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**Department of Health and  
Mental Hygiene  
Fiscal 2009 Budget Overview**

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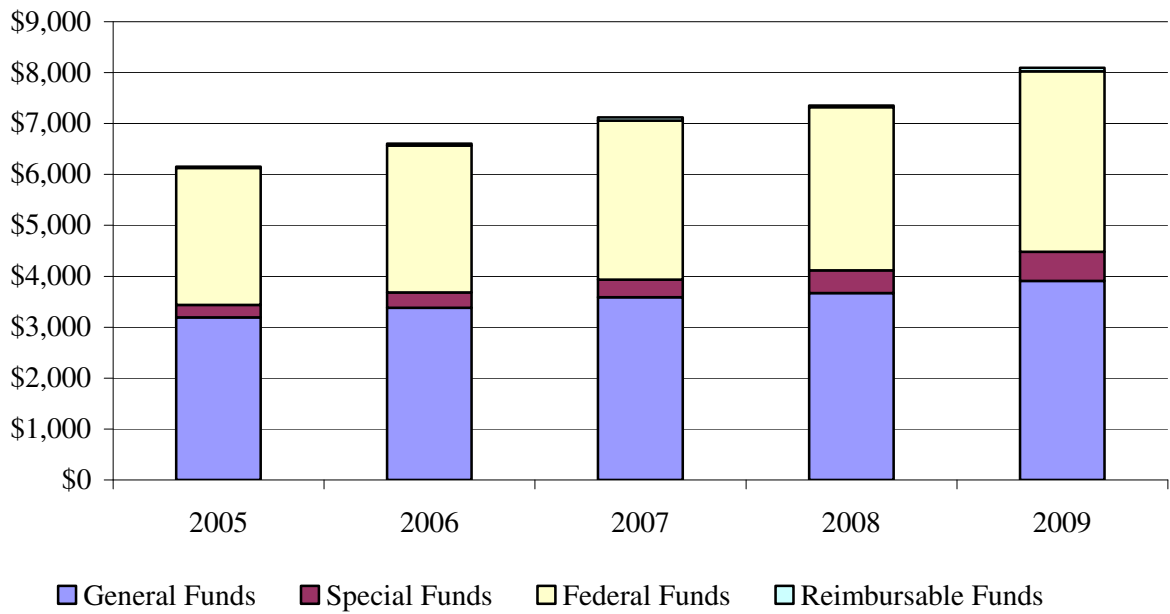
**Department of Legislative Services  
Office of Policy Analysis  
Annapolis, Maryland**

**January 2008**

*M00 – DHMH – Fiscal 2009 Budget Overview*

**M00**  
**Department of Health and Mental Hygiene**  
**Fiscal 2009 Budget Overview**

**Department of Health and Mental Hygiene**  
**Five-year Funding Trends**  
**Fiscal 2005-2009**  
**(\$ in Millions)**



*M00 – DHMH – Fiscal 2009 Budget Overview*

**Department of Health and Mental Hygiene  
Budget Overview: Expenditure Growth Accelerates  
Fiscal 2005-2009  
(\$ in Millions)**

	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>	<b>Change 2007-08</b>
Operations	\$540	\$566	\$612	\$626	\$648	\$22
Contractual Services	5,518	5,943	6,395	6,614	7,329	\$715
Grants	96	95	114	112	120	\$7
<b>Total</b>	<b>\$6,154</b>	<b>\$6,604</b>	<b>\$7,121</b>	<b>\$7,352</b>	<b>\$8,096</b>	<b>\$744</b>
General Fund	\$3,191	\$3,382	\$3,588	\$3,671	\$3,911	\$240
Special Fund	\$248	\$303	\$348	\$443	\$569	\$126
Federal Funds	\$2,686	\$2,884	\$3,121	\$3,208	\$3,548	\$340
Reimbursable Funds	\$29	\$36	\$64	\$30	\$68	\$38
<b>Total</b>	<b>\$6,154</b>	<b>\$6,604</b>	<b>\$7,121</b>	<b>\$7,352</b>	<b>\$8,096</b>	<b>\$744</b>
<b>Annual % Change from Prior Year</b>	<b>4.5%</b>	<b>7.3%</b>	<b>7.8%</b>	<b>3.2%</b>	<b>10.1%</b>	

Note: Excludes fiscal 2008 deficiencies and fiscal 2009 contingent reductions.

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

*M00 – DHMH – Fiscal 2009 Budget Overview*

**Department of Health and Mental Hygiene  
Fiscal 2008 Deficiencies, Planned General Fund Reversions and  
Revenue Adjustments, and Fiscal 2009 Contingent Appropriation  
Reductions and Revenue Adjustments**

<u>Program</u>	<u>Item</u>	<u>General Fund Impact</u>	<u>Total Fund Impact</u>
<b>Fiscal 2008 Deficiencies</b>			
Community and Family Health Administrations	Increased federal funding for Women, Infants, and Children (WIC) program	\$0	\$12,931,385
Developmental Disabilities Administration	Supplemental funding to leverage additional revenues from the ICF-MR provider fee on State Residential Centers	598,863	598,863
<b>Fiscal 2008 Deficiencies Total</b>		<b>\$598,863</b>	<b>\$13,530,248</b>
<b>Fiscal 2008 Planned General Fund Reversions</b>			
Medicaid	Overbudgeted fiscal 2007 funds	30,000,000	
Medicaid	Overbudgeted fiscal 2007 Maryland Children's Health Program funds	1,000,000	
<b>Fiscal 2009 Contingent Reductions and Appropriations</b>			
Medicaid	Reduction contingent on legislation authorizing the use of additional funding from the Rate Stabilization Fund during fiscal 2009 (if approved this general fund reduction is back-filled by special funds)	\$21,275,000	
AIDS	\$2.2 million of special funds is contingent on legislation clarifying that drug rebate funding is held in a non-lapsing special fund		2,200,000
<b>Fiscal 2008 and 2009 Revenue Adjustments</b>		<b>Fiscal 2008</b>	<b>Fiscal 2009</b>
Fees collected by Vital Records for birth certificates required by Medicaid to comply with new federal mandates regarding citizenship and identification verification (Note: This double-counts revenue already anticipated for fiscal 2008.)		\$1,560,000	
State Residential Center Hospital Recoveries and ICF-MR tax revenues		-1,702,923	-11,729,782

ICF-MR: Immediate Care Facilities for the Mentally Retarded

Source: Department of Legislative Services; Governor's Budget Books, Fiscal 2009

*M00 – DHMH – Fiscal 2009 Budget Overview*

**Department of Health and Mental Hygiene  
Budget Overview: All Funding Sources  
Fiscal 2007-2009  
(\$ in Thousands)**

