to cost containment .....	-60
Vehicles costs for the Office of Food Protection and Consumer Health .....	-90

*M00F02 – DHMH – Community and Family Health Administration*

**Where It Goes:**

Reduced federal support for surveillance, sexually transmitted diseases, laboratory support, and tuberculosis efforts .....	-436
<b>Cigarette Restitution Fund Program</b>	
Increased funding to the Office of Minority Health for infant mortality .....	1,000
Adult health disparity funding for the Office of Minority Health .....	250
<b>Office of Preparedness and Response</b>	
Center for Disease Control and Prevention Pandemic Influenza Funding .....	-285
Funding from the Center for Disease Control and Prevention for the City Readiness initiative .....	-432
Centers for Disease Control and Prevention base grant funding .....	-583
Health Research Services Administration funding for hospital preparedness .....	-1,746
Other .....	-98
<b>Total</b>	<b>\$19,972</b>

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

The Community and Family Health Administration’s budget increases by almost \$20.0 million, or 6.7%, in the allowance. However, the actual change is masked by one-time health insurance savings used to fund a portion of health insurance premiums in fiscal 2008 and the first-time inclusion of Other Post Employment Benefits in the fiscal 2009 allowance. The Community and Family Health Administration’s underlying change is increasing by \$18.5 million, or 6.2%.

General funds are increasing \$9.3 million due to the transfer of the grant for Montebello Rehabilitation Center to the Family Health Administration (\$3.0 million), new oral health initiatives (\$2.1 million), increase in core funding to the local health departments (\$1.8 million), and infant mortality funding for the Office of Minority Health (\$1.0 million).

Federal funds are increasing by a net of \$10.4 million. The \$14.0 million federal fund increase for WIC is offset by a \$3.8 million decrease in federal funding for the OPR.

**Personnel**

The fiscal 2009 allowance includes 5.3 fewer regular positions and 0.7 fewer contractual positions than the fiscal 2008 working appropriation. FHA’s regular positions are decreasing by 2.0, OPR’s positions are decreasing by 2.0, and CHA’s positions are decreasing by 1.3 regular positions. All 5.3 regular positions were abolished at the Board of Public Works (BPW) meeting January 30, 2008.

The vacancy rate as of January 1, 2008, was 9.8%, which is more than the budgeted turnover of 5.8%. At that point, the Community and Family Health Administration had 14.3 more vacant positions than needed to meet budgeted turnover. After the BPW abolitions, the vacancy rate for the Community and Family Health Administration dropped to 8.4%, with 28.7 vacant positions.

### **Impact of Cost Containment**

CHA eliminated two hepatitis related activities supported with general funds for cost containment purposes. The first cost containment activity was eliminating \$60,000 in general fund contracts with the Baltimore City Health Department and the Prince George's Health Department to treat patients and provide epidemiological data on Hepatitis C. Also, CHA eliminated a grant in the amount of \$30,000 to the Frederick County hepatitis clinic due to cost containment.

### **Montebello Rehabilitation Center at Kernan Hospital**

Chapter 248 of 1992 authorized the transfer of the Montebello Rehabilitation Center, which provides comprehensive rehabilitation services, from DHMH to the University of Maryland Medical System (UMMS). The legislation transferring the center to UMMS noted the financial and administrative limitations of continuing to provide comprehensive services within the system of State government. It was the General Assembly's intent that the operational expertise and financial independence of a major teaching and research institution would allow for continued improvements to patient care.

The legislation provided for ongoing State support for operations at Montebello to offset the cost of uncompensated care and to offset a portion of the capital costs. It was established that the State would pay specified amounts through fiscal 1997, after which the State would provide an amount jointly established by DHMH and the medical system. Since fiscal 2003, the amount of uncompensated care has been calculated at 4.29% of adjusted gross regulated revenue, a percentage agreed upon by the Department of Budget and Management, the Health Services Cost Review Commission, and UMMS. Funding has also been provided to offset capital costs.

State aid to the Montebello Rehabilitation Center from fiscal 2005 through 2009 is shown in **Exhibit 14**. The Governor's proposed budget includes \$2.3 million for uncompensated care costs not otherwise included in hospital rates. The allowance also includes \$750,000 for debt service on bonds issued to support construction of the rehabilitation center at Kernan Hospital, the facility at which UMMS has housed the Montebello Rehabilitation Program since 1996. The allowance level funds the Montebello Rehabilitation Center at the fiscal 2008 legislative appropriation, but the BPW actions in July 2007 reduced the fiscal 2008 working appropriation by \$117,488 for cost containment. **The department should explain why this cost containment action was not continued through fiscal 2009.**

**Exhibit 14  
State Aid to the Montebello Rehabilitation Center  
Fiscal 2005 -2009**

	<u>Actual 2005</u>	<u>Actual 2006</u>	<u>Actual 2007</u>	<u>Working Appropriation 2008</u>	<u>Allowance 2009</u>	<u>Difference 2008-09</u>
<b>Montebello Rehabilitation Program</b>						
Debt service	\$750,000	\$750,000	\$750,000	\$750,000	\$750,000	0.00%
Uncompensated care	1,963,512	2,074,223	2,187,191	2,187,191	2,304,679	5.37%
<b>General Fund Total</b>	<b>\$2,713,512</b>	<b>\$2,824,223</b>	<b>\$2,937,191</b>	<b>\$2,937,191</b>	<b>\$3,054,679</b>	<b>4.00%</b>

Source: Department of Budget and Management; Department of Legislative Services

**The department should explain to the budget committees the purpose of transferring the Montebello Rehabilitation Center from the UMMS budget to the FHA budget. Also, the department should explain how the management and services at the Montebello Rehabilitation Center will change, if at all, with the transfer to the FHA budget.**

**Additional Infant Mortality Funding**

FHA received funding in fiscal 2007 to implement the Babies Born Healthy program to reduce infant mortality and improve infant health in Maryland. The program provides direct care services, such as prenatal, preconception/family planning, and postnatal care for uninsured, low-income pregnant women and children. The target population includes women with a history of a poor pregnancy outcome, low socio-economic status, and racial and ethnic minorities. Priority areas of funding include (1) increasing reproductive health and family planning services to post-partum women; (2) enhancing outreach and education for high-risk pregnant women; (3) improving access to prenatal care for low-income, uninsured pregnant women; and (4) ensuring appropriate newborn screening and follow-up.

Funding for the Babies Born Healthy program was \$1.3 million in fiscal 2007, and the funding for the program was expected to increase \$1.0 million for the following two fiscal years. In fiscal 2008, the Babies Born Healthy program received the \$1.6 million in additional funding, which makes the fiscal 2008 funding level for the program \$2.9 million. The fiscal 2009 allowance does not provide an additional \$1.0 million for the Babies Born Healthy program as FHA had anticipated. Instead, the allowance includes \$1.0 million in new funding for the Office of Minority Health and Health Disparities, which happens to be placed in the same budget code as FHA, but the funding was distinctly not provided to the Babies Born Healthy program.

