

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

Operating Budget Data

(\$ in Thousands)

	<u>FY 08</u> <u>Actual</u>	<u>FY 09</u> <u>Working</u>	<u>FY 10</u> <u>Allowance</u>	<u>FY 09-10</u> <u>Change</u>	<u>% Change</u> <u>Prior Year</u>
General Fund	\$119,998	\$121,405	\$114,184	-\$7,221	-5.9%
Contingent & Back of Bill Reductions	0	0	-14,866	-14,866	
Adjusted General Fund	\$119,998	\$121,405	\$99,318	-\$22,087	-18.2%
Special Fund	45,208	52,814	60,480	7,666	14.5%
Contingent & Back of Bill Reductions	0	0	-4,441	-4,441	
Adjusted Special Fund	\$45,208	\$52,814	\$56,039	\$3,225	6.1%
Federal Fund	145,463	147,163	155,888	8,724	5.9%
Contingent & Back of Bill Reductions	0	0	-60	-60	
Adjusted Federal Fund	\$145,463	\$147,163	\$155,828	\$8,665	5.9%
Reimbursable Fund	670	809	1,170	361	44.6%
Adjusted Reimbursable Fund	\$670	\$809	\$1,170	\$361	44.6%
Adjusted Grand Total	\$311,340	\$322,192	\$312,354	-\$9,837	-3.1%

- The fiscal 2010 Allowance for the Community and Family Health Administrations decreases by \$9.8 million, or 3.1%, with general funds decreasing by 18.2% while special and federal funds increase.
- The major changes from the fiscal 2009 working appropriation to the fiscal 2010 allowance are \$10.1 million general fund decrease to the Targeted Local Health Formula; \$10.0 million federal fund increase for the Women, Infants, and Children program; \$7.4 million special fund increase for the Cigarette Restitution Fund (CRF) programs; \$2.5 million general fund increase for the Breast and Cervical Cancer Diagnosis and Treatment Program (BCCDTP); and \$1.4 million federal fund decrease for Office of Preparedness and Response.

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

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- Contingent reductions to the fiscal 2010 allowance included in the budget bill are a \$19.2 million reduction to funding for CRF programs; a \$14.8 million general funds reduction to the Breast and Cervical Cancer Program that is backfilled with special funds from the CRF programs; and a \$0.2 million reduction resulting from contingent language eliminating funding for deferred compensation in fiscal 2010.

Personnel Data

	<u>FY 08 Actual</u>	<u>FY 09 Working</u>	<u>FY 10 Allowance</u>	<u>FY 09-10 Change</u>
Regular Positions	340.40	335.40	339.40	4.00
Contractual FTEs	<u>8.53</u>	<u>11.08</u>	<u>10.56</u>	<u>-0.52</u>
Total Personnel	348.93	346.48	349.96	3.48

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	17.51	5.16%
Positions and Percentage Vacant as of 12/31/08	22.00	6.56%

- The number of regular positions allocated to the Community and Family Health Administrations increase by a net of 4 positions from the fiscal 2009 working appropriation to the fiscal 2010 allowance. Contractual positions for the Community and Family Health Administrations decrease by 0.5 positions.
- The fiscal 2010 allowance transfers 5 positions from the Developmental Disabilities Administration to the CRF programs, but these positions are included in the contingent reduction language reducing the funding for the CRF tobacco programs.
- One position was transferred from the Family Health Administration to the Laboratories Administration in the fiscal 2010 allowance.
- As of December 31, 2008, the Community and Family Health Administrations' vacancy rate was 6.6% with 22.0 vacant positions. This vacancy rate is slightly higher than the budgeted turnover allocated in the fiscal 2010 allowance.

Analysis in Brief

Major Trends

Community Health Administration: According to a United States Centers for Disease Control and Prevention survey released in September 2008, Maryland had the highest percentage of children ages 19 to 35 months, fully vaccinated with all the vaccines in the series of recommended vaccines.

The Family Health Administration: Following the national trend, Maryland's overall infant mortality rate increased from calendar 2002 through 2003 but declined to 7.3 deaths per 1,000 live births in calendar 2005. However, in calendar 2006, the overall infant mortality rate increased and remained level in calendar 2007. The number of children with elevated blood lead levels has decreased over 70% since 2000 with a one-year decrease of almost 30% from calendar 2006 to 2007.

Cigarette Restitution Fund Program: The Cancer Prevention, Education, Screening, and Treatment Program has successfully reduced the overall cancer mortality rate, which has consistently been just above the national rate. The Tobacco Use and Prevention and Cessation Program has made improvements toward educating adults about the harms of secondhand smoke on children and increasing the proportion of smoke-free households with minor children.

Office of Preparedness and Response: In a national assessment of public health preparedness, Maryland tied with five other states for the lowest score by receiving a passing grade on 5 of the 10 indicators.

Issues

Breast and Cervical Cancer Expenditures Continue to Grow: In recent years, the BCCDTP expenditures have increased at a significant rate. Budget bill language reduces the general fund allocation for the program by replacing the general funds with CRF funds, and the BCCDTP fiscal 2010 allocation appears to be underfunded.

Oral Health Initiatives: The fiscal 2009 Family Health Administration (FHA) budget included new funding to improve the State's public dental health infrastructure through operational grants, capital grants, a mobile dental van, and school-based services. The Office of Oral Health was level funded in fiscal 2010 for the oral health initiative except for the capital grants, which was not included in the capital budget.

Two Infant Mortality Programs Operating within FHA: In fiscal 2007, the Babies Born Healthy Initiative was established to reduce infant mortality and improve infant health in the State. In fiscal 2009, the Office of Minority Health and Health Disparities also received funding to combat infant mortality. The programs are coordinating by analyzing data and educating policymakers, but the programs are not coordinating the distribution of grant funding. The fiscal 2010 allowance reveals the administration's desire to operate two infant mortality programs with the same goals and focus within the same administration in the Department of Health and Mental Hygiene.

Stockpile of Antiviral Treatments: The federal government has offered states a subsidized price to purchase antiviral treatments to develop stockpiles. By the original deadline of the federal program, the Office of Preparedness and Response has purchased 90% of the antivirals available to Maryland under the federal offer. The federal government has extended the deadline, and the Office of Preparedness and Response is working to purchase the remainder of the federal allotment with public-private partnership collections.

Recommended Actions

	<u>Funds</u>	<u>Positions</u>
1. Reduce general fund support for the Women, Infants, and Children program.	\$ 102,360	
2. Add budget bill language restricting funds appropriated for the Office of Minority Health and Health Disparities to be used for the Babies Born Healthy Initiative.		
3. Amend the budget bill language contingent on the Budget Reconciliation and Financing Act of 2009 provision reducing the mandated funding of Cigarette Restitution Fund tobacco programs to strike the language deleting five positions.		
4. Delete five new positions for the Cigarette Restitution Fund tobacco programs.	334,597	5.0
5. Adopt committee narrative requesting the Office of Oral Health include budgetary detail to the report required by the Oral Health Safety Net Act.		
6. Adopt committee narrative requesting a report updating the committees on the number of antiviral treatments purchased for the State’s stockpile.		
Total Reductions	\$ 436,957	5.0

Updates

Clean Indoor Air Act: As of February 1, 2008, Maryland statute dictates that smoking is prohibited in most indoor areas. The Community Health Administration (CHA), along with local health departments, is responsible for the enforcement of the prohibition of indoor smoking. The department worked with the local health departments to implement the Clean Indoor Air Act, and CHA continues to work with the local health departments to enforce the law.

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Department of Health and Mental Hygiene

Operating Budget Analysis

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 (CRF) 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 CRF 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 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.

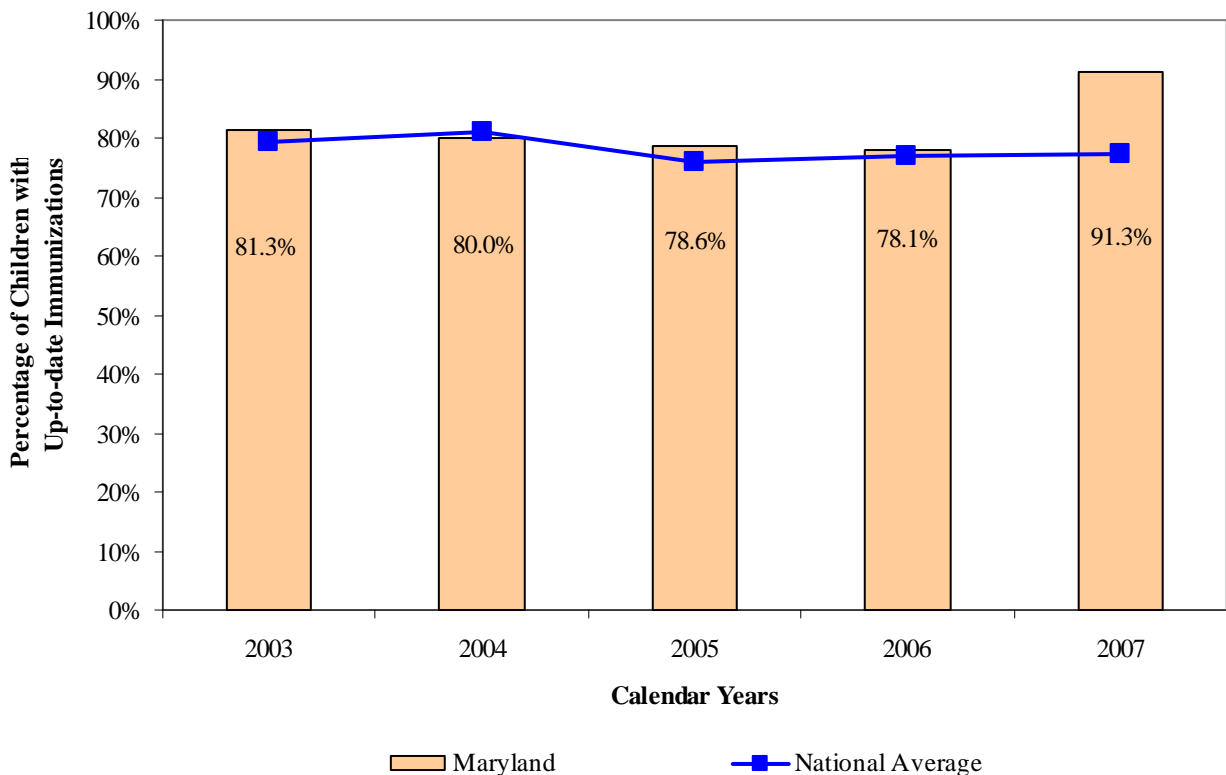
Performance Analysis: Managing for Results

Community Health Administration

Immunizations

According to a United States Centers for Disease Control and Prevention survey released in September 2008, Maryland had the highest percentage of children, ages 19 to 35 months, fully vaccinated with all the vaccines in the series of recommended vaccines. As shown in **Exhibit 1**, more than 91% of the children in Maryland received the typical coverage of vaccinations, compared with the national average of 77%. The rate of immunization jumped 13 percentage points from calendar 2006 to 2007, but CHA does not know the reason for this increase. Therefore, it is unclear whether the percent of children with up-to-date immunizations will remain at the 2007 level in future years.

