

SURVEY OF LOCAL HEALTH DEPARTMENTS IN MARYLAND



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Survey of Local Health Departments in Maryland

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DEPARTMENT OF LEGISLATIVE SERVICES
OFFICE OF POLICY ANALYSIS
MARYLAND GENERAL ASSEMBLY

Warren G. Deschenaux
Director

January 4, 2013

The Honorable Thomas V. Mike Miller, Jr., President of the Senate
The Honorable Michael E. Busch, Speaker of the House
Members of the General Assembly

Ladies and Gentlemen:

The attached report, titled *Survey of Local Health Departments in Maryland*, examines the provision of local public health services in the State. More specifically, the report assesses (1) how local health departments (LHD) finance public health services; (2) the impact of federal health care reform on LHDs; and (3) the regionalization of public health services in the State.

In order to evaluate these three areas, the Department of Legislative Services (DLS) distributed to each of the local health officers in the State an electronic survey containing questions concerning LHD operations, programs, funding, and staffing. DLS received a response from every jurisdiction; these responses significantly informed the analysis of the enclosed report. DLS would like to acknowledge the cooperation and assistance provided by the State's 24 LHDs, the Maryland Association of County Health Officers, and the Department of Health and Mental Hygiene (DHMH) throughout the survey process.

The survey revealed that LHDs are serving Marylanders admirably despite continued cost containment measures. However, in anticipation of the full implementation of federal health care reform, it is critical for LHDs to continue to be agile in meeting the public's shifting needs. Thus, DLS offers three recommendations designed to address billing-related challenges as well as explore potential options with regard to funding and regionalization.

Several key findings inform DLS' recommendations. First, DLS found that, while State Core Funds make up only a small portion of LHD revenues, local jurisdictions' reliance on these funds is likely to increase as funding for State-only safety net programs continues to decline under federal health care reform. It is critical that LHDs are funded not only adequately but also equitably to limit disparities in public health services. Thus, DLS acknowledges the need for additional research to be conducted in the 2013 legislative session to determine whether the current distribution of funds under the Core Funding Program is effective.

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DLS also found that, despite recent legislative attempts to remove barriers to contracting between LHDs and private entities, LHDs continue to experience difficulties in contracting with third-party insurers. To the extent that LHDs continue to act as direct service providers after federal health care reform is fully implemented and fewer individuals are insured, LHDs' ability to contract with and bill third-party insurers is critical. Thus, DLS recommends that committee narrative be adopted in the 2013 *Joint Chairmen's Report* requiring DHMH to report on its ongoing efforts to address the challenges that LHDs are currently facing with regard to billing.

Finally, DLS found that, while a majority of LHDs are either considering or actively pursuing voluntary public health accreditation, lack of funding is a primary barrier to many. DLS advises that regionalization of public health services is a potential tool for overcoming financial barriers to accreditation and for ensuring that public health services are consistent throughout the State. Accordingly, DLS will conduct additional research during the 2013 legislative interim to determine whether Maryland's LHDs could benefit from increased regionalization of public health services.

DLS looks forward to the continued cooperation of State and local public health entities in its continued study of the provision of local public health services in the State. If you have any questions concerning the contents of this report, please do not hesitate to contact its primary authors, Jennifer A. Ellick and Erin K. McMullen.

Sincerely,

Warren G. Deschenaux
Director

WGD/EKM/jac

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Executive Summary

Public health systems in Maryland and nationwide are currently facing a number of critical challenges, due in part to fiscal constraints brought on by the recession that began in December 2007. To better understand how local health departments (LHD) in Maryland are confronting these challenges, the Department of Legislative Services (DLS) undertook a research project in the 2012 legislative interim that examined LHD operations, programs, funding, and staffing.

Among other research activities, the project included an electronic survey that was sent to, and completed by, each of the local health officers in the State. Responses to the survey significantly informed the analysis contained in this report. Findings and recommendations are summarized below.

State Core Funding supports seven service areas: administration and communications, adult and geriatric health, communicable disease control, environmental health, family planning, maternal and child health, and wellness promotion. Data shows that reductions to State Core funding have resulted in reductions to all seven service areas, with the most significant reductions occurring in administration and communications, environmental health services, and maternal and child health services. Although State Core Funding represents only a small portion (6%) of LHD revenues, DLS notes that this source of funding has decreased by 43% since fiscal 2009.

All 24 respondents to the LHD survey indicated that State budget cuts have resulted in reductions to programs, and 20 LHDs reported that they have been forced to eliminate programs. Furthermore, all 24 respondents indicated that positions were eliminated as a result of funding reductions, and 16 respondents reported having to raise fees.

Currently, LHDs in Maryland are being funded below the 1997 level that was established by the Core Funding Program. While Core Funding represents only a small fraction of LHD revenues, local jurisdictions' reliance on these funds is likely to increase given that funding for State-only safety net programs will continue to decline under federal health care reform. It is critical not only that LHDs have sustainable funding but also that funding be distributed equitably to limit disparities in basic public health services. **Therefore, DLS will conduct additional research in the 2013 legislative interim to determine whether the current distribution of funds under the Core Funding Program is effective to finance local public health services. Other states' funding formulas, as well as deficiencies (if any) in Maryland's current funding system, will also be examined.**

Despite recent legislative attempts to remove barriers to contracting between LHDs and private entities, survey respondents generally reported continued difficulties in contracting with third-party insurers. Specifically, survey respondents cited the requirement for LHDs to unconditionally indemnify the payor (even though statute prohibits State officials from

doing so) as the most problematic contractual provision required by insurers.

The Department of Health and Mental Hygiene (DHMH) advises that the department, along with the Office of the Attorney General, is attempting to address these contracting hurdles by negotiating statewide contracts with the various insurance plans. According to DHMH, the department is in the process of reaching out to major health insurers and third-party payors in an attempt to determine how best to negotiate statewide contracts (or other network relationships) with the insurers for the benefit of LHDs. DHMH further advises that it is currently still conducting outreach efforts but has been provided with at least one proposed contract from a health insurer. Almost all LHDs reported that they are aware of DHMH's efforts in this area.

To the extent that LHDs continue to act as direct service providers after federal health care reform is fully implemented and fewer individuals are uninsured, LHDs' ability to contract with and bill third-party insurers is critical. **Therefore, DLS recommends that committee narrative be adopted in the 2013 *Joint Chairmen's Report* requiring DHMH to report on its efforts to address the challenges that LHDs are currently facing with regard to billing generally and third-party contracting in particular. DHMH should also advise whether statutory changes are necessary and/or feasible.**

DHMH has encouraged LHDs to pursue accreditation, and a majority of survey respondents indicated that they are either considering or actively pursuing accreditation. However, lack of funding was noted by half of LHDs as a primary barrier to accreditation. Competing priorities and

lack of staff time were also cited as barriers. Only one LHD suggested that LHD accreditation is unnecessary. In general, survey responses revealed that LHDs are interested in becoming accredited but that they have had limited success in obtaining the funds to do so.

DLS advises that regionalization is a potential tool for overcoming financial barriers to accreditation and for ensuring that the quality of public health services is consistent throughout the State. **Accordingly, DLS will conduct additional research in the 2013 legislative interim to determine whether Maryland's LHDs could benefit from increased regionalization of public health services.**

Chapter 1: Overview

The Local Health Department Survey Process

Public health systems in Maryland and nationwide are currently facing a number of critical challenges, due in part to fiscal constraints brought on by the recession that began in December 2007. To better understand how local health departments (LHD) in Maryland are confronting these challenges, the Department of Legislative Services (DLS) undertook a research project in the 2012 legislative interim to examine LHD operations, programs, funding, and staffing. DLS' findings from that study are outlined in the present report. DLS had last conducted an in-depth study of LHDs in 1997.

Research Activities

DLS utilized several research activities to complete this report.

- **Electronic Survey** – DLS sent an electronic survey to each of the local health officers in the State. The survey contained questions primarily concerning operations, programs, funding, and staffing. DLS received a response from every jurisdiction; these responses significantly informed the analysis of this report. Throughout the survey process, LHD and Department of Health and Mental Hygiene (DHMH) staff were helpful and responsive to DLS' requests for information. Individual responses are neither quoted in, nor included as an appendix to, this report; rather, data from these responses generally are aggregated for presentation and analysis.
- **Interviews** – Structured interviews were conducted with staff of each LHD (either by telephone, electronically, or through a combination of both) to supplement and clarify the survey responses. As with the survey responses, interview responses are neither quoted in, nor included as an appendix to, this report.
- **Literature and Document Reviews** – DLS reviewed several sources of literature on local health, including but not limited to information from the National Conference of State Legislatures (NCSL) and the National Association of County and City Health Officials (NACCHO) on local health entities in other states; pertinent academic and professional journals; the Annotated Code of Maryland; and the Code of Maryland Regulations (COMAR).
- **Site Visits/Observation** – DLS visited a number of LHDs – including departments in Western Maryland, Southern Maryland, Central Maryland, and the Eastern Shore – to gain a better understanding of the issues confronting LHDs in various regions of the State. In addition, DLS visited two Federally Qualified Health Centers and observed a local health improvement process meeting.

Report Organization and Objective

This report consists of five chapters. **Chapter 1** provides an overview of the report; describes the various roles of the federal, State, and local governments in the provision of public health services; and identifies local public health programs and partnerships. **Chapter 2** explains the origins of LHD funding; utilizes the LHD survey responses to evaluate local expenditures and revenues; and discusses the impact of cost containment on local programs. **Chapter 3** explores the impact of federal health care reform on the provision of local public health services and addresses issues related to billing. **Chapter 4** discusses the regionalization of local public health services, and **Chapter 5** summarizes and concludes the report.

Five appendices are included as supplements to the report. **Appendix 1** contains the survey that was sent by DLS to local health officers, while **Appendix 2** contains a discussion of public health programs within DHMH. **Appendix 3** provides an overview of LHD expenditures and revenues in fiscal 2011 for each county and Baltimore City. **Appendix 4** outlines the State Health Improvement Process, and **Appendix 5** describes Health Enterprise Zone eligibility and criteria.

The Provision of Public Health Services in Maryland

In Maryland, responsibility for providing public health care and related services is shared between the State and local governments. Statewide policy for health services (as well as the monitoring and evaluation of these services) is the responsibility of DHMH, while the implementation of such policy is a shared responsibility of DHMH and the LHDs in each county and Baltimore City. However, LHDs are responsible for the actual delivery of most public health services.

Public health agencies in each community assess local public health needs and develop policies to meet those needs. In Maryland, the public health system consists of a health care assurance system and preventative health services for low-income citizens and the uninsured; environmental health services, disease control, and food protection for the general public; treatment services for individuals with substance abuse problems, mental health illness, and developmental disabilities; and regulatory services that monitor public and private health care providers, school health programs, and health education. State-operated hospitals include two chronic disease hospitals and five psychiatric facilities (in addition to two residential treatment centers for the mentally ill). Beyond these facilities, Maryland has an all-payor payment system in which the same rates apply to all payors of hospital services. Financing for bad debt and charity care is included in hospital rates – disincentivizing hospitals from “dumping” patients who are either uninsured or unable to pay. No similar system exists for outpatient services, with the exception of low-cost services provided by LHDs and Federally Qualified Health Centers.

Financial support for public health services is a shared responsibility of the federal, State, and local governments. Federal monies – consisting of Medicaid reimbursements and block grants – are generally either used to fund programs operated by DHMH and other providers or funneled through the State to LHDs; however, several LHDs receive some funding directly from the federal government.

Federal Role in Public Health

The U.S. Department of Health and Human Services oversees the federal government's public health activities, which are carried out primarily by three public health agencies: the U.S. Centers for Disease Control and Prevention is the main federal agency for public health activities; the National Institutes of Health is the federal agency charged with carrying out and supporting medical research; and the U.S. Food and Drug Administration oversees the safety, effectiveness, and affordability of food, drugs, cosmetics, and other items, including biological products.

State Role in Public Health

DHMH oversees public health at the State level through several administrations, independent commissions, and other programs. DHMH also assumes full responsibility for funding and administering State mental health facilities, State Residential Centers for individuals with developmental disabilities, and chronic disease centers; and for the operation of certain other functions (such as postmortem examinations). In addition, State statute grants the Secretary of Health and Mental Hygiene emergency public health powers under the Catastrophic Health Emergency Disease Surveillance and Response Program; these powers are intended to be used to detect catastrophic health emergencies, investigate exposures to deadly agents, and address the effects of exposures to deadly agents.

With regard to funding, State support for public health services is provided through (1) appropriations for the operation of programs by the department; (2) grant funding for community-based services provided by LHDs, other public agencies, and private providers; and (3) the targeted local health formula established by the Core Funding Program. Local governments also provide support for local public health services through a required match under the targeted local health formula and through additional funds that local governments may elect to budget based on community priorities. A more detailed discussion of LHD financing can be found in **Chapter 2** of this report.

Most public health services in the State are funded in whole or in part by DHMH through four divisions: (1) Operations; (2) Health Care Financing; (3) Behavioral Health and Disabilities; and (4) Public Health Services. Administrative functions are organized under the Operations division, while the remaining three divisions play an important role in the delivery of local health services. Programs and administrations housed in or administered by these divisions include the Maryland Medical Assistance Program; the Maryland Children's Health Program; the Family Planning Program; the Primary Adult Care Program; the Kidney Disease

Program; the Employed Individuals with Disabilities Program; various health regulatory commissions; the Alcohol and Drug Abuse Administration (ADAA); the Developmental Disabilities Administration (DDA); the Mental Hygiene Administration (MHA); the Office of Preparedness and Response; the Laboratories Administration; the Prevention and Health Promotion Administration; and the Health Systems and Infrastructure Administration. **Appendix 2** contains a detailed discussion of each of these divisions and the various programs and commissions contained within them.

Other State agencies also have a role in directing and coordinating two services generally provided by LHDs: environmental health and school health. Environmental health policies are delivered in conjunction with the Maryland Department of the Environment, while school health programs involve the Maryland State Department of Education.

Local Role in Public Health

Maryland was the first state in the nation to have an LHD in each of its jurisdictions. In Maryland, LHDs serve as the operational arms of both DHMH and local governments for the design, implementation, and delivery of public health services. LHDs also administer and enforce State, county, and municipal health laws, regulations, and programs. Although there is some commonality across jurisdictions, programs offered by LHDs are tailored to each community's specific needs in order to provide services such as preventative care, immunizations, health education, drug and alcohol abuse counseling, and rabies and communicable disease prevention.

LHDs provide direct public preventative health services and, within some programs, act as case managers. Although LHDs primarily serve individuals who are either Medicaid-eligible, uninsured, or underinsured, they are beginning to serve a larger proportion of privately insured individuals. Typically, LHDs offer health services on a sliding fee scale that is based on an individual's income. More detailed discussions of LHD billing and collections can be found in **Chapters 2 and 4** of this report.

Each county is required by State law to establish a local board of health, which in turn is charged with setting and implementing health policy at the local level. A local health officer nominated by the county (and appointed by the Secretary of Health and Mental Hygiene) serves as the executive director of the board, appoints LHD staff, and enforces policies adopted by the Secretary and the local jurisdiction. Boards of health may impose fees as part of a regulation but must first obtain DHMH approval if the service for which the fee is to be charged is covered in whole or in part by State or federal funds.

Different Forms of County Government and Powers of Local Boards of Health

Several forms of government exist at the local level in Maryland. Specifically, each of the 23 counties operates under charter home rule, code home rule, or the commissioner system, while Baltimore City has its own unique system of local government. The various forms of county government and the associated powers of local boards of health are displayed in **Exhibit 1.1**.