The new \$1.0 million in the Office of Minority Health and Health Disparities is to be used to reduce infant mortality among minorities in one or more of three jurisdictions that have the highest minority infant mortality rates, but the plan is not established past that level of detail. In contrast,

FHA's Center for Maternal and Child Health has a year-three plan that incorporates an additional \$1.0 million in fiscal 2009. With the additional funding, the Babies Born Healthy program had planned to increase the funding for prevention services by 76% and increase the funding for the quality component 25%. In addition, the Center for Maternal and Child Health has expertise in the area of infant mortality, which is inherently a health disparity issue.

Besides the fact that the Office of Minority Health and Health Disparities has not shared any established plan for the use of the new funding, as developed in statute, the Office of Minority Health and Health Disparities was never intended to provide services or administer general fund grant programs. In Health-General 20-1004, the statute details the duties for the Office of Minority Health and Health Disparities, which includes being an advocate, analyzing research, serving as a resource library, developing strategic plans, developing criteria for awarding grants, and publishing reports. The duties of the director do include distributing special and federal funds to community-based health groups, but the statute specifies that "it is the intent of the General Assembly that the Office be funded from federal and special funding sources". However, the Office of Minority Health and Health Disparities received \$1.0 million in general funds in the fiscal 2009 allowance to fund projects designed to reduce infant mortality among minorities.

**Since FHA has a comprehensive plan to utilize the funding in the manner intended in the allowance, and since the Office of Minority Health and Health Disparities is intended to be funded with federal and special funds, the Department of Legislative Services (DLS) recommends restricting the \$1.0 million of new funds allocated to the Office of Minority Health and Health Disparities to be used for the Babies Born Healthy program.**

### **Improving Access to Dental Care**

FHA's Office of Oral Health received \$1.4 million in general funds to improve access to dental care. The funding is not intended to support the Oral Health Safety Net Program that was passed (but not funded) by the General Assembly in the 2007 regular session. However, the money is intended to be used for similar activities, which include building the public dental health infrastructure.

In fiscal 2009, the Office of Oral Health plans to award funds to LHDs that can utilize the funds internally or choose to partner with nonprofit or private entities serving the public. The office plans to target the geographic areas of the Upper Eastern Shore and Southern Maryland because these geographic regions have been found to have the worst problem with respect to public dental access.

The Office of Oral Health is planning on releasing the Request for Application on May 1, 2008, with awardees receiving notice at the beginning of fiscal 2009. The fiscal 2009 Request for Application will focus on two areas:

- Operational Funds for New Oral Health Services (\$295,000) – contracting with existing private dental providers to secure comprehensive oral health services or leasing available dental space.

- New Dental Clinic Construction (\$850,000) – constructing new dental clinics to provide comprehensive oral health services through LHDs or through another private or public dental program.

All applications will be reviewed by the Dental Public Health Infrastructure Sub-Committee of the Dental Action Committee (DAC) to make recommendations on the awards.

The Office of Oral Health has prepared a four-year plan that is shown in **Exhibit 15**. In the out-years, the office plans to focus more funding on construction and the Dental Expansion and Enhancement Program, which provides funding for pre-existing dental programs in LHDs or federally qualified health centers to replace equipment or increase the size of clinics.

**Exhibit 15**  
**Multi-year Plan to Expand Public Dental Health Access**  
**Fiscal 2009-2012**  
**(\$ in Thousands)**

	<u>2009</u>	<u>2010</u>	<u>2011</u>	<u>2012</u>
Operational Funds for Oral Health Services	\$295	\$0	\$0	\$0
New Dental Clinic Construction	850	1,600	925	125
Post-Construction Operational Costs	0	0	250	250
Dental Expansion and Enhancement Program	100	100	765	1,565
Monitoring and Evaluating	100	100	100	100
<b>Total</b>	<b>\$1,345</b>	<b>\$1,800</b>	<b>\$2,040</b>	<b>\$2,040</b>

Source: Department of Health and Mental Hygiene

The Federally Qualified Health Centers Grant Program is a program administered through the capital budget that provides grants for acquisition, construction, renovation, and equipping of federally qualified health centers. This program is very similar to the new program funded in the Family Health Administration. **The department should explain why the new program was not implemented through the capital budget or the PAYGO process. DLS recommends reducing the operating budget for the Family Health Administration for the construction and equipping costs of the new program. DLS recommends that these types of grant support should be provided through a capital or PAYGO program.**

**School-based Dental Services**

The Office of Oral Health also received \$700,000 in general funds for school-based dental health services because school-based oral health services eliminate the major problems with respect to children receiving dental care: transportation and no-show appointments. This dental initiative will be comprised of two components: a dental van and school-linked portable dental programs.

The dental van will be outfitted with all the dental equipment and supplies needed to provide comprehensive dental services. The Office of Oral Health plans to use the dental van in areas where there are no available or accessible dental providers or services. DHMH estimates the dental van and the cost of running the program will cost \$350,000 to \$400,000.

The remaining \$300,000 to \$350,000 will be used to establish two school-linked portable dental programs. These programs will consist of portable dental equipment, staffed by a full-time dental hygienist and a full-time dental assistant. Services at the schools will include screenings, education, and prevention services. Also, for those patients needing additional dental treatment, the program will make appointments for those patients at existing oral health treatment sites.

### **Adult Minority Health Disparities**

The Office of Minority Health and Health Disparities received \$250,000 in general funds to fund projects designed to reduce minority health disparities among adult non-cancer chronic diseases such as heart disease, diabetes, or Sickle Cell. However, this funding has the same issues discussed in the section above title “Additional Infant Mortality Funding.” By statute, the duties of the Office of Minority Health and Health Disparities are being an advocate, analyzing research, serving as a resource library, developing strategic plans, developing criteria for awarding grants, and publishing reports. The duties of the director do include distributing special and federal funds to community-based health groups, but the statute specifies that “it is the intent of the General Assembly that the Office be funded from federal and special funding sources.” **DLS recommends deleting the \$250,000 in general funds allocated to the Office of Minority Health and Health Disparities because the plan for utilizing the funding is unclear and the Office of Minority Health and Health Disparities is not intended to be funded with general funds.**

### **Cigarette Restitution Funds**

Statute requires the Governor to include in the allowance \$21 million for tobacco use and prevention activities and \$15.4 million for the statewide academic health centers. However, the fiscal 2009 allowance for these items is based on the fiscal 2008 working appropriation which reflects the BPW cuts noted above. Thus, the statutory funding requirements are not met. It is anticipated that the following additional expenditures will be added through a supplemental budget in order to fulfill the statutory funding mandates:

- \$1.1 million in the Tobacco Use Prevention and Cessation Program for local public health programs; and
- \$2.0 million for statewide Academic Health Centers.