Exhibit 1
Rates of Children Ages 19 to 35 Months with Up-to-date Immunizations
Calendar 2003-2007



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

Maryland is able to keep the vaccination rates of children high for a couple of reasons. First, the State allows parents to opt out of vaccinating toddlers for medical or religious reasons, but not for philosophical reasons. Also, the Department of Health and Mental Hygiene (DHMH) operates the Maryland Vaccines for Children program, which works with 750 providers at 1,000 public and private practice vaccine delivery sites to provide all routinely recommended vaccines, free of cost, to children 18 years old and younger who:

- are Maryland Medicaid eligible;
- are uninsured;
- are Native American or Alaskan Native; or
- are underinsured (children who have health insurance that does not cover immunization).

Family Health Administration

Infant Mortality Rates

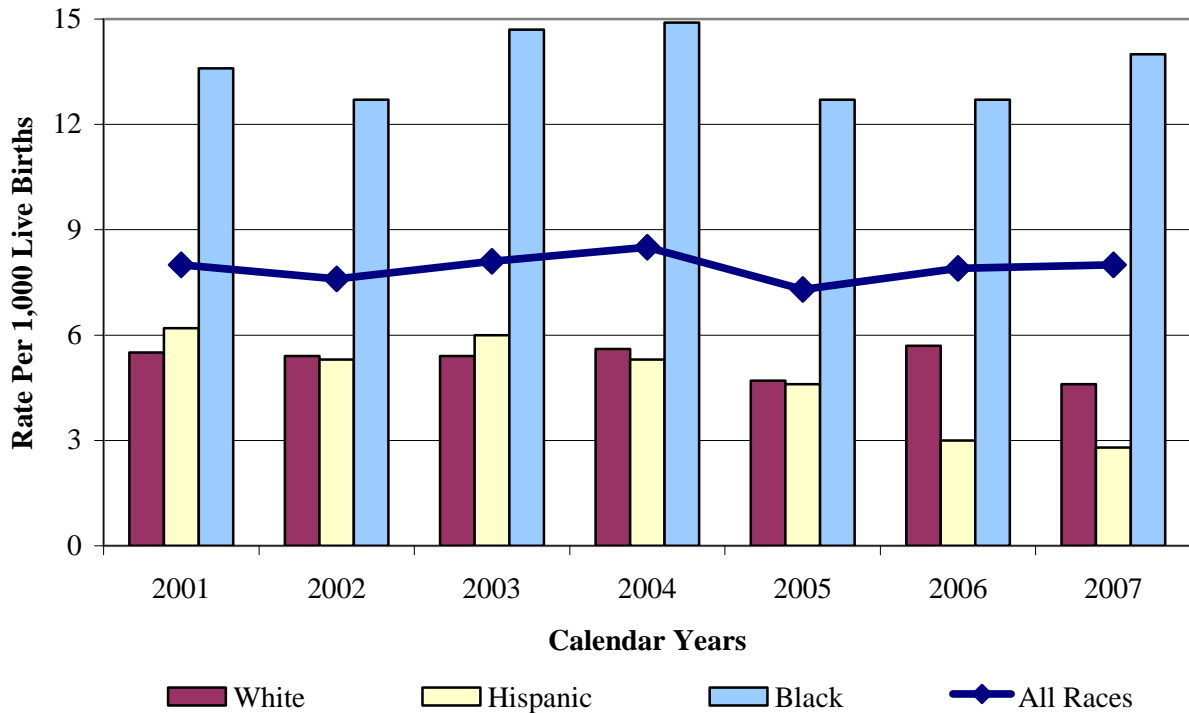
The Center for Maternal and Child Health within FHA is charged with reducing infant mortality and promoting the health and well-being of all women and children. Infant mortality rates are used to indicate the total health of populations in the United States and internationally. During the second half of the twentieth century, infant mortality rates in the United States fell from 29.2 to 6.9 per 1,000 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 calendar 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 calendar 2002 through 2004 to 8.5 deaths per 1,000 live births but declined to 7.3 in calendar 2005. However, as shown in **Exhibit 2**, the overall infant mortality rate increased to 7.9 deaths per 1,000 live births in calendar 2006 and remained relatively level in calendar 2007.

Following national trends, Maryland's African American infant mortality rate has consistently been higher than other races. While the overall infant mortality in the State remained level from calendar 2007 to 2008, the rate for African Americans increased 10%.

Since fiscal 2007, the State had focused resources toward reducing the infant mortality rate by funding prenatal services. As a result, it is expected that infant mortality rates should decrease in calendar 2008 and 2009.

Exhibit 2
Infant Mortality¹ Rates
Cases Per 1,000 Live Births
Calendar 2001-2007



¹ Death during the first year of life.

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

Elevated Blood Lead

CDC has a national goal to eliminate 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.

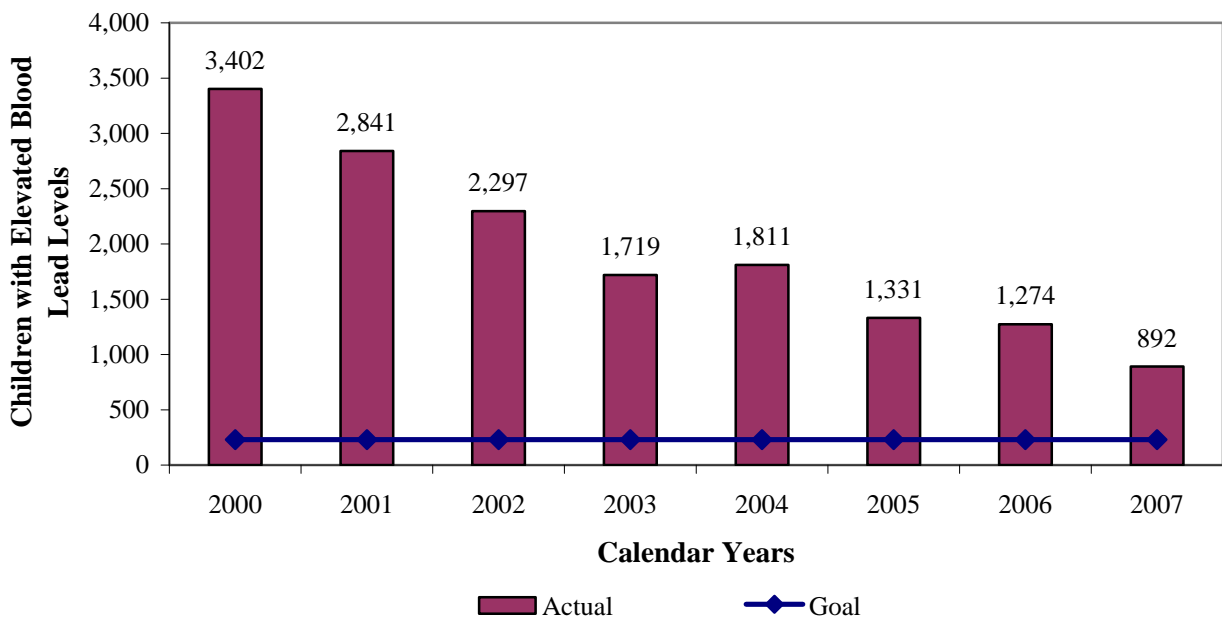
Common sources of lead exposure include house dust contaminated with lead paint, soil contaminated with lead paint, and industrial or motor vehicle emissions. Nationally, elevated blood lead levels are more prevalent with children living in houses built before 1946. Also, income is a factor in the prevalence 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’s goal is to have no more than 230 children with elevated blood lead levels (greater than 10 $\mu\text{g/dL}$) by calendar 2010. As shown in **Exhibit 3**, 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 70% since 2000 with a one-year decrease of almost 30% from calendar 2006 to 2007.

Exhibit 3
Children Under the Age of Six with Elevated Blood Lead Levels
Calendar 2000-2007



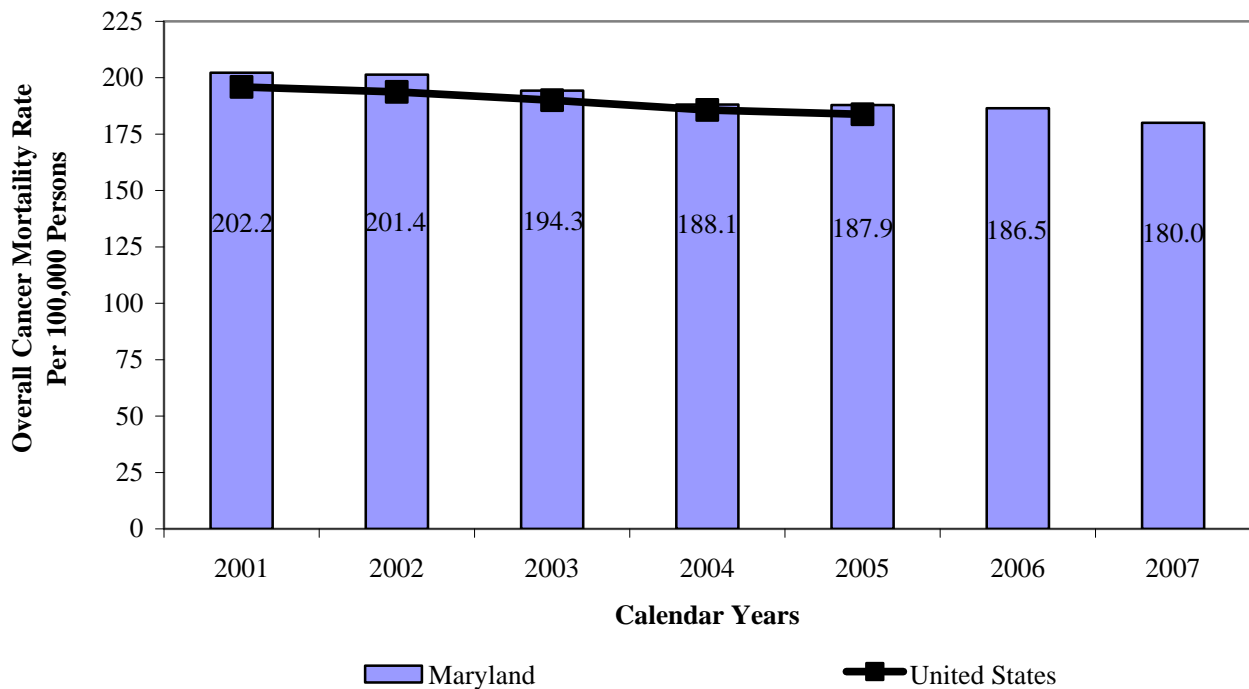
Source: Department of Health and Mental Hygiene

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. The mission of the program is to reduce the burden of cancer among Maryland residents, and overall goal of the program is to reduce the overall cancer mortality in the State. **Exhibit 4** shows the program has successfully reduced the overall cancer mortality rate, which has consistently been just above the national rate.