Exhibit 1.1

Forms of County Government and Associated Health Powers

<u>Form of Government</u>	<u>Counties</u>	<u>Enumerated Health Powers</u>
Commissioner System	Calvert Carroll Cecil* Frederick** Garrett St. Mary's Somerset Washington	“To prevent and remove nuisances; to prevent the introduction of contagious diseases into the county; to approve the location for the manufacturing of soap and fertilizer; to approve the location of slaughterhouses, packinghouses, and all places which may involve or give rise to unsanitary conditions or conditions detrimental to health. However, the provisions of this subsection may not be construed to affect in any manner any of the powers and duties of either the Secretary of Health and Mental Hygiene or the Secretary of the Environment, or any public general law relating to the subject of health. This subsection also shall be applicable in Dorchester County and the County Commissioners shall have the powers provided in this section.” [Md. Ann. Code, Art. 25, §3(n)]
Charter Home Rule	Anne Arundel Baltimore County Cecil*** Dorchester Frederick **** Harford Howard Montgomery Prince George's Talbot Wicomico	“To prevent, abate and remove nuisances; to prevent the introduction of contagious diseases into such county; and to regulate the places of manufacturing soap and candles and fertilizers, slaughterhouses, packinghouses, canneries, factories, workshops, mines, manufacturing plants and any and all places where offensive trades may be carried on, or which may involve or give rise to unsanitary conditions or conditions detrimental to health. Nothing in this article or section contained shall be construed to affect in any manner any of the powers and duties of either the Secretary of Health and Mental Hygiene or the Secretary of the Environment or any public general laws of the State relating to the subject of health.” [Md. Ann. Code, Art. 25A, §5(J)]
Code Home Rule	Four “Classes”: <u>Central Maryland</u> No members <u>Eastern Shore</u> Caroline Kent Queen Anne's Worcester <u>Southern Maryland</u> Charles <u>Western Maryland</u> Allegany	“If a county adopts code home rule status...it may exercise those powers enumerated in Article 25 [for commissioner counties] and in §5 of Article 25A [for charter home rule counties], except for subsections (A), (P) and (S) of §5 of Article 25A...; and no county adopting code home rule status shall be excepted. These powers are in addition to any powers any county may now have under any public general or local law applicable to the county.” [Md. Ann. Code, Art. 25B, §13]

<u>Form of Government</u>	<u>Counties</u>	<u>Enumerated Health Powers</u>
Baltimore City	Baltimore City	“To provide for the preservation of the health of all persons within the City; to prevent the introduction of contagious diseases within the City, and within three miles of the same upon land, and within fifteen miles thereof upon the navigable waters leading thereto; and to prevent and remove nuisances.” [Baltimore City Charter, Art. II, §(11)]

*Until December 2012.

** Until December 2014.

***After December 2012.

****After December 2014.

Source: Local Health Department Survey

Commissioner counties have legislative and executive powers granted directly by the General Assembly to the elected board of commissioners, which makes decisions by majority vote and acts as a corporate entity. The board of commissioners serves as the board of health. (This cannot be changed at the county level.)

Charter home rule counties have more independence and are allowed, with certain limitations, to pass local legislation. When a county votes to have a charter home rule form of government, it approves a charter outlining the county’s rights, duties, and governmental structure. The county council and the county executive (if there is one) comprise the board of health unless the county code or charter specifies otherwise. Several counties (Anne Arundel, Harford, Montgomery, and Prince George’s) have passed ordinances designating the county council as the board of health, thereby providing that the county executive has no role on the board.

Code home rule counties have a combination of charter home rule and commissioner forms of government. These counties have no charter but do have the power to amend, repeal, or pass local laws. Unlike charter home rule counties, however, code home rule counties still have the General Assembly passing some local laws for their jurisdictions. The county commissioners serve as the board of health unless they have passed an ordinance otherwise constituting the board of health. To date, however, no code home rule county has adopted a provision to alter the composition of its board of health.

Baltimore City is an independent political subdivision that has its own unique legal framework. The city is a municipal corporation but is generally treated as a county for purposes of State law and operates under the charter home rule form of government. The mayor generally appoints boards and departments and is responsible for their supervision, while the city council is responsible for the passage of city ordinances.

Classification of Local Health Department Employees

Home rule counties may elect to consider LHD staff to be either State employees or county employees. In other counties, LHD employees generally are included in the State's merit system and are paid through the State's Central Payroll Bureau (although LHD employees are typically excluded from counts of State employees). Meanwhile, LHD employees in Baltimore City and Baltimore, Montgomery, and Prince George's counties are considered to be employees of the local jurisdiction. However, the classification of LHD staff as either State or local employees relates mainly to accounting processes and has no effect on how those positions are funded.

Programs, Partnerships, and Other Local Entities

Increasingly, LHDs are serving as program administrators rather than providing certain services directly. DLS asked survey respondents to report on various programs and partnerships, including which programs are offered by the LHD (whether directly, indirectly, or both) and whether the LHD has partnerships (whether formal, informal, or both) with the following entities: (1) academic institutions; (2) community health centers; (3) Federally Qualified Health Centers; (4) libraries and nonprofits/faith-based organizations; (5) local management boards; (6) local planning boards; (7) local task forces; (8) private physicians/providers; and (9) other entities. A number of other local entities also work with LHDs to deliver health care services on the local level; these include mental health services entities, developmental disabilities resource coordination entities, and substance abuse treatment services entities.

Local Public Health Programs

While LHD programs vary by jurisdiction, certain services – including those related to immunizations, communicable disease, substance abuse, family planning, and cancer screening – are offered by the majority of LHDs, although whether such programs are offered directly, indirectly, or both, varies by both jurisdiction and program type. (Programs offered indirectly include programs through which LHDs contract with other providers rather than provide services themselves.) Almost all LHDs reported that they provide immunization services,¹ communicable disease services, and substance abuse services directly. LHDs that offer family planning programs are far more likely to offer those services directly than indirectly, while a minority offers such services both directly and indirectly. Meanwhile, about a quarter of LHDs administer cancer screening programs indirectly, while approximately three quarters of LHDs provide these services either directly or both directly and indirectly.

¹ Through the federally funded Vaccines for Children program – which provides vaccines at no cost for children who, due to inability to pay, might otherwise not be vaccinated – vaccines are distributed at no charge to grantees (many of which are LHDs).

Partnerships Among Local Entities

LHDs reported formal and informal partnerships with a variety of local entities. (Formal partnerships include those established by contract or similar agreement.) The most commonly identified formal partnerships among local entities are those between LHDs and their local management boards (LMBs); 20 LHDs indicated that they have a formal partnership with their LMB, while 3 respondents indicated they have both informal and formal partnerships with their LMB. In addition, formal partnerships are common between respondents and academic institutions (with 13 LHDs reporting such partnerships) and between respondents and local task forces (with 11 respondents reporting such relationships). Additionally, 8 jurisdictions reported having both informal and formal partnerships with academic institutions; and 6 respondents noted having both informal and formal partnerships with task forces, while 2 indicated they had informal partnerships with task forces. Survey responses also indicated that partnerships between LHDs and physicians/providers are typically formal, with 10 respondents reporting both informal and formal partnerships with providers and an additional 8 LHDs reporting only formal partnerships.

LHDs and Federally Qualified Health Centers are more likely to have formal than informal partnerships. Six respondents indicated a formal relationship with Federally Qualified Health Centers, and an additional 9 reported that they have both informal and formal partnerships. Additionally, 4 LHDs noted that they have an informal partnership with a Federally Qualified Health Center. The remaining 5 respondents that reported no partnerships generally indicated there are no Federally Qualified Health Centers within their jurisdictions. In addition, a total of 6 respondents noted that they have formal partnerships with other entities, while 8 reported both informal and formal partnerships with other entities, and 2 reported only informal partnerships with other entities.

Partnerships with community health centers (neighborhood clinics that play an important role in serving the health care needs of the uninsured and underinsured) are not as common among LHDs. Only 6 respondents indicated they had formal partnerships with community health centers. One LHD indicated that it has both an informal and formal relationship with a community health center, while 3 respondents reported informal relationships. Similarly, partnerships with local planning boards are less common; 12 respondents indicated that they have no partnership with their local planning board, while 9 LHDs reported having formal partnerships and 2 indicated that they have informal partnerships.

Survey responses generally indicated that informal partnerships are less common among local jurisdictions, with the exception of partnerships with libraries and nonprofits/faith-based organizations. A total of 10 respondents indicated that they have an informal partnership with at least one of the aforementioned organizations, while an additional 9 LHDs indicated that they have both formal and informal partnerships with such organizations. Five respondents indicated they do not have any partnerships with such organizations.

Many Local Health Departments Serve as the Core Service Agency for Their Jurisdiction

State law establishes mental health advisory boards at both the State and local levels. At the State level, the Maryland Advisory Council on Mental Hygiene (members of which are appointed by the Governor) is charged with advising DHMH on mental health issues and advocating for a comprehensive, broad-based approach. At the local level, mental health advisory committees in each jurisdiction serve in an advisory capacity to local governments and core service agencies. Voting members typically include representatives of local government, mental health professionals, State officials, recipients of mental health benefits, parents of children or adults with mental disorders, and members of the general public.

Core service agencies are agents of local government and are responsible for planning, coordinating, and monitoring publicly funded mental health services. (Some core service agencies also act as direct service providers.) Half of LHDs (12) serve as the core service agency for their jurisdiction. A complete listing of the 20 core service agencies by location and type is provided in **Exhibit 1.2**. Core service agencies receive administrative and service funding in the form of grants and contracts from MHA. Further discussion of MHA appears in **Appendix 2**.

Exhibit 1.2 Core Service Agencies in Maryland

Core Service Agency

Allegany County	Allegany County Health Department
Anne Arundel County	Anne Arundel County Mental Health Agency
Baltimore City	Baltimore City Health Department
Baltimore County	Baltimore County Health Department
Calvert County	Calvert County Health Department
Caroline County	Mid-Shore Mental Health Services
Carroll County	Carroll County Health Department
Cecil County	Cecil County Health Department
Charles County	Charles County Health Department
Dorchester County	Mid-Shore Mental Health Systems
Frederick County	The Mental Health Management Agency
Garrett County	Garrett County Health Department
Harford County	Office of Mental Health/CSA of Harford County
Howard County	Mental Health Authority
Kent County	Mid-Shore Mental Health Services

Core Service Agency

Montgomery County	Montgomery County Department of Health and Human Services
Prince George's County	Prince George's County Health Department
Queen Anne's County	Queen Anne's County Local Management Board
Somerset County	Wicomico County Health Department
St. Mary's County	St. Mary's County Department of Aging and Human Services
Talbot County	Mid-Shore Mental Health Services
Washington County	The Washington County Mental Health Authority
Wicomico County	Wicomico County Health Department
Worcester County	Worcester County Health Department

CSA: Core service agency

Source: Department of Legislative Services; Local Health Department Survey

Many Local Health Departments Provide Developmental Disabilities Resource Coordination Services for Their Jurisdiction

DDA provides direct services to developmentally disabled individuals in two State Residential Centers and through funding of a coordinated service delivery system that supports the integration of these individuals into the community. DDA provides resource coordination to all individuals participating in a DDA Medicaid Waiver program, individuals receiving State funded services, and those on the waiting list. (Further discussion of DDA appears in **Appendix 2**.) Resource coordination agencies have numerous mandated responsibilities that are specified in regulation, including the development and implementation of Individual Plans (IPs) for DDA clients. An IP is a single plan for the provision of all services and supports, including non-DDA-funded services; it is outcome-oriented and intended to specify all assessments, services, and training needed for DDA clients. An IP must, among other requirements, be reassessed annually and contain measurable goals and strategies to work toward an outcome.

More than half of LHDs (15) provide DDA-funded resources coordination services in their jurisdictions; other jurisdictions utilize separate resource coordination agencies (such as Services Coordination, Inc., which is utilized by all but two of the jurisdictions that do not provide resource coordination services through their LHDs). A complete list of the resource coordination entities through which DDA funds resource coordination services is shown in **Exhibit 1.3**. Resource coordination entities receive funding in the form of grants and contracts from DDA.

Exhibit 1.3

Resource Coordination Agencies in Maryland

	<u>Resource Coordination Entity</u>
Allegany County	Services Coordination, Inc.
Anne Arundel County	Services Coordination, Inc.
Baltimore City	Baltimore City Health Department
Baltimore County	Baltimore County Health Department
Calvert County	Calvert County Health Department
Caroline County	Caroline County Health Department
Carroll County	Services Coordination, Inc.
Cecil County	Cecil County Health Department
Charles County	Charles County Health Department
Dorchester County	Dorchester County Health Department
Frederick County	Services Coordination, Inc.
Garrett County	Services Coordination, Inc.
Harford County	Harford County Government
Howard County	Services Coordination, Inc.
Kent County	Kent County Health Department
Montgomery County	Montgomery County Department of Health and Human Services
Prince George's County	Resource Connections of Prince George's County
Queen Anne's County	Queen Anne's County Health Department
Somerset County	Somerset County Health Department
St. Mary's County	St. Mary's County Health Department
Talbot County	Talbot County Health Department
Washington County	Services Coordination, Inc.
Wicomico County	Wicomico County Health Department
Worcester County	Worcester County Health Department

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

Local Health Departments Work Closely with Substance Abuse Treatment Services Entities

ADAA oversees the provision and funding of substance abuse treatment and prevention services in Maryland. Services are provided through grants and contracts with private agencies, nonprofit organizations, or LHDs. Treatment services are provided to the uninsured and underinsured as well as to Medicaid-eligible individuals for services not eligible for Medicaid reimbursement. (Further discussion of ADAA appears in **Appendix 2.**)

Chapters 237 and 238 of 2004 formalized a local planning role for drug and alcohol abuse services. Specifically, that legislation required each county to have a local drug and alcohol abuse council and develop a local plan that includes the plans, strategies, and priorities of the county in meeting identified needs of both the general public and the criminal justice system for alcohol and drug abuse evaluation, prevention, and treatment services.

ADAA has indicated that these local plans are key to determining specific program activities in each jurisdiction – and survey responses indicated that LHDs are, in fact, closely involved with their local drug and alcohol abuse councils. With the exception of just one county (in which ADAA funding goes not to the LHD but rather to the County Department of Aging and Human Services), each LHD has a staff member who serves on the local alcohol and drug abuse council.

Chapter 2: Financing of Public Health Services

The delivery of public health services in Maryland is primarily the joint responsibility of the State and local health departments (LHD), while the funding for these services is obtained from federal, State, local, and (in some instances) private sources. While the Core Funding Program is the sole statutory funding mechanism for LHDs and is the funding source that receives the most attention at the State level, the LHD survey revealed that Core funds represent only 6% of total LHD revenues. However, it is important to note that this source of funding has decreased by 43% since 2009. Furthermore, while the Core Funding Program provides funding for personnel, it does not include a cost-of-living adjustment (COLA) when a COLA is included in the State budget for State employees.