## ***Issues***

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### **1. Access to Dental Care**

#### **Background**

The issue of dental access came to the forefront in Maryland in 2007 with the untimely death of a 12-year-old Prince George's County child who had an untreated tooth infection that spread to his brain. At the time the child fell ill, the child's Medicaid coverage had lapsed. Nonetheless, when covered by Medicaid, the mother said it took her seven months to obtain dental treatment for another child that appeared to have more serious dental problems.

Concern over dental access in Maryland is not new. Nor is the problem isolated to the Medicaid population. For example, the *Survey of the Oral Health of Maryland School Children: 2005-2006* conducted by the Department of Pediatric Dentistry, University of Maryland, Baltimore College of Dental Surgery, and DHMH's Office of Oral Health, found that:

- 33% of Maryland children in kindergarten and third grade had untreated decay; and
- less than 30% of Maryland children in kindergarten and third grade had dental sealants.

With regard to the first measure, the survey revealed some improvement over the *2000-2001 Survey of the Oral Health Status of Maryland School Children*, which found that 53% of Maryland children in kindergarten and third grade had untreated decay in their primary teeth.

In response to the tragic death of the 12-year-old youth, numerous actions were taken to address the issue of dental access in Maryland. First, during the 2007 regular session, the General Assembly passed a bill establishing the Oral Health Safety Net Program. Then, over the summer, DHMH formed a Dental Action Committee.

#### **Oral Health Safety Net Program**

The Oral Health Safety Net Program was to be administered by DHMH's Office of Oral Health. The program would have awarded grants to LHDs, federally qualified health centers, and entities providing dental services within State facilities to increase dental provider capacity for the underserved. Priority was to be given to grant proposals that targeted to regions of the State where oral health services are most scarce for low-income, disabled, and Medicaid populations. The program was to provide \$1.2 million in grants annually from fiscal 2009 through 2011.

To evaluate the effectiveness of the program, the Office of Oral Health is directed to conduct annual evaluations of the program and submit an annual report to the Governor and the General Assembly on the results of the evaluation. Also, at the end of the program, DHMH is to conduct a statewide follow-up survey concerning the oral health status of school children in the State.

In addition to administering the grants, the Office of Oral Health is directed to contract with a licensed dentist to provide expertise in dental public health issues for the office. Also, the Office of Oral Health should provide appropriate continuing education courses for providers that offer oral health treatments to underserved populations.

The fiscal 2009 allowance does provide \$1.4 million to improve access to public dental care in similar ways as laid out by the Oral Health Safety Net Program, but DHMH is not using the new money to fund the Oral Health Safety Net Program. **The department should explain to the budget committees why the Oral Health Safety Net Program, as adopted by the General Assembly during the 2007 regular session, was not funded with the \$1.4 million provided to the Office of Oral Health to expand public dental health services and facilities.**

### **Dental Action Committee**

DAC consists of a broad-based group of stakeholders concerned about children's access to oral health services. The committee was charged with developing recommendations in four targeted areas: (1) Medicaid reimbursements and alternative models; (2) public health strategies; (3) oral health education and outreach to parents and caregivers; and (4) provider participation, capacity, and scope of practice. The primary needs identified by DAC are more dental providers in the State, more dental treatment services, and more targeted case management.

The committee came up with seven main recommendations in the four targeted areas. Two of the recommendations were made in the target area of Medicaid Reimbursements and Alternative Models. The remaining five recommendations in the target areas that relate to FHA's Office of Oral Health are discussed below.

### **Public Health Strategies**

Only half of Maryland's LHDs have clinical dental services available onsite, and only 9 LHDs provide dental care to Medicaid enrollees. In addition, only 10 of the 16 federally qualified health centers offer dental services. As a result, the committee recommended DHMH ensure that each local jurisdiction has a LHD dental clinic and a community oral health safety net clinic.

The other recommendation DAC made in the area of public health strategies was to incorporate dental screenings with school-based vision and hearing screenings for public school children and/or require dental exams prior to school entry.

### **Education and Outreach for Parents and Caregivers**

The sole recommendation in the area of education and outreach for parents and caregivers is for DHMH to develop a unified culturally and linguistically appropriate oral health message for use throughout the State. The message is to be used to educate parents and caregivers of young children about oral health and the prevention of oral disease.

## **Provider Participation, Capacity, and Scope of Practice**

To address the lack of dentists in the public health setting, DAC recommended changing the supervision requirements for dental hygienists working in the public health setting. Specifically, DAC recommended allowing dental hygienists to perform screenings, prophylaxis, fluoride varnish, sealants, and x-rays without the supervision of a dentist.

The other recommendation made in this area is to provide training to dental and medical providers on oral health risk assessments to educate parents/caregivers about oral health, and to assist families in establishing a dental home for all children. This recommendation did meet some resistance from the dental professionals because they felt that if an oral risk assessment was conducted by a non-dental medical professional, then parents may feel their child's dental needs had been met when the oral health risk assessment is a superficial screening that will not detect all dental problems.

### **Next Steps**

DAC recommendations were submitted to the Secretary of DHMH for consideration on September 11, 2007. Also, DAC proposed that the committee continue to meet quarterly to assist DHMH with the implementation of the recommendations and to evaluate the department's progress toward establishing a dental home for every low-income child in the State.

**The department should brief the budget committees on any progress made toward implementing DAC recommendations not included in the fiscal 2009 budget.**

## **2. Failure to Meet the Centers for Disease Control and Prevention Recommended Tobacco Prevention Spending**

A report published by the Campaign for Tobacco Free Kids in December 2007 found that the states have made important progress by increasing funding for tobacco prevention and cessation programs by 20% to a total of \$717.2 million in fiscal year 2008, which is the highest level in six years. However, most states still fail to fund tobacco prevention programs at minimum levels recommended by the CDC, and altogether, the states are providing less than half what the CDC has recommended.

## **Restrictions on CRF Spending**

The use of the CRF is restricted by Maryland statute in a variety of ways. For example:

- at least 50% of the funds must be appropriated to eight health- and tobacco-related priorities including tobacco production alternatives, tobacco control and cessation, cancer prevention, treatment and research, and substance abuse treatment and prevention;
- at least 30% of the funds must be appropriated to Medicaid;
- at least 0.15% of the fund is dedicated to enforcement of Title 16, Subtitle 5 of the Business Regulation Article (Escrow Requirements for Nonparticipating Tobacco Product Manufacturers) by the Office of the Attorney General (OAG); and
- the Governor's allowance must include \$21.0 million for tobacco use and prevention activities and \$15.4 million for the statewide academic health centers.

CDC's recommendations are limited to comprehensive tobacco control programs and do not speak to the other programs supported by the CRF: cancer prevention, screening and treatment, substance abuse treatment, Medicaid, aid to nonpublic schools, and tobacco crop conversion programs.