	<b>Actual 2007</b>	<b>Working 2008</b>	<b>Allowance 2009</b>	<b>\$ Change 2008-09</b>	<b>% Change 2008-09</b>
<b>Medical Programs/Medicaid</b>	<b>\$4,777,045</b>	<b>\$4,922,388</b>	<b>\$5,503,340</b>	<b>\$580,952</b>	<b>11.8%</b>
Provider Reimbursements	4,534,122	4,664,467	5,130,828	466,361	10.0%
MD Children’s Health Program	179,039	190,217	194,901	4,684	2.5%
Other	63,884	67,704	177,611	109,907	162.3%
<b>Mental Hygiene</b>	<b>\$858,338</b>	<b>\$893,638</b>	<b>\$939,415</b>	<b>\$45,777</b>	<b>5.1%</b>
Program Direction	7,094	7,178	7,621	443	6.2%
Community Services	568,501	605,343	633,537	28,194	4.7%
Facilities	282,743	281,117	298,257	17,140	6.1%
<b>Developmental Disabilities</b>	<b>\$705,701</b>	<b>\$742,266</b>	<b>\$787,898</b>	<b>\$45,632</b>	<b>6.1%</b>
Program Direction	6,212	5,854	5,900	46	0.8%
Community Services	621,696	660,352	714,268	53,916	8.2%
Facilities	77,793	76,060	67,730	-8,330	-11.0%
<b>Community and Family Health</b>	<b>\$316,191</b>	<b>\$299,860</b>	<b>\$319,832</b>	<b>\$19,972</b>	<b>6.7%</b>
Targeted Local Health	68,161	71,484	73,253	1,769	2.5%
Women, Infants, and Children	74,510	72,871	86,829	13,957	19.2%
Cigarette Restitution Fund					
Tobacco and Cancer	50,122	46,218	46,555	337	0.7%
Other	123,398	109,287	113,195	3,909	3.6%
<b>Alcohol and Drug Abuse</b>	<b>\$138,256</b>	<b>\$143,132</b>	<b>\$148,491</b>	<b>\$5,359</b>	<b>3.7%</b>
<b>Other Budget Areas</b>	<b>\$325,542</b>	<b>\$350,923</b>	<b>\$396,822</b>	<b>\$45,899</b>	<b>13.1%</b>
DHMH Administration	43,962	44,425	48,079	3,654	8.2%
Office of Health Care Quality	14,935	15,675	17,675	2,000	12.8%
Health Occupations Boards	21,485	24,481	27,182	2,701	11.0%
Chronic Disease Hospitals	44,002	44,164	47,017	2,853	6.5%
AIDS Administration	68,670	71,071	70,933	-138	-0.2%
Chief Medical Examiner	8,888	8,895	9,589	694	7.8%
Laboratories Administration	22,533	22,454	22,846	392	1.7%
Health Regulatory Commissions	101,067	119,758	153,501	33,743	28.2%
<b>Total Funding</b>	<b>\$7,121,072</b>	<b>\$7,352,207</b>	<b>\$8,095,798</b>	<b>\$743,591</b>	<b>10.1%</b>

DHMH: Department of Health and Mental Hygiene

Notes: Numbers may not sum to total due to rounding.  
Excludes fiscal 2008 deficiencies and fiscal 2009 contingent reductions.

Source: Department of Legislative Services; Governor’s Budget Books, Fiscal 2009

*M00 – DHMH – Fiscal 2009 Budget Overview*

**Department of Health and Mental Hygiene  
Budget Overview: General Funds Only  
Fiscal 2007-2009  
(\$ in Thousands)**

	<u>Actual</u> <u>2007</u>	<u>Working</u> <u>2008</u>	<u>Allowance</u> <u>2009</u>	<u>\$ Change</u> <u>2008-09</u>	<u>% Change</u> <u>2008-09</u>
<b>Medical Programs/Medicaid</b>	<b>\$2,227,123</b>	<b>\$2,261,952</b>	<b>\$2,435,541</b>	<b>\$173,589</b>	<b>7.7%</b>
Provider Reimbursements	2,132,843	2,162,194	2,319,249	157,055	7.3%
MD Children’s Health Program	60,498	65,859	67,768	1,909	2.9%
Other	33,782	33,898	48,524	14,626	43.1%
<b>Mental Hygiene</b>	<b>\$594,784</b>	<b>\$623,262</b>	<b>\$653,369</b>	<b>\$30,107</b>	<b>4.8%</b>
Program Direction	5,629	5,621	5,892	271	4.8%
Community Services	313,551	343,925	356,955	13,030	3.8%
Facilities	275,604	273,716	290,522	16,806	6.1%
<b>Developmental Disabilities</b>	<b>\$453,634</b>	<b>\$472,965</b>	<b>\$486,306</b>	<b>\$13,341</b>	<b>2.8%</b>
Program Direction	4,646	4,346	4,304	-42	-1.0%
Community Services	371,589	392,971	414,704	21,733	5.5%
Facilities	77,399	75,648	67,298	-8,350	-11.0%
<b>Community and Family Health</b>	<b>\$123,138</b>	<b>\$117,082</b>	<b>\$126,415</b>	<b>\$9,333</b>	<b>8.0%</b>
Targeted Local Health	68,161	71,484	73,253	1,769	2.5%
Women, Infants, and Children	250	250	250	0	0.0%
Cigarette Restitution Fund					
Tobacco and Cancer	1,374	1,092	1,109	17	1.6%
Other	53,354	44,255	51,802	7,547	17.1%
<b>Alcohol and Drug Abuse</b>	<b>\$84,677</b>	<b>\$89,833</b>	<b>\$94,081</b>	<b>\$4,248</b>	<b>4.7%</b>
<b>Other Budget Areas</b>	<b>\$104,647</b>	<b>\$106,029</b>	<b>\$115,146</b>	<b>\$9,117</b>	<b>8.6%</b>
DHMH Administration	25,746	25,565	29,563	3,998	15.6%
Office of Health Care Quality	9,217	9,713	10,963	1,250	12.9%
Health Occupations Boards	220	317	337	20	6.3%
Chronic Disease Hospitals	38,961	38,867	41,583	2,716	7.0%
AIDS Administration	4,328	4,693	4,542	-151	-3.2%
Chief Medical Examiner	8,610	8,617	9,281	664	7.7%
Laboratories Administration	17,565	18,257	18,877	620	3.4%
Health Regulatory Commissions	0	0	0	0	0.0%
<b>Total Funding</b>	<b>\$3,588,004</b>	<b>\$3,671,123</b>	<b>\$3,910,859</b>	<b>\$239,736</b>	<b>6.5%</b>

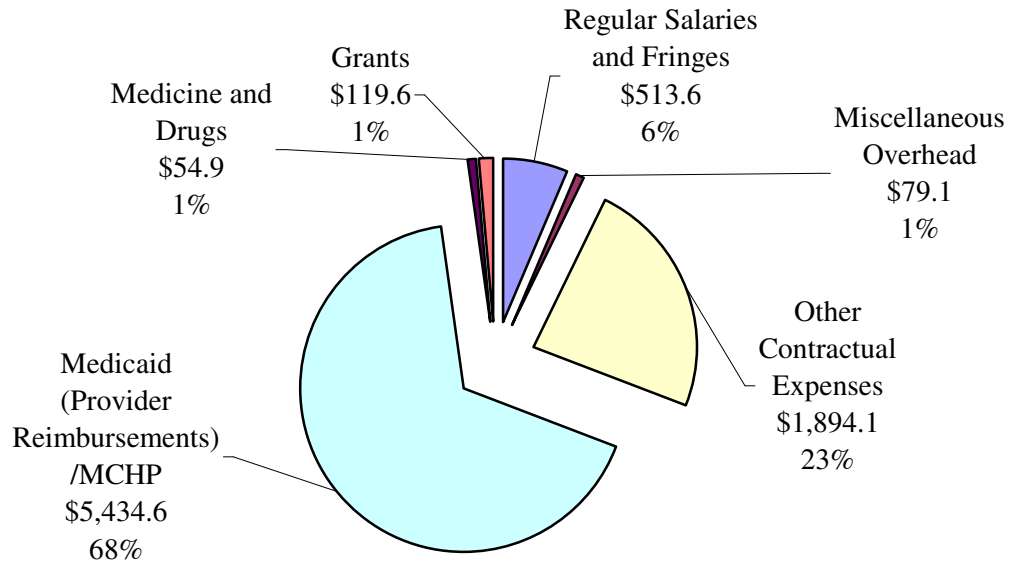
DHMH: Department of Health and Mental Hygiene

Notes: Numbers may not sum to total due to rounding.  
Excludes fiscal 2008 deficiencies and fiscal 2009 contingent reductions.