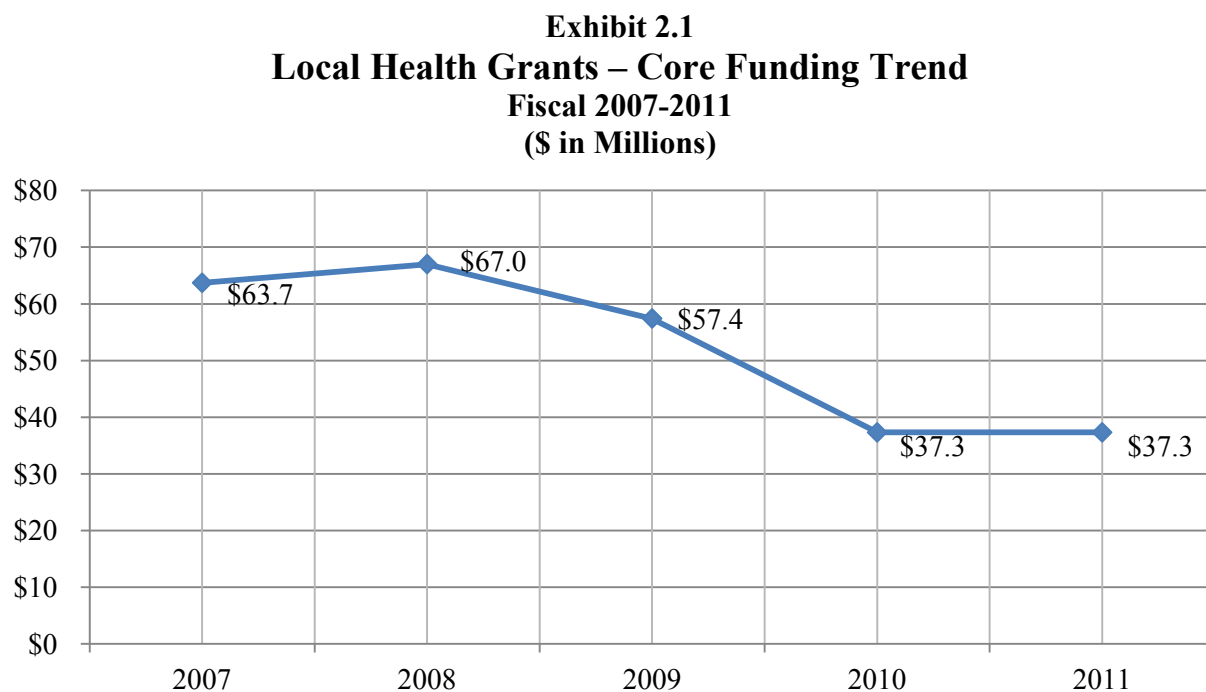
Core Public Health Funding Is the Sole Statutory Funding Mechanism for Local Health Services

Maryland was the first state in the nation to have an LHD in each of its jurisdictions. In 1956, the State began supporting LHDs through the Case formula, which was named after the chairman of the commission that developed the formula and made related recommendations. In accordance with the commission's recommendations, the State calculated minimum budgets for each LHD (based on the jurisdiction's population and corresponding minimum staffing needs) and annual budget bill language specified the respective State and local shares (based on the wealth of the jurisdiction) of each LHD's minimum budget. Under this nonstatutory budget process, State Core funds for local health services peaked at \$47.8 million in fiscal 1990 before falling – with the onset of the State's fiscal crisis in fiscal 1991 – to \$32.5 million in fiscal 1992 and \$14.6 million in fiscal 1993.

Subsequent legislation was enacted in 1995 to create a new funding mechanism for local health services called the Core Funding Program. Current statutory law governing the program establishes a base amount of \$41 million in State general funds for local health services for fiscal 1997 and specifies that an adjustment factor is to be applied to the base amount in subsequent years in order to provide increases over time. (The formula adjustment factor is calculated by combining an inflation factor with a population growth factor.) Statute further specifies that the Secretary of Health and Mental Hygiene must, in consultation with LHDs, adopt regulations to guide the distribution of required funding and that the regulations must give consideration to appropriate measures of community health need, local funding effort, and other relevant factors. Current regulations provide that the annual formula adjustment and any other adjustments for local health services must be allocated to each jurisdiction based on its percentage share of State funds distributed in the previous fiscal year and to address a substantial change in community health need, if any, as determined in the discretion of the Secretary after consultation with local health officers.

Impact of Recent Cost Containment Efforts on Core Funding Program

Due to recent budget constraints and cost-cutting measures, the fiscal 2010 appropriation for local health services was reduced to \$37.3 million – which was below even the fiscal 1997 mandated Core funding level. During the 2010 session, the statute underlying the health aid formula was amended to rebase the formula at the fiscal 2010 level for fiscal 2011 and 2012. **Exhibit 2.1** shows the Core funding level for the program from fiscal 2007 to 2011. It is important to note that Exhibit 2.1 does not include federal funds administered through the Core Funding Program.



Note: Amounts do not include federal pass-through funds administered through the Core Funding Program.

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

A local match is required for LHDs to secure State and federal funds. The match rate varies depending on a jurisdiction's wealth, from a minimum of 20% to a maximum of 80%. No jurisdiction's match rate may exceed its fiscal 1996 rate. In every jurisdiction, local funding for the LHD exceeds the required match. **Exhibit 2.2** shows LHD funding by jurisdiction for fiscal 2011, as well as the required and actual match provided by each jurisdiction. Not depicted here, however, are fee collections from LHDs, which offset the cost of services. It is important to note that for fiscal 2011, the actual county match totaled \$153.7 million statewide, which represents a 5% decrease from the fiscal 2008 local match of \$162.5 million.

Exhibit 2.2
Local Health Grants – Core Funding Program
Fiscal 2011

<u>County</u>	<u>State Aid</u>	<u>Required Local Match</u>	<u>Actual County Match</u>	<u>Local Funding Provided Above the Required Match</u>	<u>Total State and Local LHD Funding</u>
Allegany	\$967,398	\$242,524	\$1,153,010	\$910,486	\$2,120,408
Anne Arundel	3,523,126	3,954,702	20,463,925	16,509,223	23,987,051
Baltimore	4,924,229	4,393,754	21,970,982	17,577,228	26,895,211
Calvert	432,944	738,339	2,041,668	1,303,329	2,474,612
Caroline	565,567	144,847	512,783	367,936	1,078,350
Carroll	1,347,122	898,099	3,373,882	2,475,783	4,721,004
Cecil	885,657	549,303	2,199,732	1,650,429	3,085,389
Charles	1,101,822	886,614	2,211,891	1,325,277	3,313,713
Dorchester	457,055	178,972	507,360	328,388	964,415
Frederick	1,662,354	1,187,889	1,557,258	369,369	3,219,612
Garrett	461,373	224,526	1,076,543	852,017	1,537,916
Harford	1,911,648	1,082,500	2,384,713	1,302,213	4,296,361
Howard	1,388,659	1,870,062	4,616,731	2,746,669	6,005,390
Kent	351,124	148,376	1,842,125	1,693,749	2,193,249
Montgomery	3,601,473	9,123,472	46,476,400	37,352,928	50,077,873
Prince George's	5,713,956	4,157,871	9,879,300	5,721,429	15,593,256
Queen Anne's	451,737	349,826	1,469,437	1,119,611	1,921,174
St. Mary's	879,549	447,861	2,072,485	1,624,624	2,952,034
Somerset	452,446	107,346	617,226	509,880	1,069,672
Talbot	355,694	436,997	2,217,579	1,780,582	2,573,273
Washington	1,491,253	727,697	5,744,414	5,016,717	7,235,667
Wicomico	1,024,070	427,174	2,645,672	2,218,498	3,669,742
Worcester	354,150	857,872	1,054,854	196,982	1,409,004
Baltimore City	7,472,078	2,035,340	15,595,405	13,560,065	23,067,483
Total	\$41,776,484	\$35,171,964	\$153,685,375	\$118,513,411	\$195,461,859

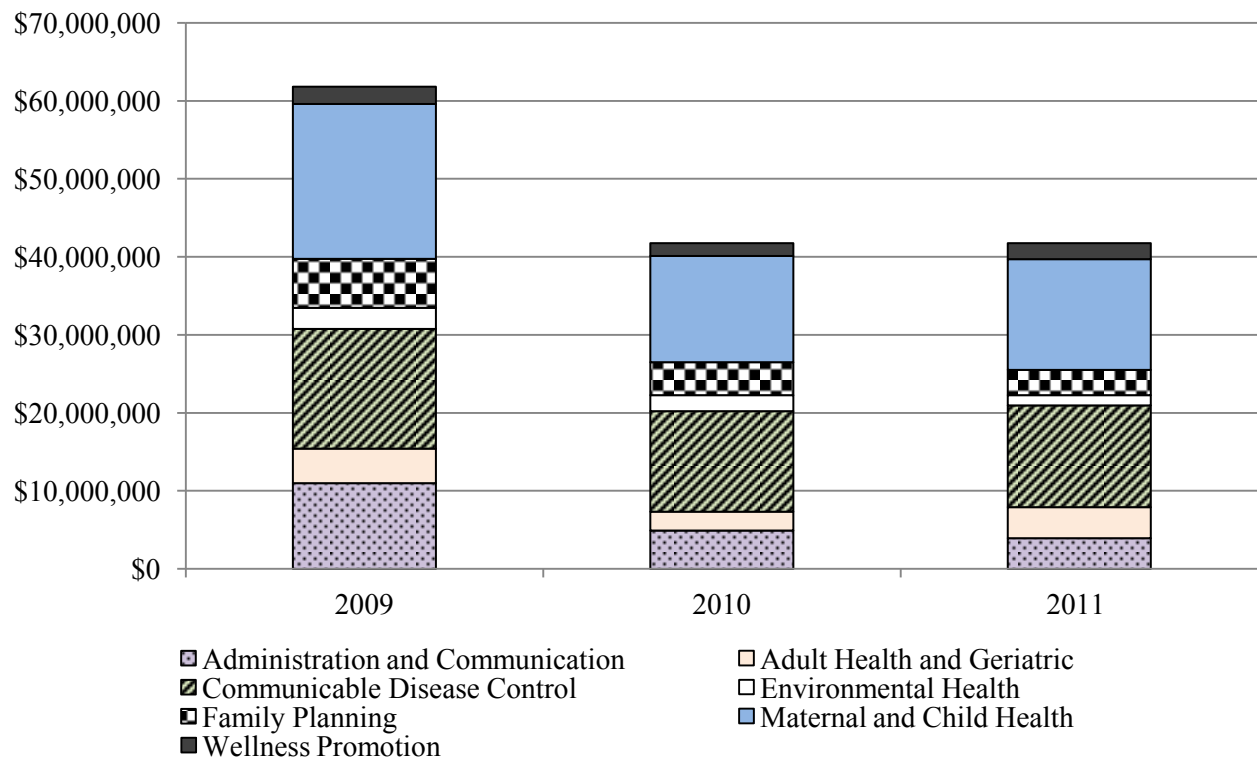
Note: Total State aid includes not only general funds but also \$4,493,000 in federal pass-through funds administered through the Core Funding Program. Required local match is based on the general fund portion of the State Core Funding award.

Source: Department of Health and Mental Hygiene

As shown in Exhibit 2.2, total State and local Core funding in fiscal 2011 totaled \$195.5 million. This funding supports seven service areas: administration and communications, adult and geriatric health, communicable disease control, environmental health, family planning, maternal and child health, and wellness promotion. It is important to note that in several jurisdictions, additional local funds are directed outside these seven service areas. Subsequently, this spending is not captured in Exhibit 2.2. For instance, funding from the Board of Education or a local management board may also support LHD operations.

Data shows that reductions to Core funding have resulted in reductions to all seven service areas, with the most significant reductions occurring in administration and communication, environmental health, and maternal and child health services. It should be noted that, to varying extents, some counties increased their contributions to offset State Core funding reductions. Programmatic and budgetary changes as a result of reductions in State Core funding are depicted in **Exhibit 2.3**.

Exhibit 2.3
Core Local Health Services – State Spending by Service Area
Fiscal 2009-2011



Source: Department of Health and Mental Hygiene

Local Health Department Expenditures

As a part of the LHD survey, the Department of Legislative Services (DLS) asked respondents to report total LHD expenditures for both fiscal 2011 and 2012. However, some LHDs were unable to provide fiscal 2012 actual expenditures as the survey coincided with the end of the fiscal year. Therefore, this report will only discuss fiscal 2011 expenditures. For the purposes of the survey, total expenditures include county, State, and federal sources, as well as funding from private organizations and LHD collections from Medicaid, Medicare, regulatory fees, and other sources (such as self-pay and third-party pay). Furthermore, LHD expenditure and revenue totals for each county do not perfectly align. This is a reflection of revenues from collections.

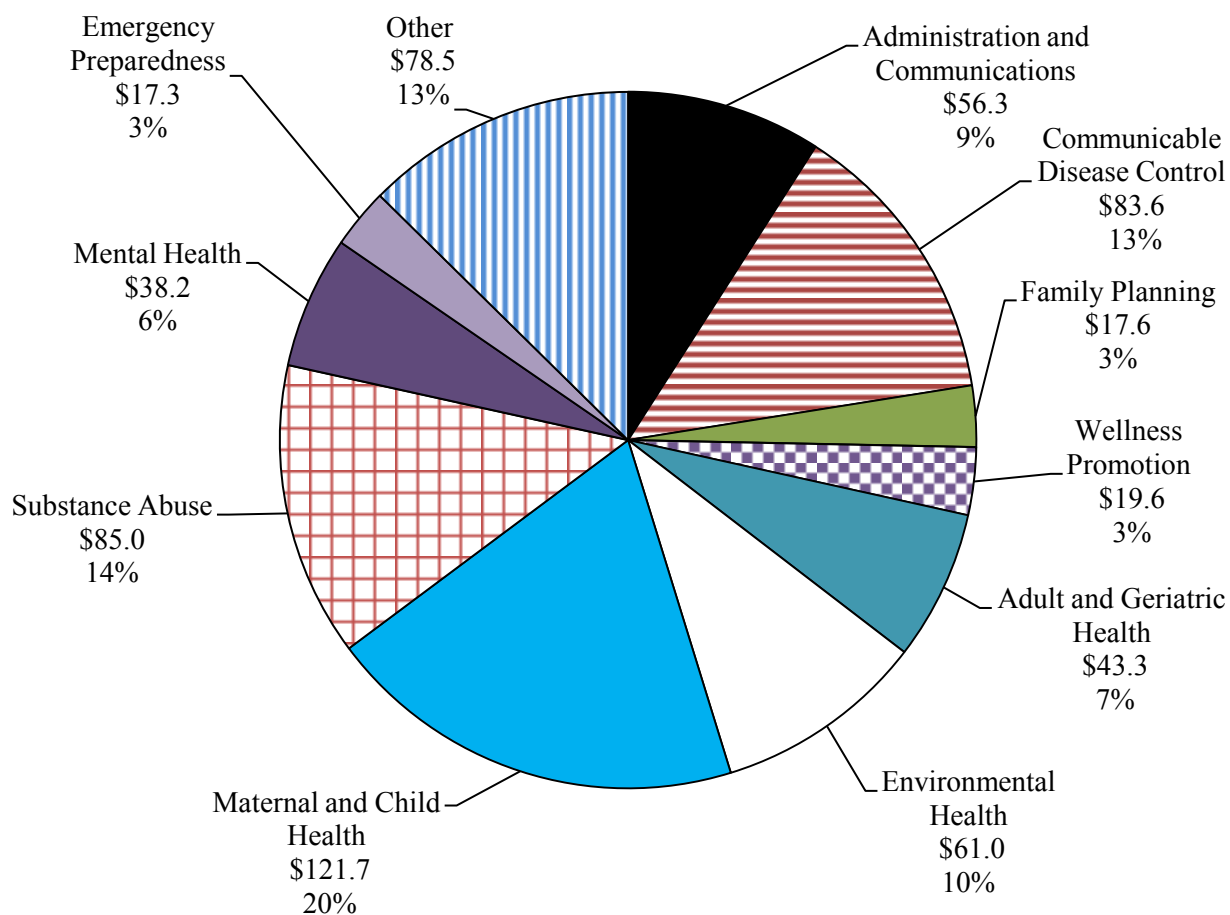
LHDs were also asked to report total spending in the following areas: (1) administration and communications; (2) communicable disease control; (3) family planning; (4) wellness promotion; (5) adult and geriatric health; (6) environmental health; (7) maternal and child health; (8) substance abuse; (9) mental health; (10) emergency preparedness; and (11) other expenditures.²

As shown in **Exhibit 2.4**, for fiscal 2011, a total of \$622.1 million was spent by LHDs in the State. Of this amount, 20% of total LHD spending was related to maternal and child health programs. In turn, approximately 45% of maternal and child health expenditures are attributable to school health programs. (For the purposes of this survey, spending on school health programs is captured in the maternal and child health category.) “Other” expenditures constituted 13% of LHD spending due to the variation of programs across jurisdictions. “Other” expenditures include, but are not limited to, transportation, dental, and healthy stores programs, as well as developmental disabilities resource coordination services. Expenditures for communicable disease control and substance abuse each constituted 13% of LHD expenditures.

Administration and communication expenditures and environmental health expenditures represented 9 and 10% of LHD spending, respectively. Finally, emergency preparedness, family planning, and wellness promotion expenditures each represented 3% of LHD spending.

² The initial survey sent to LHDs did not request information regarding emergency preparedness expenditures. After receiving initial survey responses, DLS sent follow-up requests for emergency preparedness expenditures for fiscal 2011 and 2012.