## **CDC Recommended Funding Levels for Comprehensive Tobacco Control Programs**

CDC first developed recommended funding levels for comprehensive tobacco control programs in 1999. At that time, CDC noted nine elements of a comprehensive tobacco control program:

- community programs to reduce tobacco use covering a wide range of prevention activities;
- chronic disease programs to reduce the burden of tobacco-related diseases, for example asthma prevention and oral health programs;
- school-based tobacco prevention programs;
- enforcement of existing tobacco laws and regulations;
- statewide programs such as the implementation of smoke-free policies and addressing disparities between specific population groups;
- counter-marketing to offset pro-tobacco influences;

*M00F02 – DHMH – Community and Family Health Administration*

- cessation programs to advise adults about tobacco use as well as provide counseling and a full range of cessation services;
- surveillance and evaluation; and
- administration and management.

For each program element, CDC established an upper and lower spending limit through a formula based on population while noting that the actual funding required for implementing programs would vary depending on state characteristics such as sociodemographic factors and tobacco use prevalence. For Maryland, the CDC lower per-capita spending limit for a comprehensive program was \$5.95 per capita, with an upper limit of \$15.43 per capita. For the purposes of this analysis, for subsequent years the CDC limits have been adjusted for population growth but not inflation (in the new 2007 report, CDC recommends adjusting the limits for inflation).

CDC recently updated its recommendations for spending on a comprehensive tobacco control program. It also refined the program elements as follows:

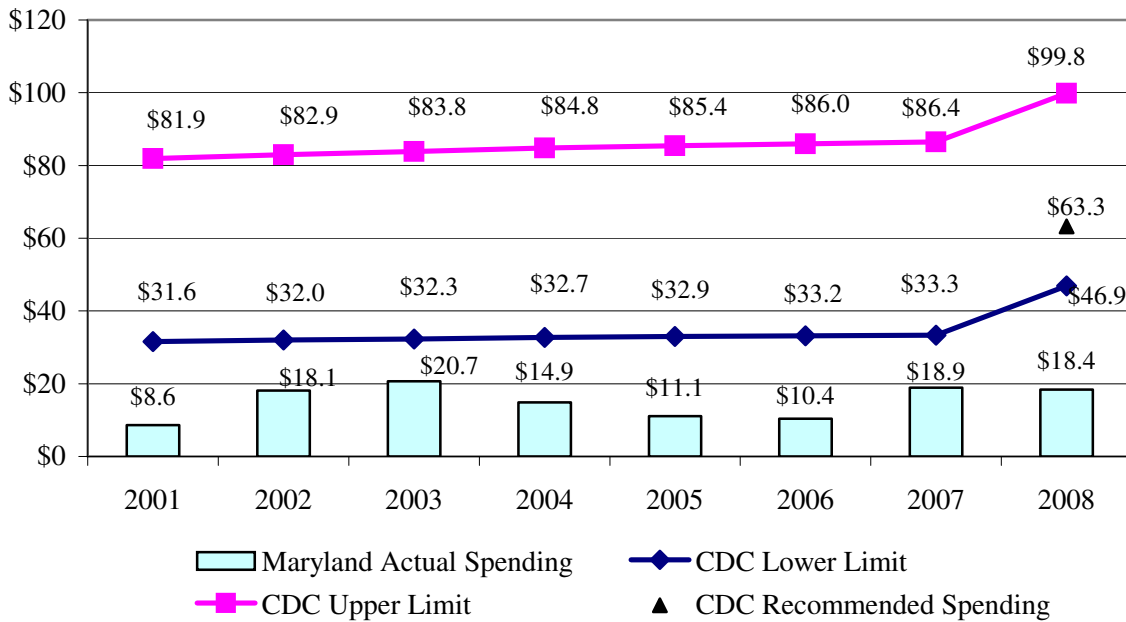
- State and community interventions that incorporate a variety of activities including chronic disease and tobacco-related disparity elimination initiatives and interventions specifically aimed at influencing youth;
- health communications interventions;
- cessation interventions;
- surveillance and evaluation; and
- administration and management.

Again, for each element CDC established upper and lower spending limits and in addition a recommended spending amount. The revised 2007 spending recommendations raise the bar for states in terms of funding comprehensive tobacco control programs. For Maryland, the lower per capita limit was increased to \$8.35 per capita, with an upper limit of \$17.77 per capita, and a recommended spending level of \$11.26 per capita.

## Maryland Spending on Tobacco Control Activities Compared to CDC Recommendations

**Exhibit 16** details Maryland spending on tobacco control activities since fiscal 2001 and compares that spending to the CDC upper and lower limits and, for fiscal 2008, CDC’s recommended spending amount. For this exhibit, Maryland spending is determined as that budgeted on tobacco use prevention and cessation in DHMH. This budget is primarily supported through the CRF but also includes a small level of State general funds. It should be noted that this excludes funding of OAG for enforcement activities and also some funding of tobacco disease-related research funded in the cancer prevention, screening and treatment program.

**Exhibit 16**  
**Maryland Spending on Tobacco Control Activities**  
**Compared to CDC Recommendations**  
**Fiscal 2001-2008**  
**(\$ in Millions)**

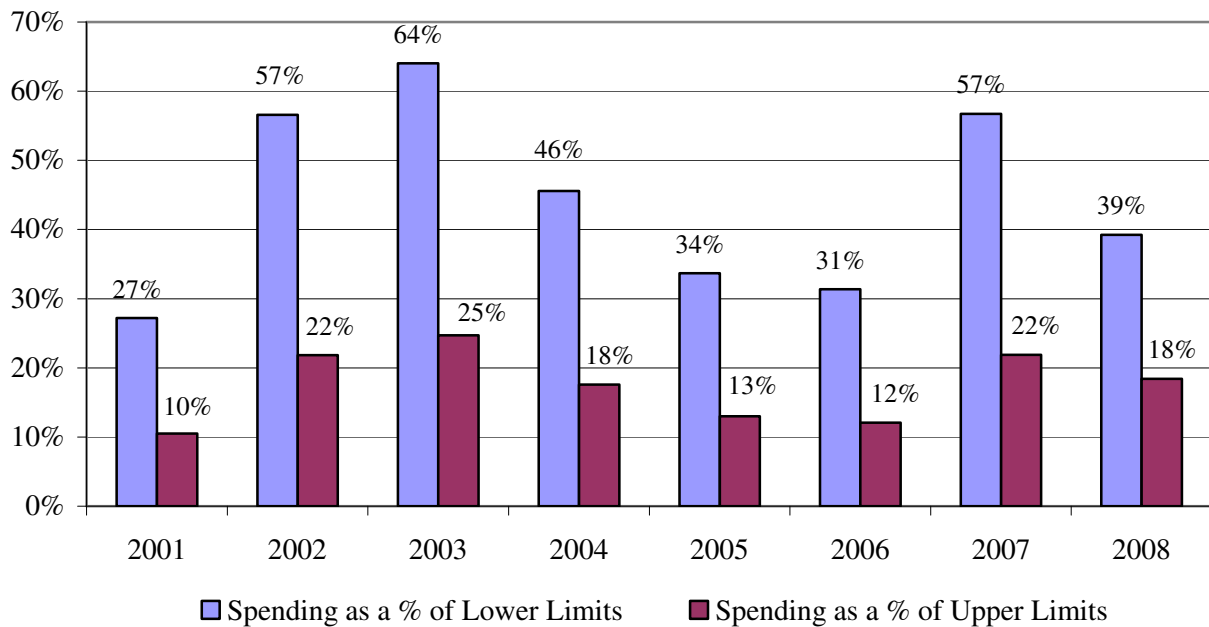


CDC: Center for Disease Control and Prevention

Source: Department of Legislative Services; Center for Disease Control and Prevention; Department of Health and Mental Hygiene; Maryland Department of Planning