Exhibit 4
Overall Cancer Mortality Rate – Maryland Versus United States
(Per 100,000 Persons)
Calendar 2001-2007



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

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. One of the program's goals is to change the existing environmental context in Maryland communities from toleration or promotion of tobacco use to a context which does not condone exposing youth less than 18 years old to secondhand smoke.

Nationally, children's exposure to secondhand smoke is responsible for:

- increases in the number of asthma attacks and severity of symptoms in 200,000 to 1 million children with asthma;
- between 150,000 and 300,000 lower respiratory tract infections (for children under 18 months of age); and,
- respiratory tract infections resulting in 7,500 to 15,000 hospitalizations each year.

Children are particularly vulnerable to the harms of secondhand smoke because children are still developing physically, have higher breathing rates than adults, and have little control over their indoor environments.

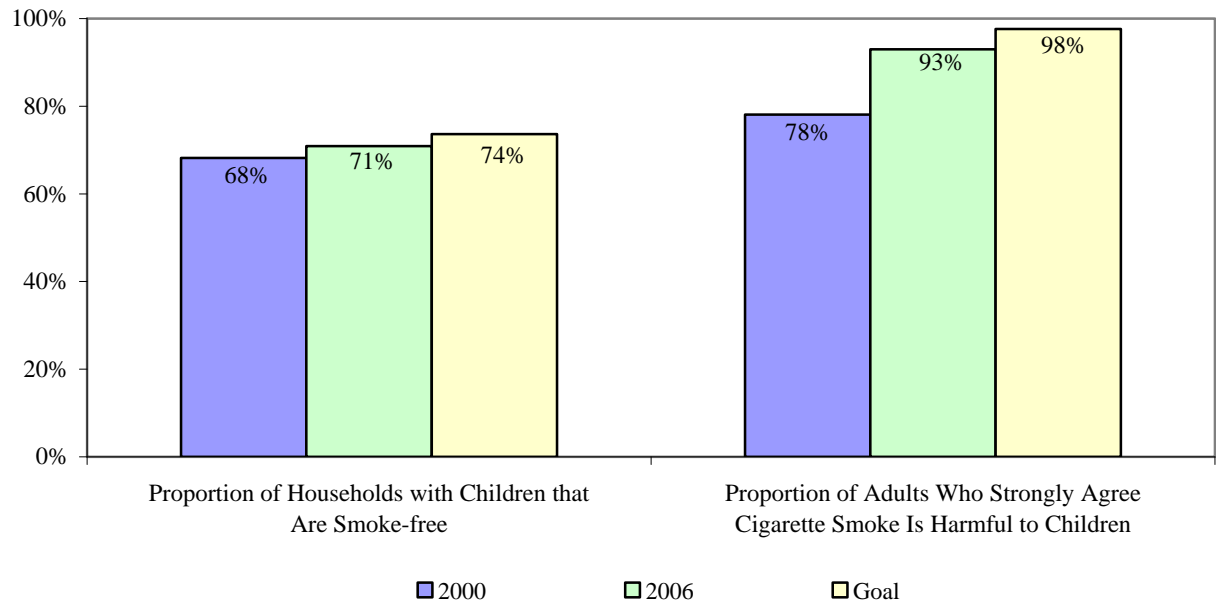
The CRF Program works to reduce the exposure of children to secondhand smoke by providing education to adults with the goal of increasing the number of Maryland adults who strongly agree that cigarette smoke is harmful to children by 25% from calendar 2000 to 2010. In addition, the CRF Program has been working to increase the proportion of Maryland households with minor children that are smoke-free by 8% from calendar 2000 to 2010. **Exhibit 5** shows the program has made improvements toward both of these goals.

Office of Preparedness and Response

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 2008 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 sixth consecutive year this report has been released, but each year the Trust for America's Health has assessed different aspects of public health preparedness.

Exhibit 5
Proportion of
Youth Living in Smoke-free Households
and
Adults that Agree Smoke Is Harmful to Children



Source: Department of Health and Mental Hygiene

The general findings from the 2008 report were that important progress has been made to protect the country from health emergencies, but funding for essential programs has been cut which puts these improvements in jeopardy. Maryland tied with five other states for the lowest score by receiving a passing grade on 5 of the 10 indicators. Maryland received a point for achieving each of the following indicators:

- has a Strategic National Stockpile distribution plan;
- public health laboratory has an intra-state courier system that operates 24 hours a day;
- public health laboratory can meet the expectations of the State’s pandemic influenza plan;
- uses a disease surveillance system that is compatible with CDC’s National Electronic Disease Surveillance System; and
- has a Medical Reserve Corps Coordinator.

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Maryland is 1 of 16 states that had not purchased 50% of their share of the federally subsidized antiviral treatments to stockpile for use during an influenza pandemic. The data collected by the Trust for America’s Health showed that DHMH had purchased only 36% of the State’s antiviral treatment allocation by September 30, 2008. However, the department submitted a report stating that by June 29, 2008, DHMH had purchased 90%, or 522,151, of the treatment doses reserved for Maryland under the federal agreement. By adding the points for this indicator, Maryland would have received a score of six, which is better, but still means that 36 states received a better score than Maryland.

Maryland is one of eight states that have “low” protections for health care volunteers during times of emergency, while 42 states and the District of Columbia have “medium” or “high” levels of protections. A majority of states (including Maryland) did not have statutes that extend some level of immunity to groups or organizations providing charitable, emergency, or disaster relief services.

Maryland narrowly lost a point for not being able to identify the pathogen responsible for reported foodborne disease outbreaks at a rate that met or exceeded the national average of 44% by only identifying 42% of the confirmed outbreaks.

The last indicator that Maryland did not pass was regarding the State’s public health budget. Maryland was 1 of 11 states and the District of Columbia that lost a point for decreasing funding for public health services from fiscal 2007 to 2008. The Trust for America’s Health views this indicator as a measure of each state’s commitment to fund public health programs that support the infrastructure necessary to adequately respond to public health emergencies. In fact, of the 11 states and the District of Columbia that decreased funding for public health services, Maryland had the highest percentage decrease in funding for public health services as shown in **Exhibit 6**.

Exhibit 6
States Reducing Public Health* Funding
Fiscal 2007-2008

<u>State</u>	<u>Percent Public Health Funding Was Decreased</u>
Maryland	-9.5%
Nevada	-6.9%
New Jersey	-4.3%
Oklahoma	-4.1%
Nebraska	-3.5%
District of Columbia	-2.8%
Idaho	-2.2%
Pennsylvania	-0.8%
West Virginia	-0.7%

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<u>State</u>	<u>Percent Public Health Funding Was Decreased</u>
Arkansas	-0.2%
Colorado	-0.2%
Connecticut	-0.2%

* “Public health” is defined to broadly include all health spending with the exception of Medicaid, State Children’s Health Insurance Program, or comparable health coverage programs for low-income residents. Also not included were federal funds; mental health funds; addiction or substance abuse-related funds; Women, Infants, and Children Food Program funds; services related to developmental disabilities or severely disabled persons; and State-sponsored pharmaceutical programs.

Source: Trust for America’s Health

Fiscal 2009 Actions

Proposed Deficiency

The Community and Family Health Administrations receive general, special, and federal fund deficiency appropriations totaling \$19.1 million. The general fund deficiency appropriation allocates \$2.2 million to the Family Health Administration’s Breast and Cervical Cancer Diagnosis and Treatment Program to cover higher than anticipated treatment costs. The special fund deficiency appropriation increased the Office of Preparedness and Response’s fiscal 2009 working appropriation by \$1.7 million to bring private collections into the budget in order to purchase antiviral treatments for the State’s stockpile. The federal fund deficiency appropriation provides \$15.2 million for the Women, Infants, and Children (WIC) program due to higher than anticipated participation.

Impact of Cost Containment

In fiscal 2009, the Community and Family Health Administrations have experienced cost containment actions totaling \$12.8 million with general funds decreasing \$5.2 million, special funds decreasing \$7.5 million, and federal funds decreasing \$0.1 million. The following is a list of the larger cost containment actions:

- reduced CRF funding for statewide academic health centers (\$5.4 million);
- arranged for the uncompensated care portion of the Montebello at Kernan grant to be provided through the all-payer hospital system rather than through a general fund grant (\$2.3 million);
- eliminated the fiscal 2009 inflationary adjustment for the targeted local health formula (\$1.8 million);

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- reduced CRF funding for tobacco prevention (\$1.1 million);
- reduction of 10% to CRF programs (excluding substance abuse, textbooks, and screening) (\$1.0 million);
- reduction of 1% to FHA grants (\$0.4 million); and
- deleted funding for the public health residency program (\$0.2 million).

Reductions to the CRF programs accounted for almost 60% of the fiscal 2009 cost containment actions in the Community and Family Health Administrations. **Exhibit 7** shows how specific CRF programs were impacted by the cost containment actions.

As presented by the Governor, the budget is balanced assuming additional fiscal 2009 cost containment actions. One of the specific anticipated actions is \$10.2 million, or 15%, reduction to the targeted local health formula. In addition, the Community and Family Health Administrations had an estimated \$0.2 million in general fund savings due to furloughs of State employees.

Proposed Budget

As shown in **Exhibit 8**, the fiscal 2010 allowance for the Community and Family Health Administrations is decreasing by \$9.8 million, or 3.1%, with general funds decreasing by 18.2% while special and federal funds increase.

The major changes from the fiscal 2009 working appropriation to the fiscal 2010 allowance are \$10.1 million general fund decrease to the Targeted Local Health Formula; \$10.0 million federal fund increase for the Women, Infants, and Children program; \$7.4 million special fund increase for the Cigarette Restitution Fund programs; \$2.5 million general fund increase for the Breast and Cervical Cancer Program; and \$1.4 million federal fund decrease for Office of Preparedness and Response.

If adopted, the contingent reductions would reduce the Community and Family Health Administrations appropriation by \$19.4 million as shown in **Exhibit 9**. The Cigarette Restitution Fund programs will be reduced by \$19.2 million if the contingent reductions are adopted, and the detail of this reduction is shown in Exhibit 7. Another contingent reduction to the fiscal 2010 allowance included in the budget bill is a \$14.8 million general funds reduction to the Breast and Cervical Cancer Program that is backfilled with special funds from the CRF programs. Also, the Community and Family Health Administrations appropriation will be reduced by \$0.2 million resulting from across-the-board language eliminating funding for deferred compensation in fiscal 2010.