Exhibit 2.4
Local Health Department Expenditures
Fiscal 2011
(\$ in Millions)



Note: The percent of local public health expenditures presented in this figure is computed by using the total amount of funds for all local health departments (LHD) for each of the expenditure categories as numerators with the total of all LHD expenditures from all sources as the denominator.

Source: Local Health Department Survey

Composition of Local Health Department Expenditures Varies Widely By Jurisdiction

While Exhibit 2.4 indicates, for fiscal 2011, a total of \$522.1 million was spent by LHDs in the State, **Appendix 3** analyzes total spending further by providing a profile of fiscal 2011 expenditures for each jurisdiction. Similar to Exhibit 2.4, expenditure profiles included an Appendix 3 outline spending in the 11 areas LHDs were surveyed on. **Exhibit 2.5** depicts the range of spending that is further detailed in Appendix 3. Ultimately, spending by program area fluctuates significantly among jurisdictions, reflecting differences in community health needs and priorities. For example, spending on communicable disease control ranges among jurisdictions from a minimum of \$0.2 million in Allegany County to a maximum of \$35.6 million in Baltimore City. On a percentage basis, such spending comprises 1% of Allegany County's budget, while communicable disease expenditures make up 28% of Baltimore City's total spending – the highest proportion of any jurisdiction. Similarly, spending on substance abuse ranges from \$0.0 in St. Mary's County,³ to \$14.6 million in Prince George's County. However, when assessed on a percentage basis, expenditures on substance abuse are highest in Kent County, where spending on substance abuse represents 41% of the county's total budget. As might be expected, for each expenditure category included in the LHD survey, the jurisdiction with the highest expenditure level has a population above 500,000 individuals. (These jurisdictions include Anne Arundel County, Baltimore City, Baltimore County, Prince George's County, and Montgomery County.)

Exhibit 2.5 Expenditure Range for Local Health Departments Fiscal 2011

<u>Expenditure Category</u>	<u>Expenditure Range (\$ in Millions)</u>	<u>Expenditure Range Based on Percentage of LHD's Budget</u>
Administration and Communications	\$0.5 (Harford County) to \$12.2 (Montgomery County)	4% (Multiple jurisdictions) to 20% (St. Mary's County)
Communicable Disease Control	\$0.2 (Allegany County) to \$35.6 (Baltimore City)	1% (Allegany County) to 28% (Baltimore City)
Family Planning	\$0.2 (Caroline County) to \$3.0 (Baltimore County)	1% (Multiple jurisdictions) to 7% (Harford County)
Wellness Promotion	\$0.0 (Multiple jurisdictions) to \$3.1 (Anne Arundel County)	0% (Multiple jurisdictions) to 18% (Dorchester County)
Adult and Geriatric Health	\$0.1 (Charles County) to \$12.6 (Baltimore City)	Less than 1% (Montgomery County) to 18% (Baltimore County)
Environmental Health	\$0.4 (Somerset County) to \$15.4 (Baltimore City)	3% (Montgomery County) to 22% (St. Mary's County)

³ St. Mary's County does not offer substance abuse services at its LHD.

<u>Expenditure Category</u>	<u>Expenditure Range (\$ in Millions)</u>	<u>Expenditure Range Based on Percentage of LHD's Budget</u>
Maternal and Child Health	\$0.0 (St. Mary's County) to \$30.5 (Baltimore City)	0% (St. Mary's County) to 37% (Anne Arundel County)
Substance Abuse	\$0.0 (St. Mary's County) to \$14.6 (Prince George's County)	0% (St. Mary's County) to 41% (Kent County)
Mental Health	\$0.0 (Multiple jurisdictions) to \$7.9 (Montgomery County)	0% (Multiple jurisdictions) to 23% (Caroline County)
Emergency Preparedness	\$0.2 (Kent County) to \$8.0 (Baltimore City)	1% (Multiple jurisdictions) to 10% (Talbot County)
Other	\$0.0 (Multiple jurisdictions) to \$25.3 (Montgomery County)	0% (Multiple jurisdictions) to 32% (St. Mary's County)

LHD: local health department

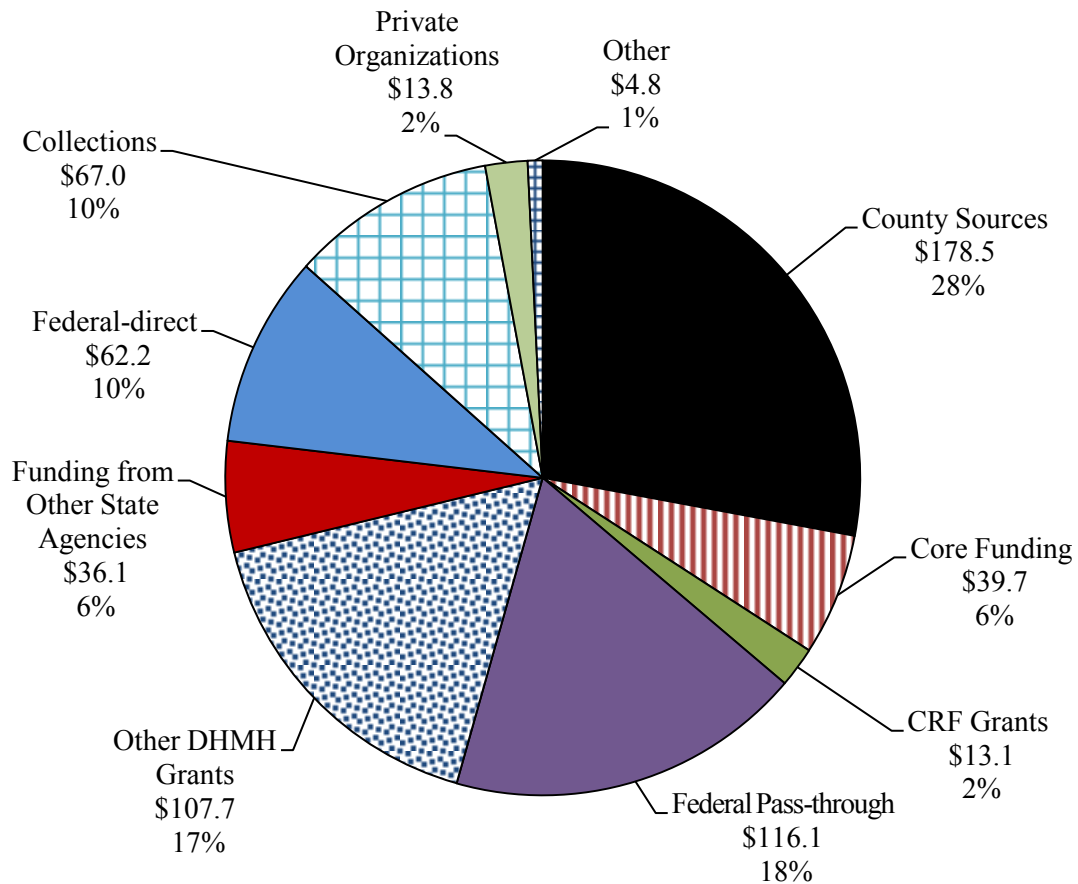
Source: Local Health Department Survey

Local Health Department Revenues

DLS also asked LHDs to report their total revenues for fiscal 2011 and 2012. Specifically, LHDs were requested to report their revenues in the following categories: (1) county sources; (2) Core Funding; (3) Cigarette Restitution Fund grants; (4) other grants from the Department of Health and Mental Hygiene (DHMH); (5) funding from State agencies other than DHMH; (6) federal pass-through sources; (7) federal-direct sources; (8) Medicaid; (9) Medicare; (10) other collections; (11) regulatory fees; (12) private organizations; and (13) other revenues. It is important to note that some health departments were unable to distinguish between general funds and federal funds that are administered through the Core Funding Program; therefore, a portion of federal funds are reflected in the Core Funding total.

As shown in **Exhibit 2.6**, LHD revenues for fiscal 2011 totaled \$639.0 million. Approximately 49% of LHD revenues are derived from DHMH or other State agencies. Federal pass-through funds and other grants from DHMH represent 18% and 17%, respectively, of LHD revenues. Among other things, federal pass-through funds include emergency preparedness funding, monies related to Women, Infants, and Children, and Title X funding. Other grants from DHMH include resource coordination funds through the Developmental Disabilities Administration, block grants administered by the Alcohol and Drug Abuse Administration, funding for core service agencies through the Mental Hygiene Administration, and grants administered by the Maryland Community Health Resources Commission. Furthermore, funding from other State agencies constitutes 8% of LHD revenues. Other State agencies that provide

Exhibit 2.6
Local Health Department Revenues
Fiscal 2011



CRF: Cigarette Restitution Fund

DHMH: Department of Health and Mental Hygiene

Note: The percent of local public health revenues presented in this figure is computed by using the total amount of funds for all local health departments (LHDs) for each of the sources as numerators with the total of all LHD revenues from all sources as the denominator.

Source: Local Health Department Survey

funding to LHDs include, but are not limited to, the Maryland Department of the Environment, the Maryland State Department of Education, the Department of Juvenile Services, the Governor's Office of Crime Control and Prevention, and the State Highway Administration.

The remaining State revenues that support LHDs are derived from Core funding (6%) and Cigarette Restitution funds (2%). While Core funding only represents a small portion of local health revenues, it is important to note that State Core funding to local jurisdictions had decreased by 43% since fiscal 2009. Similarly, CRF has also been significantly reduced. Therefore, it is unsurprising that county funds constitute a large proportion of overall revenues for LHDs – comprising 28% of total funds. County funds include matching funds required under the Core Funding formula as well as funding from other county entities, such as local boards of education. In comparison, federal-direct and other revenues represent 10% and 1% of LHD revenues, respectively. A large portion of federal-direct funds are derived from Ryan White Part A grants that are awarded to Eligible Metropolitan Areas (EMA). In order to qualify for EMA designation, an area must have reported at least 2,000 AIDS cases in the most recent five years and have a population of at least 50,000. Funding is used to provide a continuum of care, including medical and support services, for people living with HIV. In Maryland, the Baltimore City Health Department serves as the grantee and overall administrator for the Ryan White Part A funds; however, the EMA consists of Baltimore City, Anne Arundel, Baltimore, Carroll, Harford, Howard and Queen Anne’s counties.

Finally, funding from private organizations represents only 2% of LHD revenues. DLS’ survey indicated that only 13 jurisdictions received private grant funding in fiscal 2011. LHDs that did not seek private funding generally indicated that reductions in staffing levels (combined, in many cases, with a lack of grant writing expertise) made it difficult to apply for private grants. LHDs that did receive private funding reported that they received grants from private organizations including (but not limited to) Susan G. Komen, Healthcare for the Homeless, ABC Charities, and the National Association of County and City Health Officials.

Composition of Local Health Department Revenues Varies Widely By Jurisdiction

While Exhibit 2.6 indicates, for fiscal 2011, revenues for LHDs totaled \$639.0 million, Appendix 3 analyzes total revenues further by providing a profile of fiscal 2011 revenue for each jurisdiction. Similar to Exhibit 2.6, revenue profiles included in Appendix 3 outline revenues based on the 13 areas LHDs were surveyed on. **Exhibit 2.7** depicts the range of revenue sources that is further detailed in Appendix 3. For each revenue category included in the LHD survey, the county with the highest level of funding has a population above 500,000 individuals. While Core funding represents only 6% of total LHD revenues in the State, this revenue source ranges from 2% of Worcester County’s budget to 12% of Harford County’s budget. More notably, the reliance on local funding differs considerably by jurisdiction. For example, county funding ranges from a minimum contribution of \$0.5 million in Caroline County to \$46.5 million in Montgomery County. Similarly, county revenues represent 6% of Caroline County’s budget, while this funding source represents 54% of Montgomery County’s budget – the highest percentage for all LHDs. Furthermore, collection levels range from a minimum of \$0.6 million (Talbot County) to a high of \$7.1 million (Prince George’s County). However, when assessed on

Exhibit 2.7
Revenue Range for Local Health Departments
Fiscal 2011

<u>Revenue Category</u>	<u>Revenue Range (\$ in Millions)</u>	<u>Revenue Range Based on Percentage of LHD's Budget</u>
County Sources	\$0.5 (Caroline County) to \$46.5 (Montgomery County)	6% (Caroline County) to 54% (Montgomery County)
Core Funding	\$0.4 (Kent County) to \$6.7 (Baltimore City)	2% (Worcester County) to 12% (Harford County)
CRF Grants	\$0.1 (Talbot County) to \$3.7 (Prince George's County)	Less than 1% (Montgomery County) to 5% (Prince George's County)
Federal Pass-through	\$0.0 (Multiple jurisdictions) to \$22.9 (Baltimore City)	0% (Multiple jurisdictions) to 46% (Washington County)
Other DHMH Grants	\$0.0 (Multiple jurisdictions) to \$14.1 (Baltimore City)	0% (Multiple jurisdictions) to 67% (Kent County)
Funding from Other State Agencies	\$0.0 (Multiple jurisdictions) to \$16.3 (Baltimore City)	0% (Multiple jurisdictions) to 21% (Dorchester County)
Federal Direct	\$0.0 (Multiple jurisdictions) to \$16.3 (Baltimore City)	0% (Multiple jurisdictions) to 27% (Baltimore City)
Collections	\$0.6 (Talbot County) to \$7.1 (Prince George's County)	2% (Baltimore City) to 39% (Caroline County)
Private Organizations	\$0.0 (Multiple jurisdictions) to \$11.1 (Baltimore City)	0% (Multiple jurisdictions) to 9% (Baltimore City)
Other	\$0.0 (Multiple jurisdictions) to \$1.2 (Allegany County)	0% (Multiple jurisdictions) to 9% (St. Mary's County)

CRF: Cigarette Restitution Fund

DHMH: Department of Health and Mental Hygiene

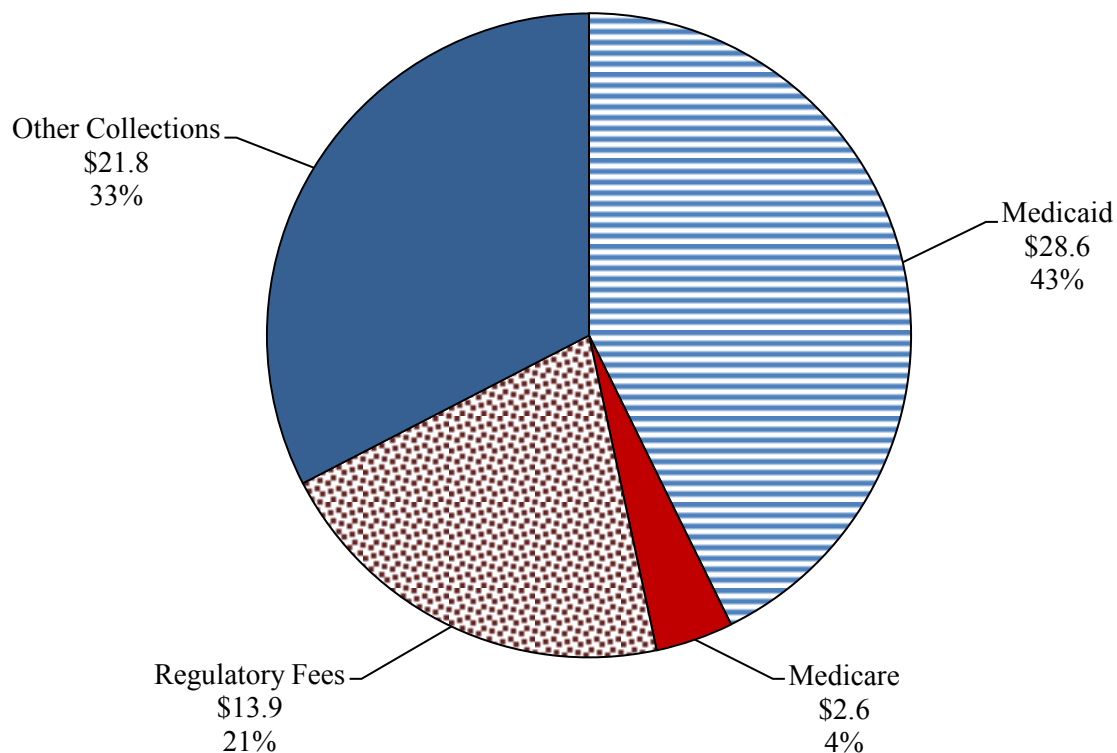
Source: Local Health Department Survey

a percentage basis, revenues from collections are lowest in Baltimore City (2%) and highest in Caroline County (39%). It is important to note that revenues derived from collections will begin to play a more important role in LHD financing with the full implementation of health care reform in 2014. This issue is discussed in greater detail in **Chapter 3** of this report.