As shown in the exhibit, Maryland spending on tobacco control activities has never reached the CDC recommended lower spending limit. **Exhibit 17** shows the same information as a percentage of CDC recommended lower and upper spending limits. With significant changes to CRF spending after fiscal 2001, primarily shifting spending to health-related programming from educational activities, in fiscal 2002 and 2003, tobacco control spending in Maryland was over 50% of the CDC lower spending limit. However, funding fell significantly in fiscal 2004 through 2006 as overall CRF revenues fell. Expenditures increased in fiscal 2007 and again went above 50% of the CDC recommended lower spending limit. While spending levels are relatively flat in fiscal 2008, the revised CDC recommended limits again sees Maryland's spending level fall below 50% of the lower spending limit.

**Exhibit 17**  
**Maryland Spending on Tobacco Control Activities as a Percentage of CDC Recommendations**  
**Fiscal 2001-2008**

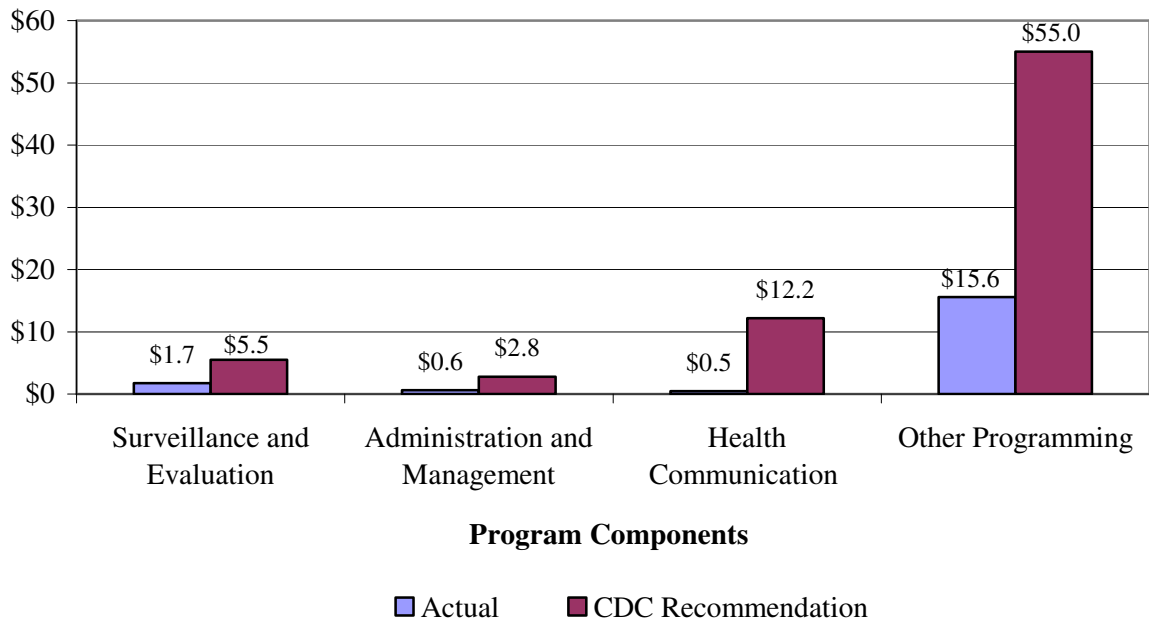


Source: Department of Legislative Services; Center for Disease Control and Prevention; Department of Health and Mental Hygiene; Maryland Department of Planning

As also clearly shown in the exhibit, Maryland's spending on tobacco control activities has never risen above one-quarter of the CDC upper spending limits.

From an accounting standpoint, Maryland’s tobacco control program elements are not exactly the same as those articulated by CDC. However, looking at fiscal 2008 only, **Exhibit 18** compares program element spending for Maryland to the CDC program element recommended level in three areas: surveillance and education, health communications (equated to counter-marketing spending), and administration and management. For the purpose of this exhibit, the remaining two program elements identified by CDC (State and Community Interventions and Cessation Interventions) are combined into “other programming.”

**Exhibit 18**  
**Spending on CDC Recommended Comprehensive Tobacco Control Program Elements**  
**Maryland Compared to CDC Recommended Level**  
**Fiscal 2008**  
**(\$ in Millions)**



Source: Department of Legislative Services; Center for Disease Control and Prevention; Department of Health and Mental Hygiene; Maryland Department of Planning

Under the revised CDC recommendations, Maryland’s spending on its tobacco control program reaches only 28% of the recommended level. Thus, unsurprisingly, spending on each program element falls short of the individual CDC recommendations. The most obvious shortfall is in the area of health communications.

## **Conclusion**

Maryland, like all other states, fails to meet the CDC recommended spending level on tobacco control programs in fiscal 2008. According to the Campaign for Tobacco-free Kids, only three states (Colorado, Delaware, and Maine) exceed the CDC minimum spending limit. Maryland currently ranks nineteenth amongst the states in terms of spending as a percentage of the CDC minimum spending limit.

However, SB 513/HB 1095 of 2008 propose to change Maryland's status on this issue by mandating that beginning in fiscal 2012, the Governor provide enough funding in the tobacco prevention budget to meet or exceed the CDC recommended level of funding for comprehensive tobacco control programs in the State. Also, the bills propose to specify that tobacco tax revenues be distributed to the CRF program to fund tobacco prevention programming.

It should be noted that Maryland has a strong record of using its CRF funds for health-related activities, including tobacco control. In fiscal 2008, 93% of the expenditures supported by the CRF are health-related. Although Medicaid is the largest single user of CRF funds, it should be noted that the original intent of the tobacco lawsuits filed by the states were to compensate them for expenses borne by the Medicaid programs.

### **3. Stockpile of Antivirals**

The timing of an influenza pandemic cannot be predicted (the most recent pandemics occurred in 1918, 1957, and 1968). Because antiviral drugs have a limited shelf-life, long-term maintenance of stockpiles may constitute a significant cost. Similarly, the size of a pandemic cannot be accurately foreseen. Therefore, it may be essential to conserve limited antiviral drug stockpiles.