Exhibit 7
Cigarette Restitution Fund Allocation with Cost Containment and Contingent Reductions
Fiscal 2009-2010

	2009		2010				
	Legislative	Board of	Working		Contingent	Adjusted	% Change from
	<u>Approp.</u>	<u>Public</u>	<u>Approp.</u>	<u>Allowance</u>	<u>Reduction</u>	<u>Allowance</u>	<u>Working Approp. to</u>
		<u>Works</u>					<u>Adjusted Allowance</u>
		<u>Reductions</u>					
Cancer Prevention, Education, Screening, and Treatment							
Local Public Health	7.2		7.2	7.2		7.2	0.0%
Univ. of MD and Johns Hopkins Institutions – Baltimore City	2.3		2.3	2.3		2.3	0.0%
Surveillance and Evaluation	1.3	-0.1	1.3	1.3		1.3	6.0%
Administration	0.8		0.8	0.8		0.8	-2.7%
Cancer Screening Data Base	0.4	-0.1	0.2	0.4		0.4	48.6%
Statewide Public Health	0.1		0.1	0.1		0.1	0.0%
Total	12.1	-0.2	11.9	12.1	0.0	12.1	1.5%
Statewide Academic Health Center							
Cancer Research Grants	10.4	-3.6	6.8	10.4	-3.6	6.8	0.0%
Tobacco Diseases Research	2.0	-0.7	1.3	2.0	-0.7	1.3	0.0%
Network Grant	3.0	-1.1	1.9	3.0	-1.1	1.9	0.0%
Total	15.4	-5.4	10.0	15.4	-5.4	10.0	0.0%
Tobacco Use Prevention and Cessation Program							
Local Public Health	12.7	-1.1	11.5	12.1	-8.3	3.8	-67.1%
Countermarketing	0.5	-0.1	0.5	0.9	-0.9	0.0	-100.0%
Statewide Public Health	2.0	-0.3	1.7	2.0	-2.0	0.0	-100.0%
Minority Outreach and Technical Assistance	1.1	-0.1	1.0	1.2	-1.2	0.0	-100.0%
Surveillance and Evaluation	1.5	-0.2	1.4	1.5	-1.0	0.5	-63.0%
Administration	0.7		0.7	0.7	-0.4	0.3	-57.3%
Management	1.0	-0.1	0.9	0.9	-0.1	0.8	-8.0%
Total	19.4	-1.8	17.6	19.3	-13.8	5.4	-69.2%
Breast and Cervical Cancer Program							
Total	47.0	-7.4	39.5	46.7	-4.4	42.3	7.0%

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

Exhibit 8
Proposed Budget
DHMH – Community and Family Health Administrations
(\$ in Thousands)

How Much It Grows:	<u>General Fund</u>	<u>Special Fund</u>	<u>Federal Fund</u>	<u>Reimb. Fund</u>	<u>Total</u>
2009 Working Appropriation	\$121,405	\$52,814	\$147,163	\$809	\$322,192
2010 Allowance	<u>114,184</u>	<u>60,480</u>	<u>155,888</u>	<u>1,170</u>	<u>331,721</u>
Amount Change	-\$7,221	\$7,666	\$8,724	\$361	\$9,530
Percent Change	-5.9%	14.5%	5.9%	44.6%	3.0%
Contingent Reduction	-\$14,866	-\$4,441	-\$60	\$0	-\$19,367
Adjusted Change	-\$22,087	\$3,225	\$8,665	\$361	-\$9,837
Adjusted Percent Change	-18.2%	6.1%	5.9%	44.6%	-3.1%

Where It Goes:

Personnel Expenses

Employee and retiree health insurance pay-as-you-go costs (after reducing fiscal 2010 for contingent reductions).....	\$466
Five positions transferred from the Developmental Disabilities Administration	335
Retirement contribution	251
Decreased budgeted turnover from 6 to 5%	227
Other fringe benefit adjustments	21
One position transferred to the Laboratories Administration.....	-88
Deferred compensation (after reducing fiscal 2010 for contingent reductions).....	-139
Reduction in Other Post Employment Benefits' unfunded liability.....	-339

Community Health Administration

Increase in federal funding for the health screenings for the Refugee and Migrant Health Program	314
Federal funding increase for grant to research cases of invasive bacterial diseases	210
Reduction in computer systems costs for Environmental Public Health Tracking	-40
Decreased funding for the Targeted Local Health Formula.....	-10,122

Family Health Administration

Increased federal funding for Women, Infants, and Children program	10,030
Increased cost of the Breast and Cervical Cancer Program	2,520
New federal funding for the Maryland Heart Disease and Stroke program.....	241
New federal grant of the Office of Oral Health for surveillance.....	239
Grants provided from the Maryland Cancer Fund	200

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Where It Goes:

Increased general funding for Women, Infants, and Children program.....	73
Reduced federal funding for the colorectal cancer screening demonstration program in Baltimore City.....	-216
End of federal grant for the Nutrition and Physical Activity Project to decrease obesity rates.....	-275
Reduced federal funding for the Infants and Toddlers Program that provides early intervention case management.....	-338
Cigarette Restitution Fund Programs	
Bringing funds for the statewide academic health centers back up to mandated level ..	5,613
Increase funding for tobacco use prevention and cessation programs	1,831
Contingent reduction to Cigarette Restitution programs.....	-19,228
Office of Preparedness and Response	
Increased federal funding for the City Readiness Initiative.....	1,002
Federal funding for public health preparedness and hospital preparedness.....	861
Reduced federal funding for activities related to pandemic influenza preparedness	-3,238
Other	-248
Total	-\$9,837

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

Exhibit 9
Community and Family Health Administrations
Fiscal 2010 Contingent Reductions

<u>Program</u>	<u>Contingent Reduction</u>	<u>General Funds</u>	<u>Special Funds</u>	<u>Total Funds</u>	<u>Positions</u>
Cigarette Restitution Fund (CRF) – Tobacco Use Prevention and Cessation Program	Fiscal 2010 allocation will be reduced by \$13.8 million if the Budget Reconciliation and Financing Act (BRFA) language is adopted to reduce the legislative mandate of CRF funding for tobacco control and cessation activities by \$14.0 million (from \$21.0 million to \$7.0 million) in fiscal 2010 and each subsequent year.	\$0	-\$13,828,224	-\$13,828,224	5.0
CRF – Statewide Academic Health Centers	Fiscal 2010 allocation will be reduced by \$5.4 million if BRFA language is adopted to reduce the legislative mandate of CRF funding for statewide academic health centers by \$5.5 million for fiscal 2010 and 2011 with the mandated appropriation returning to \$15.4 million in fiscal 2012.	0	-5,400,000	-5,400,000	
Breast and Cervical Cancer Program	Fiscal 2010 general fund allocation will be reduced by \$14.8 million, and the special fund appropriation will increase by \$14.8 million if both the CRF tobacco and CRF statewide academic health centers BRFA provisions are adopted.	-14,800,000	14,800,000	0	
All Programs	Deferred compensation match.	-66,174	-12,950	-138,853	
Total		-\$14,866,174	-\$4,441,174	-19,367,077	5.0

Note: The remainder of the CRF contingent reductions (\$4.4 million) will be transferred to the Medicaid program to reduce the general fund need for that program.

Source: Department of Legislative Services; State Budget

Personnel

The number of positions allocated to the Community and Family Health Administrations increase by a net of 4 positions from the fiscal 2009 working appropriation to the fiscal 2010 allowance. Contractual positions for the Community and Family Health Administrations decrease by 0.5 positions.

The fiscal 2010 allowance transfers five positions from the Developmental Disabilities Administration to the CRF programs to provide administrative support. However, the budget bill, as submitted by the Governor, contains budget bill language deleting these five positions contingent on enactment of a Budget Reconciliation and Financing Act (BRFA) provision reducing CRF funding for tobacco programs. If the contingent reduction is not adopted, it is not clear that the CRF programs need five new positions because the work of the CRF programs has not changed. **The Department of Legislative Services (DLS) recommends deleting these five positions whether or not the BRFA provision is adopted.**

The fiscal 2010 allowance transfers one position from the Family Health Administration's Office for Genetics and Children with Special Health Care Needs to the Laboratories Administration. As of January 1, 2009, the Laboratories Administration is the only laboratory in the State to conduct newborn screening tests. This position being transferred to the Laboratories Administration is the only position provided to the Laboratory Administration to assist with the roughly 40% increased workload.

As of December 31, 2008, the Community and Family Health Administrations' vacancy rate was 6.6% with 22.0 vacant positions. This vacancy rate is slightly higher than the budgeted turnover allocated in the fiscal 2010 allowance.

Targeted Local Health Formula

Exhibit 8 shows the funding for the targeted local health formula is decreasing by \$10.1 million from the fiscal 2009 working appropriation to the fiscal 2010 allowance. However, it is expected the formula will be level funded from fiscal 2009 to 2010. As presented by the Governor, the budget is balanced assuming additional fiscal 2009 cost containment actions. One of the specific anticipated cost containment actions is a \$10.1 million, or 15%, reduction to the targeted local health formula. **Exhibit 10** shows the fiscal 2009 changes to the funding of the targeted local health formula, and the impact of these cost containment actions by jurisdiction is shown in **Appendix 5**.

Exhibit 10 also shows the targeted local health formula is level funded in the fiscal 2010 allowance and does not include an inflationary adjustment for population growth and inflation. The Administration has determined the statute does not mandate annual inflationary adjustments to the targeted local health formula, which is accurate. Specifically, the statute states for "...fiscal year 1998 and each subsequent fiscal year, the amount of funding for fiscal year 1997 adjusted for..." (Health-General § 2-302) inflation and population growth. However, since the inception of the targeted local health formula, the inflationary adjustment has been made to the previous year's base allocation, not the level in 1997. Under this interpretation, the mandated amount would be \$43.1 million.

Exhibit 10
Funding of Targeted Local Health Formula
Fiscal 2009-2010

Fiscal 2009	
Base	\$59.8
Inflationary Adjustment	1.8
Cumulative Personnel Adjustments	7.2
Legislative Appropriation	\$68.8
Cost-of-living Adjustment	\$0.5
Board of Public Works Cost Containment	-1.8
Working Appropriation	67.5
Anticipated Cost Containment	-10.1
Adjusted Working Appropriation	\$57.4
Fiscal 2010	
Base	\$57.4
Inflationary Adjustment	0.0
Cumulative Personnel Adjustments	0.0
Allowance	\$57.4

Source: Maryland State Budget

Breast and Cervical Cancer Diagnosis and Treatment Program

In recent years, the Breast and Cervical Cancer Diagnosis and Treatment Program (BCCDTP) expenditures have increased at a significant rate. Exhibit 8 shows the program expenditures are increasing \$2.5 million from the fiscal 2009 working appropriation to the fiscal 2010 allowance. However, this increase does not take into account the fiscal 2009 deficiency appropriation in the amount of \$2.2 million. When the fiscal 2009 deficiency appropriation is included, the fiscal 2010 allowance provides BCCDTP with a \$0.3 million, or 2.0%, increase for a program with expenditures expected to grow by 12.5% in fiscal 2010.

The budget bill includes a contingent reduction to reduce the general fund allocation for the program by \$14.8 million, and replace the general funds with CRF funds that will be reduced from the CRF programs.

Cigarette Restitution Fund Programs

Exhibit 8 shows the funding for the CRF programs to be increasing by \$7.4 million, which brings the fiscal 2010 allowance closer to the legislative mandated funding for these programs. However, as shown in Exhibit 7, contingent reductions included in the Governor's budget plan reduces the funding for these programs by a total of \$19.2 million, or 33%, from the fiscal 2010 allowance.

