

M00F03
Prevention and Health Promotion Administration
Department of Health and Mental Hygiene

Operating Budget Data

(\$ in Thousands)

	<u>FY 12</u> <u>Actual</u>	<u>FY 13</u> <u>Working</u>	<u>FY 14</u> <u>Allowance</u>	<u>FY 13-14</u> <u>Change</u>	<u>% Change</u> <u>Prior Year</u>
General Fund	\$38,832	\$52,460	\$53,156	\$696	1.3%
Contingent & Back of Bill Reductions	0	0	-17	-17	
Adjusted General Fund	\$38,832	\$52,460	\$53,139	\$679	1.3%
Special Fund	95,080	88,319	85,962	-2,358	-2.7%
Contingent & Back of Bill Reductions	0	0	-2	-2	
Adjusted Special Fund	\$95,080	\$88,319	\$85,960	-\$2,360	-2.7%
Federal Fund	205,270	208,453	215,097	6,645	3.2%
Contingent & Back of Bill Reductions	0	0	-27	-27	
Adjusted Federal Fund	\$205,270	\$208,453	\$215,071	\$6,618	3.2%
Reimbursable Fund	1,757	1,929	2,051	122	6.3%
Adjusted Reimbursable Fund	\$1,757	\$1,929	\$2,051	\$122	6.3%
Adjusted Grand Total	\$340,939	\$351,161	\$356,220	\$5,059	1.4%

- The Governor's proposed allowance for the Prevention and Health Promotion Administration (PHPA) increases by \$5.1 million, or 1.4%, over the fiscal 2013 working appropriation.
- There are three proposed deficiencies for fiscal 2013 for the Women, Infant, and Children program (\$1,827,885), Maryland's integrated behavioral health/primary care network (\$1,313,643), and development of strategic plans for billing immunization services in health department clinics (\$594,002).

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

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Personnel Data

	<u>FY 12 Actual</u>	<u>FY 13 Working</u>	<u>FY 14 Allowance</u>	<u>FY 13-14 Change</u>
Regular Positions	366.30	364.80	362.80	-2.00
Contractual FTEs	<u>4.01</u>	<u>8.78</u>	<u>8.93</u>	<u>0.15</u>
Total Personnel	370.31	373.58	371.73	-1.85

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	18.14	5.00%
Positions and Percentage Vacant as of 12/31/12	36.20	9.92%

- The fiscal 2014 allowance includes 2.0 fewer regular employees for PHPA. Full-time contractual employees increase by 0.15.
- As of December 31, 2012, the agency had 36.2 vacant positions. PHPA had intentionally left positions vacant prior to the reorganization of Public Health Services, and the agency is in the process of filling these positions.

Analysis in Brief

Major Trends

Infant Mortality Rates: The overall infant mortality rate in Maryland decreased from 7.2 deaths per 1,000 live births in calendar 2009 to 6.7 deaths per 1,000 live births in calendar 2011. This is the lowest infant mortality rate reported in the history of the State. However, Maryland's African American infant mortality rate increased over the 2010 level from 11.8 to 12.0 deaths per 1,000 live births.

Cancer Mortality Rates Continue to Improve: One of the main functions of the Cancer Prevention, Education, Screening, and Treatment Program within the Cigarette Restitution Fund (CRF) 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 by reducing overall cancer mortality in the State. The overall mortality rate for cancer in Maryland continues to decrease, as does the rate for breast cancer mortality. Moreover, the percentage of middle school and high school students who currently smoke cigarettes continues to decline.

Childhood Vaccinations Rate Remains High: In calendar 2011, 78% of children ages 19 to 35 months received the typical coverage of vaccinations, which is slightly above the national average of 77%. Moreover, 83% of children enrolled in Maryland's Medicaid program received the typical coverage of vaccinations.

Syphilis and Chlamydia Rates Remain Higher Than the National Average: Both the rate of primary and secondary syphilis and the rate of Chlamydia infections in Maryland remain higher than the national average.

Second Highest AIDS Rate of Any State: In 2010, the Centers for Disease Control and Prevention reported that Maryland had the second highest AIDS case rate in the nation behind the District of Columbia. In calendar 2012, the State had 1,822 new Human Immunodeficiency Virus (HIV) diagnoses, a 1% decrease over the calendar 2011 level. Moreover, there were an estimated 690 new AIDS diagnoses in calendar 2012. This represents a 12% decrease over the previous calendar year.

Varying Enrollment Trends in Health Services Programs: The Maryland AIDS Drug Assistance Program (MADAP) is the largest HIV/AIDS program run by PHPA, and enrollment has steadily increased. The MADAP-Plus program's enrollment is increasing significantly due to the downturn in the economy and the termination of the Maryland AIDS Insurance Assistance Program. Other HIV/AIDS funding programs show a direct relationship between funding and the number of case management and dental services provided to clients.

Issues

CRF Allocations Increase to Levels Specified by the Budget Reconciliation and Financing Act of 2010: An increase in CRF support for the Tobacco Use Prevention and Cessation program and the Statewide Academic Health Centers results in those programs being funded at the mandated level established by the Budget Reconciliation and Financing Act of 2010. However, funding levels still remain below the original level.

Breast and Cervical Cancer Diagnosis and Treatment Program: In recent years, the expenditures for the Breast and Cervical Cancer Diagnosis and Treatment Program have been growing at a significant rate, even as patient population has decreased. This issue will evaluate program growth and the implications of federal health care reform.

Public Health Reorganization: Effective July 1, 2012, the Department of Health and Mental Hygiene's (DHMH) Public Health Services Division was reorganized to further integrate public health planning and strengthen the division's capacity to deliver public health programs. The reorganization involved merging the Infectious Disease and Environmental Health Administration with the Family Health Administration to create PHPA. A second agency – the Health Systems and Infrastructure – was also created to oversee population-based programs.

Recommended Actions

1. Adopt committee narrative requiring the department to report on enrollment in the Breast and Cervical Cancer Diagnosis and Treatment program.

Updates

Severe Combined Immunodeficiency Disease Screening of Newborns in Maryland: The 2012 *Joint Chairmen's Report* (JCR) included language which required DHMH, in conjunction with the State Advisory Council on Hereditary and Congenital Disorders, to submit a report on the feasibility of implementing severe combined immunodeficiency disease screening of newborns in Maryland.

In-state Development of Devices for the Treatment of Cancer: The 2012 JCR required DHMH, in conjunction with the Department of Business and Economic Development, to submit a report on research and development collaborations between Maryland companies and Maryland academic researchers that accelerates the development of devices, diagnostics, and therapeutics that improve cancer outcomes.

Home Visiting Programs: The 2012 JCR directed DHMH, in conjunction with the Maryland State Department of Education, and the Children's Cabinet to report to the committees on the feasibility of consolidating existing home visiting programs under one agency.

M00F03
Prevention and Health Promotion Administration
Department of Health and Mental Hygiene

Operating Budget Analysis

Program Description

The mission of the Prevention and Health Promotion Administration (PHPA) is to protect, promote, and improve the health and well-being of Marylanders and their families through the provision of public health leadership and through community-based public health efforts in partnership with local health departments, providers, community-based organizations, and public and private sector agencies, giving special attention to at-risk and vulnerable populations.

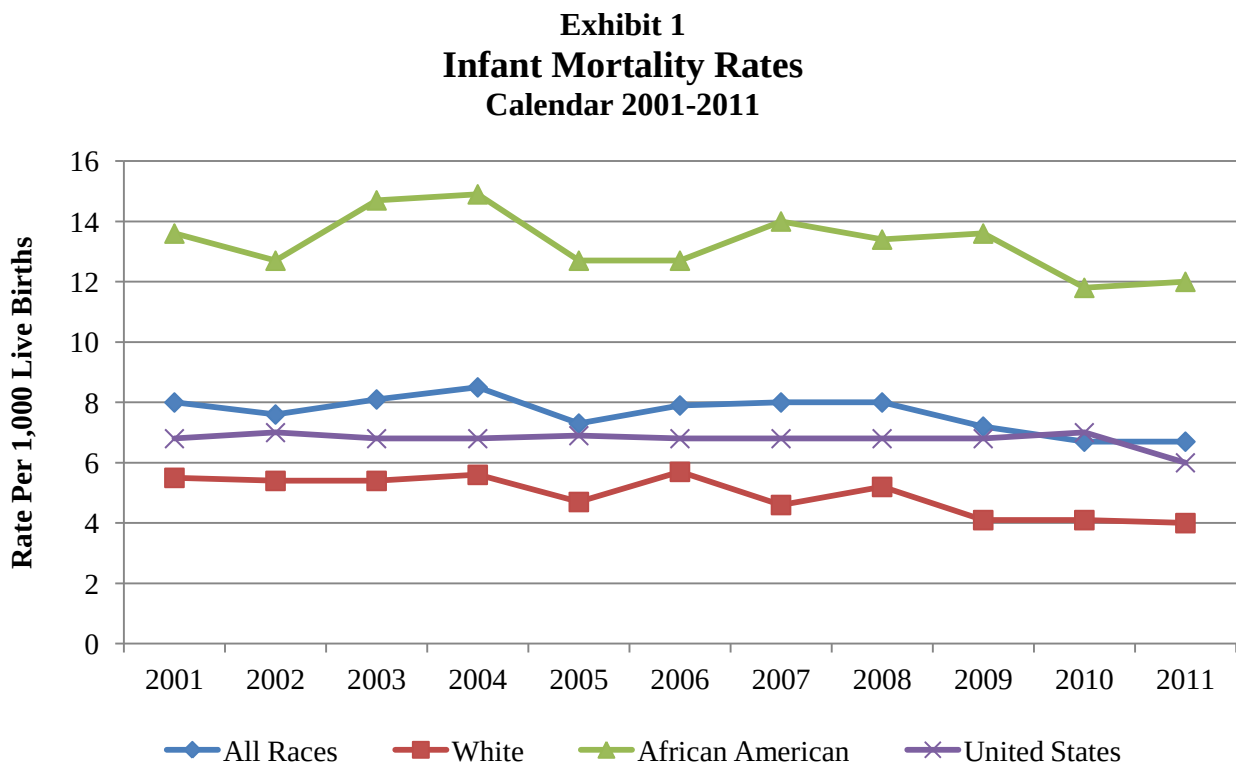
PHPA protects, promotes, and improves the health and well-being of all Marylanders through partnerships with local health departments and private sector agencies in efforts focusing in part on the prevention and control of infectious diseases, investigation of disease outbreaks, protection from food-related and environmental health hazards, and helping impacted persons live longer, healthier lives. Additionally, the administration works to assure the availability of quality primary, prevention and specialty care health services, with special attention to at-risk and vulnerable populations. Finally, the administration aims to prevent and control chronic diseases, engage in disease surveillance and control, prevent injuries, provide health information, and promote health behaviors. The administration was formed from the integration of the former Infectious Disease and Environmental Health Administration and the Family Health Administration on July 1, 2012.

Performance Analysis: Managing for Results

1. Infant Mortality Rates

The Maternal and Child Health Bureau within PHPA 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%. 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. Since that time, Maryland has made steady progress to reduce the infant mortality rate to 6.7 in calendar 2011, as shown in **Exhibit 1**. It is important to note that this rate is identical to the 2010 level and reflects the lowest rate ever recorded in Maryland. The overall reduction in the infant mortality rate was driven by large declines in the number of infant deaths in Baltimore City and Montgomery County. However, as the exhibit shows, the rate has fluctuated over the past few years, and infant mortality rates have only fallen slightly over the past decade.