Source: Department of Legislative Services; Governor’s Budget Books, Fiscal 2009

*M00 – DHMH – Fiscal 2009 Budget Overview*

**Department of Health and Mental Hygiene  
Functional Breakdown of Spending  
Fiscal 2009 Allowance  
(\$ in Millions)**



MCHP: Maryland Children's Health Program

*M00 – DHMH – Fiscal 2009 Budget Overview*

**Governor’s Proposed Budget Changes  
Department of Health and Mental Hygiene  
(\$ in Thousands)**

	<u>General Fund</u>	<u>Special Fund</u>	<u>Federal Fund</u>	<u>Reimb. Fund</u>	<u>Total</u>
2008 Working Appropriation	\$3,671,123	\$443,436	\$3,207,581	\$30,067	\$7,352,207
2009 Governor’s Allowance	<u>3,910,860</u>	<u>569,176</u>	<u>\$3,547,793</u>	<u>67,970</u>	<u>8,095,799</u>
Amount Change	239,737	125,740	340,212	37,902	743,592
Percent Change	6.5%	28.4%	10.6%	126.1%	10.1%

**Where It Goes:**

<b>Major Personnel Expense Changes</b>	<b>\$22,645</b>
Health insurance: reduce long-term OPEB liability .....	24,633
Employee and retiree health insurance pay-as-you-go costs .....	8,520
Fiscal 2008 Budget Section 45 one-time hiring freeze savings.....	4,044
Other fringe benefit adjustments .....	47
Regular earnings (increments and new positions offset by position abolitions) .....	-406
Workers’ compensation premium assessment.....	-1,002
Turnover .....	-1,779
Personnel savings from the closure of Rosewood offset by additional costs at other facilities for forensic patients currently served at Rosewood.....	-11,411
<b>Major Programmatic Changes (Excluding Medicaid)</b>	<b>\$139,348</b>
<b>Alcohol and Drug Abuse Administration</b>	
Provider cost-of-living adjustment (1.5%) .....	1,900
Annualization and expansion of Buprenorphine Therapy Expansion .....	1,600
Statewide contracts.....	1,500
<b>Mental Hygiene Administration</b>	
Community mental health fee-for-service enrollment, utilization, and a 1.5% provider cost-of-living adjustment.....	14,579
End hospital day limits 12/31/2008.....	5,625
RTC Diversion .....	5,607
Veterans mental health .....	3,100
<b>Developmental Disabilities Administration</b>	
Deinstitutionalization (services to 153 clients) .....	20,547
Transitioning youth initiative (services to 625 clients) .....	12,331
Provider cost-of-living-adjustment (1.5%).....	8,135
Annualization of prior year community placements .....	5,262
Emergency placements (services to 106 clients).....	3,120
Waiting List Equity Fund (services to 80 clients).....	2,707
<b>Community and Family Health Administrations</b>	
WIC (supplemental nutrition grants and counseling).....	13,957
Transfer of UMMS subsidy for uncompensated care and capital costs for Montebello at Kernan....	3,055
Targeted local health formula .....	1,769

**M00 – DHMH – Fiscal 2009 Budget Overview**

**Where It Goes**

Expansion of Oral Health Safety Net Program (grants to Southern Maryland and Eastern Shore) .....	1,400
Babies Born Healthy program expansion with a focus on health disparities .....	1,000
Expansion of school-based dental services .....	700

**Other Programs**

Health Regulatory Commissions: Implementation of Chapter 7 of 2007 special session; Small Employer Health Benefit Plan Premium Subsidy Program .....	30,000
Health Regulatory Commissions: Increase in Uncompensated Care Fund .....	3,000
Health Regulatory Commissions: Increase in Community Health Resource Commission Grants .....	1,500
Office of Preparedness and Response: reductions in various federal grants .....	-3,046

**Medicaid/Medical Care Programs Administration** **\$580,190**

Medical inflation and utilization changes increase 5.4% – does not include MCO rate increase for calendar 2009.....	\$302,554
Medicaid expansion to adults (Chapter 7 of 2007 special session).....	94,550
Enrollment growth of about 3% – primarily children .....	55,468
Nursing home cost containment offset by nursing assessment and rate increase.....	55,211
End hospital day limits 12/31/2008.....	31,875
Double-budgeted general funds (reduction contingent on legislation enabling use of funds from the Rate Stabilization fund) .....	21,275
Increase Medicaid’s dental provider reimbursements .....	14,000
Enhance physician rates with HMO premium tax revenues/federal matching funds.....	9,200
Home- and community-based provider rates (1.5% increase) .....	3,557
Use of anti-psychotic drugs .....	-2,000
Shift MCO calendar 2009 quality incentive funding to fiscal 2010.....	-2,500
Additional rebates from HIV drug carve-out .....	-3,000

**Other** **\$1,410**

**Total Change** **\$743,592**

- HMO: Health Maintenance Organization
- MCO: Managed Care Organization
- OPEB: Other Post Employment Benefits
- RTC: Residential Treatment Center
- WIC: Women, Infants, and Children Food Program
- UMMS: University of Maryland Medical System