As part of the CDC's Pandemic Influenza Strategy Program, the federal government has offered the states a subsidized price to purchase antiviral drugs to develop antiviral drug stockpiles. Through this arrangement with CDC, states are able to purchase antiviral treatment doses of Tamiflu or Relenza.

Both Tamiflu and Relenza are used to treat symptoms caused by the flu virus (influenza). It helps make the symptoms (e.g., stuffy nose, fever/chills, aches, tiredness) less severe and shortens the recovery time by a couple of days. However, while Tamiflu is approved for use in children age one and older; Relenza is only approved for ages seven and older. Also, Tamiflu can also be used to prevent the flu for people that have been exposed to someone who already has the flu.

The subsidized price is available for an allotment of treatment doses to cover approximately 25% of each state's population. For Maryland that is 578,754 treatment doses, and OPR has reserved the total amount of treatment doses allowable under the current agreement. Also, OPR has requested 578,754 additional doses should another opportunity be available in the future.

Although OPR has reserved 578,754 doses, as of October 30, 2008, DHMH had actually purchased only 210,727 treatment doses (168,530 of Tamiflu and 42,197 of Relenza), which cost a total of \$3.1 million. OPR paid for these treatment doses with surplus federal funds with prior approval from the federal government.

The State has until June 29, 2008, to take advantage of the federal subsidized price. As shown in **Exhibit 19**, it would cost \$5.4 million to purchase the remaining 368,027 treatment doses reserved for Maryland under the current agreement. DHMH says they are currently exploring funding options through private/public partnership. **The department should update the committees on progress in establishing a public-private partnership to attain the antivirals through the federally subsidized price.**

**Exhibit 19**  
**Maryland’s Antiviral Purchase Plan**  
**As of October 30, 2007**

	Number of Treatment Dosed			Funds Used to Purchase			
	<u>Total</u>	<u>Purchased</u>	<u>Remaining</u>	<u>General</u>	<u>Private</u>	<u>Federal</u>	<u>Needed</u>
<b>Allotted Antivirals Under Current Federal Agreement</b>							
Tamiflu	462,952	168,530	294,422	\$0	\$0	\$2,431,888	\$4,248,509
Relenza	115,802	42,197	73,605	0	0	687,389	1,199,025
<b>Total</b>	<b>578,754</b>	<b>210,727</b>	<b>368,027</b>	<b>\$0</b>	<b>\$0</b>	<b>\$3,119,277</b>	<b>\$5,447,534</b>
<b>Requested Antivirals for Potential Future Federal Agreements</b>							
Tamiflu	463,003	0	463,003	\$0	\$0	\$0	\$8,908,178
Relenza	115,751	0	115,751	0	0	0	2,514,112
<b>Total</b>	<b>578,754</b>	<b>0</b>	<b>578,754</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$11,422,290</b>

Source: Department of Health and Mental Hygiene

#### 4. Local Health Department Funding Formula

The 2007 *Joint Chairmen’s Report* (JCR) directed DHMH to work with the Maryland Association of County Health Officers (MACHO) to examine the local health department funding formula. The committees were concerned with how State funding for State employees in LHDs is provided through DHMH’s Core Local Health Funding Formula (core funding). Core funding for LHDs provide funding for personnel; however, the formula does not include a cost-of-living adjustment (COLA) when a COLA is included in the State budget for State employees. DHMH and MACHO were directed to examine four specific areas:

*M00F02 – DHMH – Community and Family Health Administration*

- possible alternatives to provide more equity in compensation adjustments between State employees in the LHD and State employees generally;
- the degree to which the core funding supports programs administered by LHDs and how this funding may be supporting increases in employee compensation;
- the impact of escalating personnel costs on programs administered by the LHD; and
- implications for the State oversight associated with any change to the LHD core funding formula.

The report points out that the problem faced by LHDs in covering COLA and other compensation-related adjustments for core funded LHD State employees are similar to the problems LHDs face with categorical grant-funded LHD employees.

### **Background**

State and federal dollars are provided to LHDs through the Targeted Local Health Program, which is funded at a level established in statute. The minimum funding level for the program was established at \$41 million in general funds in fiscal 1997. In each subsequent year, the amount of general funds provided through the formula is to be adjusted for:

- Inflation, as measured by the Consumer Price Index (CPI) for all urban consumers for the second preceding fiscal year as calculated by the U.S. Department of Commerce; and
- Population growth, as measured by the growth in the total population of the State of Maryland for the second preceding fiscal year, according to the most recent statistics available through DHMH.

The increases based on inflation and population growth have increased minimum funding to almost \$60 million in fiscal 2008.

Some years the funding formula includes core funding for COLAs and compensation-related adjustments, but these adjustments are not mandated in statute. As shown in **Exhibit 20**, the funding did include funding for a COLA in most years the State provided a COLA. However, when State funding is not provided for personnel enhancements, local jurisdictions are responsible to cover these costs.

**Exhibit 20**  
**Annual Adjustments to the Core Public Health Funding Formula**  
**and State COLA**  
**Fiscal 1997-2009**

<b><u>Fiscal Year</u></b>	<b><u>Formula Increases</u></b>	<b><u>COLA Adjustments</u></b>	<b><u>Other Adjustments</u></b>	<b><u>Total</u></b>	<b><u>State COLA</u></b>
1997	\$0	\$0	\$0	\$41,000,000	None
1998	1,521,100	0	0	42,521,100	None
1999	1,264,476	1,368,698	0	45,154,274	\$900 and \$375 <sup>1</sup>
2000	978,618	1,368,524	935,721	48,437,137	\$638 and \$637 <sup>2</sup>
2001	1,199,680	1,790,770	2,576,279	54,003,866	4%
2002	2,017,814	1,631,023	2,320,550	59,973,253	4%
2003	1,962,451	0	0	61,935,704	None
2004	1,158,704	0	-2,658,704	60,435,704	None
2005	1,706,835	442,280	-1,706,835	60,877,984	\$752
2006	2,218,006	372,000	-1,609,003	61,858,987	1.50%
2007	1,848,930	576,344	-616,310	63,667,951	\$900, \$1,400, or 2% <sup>3</sup>
2008	2,889,332	434,000	0	66,991,283	2%
2009	1,769,072	0	0	68,760,355	2%
	<b>\$20,535,018</b>	<b>\$7,983,639</b>	<b>-\$758,302</b>		

COLA: cost-of-living adjustment

<sup>1</sup> Effective July 1, 1998, and January 1, 1999

<sup>2</sup> Effective July 1, 1999, and January 1, 2000

<sup>3</sup> Fiscal 2007 general salary increases are \$900 for employees making less than \$45,000 at the end of fiscal 2006, \$1,400 for employees making \$70,000 or more, and 2% for those remaining.