These reductions are contingent on the passage of provisions in the BRFA that reduce the statutory mandated level of funding for the CRF programs, as shown in Exhibit 9. The BRFA provision impacting the CRF funding for tobacco use and prevention activities reduces the mandated funding for these programs from \$21.0 million to \$7.0 million for fiscal 2010 and each fiscal year thereafter. Exhibit 7 shows the distribution of the contingent reduction among the tobacco programs. The allocation of the contingent reduction eliminates three aspects of the Tobacco Use Prevention and Cessation Programs: (1) statewide public health (\$2.0 million); (2) Minority Outreach and Technical Assistance (\$1.2 million); and (3) countermarketing (\$0.9 million).

Three BRFA provisions impact the mandated funding levels for the statewide academic health centers: (1) mandated funding for cancer research grants is reduced from \$10.4 million to \$6.7 million; (2) mandated funding for tobacco-related diseases research grant decreases from \$2.0 million to \$1.3 million; and (3) mandated funding for the network grant decreases from \$3.0 million to \$1.9 million. The statewide academic health center provisions are effective for fiscal 2010 and 2011, and in fiscal 2012, the mandated funding levels return to the current levels.

If adopted, the BRFA provisions reduce mandated funding levels for the CRF programs by \$19.5 million, but the contingent reductions only decrease the fiscal 2010 appropriations for the CRF programs by \$19.2 million. The funding for the statewide academic health centers will be \$0.1 million more than the mandated level.

Maryland P3 Diabetes Management Program

Since fiscal 2007, legislative action has restricted a portion of FHA's budget to fund the University of Maryland School of Pharmacy for the Maryland P3 Diabetes Management Project. The fiscal 2010 allowance includes \$0.1 million in general funds to fund the program, which serves as the required State match for the CDC Diabetes grant, which requires a \$1 State to \$4 federal.

The P3 (Patients, Pharmacists, Partnerships) Program links pharmacists who are trained to help patients manage their diabetes through regular counseling sessions. The specially trained pharmacists also work with the patient's physician for the appropriate pharmaceutical management of diabetes. The infrastructure built by this program can be expanded to improve chronic disease care and contain costs for other populations (*e.g.*, State employees and patients of Federally Qualified Health Centers).

Issues

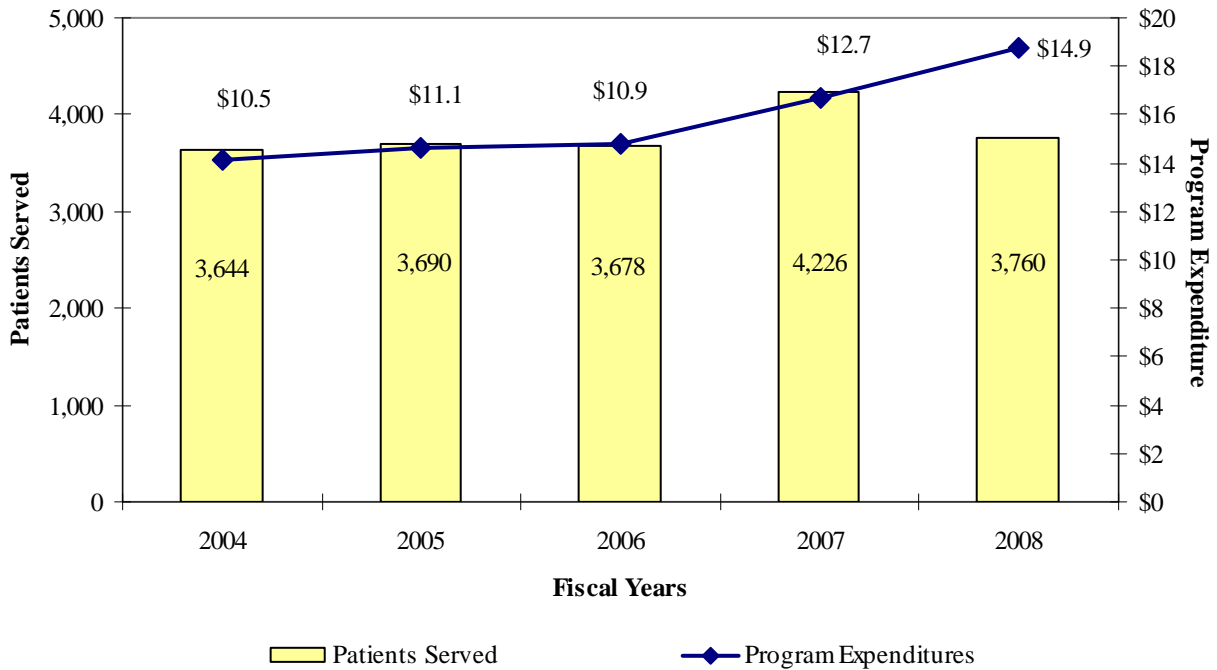
1. Breast and Cervical Cancer Expenditures Continue to Grow

FHA administers the Breast and Cervical Cancer Diagnosis and Treatment Program, which funds breast and cervical cancer diagnostic and treatment services for uninsured, low-income (below 250% of the federal poverty level) women age 40 and older that are not Medicaid eligible. BCCDTP covers the following services:

- breast and cervical cancer diagnostic procedures including ultrasound, biopsy, colposcopy, surgical consultations, etc.;
- breast and cervical cancer treatment procedures including cryotherapy, laser hysterectomy, lumpectomy, mastectomy, radiation therapy, and chemotherapy;
- physical therapy, occupational therapy, and a home health nurse, when required because of breast or cervical cancer;
- medications required for the treatment of breast or cervical cancer;
- medical equipment when required because of breast or cervical cancer;
- breast prosthesis and bras;
- wigs;
- breast reconstruction; and
- other costs related to diagnosis and treatment (laboratory tests, x-rays, and hospital care).

In fiscal 2008, the program served approximately 3,760 patients at a cost of \$14.9 million in general funds. **Exhibit 11** shows the number of patients served by BCCDTP from fiscal 2004 through 2008. While the number of patients served has not increased significantly over this time period, the program's expenditures have increased significantly starting in fiscal 2007. Specifically, in both fiscal 2007 and 2008, the program's expenditures increased more than 15%.

Exhibit 11
Enrollment and Expenditures for the Breast and Cervical
Cancer Diagnosis and Treatment Program
Fiscal 2004-2008
(\$ in Millions)



Source: Department of Health and Mental Hygiene

Audit Finding

According to BCCDTP’s written policy, all recipients are required to apply for Medicaid and, if the recipient subsequently becomes eligible for Medicaid, then the provider is to repay BCCDTP for the payments made during the dual eligibility period. The provider then must bill Medicaid for the services provided. However, an audit of FHA conducted by the Office of Legislative Audits released July 2008 included a repeat finding that FHA was not doing its due diligence in seeking Medicaid coverage and, therefore, not maximizing federal recoveries and minimizing State expenditures.

The audit identified two issues with regard to maximizing Medicaid eligibility. First, FHA was not requiring recipients to apply for Medicaid when initially enrolling in BCCDTP or during the annual re-enrollment process. FHA did send letters to recipients after they were enrolled in BCCDTP requesting they apply for Medicaid, but the program did not follow up to ensure the individual

submitted the application. Specifically, the audit found 745 BCCDTP recipients did not respond to FHA’s letters and could potentially be eligible for Medicaid coverage.

The other issue was that FHA was not always aware when some recipients were enrolled in Medicaid. Specifically, the weekly automated matches of BCCDTP’s database of new recipients with the Medicaid database did not identify all eligible recipients.

The audit recommended FHA implement appropriate follow-up procedures to ensure that recipients apply for Medicaid and correct deficiencies in the computer program that generates the weekly match so that the reports include all recipients that became eligible for Medicaid. FHA did develop a computer report in response to the audit finding to assist them in identifying those individuals that were dually enrolled in BCCDTP and Medicaid.

Fiscal 2010 Expenditures

Exhibit 12 shows actual spending for BCCDTP in recent years and the fiscal 2009 and 2010 allocations for the program.

Exhibit 12
Breast and Cervical Cancer Diagnosis and Treatment Program Expenditures
Fiscal 2006-2010

	<u>General Funds</u>	<u>Special Funds</u>	<u>Total Funds</u>	<u>Annual % Change</u>
Fiscal 2006 Actual	10.9		10.9	
Fiscal 2007 Actual	12.7		12.7	15.8%
Fiscal 2008 Actual	14.9		14.9	18.2%
Fiscal 2009				
Legislative Appropriation	12.3		12.3	
Deficiency Appropriation	2.2		2.2	
Adjusted Appropriation	14.5		14.5	-3.2%
Fiscal 2010				
Allowance	14.8		14.8	
Contingent Reduction	-14.8	14.8	0.0	
Adjusted Appropriation	0.0	14.8	14.8	2.3%
Additional Estimated Need	2.0		2.0	

Source: Department of Legislative Services; State Budget

As shown in Exhibit 12, with the \$2.2 general fund deficiency appropriation, the fiscal 2009 appropriation is 3.2% below the actual expenditures in fiscal 2008. This could potentially be an adequate level of funding because FHA thinks roughly 15% of BCCDTP are newly eligible for Medicaid coverage with the expansion of Medicaid coverage to parents with incomes up to 116.0% of the federal poverty level (up from roughly 40.0% of the federal poverty level). Allowing for 15.0% growth in expenditures and taking into account new Medicaid eligibility levels, BCCDTP expenditures are estimated to be \$14.6 million in fiscal 2009. **FHA should discuss how enrollment in the Breast and Cervical Cancer Diagnosis and Treatment Program has been impacted by the expansion of Medicaid to parents with incomes up to 116% of the federal poverty level as of July 1, 2008.**

If the Medicaid eligibility assumptions hold true, and the program's expenditures grow 15.0% off the estimated spending of \$14.6 million in fiscal 2009, then fiscal 2010 expenditures are expected to amount to \$16.8 million. This would mean the program is underfunded in fiscal 2010 by \$2.0 million.

The proposed fiscal 2010 contingent reductions reduce general funds for BCCDTP by \$14.8 million and replace the general funds with special funds from CRF. This fund swap is contingent on language in the BRFA reducing CRF funding for both CRF tobacco programs and CRF statewide academic health centers. If the provision reducing the mandated appropriation for the CRF tobacco programs from \$21.0 million to \$7.0 million is adopted, the Department of Legislative Services recommends the \$14.0 million continue to be used to reduce the general fund expenditures for BCCDTP.

FHA should provide an assessment to the budget committees about the adequacy of funding for the Breast and Cervical Cancer Diagnosis and Treatment Program in fiscal 2009 and 2010.

2. Oral Health Initiatives

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 summer 2007, DHMH formed a Dental Action Committee.

The fiscal 2009 budget solidified the State’s commitment toward improving dental outcomes for children in the State by allocating \$16.0 million for that purpose in a tight budget year. The Medicaid budget included \$14.0 million to improve dental reimbursement rates in Medicaid. The Office of Oral Health was provided an additional \$1.5 million to support local dental health programs and expand school-based dental services. Also, \$0.5 million was included in the capital budget to establish dental clinical physical infrastructure.