Note: Numbers may not sum to total due to rounding

*M00 – DHMH – Fiscal 2009 Budget Overview*

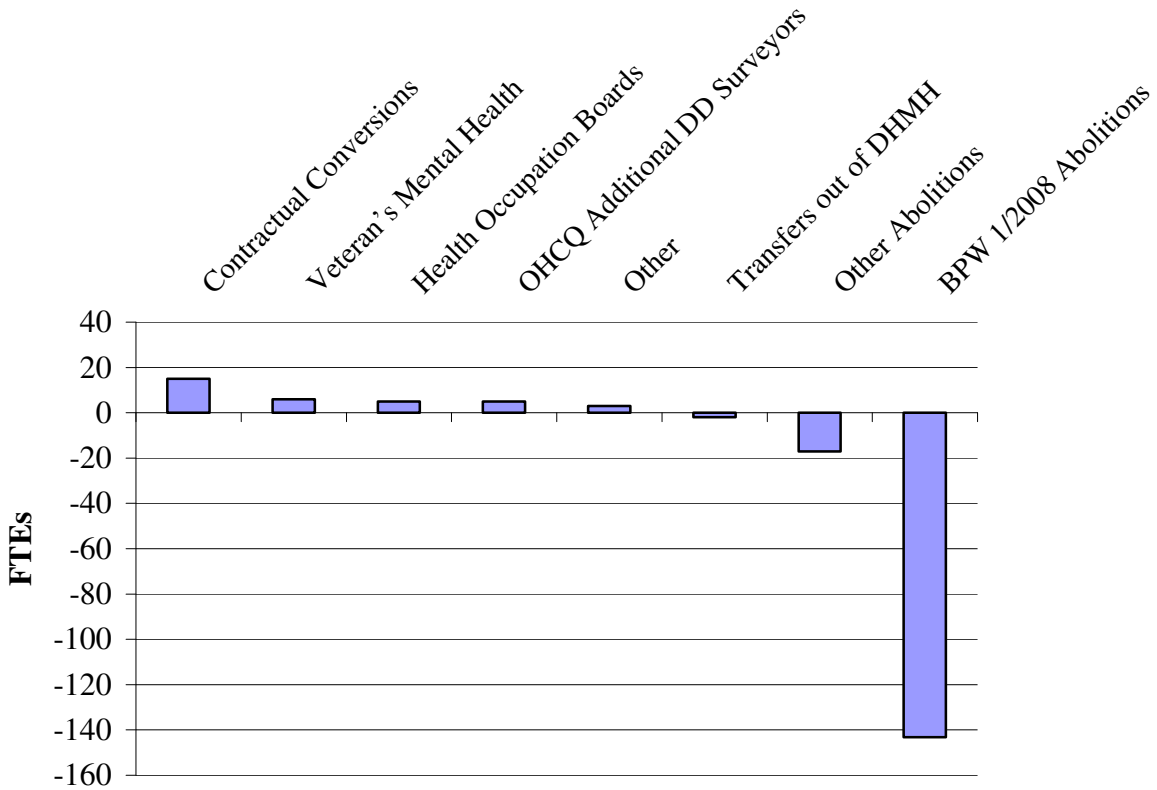
**Department of Health and Mental Hygiene  
Regular Employees (FTEs)  
Fiscal 2007-2009**

	<b>Actual <u>2007</u></b>	<b>Working <u>2008</u></b>	<b>Allowance <u>2009</u></b>	<b>Change <u>2008-09</u></b>	<b>% Change <u>2008-09</u></b>
DHMH Administration	489.5	479.2	468.2	-11.0	-2.3%
Office of Health Care Quality	194.4	194.4	199.4	5.0	2.6%
Health Occupations Boards	228.0	231.3	242.3	11.0	4.8%
Community and Family Health Administrations	350.7	345.7	340.4	-5.3	-1.5%
AIDS Administration	124.0	121.0	111.0	-10.0	-8.3%
Chief Medical Examiner	76.0	80.0	80.0	0.0	0.0%
Chronic Hospitals	568.3	568.3	566.3	-2.0	-0.4%
Laboratories Administration	271.5	261.0	253.0	-8.0	-3.1%
Alcohol and Drug Abuse Administration	65.0	63.0	62.0	-1.0	-1.6%
Mental Hygiene Administration	3,389.1	3,357.3	3,333.7	-23.6	-0.7%
Administration Institutions	101.7	97.9	101.4	3.5	3.6%
Developmental Disabilities Administration	3,287.4	3,259.4	3,232.4	-27.1	-0.8%
Administration Institutions	1,232.2	1,232.5	1,160.0	-72.5	-5.9%
Medical Care Programs Administration	171.0	178.8	174.8	-4.0	-2.2%
Health Regulatory Commissions	1,061.2	1,053.7	985.2	-68.5	-6.5%
Administration	606.3	605.0	601.0	-4.0	-0.7%
Health Regulatory Commissions	96.9	99.4	92.6	-6.8	-6.8%
<b>Total Regular Positions</b>	<b>7,691.8</b>	<b>7,638.0</b>	<b>7,509.9</b>	<b>-128.1</b>	<b>-1.7%</b>

Source: Governor's Budget Books, Fiscal 2009

*M00 – DHMH – Fiscal 2009 Budget Overview*

**Department of Health and Mental Hygiene  
Regular Employee Position Change (FTEs)  
Fiscal 2008-2009**



BPW: Board of Public Works  
DD: Developmental Disability  
DHMH: Department of Health and Mental Hygiene  
OHCQ: Office of Health Care Quality

*M00 – DHMH – Fiscal 2009 Budget Overview*

**Department of Health and Mental Hygiene  
Regular Employees (FTEs) – Vacancy Rates  
December 28, 2007**

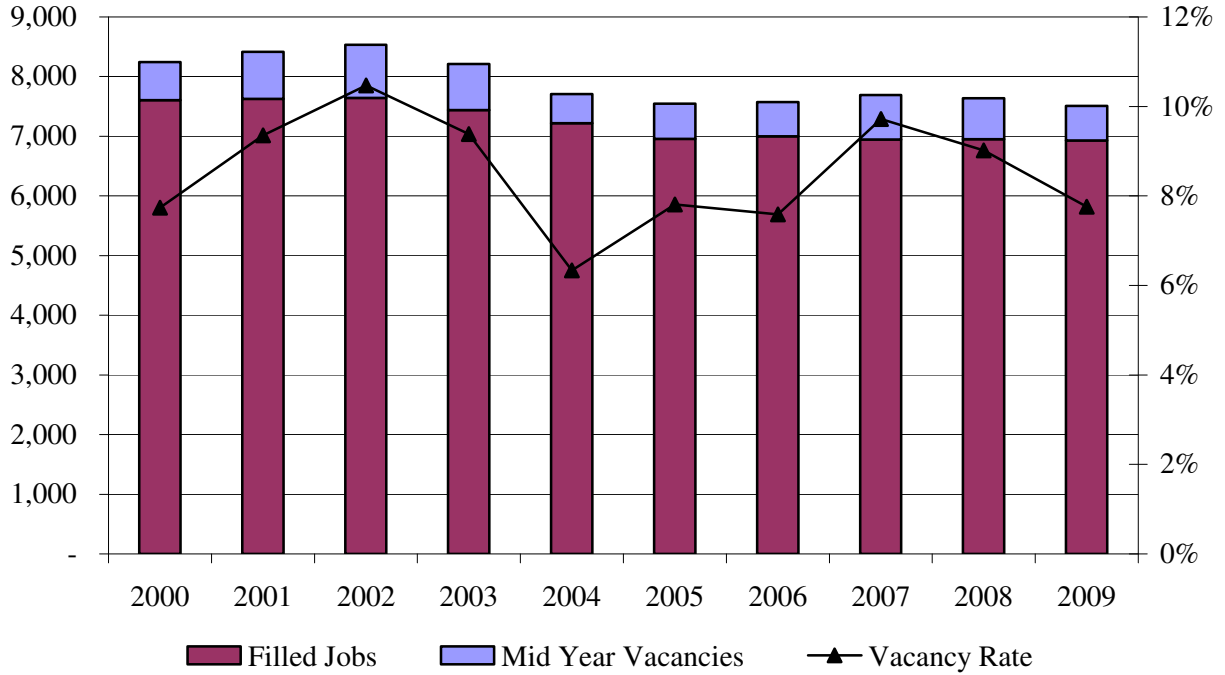
	<u>FTE Positions</u>	<u>FTE Vacancies</u>	<u>Vacancy Rate</u>
DHMH Administration	479.2	40.6	8.47%
DHMH Office of Health Care Quality	194.4	27.6	14.20%
DHMH Health Occupation Boards	231.3	22.5	9.73%
DHMH Community and Family Health Administration	345.7	24	6.94%
DHMH AIDS Administration	121	25	20.66%
DHMH Office of the Chief Medical Examiner	80	9.5	11.88%
DHMH Chronic Disease Services	568.3	57.75	10.16%
DHMH Laboratories Administration	261	35	13.41%
DHMH Alcohol and Drug Abuse Administration	63	6	9.52%
DHMH Mental Hygiene Administration	3,357.25	247.55	7.37%
DHMH Developmental Disabilities Administration	1,232.45	119.5	9.70%
DHMH Medical Care Programs Administration	605	57	9.42%
DHMH Health Regulatory Commissions	99.4	16.6	16.70%
<b>Total</b>	<b>7,638</b>	<b>688.6</b>	<b>9.0%</b>

DHMH: Department of Health and Mental Hygiene

Source: Governor's Budget Books, Fiscal 2009

*M00 – DHMH – Fiscal 2009 Budget Overview*

**Department of Health and Mental Hygiene  
Regular Employee Filled Jobs (FTEs) and Vacancy Rates (%)  
Fiscal 2000-2009**



Note: Fiscal 2009 data are authorized positions and budgeted turnover rate.