Local Health Department Collections

As shown in Exhibit 2.6, 10% of LHD funding was derived from collections in fiscal 2011. Collections include those from Medicaid; Medicare; regulatory fees; and other sources, including self-pay and third-party reimbursement. However, **Exhibit 2.8** more closely looks at LHD collections and reveals that 43% of collections are derived from Medicaid, while 33% of funds are derived from other collections, including self-pay and third-party reimbursement. In comparison, regulatory fees (including environmental health fees and vital records fees) constitute 21% of LHD collections. Finally, Medicare collections represent only 4% of LHD collections. (LHDs generally do not provide services that are reimbursable through Medicare.)

Exhibit 2.8
Local Health Department Collections
Fiscal 2011
(\$ in Millions)



Source: Local Health Department Survey

Title 16 of the Health-General Article sets forth the State's policy on responsibility for cost of care to individuals who receive treatment or other services provided by DHMH. The Secretary must adopt rules and regulations to set charges for services provided in State-operated clinics, day care, group homes, hospitals, or any other such facility. In addition, the title requires the Secretary to require political subdivisions and other grantees to set (subject to the Secretary's approval) fees for services that are wholly or partly supported by State or federal funds administered by the department.

In accordance with the law, DHMH has established various clinic service fees to allow LHDs to recoup the costs of providing certain services. These fees are charged on a sliding scale, based on the income and number of dependents of the patient examined, tested, or treated. The fees are fairly consistent for each county unless a special service is provided. However, LHDs generally indicated in their survey responses that individuals are typically not denied key services due to inability to pay, that only a small fraction of individuals are actually charged on a sliding fee scale, and that the established fees are generally not sufficient to recover the costs of services provided. Other challenges that LHDs are facing with regard to collections are discussed in **Chapter 4**.

Impact of Cost Containment

The 2010 *Joint Chairmen's Report* requested DHMH, in conjunction with LHDs, to submit a report on the budgets of the 24 LHDs. Specifically, the department was required to outline how State funds were used programmatically by LHDs in fiscal 2010 and 2011 and to describe programmatic and budgetary changes made in response to State cost containment measures in those years. Specific examples of programmatic changes as a result of Core funding reductions include:

- **Administration and Communication Services** – Cuts in this area have resulted in delayed billing, reduced oversight of leases and purchasing, reductions in website and maintenance support, and reduced emergency response capacity.
- **Adult Health and Geriatric Services** – Queen Anne's County is one of three counties in Maryland that oversee an Adult Day Care Center. Cuts to Core funding have reduced support to the center. In Prince George's County, the LHD eliminated diabetes educational sessions and screening services.
- **Communicable Disease Services** – Funding allocated in this area supports the prevention and control of communicable disease such as flu and rabies. It also supports foodborne outbreak investigation, child and adult immunization, tuberculosis and sexually transmitted infections (STI) treatment. Reductions in funding have resulted in the elimination of school-based vaccinations in Frederick and Montgomery counties. In addition, Prince George's County reduced the number of clients seen in its STI clinic due to position reductions. Howard County also eliminated its HIV/AIDS case management services and closed its HIV clinic.

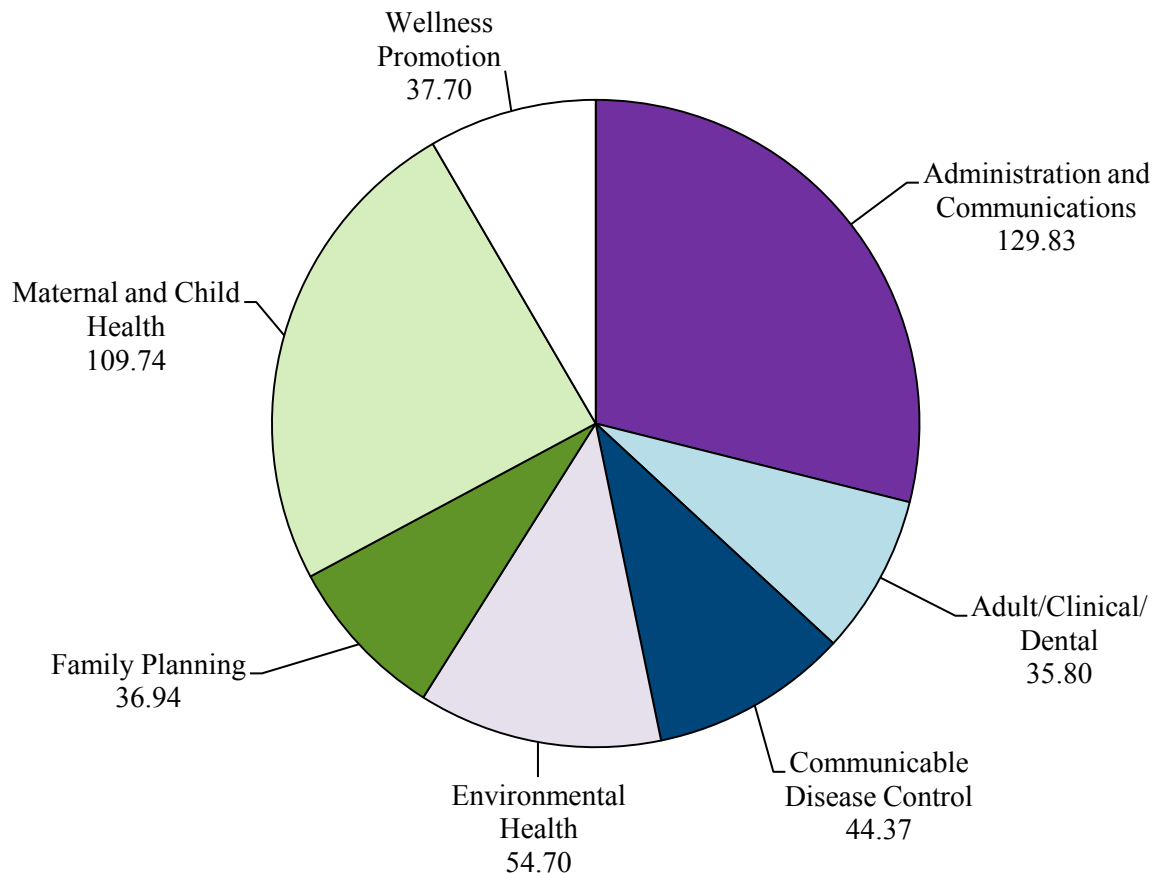
- **Environmental Health** – Budget reductions have caused many counties to delay filling of vacant sanitarian positions, resulting in longer response times for food service facility inspections. Cecil County no longer conducts water sampling, while Howard County has reduced positions related to pool inspections and food safety.
- **Family Planning** – Reductions in funding have resulted in decreased walk-in family planning services. Cecil County has eliminated pregnancy testing as a stand-alone service, while Wicomico County has reduced its family planning services by 40%.
- **Maternal and Child Health Services** – Multiple counties reported having reduced home visiting services for pregnant women and for mothers and children. Some counties have reduced services by up to 40%.
- **Wellness Promotion Services** – Funding allocated in this service area supports tobacco prevention and cessation, cardiovascular disease prevention, injury prevention, and breast and cervical cancer screening. LHDs generally reported that funding for health education has been either significantly reduced or eliminated completely.

To supplement the findings of the *Joint Chairmen's Report*, DLS surveyed LHDs regarding the impact of State budget cuts. All 24 respondents in the LHD survey indicated that State budget cuts have resulted in reductions to programs. Furthermore, 20 LHDs reported that they have had to eliminate programs entirely, and 16 LHDs indicated that they have had to increase their regulatory fees. Only 6 LHDs reported that other funding sources, such as local funding, have increased to offset State funding reductions. DLS also asked LHDs if there were specific areas of priority to which they would direct monies if State funding was to increase; while respondents indicated that they would direct additional funds to all 7 Core funding areas, over 60% of LHDs indicated that additional funds are needed specifically to address chronic disease prevention and treatment.

Staffing Reductions

All 24 respondents to the LHD survey indicated that positions were eliminated as a result of funding reductions. When State Core Funding dollars were reduced, the required match from local jurisdictions was also reduced. One-time federal funds that were available to address the H1N1 epidemic in fiscal 2009 and 2010 temporarily delayed staffing reductions at LHDs; however, once H1N1 funding ran out, layoffs were inevitable for most local jurisdictions. From fiscal 2009 to 2011, at least 449 regular and contractual positions have been eliminated statewide. (In fiscal 2012, there were 5,175 full-time equivalent positions at LHDs statewide.) Reductions to staffing by services area are summarized in **Exhibit 2.9**.

Exhibit 2.9
Local Health Departments Positions (FTEs) Reduced
Due to State Core Funding Reductions
Fiscal 2009-2011



FTE: Full-time equivalent

Source: Department of Health and Mental Hygiene

Other Impacts of Cost Containment

Health services providers have been encouraged to utilize electronic health records as a means of improving the quality, safety, and efficiency of health care delivery – and survey responses revealed that LHDs have, in large part, embraced the move toward electronic health records. Specifically, 18 LHDs indicated that they either utilize electronic health records or are in the process of implementing systems to enable them to do so. Conversely, only 6 LHDs indicated that they do not utilize any electronic health records; each of these LHDs further identified lack of funding to be the primary reason for the nonuse of electronic health records.

LHDs that currently use electronic health records but are interested in improving or expanding their use of such records also cited lack of funding as the primary barrier.

Similarly, LHDs noted lack of funding as a primary barrier to the pursuit of accreditation. LHD accreditation is discussed in **Chapter 4**.

Other Approaches to Local Health Services Funding

All of Maryland's neighboring jurisdictions except for Delaware have established funding schemes to pay for the provision of local health services. Delaware has no clear statutory funding mechanism for the payment of, or reimbursement for, the provision of such services by its counties. In Virginia, payment for the provision of local health services is shared between the state and the counties. Their respective contributions are determined by a funding formula based on a jurisdiction's ability to pay. Similar to the Core Funding Program, local government matching contributions range from a low of 20% to a maximum of 45%. In comparison, local health services funding in West Virginia varies significantly from Maryland and Virginia's funding formulas.

Local Health Services Funding in West Virginia

Due to growing concern that state funds were not distributed on an equitable basis, in calendar 2010, West Virginia adopted a formula to distribute funding to LHDs. The formula accounts for the following factors: (1) a poverty factor, which is the percentage of individuals in the county living below the federal poverty level; (2) a health status factor, which is the years of potential life lost in the county; (3) a population density factor, which is the density of individuals living in the county less than the state average; (4) an intervention factor, which is the number of interventions per thousand population above the state average in the county; and (5) a consolidation factor, which is included to encourage counties to merge in the provision of local public health services. These factors are used to create a weighted population calculation, and a base amount is then calculated to determine a base funding level for the 55 counties. A per capita distribution is subsequently determined by subtracting the total base amount from the funds available for distribution and then dividing the weighted population of each county into the amount remaining to determine the per capita distribution for each LHD. The formula also has a hold harmless provision.

In addition to State funding, an LHD may receive funding from the general fund of either a county or municipality; however, there is no obligation for local entities to provide any specific funding level to LHDs. As in Maryland, LHDs receive a variety of specific grants, such as federal-pass through funds, or other categorical grants.

Local Health Services Funding in Maryland Under Health Care Reform

Upon full implementation of the federal Patient Protection and Affordable Care Act (PPACA) in January 2014, the role of LHDs in Maryland will likely change. Services related to communicable disease surveillance, as well as environmental health programs, such as those related to food safety, will largely go unaffected; however, the volume of direct care services provided by LHDs will decrease to the extent that a greater percentage of individuals begin to obtain private insurance. Accordingly, LHDs must determine whether it is advisable for them to continue to provide direct care services within their jurisdictions. (Some LHDs in Maryland have already moved away from providing direct care, either by choice or due to State and local budget cuts.) Furthermore, LHDs that continue to provide direct care under PPACA will need to address barriers to third-party contracting, as discussed in **Chapter 3**. It is critical that LHDs examine the services that they provide and adjust to the evolving health care system. Similarly, it is important to examine how local public health services are financed in the State.

As noted above, LHDs in Maryland are currently being funded below the 1997 level that was established by the Core Funding Program. While State Core funding only represents 6% of LHD revenues, local jurisdictions will most likely begin to rely on these funds more as funding for State-only safety net programs will continue to decline under PPACA. Furthermore, LHDs will soon come under additional pressure to increase employee compensation as COLAs (which are not included in State Core funds) are reinstated for State employees. While it is imperative that LHDs have sustainable funding, it is also important that funding be distributed equitably to ensure that disparities in basic public health services do not exist. **Therefore, DLS will conduct additional research in the 2013 legislative interim to determine whether the current distribution of funds under the Core Funding Program is effective to finance local public health services. Other states' funding formulas, as well as deficiencies (if any) in the State's current funding system, will also be examined.**

Chapter 3: Impact of Health Care Reform on the Provision of Local Public Health Services

On March 23, 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act (PPACA), as amended by the Health Care and Education Recovery Act of 2010. Among many other provisions of PPACA is a requirement for individuals to obtain health insurance. (This has become known as the “individual mandate.”) This requirement takes effect January 1, 2014.

The Maryland Health Care Reform Coordinating Council (HCRCC), established by executive order in March 2010, has advised that Maryland’s public health infrastructure – including local health departments (LHD) as well as population-based programs – serves unique functions that will not be supplanted by the health insurance coverage aspects of federal health care reform. However, of the 16 recommendations HCRCC issued in 2012 regarding how Maryland should approach health care reform and implementation, 3 are specifically applicable to LHDs. The recommendations are to:

- develop State and local strategic plans to improve health outcomes;
- encourage active participation of safety net providers in health reform and new insurance options; and
- achieve reduction of health disparities through exploration of financial performance-based incentives and incorporation of other strategies.

The status of implementation of these recommendations is, along with barriers to implementation, discussed below.

Developing State and Local Health Improvement Processes

HCRCC’s first recommendation related to LHDs is that Maryland undertake interconnected State and local planning efforts in order to address opportunities to improve coordination of care for individuals who remain uninsured even after the implementation of federal health care reform. Specifically, HCRCC has advised that the Department of Health and Mental Hygiene (DHMH) develop a State Health Improvement Process (SHIP) that includes a health needs assessment that identifies priorities and sets goals for health status, access, provider capacity, consumer concerns, and health equity within the State. Through SHIP, the department has designated public and private sector partners to work with LHDs and the State to monitor a number of performance metrics. HCRCC has further recommended that local implementation processes be developed and involve LHD-led collaborations in order to identify systemic issues that must be addressed to achieve SHIP goals. Finally, HCRCC has recommended that the Maryland Community Health Resources Commission (MCHRC) provide technical assistance in

the development of these processes, as well as with piloting models and in sharing lessons learned.

State Health Improvement Process

In September 2011, DHMH launched SHIP to improve accountability and reduce health disparities in Maryland by 2014 through implementing local action and engaging the public. As shown in **Appendix 4**, SHIP includes 39 measures of health in six vision areas: healthy babies, healthy social environments, safe physical environments, infectious disease, chronic disease, and healthcare access. Of the 39 SHIP measures, 24 objectives have been identified as critical racial/ethnic health disparities measures; in addition, health disparities exist for all measures related to healthy babies, infectious diseases, and chronic diseases. Each measure has a data source and a target and, where possible, can be assessed at the city or county level. SHIP also provides counties with tools to set local priorities and mobilize communities to improve residents' health; one example is the Maryland Tobacco "Quitline."