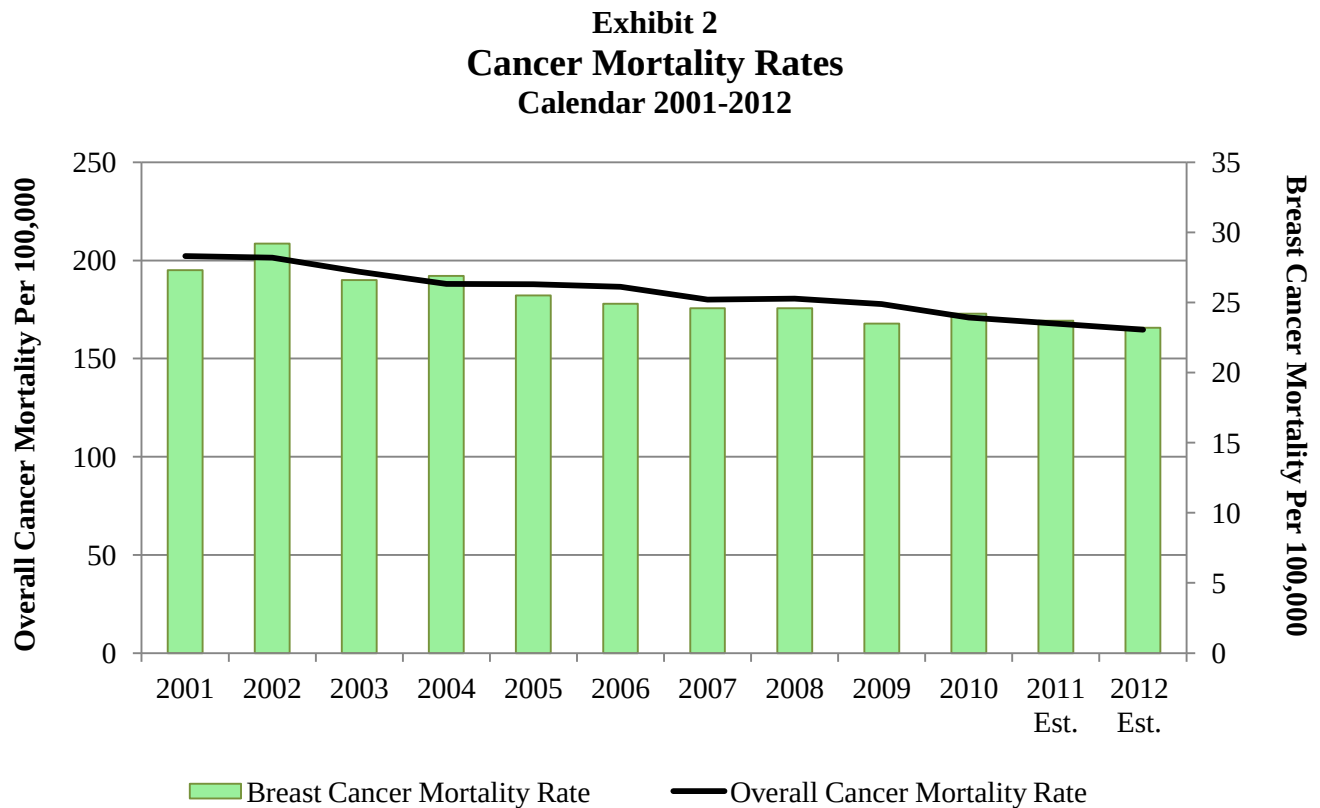


Source: Department of Health and Mental Hygiene

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 did not fluctuate from calendar 2010 to 2011, the rate for African Americans increased slightly from 11.8 to 12.0 over the same time period. Furthermore, the white infant mortality rate fell slightly from 4.1 in 2010 to 4.0 in 2011. However, the Department of Health and Mental Hygiene (DHMH) advises that these changes were not statistically significant.

2. Cancer Mortality Rates Continue to Improve

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 by reducing overall cancer mortality in the State. **Exhibit 2** shows that there has been a steady decline in both the overall cancer mortality rate and the breast cancer mortality rate in Maryland. The cancer programs within the Cigarette Restitution Fund (CRF) program target colorectal cancer, prostate cancer, and cancers associated with tobacco use.



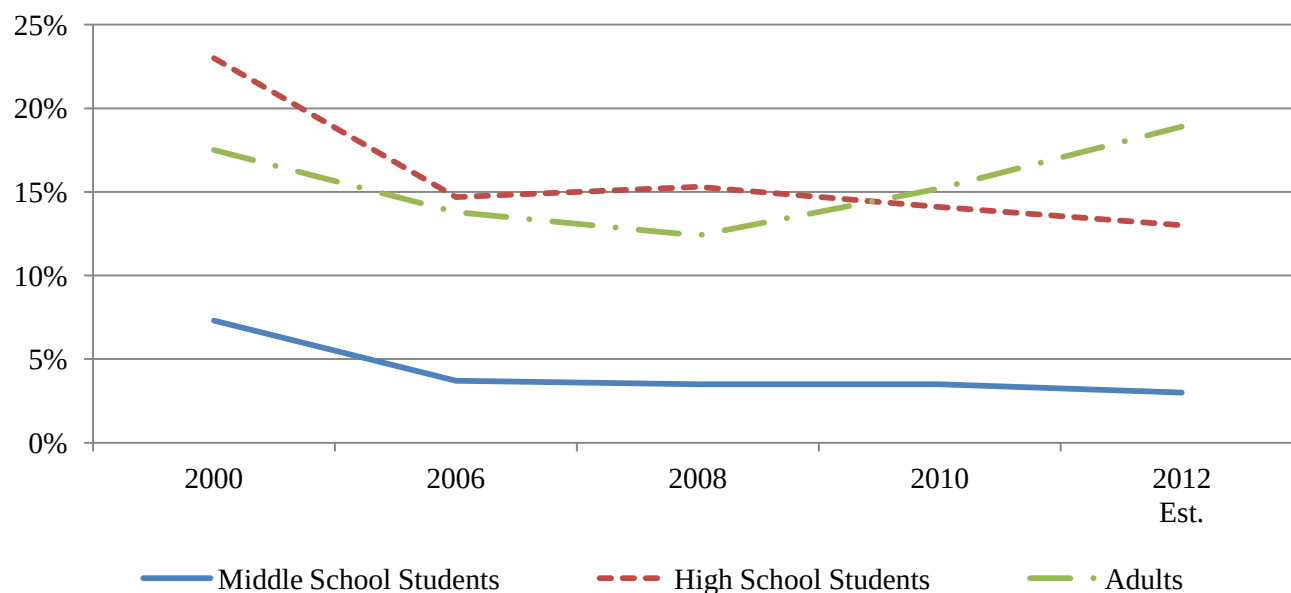
Source: Department of Health and Mental Hygiene

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 goals of the program is to reduce the proportion of Maryland youth and adults who currently smoke cigarettes. Two surveys funded with CRF revenue are the Maryland Youth Tobacco

Survey and the Maryland Adult Tobacco Survey. Surveys such as these are intended to track smoking preferences and usage among Marylanders. **Exhibit 3** shows tobacco use rates for Maryland middle school students, high school students, and adults. It is important to note that data for middle school and high school students are estimates as youth tobacco-use surveys are currently being conducted. As the graph demonstrates, there was a decrease in usage between calendar 2000 and 2006. However, since that time, usage rates have stayed relatively consistent. In the case of high school students, the usage rate went up between calendar 2006 and 2008, and has declined slightly in calendar 2010 and 2012. One reason for the stagnation in the trend of declining usage rates may be the elimination of funding for programs such as countermarketing and media initiatives which fund anti-smoking campaigns targeted to school-aged children, although no concrete evidence citing causation exists.

Exhibit 3
Tobacco Usage Rates
Calendar 2000-2012



Note: See text for discussion of survey methodology.

Source: Department of Health and Mental Hygiene

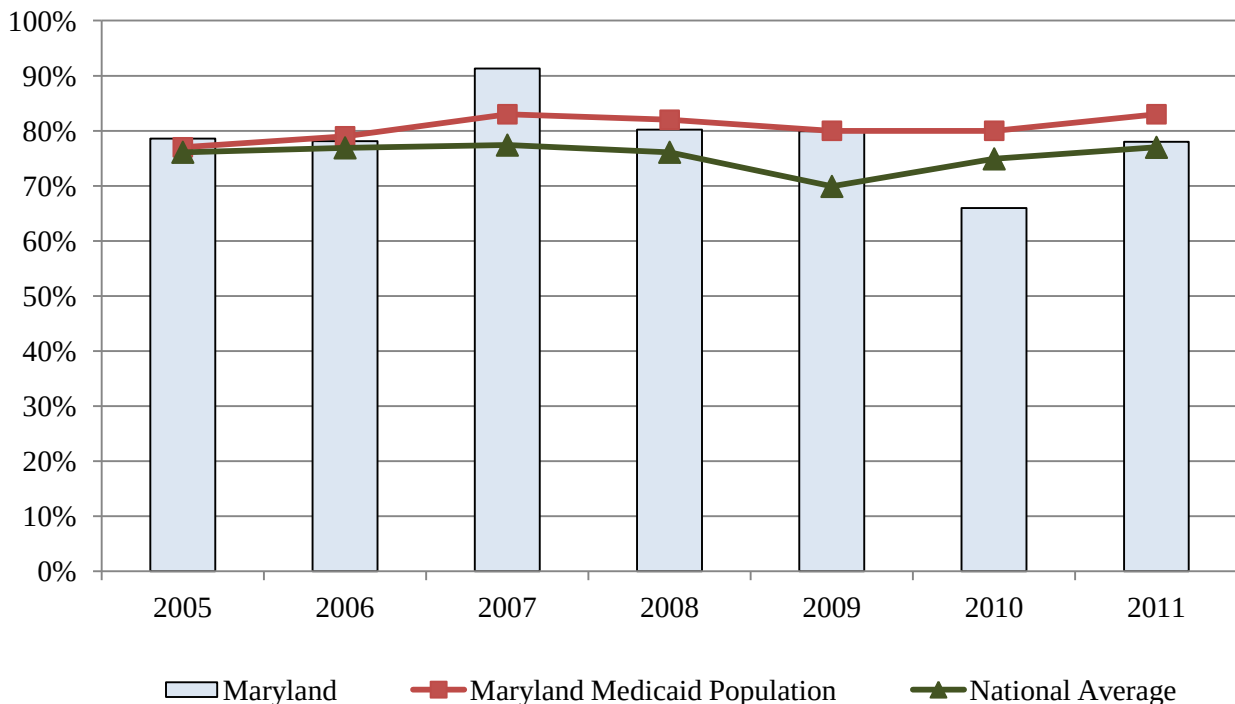
At first glance it appears that the percent of adults who currently smoke cigarettes increased significantly from calendar 2008 through 2012; however, this is not entirely accurate. In order for the survey data to be generalized to the adult population in Maryland as a whole, survey results must be weighted. Beginning in 2011, the Centers for Disease Control and Prevention (CDC) began using a new weighting methodology that is more comprehensive and generates better estimates of tobacco

use in Maryland. Therefore, higher estimates in tobacco use among adults are a result of changes in survey methodology and do not necessarily increase in tobacco use.

3. Childhood Vaccinations Rate Remains High

According to a CDC survey released in September 2012, Maryland had one of the highest percentages of children, ages 19 to 35 months, fully vaccinated with all of the vaccines in the series of recommended childhood vaccines in 2011. As shown in **Exhibit 4**, 78% of children in Maryland received the typical coverage of vaccinations, which is slightly above the national average of 77%. Moreover, 83% of children enrolled in the Medicaid program received the typical coverage of vaccinations. Immunization rates among the Medicaid population have been consistently above the statewide average since 2005. Between 2006 and 2007, the rate of immunizations jumped 13 percentage points; however, reasons for this increase were unclear. In 2008, the vaccination rate returned to historic levels; however, vaccination rates declined in 2010 due to a nationwide vaccine shortage.

Exhibit 4
Rates of Children, Ages 19 to 35 Months, with Up-to-date Immunizations
Calendar 2005-2011



Source: Department of Health and Mental Hygiene

Maryland is able to keep the vaccination rates of children high for several reasons. First, the State allows parents to opt out of vaccinating toddlers for medical or religious reasons, but not for philosophical reasons. Also, DHMH operates the Maryland Vaccines for Children program, which works with 850 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 or younger who:

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

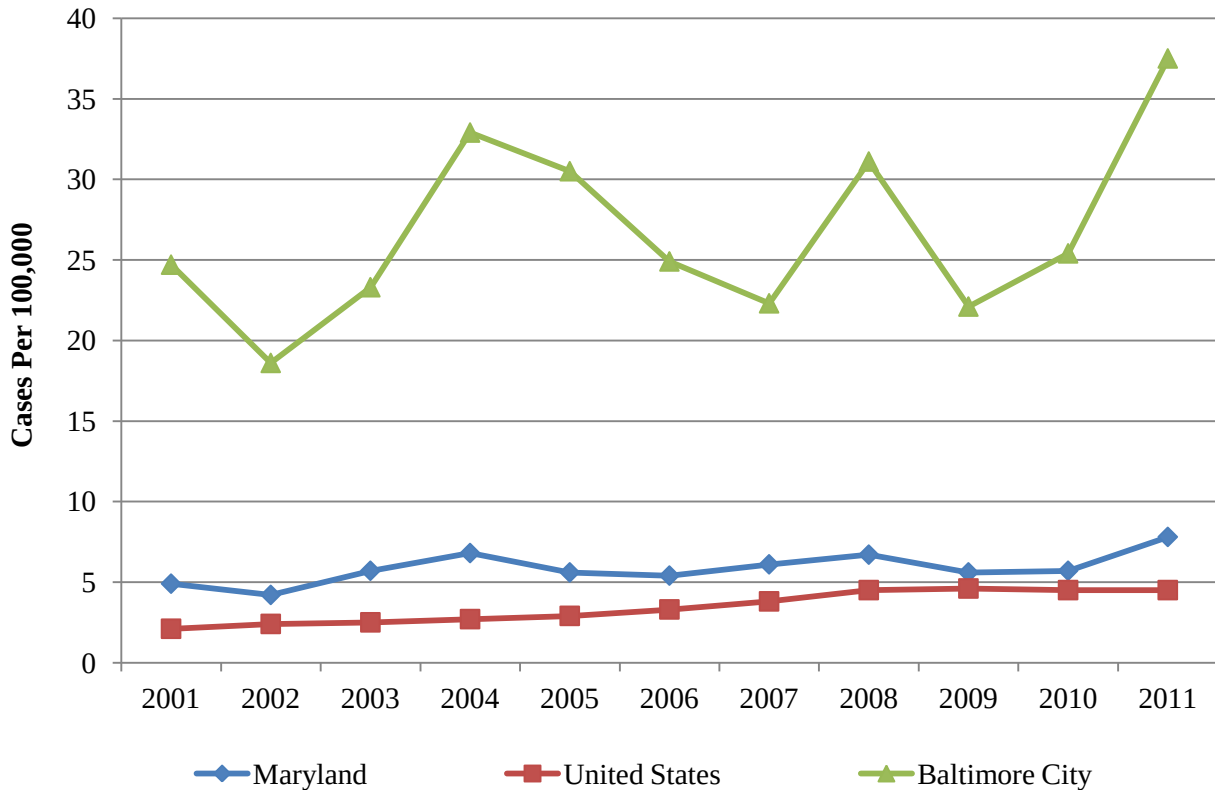
4. Syphilis and Chlamydia Rates Remain Higher Than the National Average