Source: Department of Legislative Services; Department of Health and Mental Hygiene

*M00 – DHMH – Fiscal 2009 Budget Overview*

**Department of Health and Mental Hygiene  
Contractual Employees (FTEs)  
Fiscal 2007-2009**

	<u>Actual 2007</u>	<u>Working 2008</u>	<u>Allowance 2009</u>	<u>Change 2008-09</u>	<u>% Change 2008-09</u>
DHMH Administration	14.45	20.02	18.08	-1.94	-9.7%
Office of Health Care Quality	4.3	5.9	5.65	-0.25	-4.2%
Health Occupations Boards	32.46	7.95	4.25	-3.7	-46.5%
Community and Family Health Administrations	11.75	11.17	10.5	-0.67	-6.0%
AIDS Administration	0	9.75	10.5	0.75	7.7%
Chief Medical Examiner	7.13	6.75	6.05	-0.7	-10.4%
Chronic Hospitals	19.73	17.71	17.71	0	0.0%
Laboratories Administration	3.49	2.78	2.78	0	0.0%
Alcohol and Drug Abuse Administration	2.62	5	5	0	0.0%
Mental Hygiene Administration	237.96	242.77	230.75	-12.02	-5.0%
Administration	3.18	3.42	3.42	0	0.0%
Institutions	234.78	239.35	227.33	-12.02	-5.0%
Developmental Disabilities Administration	74.94	71.11	71.32	0.21	0.3%
Administration	15.85	6.87	6.87	0	0.0%
Institutions	59.09	64.24	64.45	0.21	0.3%
Medical Care Programs Administration	35.23	74.71	65.71	-9	-12.0%
Health Regulatory Commissions	0.62	1	1	0	0.0%
<b>Total Contractual Positions</b>	<b>444.68</b>	<b>476.62</b>	<b>449.3</b>	<b>-27.32</b>	<b>-5.7%</b>

Source: Governor's Budget Books, Fiscal 2009

*M00 – DHMH – Fiscal 2009 Budget Overview*

**Department of Health and Mental Hygiene  
Budget Overview: Selected Caseload Measures  
Fiscal 2006-2009**

	<u>Actual 2006</u>	<u>Actual 2007</u>	<u>Working Allowance 2008</u>	<u>Working Allowance 2009</u>	<u>Change 2008-09</u>	<u>% Change 2008-09</u>
<b>Medical Programs/Medicaid</b>						
Medicaid Enrollees	524,656	520,436	526,331	536,700	10,369	2.0%
Maryland Children's Healthcare Program	102,813	105,999	106,053	114,400	8,347	7.9%
Medicaid Expansion to Parents				31,115	n/a	n/a
Primary Adult Care Program	49,462*	23,000	27,000	30,000	3,000	11.1%
<b>Developmental Disabilities Administration</b>						
Residential Services	4,888	5,036	5,257	5,430	173	3.3%
Day Services	9,335	9,768	10,347	11,257	910	8.8%
In-home support services	7,846	7,893	8,194	8,194	0	0.0%
Average daily census at institutions	358	335	328	232	-96	-29.3%
<b>Mental Hygiene Administration</b>						
Number receiving community mental health services:						
Medicaid eligible	74,821	78,434	79,220	80,770	1,550	2.0%
Medicaid ineligible	17,894	15,499	15,190	16,690	1,500	9.9%
<b>Total</b>	<b>92,715</b>	<b>93,933</b>	<b>94,410</b>	<b>97,460</b>	<b>3,050</b>	<b>3.2%</b>
<b>Alcohol and Drug Abuse Administration</b>						
Clients served in various setting:	60,715	60,202	61,794	61,892	98	0.2%

\*Fiscal 2006 data represents enrollment for the Maryland Pharmacy Program. The Primary Adult Care (PAC) began in fiscal 2007, but all individuals previously enrolled in the pharmacy program were automatically enrolled in PAC.

Source: Department of Legislative Services; Department of Health and Mental Hygiene

## ***Issues***

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### **1. Cigarette Restitution Fund Issues**

The Cigarette Restitution Fund (CRF) was established by Chapter 173 of 1999 and is supported by payments made under the Master Settlement Agreement (MSA). Through the MSA, the settling manufacturers will pay the litigating parties – 46 states (4 states, Florida, Minnesota, Texas, and Mississippi had previously settled litigation), 5 territories, and the District of Columbia – approximately \$206 billion over the next 25 years and beyond, as well as conform to a number of restrictions on marketing to youth and the general public.

#### **CRF Programmatic Support**

The distribution of MSA funds among the states is determined by formula, with Maryland receiving 2.26% of MSA monies which are adjusted for inflation, volume, and prior settlements. In addition, the State will collect 3.30% of monies from the Strategic Contribution Fund, distributed according to each state's contribution toward resolution of the state lawsuits against the major tobacco manufacturers.

The use of the CRF is restricted by 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; and
- 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).

**Exhibit 1** provides CRF revenue and expenditure detail for fiscal 2007 to 2009. A number of points can be made from the exhibit:

- The fiscal 2007 fund balance carried forward into fiscal 2008 was slightly lower than the \$17.0 million anticipated during fiscal 2008 budget deliberations. This was due to lower than anticipated revenues.

**Exhibit 1**  
**Cigarette Restitution Fund Budget Estimates**  
**Fiscal 2007-2009**  
**(\$ in Millions)**

	<u>2007 Actual</u>	<u>2008 Working</u>	<u>2009 Allowance</u>
Beginning Fund Balance	\$4.5	\$12.9	\$4.2
Settlement Payments	154.5	150.7	151.5
NPM and Other Shortfalls in Payments <sup>1</sup>	-16.1	-16.5	-16.5
Other Adjustments	7.7	36.1	35.7
<b>Subtotal</b>	<b>\$150.7</b>	<b>\$183.2</b>	<b>\$175.0</b>
Prior Year Recoveries	1.1	1.0	
<b>Total Available Revenue</b>	<b>\$151.8</b>	<b>\$184.2</b>	<b>\$175.0</b>
<b>Health</b>			
Tobacco Use Prevention/Cessation	17.8	17.3	17.3
Cancer Prevention, Evaluation, and Treatment	28.1	25.4	25.5
Substance Abuse	17.1	17.1	17.1
Medicaid	63.7	106.7	97.5
Administration	0.5	1.0	1.0
<b>Subtotal</b>	<b>\$127.1</b>	<b>\$167.5</b>	<b>\$158.5</b>
<b>Other</b>			
Aid to Nonpublic Schools	4.0	3.7	3.7
Crop Conversion	7.6	8.3	8.5
Attorney General	0.2	0.4	0.5
<b>Subtotal</b>	<b>\$11.8</b>	<b>\$12.4</b>	<b>\$12.7</b>
<b>Total Expenses</b>	<b>\$138.9</b>	<b>\$179.9</b>	<b>\$171.1</b>
<b>Ending Fund Balance</b>	<b>\$12.9</b>	<b>\$4.2</b>	<b>\$3.9</b>

NPM: Nonparticipating Manufacturer

<sup>1</sup>The NPM adjustment represents \$15.7 million of this \$16.1 million in fiscal 2007; an estimate of \$16.5 million is used in fiscal 2008 and 2009.