Local Health Improvement Process

SHIP supports local health improvement coalitions in counties and regions around the State to identify priorities, make plans, and take action by creating a local health improvement process. Maryland has 18 active local or regional health coalitions, with memberships ranging from 10 to 60 individuals.⁴ To date, each coalition has met, assessed the health of its community, and developed health priorities. Each jurisdiction or region was required to develop an action plan for 2012 that includes three to five community health priorities that align with SHIP goals. These action plans (which may also include locally identified issues) were expected to serve as each coalition's short-term work schedule for 2012, as local coalitions began to develop their local health improvement processes.

Funding for local coalitions as well as the development of local health improvement processes have both been expanded with assistance from the Maryland Hospital Association and through MCHRC. The association agreed to provide start-up funds to support the operations of local coalitions in counties and regions where hospitals were not already supporting existing coalitions; these funds will be used to provide the needed infrastructure to ensure that the coalitions are organized, appointed, convened, and staffed for fiscal 2012. To date, the Maryland Hospital Association has facilitated hospital support for nine local planning coalitions in counties and regions. In addition, the fiscal 2012 budget for MCHRC included \$0.5 million in grant funds to assist with local health coalition development in accordance with HCRCC's recommendation. However, the fiscal 2013 budget did not include additional funding for local health improvement processes or local coalitions.

⁴ The Lower Shore (Somerset, Wicomico, and Worcester counties) and the Upper Shore (Caroline, Dorchester, Kent, Queen Anne's, and Talbot counties) are the only two local coalitions that include more than one county.

The Department of Legislative Services asked survey respondents to identify any areas that their local health improvement coalition had identified as community priorities under SHIP. As shown in **Exhibit 3.1**, 100% of local health improvement coalitions identified one or more measures within the fifth vision area – chronic disease – as a community health priority. Among other measures, this vision area includes measures related to heart disease, hypertension-related emergency department visits, and the proportion of adults who are at a healthy weight. Although additional State funds have not been appropriated to target chronic disease disparities, newly awarded federal funds do target such disparities.

Exhibit 3.1
Local Health Improvement Coalition
Community Priorities

<u>SHIP Vision Area</u>	<u>Percentage of Local Health Improvement Coalitions That Have Identified One or More Measures Within a Vision Area</u>
Healthy Babies	39%
Healthy Social Environments	33%
Safe Physical Environments	5%
Infectious Disease	28%
Chronic Disease	100%
Health Care Access	56%

SHIP: State Health Improvement Process

Source: Department of Legislative Services

Community Transformation Grant Program

Federal health care reform established the Prevention and Public Health Fund to prevent illnesses and injuries before they occur, thereby resulting in significantly lower health care costs. For example, the fund authorizes funding for the Community Transformation Grant Program, which provides competitive grants to reduce chronic disease rates, address health disparities, and develop a stronger evidence base of effective prevention programming at the local level. In September 2011, DHMH was awarded \$9.5 million in federal funding (\$1.9 million a year for five years) through the Community Transformation Grant Program. Overall, the U.S. Department of Health and Human Services awarded approximately \$103.0 million in prevention grants to 61 states and communities. In Maryland, this funding will be used to

support efforts among 19 of Maryland's smaller jurisdictions.⁵ In addition, the grant will be used to build new resources to improve wellness statewide. For instance, a portion of grant funding is being used to establish the Institute for a Healthiest Maryland, which will direct its efforts to obesity prevention, tobacco cessation, and the reduction of hypertension and high cholesterol. The institute will also link LHDs and community leaders to proven interventions in health and wellness, as well as coordinate the "Healthiest Maryland Advocacy Network," an initiative that is intended to support local coalitions under SHIP.

Federal guidelines require that at least 50% of the annual grant funding support local activities and that at least 20% of the funding be directed to rural/frontier areas. (Maryland has seven rural counties – Caroline, Dorchester, Garrett, Kent, St. Mary's, Talbot, and Worcester – per the Office of Management and Budget's definition.) DHMH has complied with these requirements through awards to LHDs and minority outreach and technical assistance organizations.

Barriers to Third-party Contracting Persist Between Local Health Departments and Private Insurers

HCRCC's second recommendation pertaining to LHDs involved the removal of certain statutory and administrative barriers to contracting between LHDs and private entities. This recommendation was addressed legislatively through the passage of Chapters 235 and 236 of 2011, which authorized a county health officer (subject to the written approval of the Secretary of Health and Mental Hygiene and the consent of the county's governing body) to enter into a contract or written agreement to participate in the financing, coordination, or delivery of health care services with a person that is authorized to provide, finance, coordinate, facilitate, or otherwise deliver health care services in the State. Nonetheless, survey respondents generally reported continued difficulties in contracting with third-party insurers.

As discussed in **Chapter 2**, budget constraints have resulted in cutbacks to services provided by LHDs; yet, prior to the passage of Chapters 235 and 236, LHDs did not have clear authority to recoup service costs through agreements with private insurers. Rather, LHDs relied on income-based sliding scales – subsidized through block grants – to bill individuals who are either uninsured or privately insured. According to the Maryland Association of Counties, this practice impeded the delivery of health services – to rural parts of the State, in particular. For example, Garrett County had advised that they offer certain services – such as home health care and mental health and substance abuse outpatient services – to many privately insured individuals in the county because it is the county's sole provider of those services. Garrett County had further advised that its ability to continue to provide these and other services (such as family planning services) increasingly depends on its ability to bill in full for its services.

⁵ Under the terms of the federal grant requirements, Baltimore City and Anne Arundel, Baltimore, Montgomery, and Prince George's counties were excluded.

Although Chapters 235 and 236 took effect on October 1, 2011, the Maryland Association of County Health Officers has advised that LHDs remain unable to contract with private insurers as they lack expertise in negotiating contracts with private entities. LHDs' responses to DLS' survey reflect these and other difficulties. For example, many LHDs reported that they have been unable to meet insurers' credentialing requirements. Furthermore, LHDs have had difficulty contracting with insurers due to certain problematic contractual requirements that are at odds with State law, including requirements that the LHD to waive or limit defenses; agree to certain confidentiality provisions; interpret a contract according to the laws of a foreign jurisdiction; agree to resolve disputes in a tribunal other than a Maryland court (*i.e.*, in arbitration proceedings or in another state); and purchase private professional liability insurance (even though the State is self-insured and, thus, has no reason to purchase such insurance). In addition, survey respondents cited a requirement for the provider to unconditionally indemnify the payor (even though statute prohibits State officials from doing so) as the most problematic contractual provision required by insurers.

Insurers' Contractual Requirements at Odds with Statutory Limits on Liability for Employees of State and Local Government

As noted above, survey respondents generally advised that insurers have been unwilling to waive contractual requirements that the LHD unconditionally indemnify the payor. However, local government employees and State personnel alike are statutorily prohibited from doing so by the Local Government Tort Claims Act (LGTCa) and the Maryland Tort Claims Act (MTCA), respectively.

LGTCa limits the liability of a local government to \$200,000 per individual claim and \$500,000 for total claims that arise from the same occurrence for damages from tortious acts or omissions (including intentional and constitutional torts). It further establishes that the local government is liable for tortious acts or omissions of its employees acting within the scope of employment. Thus, LGTCa prevents local governments from asserting a common law claim of governmental immunity from liability for such acts of its employees. LGTCa defines local government to include counties, municipal corporations, Baltimore City, and other specified local agencies and authorities.

Under MTCA, State personnel are immune from liability for acts or omissions performed in the course of their official duties, so long as the acts or omissions are made without malice or gross negligence. Under MTCA, the State essentially waives its own common law immunity. However, MTCA limits State liability to \$200,000 to a single claimant for injuries arising from a single incident. MTCA covers a multitude of personnel, including some local officials and nonprofit organizations. In actions involving malice or gross negligence or actions outside of the scope of the public duties of the State employee, the State employee is not shielded by the State's color of authority or sovereign immunity and may be held personally liable.

For causes of action arising during calendar 2012 that are not covered by MTCA, State law limits noneconomic damages to \$710,000 for health care malpractice claims. This limit increases annually as specified in statute.

DHMH advises that insurers have been unresponsive to LHDs' requests to modify their form contracts in order to accommodate State contracting constraints. Similarly, survey respondents generally reported that negotiations with insurers as to contractual provisions have been unsuccessful. Thus, LHDs' attempts to contract with third-party insurers have stalled.

Efforts at State Level to Address Challenges Related to Contracting and Billing Are Ongoing

DHMH advises that the department, along with the Office of the Attorney General, is attempting to address the contracting hurdles faced by LHDs by negotiating statewide contracts with the various insurance plans. According to DHMH, the department is in the process of reaching out to major health insurers and third-party payors in an attempt to determine how best to negotiate statewide contracts (or other network relationships) with the insurers for the benefit of LHDs. DHMH further advises that it is currently still conducting outreach efforts but has been provided with at least one proposed contract from a health insurer. Almost all LHDs reported that they are aware of DHMH's efforts in this area.

A number of LHDs also reported that they are experiencing challenges with billing generally. In most cases, these challenges were attributed to a lack of staff time and/or billing expertise. DHMH advises that it is currently working to develop and implement a strategy to facilitate LHD billing. Although this project is focused primarily on billing for immunizations, the department anticipates that strategies developed for the project will be fully applicable to billing for other services provided by LHDs.

To the extent that LHDs continue to act as direct service providers after federal health care reform is fully implemented and fewer individuals are uninsured, LHDs' ability to contract with and bill third-party insurers is critical. **Therefore, the Department of Legislative Services recommends that committee narrative be adopted in the 2013 Joint Chairmen's Report requiring DHMH to report on its efforts to address the challenges that LHDs are currently facing with regard to billing generally and third-party contracting in particular. DHMH should also advise whether statutory changes are necessary and/or feasible.**

Reducing Health Disparities through Exploration of Financial Performance-based Incentives and Incorporation of Other Strategies

HCRCC's final recommendation related to LHDs was for the Maryland Health Quality and Cost Council Health Disparities Workgroup to develop recommendations to address disparities – including using local health improvement processes to identify and address disparities and to monitor the performance of efforts to mitigate them. Furthermore, HCRCC

recommended that the State improve data collection and analysis of disparities through SHIP, local health implementation processes, and the Maryland Health Care Commission's (MHCC) ongoing work to encourage common reporting of race and ethnicity among health plans.

On January 5, 2012, the workgroup provided its recommendations to HCRCC and proposed three interventions to address disparities: (1) create the "Maryland Health Innovation Prize;" (2) expand the scope of Maryland's current reimbursement incentives for quality and make them race and ethnicity-specific; and (3) create Health Enterprise Zones (HEZs).⁶ This report discusses only the third recommendation in detail, as it is the only intervention that directly relates to local jurisdictions and utilizes health disparity data available through SHIP and local health improvement processes.

Health Enterprise Zone Program Established

An HEZ is a geographic area in Maryland that has documented health disparities within its jurisdiction. A zone can be designated using various criteria, including high rates of chronic disease and poor access to primary care. In HEZs, community-based organizations apply for funds specifically to improve health in their designated zone.

Chapter 3 of 2012 created the statutory framework for a four-year, pilot HEZ Program. Aspects of the HEZ model include access to the Loan Assistance Repayment Program to support existing and new primary care clinicians in an HEZ; income, property, and/or hiring tax credits; assistance for health information technology; priority to enter the State's patient-centered medical home program; other grant funding from the Community Health Resources Commission (CHRC); capital and capital equipment grants; and other medical practice expenses. Ultimately, the goal of an HEZ is to work with existing providers, insurers, the public health system, nonmedical community agencies, and other stakeholders to create an integrated health care system with improved health care access. A more detailed discussion of HEZ eligibility criteria, review criteria, and eligible jurisdictions can be found in **Appendix 5**.

Implementation of HEZs in Maryland: Financing

As envisaged by DHMH and CHRC, it is anticipated that two to four HEZs will be designated under this initiative and that a total of \$4 million per year (for a four-year period) will be made available to the designated HEZs beginning in calendar 2013. However, specific details regarding the awards and the number of HEZs will not be known until applications are reviewed. (A total of 19 applications requesting HEZ designation were received by the November 2012

⁶ The Maryland Health Innovation Prize would be a financial reward to an individual, group, organization, or coalition to acknowledge innovative health interventions. The workgroup's second recommendation included proposing legislation directing the Health Services Cost Review Commission (HSCRC) and MHCC to include racial and ethnic data as part of their data collection, or requiring HSCRC and MHCC to study the feasibility of including racial/ethnic performance data tracking in quality incentive program and report to the General Assembly by the 2013 session.

deadline.) However, applicants were encouraged to think both large and small in terms of annual budgets (from \$500,000 to \$2 million annually). DHMH and MCHRC have developed a budget template for applicants to specifically detail how potential funding will be allocated.

Funding beyond calendar 2013 will be contingent on continued progress in meeting performance standards and evaluation measures (agreed to as a condition for receiving the award). Reporting on sustainability goals is also required during the four-year grant period. Beyond calendar 2016, HEZs are required to develop alternative funding sources.

Because the HEZ pilot will now be financed for calendar 2013 through 2016, it may be necessary to amend the implementing statute to clarify that the HEZ pilot will run for four calendar years, rather than for four fiscal years (as previously specified), as well as to clarify that tax benefits will be available for the full four-year period rather than through tax year 2015 (as currently provided).

Status of HEZ Designations

Of the 19 applications requesting HEZ designation, 7 were submitted on behalf of LHDs in Allegany, Baltimore, Cecil, Charles, Dorchester, Prince George's, and Somerset counties. In total, applications were submitted by entities (including LHDs) in 16 counties and Baltimore City.⁷

It is anticipated that the Secretary of Health and Mental Hygiene will announce the award of HEZ designation(s) at the end of calendar 2012. The report submitted by MCHRC has added substantial detail to the statutory framework within which the Secretary will make his determination. As noted earlier, the criteria to be used in choosing HEZs provides opportunity for broad participation as well as for cross-jurisdictional efforts to improve health outcomes at the local level. (Some applications were submitted on behalf of multiple counties, as zip codes cover more than one county in some instances.) The proposed implementation plan does rely on ongoing annual funding of \$4 million, which at this point is assumed to come from the MCHRC's special fund sources. As such, it provides the budget committees with continued oversight opportunities during the duration of the pilot program.

⁷ The counties from which no applications were received were Carroll, Garrett, Harford, Howard, Queen Anne's, Talbot, and Washington counties.

Chapter 4: Regionalization of Local Public Health Services

As they do in Maryland, state and local governments in other states generally share responsibility for providing health care and related services to their citizens. However, the organization of local health entities varies widely throughout the nation as the regionalization of public health services is increasing. In part, this reflects a national movement towards voluntary public health accreditation.

National Voluntary Accreditation for Public Health Departments Supported by the Centers for Disease Control and Prevention

The U.S. Centers for Disease Control and Prevention, in partnership with the Robert Wood Johnson Foundation, are supporting the implementation of a national voluntary accreditation program for local, state, territorial and tribal health departments. The Public Health Accreditation Board (PHAB) is a nonprofit entity, which was established to serve as the independent accrediting body.

Among other issues, PHAB accreditation standards address areas related to population health, environmental health, wellness promotion, community outreach, and the enforcement of public health laws. Furthermore, standards also focus on improving access to health care services, maintaining a competent public health workforce, evaluating and improving health department programs, and applying evidenced-based public health practices. This is done through accreditation assessments, which provide measureable feedback to local health departments (LHD) on the aforementioned standards. In order to be eligible for accreditation, a health department must have three documents that have been updated in the last five years: (1) a community health assessment; (2) a community health improvement plan; and (3) a strategic plan.

The accreditation process includes seven steps: (1) pre-application, which includes submitting a statement of intent and online orientation; (2) application, which requires a health department to submit application forms and the applicable fee; (3) document selection and submission, which requires a health department to demonstrate its conformity with accreditation measures; (4) site visit by PHAB trained site visitors; (5) accreditation decision by PHAB; (6) reports, which are required on an annual basis if accreditation is received; and (7) reaccreditation.⁸

While accreditation is focused on improving the quality of public health departments, it is important to note that accreditation also highlights the capacity and capability of a health department, which may result in increased opportunities for resources. PHAB advises that potential resources may include funding to support quality and performance improvement;

⁸ The cost of accreditation varies based on the size of the jurisdictional population served by the health department. In calendar 2012, fees range from \$12,720 for populations less than 50,000 to \$95,400 for populations greater than 15 million.

funding to address infrastructure gaps identified through the accreditation process; opportunities for pilot programs; streamlined application processes for grants and programs; and acceptance of accreditation in lieu of other accountability processes.