Syphilis Infection Rates

PHPA is charged with preventing and controlling the transmission of infectious diseases, including sexually transmitted diseases (STD). The administration has developed initiatives to reduce the spread of STDs, with an emphasis on populations at risk, such as economically disadvantaged and incarcerated populations. Syphilis continues to be a major concern in the State, with the rate of infection in Maryland the second highest in the nation (as of the most recent national comparison which was conducted with data from calendar 2011). In addition to its primary effects, syphilis presents public health concerns for its role in facilitating transmission of Human Immunodeficiency Virus (HIV). Untreated syphilis in pregnant women can result in infant death in up to 40% of cases.

Syphilis rates in Maryland and Baltimore City, compared to the national average are displayed in **Exhibit 5**. In 2011, CDC reported a statewide infection rate of primary and secondary syphilis in Maryland of 7.8 cases per 100,000 population, which represents a 36.8% increase over the 2010 rate. However, the primary and secondary syphilis rate in Baltimore City remains more than four times the State average at 37.5 cases per 100,000 population.

Exhibit 5
Rates of Primary/Secondary Syphilis
Calendar 2001-2011

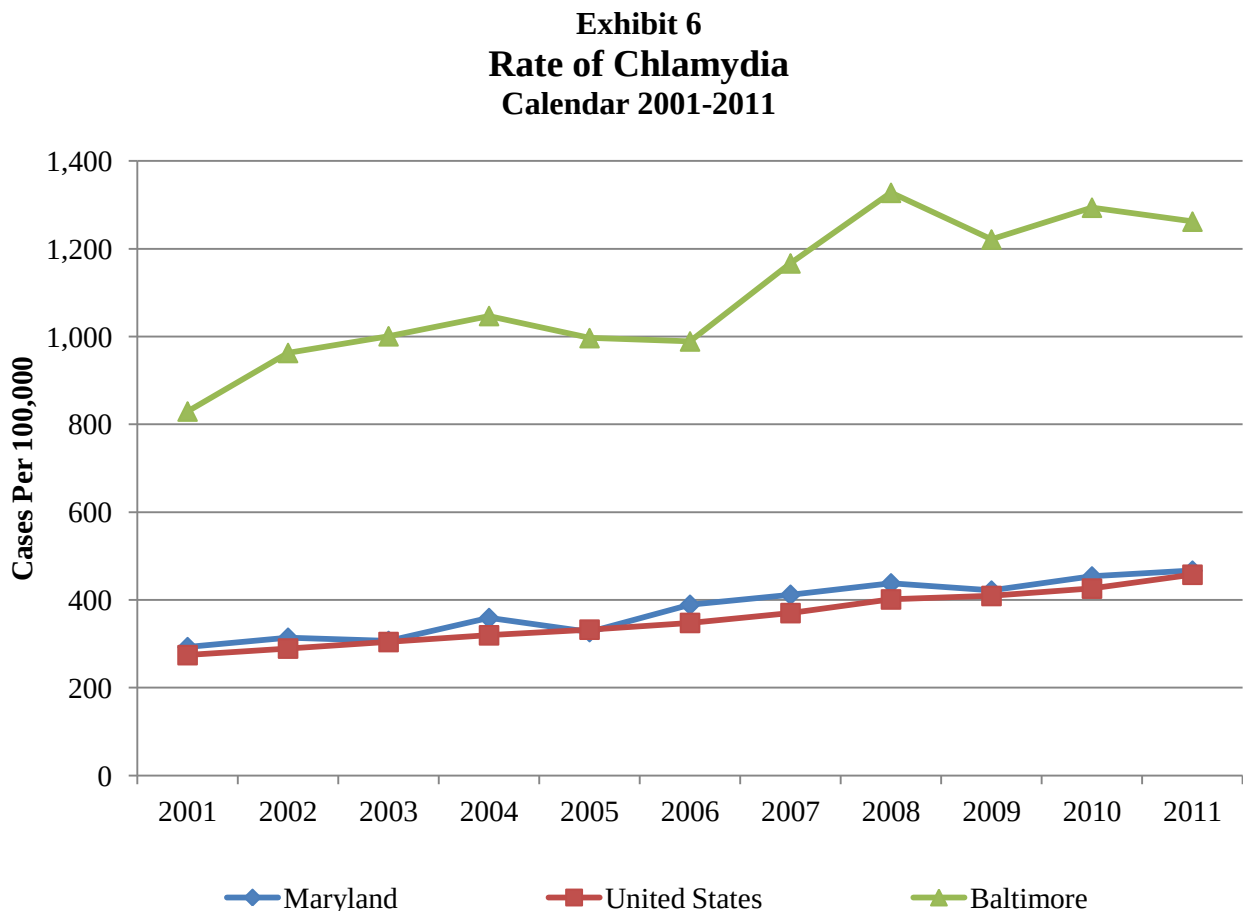


Source: Department of Health and Mental Hygiene; Center for Disease Control and Prevention

CDC has indicated that syphilis remains a major health problem with increases in rates persisting among men who have sex with men. Moreover, cases that involve men who have sex with men have been characterized by high rates of HIV co-infection. In fiscal 2011, 72% of primary and secondary syphilis cases in 46 states and the District of Columbia that provided information about sex partners were among men who have sex with men. DHMH advises that this trend is consistent with increased syphilis infection rates seen in Maryland. More specifically, infection rates are increasing among African American men who have sex with men and transgender populations. Therefore, the Baltimore City Health Department has implemented new programs that target this population. **The agency should inform the committees of specific interventions in Baltimore City to reduce the rate of primary and secondary syphilis infections.**

Chlamydia Infection Rates

Chlamydia also continues to be a concern throughout the State as the rate of infection continues to trend above the national average, especially in Baltimore City. **Exhibit 6** shows the chlamydia rate in Maryland compared to the national average, as well as the chlamydia rate in Baltimore City, for all ages, from calendar 2001 to 2011. In 2011, the chlamydia rate in Maryland was 466.9 per 100,000 population compared to the national average of 457.6; however, the rate in Baltimore City was 1,262.1 infections per 100,000.



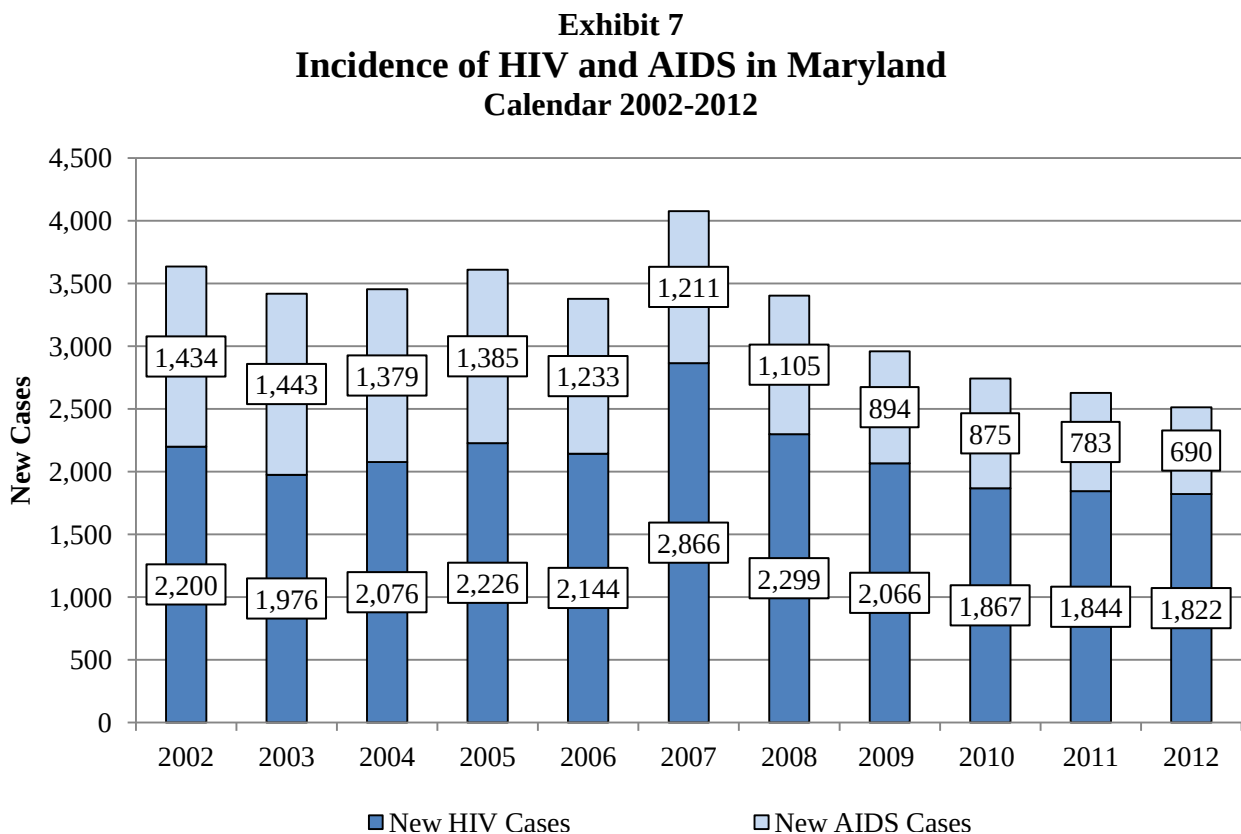
Source: Department of Health and Mental Hygiene; Center for Disease Control and Prevention

The Baltimore City Health Department receives funding directly from CDC to respond to sexually transmitted infections. Among other things, the city has an active outreach program to find and test high risk individuals, including commercial sex workers. It also has two sexually transmitted disease clinics that provide free testing and treatment, as well as school-based clinics that test for chlamydia and gonorrhea. The department also works with the Baltimore City Central Booking and

Intake Facility to link inmates who are HIV positive to care prior to their release. Finally, the city has an Expedited Partner Therapy (EPT) pilot project for chlamydia and gonorrhea which allows individuals with these STDs to distribute antibiotics to their sexual partners. Patients can deliver antibiotics to up to three of their partners without a prescription for their partners and without the health care provider first examining their partners. By treating individuals and their partners through the EPT program, the department aims to prevent individuals from being reinfected with the disease by their partners.

5. Second Highest AIDS Rate of Any State

Exhibit 7 details the trends in new reported cases of HIV and AIDS in Maryland. In calendar 2012, the State had 1,822 new HIV diagnoses, a 1% decrease over the calendar 2011 level. Moreover, there were an estimated 690 new AIDS diagnoses in calendar 2012. This represents a 13% decrease over the previous calendar year.



HIV: Human Immunodeficiency Virus

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

According to the national comparison conducted by the CDC of the calendar 2010 data, Maryland had the ninth highest number of cumulative AIDS cases, the seventh highest number of newly reported AIDS cases, and the second highest AIDS rate, behind only Washington, DC. The CDC analysis reported that in 2010, nationally, the AIDS rate was 10.8 AIDS cases per 100,000 population compared with the Maryland rate of 22.1 per 100,000 population.

6. Varying Enrollment Trends in Health Services Programs

PHPA provides two major health services programs related to HIV/AIDS: Maryland AIDS Drug Assistance Program (MADAP) and MADAP-Plus. A third program – the Maryland AIDS Insurance Assistance Program (MAIAP) – was eliminated in 2009. These are outlined in **Exhibit 8**.