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

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

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- The fiscal 2008 working appropriation has changed significantly from that originally approved during the 2007 session. Specifically, in a July 2007 action taken by the Board of Public Works (BPW), an across the board reduction of 8% was taken to all CRF-supported programs with the exception of OAG legal expenses and substance abuse treatment programs. This reduction, amounting to just over \$14.1 million, was made to address potential shortfalls in payments to the CRF due to legal issues surrounding payments by participating manufacturers based on market share and the diligent enforcement of the State’s qualifying statute (discussed further below). As a result of this reduction, most programs will see a reduction in spending from fiscal 2007 to 2008.
- The fiscal 2009 allowance utilizes slightly less CRF funds than in fiscal 2008, primarily due to the anticipated lower available opening balance.
- Spending changes, as shown in Exhibit 1, are minimal, primarily a reduction in CRF funds devoted to Medicaid.
- Statute also 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.

When added to the expenditures in the allowance, these supplemental expenditures will reduce the fund balance below \$1 million.

However, it should also be noted that the adjustment made to fiscal 2009 revenue to represent the escrowing of payments associated with nonparticipating manufacturers may be greater than required. Because market share losses associated with sales year 2005 on which the fiscal 2009 revenue stream is based, have fallen, the amount of funding at issue (and thus escrowed) will also likely fall, perhaps by as much as \$4.3 million.

### **Legal Challenges to the Master Settlement Agreement**

Legal actions by manufacturers participating in the MSA continue to influence the amount of tobacco settlement revenues available to the states. These manufacturers contend that manufacturers not participating in the agreement have increased market share by exploiting legal loopholes to reduce their escrow payments to the states, giving those manufacturers a competitive advantage in the pricing of their products.

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The MSA authorizes participating manufacturers that lose a certain share of the market to withhold three times the amount of their losses. This withholding is known as a nonparticipating manufacturer (NPM) adjustment. The agreement allows participating manufacturers to pursue this adjustment on an annual basis. In April 2005, the participating manufacturers gave notice to state Attorneys General that they were pursuing an NPM adjustment with respect to a loss of market share in sales year 2003 (impacting revenue in fiscal 2007). A similar adjustment has been sought for sales year 2004 (fiscal 2008) and is expected for sales year 2005 (fiscal 2009).

According to the MSA, the litigants must meet a three-prong test in order to reduce their MSA payments:

- There must be a demonstrated market share loss by participating manufacturers.
- If a market share is demonstrated, participation in the MSA must be ruled as a significant factor contributing to that loss.
- A state must be found to be not diligently enforcing its qualifying statute in that specific sales year. The qualifying statute is a model statute that was included in the MSA and intended to level the playing field with respect to price between participating and nonparticipating tobacco manufacturers by requiring nonparticipating manufacturers to either join the MSA or make refundable deposits into an escrow account based on the number of cigarettes they sell in the state. Maryland formally adopted its qualifying statute in Chapter 169 of 1999, subsequently amended in 2001 and 2004.

There is no doubt that manufacturers participating in the MSA have lost market share since the MSA was signed. Market share loss (off of the base established in the MSA) in sales year 2003 for example, was calculated at 6.2%. In March 2006, an arbitrator ruled that the MSA was a significant factor contributing to the participating manufacturers' 2003 loss of market share thus allowing a 2003 NPM adjustment. A similar ruling has been made for sales year 2004, and the same outcome is anticipated for sales year 2005. The March 2006 ruling entitled the tobacco manufacturers to reduce their 2006 Master Settlement payment by approximately \$1.1 billion, or 18%, of which Maryland's share is approximately \$26.0 million. Of this amount, \$15.7 million (representing the payments from RJ Reynolds and Lorillard) was placed into escrow pending the resolution of this litigation. Philip Morris and several other participating manufacturers ultimately chose to continue to make its payments under the MSA and those payments are reflected in State CRF revenues but are nonetheless subject to dispute.

At this point, it is the third part of the process outlined above that is being litigated. That litigation falls into two parts:

- Who should make the determination that the State was not diligently enforcing its qualifying statute?
- Was the State diligently enforcing its qualifying statute?

In May 2006, Maryland filed two motions in Baltimore City Circuit Court for a declaratory judgment. The first motion sought a court ruling on whether the dispute would be decided by the courts or by arbitration, and the second motion argued that the State has diligently enforced its qualifying statute. In January 2007, the judge ruled that the language in the MSA was clear in its directive that the dispute should be decided by arbitration. Maryland is in the process of appealing the decision and oral arguments were held at the beginning of January 2008 at the Court of Special Appeals.

Consideration of whether the State has been diligent in enforcing its qualifying statute will occur after the jurisdiction is decided. Diligent enforcement of the statute will be determined on a state-by-state basis.

The potential consequences of this litigation are significant. If one state wins diligent enforcement, that state's share of the NPM adjustment will be deducted from those states that are found not to have diligently enforced. Consequently, if Maryland is found not to have diligently enforced its qualifying statute, it is possible that Maryland's share of the 2003 adjustment could exceed \$26.0 million, rising up to the value of the State's full 2006 Master Settlement payment or approximately \$158.2 million. The actual amount would depend on how many other states are found not to have diligently enforced their qualifying statute. A similar process will occur for sales year 2004 and likely for sales year 2005.

## **2. Prince George's County Health System**

The Prince George's County Health System (the system) consists of number of parts: Prince George's Hospital Center, a 269-bed acute-care hospital and regional referral center; Laurel Regional Hospital, a 138-bed acute-care community hospital; the Gladys Spellman Specialty Hospital and Nursing Center, a 110-bed comprehensive care and chronic care facility; the Bowie Health Center; and Dimensions Surgery Center. These facilities are owned by Prince George's County but operated by Dimensions Healthcare System, Inc. (Dimensions). Dimensions has a lease agreement with the county through 2042.

### **The System Remains Dependant on Government Support**

In recent years, the system has struggled financially, primarily due to losses at the Prince George's Hospital Center. These losses have prompted the State to provide significant operating and capital support for the health system: \$13.3 million in operating and the same amount in capital support in the period fiscal 2003 to 2007. In most cases, State support was tied to an even greater level of support from Prince George's County. In addition to the direct State support, the system received rate support that added \$10.0 million in revenues over the same period.

However, despite this government support, the system's finances remain perilous. The most recent audited financial statement notes that as of June 30, 2007, Dimensions "had a deficit in net assets, substantial capital needs, significant unfunded pension obligations and limited cash resources." Echoing comments in the 2006 audited financial statement, doubt was again cast on "the ability of the Corporation to continue as a going concern." Although Dimensions operational

financial position was positive in 2006 and 2007, this was solely due to the level of government and grant support. Absent this support operational deficits would have been almost \$14.0 million and just over \$6.8 million in the years ending June 30, 2007 and 2006 respectively.