Exhibit 13 shows how the non-Medicaid portion of the new dental funding was allocated in fiscal 2009 and the planned expenditures for fiscal 2010 and 2011.

Exhibit 13
DHMH Plan for Funding Public Dental Health Programs
Fiscal 2009-2011

	<u>2009</u>	<u>2010*</u>	<u>2011</u>
Local Dental Health Programs			
Establishing Access to Care	\$0.4	\$0.4	\$0.4
Initiating or Expanding Clinical Services	0.4	0.4	0.4
Dental Clinical Physical Infrastructure	0.5	0.5	0.5
Subtotal	\$1.3	\$1.4	\$1.4
School-based Oral Health Services			
Mobile Dental Van	\$0.3	\$0.3	\$0.3
Prevention Services	0.3	0.3	0.3
Access Programs	0.1	0.1	0.1
Subtotal	\$0.7	\$0.7	\$0.7
Total	\$2.0	\$2.1	\$2.1

DHMH: Department of Health and Mental Hygiene

* The fiscal 2010 allowance does not include \$0.5 million in funding in the Dental Clinical Physical Infrastructure portion of the Office of Oral Health’s plan.

Source: Department of Health and Mental Hygiene

Operational and Capital Grant Awards

The Office of Oral Health focused the distribution of the operational and the capital funds on five jurisdictions in the State without a public health dental clinical program. These targeted jurisdictions were Calvert, Kent, Queen Anne's, St. Mary's, and Worcester counties.

In response to the requests for proposals, the Office of Oral Health received four grant proposals for capital funding and 14 grant proposals for operational dental services. The recipient of the capital funding was the Worcester County Health Department, and the recipients of the dental operational grants were the Worcester County Health Department, the Calvert Memorial Hospital, and a partnership of the Kent and Queen Anne's County Health Departments.

Of the five targeted jurisdictions, St. Mary's County was the only jurisdiction that did not request funding and, therefore, the only targeted jurisdiction that did not receive funding. As a result, St. Mary's County is the only jurisdiction in the State without a public health dental clinical program.

The Office of Oral Health also issued targeted funding grants to provide new or expanded dental services to local health departments in Carroll, Charles, Harford, Howard, and Prince George's counties. This funding established public health dental clinics in the Charles and Harford County Health Departments for the first time. In addition, two community organizations received funding to provide new or expanded dental services: Choptank Community Health Services, Inc. on the Eastern Shore and Health Up Mission in Baltimore City.

Mobile Dental Van

The Office of Oral Health provided a grant to the Robert T. Freeman Dental Society Foundation, which is a nonprofit professional society comprised of African American dentists from Montgomery and Prince George's counties that partners with the Prince George's County Health Department, to help fund the mobile dental van project.

The process of purchasing a permanent mobile van will take some time, but for the time being, the foundation has rented a mobile van to provide school-based services. So far, children in nine schools in Montgomery and Prince George's counties have received a dental screening.

The Office of Oral Health insisted as part of this project that the foundation not only provide dental services on the mobile van but also link children to local dentists for services not available through the mobile dental van. To assist in this effort, the foundation has a partnership with approximately 60 local dentists.

School-based Services

The Office of Oral Health has provided school-based dental prevention services to Baltimore, Caroline, Cecil, Garrett, Somerset, and St. Mary's counties and Baltimore City. The funding expands critically needed preventive dental sealant programs and fluoride application programs. The programs

targets children in Title I schools to provide preventive dental sealant and fluoride application services needed to prevent the onset of dental decay in these high-risk, low-income students.

The other portion of the school-based initiative provides oral health access, which provides funding to Kent and Queen Anne’s County Local Health Departments. With these funds the local health departments are developing school-based dental access points and prevention services. The project includes schoolwide oral health education to Medicaid/Maryland Children’s Healthcare Program enrollees and uninsured students on location at 11 schools in Kent and Queen Anne’s counties using a dental team comprised of a dental hygienist and dental assistant. Selected patients will receive an oral health assessment, cleaning, and sealant treatment. Patients with additional dental needs will be linked to an existing dental home such as the University of Maryland Dental School clinic in Cecil County or Choptank Community Health Systems, Inc.

Fiscal 2010 Allowance

The fiscal 2010 allowance level funds the Office of Oral Health for the operational grant program, the mobile dental van, and the school-based services. As shown in Exhibit 13, the office anticipates level funding these activities.

The Office of Oral Health did receive new federal funds from the Centers for Disease Control and Prevention. The federal grant amounts to \$1.3 million over the next five years and \$0.2 million in fiscal 2010. The funding will assist the Office of Oral Health with developing the State Oral Health Plan and expanding current prevention and surveillance efforts. While these funds cannot be used for direct services, the money will help to formalize the statewide strategic planning process and enhance the Office of Oral Health’s efforts to incorporate more statewide preventive approaches utilizing dental sealants and water fluoridation.

The fiscal 2010 capital budget allowance does not include funding for the capital portion of the Office of Oral Health’s planned expenditures. Last year, budget bill language was added to the capital budget directing the department to submit a report outlining how the \$0.5 million in capital grants was allocated. Also, the language directed the department to include draft legislation with the report formally establishing the Oral Health Safety Net Program, which was the name provided to the capital funding included in the fiscal 2009 capital budget. The department did submit a report and draft legislation, but the draft legislation was not to establish a capital grant program. The draft legislation repealed the September 30, 2011, termination date for the Oral Health Safety Net Program which was established as an operating budget program during the 2007 regular session.

Admittedly, there was confusion in the name of the capital program and non-specificity of the budget bill language. However, the intent of the language added to the capital budget bill was for the department to submit draft legislation establishing a capital grant program for public dental health clinics.

The department should explain why the department decided not to submit legislation establishing a capital grant program for public dental health clinics and why no funding was provided in the fiscal 2010 operating or capital budget for the dental clinic physical infrastructure portion of the funding plan.

3. Two Infant Mortality Programs Operating within FHA

FHA received funding in fiscal 2007 to implement the Babies Born Healthy Initiative 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.

The Funding

Funding for the Babies Born Healthy Initiative 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 Initiative received \$2.9 million.

The fiscal 2009 allowance reduced the funding for the Babies Born Healthy Initiative by \$0.5 million to \$2.4 million. In addition, the fiscal 2009 allowance included \$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 Babies Born Healthy Initiative.

The General Assembly added budget bill language restricting \$0.7 million of the new \$1.0 million general funds appropriated to the Office of Minority Health and Health Disparities to be used to fund the Babies Born Healthy Initiative. Funding of these two programs as reflected in the fiscal 2009 working appropriation does not indicate that the \$0.7 million for the Babies Born Healthy Initiative has been allocated to that program. However, the Babies Born Healthy Initiative has awarded the \$0.7 million to three different grantees.

As shown in **Exhibit 14**, the fiscal 2010 allowance level funds both programs from the fiscal 2009 working appropriation, which does not reflect the \$0.7 million shifted to the Babies Born Healthy Initiative allocation. The three grant awards provided by the Babies Born Healthy Initiative in fiscal 2009 are multi-year awards. **DHMH should explain to the budget committees why the Babies Born Healthy Initiative funding remains in the allocation for the Office of Minority Health and Health Disparities.**

Grant Awards

The language also requested the Office of Minority Health and Health Disparities and the Babies Born Healthy Initiative to work in collaboration to reduce infant mortality, and the department was asked to submit a report regarding the status of both infant mortality programs and the collaborative efforts.

Exhibit 14
Funding for Infant Mortality Programs
Fiscal 2008-2010

	2008	2009	2010
	<u>Actual</u>	<u>Working</u>	<u>Allowance</u>
		<u>Appropriation</u>	
The Budget			
Babies Born Healthy Initiative	\$2.4	\$2.4	\$2.4
Office of Minority Health and Health Disparities	0.0	1.0	1.0
Total Infant Mortality Funding	\$2.4	\$3.4	\$3.4
Legislative Intent			
Babies Born Healthy Initiative	\$2.4	\$3.1	\$3.1
Office of Minority Health and Health Disparities	0.0	0.3	0.3
Total Infant Mortality Funding	\$2.4	\$3.4	\$3.4

Source: Maryland State Budget

The Babies Born Healthy Initiative continued the activities begun in fiscal 2008 and with the new \$0.7 million, provided three new grants in fiscal 2009. Two of the grants focus on Baltimore City and one grant focuses on Prince George’s County. The Baltimore City Health Department received funding for Baltimore Healthy Start Inc. to fund expansion of outreach and community-based services to new high-risk neighborhoods. Also, the funding to the Baltimore City Health Department will add a new mobile delivery system to provide social and mental support services.

Planned Parenthood, Inc. of Maryland also received funding from the Babies Born Healthy Initiative to develop preconception and prevention services for women receiving services in Baltimore City. The funding will also go toward funding a public awareness campaign to increase awareness in the community about infant mortality and low birth weight babies to promote preconception health services.

The Babies Born Healthy Initiative funding in Prince George’s County focused on expanding provider capacity and strengthening safety net resources. Funding went to re-establish a women’s wellness center at the Prince George’s County Health Department’s Cheverly Health Center. Also, funding went to the Greater Baden Medical Services, Inc. in Suitland, Maryland to provide outreach and serve women at risk of poor pregnancy outcomes with preconception and family planning services.

The Office of Minority Health and Health Disparities entered into a cooperative agreement with the Prince George’s County Health Department to establish a pilot project with the goal of assisting the community with obtaining resources to sustain effective interventions. The Office of Minority Health and Health Disparities will be providing the \$0.3 million allocated to the office in fiscal 2009 as grant

funding to the Prince George’s County Health Department. **The Office of Minority Health and Health Disparities should provide the budget committees with detail on how the \$0.3 million in grant funding to the Prince George’s County Health Department will be used.**

Collaboration

Representatives of the Babies Born Healthy Initiative and the Office of Minority Health and Health Disparities have met a few times throughout the year to share information about new activities underway in their respective programs. Staff from both programs has agreed to meet regularly to discuss data analysis approaches. In looking through the data, the programs have agreed that while the African American disparities in infant mortality must be the primary focus of the programs, adverse outcomes among Hispanic births also need to be monitored closely.

Other collaborative activities between the programs are educating policymakers about the issues of infant mortality and racial disparities. While the programs have worked together in some respects, the programs did not coordinate the grant awards to make the best use of the State’s money, which is particularly critical given the current fiscal condition of the State. Both programs have/will provide fiscal 2009 funding to the Prince George’s County Health Department, and there seems to have been no coordination in allocating this funding.

DHMH and the Department of Budget and Management should explain to the budget committees the logic of operating two such similar programs, with the same goals and focus, within the same department and the same administration.

4. Stockpile of Antiviral Treatments

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

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, and 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.

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.