Exhibit 8 PHPA – Health Services Programs for HIV/AIDS

	<u>Benefit</u>	<u>Income Eligibility</u>	<u>Fund Source</u>
MADAP	Assistance with HIV/AIDS-related drug costs	116 to 500% of FPL	Federal funds
MADAP-Plus	Maintains health insurance for individuals testing positive for HIV who can no longer work due to their illness	116 to 500% of the FPL	Federal and special funds
MAIAP*	Provided health insurance assistance to persons at risk of losing private health insurances coverage	301 to 500% of the FPL	General funds

FPL: Federal Poverty Level

HIV: Human Immunodeficiency Virus

MADAP: Maryland AIDS Drug Assistance Program

MAIAP: Maryland AIDS Insurance Assistance Program

PHPA: Prevention and Health Promotion Administration

*MAIAP ended on June 30, 2009.

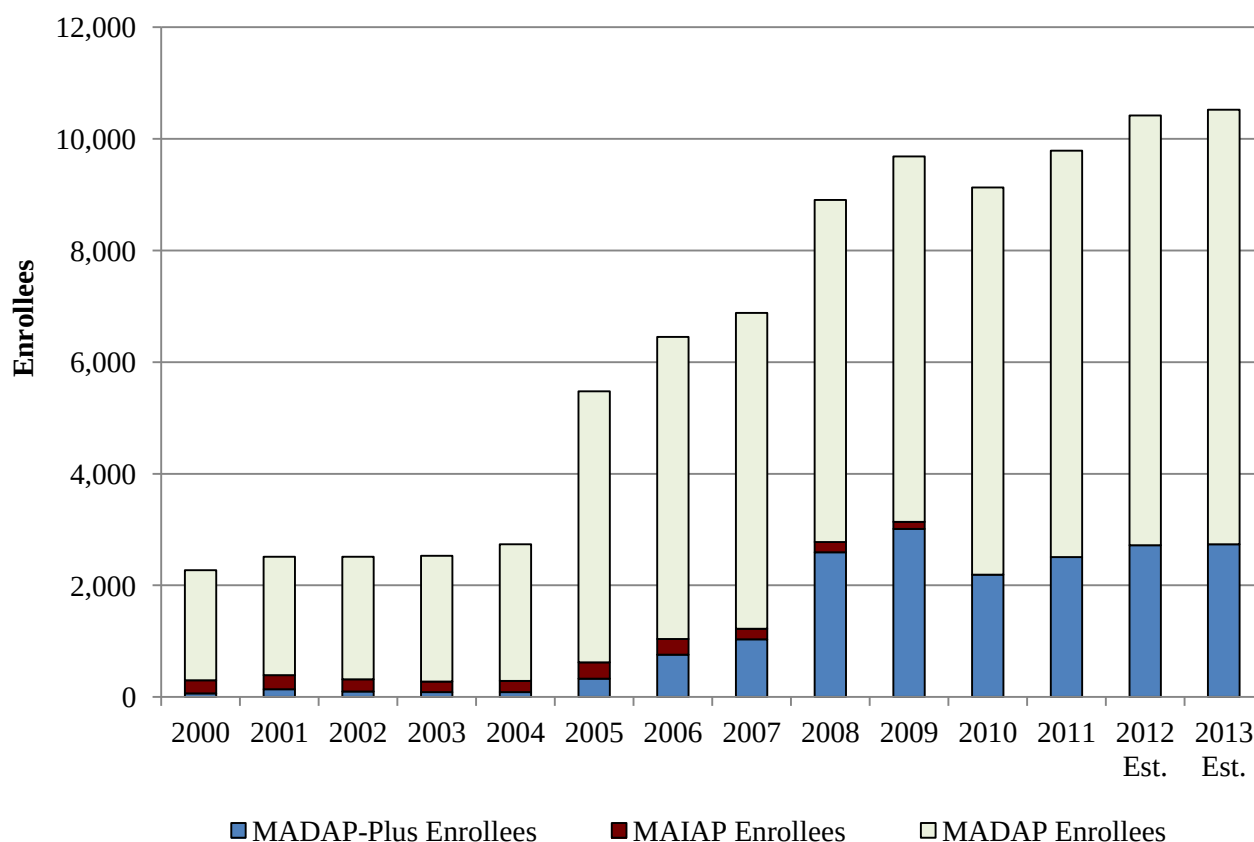
Source: Department of Health and Mental Hygiene

MADAP is the largest of the two programs with an estimated 7,700 enrollees in 2012. MADAP helps low- to moderate-income Maryland residents pay for certain drugs prescribed to treat HIV/AIDS. Clients are certified eligible for MADAP for a one-year period, after which time they may reapply for certification. Following the increase in eligibility limits promulgated by the AIDS Administration in 2004, MADAP has one of the nation's most expansive eligibility requirements along with extremely generous drug coverage.

MADAP-Plus offers health insurance assistance to individuals living with HIV/AIDS. MADAP-Plus experienced significant enrollment increases in calendar 2005, and the program had an estimated 2,718 enrollees in 2012.

As shown in **Exhibit 9**, MADAP and MADAP-Plus continue to experience enrollment growth. MADAP-Plus enrollment has increased due to the elimination of MAIAP in June 2009 and the recession as a higher number of individuals were in need of health insurance. In calendar 2013, the agency anticipates MADAP and MADAP-Plus enrollment to reach 7,789 and 2,736 enrollees, respectively. However, the fiscal 2014 allowance reflects a decline in MADAP program enrollment due to the implementation of federal health care reform.

Exhibit 9
MADAP, MADAP-Plus, and MAIAP Enrollment
Calendar 2000-2013



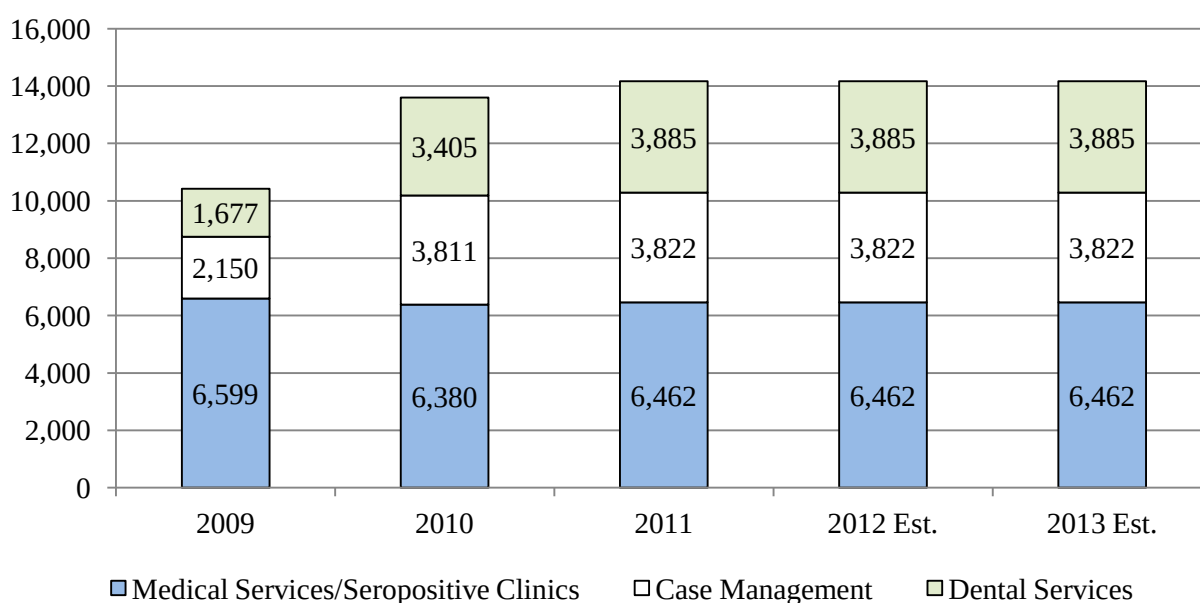
MADAP: Maryland AIDS Drug Assistance Program
MAIAP: Maryland AIDS Insurance Assistance Program

Source: Department of Health and Mental Hygiene

HIV/AIDS Funding Directly Related to Services Provided

Exhibit 10 demonstrates the direct relationship between the funding level and the amount of services provided by PHPA in the areas of case management and dental services. From 2009 to 2010, funding for case management increased, corresponding with an increase in the numbers of individuals served. However, in calendar 2011, the average cost of care increased by 62% over the previous year, and costs continued to increase in 2012. Therefore, the number of individuals receiving case management services has remained constant. In comparison, funding for medical services has decreased; the number of individuals receiving services has remained constant due to a decrease in the cost of care.

Exhibit 10
Various Services and the Budget
Calendar 2009-2013



(\$ in Millions)

	<u>2009</u>	<u>2010</u>	<u>2011</u>	<u>2012 Est.</u>	<u>2013 Est.</u>
Budget for Medical Services/Seropositive Clinics	\$3.3	\$3.7	\$3.5	\$3.5	\$3.5
Budget for Case Management	3.0	2.6	4.2	5.3	5.3
Budget for Dental Services	0.7	0.6	0.6	0.6	0.6
Total Budget	\$6.9	\$6.9	\$8.3	\$9.4	\$9.4

Source: Department of Health and Mental Hygiene

Fiscal 2013 Actions

Personnel Actions

Section 25 of Chapter 1 of the First Special Session of 2012 – the Budget Reconciliation and Financing Act (BRFA) of 2012 – required the Governor to abolish at least 100 vacant positions as of January 1, 2013, saving at least \$6 million in general funds. PHPA saw a reduction of 2 positions.

Proposed Deficiency

There are three proposed deficiencies for fiscal 2013 to provide additional federal funds to PHPA for an integrated behavioral health and primary care network (\$1,313,643); to develop strategic plans to allow local health departments (LHD) to bill for immunization services (\$594,002); and for the Women, Infant, and Children (WIC) program (\$1,827,885). The budget analysis for the Health Systems and Infrastructure Administration includes additional information regarding barriers LHDs are encountering in regard to billing.

Proposed Budget

The Governor's fiscal 2014 budget, as shown in **Exhibit 11**, increases by \$5.1 million, or 1.4%. General funds increase by \$679,000, or 1.3%, from fiscal 2013. Special funds decrease by \$2.4 million, or 2.7%, and the federal fund allowance increases by \$6.6 million, or 3.2%, from fiscal 2013. Finally, reimbursable funds increase by \$122,000, or 6.3%. However, after accounting for deficiency appropriations, the budget is actually increasing by only \$1.3 million.

Exhibit 11
Proposed Budget
DHMH – Prevention and Health Promotion Administration
(\$ 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>
2013 Working Appropriation	\$52,460	\$88,319	\$208,453	\$1,929	\$351,161
2014 Allowance	<u>53,156</u>	<u>85,962</u>	<u>215,097</u>	<u>2,051</u>	<u>356,266</u>
Amount Change	\$696	-\$2,358	\$6,645	\$122	\$5,105
Percent Change	1.3%	-2.7%	3.2%	6.3%	1.5%
Contingent Reduction	-\$17	-\$2	-\$27	\$0	-\$46
Adjusted Change	\$679	-\$2,360	\$6,618	\$122	\$5,059
Adjusted Percent Change	1.3%	-2.7%	3.2%	6.3%	1.4%
Where It Goes:					
Personnel Expenses					
Employee retirement.....					\$611
Employee and retiree health insurance					419
Annualized salary increase					256
Regular salaries.....					62
Workers' compensation premium assessment					8
Other fringe benefit adjustments.....					6
Abolished positions (2.0)					-133
Turnover adjustments.....					-274
Maternal and Child Health					
WIC program contractual costs, primarily increased food costs					6,989
Maternal and Child Health Quality Initiatives.....					-389
PPACA – Maternal, Infant, and Early Childhood Home Visiting Program					-1,632
Prevention and Disease Control					
CRF Statewide Academic Health Centers program.....					7,200
CRF Tobacco Program, including Statewide Public Health, Local Public Health, Surveillance and Education, and the Maryland Quitline.....					4,297
Oral health workforce activities.....					462
Funding for community health workers at Sinai Hospital					250
Maryland Cancer Registry					166
Coordinated chronic disease prevention and health promotion					-160

M00F03 – DHMH – Prevention and Health Promotion Administration

Where It Goes:

Breast and cervical cancer grants	-336
Montebello Rehabilitation Center grant to offset capital costs	-307
Maryland Heart Disease and Stroke Prevention Program.....	-416

Infectious Disease

HIV primary and specialty medical care.....	1,899
SAMHSA-funded HIV prevention services for the Baltimore-Towson MSA	1,351
HIV prevention activities targeted at substance abusers.....	1,229
HIV Surveillance and Epidemiology	360
Maryland Immunization Grant.....	279
Emerging Infections Program (PPHF)	201
Housing Opportunities for Persons with AIDS program	-107
Removal of funds for HIV Youth Initiative	-372
HIV counseling and testing services.....	-1,378
MADAP pharmaceuticals	-3,644
Purchase of care services – MADAP-Plus program	-12,005