Source: Department of Health and Mental Hygiene; Maryland State Budget; Department of Legislative Services

**Possible Alternatives for More Equitable Compensation**

DHMH and MACHO recommend that the current statute be amended in two ways. First, instead of the core funding adjusting annually for inflation based on the CPI, the annual change should be based on the percent change in State salaries and fringe benefits. Second, statute should require COLAs and other compensation-related adjustments to be equitably distributed to all LHDs.

## **Degree to Which Core Funding Supports LHD Operations**

LHD financial data was obtained for the period fiscal 2005 through 2007. However, DHMH and MACHO were only able to use the data from 20 out of the 24 jurisdictions to conduct the analysis because the four excluded jurisdictions (Baltimore City, Baltimore County, Montgomery County, and Prince George's County) do not report through the State Financial Management Information System. For the 20 jurisdictions, salaries and related fringe benefits from core funding (through the funding formula and the local matching funds) comprise almost 80.0% of LHD expenditures (ranging from 76.4% to 79.8%)

## **Impact of Escalating Personnel Costs in LHDs**

The DHMH/MACHO report in response to the JCR request included a comparison of the annual percent changes in core funding with the annual percent changes to the average cost of salaries and fringe benefits for LHD State employees. On average, annual increases in core funding were lower than the increases in salaries and fringe benefits for a typical LHD State employee (4.2% versus 5.7%). In light of significant change in State financial support, LHDs acted to limit increases in personnel costs as salaries and fringe benefits for typical LHD State employees increased on average by only 2.05% annually during the fiscal 2004 to 2007 period.

## **Implications for State Oversight**

DHMH and MACHO assert that the implications for State oversight would depend upon the extent of any changes to statute. For example, if the report's recommendations are implemented, no change with respect to State oversight would be indicated. However, a greater State financial commitment could lead to an enhanced level of State oversight.

**The department should comment on whether either of the recommendations discussed in the report are being pursued.**

## ***Recommended Actions***

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- |   | <b><u>Amount<br/>Reduction</u></b> |    |
|---|------------------------------------|----|
| 1. Reduce general fund support for the Women, Infant, and Children Food Program. Statute mandates that the Governor include in the budget allowance at least \$250,000 in general funds to support the administrative and food costs of the Women, Infant, and Children Food Program. The Family Health Administration (FHA) uses \$65,000 of this appropriation to receive a federal fund match for the Farmers Market Coupon Program, which is dually administered by FHA and the Maryland Department of Agriculture. The remaining funds are used to supplement the federal funding for the program, which has been sufficient in recent years to cover the cost of the program. | \$ 185,000                         | GF |
| 2. Add the following language to the general fund appropriation:<br><br><u>, provided that \$1,000,000 of this appropriation for the Office of Minority Health and Health Disparities to reduce infant mortality may not be expended for that purpose and may only be used to fund the expansion of the Family Health Administration’s Babies Born Healthy program.</u>   |                                    |    |

**Explanation:** The Governor’s allowance provides new general funds in the amount of \$1.0 million for the Office of Minority Health and Health Disparities to reduce infant mortality. However, by statute, the General Assembly has expressed intent that the Office of Minority Health and Health Disparities be funded with federal and special fund sources. Also, in anticipation of receiving additional general funds in fiscal 2009, the Family Health Administration (FHA) has a comprehensive plan to utilize the funding in the manner intended in the allowance through the expansion of the Babies Born Healthy program. Therefore, the \$1.0 million dollars would be best utilized through the Babies Born Healthy program that is administered by FHA.

*M00F02 – DHMH – Community and Family Health Administration*

	<b><u>Amount Reduction</u></b>	
3. Delete general funds to reduce health disparities in the Office of Minority Health and Health Disparities. By statute, the General Assembly has expressed intent that the Office of Minority Health and Health Disparities be funded with special and federal fund sources. Also, the Office of Minority Health and Health Disparities has not set forth a comprehensive plan for utilizing the funds in a manner that would effectively reduce adult health disparities.	250,000	GF
4. Reduce the funding for the new program in the Office of Oral Health for constructing and equipping community-based dental clinics. Funding for the program should be provided through the capital budget or a PAYGO appropriation.	950,000	GF
<b>Total General Fund Reductions</b>	<b>\$ 1,385,000</b>	

## ***Updates***

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### **1. Maryland Cancer Fund**

The Maryland Cancer Fund was established during the 2004 session, and it is administered by FHA. The fund is financed through voluntary contributions made primarily from an option on the State's income tax form, and the funds are to be used to award grants for cancer research, prevention, and treatment.

In October 2006, regulations were adopted to facilitate the implementation of the Maryland Cancer Fund. Fiscal 2007 was the third year funds were collected by the Maryland Cancer Fund, and the fund balance at the end of fiscal 2007 was \$1.4 million. However, the fund has yet to award grants, which was a finding in the audit of DHMH Office of the Secretary and Other Units released August 2007.

FHA anticipates that funds will be awarded in fiscal 2008. As of October 2007, grant application instructions were in draft form. Also, a grant coordinator had recently been hired to oversee the grant distribution process, finalize the grant applications, publicize the availability of funds, and convene a separate grant review committee for evaluating grants for each component of the Maryland Cancer Fund. The department anticipated that it would take until May through October 2008 to implement these activities.

## ***Current and Prior Year Budgets***

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

	<b><u>General Fund</u></b>	<b><u>Special Fund</u></b>	<b><u>Federal Fund</u></b>	<b><u>Reimb. Fund</u></b>	<b><u>Total</u></b>
<b>Fiscal 2007</b>					
Legislative Appropriation	\$115,883	\$53,619	\$127,020	\$497	\$297,019
Deficiency Appropriation	0	0	12,655	0	12,655
Budget Amendments	7,255	49	3,037	100	10,442
Reversions and Cancellations	0	-1,788	-2,067	-70	-3,925
<b>Actual Expenditures</b>	<b>\$123,138</b>	<b>\$51,881</b>	<b>\$140,645</b>	<b>\$527</b>	<b>\$316,191</b>
<b>Fiscal 2008</b>					
Legislative Appropriation	\$116,492	\$48,791	\$137,091	\$645	\$303,019
Cost Containment	-104	-3,790	0	0	-3,894
Budget Amendments	694	41	0	0	735
<b>Working Appropriation</b>	<b>\$117,082</b>	<b>\$45,042</b>	<b>\$137,091</b>	<b>\$645</b>	<b>\$299,860</b>

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

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## **Fiscal 2007**

The Community and Family Health Administrations spent \$316.2 million in fiscal 2007, which is \$19.2 million more than the legislative appropriation. General funds increased by a net of \$7.3 million through budget amendments. The general funds were moved from other agencies within DHMH, and significant increases were made in the following areas:

- \$5.0 million to cover the cost of a grant to Prince George's Hospital Center to support essential public health services;
- \$1.1 million to cover the cost of flu-mist vaccines for school children;
- \$0.8 million for COLAs; and
- \$0.3 million to cover the cost of federal requirements of the Health Insurance Portability and Accountability Act.