The State had until June 29, 2008, to take advantage of the federal subsidized price. As shown in **Exhibit 15**, by the program deadline, DHMH had purchased 90%, or 522,151, of the treatment doses reserved for Maryland under the federal agreement. The antivirals were purchased using mostly surplus federal funds with prior approval from the federal government.

Exhibit 15
Maryland’s Antiviral Purchase Plan
As of January 1, 2009

Number of Treatment Doses Allotted

	<u>Total Allotment</u>	<u>Purchased</u>	<u>Remaining</u>
Tamiflu	462,952	418,804	44,148
Relenza	115,802	105,851	9,951
Total	578,754	524,655	54,099

Funds Used to Purchase

<u>General</u>	<u>Local</u>	<u>Private</u>	<u>Federal</u>	<u>Total Spent</u>
\$0	\$494,775	\$227,526	\$5,119,278	\$5,841,579
0.0%	8.5%	3.9%	87.6%	100.0%

Source: Department of Health and Mental Hygiene

The federal government did extend the deadline to purchase the first allotment of antiviral treatments to September 1, 2009. Purchasing the remaining allotment is important because the federal government will only extend future programs offering federally subsidized price for antiviral treatment regimens to develop a stockpile to states that have purchased the full initial allotment.

The Office of Preparedness and Response did receive a fiscal 2009 deficiency appropriation bringing \$1.7 million in special fund revenue from public-private partnership collections for the antiviral treatment stockpile. OPR has collected \$0.2 million of this money from Harford, Howard, Garrett, and Talbot counties and the Johns Hopkins Applied Physics Laboratory. The balance of the deficiency appropriation is what the office expects to receive in public-private partnership collections.

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The Office of Preparedness and Response mentioned in their report that it would cost \$0.8 million to fully purchase the remainder of the State’s federal allotment. **The office should explain why the deficiency appropriation is \$0.9 million more than they said it would cost to purchase the remainder of the State’s federal allotment.**

The Office of Preparedness and Response should also update the budget committees on the status of public-private partnership collections and the office’s plans to ensure the remainder of the federal allotment is purchased by the September 1, 2009 deadline.

Recommended Actions

	<u>Amount Reduction</u>	<u>Position Reduction</u>
1. Reduce general fund support for the Women, Infants, and Children (WIC) program. Statute mandates that the Governor include in the budget allowance at least \$250,000 in general funds to support the administration and food costs of WIC. Almost \$150,000 of the general funds allocated to WIC are used to cover expenses that federal funds cannot cover, such as the federal fund match for the Farmers Market Coupon Program, NetworkMaryland expenses, and Vitamin D supplements. However, a little more than \$100,000 of the expenses covered by general funds in the fiscal 2010 allowance can be covered by federal funds.	\$ 102,360	GF

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

Further provided that \$665,000 of this appropriation made for the Office of Minority Health and Health Disparities to reduce infant mortality may not be expended for that purpose but instead may only be used to fund ongoing grants in the Babies Born Healthy Initiative. Also, the Office of Minority Health and Health Disparities shall work in collaboration with the Babies Born Healthy Initiative to reduce the rate of infant mortality in the State and make the best use of the State’s funding. The Department of Health and Mental Hygiene shall report to the budget committees by November 1, 2009, to provide a status report on both infant mortality programs, detail regarding how both programs allocated grant funding, and the collaborative efforts of the Office of Minority Health and Health Disparities and the Babies Born Healthy Initiative.

Explanation: The fiscal 2010 allowance allocates \$665,000 to the Office of Minority Health and Health Disparities that the Babies Born Healthy Initiative depends on to fund the second year of grant funding to entities receiving a three-year grant award in fiscal 2009. This language restricts the funding allocated to the Office of Minority Health and Health Disparities to be used to fund the grants awarded by the Babies Born Healthy Initiative. The Department of Health and Mental Hygiene (DHMH) administers two infant mortality programs, and the budget committees would like to ensure these programs are working together to make the best use of the funding available. The language requires a report to be submitted November 1, 2009, to provide a status report to the budget committees about the two infant mortality programs, how the funds have been allocated, and how the programs are working together.

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Information Request	Author	Due Date
Status on funding and collaborative efforts of both infant mortality programs	DHMH	November 1, 2009

3. Amend the following language to the special fund appropriation:

Further provided that this appropriation shall be reduced by \$13,828,224 and ~~5 positions contingent on enactment of legislation reducing funding from the Cigarette Restitution Fund to tobacco programs.~~

Explanation: The Budget Reconciliation and Financing Act (BRFA) of 2009 proposes to reduce the mandated appropriation for the Cigarette Restitution Fund (CRF) tobacco programs from \$21.0 million to \$7.0 million. The language in the budget bill contingent on this provision of the BRFA deletes five positions that are transferred to the CRF tobacco programs in the fiscal 2010 allowance. The administration of the CRF tobacco programs has not changed in recent years, so the programs do not need five new positions. The Department of Legislative Services recommends deleting these five positions whether the BRFA provision is adopted or not.

	<u>Amount Reduction</u>	<u>Position Reduction</u>
4. Delete five new positions for the Cigarette Restitution Fund (CRF) tobacco programs. The fiscal 2010 allowance transferred five positions into the CRF tobacco programs, and the budget bill contains contingent reduction language deleting these five positions if a provision in the Budget Reconciliation and Financing Act (BRFA) of 2009 reducing the mandated appropriation for CRF tobacco programs is adopted. However, the administration of the CRF tobacco programs has not changed in recent years, so the CRF tobacco programs does not have a need for five new positions whether or not the BRFA provision is adopted.	\$334,597 SF	5.0
5. Adopt the following narrative:		

Office of Oral Health Include Budget Detail: The budget committees note that the Office of Oral Health has numerous reporting requirements. Without adding an additional reporting requirement for the Office of Oral Health, the budget committees request the Office of Oral Health include budget detail in the report required by the Oral Health Safety Net Act. Also, the Office of Oral Health should ensure the report is submitted to the budget committees.

6. Adopt the following narrative:

Stockpile of Antiviral Treatments: The committees note the federal government is offering to sell the states enough antiviral treatments to treat 25% of each state’s population at a significantly reduced priced. To date, the department has purchased 90% of the antiviral treatments allotted to the State under the federal subsidized price. To take advantage of the federal government’s offer, the Department of Health and Mental Hygiene (DHMH) must purchase the antiviral treatments by September 1, 2009. The committees request that DHMH provide a report by October 1, 2009, detailing how much of the antiviral treatments were purchased at the federal subsidized price and the source of funding the purchases.

Information Request	Author	Due Date	
Report on the antiviral treatments purchased	DHMH	October 1, 2009	
Total Reductions		\$ 436,957	5.0
Total General Fund Reductions		\$ 102,360	
Total Special Fund Reductions		\$ 334,597	

Updates

1. Clean Indoor Air Act

The Clean Indoor Air Act prohibits smoking in indoor areas open to the public except in limited circumstances, and the law became effective February 1, 2008. The Department of Health and Mental Hygiene’s Community Health Administration along with local health departments and the Department of Labor, Licensing, and Regulation was provided the regulatory authority for portions of the Clean Indoor Air Act related to public areas.

Pursuant to Health-General § 24-507(B) the Department of Health and Mental Hygiene is required to submit an annual report regarding the Clean Indoor Air Act enforcement activities.

The department was responsible for developing the regulations for the Clean Indoor Air Act, and CHA conducted three public meetings to ensure all stakeholder perspectives were considered in the development of the regulations. The final regulations adopted by CHA were modeled after similar regulations adopted in New York and the District of Columbia.

The regulations defined “indoor area” as “all space in a structure or building with a ceiling that is enclosed on all sides by any combination of permanent or temporary walls, windows, or doorways, whether opened or closed, or other physical barriers extending from the floor to the ceiling.” In addition, the regulations defined the waiver provisions of the Clean Indoor Air Act by adopting criteria for economic hardship when the party is able to demonstrate at least 15% decrease in gross sales of food and beverage over two consecutive months when compared to the same two months the previous year.

In the implementation of the law, CHA conducted outreach and education activities. The department distributed approximately 7,000 educational toolkits to restaurants, bars, hotels, and local health departments. The department established a toll-free help line to assist businesses, new media, elected officials, and the public with the new law. This phone number received more than 520 phone calls. The total volume of inquiries regarding the Clean Indoor Air Act peaked around the implementation date and decreased within a couple days.

The department worked with the local health departments to implement the Clean Indoor Air Act, and CHA continues to work with the local health departments to enforce the law. To ensure consistency across the State in the implementation and enforcement of the new law, CHA conducted four trainings throughout the State for a total of 250 local health department employees.

As of September 1, 2008, there had been a dozen violations of the Clean Indoor Air Act, which were all first violations that received a letter of reprimand. According to the department’s assessment, the enforcement efforts have been relatively consistent across the State.

The department received significant interest in the waiver application process. However, as of September 10, 2008, only 12 waiver applications had been received. The department worked with

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the Office of the Comptroller to conduct fiscal analyses of the applications claiming financial hardship. After reviewing the applications, CHA and the local health departments have approved five waivers, denied three waivers, and four applications were still being reviewed. For the waivers that have been approved, the businesses are required to gradually increase the amount of time the business is operated smoke-free to ensure full compliance of the Clean Indoor Air Act by the end of the waiver period.

Nationally, research demonstrates that smoke-free laws encourage individuals to quit smoking by reducing exposure to nicotine and changing perceptions of social acceptability. The Clean Indoor Air Act seems to have had a similar effect with calls to the Maryland Tobacco Quitline increased by 120% in February 2008 over February 2007.

The report submitted by the department identified the following list of future challenges with the Clean Indoor Air Act:

- enforcement with respect to hookah and cigar bars;
- maintenance of consistent enforcement policies across the State;
- review and revision of regulations;
- documentation of local health department activities; and
- measurement of outcomes related to the Clean Indoor Air Act.

Current and Prior Year Budgets

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

	<u>General Fund</u>	<u>Special Fund</u>	<u>Federal Fund</u>	<u>Reimb. Fund</u>	<u>Total</u>
Fiscal 2008					
Legislative Appropriation	\$116,492	\$48,791	\$137,091	\$645	\$303,019
Deficiency Appropriation	2,284	0	13,437	0	15,721
Budget Amendments	\$1,383	\$5,453	\$100	\$50	6,986
Cost Containment	-\$161	-\$3,790	-\$106	\$0	-4,056
Reversions and Cancellations	0	-5,246	-5,059	-25	-10,330
Actual Expenditures	\$119,998	\$45,208	\$145,463	\$670	\$311,340
Fiscal 2009					
Legislative Appropriation	\$125,725	\$48,223	\$147,226	\$809	\$321,983
Cost Containment	-5,203	-7,453	-63	0	-12,719
Budget Amendments	884	12,044	0	0	12,928
Working Appropriation	\$121,405	\$52,814	\$147,163	\$809	\$322,192

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

Fiscal 2008

The Community and Family Health Administrations spent \$311.3 million in fiscal 2008, which is \$8.3 million more than the legislative appropriation. General funds increased by a net of \$3.5 million. The general fund support for the Breast and Cervical Cancer Program increased by a total of \$3.1 million between a \$2.3 million general fund deficiency appropriation and a DHMH close out amendment redistributing \$0.8 million in general funds to the program. The general fund also increased due to cost-of-living adjustments (COLAs) (\$0.7 million) and deficits in the areas of salaries, health insurance, and telecommunications costs (\$0.2 million). These increases were offset by a \$0.3 million general fund decrease due to higher than anticipated turnover and cost containment reductions in the amount of \$0.2 million that reduced spending for salaries, communications, supplies, travel, and fixed charges.