Environmental Health

Maryland Public Health Strategy for Climate Change	215
Bed bugs grant for Baltimore City Health Department	-100
Other changes.....	52

Total **\$5,059**

CRF: Cigarette Restitution Fund

HIV: Human Immunodeficiency Virus

MADAP: MD AIDS Drug Assistance Program

MSA: Metropolitan Statistical Area

PPACA: Patient Protection and Affordable Care Act

PPHF: Prevention and Public Health Fund

SAMHSA: Substance Abuse and Mental Health Services Administration

WIC: Women, Infants, and Children Program

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

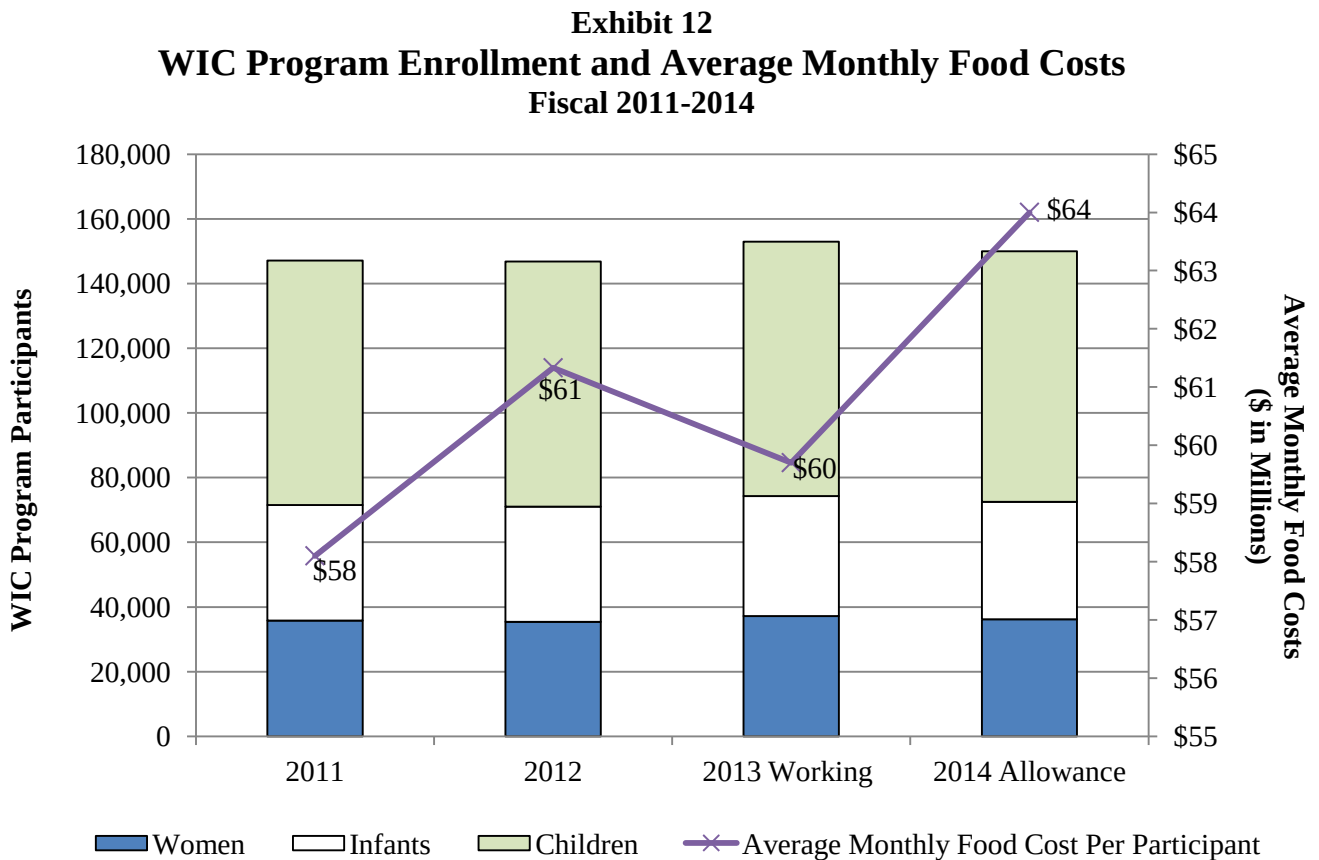
Personnel

Overall, personnel expenses for PHPA increase by \$955,000 over the fiscal 2013 appropriation. Employee retirement contributions increase by \$611,000 due to underattainment in investment returns, adjustments in actuarial assumptions, and an increase in the reinvestment of savings achieved in the 2011 pension reform. Furthermore, employee and retiree health insurance expenses increase by \$419,000. The annualization of the fiscal 2013 cost-of-living adjustment (COLA) for State employees increases the budget by \$256,000. Expenditures also increase for regular salaries (\$62,000), workers' compensation (\$8,000), and other fringe benefits adjustments (\$7,000). These increases are offset by a \$133,000 decline in regular salaries. This decrease reflects savings from positions abolished in fiscal 2013. Turnover adjustments also decrease the budget by \$274,000. This reflects increasing the existing turnover rate from 4.09 to 5.00%.

Maternal and Child Health

Women, Infant, and Children Program

Funding for the WIC program in the fiscal 2014 allowance increases by \$7.0 million. This includes a \$7.3 million increase for food expenditures and supplies to administer the program. The contractual costs for the program total \$114.3 million and are comprised primarily of the food service contract (\$84.3 million) and the cost to administer the program (\$27.8 million). The food service contract, which covers the expense of WIC foods purchased by participants increases from the fiscal 2013 working appropriation by \$5.1 million due to an increase in average monthly food package costs. **Exhibit 12** shows the number of women, infants, and children enrolled in the program, as well as monthly food package costs for fiscal 2011 through 2014. While the number or program enrollees in the WIC program have remained constant since fiscal 2011, monthly food costs have increased by 10% over the same time period.



WIC: Women, Infants, and Children Program

Source: Department of Health and Mental Hygiene

While the food service contract increases significantly in the allowance, the funds dedicated to administer the program increase by \$2.1 million. Federal funds for administration are distributed to LHDs and private agencies for the provision of WIC services. The increase to food service contracts combined with the increase in administrative costs totals accounts for the \$7.3 million increase for WIC contractual services. This increase is offset by a \$100,000 decrease in administrative support for the WIC Breastfeeding Peer Counselor Program at local health departments and private providers due to a slight decline in program participants. Funding for the development of the WIC electronic benefits transfer also decreases by \$150,000.

Maternal, Infant, and Early Childhood Home Visiting Program

Beginning in fiscal 2012, DHMH began receiving funding through the Patient Protection and Affordable Care Act (ACA) for the Maternal, Infant, and Early Childhood Home Visiting Program. The purpose of the program is to provide evidence-based home visitation services to improve outcomes for children and families who reside in at-risk communities. The home visiting program that states choose to implement must also be linked to benchmark areas of improvement at the state level. In fiscal 2012 and 2013, \$1.0 million and \$2.9 million were awarded to the department under this grant, respectively. The fiscal 2014 allowance includes \$1.3 million for this program, which represents a \$1.6 million decline over the working appropriation. A total of \$750,000 will be provided to LHDs for evidence-based home visiting programs in high-risk communities, including Baltimore City, Dorchester, Prince George's, Washington, and Wicomico counties. Additional funds will also be awarded to the Prince George's County local management board (\$220,000) and the Family League of Baltimore City (\$160,000). Funding for other maternal and child health quality initiatives also decreases by \$389,000.

Prevention and Disease Control

Cigarette Restitution Fund Programs

An increase in CRF support for the Tobacco Use Prevention and Cessation program and the Statewide Academic Health Centers results in those programs being funded at the mandated level established by the BRFA of 2010. Funding for the Tobacco Use Prevention and Cessation program and the Statewide Academic Health Centers program increases by \$4.3 million and \$7.2 million, respectively. It is important to note that funding for these two programs is still below the originally mandated funding levels. A more in-depth discussion of funding for CRF programs is included in the Issues section of this document.

Other Prevention and Disease Control Spending

The fiscal 2014 budget includes \$0.5 million for oral health workforce activities. Of this amount, approximately \$100,000 will be provided to the Maryland Institute for Policy Analysis and Research to support community health education and outreach for an oral health literacy campaign. Funding will also be provided to LHDs to support the coordination, development, implementation, and evaluation of a targeted dental sealant and oral health prevention services throughout the State

(\$180,000). Funding will be provided to various vendors to develop oral health infrastructure processes including technical assistance to fluoridating water systems (\$180,000).

The budget also includes an additional \$250,000 for an initiative at Sinai Hospital to allow for community health workers to strengthen patient-physician communication during clinic visits and improve chronic disease management of patients at home. Finally, contracted quality assurance and database management services for the Maryland Cancer Registry increases the budget by \$166,000.

These increases are offset by a decrease in funding for the following initiatives:

- coordinated chronic disease prevention and health promotion (\$160,000);
- Montebello Rehabilitation Center grant to offset capital costs (\$307,000);
- breast and cervical cancer screening grants (\$336,000); and
- the Maryland Heart Disease and Stroke Prevention Program (\$416,000).

Infectious Disease

HIV/AIDS Services

Funds for HIV primary and specialty medical care increase the budget by \$1.9 million. Funds are available through the Health Resources and Services Administration under a formula grant authorized by Ryan White Part B to provide HIV health and support services to those infected with HIV/AIDS.

Federal funds from the Substance Abuse and Mental Health Services Administration increase by \$1.4 million to support Maryland's Enhanced Comprehensive HIV Prevention Plan for the Baltimore-Towson Metropolitan Statistical Area (MSA). Of this amount, \$1.1 million will be used to provide seamless access for new or existing clients in the Baltimore-Towson MSA in the mental health, substance abuse, and HIV public health system of care. Among other entities, these funds will be awarded to local health departments, Baltimore Mental Health Systems, and the University of Maryland Baltimore County (UMBC). Funding will also be provided to Baltimore Substance Abuse Systems to provide routine screening for HIV and sexually transmitted infections for individuals with a substance abuse disorder that are at high risk for, or have, a mental illness (\$0.2 million).

Federal funds for substance-abuse related HIV prevention programs increase by \$1.2 million. These funds were transferred to PHPA from the Alcohol and Drug Abuse Administration. These funds will be used to collaborate with drug treatment centers and the Baltimore Substance Abuse Systems to develop and implement HIV testing programs targeting drug users who are engaged in treatment, in order to increase the number of people living with HIV who are aware of their status and connect them to care and other necessary services.

Federal funds for HIV surveillance and epidemiology increase by \$360,000. Funding will be used to provide a grant with the Johns Hopkins University to provide HIV/AIDS case investigation and surveillance. Additional funding will also support HIV/AIDS case investigation and surveillance at the Baltimore City Health Department.

The remaining changes to the Infectious Disease budget include decreases in federal funding for the Department of Housing and Urban Development's Housing Opportunities for Persons with AIDS program (\$107,000). Funding levels are determined by an annual funding formula and support tenant-based rental assistance for person living with HIV/AIDS whose income is at or below 80% of the mean income in their county of residence. The fiscal 2014 allowance also reflects the removal of Ryan White Part D Youth Initiative funds which are awarded on a competitive basis (\$372,000). HIV prevention programs at LHDs and other State entities decrease due to a change in the CDC's funding methodology to the State (\$1.4 million).

MADAP and MADAP-Plus Programs

Funds for the MADAP and MADAP-Plus programs decrease by \$3.6 million (\$1.6 million in special funds and \$2.0 million in federal funds) and \$12.0 million (special funds), respectively. Special funds are available through drug rebates from the MADAP program. The program enables income-eligible persons living with HIV and AIDS access to health insurance coverage. Effective January 1, 2014, it is anticipated that demand for the MADAP and MADAP-Plus programs will decline due to the implementation of health care reform.

The \$12.0 million decrease in special funds within the MADAP-Plus program is based on the following assumptions:

- a decline in program growth (\$1.1 million);
- lower premium costs paid to the Maryland Health Insurance Plan (\$3.5 million); and
- a greater proportion of individuals will be served within the Medicaid program, or will obtain private insurance during the second half of the fiscal year due to the full implementation of federal health care reform (\$7.4 million).

Other Changes

Federal funds for the Maryland Immunization grant program increase by \$279,000. These funds will be utilized to implement a hepatitis B vaccination pilot program that targets adults who present for medical care in high risk settings or who have behaviors that increase their risk of hepatitis B virus infection.