Added to this bleak fiscal picture are:

- falling patient volumes;
- declining revenues from commercial payers; and
- growing difficulty in the recruitment and retention of employees given the uncertain future of the system (although the system is back-filling with agency employees, this is an expensive solution and creates inefficiencies).

### **Fashioning a Long-term Solution to the System's Fiscal Problems**

The most recent efforts to secure the long-term future of the system have centered on legislative solutions. House Bill 510 in the 2007 session, for example, among other things, would have established a Prince George's Hospital Authority as a State entity to develop a long-term strategy for delivering hospital and related health care services in the county. During deliberations on the bill, a total of \$329.0 million in fiscal 2007 to 2014 operating and capital support was proposed to stabilize and transform the system (including the building of a new hospital to replace Prince George's Hospital). As part of the final deliberations on the bill, the State offered to provide \$38.6 million in immediate operating support, \$82.0 million in capital support, and rate support of \$38.1 million. Indeed, \$20.0 million was appropriated to the Dedicated Purpose Account (DPA) in the fiscal 2008 budget to provide immediate support to Prince George's Hospital if House Bill 510 or similar legislation was successful. However, no agreement could be reached on the bill leaving the \$20.0 million in the DPA ostensibly to facilitate the orderly closure of the hospital.

During the 2007 special session, unsurprisingly, the status of the system re-emerged. Ultimately language was included in the Budget Reconciliation Act (Chapter 2 of the 2007 special session), authorizing the Governor to transfer the \$20 million available in the DPA to the Department of Health and Mental Hygiene (DHMH). DHMH would in turn provide a grant to an independent entity with authority over the system until the facilities in the system and the obligation to provide the services currently provided by the system are transferred to a new owner or operator. However, the grant cannot be made until a long-term comprehensive solution to the system's problems is reached either through legislation or a memorandum of understanding between the State and Prince George's County.

The language also requires that the comprehensive solution must address issues concerning transfer of ownership and maintaining current service obligations; a plan for the system's current assets; a mechanism for a steady revenue stream to meet operating needs, debt support and pension obligations; and a mechanism to ensure equitable and sustainable funding from the county and the State.

Similar language was added to legislation expanding access to health care (Chapter 7 of the 2007 special session), providing the same contingency to proposed grants of \$10 million in each of fiscal 2011, 2012, and 2013, for a total State commitment from fiscal 2008 to 2013 of \$50 million. While this amount is less than proposed by the State during 2007 session deliberations on House Bill 510, any negotiated comprehensive solution could result in additional State support.

## **Conclusion**

Although the underlying economics of the system are largely worse at the beginning of 2008 than at the beginning of 2007, some positive changes have occurred in the past year: relations between the County Executive and the new leadership of the Dimensions Board of Directors appears improved; management has developed a stabilization plan encompassing seven key areas (physician development, system growth, pension plan restructuring, work force development, image, operational improvement, and financial performance and re-capitalization); efforts continue to find a buyer for the system; and the system has been able to sell some assets including land and the free standing surgery center in Bowie. Additionally, recent media reports noted that the County Executive is preparing to shortly submit a proposal to secure the long-term financial future of the system.

It remains to be seen if these positive signs translate into a legislative or other negotiated solution that meets the requirements articulated in legislation adopted in the 2007 special session. **DHMH should be prepared to comment on the development of any Executive Branch initiatives/discussions with Prince George’s County government to resolve the long-term future of the Prince George’s County Health System since the special session.**

### **3. The State of the State’s Health – 2007**

One of the more comprehensive nationwide health rankings is developed by the United Health Foundation (a nonprofit, private foundation established by UnitedHealth Group), the American Public Health Association (an organization representing public health professionals), and Partnership for Prevention (a national nonprofit organization dedicated to health improvement). Since 1990 in a publication entitled *America’s Health: State Health Rankings*, individual state rankings have been produced using data that represent a broad range of issues affecting a population’s health, that are available at a state level, and that are current. Data and the ranking methodology are regularly reviewed by a large panel of public health experts and can change from year-to-year.

The purpose of these rankings is two-fold: to stimulate public conversation concerning health in the states and to provide information to facilitate citizen participation in discussions about health policy.

Data are collected in two broad categories:

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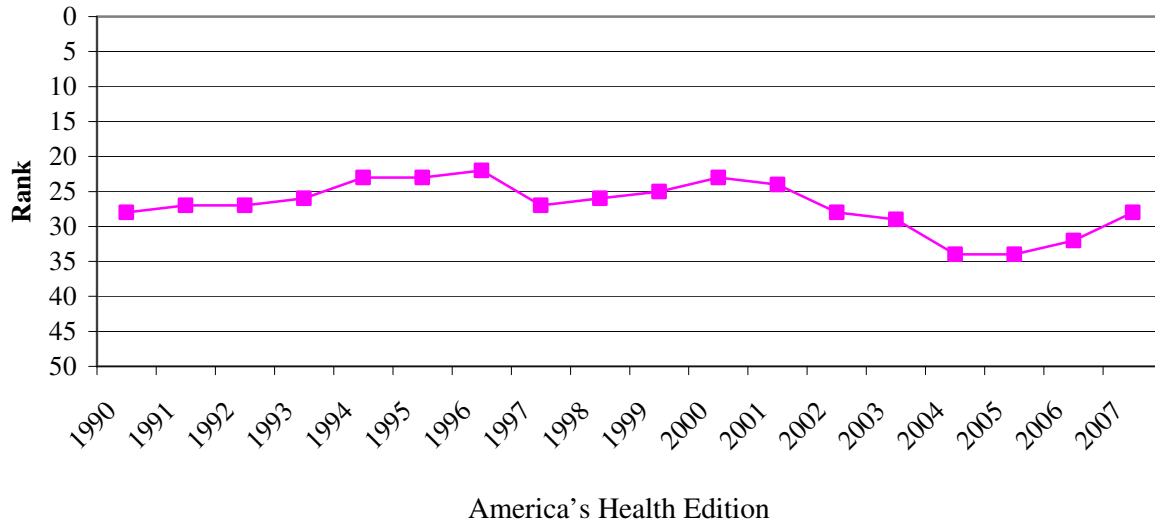
- Risk factors which are in turn broken into four groupings:
  - personal behaviors (prevalence of smoking, prevalence of binge drinking, prevalence of obesity, and high school graduation);
  - community environment (violent crime offenses, infectious disease, children in poverty, and occupational fatalities);
  - public health policies (lack of health insurance, per capita public health spending, and immunization coverage); and
  - clinical care (adequacy of prenatal care, availability of primary care physicians, and preventable hospitalizations).
- Outcomes (poor mental health days, poor physical health days, cardiovascular deaths, cancer deaths, infant mortality, and premature death).

New factors for 2007 are prevalence of binge drinking which replaces motor vehicle deaths; the number of primary care physicians per 100,000 population; and preventable hospitalizations (measured as the discharge rate per 1,000 Medicare enrollees for diagnoses that are amenable to non-hospital-based care).

Data for each component is appropriately adjusted and weighted and combined into a single state overall health score. Risk factors ultimately contribute 70% of a state's overall score, with outcomes 30%.