As of November 2012, 106 health departments had submitted statements of intent and applications to PHAB. Among other challenges, limited resources have prevented health departments from seeking accreditation and have hampered the abilities of LHDs to meet PHAB standards. To address this issue, the National Association of County and City Health Officials (NACCHO) and the Robert Wood Johnson Foundation supported efforts in Kansas and Massachusetts to develop and consider new regional LHD agreements as a means of meeting the PHAB voluntary accreditation standards. Consequently, regional models in these states were explored to more effectively provide public health services and to better position LHDs to achieve accreditation status in the future.

Regionalization in Kansas

As in Maryland, LHDs in Kansas receive a large percentage of their funding from local governments. Due to an overall decline in county funding, LHDs found it extremely difficult to meet public health accreditation standards. It was determined that regional cooperation would allow for locally governed health departments to remain intact, but that some public health responsibilities would be best fulfilled across multiple jurisdictions, ultimately reducing disparities in public health services across jurisdictions. After assessing legal and financial factors relevant to regionalization, Kansas gradually implemented regional cooperation agreements in several regions of the state to address gaps in services.

Regionalization in Massachusetts

Funding for local public health in Massachusetts comes primarily from local tax dollars and fee revenues because there is no direct state funding for LHDs. Furthermore, all municipalities are expected to provide state mandated and locally mandated public health services. However, while some of the larger jurisdictions are able to meet these obligations, many of the smaller jurisdictions are not. This led to disparities in public health services across the state, which LHDs addressed through regional programming, including emergency preparedness planning and tobacco control measures.

In January 2009, the Act Relative to Public Health Reorganization was signed into law, giving communities the authority to voluntarily form public health districts. While the new law did not provide funding for public health districts, it did provide the legal basis for state-matched funding of district start-up and operating costs. In order to create further incentive for regionalization, five-year grants have been awarded under the Public Health District Incentive Grant Program. Among other uses, grant funding can be utilized to establish a governance structure for the district, conduct a region-wide Community Health Assessment, evaluate the performance of the district, and to meet workforce requirements. Technical assistance, such as legal and financial training, is also available to all grantees.

Regionalization of Local Health Entities in Maryland's Surrounding States

Each of Maryland's neighboring states – Delaware, Pennsylvania, Virginia, and West Virginia – requires local governments (county, city, or other municipality) to establish local health entities to provide general health care services to those within the jurisdiction. This entity is usually called the local health board. In Pennsylvania, however, statute allows for greater regionalization of services. For instance, each county is required to establish a single county department of health or a joint county department of health. A total of 16 health departments currently operate in Pennsylvania (which has 67 counties).

Similarly, Virginia has established a unique organizational arrangement to provide for the regionalization of local health services. This arrangement is part of Virginia's Cooperative Health Department Program. All cities and counties in Virginia must establish a LHD headed by a physician. The LHD has the option to contract with the state to provide public health services either as a single jurisdiction or in combination with neighboring cities and counties. The size of a particular health district depends solely on whether or not operating agreements have been reached between nearby local governing bodies. A total of 35 health districts have been formed in Virginia under this organizational arrangement.

Regionalization in Maryland

Maryland law provides that there is a health officer for each county. Except to specify that an individual may serve as a health officer for multiple counties, statute does not expressly provide for regionalization among LHDs. However, survey responses revealed that 75% of jurisdictions provide one or more programs in conjunction with another jurisdiction. For example, numerous smaller jurisdictions administer a Women, Infants, and Children (WIC) program in collaboration with another jurisdiction. Regional WIC programs have been established in the following jurisdictions: Cecil and Harford counties; Caroline, Talbot, and Dorchester counties; and Somerset, Wicomico, and Worcester counties. Furthermore, Allegany and Garrett counties jointly conduct a regional hospital preparedness program, while Talbot and Dorchester counties share a joint sexually transmitted diseases surveillance program. In general, regional collaboration is more common among smaller jurisdictions; three of the larger counties reported that they did not conduct any programs with neighboring LHDs.

Many Smaller Local Health Departments Are Unable to Obtain Accreditation

According to NACCHO's *2008 Profile on Local Health Departments*, 64% of the nation's LHDs serve populations of fewer than 50,000 individuals. Many of these smaller LHDs do not have the capacity to meet PHAB standards individually. NACCHO, therefore, advises regional arrangements as a strategy to assist smaller LHDs in meeting accreditation standards to

ensure that their jurisdictions are receiving all essential public health services required under accreditation.⁹

As shown in **Exhibit 4.1**, the majority of LHDs in Maryland serve populations greater than 50,000. However, seven health departments, primarily on the Eastern Shore, serve populations ranging from approximately 20,200 to 48,000. In these counties, the regionalization of certain services is already occurring. For instance, Mid-Shore Mental Health Services (a core service agency) oversees Caroline, Dorchester, Kent, and Talbot counties.

Exhibit 4.1
Maryland Population by County

<u>County</u>	<u>Population</u>
Montgomery County	971,777
Prince George's County	863,420
Baltimore County	805,029
Baltimore City	620,961
Anne Arundel County	537,656
Howard County	287,085
Harford County	244,826
Frederick County	233,385
Carroll County	167,134
Washington County	147,430
Charles County	146,551
St. Mary's County	105,151
Cecil County	101,108
Wicomico County	101,108
Calvert County	88,737
Allegany County	75,087
Worcester County	51,454
Queen Anne's County	47,798
Talbot County	37,782
Caroline County	33,066

⁹ NACCHO's *2008 Profile on Local Health Departments* indicated that regional health departments provide a more comprehensive set of services when compared to small LHDs. This was attributed, in part, to the budget constraints faced by small jurisdictions.

<u>County</u>	<u>Population</u>
Dorchester County	32,618
Garrett County	30,097
Somerset County	26,470
Kent County	20,197

Source: Maryland Department of Planning

LHDs have been encouraged by the Department of Health and Mental Hygiene to pursue accreditation – and a majority of survey respondents (17) indicated that they are either considering or actively pursuing accreditation. However, lack of funding was noted by 12 LHDs as a primary barrier to accreditation. Competing priorities and lack of staff time were also cited as barriers. Only one LHD suggested that LHD accreditation is unnecessary, although another LHD indicated that it lacked any financial incentive to pursue accreditation. In general, however, survey responses revealed that LHDs are interested in becoming accredited but that they have had limited success in obtaining the funds to do so.

The Department of Legislative Services (DLS) advises that regionalization may be an effective tool for overcoming financial barriers to accreditation and ensuring that public health services are consistent throughout the State. **Therefore, DLS will conduct additional research in the 2013 legislative interim to determine whether Maryland’s LHDs could benefit from increased regionalization of public health services.**

Chapter 5: Conclusion

In conducting this project, the Department of Legislative Services (DLS) found local health department (LHD) staff to be engaged with – and proactive in responding to – the critical issues that LHDs are currently facing. Throughout the State, LHDs are serving Marylanders admirably despite limited resources.

LHDs must continue to be agile in meeting the public's shifting needs – particularly against the backdrop of continued cost containment and in anticipation of the full implementation of federal health care reform. As the population served by LHDs changes, the role fulfilled by LHDs will likely change in turn. It is critical not only to confront the many challenges currently facing LHDs but also to closely examine and evaluate the tools available to LHDs to meet those challenges. Accordingly, DLS concludes the following:

- **Committee narrative should be adopted in the 2013 *Joint Chairmen's Report* requiring the Department of Health and Mental Hygiene (DHMH) to report on its efforts to address the challenges that LHDs are currently facing with regard to billing generally and third-party contracting in particular. DHMH should also advise whether statutory changes are necessary and/or feasible.**
- **DLS will conduct additional research in the 2013 legislative interim to determine whether the current distribution of funds under the Core Funding Program is effective to finance local public health services. Other states' funding formulas, as well as deficiencies (if any) in Maryland's current funding system, will also be examined.**
- **DLS will conduct additional research in the 2013 legislative interim to determine whether Maryland's LHDs could benefit from increased regionalization of public health services.**

Appendix 1
State of Maryland
Department of Legislative Services
Maryland General Assembly

Survey of Local Health Departments in Maryland

The Department of Legislative Services (DLS) is undertaking a research project on issues affecting local health departments (LHD). As a part of this project, DLS is conducting a survey of LHDs in the State.

The following questions primarily concern LHD operations, programs, staffing and funding. Please take a few moments to fill out this survey or direct the survey to the appropriate person(s) within your department with knowledge of these areas. Your responses are important to us as they will provide critical context and perspective of LHD operations in the State. Although the survey appears to be lengthy, most of the questions simply require a “yes” or “no” answer and/or short explanation.

Your responses will not be attributed to you by name, and the completed survey forms will ***not*** be shared with any other State agency. Generally, all data will be aggregated for presentation.

We would appreciate receiving your completed survey by August 10, 2012. Please email your responses to: jennifer.ellick@mlis.state.md.us. If you need additional time, please contact us.

Thank you in advance for your assistance. If you have any questions, please contact Jennifer Ellick or Erin McMullen at (410) 946-5510 or (410) 946-5530.

I. LHD Contact Information

Please provide the following information for the person you would like us to contact in the event that we have any follow-up questions.

Name of jurisdiction:	
Name of person to contact regarding the completed survey:	
Telephone number of contact person:	
Email address of contact person:	

II. Funding

Please fill in the blanks with the requested information.

1. What were the LHD's total expenditures in fiscal 2011 and 2012? (*Please specify an amount for each type of expenditure.*)

Expenditures	FY 2011	FY 2012
Administration and Communication	\$	\$
Communicable Disease Control	\$	\$
Family Planning	\$	\$
Wellness Promotion	\$	\$
Adult and Geriatric Health	\$	\$
Environmental Health	\$	\$
Maternal and Child Health	\$	\$
Substance Abuse	\$	\$
Mental Health	\$	\$
Other (<i>please specify</i>):	\$	\$
Total Expenditures	\$	\$

2. Do fiscal 2011 and 2012 expenditures shown above for Administration and Communication account for indirect costs, such as those related to personnel and overhead? *(Please mark one and provide additional details as appropriate.)*

Yes, in full	
Yes, in part <i>(please explain)</i> :	
No	

3. Please describe the LHD's budget process, including how information is reported to the county and how the LHD accounts to the State for total revenues and expenditures.

--

4. What system is used to meet the LHD's accounting needs? *(Please mark one and provide additional details as appropriate.)*

Financial Management Information System (FMIS)	
Other <i>(please specify)</i> :	

5. What were the LHD's total revenues in fiscal 2011 and 2012? (*Please specify an amount for each type of revenue.*)

Revenues	FY 2011	FY 2012
County Sources	\$	\$
State Sources	\$	\$
Core Funding	\$	\$
Cigarette Restitution Fund Grants	\$	\$
Federal Sources – passed through the State (<i>If you are unable to report indirect funds separately, please indicate why</i>):	\$	\$
Other Block Grants from the Department of Health and Mental Hygiene	\$	\$
Funding from other State agencies/sources (<i>please specify</i>):	\$	\$
Federal Sources – direct (<i>please specify</i>):	\$	\$
Collections	\$	\$
Medicaid	\$	\$
Medicare	\$	\$
Regulatory Fees	\$	\$
Other collections (<i>please specify</i>):	\$	\$
Private Organizations	\$	\$
Other (<i>please specify</i>):	\$	\$
Total Revenues	\$	\$

6. For **fiscal 2011**, is there any funding that is not included on the LHD's Unified Funding Document? *(Please mark one and provide additional details as appropriate.)*

Yes <i>(please specify)</i> :	
No	

7. For **fiscal 2012**, is there any funding that is not included on the LHD's Unified Funding Document? *(Please mark one and provide additional details as appropriate.)*

Yes <i>(please specify)</i> :	
No	

8. Since fiscal 2009, have State budget cuts impacted the LHD's operations in any of the following ways? *(Please mark one and provide additional details as appropriate.)*

Staffing cutbacks

Yes <i>(please describe)</i> :	
No	

Programs eliminated

Yes <i>(please describe)</i> :	
No	

Programs reduced

Yes <i>(please describe)</i> :	
No	

Fees raised

Yes (<i>please describe</i>):	
No	

Other

Yes (<i>please describe</i>):	
No	

9. Since fiscal 2009, have other funding sources, such as contributions from the county government, increased to offset State budget cuts? (*Please mark one and provide additional details as appropriate.*)

Yes (<i>please describe</i>):	
No	

10. Are there specific areas of priority to which the LHD would direct monies if State funding was increased? (*Please mark one and provide additional details as appropriate.*)

Yes (<i>please specify</i>):	
No	

III. Staffing

1. What was the total number of ***filled*** full-time equivalent (FTE) regular/permanent positions at the LHD on the following dates? (*Please specify.*)

June 30, 2012	
June 30, 2011	
June 30, 2010	
June 30, 2009	
June 30, 2008	

2. What was the total number of ***filled*** FTE contractual positions at the LHD on the following dates? (*Please specify.*)

June 30, 2012	
June 30, 2011	
June 30, 2010	
June 30, 2009	
June 30, 2008	

IV. Programs and Partnerships

1. What programs are offered by the LHD? *(Please specify below and indicate whether the program is offered directly or indirectly.)*

[illegible]

2. Does the LHD conduct any programs in conjunction with another LHD? (*Please mark one and provide additional details as appropriate.*)

Yes (<i>please specify</i>):	
No	

3. What entity serves as the jurisdiction's Core Service Agency? *(Please specify and provide additional details as appropriate.)*

The LHD	
Another entity <i>(please specify)</i> :	

4. What entity provides resource coordination services funded by the Developmental Disabilities Administration? *(Please specify and provide additional details as appropriate.)*

The LHD	
Another entity <i>(please specify)</i> :	

5. Does the LHD engage in any partnerships with the entities shown below? *(Please mark whether these partnerships are formal ("F") or informal ("I") and describe the LHD's relationship with each marked entity.)*

	F	I	Description of Relationship
Academic Institutions			
Community Health Centers			
Federally Qualified Health Centers			
Libraries and Nonprofit/Faith-Based Organizations			

Local Management Board			
Local Planning Board			
Local Task Forces			
Private Physicians/Providers			
Other Local/Regional Entities			

6. What is the LHD's relationship with the local Alcohol and Drug Abuse Council? (*Please specify.*)

--

7. Does a representative of the LHD serve on the council? (*Please mark one.*)

Yes	
No	

8. Has the county's Local Health Improvement Coalition identified any areas of priority under the State Health Improvement Process? *(Please mark one and provide additional details as appropriate.)*

Yes <i>(please specify):</i>	
No	

V. Other

1. Is the LHD pursuing accreditation? *(Please mark one and provide additional details as appropriate.)*

Yes <i>(please describe the LHD's progress in the accreditation process):</i>	
Anticipated Accreditation Date:	
No	

2. Does the LHD utilize electronic health records? *(Please mark one and provide additional details as appropriate.)*

Yes <i>(please describe):</i>	
No <i>(please explain):</i>	

3. Does the LHD contract with third-party providers and/or insurers? *(Please mark one and provide additional details as appropriate.)*

Yes <i>(please specify):</i>	
No <i>(please explain):</i>	

4. Please describe any barriers (not already discussed above) encountered by the LHD in its efforts to contract with third-party providers/insurers:

--

5. Has the LHD sought counsel/assistance from the State regarding the barriers described above (if any)? *(Please mark one and provide additional details as appropriate.)*

Yes <i>(please describe what counsel/assistance was provided and indicate whether the counsel/assistance has been effective):</i>	
No	
N/A	

6. Please describe any other challenges that the LHD is experiencing related to billing and reimbursement:

--

**Please attach any additional information you would like us to consider.
Thank you for your time and assistance.**

Appendix 2

Public Health Programs in the Department of Health and Mental Hygiene

Most health services in the State are provided on the local level and are funded in whole or in part by the Department of Health and Mental Hygiene (DHMH) through four divisions: (1) Operations; (2) Health Care Financing; (3) Behavioral Health and Disabilities; and (4) Public Health Services. Administrative functions are organized under the Operations division. The remaining three divisions play an important role in the delivery of local health services, as discussed below.