Federal funds for the Emerging Infections program increase by \$201,000. These funds support Maryland's existing epidemiology and laboratory capacity by providing educational and training opportunities, integrating electronic data collection methods into existing processes, and

collaborating with the State's academic health centers. Among other things, these collaborations include scientific support related to foodborne pathogens, including case control studies.

Environmental Health

Funding for the Maryland Public Health Strategy for Climate Change increases the budget by \$215,000. This project is supported by a five-year grant from the federal government and operates as a component of the State's comprehensive plan adopted by the Maryland Commission on Climate Change. This plan includes various strategies specifically focused on ensuring the health and safety of Marylanders in response to climate change. Among other things, funding will provide epidemiologic support at UMBC.

Other changes increase the budget by \$52,000. These increases are offset by the removal of federal funds for a one-time grant for the Bed Bugs Bite program (\$100,000). These funds were used in fiscal 2013 to promote integrated pest management techniques through a collaborative education and training program with the Baltimore City Health Department.

Issues

1. CRF Allocations Increase to Levels Specified by the Budget Reconciliation and Financing Act of 2010

There are two main program administered by PHPA with CRF support: (1) cancer prevention, screening, and diagnosis, including the grants to the Statewide Academic Health Centers for cancer research; and (2) tobacco use prevention and cessation. Language in the BRFA of 2010 changed the mandated funding levels for cancer and tobacco programs in fiscal 2011 and beyond. **Exhibit 13** shows the mandated funding level for each program as specified by Chapters 17 and 18 of 2000 and the fiscal 2014 allowance.

Exhibit 13 Cigarette Restitution Fund Allocations (\$ in Millions)

	Level Established Under Chapters 17 and 18 <u>of 2000</u>	Working Appropriation <u>2013</u>	Allowance <u>2014</u>	Change from Level Established Under Chapters 17 and 18 of 2000
Tobacco Use Prevention and Cessation*	\$21.0	\$6.0	\$10.2	-51.4%
Statewide Academic Health Centers				
Cancer Research Grants	\$10.4	\$5.8	\$13.0	25.0%
Tobacco-related Disease Research Grants	2.0	0.0	0.0	
Statewide Network Grants	3.0	0.0	0.0	
Total	\$15.4	\$5.8	\$13.0	-15.6%

*Tobacco Use Prevention and Cessation includes all fund types.

Source: Department of Health and Mental Hygiene

As the exhibit shows, the funding for Tobacco Use Prevention and Cessation and grants to the Statewide Academic Health Centers is partially restored in fiscal 2014. Funding for tobacco programs, which includes the CRF and other funds, increases to \$10.2 million. Although that represents a 41.2% increase over fiscal 2013, it is 51.4% lower than the level established by Chapters 17 and 18 of 2000. Funding for Statewide Academic Health Centers increases to \$13.0 million in fiscal 2014, a 124.1% increase over the fiscal 2013 level, and only 15.6% lower than the original permanent amount. The statute requiring funding for these two programs does not specify the fund source that must be used; historically the majority of the funding originated from the CRF.

Exhibit 14 shows funding for specific CRF programs in prior years, as well as funding that is included in the fiscal 2014 allowance. It is important to note that Exhibit 8 does not include general or federal fund support for CRF programs.

Exhibit 14
Cigarette Restitution Fund Allocations
Fiscal 2011-2014
(\$ in Millions)

	<u>2011 Actual</u>	<u>2012 Actual</u>	<u>2013 Working</u>	<u>2014 Allowance</u>
Cancer Prevention, Education, Screening, and Treatment				
Local Public Health	\$7.5	\$7.5	\$7.5	\$7.5
University of Maryland, JHI, and Baltimore City	2.3	2.4	2.4	2.4
Surveillance and Evaluation	1.1	1.2	1.2	1.2
Administration	0.5	0.5	0.6	0.6
Cancer Screening Database	0.2	0.2	0.2	0.2
Statewide Public Health	-	-	-	-
Total	\$11.7	\$12.0	\$12.0	\$12.0
Statewide Academic Health Centers				
Cancer Research Grants	\$2.4	\$2.4	\$5.8	\$13.0
Tobacco Diseases Research	-	-	-	-
Network Grant	-	-	-	-
Total	\$2.4	\$2.4	\$5.8	\$13.0
Tobacco Use Prevention and Cessation Program				
Local Public Health	\$2.9	\$2.9	\$2.9	\$3.9
Countermarketing	-	-	-	-
Statewide Public Health	-	-	-	2.4
Tobacco Prevention and Cessation	0.1	0.1	0.2	0.2
Surveillance and Evaluation	0.5	0.4	0.5	1.0
Administration	0.2	0.1	0.1	0.2
Management	-	-	-	-
Total	\$3.6	\$3.5	\$3.7	\$7.7
Breast and Cervical Cancer Diagnosis and Treatment Program	\$13.8	\$15.2	\$14.7	\$14.7
Total	\$31.5	\$33.1	\$36.1	\$47.4

JHI: Johns Hopkins Institute

Note: This exhibit does not include general or federal fund support for the Cigarette Restitution Fund programs.

Source: Department of Health and Mental Hygiene

During the 2012 legislative interim, the Department of Legislative Services (DLS) prepared a report titled *Survey of Local Health Departments in Maryland*. Among other things, the report examined the provision of local health services in the State, including CRF-funded programs. The survey revealed that for fiscal 2011, CRF grants represented only 2% of total LHD revenues. Through the survey, DLS also asked LHDs if there were specific areas of priority to which they would direct monies if State funding were to increase. Over 60% of LHDs indicated that additional funds are needed specifically to address chronic disease prevention and treatment. The partial restoration of CRF funds will allow LHDs to target additional funds in this area.

2. Breast and Cervical Cancer Diagnosis and Treatment Program

The Cancer and Chronic Disease Bureau within PHPA is dedicated to reducing the burden of cancer in Maryland, particularly breast and cervical cancer. PHPA uses general funds; special funds from the CRF; and federal grant funds to screen, diagnose, and treat Marylanders. While there are multiple screening programs for breast and cervical cancer, there has historically been only one program that the State has relied on to diagnose and treat those patients. The Breast and Cervical Cancer Diagnosis and Treatment Program (BCCDTP) was established in 1992 with State general funds in order to provide these services to women.

In recent years, the cost of the program had increased considerably even while the number of patients leveled off. The costly services to treat cancer account for the increased expenditures of the program. However, the emergence of a Medicaid program, the Women's Breast and Cervical Cancer Health Program (WBCCHP), has the potential to alleviate the State's financial burden. In order to be eligible for the WBCCHP, patients must be seen through a federal screening program. The sections below describe in detail the three breast and cervical cancer programs and how the State can divert patients to the Medicaid program in order to reduce the financial liability of the State-funded BCCDTP.

Breast and Cervical Cancer Screening Program

The Breast and Cervical Cancer Screening Program (BCCP) was established by the Breast and Cervical Cancer Mortality Prevention Act, passed by the U.S. Congress in 1990 to provide screening services to uninsured women with incomes below 250% of the federal poverty guideline aged 40 to 64. CDC federal funds are provided to DHMH for this program. In 1998, the Maryland General Assembly approved legislation that provided additional State general funds for this program.

In fiscal 2013, the budget included \$6.1 million to be distributed to various local health agencies to perform the screenings. The agency expects to perform nearly 26,000 screenings in fiscal 2013. Most of the women screened under this program are eligible for the WBCCHP. Before Maryland was approved for the WBCCHP Medicaid waiver program, women screened under the BCCP would have been enrolled in the BCCDTP using State funds to treat any instance of breast or cervical cancer.

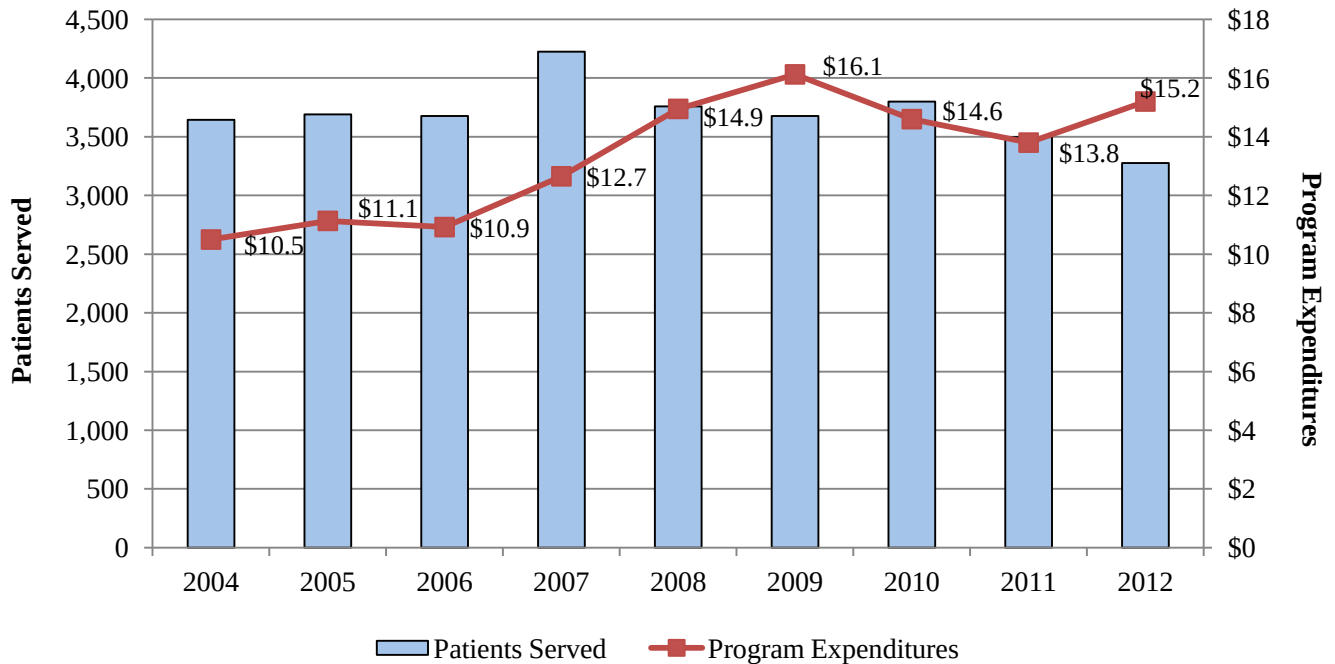
Breast and Cervical Cancer Diagnosis and Treatment Program

PHPA administers the BCCDTP, which funds breast and cervical cancer diagnostic and treatment services for uninsured, low-income (below 250% of the federal poverty level) women age 19 and older. The 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 2012, the program served approximately 3,277 patients at a cost of \$15.0 million. **Exhibit 15** shows the number of patients served by the BCCDTP from fiscal 2004 through 2012 and the program costs for the BCCDTP. While the number of patients served has leveled off in recent years, the program's expenditures peaked in 2009 at \$16.1 million.

Exhibit 15
Enrollment and Expenditures for the Breast and
Cervical Cancer Diagnosis and Treatment Program
Fiscal 2004-2012
(\$ in Millions)



Source: Department of Health and Mental Hygiene

The expenses of the program decreased in fiscal 2010 for the first time since 2006, partially due to the availability of State and federal screening programs that identify women eligible for the WBCCHP that may have otherwise been enrolled into the BCCDTP. Costs to administer the program increased in fiscal 2012 due to an increase in the cost of care. The fiscal 2013 budget also assumed a savings to the program of \$0.5 million due to an initiative to enroll high cost patients into the Maryland Health Insurance Plan, which will further decrease the amount of funding needed for the BCCDTP.

Women's Breast and Cervical Cancer Health Program

The WBCCHP was established by the Breast and Cervical Cancer Prevention and Treatment Act passed by the U.S. Congress in 2000. In 2002, Maryland was approved for a Medicaid waiver for the WBCCHP. Treatment for breast and cervical cancer is available to women diagnosed with precancer or cancer through the BCCP mentioned above. The federal government provides a 65% match for costs associated with the WBCCHP.

Implications of Federal Health Care Reform

According to the Health Care Reform Coordinating Council, an estimated 400,000 individuals will remain uninsured after the implementation of health care reform. Therefore, some individuals will continue to rely on the health care safety net system, such as the BCCP and the BCCDTP. However, a proportion of individuals that are currently screened through the BCCP and subsequently enrolled in the BCCDTP will be eligible either for expanded Medicaid coverage or for federally subsidized plans purchased through the Maryland Health Benefits Exchange (MHBE). At the time of this writing, it is unclear what savings will be realized within the BCCP and the BCCDTP as a result of the implementation of federal health care reform. **Therefore, DLS recommends that the committees adopt narrative that requires DHMH to report on program enrollment for the BCCDTP in fiscal 2014. More specifically, the report should summarize data on a quarterly basis to account for the mid-year implementation of the individual mandate under federal health care reform. Quarterly program costs should also be discussed. Finally, the report should advise on projected program enrollment for fiscal 2015 based on the availability of expanded Medicaid coverage and federally subsidized plans purchased through MHBE.**

3. Public Health Reorganization

Effective July 1, 2012, DHMH's Public Health Services Division was reorganized to further integrate public health planning and strengthen the division's capacity to deliver public health programs. The reorganization involved merging the Infectious Disease and Environmental Health Administration with the Family Health Administration to create PHPA, within which there are four bureaus: (1) Maternal and Child Health; (2) Environmental Health; (3) Infectious Disease; and (4) Cancer and Chronic Disease. The reorganization also resulted in the creation of the Health Systems and Infrastructure Administration which focuses on population-based health. The new public health structure is shown in **Exhibit 16**.