As shown in **Exhibit 2**, in the 2007 edition of *America's Health* Maryland's overall ranking based on this combined health score is twenty-eighth, a good improvement over 2006. Indeed, Maryland's overall health score showed the third highest improvement compared to all other states in the period 2006 to 2007.

**Exhibit 2**  
**America's Health: State Health Rankings**  
**1990-2007**  
**Maryland**



Source: *America's Health*, State Health Rankings, 2007 Edition

Of particular note, as shown in **Exhibit 3**, are improvements in the prevalence of smoking, the percentage of children in poverty, the violent crime rate, cardiovascular deaths, and premature deaths. The only significant negative trend is the percentage of immunization coverage amongst children 19 to 35 months.

The key challenges that remain are those that have been evident for some years: prevalence of obesity and the lack of health care coverage. Obviously, Chapter 7 of the 2007 special session was a step to begin addressing the ongoing problem of uninsurance.

A cautionary note about the use of selected statistics to make state-by-state comparisons is well-demonstrated, ironically, in a statistic in which Maryland appears to rate well: the number of primary care physicians per 100,000 population. In the *America's Health* survey, Maryland ranked highest amongst all states. Yet this positive ranking comes at the same time that MedChi (the State's medical society) and the Maryland Hospital Association (MHA) have released a workforce shortage study noting that Maryland has 16% fewer physicians in clinical practice than the national per capita coverage. Further, the MedChi/MHA report notes shortages of primary care physicians in virtually every area of Maryland.

**Exhibit 3**  
**Various Health Outcomes and Risk Factors**  
**Maryland and Maryland's National Ranking: 1990, 2006, and 2007**

<b>Outcome</b>	<b>1990</b>		<b>2006</b>		<b>2007</b>		<b>Long-term Trend</b>	<b>Short-term Trend</b>
	<b>Maryland</b>	<b>Maryland Rank</b>	<b>Maryland</b>	<b>Maryland Rank</b>	<b>Maryland</b>	<b>Maryland Rank</b>		
Cardiovascular Deaths (Deaths Per 100,000 Population)	409	28	314.9	27	303.1	27	✓	✓
Cancer Deaths (Deaths Per 100,000 Population)	219.7	49	203.9	29	200.8	23	✓	✓
Infant Mortality (Deaths Per 1,000 Live Births)	11.6	41	8.4	44	7.5	33	✓	✓
Premature Death (Years Lost Per 100,000 Population)	9,145	36	8,117	35	7,889	33	✓	✓
Poor Mental Health Days (Days in Previous 30 Days)		n/a	3.2	23	3.1	17		✓
Poor Physical Health Days (Days in Previous 30 Days)		n/a	3.1	7	3.0	6		✓
<b><u>Risk Factor</u></b>								
Prevalence of Smoking (% of Population)	29.7	26	18.9	11	17.7	11	✓	✓
Prevalence of Obesity (% of Population)	12.0	29	24.4	25	24.9	25	×	×
High School Graduation (% of Incoming 9th Graders)	76.5	25	79.2	15	79.5	15	✓	✓
Prevalence of Binge Drinking (% of Population)		n/a	13.8	16	11.9	10		✓
Violent Crime (Offenses Per 100,000 Population)	768.0	45	704.0	47	679.0	43	✓	✓
Lack of Health Insurance (% without Coverage)	8.9	11	13.4	24	13.8	25	×	×
Infectious Disease (Cases Per 100,000 Population)	41.1	38	36.5	48	36.9	48	✓	×
Children in Poverty (% of Persons Under 18)	16.4	17	13.3	13	10.9	6	✓	✓
Occupational Fatalities (Deaths Per 100,000 Workers)	5.7	5	5.0	20	5.2	18	✓	×
Per capita Public Health Spending (\$ Per Person)		n/a	189.0	14	189.0	14		No Change
Immunization Coverage (% of Children 19-35 Months Receiving Selected Vaccines)		n/a	82.3	23	80.1	29		×
Adequacy of Prenatal Care (% of Pregnant Women Receiving Adequate Care)			70.1	38	70.1	38		No Change
Primary Care Physicians (Number per 100,000 population)			176.8	1	179.0	1		✓
Preventable Hospitalizations (Discharges per 1,000 Medicare enrollees)			73.3	26	75.1	26		×

Note: Year refers to year that the ranking is made. The data used to make that ranking are the most current available.

Source: *America's Health*, State Health Rankings, 2007 Edition

This apparent discrepancy perhaps relates to two issues:

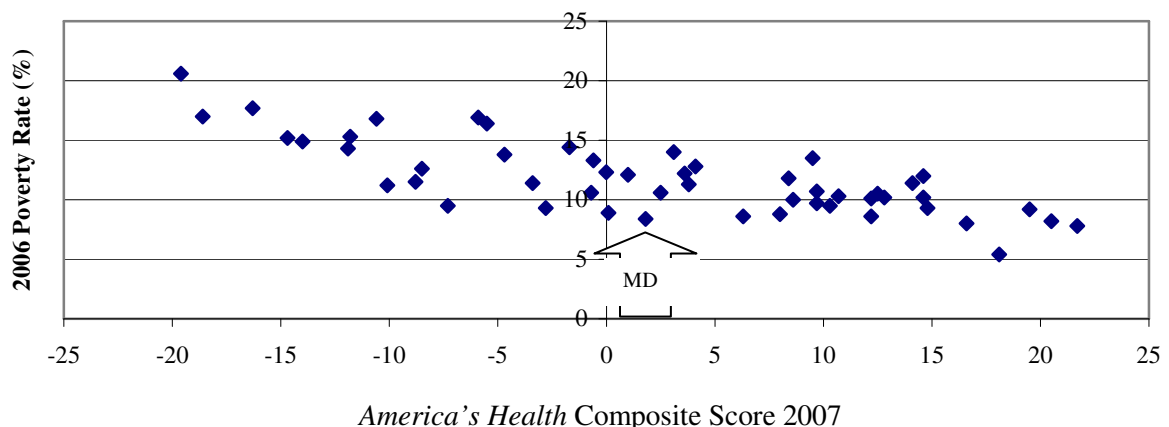
- The definition of “primary care physician” in the MedChi/MHA report is narrower than that used by the *America’s Health* report.
- The *America’s Health* data relies on American Medical Association data on physicians, whereas the MedChi/MHA utilizes data from the Maryland Board of Physicians (MBP). This distinction is important because the MBP data has been “scrubbed” to better reflect physicians actually practicing in Maryland. For example, Maryland has 25,000 licensed physicians (the second-highest rate per capita of any state), but almost 40% are either based out-of-state, non-practicing and/or engaged in teaching, research, and administrative duties. This data difference is significant, although it should be noted that Maryland’s ratio of in-state practicing physicians to total licensed physicians is actually not much worse than the national average.

Finally, **Exhibit 4** tracks state health scores against state poverty rates. As might be expected, there is an evident relationship between the two. States with high poverty rates tend to have low (negative) scores; conversely, states with low poverty rates tend to have high (positive) scores. What is interesting for Maryland is that while the State has a relatively low poverty rate, there are:

- numerous states with similarly low poverty levels that have much better scores; and
- states with significantly higher poverty rates that still score much better than Maryland.

Clearly, under this set of variables, it might be expected that Maryland’s relative wealth would yield better results.

**Exhibit 4**  
***America’s Health* State Health Scores and Poverty Rates**



Source: Department of Legislative Services; *America’s Health*, State Health Rankings, 2007 Edition; U.S. Census Bureau