Special funds increased by a net of \$1.7 million. Budget amendments added an additional \$5.4 million as a result of private collections to purchase the antiviral treatments through the federal government's subsidized price. This increase was offset with a \$3.8 million cost containment reduction to Cigarette Restitution Fund grants in the areas of cancer and tobacco prevention.

Federal funds increased by a total of \$13.5 million with the major increase in the Women, Infants, and Children program due to increased participation and increased cost of food (\$12.9 million). Also, federal funding for environmental public health tracking increased by \$0.6 million, while cost containment to positions reduced federal funds by \$0.1 million.

The Community and Family Health Administrations canceled \$10.3 million in fiscal 2008. Special funds were canceled due to lower than anticipated participation from the private sector in purchasing antiviral treatments (\$4.9 million), Maryland Cancer Fund grants not awarded (\$0.1 million), less than anticipated need for Spinal Cord Injury funds (\$0.1 million), and less than anticipated Cigarette Restitution Fund spending (\$0.1 million). Federal funds were canceled as a result of less than anticipated spending in the areas of emergency preparedness (\$3.8 million) and WIC (\$1.1 million).

Fiscal 2009

The Community and Family Health Administrations have a fiscal 2009 working appropriation of \$322.2 million, which is \$0.2 million more than the legislative appropriation. COLAs increased both general and special funds by almost \$0.8 million. General funds increased another \$0.2 million for annual salary review adjustments and inflationary adjustments for community providers. Special funds increased \$12.0 million to include funding from the Dedicated Purpose Account to implement Chapter 680 of 2008, which provides a grant to the Prince George's County Hospital Authority. However, these increases were more than offset by \$12.7 million in cost containment that reduced general funds by \$5.2 million, special funds by \$7.5 million, and federal funds by \$0.1 million. The following is a list of the larger cost containment actions:

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- reduced CRF funding for academic health centers (\$5.4 million);
- eliminated the uncompensated care portion of the Montebello at Kernan grant (\$2.3 million);
- eliminated the fiscal 2009 inflationary adjustment for the targeted local health formula (\$1.8 million);
- reduced CRF funding for tobacco prevention (\$1.1 million);
- reduction of 10% to CRF programs (excluding substance abuse, textbooks, and screening) (\$1.0 million);
- reduction of 1% to FHA grants (\$0.4 million); and
- reduced the public health residency program (\$0.2 million).

Audit Findings

Audit Period for Last Audit:	September 14, 2004 – October 31, 2007
Issue Date:	July 2008
Number of Findings:	8
Number of Repeat Findings:	1
% of Repeat Findings:	13%
Rating: (if applicable)	n/a

- Finding 1:** FHA did not take any substantive action when a vendor failed to attain a national certification for Maryland’s cancer registry, as required by the contract. In addition, certain registry data under the control of the vendor was determined to be deliberately altered.
- Finding 2:** FHA did not exercise adequate oversight of CRF grants to ensure compliance with program goals and fiscal requirements.
- Finding 3:** The eligibility criteria for the CRF programs were not consistent throughout the State.
- Finding 4:** FHA did not submit the required reports to the Governor and General Assembly detailing, in part, the effectiveness of the CRF programs in a timely manner.
- Finding 5:** Certain internal control deficiencies were noted regarding the Breast and Cervical Cancer Treatment Program claims processing.
- Finding 6:** **FHA did not have adequate procedures to follow up on recipients who failed to respond to its requests to apply for Medicaid or identify all Breast and Cervical Cancer Treatment Program recipients that were retroactively eligible for Medicaid.**
- Finding 7:** Grant funds awarded to the Prince George’s Hospital Center were not properly monitored and accounted for, in accordance with State law.
- Finding 8:** FHA did not adequately monitor Family Planning grants and contracts.

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

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

<u>Object/Fund</u>	<u>FY08 Actual</u>	<u>FY09 Working Appropriation</u>	<u>FY10 Allowance</u>	<u>FY09 - FY10 Amount Change</u>	<u>Percent Change</u>
Positions					
01 Regular	340.40	335.40	339.40	4.00	1.2%
02 Contractual	8.53	11.08	10.56	-0.52	-4.7%
Total Positions	348.93	346.48	349.96	3.48	1.0%
Objects					
01 Salaries and Wages	\$ 25,171,971	\$ 26,801,197	\$ 27,674,109	\$ 872,912	3.3%
02 Technical and Spec. Fees	480,897	473,329	520,442	47,113	10.0%
03 Communication	556,753	530,339	516,049	-14,290	-2.7%
04 Travel	607,334	624,162	649,757	25,595	4.1%
07 Motor Vehicles	270,844	143,856	182,592	38,736	26.9%
08 Contractual Services	178,979,339	177,470,913	189,258,353	11,787,440	6.6%
09 Supplies and Materials	5,811,135	2,605,478	2,799,725	194,247	7.5%
10 Equipment – Replacement	36,293	0	0	0	0.0%
11 Equipment – Additional	526,868	668,746	685,669	16,923	2.5%
12 Grants, Subsidies, and Contributions	98,822,298	112,809,927	109,367,384	-3,442,543	-3.1%
13 Fixed Charges	76,366	63,749	67,334	3,585	5.6%
Total Objects	\$ 311,340,098	\$ 322,191,696	\$ 331,721,414	\$ 9,529,718	3.0%
Funds					
01 General Fund	\$ 119,998,124	\$ 121,405,229	\$ 114,183,915	-\$ 7,221,314	-5.9%
03 Special Fund	45,208,432	52,814,147	60,479,821	7,665,674	14.5%
05 Federal Fund	145,463,379	147,163,364	155,887,776	8,724,412	5.9%
09 Reimbursable Fund	670,163	808,956	1,169,902	360,946	44.6%
Total Funds	\$ 311,340,098	\$ 322,191,696	\$ 331,721,414	\$ 9,529,718	3.0%

Note: The fiscal 2009 appropriation does not include deficiencies. The fiscal 2010 allowance does not include contingent reductions.

Fiscal Summary
DHMH – Community and Family Health Administrations

<u>Program/Unit</u>	<u>FY08 Actual</u>	<u>FY09 Wrk Approp</u>	<u>FY10 Allowance</u>	<u>Change</u>	<u>FY09 - FY10 % Change</u>
03 Community Health Services	\$ 19,032,513	\$ 18,653,707	\$ 19,544,303	\$ 890,596	4.8%
07 Core Public Health Services	71,484,283	71,974,420	61,852,207	-10,122,213	-14.1%
02 Family Health Services and Primary Care	120,012,602	134,576,030	144,666,240	10,090,210	7.5%
06 Prevention and Disease Control	80,167,070	76,969,730	87,049,461	10,079,731	13.1%
01 Office of Preparedness and Response	20,643,630	20,017,809	18,609,203	-1,408,606	-7.0%
Total Expenditures	\$ 311,340,098	\$ 322,191,696	\$ 331,721,414	\$ 9,529,718	3.0%
General Fund	\$ 119,998,124	\$ 121,405,229	\$ 114,183,915	-\$ 7,221,314	-5.9%
Special Fund	45,208,432	52,814,147	60,479,821	7,665,674	14.5%
Federal Fund	145,463,379	147,163,364	155,887,776	8,724,412	5.9%
Total Appropriations	\$ 310,669,935	\$ 321,382,740	\$ 330,551,512	\$ 9,168,772	2.9%
Reimbursable Fund	\$ 670,163	\$ 808,956	\$ 1,169,902	\$ 360,946	44.6%
Total Funds	\$ 311,340,098	\$ 322,191,696	\$ 331,721,414	\$ 9,529,718	3.0%

Note: The fiscal 2009 appropriation does not include deficiencies. The fiscal 2010 allowance does not include contingent reductions.

**Cost Containment to the Targeted Local Health Formula⁽¹⁾ by Jurisdiction
Fiscal 2009-2010**

<u>Jurisdiction</u>	2009					2010	<u>% of Formula</u>
	<u>Legislative Appropriation</u>	<u>Net BPW Reduction and COLA</u>	<u>Working Appropriation</u>	<u>Anticipated Cost Containment</u>	<u>Adjusted Working Appropriation</u>	<u>Allowance</u>	
Allegany	\$1.62	-\$0.03	\$1.59	-\$0.24	\$1.35	\$1.35	2.4%
Anne Arundel	5.80	-0.11	5.69	-0.85	4.84	4.84	8.4%
Baltimore County	8.05	-0.15	7.90	-1.18	6.71	6.71	11.7%
Calvert	0.70	-0.01	0.69	-0.10	0.59	0.59	1.0%
Caroline	0.95	-0.02	0.93	-0.14	0.79	0.79	1.4%
Carroll	2.24	-0.04	2.19	-0.33	1.86	1.86	3.3%
Cecil	1.47	-0.03	1.44	-0.22	1.22	1.22	2.1%
Charles	1.82	-0.03	1.79	-0.27	1.52	1.52	2.6%
Dorchester	0.76	-0.01	0.75	-0.11	0.64	0.64	1.1%
Frederick	2.75	-0.05	2.70	-0.41	2.30	2.30	4.0%
Garrett	0.77	-0.01	0.76	-0.11	0.65	0.65	1.1%
Harford	3.17	-0.06	3.11	-0.47	2.64	2.64	4.6%
Howard	2.27	-0.04	2.23	-0.33	1.89	1.89	3.3%
Kent	0.59	-0.01	0.58	-0.09	0.49	0.49	0.9%
Montgomery	5.81	-0.11	5.70	-0.86	4.85	4.85	8.4%
Prince George's	9.35	-0.17	9.18	-1.38	7.80	7.80	13.6%
Queen Anne's	0.75	-0.01	0.74	-0.11	0.63	0.63	1.1%
St. Mary's	1.46	-0.03	1.43	-0.22	1.22	1.22	2.1%
Somerset	0.76	-0.01	0.75	-0.11	0.63	0.63	1.1%
Talbot	0.59	-0.01	0.58	-0.09	0.49	0.49	0.9%
Washington	2.48	-0.05	2.44	-0.37	2.07	2.07	3.6%
Wicomico	1.71	-0.03	1.67	-0.25	1.42	1.42	2.5%
Worcester	0.58	-0.01	0.57	-0.09	0.48	0.48	0.8%
Baltimore City	12.30	-0.23	12.07	-1.81	10.26	10.26	17.9%
Total	\$68.76	-\$1.28	\$67.48	-\$10.12	\$57.36	\$57.36	100.0%

BPW: Board of Public Works
COLA: cost-of-living-adjustment

⁽¹⁾ General funds only.