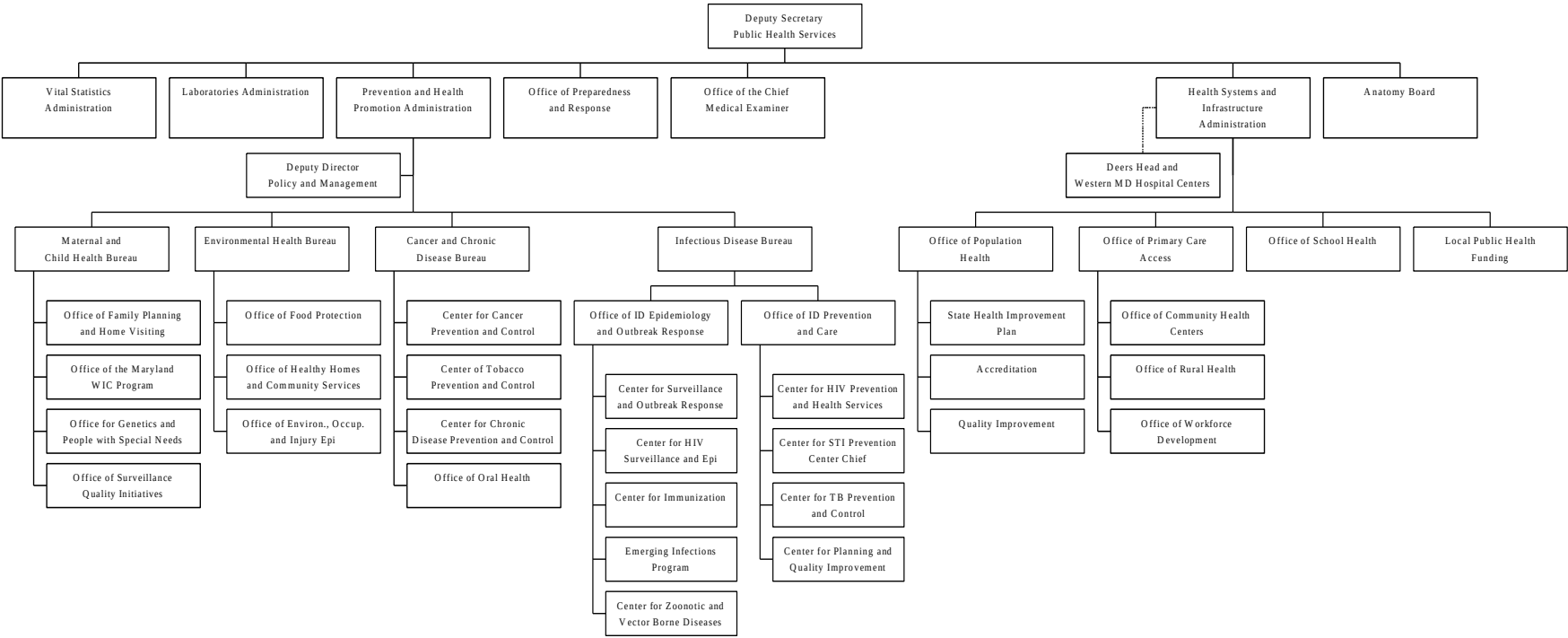
Maternal and Child Health Bureau

The Maternal and Child Health Bureau oversees the WIC program, programs for people with special health care needs, home visiting programs in the State as well as the Title X Family Planning Services Program, which provides free or sliding scale fee-for-service planning services (through LHDs, Planned Parenthood clinics, and other outpatient units) to women who are ineligible for Medicaid family planning services. In fiscal 2012, the program served approximately 79,000 women at more than 60 clinics.

Environmental Health Bureau

The Environmental Health Bureau works in conjunction with the Maryland Department of the Environment to increase awareness of environmental hazards. The bureau also houses the Office of Food Protection, which is focused on preventing foodborne illnesses and the spread of communicable diseases through regular inspections and licensing. LHDs work in conjunction with this bureau to enforce numerous environmental health mandates.

Exhibit 16
DHMH: Deputy Secretariat for Public Health Services



DHMH: Department of Health and Mental Hygiene

Source: Department of Health and Mental Hygiene

Infectious Disease Bureau

The Infectious Disease Bureau administers programs related to infectious disease prevention; HIV prevention, surveillance, and care services; infectious disease reporting; outbreak response, including zoonotic and vector borne diseases; and tuberculosis prevention and control. HIV education services are, in large part, federally funded and include statewide HIV counseling, testing, and referral services; HIV partner programs that provide notification and counseling to individuals who are sexual or needle-sharing partners of HIV-infected persons; an HIV prevention program that is designed to reduce perinatal HIV transmission; an HIV prevention program that targets the deaf and hearing-impaired; and a program for the purchase of HIV prevention literature and condoms for free distribution statewide. The division also administers the MADAP and MADAP-Plus programs.

Cancer and Chronic Disease Bureau

The Cancer and Chronic Disease Bureau aims to reduce the incidence of cancer in Maryland and promotes healthy lifestyles that will reduce chronic disease by focusing its efforts on communities, health care, schools, and businesses. Programs within the bureau include the Breast and Cervical Cancer Program; the Breast and Cervical Cancer Diagnosis and Treatment Program; the Colorectal Cancer Screening Program; the Tobacco Use Prevention and Cessation Program; the Cancer Prevention, Education, Screening, and Treatment Program; and the Statewide Academic Health Centers program. LHDs receive federal and general funds, as well as special funds from the CRF to administer these programs. The bureau also oversees the Office of Oral Health and the Center for Chronic Disease Prevention and Control.

Recommended Actions

1. Adopt the following narrative:

Breast and Cervical Cancer Diagnosis and Treatment Program Report: The committees direct the Department of Health and Mental Hygiene (DHMH) to report on program enrollment for the Breast and Cervical Cancer Diagnosis and Treatment Program (BCCDTP) in fiscal 2014. Two reports should be submitted – one for the first half of the fiscal year and one for the second half. More specifically, the reports should summarize enrollment data on a quarterly basis to account for the mid-year implementation of the individual mandate under federal health care reform. Quarterly program costs should also be discussed. The final report should also advise on projected program enrollment for fiscal 2015, based on the availability of expanded Medicaid coverage and federally subsidized plans purchased through the Maryland Health Benefits Exchange.

Information Request	Author	Due Date
Report on BCCDTP enrollment data	DHMH	January 15, 2014, and September 1, 2014

Updates

1. Severe Combined Immunodeficiency Disease Screening of Newborns in Maryland

The 2012 *Joint Chairmen's Report* (JCR) included language which required DHMH, in conjunction with the State Advisory Council on Hereditary and Congenital Disorders, to submit a report on the feasibility of implementing severe combined immunodeficiency disease (SCID) screening of newborns in Maryland. More specifically, DHMH was required to report on the following issues:

- the impact of implementing SCID screening, including an analysis of screening costs, and start-up costs for the necessary medical equipment and staff that would be needed to implement SCID screening;
- how insurance reimbursement pertains to screening costs and the financial impact on Medicaid should a newborn fail to be diagnosed with SCID;
- whether DHMH plans on adding SCID screening or other hereditary and congenital conditions to the newborn screening program; and
- the department's prior and future efforts to obtain federal funding for SCID screening.

Background

SCID – commonly known as the “bubble boy disease” – affects 1 in 66,000 live births. Infants who go undiagnosed and untreated rarely survive past their first birthday due to complications related to infections. Infections are often secondary to the recommended course of pediatric vaccinations, including rotavirus, Varicella, measles, mumps and rubella. Hematopoietic stem cell transplantation can cure SCID, but only if it is performed early in life before a baby has multiple infections. Therefore, early detection of SCID in newborns is critical.

In 2010, the Secretary of the U.S. Department of Health and Human Services recommended that SCID be included in routine newborn screening programs. Consequently, the State Advisory Council on Hereditary and Congenital Disorders recommended that SCID be added to the newborn screening program in June 2011; however, the screening program has not yet been implemented in the State.

Financial Impact of SCID Screening

According to the Wisconsin State Laboratory of Hygiene, approximately five newborns have been diagnosed with SCID recently. All of these cases were diagnosed late. As a result, the average hospital bill related to each newborn was \$2.2 million. In comparison, medical bills for a newborn

that was diagnosed early totaled \$250,000. Similarly, in Florida, there are at least two examples that illustrate the financial impact on Medicaid should a newborn fail to be diagnosed with SCID. The first infant died at the age of five months and was treated in the hospital for 10 days at a cost of \$500,000. The second newborn was hospitalized for six months at a cost of \$2.2 million to Medicaid.

DHMH estimates that start-up costs to implement SCID screening will total \$745,000. This includes funding for supplies, instruments, and two public health laboratory scientists. In subsequent years, these expenditures are expected to decrease to \$472,000. Therefore, if 75,000 babies are born annually, the cost per newborn is estimated at \$6.29.

The agency has unsuccessfully sought federal funding to implement SCID screening in Maryland. Once funding is available, the department advises it could begin SCID screening within six to eight months, and the department is considering requesting funding for SCID screening during the fiscal 2015 budget process. Ultimately, the annual treatment costs saved through SCID screening is estimated at \$465,000 per infant.

2. In-state Development of Devices for the Treatment of Cancer

The 2012 JCR included language which required DHMH, in conjunction with the Department of Business and Economic Development (DBED), to submit a report on research and development collaborations between Maryland companies and Maryland academic researchers that accelerate the development of devices, diagnostics, and therapeutics that improve cancer outcomes.

Report Summary

Background

Maryland is home to over 500 bioscience companies, of which 91 are actively engaged in research and development of products related to cancer. Since the inception of the Maryland Industrial Partnerships (MIPS) program in 1987, the State has been committed to the development of collaborative relationships between companies and universities. More specifically, Johns Hopkins University and the University of Maryland are involved in nearly 30 cancer-related research projects with companies based in Maryland. Though some of these projects have been funded through the CRF, the vast majority have not. Cumulatively, these projects represent nearly \$10 million in funding. Moreover, these collaborations and clinical studies involve the evaluation of cancer drug therapies and protocols for treatment related to cancer. Treatment regimens range from small molecule to biologics, including cellular therapies and vaccines.

Some of these university collaborations have been based on, or resulted in, technology transfer activities. These collaborations include, but are not limited to, A&G Pharmaceutical, Gliknik, Xcision, and Profectus, who licensed their technologies from the University of Maryland, and Biomarker Strategies who licensed their technology from Johns Hopkins University.

CRF Funding to Statewide Academic Health Centers

While a variety of programs promote collaborations between academic researchers and biotechnology companies in Maryland, CRF funds are the only source of State funding specifically targeted at cancer. The Health General Article requires each academic health center to enter into a memorandum of understanding (MOU) with the following State agencies: DHMH, DBED, and the Maryland Technology Development Corporation (TEDCO). The purpose of the MOU as outlined by the statute is to:

- establish a plan for expediting the translation of cancer research activities into treatment protocols and clinical trials;
- establish the scope of the State's ownership or other financial interest in the commercialization and other benefits of the results, products, inventions, and discoveries of cancer research activities funded by a Statewide Academic Health Center cancer research grant under the CRF; and
- reflect the intellectual property policies of the Statewide Academic Health Center.

With regard to commercialization, the MOU also specifies that for each invention assigned to the university, the university shall make its best effort to commercialize each invention through a license or similar arrangement with an entity in Maryland. Moreover the university must consult with DBED and TEDCO to identify potential licensees.

Other Funding for Research

The following programs also support research and development in Maryland:

- ***Maryland Biotechnology Center Translational Research Award:*** Funding supports collaborations between private companies in the State and academic research programs.
- ***Biotechnology Investment Incentive Tax Credit Program (BIITC):*** The BIITC provides income tax credits equal to 50% of an eligible investment for investors in qualified Maryland biotechnology companies. Total credit certificates issued in a fiscal year cannot exceed the budgeted amount.
- ***InvestMaryland:*** Through a premium insurance tax credit auction sale, where future tax credits are sold to insurance companies at a discount, the State raised \$84 million in venture capital funding to invest in early stage technologies in areas of life sciences, software, communications, and cybersecurity.