Also, general funds decreased by \$0.4 million in the area of salaries and wages for purposes of cost containment.

Budget amendments added an additional \$49,487 in special funds for COLAs (\$32,039) and human services contracts (\$17,448).

Federal funds increased by a total of \$15.7 million with \$12.7 million of the increase from deficiency appropriations and the remaining \$3.0 million from budget amendments. The federal fund deficiency appropriations went to various programs, and the major allocations are as follows:

- the WIC program due to increased participation (\$9.1 million);
- the Community Health Administration for childhood immunization (\$1.1 million), tuberculosis (\$0.2 million), and sexually transmitted disease (\$0.2 million) activities;
- the Office of Preparedness and Response to purchase the Tamiflu vaccine (\$0.8 million);
- FHA to develop a web-based data analysis portal (\$0.6 million); and
- Family Planning for HIV/AIDS grants (\$0.4 million) and a database contract (\$0.1 million).

The increase in federal funds through budget amendment was caused by increased enrollment for WIC (\$3.2 million), and this amount was offset by shortfalls in the abstinence education and the grants for State loan repayment programs.

*M00F02 – DHMH – Community and Family Health Administration*

Funds transferred from the Department of Human Resource's Maryland Office for New Americans increased reimbursable funds by \$100,404 to cover the cost of human service contracts to LHDs for refugee health screenings.

The Community and Family Health Administrations canceled \$3.9 million in fiscal 2007. Special funds were canceled due to less than anticipated CRF spending (\$1.8 million). Federal funds were canceled as a result of less than anticipated spending in the areas of emergency preparedness (\$0.8 million), hospital preparedness (\$0.6 million), WIC (\$0.6 million), and tuberculosis control (\$0.1 million).

**Fiscal 2008**

The Community and Family Health Administrations have a fiscal 2008 working appropriation of \$299.8 million, which is \$3.2 million less than the legislative appropriation. COLAs increased both general and special funds by more than \$0.7 million. However, these increases were more than offset by \$3.9 million in cost containment that reduce general funds by \$0.1 million and special funds by \$3.8 million. Cost containment reduced the following services: cancer programs (\$2,445,000), tobacco use and prevention programs (\$1,345,000), salaries (\$20,745), communications (\$18,127), supplies (\$19,666), travel (\$42,729), and fixed charges (\$2,900).

**Object/Fund Difference Report  
DHMH Community and Family Health Administration**

<u>Object/Fund</u>	<u>FY07 Actual</u>	<u>FY08 Working Appropriation</u>	<u>FY09 Allowance</u>	<u>FY08-FY09 Amount Change</u>	<u>Percent Change</u>
<b>Positions</b>					
01 Regular	350.70	345.70	340.40	-5.30	-1.5%
02 Contractual	11.75	11.17	10.50	-0.67	-6.0%
<b>Total Positions</b>	<b>362.45</b>	<b>356.87</b>	<b>350.90</b>	<b>-5.97</b>	<b>-1.7%</b>
<b>Objects</b>					
01 Salaries and Wages	\$ 24,360,229	\$ 26,307,999	\$ 27,482,746	\$ 1,174,747	4.5%
02 Technical and Spec. Fees	514,591	489,153	480,165	-8,988	-1.8%
03 Communication	630,934	635,149	658,491	23,342	3.7%
04 Travel	607,138	581,392	624,801	43,409	7.5%
07 Motor Vehicles	174,851	244,695	143,856	-100,839	-41.2%
08 Contractual Services	175,541,182	164,984,352	177,477,736	12,493,384	7.6%
09 Supplies and Materials	4,781,813	2,552,540	2,465,509	-87,031	-3.4%
10 Equip. – Replacement	195,406	39,896	0	-39,896	-100.0%
11 Equip. – Additional	866,583	748,879	674,931	-73,948	-9.9%
12 Grants, Subsidies, and Contributions	108,445,954	103,207,997	109,758,755	6,550,758	6.3%
13 Fixed Charges	72,150	67,859	65,318	-2,541	-3.7%
<b>Total Objects</b>	<b>\$ 316,190,831</b>	<b>\$ 299,859,911</b>	<b>\$ 319,832,308</b>	<b>\$ 19,972,397</b>	<b>6.7%</b>
<b>Funds</b>					
01 General Fund	\$ 123,138,322	\$ 117,081,978	\$ 126,415,198	\$ 9,333,220	8.0%
03 Special Fund	51,880,674	45,041,656	45,153,388	111,732	0.2%
05 Federal Fund	140,645,291	137,091,262	147,454,766	10,363,504	7.6%
09 Reimbursable Fund	526,544	645,015	808,956	163,941	25.4%
<b>Total Funds</b>	<b>\$ 316,190,831</b>	<b>\$ 299,859,911</b>	<b>\$ 319,832,308</b>	<b>\$ 19,972,397</b>	<b>6.7%</b>

Note: The fiscal 2008 appropriation does not include deficiencies.

**Fiscal Summary  
DHMH Community and Family Health Administration**

<u>Program/Unit</u>	<u>FY07 Actual</u>	<u>FY08 Wrk Approp</u>	<u>FY09 Allowance</u>	<u>Change</u>	<u>FY08-FY09 % Change</u>
03 Community Health Services	\$ 21,420,736	\$ 18,562,839	\$ 19,102,475	\$ 539,636	2.9%
07 Core Public Health Services	68,160,951	71,484,283	73,253,355	1,769,072	2.5%
02 Family Health Services and Primary Care	123,179,241	108,694,650	123,059,256	14,364,606	13.2%
06 Prevention and Disease Control	80,167,079	77,232,830	84,340,303	7,107,473	9.2%
01 Office of Preparedness and Response	23,262,824	23,885,309	20,076,919	-3,808,390	-15.9%
<b>Total Expenditures</b>	<b>\$ 316,190,831</b>	<b>\$ 299,859,911</b>	<b>\$ 319,832,308</b>	<b>\$ 19,972,397</b>	<b>6.7%</b>
General Fund	\$ 123,138,322	\$ 117,081,978	\$ 126,415,198	\$ 9,333,220	8.0%
Special Fund	51,880,674	45,041,656	45,153,388	111,732	0.2%
Federal Fund	140,645,291	137,091,262	147,454,766	10,363,504	7.6%
<b>Total Appropriations</b>	<b>\$ 315,664,287</b>	<b>\$ 299,214,896</b>	<b>\$ 319,023,352</b>	<b>\$ 19,808,456</b>	<b>6.6%</b>
Reimbursable Fund	\$ 526,544	\$ 645,015	\$ 808,956	\$ 163,941	25.4%
<b>Total Funds</b>	<b>\$ 316,190,831</b>	<b>\$ 299,859,911</b>	<b>\$ 319,832,308</b>	<b>\$ 19,972,397</b>	<b>6.7%</b>

Note: The fiscal 2008 appropriation does not include deficiencies.