Research and Development Tax Credit

- **MIPS:** MIPS accelerates the commercialization of technology in Maryland by funding collaborative research and development projects between companies and University of Maryland faculty.
- **TEDCO Funding:** There are various funding streams in TEDCO, including the Maryland Technology Transfer Fund, the Johnson and Johnson Investment Program, and Innovate Maryland.

3. Home Visiting Programs

The 2012 JCR directed DHMH, in conjunction with the Maryland State Department of Education (MSDE), and the Children's Cabinet to report to the committees on the feasibility of consolidating existing home visiting programs under one agency. More specifically, the aforementioned entities were required to inform the committees on where the program should be located, and who should administer the funds. Furthermore, the report was to identify the benefits of consolidating the program and indicate whether the fragmentation of current programs is appropriate given the maintenance of effort requirement related to the Maternal, Infant, and Early Childhood Home Visiting Program funded through the ACA.

Report Summary

Background

DHMH, MSDE, the Department of Human Resources, and the Governor's Office for Children, on behalf of the Children's Cabinet, each provide funding for home visiting programs using different funding streams that are summarized below.

- **DHMH Programs:** DHMH administers both the federal Title V Maternal and Child Health grant program and the new federal Maternal, Infant, and Early Childhood Home Visiting program. Funding administered under the Maternal, Infant, and Early Childhood Home Visiting program is the only dedicated source of funding for home visiting administered by DHMH. In addition to standard federal reporting requirements, this grant mandates an annual progress report on program outcomes. Funding administered through Title V may be used to fund home visiting programs, but ultimately this decision is made at the local level by LHDs.
- **Department of Human Resources Program:** The Department of Human Resources funds home visiting programs through federal Promoting Safe and Stable Family grants, which includes quarterly reporting requirements. These funds are provided to local jurisdictions through the local Department of Social Services offices. Local offices may choose to fund home visiting programs; however, this is not a requirement of the federal grant.

- ***Governor’s Office for Children Program:*** Funding is provided to Local Management Boards (LMB) for evidence-based home visiting programs, but there is no dedicated funding for home visiting. LMBs may choose to fund programs based on local needs. Programs must align with the Children’s Cabinet’s priorities.
- ***MSDE Program:*** MSDE funds home visiting programs through LMBs. Moreover, funding is used to fund different home visiting programs based on local needs. Early Head Start targets low-income pregnant women and families with children birth to age three, and the Healthy Families America program, which targets parents facing challenges, such as substance abuse and mental health issues. The Home Instruction Program for Preschool Youngsters aims to promote preschool readiness and provides home site visits as well as monthly group meetings. The Nurse-Family Partnership is designed for first-time, low-income mothers and their children. It includes one-on-one visits by a trained public health nurse. The Parents as Teachers program aims to provide parents with child development knowledge and improve parenting practices.

Consolidation of Programs Is Not Beneficial for the State

DHMH, MSDE, and the Children’s Cabinet identified the following reasons why consolidation was not beneficial for the State:

- there are various funding streams and outcomes for each program;
- there are various federal requirements for each program;
- the program models are diverse, funded by numerous agencies, and having one agency as the lead may create a loss in program diversity;
- local decisionmaking would be compromised;
- there would be no savings realized through consolidation; and
- the maintenance of effort requirement under the Maternal, Infant, and Early Childhood Home Visiting grant is currently being fulfilled through the various funding streams and is not impacted by the separation of programs.

DHMH, MSDE, and the Children’s Cabinet advise that consolidating existing home visiting programs would not be beneficial to the State or program recipients. Instead, increased collaboration could be attained with existing funding, and is, in part, required by the Home Visiting Accountability Act of 2012 (Chapter 79 of 2012).

The Home Visiting Accountability Act of 2012

The Home Visiting Accountability Act of 2012 requires that:

- the State only fund evidence-based or promising practice home visitation programs for improving parent and child outcomes;
- no less than 75% of State funding for home visiting programs be made available to evidence-based home visiting programs;
- State-funded home visiting programs submit regular reports that account for expended funding, identify the number and demographic characteristics of the individuals served, and note the outcomes achieved by the home visiting programs; and
- the Governor's Office for Children develop the reporting and monitoring procedures for State-funded home visiting programs.

The agencies administering home visiting programs advise that the maintenance of effort requirement under the ACA grant can be maintained without consolidating programs. However, it was suggested that there is increased coordination for trainings. This includes collaboration with the Maryland Family Network to sponsor an annual conference that would include home visiting training. Moreover, additional coordination in data collection was recommended.

Current and Prior Year Budgets

Current and Prior Year Budgets DHMH – Prevention and Health Promotion Administration (\$ in Thousands)

	<u>General Fund</u>	<u>Special Fund</u>	<u>Federal Fund</u>	<u>Reimb. Fund</u>	<u>Total</u>
Fiscal 2012					
Legislative Appropriation	\$41,093	\$58,281	\$202,975	\$1,811	\$304,161
Deficiency Appropriation	121	25,563	7,330	0	33,014
Budget Amendments	-1,281	15,218	1,035	137	15,109
Reversions and Cancellations	0	-3,982	-5,442	-191	-9,615
Actual					
Expenditures	\$39,933	\$95,080	\$205,899	\$1,757	\$342,669
Fiscal 2013					
Legislative Appropriation	\$53,151	\$88,245	\$207,854	\$1,929	\$351,179
Budget Amendments	-691	75	599	0	-18
Working					
Appropriation	\$52,460	\$88,319	\$208,453	\$1,929	\$351,161

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

Fiscal 2012

PHPA spent \$342.7 million in fiscal 2012, which is \$38.5 million above the original legislative appropriation. It is important to note that due to the reorganization of public health services, the fiscal 2012 closeout information for PHPA may include expenditures within DHMH's Health Systems and Infrastructure Administration.

Deficiency appropriations increased PHPA's legislative appropriation by \$33.0 million. This includes \$0.1 million in general funds to support the 2-1-1 Maryland System and \$25.6 million in special funds for MADAP. Additional federal funds were awarded to PHPA for the WIC program (\$2.5 million); State chronic disease planning (\$1.6 million); HIV prevention activities for the Baltimore-Towson Metropolitan Statistical area (\$1.2 million); the Minority AIDS Initiative (\$1.0 million); and vaccine immunization activities (\$1.0 million).

Budget amendments increased the legislative appropriation of PHPA by \$15.1 million. General funds decreased by \$1.0 million to realign funds within DHMH. These general funds were available due to increased turnover within the agency. Additionally, \$0.4 million in general funds was transferred from the Family Health Services and Primary Care Program to the Office of the Secretary. These decreases were offset by the transfer of funds from the Department of Budget and Management (DBM) to PHPA for the \$750 one-time bonus for State employees (\$115,135 in general funds, \$12,912 in special funds, and \$155,760 in federal funds). General funds also increased to realign DBM telecommunication appropriations within DHMH from programs with telecommunications surpluses to those with deficits (\$59,868).

Budget amendments increased the special fund appropriation for PHPA by \$15.2 million. The majority of this funding (\$15.0 million) was needed for the grant to Prince George's Hospital System. This amendment transferred funds from the Dedicated Purpose Account to PHPA for the purpose of disbursement of the grant and required approval by the budget and legislative policy committees. One amendment increased special funds by \$0.2 million to cover the cost of grants for cancer research, prevention, and treatment services. These special funds were available through the Maryland Cancer Fund. Special funds were also needed for the ChopChop Maryland program that distributes healthy dietary recipes using Maryland ingredients (\$5,000). Finally, one amendment increased the federal fund appropriation by \$879,340 to promote immunization activities and to provide HIV-related data entry services.

PHPA cancelled \$9.6 million in fiscal 2012. This amount includes \$4.0 million in special funds. Specifically, \$3.7 million were cancelled due to lower than anticipated expenditures for MADAP prescription drug rebates. The remaining funds (\$250,022) were cancelled due to decreased expenditures for the Maryland Cancer Income Tax check off and for administrative expenditures in the CRF program. In addition, \$5.4 million in federal funds were cancelled. The majority of funds were cancelled in the WIC program (\$3.5 million) and HIV prevention activities (\$1.2 million). The remaining funds (\$0.7 million) were cancelled for various programs including prevention and wellness, and maternal and

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child health. Finally, reimbursable funds were cancelled due to less than anticipated refugee health screenings (\$166,466) and decreased attainment from the University of Maryland, Baltimore (\$25,000).

Fiscal 2013

The fiscal 2013 budget for DBM included centrally budgeted funds for the 2013 COLA for State employees. This resulted in the transfer of funds from DBM and PHPA (\$74,695 in special funds and \$135,590 in federal funds). One amendment decreased general and federal funds by \$691,025 and 110,503, respectively. This reflects the reorganization of the Public Health Services Division of DHMH. Federal funds also increased to cover the cost of programs associated with food safety and to strengthen Maryland's ability to respond to food related emergencies (\$463,058).

Object/Fund Difference Report
DHMH – Prevention and Health Promotion Administration

<u>Object/Fund</u>	<u>FY 12 Actual</u>	<u>FY 13 Working Appropriation</u>	<u>FY 14 Allowance</u>	<u>FY 13 - FY 14 Amount Change</u>	<u>Percent Change</u>
Positions					
01 Regular	366.30	364.80	362.80	-2.00	-0.5%
02 Contractual	4.01	8.78	8.93	0.15	1.7%
Total Positions	370.31	373.58	371.73	-1.85	-0.5%
Objects					
01 Salaries and Wages	\$ 29,908,243	\$ 30,422,062	\$ 31,423,404	\$ 1,001,342	3.3%
02 Technical and Spec. Fees	222,142	352,964	369,162	16,198	4.6%
03 Communication	478,418	601,951	972,164	370,213	61.5%
04 Travel	526,509	619,466	669,761	50,295	8.1%
07 Motor Vehicles	157,423	110,847	127,634	16,787	15.1%
08 Contractual Services	239,420,546	234,698,871	237,805,740	3,106,869	1.3%
09 Supplies and Materials	38,667,712	47,734,482	43,420,708	-4,313,774	-9.0%
10 Equipment – Replacement	97,060	5,026	4,399	-627	-12.5%
11 Equipment – Additional	966,596	634,895	625,258	-9,637	-1.5%
12 Grants, Subsidies, and Contributions	30,201,027	35,582,323	40,455,336	4,873,013	13.7%
13 Fixed Charges	293,235	398,418	392,667	-5,751	-1.4%
Total Objects	\$ 340,938,911	\$ 351,161,305	\$ 356,266,233	\$ 5,104,928	1.5%
Funds					
01 General Fund	\$ 38,831,545	\$ 52,459,706	\$ 53,156,152	\$ 696,446	1.3%
03 Special Fund	95,080,492	88,319,358	85,961,587	-2,357,771	-2.7%
05 Federal Fund	205,270,315	208,452,753	215,097,325	6,644,572	3.2%
09 Reimbursable Fund	1,756,559	1,929,488	2,051,169	121,681	6.3%
Total Funds	\$ 340,938,911	\$ 351,161,305	\$ 356,266,233	\$ 5,104,928	1.5%

Note: The fiscal 2013 appropriation does not include deficiencies. The fiscal 2014 allowance does not include contingent reductions.

Fiscal Summary
DHMH – Prevention and Health Promotion Administration

<u>Program/Unit</u>	<u>FY 12 Actual</u>	<u>FY 13 Wrk Approp</u>	<u>FY 14 Allowance</u>	<u>Change</u>	<u>FY 13 - FY 14 % Change</u>
01 Administrative, Policy, and Management Systems	\$ 131,914,384	\$ 133,903,850	\$ 122,042,839	-\$ 11,861,011	-8.9%
04 Family Health and Chronic Disease Services	209,024,527	217,257,455	234,223,394	16,965,939	7.8%
Total Expenditures	\$ 340,938,911	\$ 351,161,305	\$ 356,266,233	\$ 5,104,928	1.5%
General Fund	\$ 38,831,545	\$ 52,459,706	\$ 53,156,152	\$ 696,446	1.3%
Special Fund	95,080,492	88,319,358	85,961,587	-2,357,771	-2.7%
Federal Fund	205,270,315	208,452,753	215,097,325	6,644,572	3.2%
Total Appropriations	\$ 339,182,352	\$ 349,231,817	\$ 354,215,064	\$ 4,983,247	1.4%
Reimbursable Fund	\$ 1,756,559	\$ 1,929,488	\$ 2,051,169	\$ 121,681	6.3%
Total Funds	\$ 340,938,911	\$ 351,161,305	\$ 356,266,233	\$ 5,104,928	1.5%

Note: The fiscal 2013 appropriation does not include deficiencies. The fiscal 2014 allowance does not include contingent reductions.