Health Care Financing Division

The Health Care Financing division of DHMH is responsible for administering Maryland's Medical Assistance Program (Medicaid), the Maryland Children's Health Program (MCHP), the Family Planning Program, the Primary Adult Care (PAC) Program, the Kidney Disease Program (KDP), and the Employed Individuals with Disabilities Program (EID).

Medicaid

Medical Assistance (Title XIX of the Social Security Act) is a joint federal and state program that provides assistance to indigent and medically indigent individuals. In Maryland, the federal government covers 50% of Medicaid costs. Medical Assistance eligibility is limited to children, pregnant women, elderly or disabled individuals, and low-income parents. In addition, applicants must pass certain income and asset tests in order to qualify for benefits.

Individuals qualifying for cash assistance through the Temporary Cash Assistance Program or the federal Supplemental Security Income (SSI) Program automatically qualify for Medicaid benefits. Such individuals comprise most of the Medicaid population and are referred to as categorically needy. The U.S. Congress has also extended eligibility to include children and pregnant women who meet certain income eligibility standards through the Pregnant Women and Children Program. In addition, federal law requires the Medicaid program to assist Medicare recipients with incomes below the federal poverty level in making their coinsurance and deductible payments. The State also provides Medicaid coverage to parents below 116% of the federal poverty level.

Another major group of Medicaid-eligible individuals is the medically needy: individuals whose income exceeds categorical eligibility standards but falls below levels set by the State. Individuals with incomes above the medically needy level may reduce their income to the requisite level through spending on medical care.

Medicaid funds a broad range of services. As mandated by the federal government, the State provides nursing facility services; hospital inpatient and outpatient services; x-ray and laboratory services; early and periodic screening, diagnosis, and treatment services for children; family planning services; transportation services; physician care; federally qualified health center

and rural health clinic services; and some nurse practitioner services. In addition, Maryland provides a number of services designated by the federal government as optional, including vision care; podiatric care; pharmaceutical care; medical supplies and equipment; intermediate-care facilities for the developmentally disabled; and institutional care for individuals who are over the age of 65 and have mental diseases.

Most Medicaid recipients are required to enroll in HealthChoice: the statewide, mandatory managed care program that began in 1997. Populations excluded from the HealthChoice program are covered on a fee-for-service (FFS) basis; in general, the FFS population includes those who are either institutionalized or dually eligible for Medicaid and Medicare.

Maryland Children's Health Program

The Maryland Children's Health Program (MCHP) is Maryland's program for medical assistance for low-income children and pregnant women. MCHP includes children who are in Medicaid (for whom the State is entitled to receive 50% federal financial participation) and children who are in the State Children's Health Insurance Program (for whom the State is entitled to receive 65% federal financial participation). Those eligible for the higher match are children under age 19 living in households with an income below 300% of the federal poverty level but above the Medicaid income levels. MCHP provides all the same services as Medicaid. A premium of approximately 2% of family income is required of child participants with family incomes above 200% of the federal poverty level.

Family Planning Program

The Family Planning Program provides medical services related to family planning for women who lose Medicaid coverage after they were covered for a pregnancy under MCHP. Covered services include medical office visits; physical examinations; certain laboratory services; family planning supplies; reproductive education, counseling and referral; and tubal ligation. Coverage for family planning services continues for five years with annual redeterminations unless the covered individual becomes eligible for Medicaid or MCHP, no longer needs birth control due to permanent sterilization, no longer lives in Maryland, or becomes income-ineligible. Chapters 537 and 538 of 2011 extended coverage under the program to women under 200% of the federal poverty level.

Primary Adult Care Program

PAC provides primary care, outpatient mental health, and pharmacy services to adults age 19 and over who earn less than 116% of federal poverty level and who are not eligible for Medicare or Medicaid. Hospital stays and specialty care are not covered under this program. Furthermore, copayments of \$7.50 (for brand name drugs that are not on the preferred drug list) and \$2.50 (for generic and preferred drugs) may be required for each eligible prescription and refill. Primary care services are provided through a managed care network. The federal government covers 50% of PAC costs. PAC coverage for certain substance abuse services and emergency room visits was added effective January 1, 2010.

Kidney Disease Program

KDP is a last-resort payor that provides reimbursement for approved services that are needed as a direct result of end-stage renal disease (ESRD). Eligibility for KDP is offered to Maryland residents who are either citizens of the United States or aliens lawfully admitted for permanent residence in Maryland; have been diagnosed with ESRD; and are receiving home dialysis or treatment in a certified dialysis or transplant facility. KDP is State-funded.

Employed Individuals with Disabilities Program

EID, also known as the “Medicaid Buy-in,” extends medical assistance to working Marylanders with disabilities. Specifically, EID allows disabled individuals to return to work while maintaining health benefits by paying a small fee. Individuals eligible for EID may earn more income and/or have greater financial resources than individuals in other Medicaid programs in Maryland. The services available to EID enrollees are the same as the services covered by Medicaid. The federal government covers 50% of the program’s costs.

Health Regulatory Commissions

The Health Regulatory Commissions are three independent agencies that operate within DHMH and variously regulate the health care delivery system, monitor the price and affordability of services offered in the industry, and improve access to care for Marylanders. The three commissions are the Maryland Health Care Commission; the Health Services Cost Review Commission; and the Maryland Community Health Resources Commission (MCHRC), which is the commission that deals directly with local public health.

MCHRC is an 11-member commission intended to improve access to primary and specialty health care for lower-income individuals and to provide operating grants to community health resource centers. In addition, the commission is charged with developing a specialty care network of practitioners who agree to provide care at a discounted fee for individuals with incomes up to 200% of the federal poverty level who are referred through a community health resource. In fiscal 2012, as discussed in the body of this report, MCHRC administered funding to support the development of local health improvement coalitions under the State Health Improvement Process.

Behavioral Health and Disabilities Division

The Deputy Secretary of Behavioral Health and Disabilities is responsible for the oversight of three administrations: the Alcohol and Drug Abuse Administration (ADAA); the Developmental Disabilities Administration (DDA); and the Mental Hygiene Administration (MHA).

Alcohol and Drug Abuse Administration

ADAA develops and operates unified programs for substance abuse research, training, prevention, and rehabilitation in cooperation with federal, State, local, and private agencies. ADAA's mission is to provide access to a quality and effective substance abuse prevention, intervention, and treatment service system for the citizens of Maryland.

ADAA maintains an integrated statewide service delivery system through a variety of treatment and prevention modalities that provide financial and geographic access to Marylanders who need assistance due to drug and alcohol addiction. Treatment is funded through grants and contracts with local health departments (LHD) and private and nonprofit providers. Maryland's community-based addiction treatment programs include primary and emergency care, intermediate care facilities, halfway houses, long-term residential programs, and outpatient care. The State also funds prevention programs.

Chapter 332 of 2009 expanded PAC's benefit package to include outpatient substance abuse treatment. Concurrent with other changes (including increased service reimbursement rates to Medicaid providers and improvements to the ability of enrollees to self-refer for services), this represented a major expansion of substance abuse treatment in the State. Funding to support this expansion of services was derived from the existing State-funded substance abuse treatment grant program in ADAA, matched with federal Medicaid dollars.

Developmental Disabilities Administration

A developmental disability is a condition attributable to a mental or physical impairment that results in substantial functional limitations in major life activities and is likely to continue indefinitely. Examples of developmental disabilities include autism, blindness, cerebral palsy, deafness, epilepsy, mental retardation, and multiple sclerosis. DDA provides direct services to these developmentally disabled individuals in two State Residential Centers and through funding of a coordinated service delivery system that supports the integration of these individuals into the community. Because the majority of the individuals served by DDA are Medicaid-eligible, the State receives federal matching funds for most services provided by DDA.

Specific goals of the administration include:

- empowerment of the developmentally disabled and their families;
- integration of individuals with developmental disabilities into community life;
- provision of quality support services that maximize individual growth and development; and
- establishment of a responsible, flexible service system that maximizes available resources.

DDA also provides resource coordination to individuals participating in a DDA Medicaid Waiver program, individuals receiving State-funded services, and those on the waiting list. There are 18 resource coordination entities in the State, including 15 LHDs.

Mental Hygiene Administration

MHA is responsible for the treatment and rehabilitation of the mentally ill in Maryland. Specifically, MHA is tasked with planning and developing comprehensive services for the mentally ill; supervising State-run psychiatric facilities for the mentally ill; reviewing and approving local plans and budgets for mental health programs; providing consultation to State agencies concerning mental health services; establishing personnel standards; and developing, directing, and assisting in the formulation of educational and staff development programs for mental health professionals.

MHA administers its responsibilities through a layered organizational structure, as described below:

- **MHA Headquarters** coordinates mental health services throughout the State according to the populations served, whether in an institutional or community setting.
- **Core Service Agencies (CSA)** work with MHA, through signed agreements, to coordinate and deliver mental health services in the counties. There are currently 19 CSAs – some housed within LHDs, others organized as nonprofit agencies, and two comprising a multi-county enterprise.
- **State-run Psychiatric Facilities** include five hospitals and two residential treatment centers – Regional Institutions for Children and Adolescents (RICA) – for the mentally ill.

Public Health Services Division

DHMH's Public Health Services division oversees the State Anatomy Board, the Vital Statistics Administration, and the Office of the Chief Medical Examiner. In addition, four administrations within the division directly or indirectly provide health care services throughout the State: (1) the Office of Preparedness and Response (OPR); (2) the Laboratories Administration; (3) the Prevention and Health Promotion Administration (PHPA); and (4) the Health Systems and Infrastructure Administration (HSIA). Each of these administrations works with local jurisdictions, public and private sector providers, and educational institutions in order to develop programs and services to respond to State and local health priorities.

Office of Preparedness and Response

OPR oversees programs focused on enhancing the public health preparedness activities for LHDs and the State. The key aspects of the work conducted under the leadership of OPR are interagency collaboration and preparedness for public health emergencies. OPR's projects are

federally funded through (1) the U.S. Centers for Disease Control and Prevention (CDC) Public Health Preparedness and Response for Bioterrorism Grant; (2) the CDC Cities Readiness Initiative and (3) the U.S. Department of Health and Human Services National Bioterrorism Hospital Preparedness Program.

OPR is entirely federally funded, but the agency's appropriation has decreased by more than 34% since fiscal 2009. This reduction in federal funds over the past few years reflects, in part, the elimination of one-time H1N1 funding in fiscal 2010. In fiscal 2011, OPR's expenditures totaled \$25.1 million.

Laboratories Administration

The mission of the Laboratories Administration is to promote, protect, and preserve the health of the people of Maryland from the consequences of communicable diseases, environmental factors, and unsafe consumer products through the following measures:

- adoption of scientific technology to improve the quality and reliability of laboratory practice in the areas of public health and environmental protection;
- expansion of newborn hereditary disorder screening;
- maintenance of laboratory emergency preparedness efforts; and
- promotion of high-quality, reliable laboratory data in support of public health and environmental programs.

DHMH has regional laboratories in Salisbury and Cumberland, in addition to the central laboratory in Baltimore. The administration receives funding from LHDs to perform laboratory tests. In fiscal 2011, the administration's budget was \$23.9 million.

Prevention and Health Promotion Administration

Effective July 1, 2012, DHMH's Public Health Services division underwent a reorganization 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 the PHPA, within which there are four bureaus: (1) Maternal and Child Health; (2) Environmental Health; (3) Infectious Disease; and (4) Cancer and Chronic Disease.

Maternal and Child Health Bureau

The Maternal and Child Health Bureau oversees 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.

The bureau also administers the Women, Infants, and Children (WIC) Supplemental Nutrition Program. Funded almost entirely with federal dollars, WIC serves pregnant, postpartum, and breastfeeding women; infants younger than one year of age; and children under five with a nutritional risk (such as anemia or poor diet) and a family income below 185% of the federal poverty level. Beneficiaries receive a nutrition assessment, supplemental foods, and referrals to other health and social service programs for which they may qualify. WIC spending is comprised primarily of food service contracts; however, LHDs and other private entities also receive funding to assist with the administration of the program. LHDs also receive funding for administrative support for the WIC Breastfeeding Peer Counselor Program.

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.

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 Maryland AIDS Drug Assistance Program (MADAP) and MADAP-Plus. A third program – the Maryland AIDS Insurance Assistance Program (MAIAP) – was eliminated in 2009. LHDs play an important role in determining individual eligibility for these programs (outlined in **Table 1**) and assisting with program enrollment.

Table 1
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% FPL	Federal funds
MADAP-Plus	Maintains health insurance for individuals testing positive for HIV who can no longer work due to their illness	115 to 500% of the FPL	Federal and special funds
MAIAP*	Provided health insurance assistance to persons at risk of losing private health insurance 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

*MAIAP ended on June 30, 2009.

Source: Department of Mental Hygiene

MADAP, the largest program run by the bureau (with an estimated 7,300 enrollees in 2011), helps low- to moderate-income Marylanders pay for certain drugs prescribed to treat HIV/AIDS. Clients are certified eligible for MADAP for a one-year period, upon the expiration of which they may reapply for certification. Following the increase in eligibility limits promulgated by the (now-defunct) AIDS Administration in 2004, MADAP has some of the nation's most expansive eligibility requirements and offers generous drug coverage.

MADAP-Plus offers health insurance assistance to individuals living with HIV/AIDS. Both MADAP and MADAP-Plus had failed to live up to enrollment expectations for a number of years; however, MADAP-Plus had significant enrollment increases in calendar 2005, and the program finally surpassed the original enrollment target of 300 with an estimated 2,600 enrollees in 2011.

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 programs. With the exception of the Statewide Academic Health Centers program, LHDs receive federal and general funds, as well as special funds from the Cigarette Restitution Fund (CRF) to administer these programs. The bureau also oversees the Office of Oral Health.

Cigarette Restitution Fund

The Cigarette Restitution Fund was created in 1999 to receive payments to the State from the Master Settlement Agreement with cigarette manufacturers. The Act establishing CRF specified nine health and tobacco-related priorities (reduction in tobacco by youth, tobacco control campaigns in schools; smoking cessation programs; enforcement of tobacco sales restrictions; primary health care in rural areas; programs concerning cancer, heart disease, lung disease, and tobacco control; substance abuse treatment and prevention; the Maryland Health Care Foundation; and crop conversion), to which no less than half of the funds must be appropriated annually. To support this goal, the General Assembly created the Tobacco Use Prevention and Cessation Program and the Cancer Prevention, Education, Screening, and Treatment Program within the PHPA to address both the causes and the effects of tobacco use. (CRF also supports existing health programs such as substance abuse treatment and Medicaid.)

The Tobacco Use Prevention and Cessation program is charged with developing initiatives to reduce tobacco use in Maryland and otherwise benefit public health. As established by law, the program consists of five components: surveillance and education, statewide public health, countermarketing, local public health, and administration. Program activity is primarily conducted through LHDs, which are responsible for developing and implementing community and school-based programming to reduce tobacco use. In addition to local programming, DHMH administers the Minority Outreach and Technical Assistance Program, through which the department contracts with four community-based organizations to develop resource materials for use in preventing tobacco usage by minority populations statewide.

The Cancer Prevention, Education, Screening and Treatment Program is charged with developing initiatives to reduce morbidity and mortality rates in Maryland for cancer and tobacco-related diseases, including grants to Statewide Academic Health Centers for cancer research. Cancer prevention, education, screening, and treatment are primarily provided by LHDs. CRF-funded programs are intended to complement existing cancer screening and treatment programs, with emphasis on ensuring that the uninsured and underinsured receive appropriate treatment.

The Budget Reconciliation and Financing Act of 2010 altered the mandated funding levels for cancer and tobacco programs in fiscal 2011, 2012, 2013, and beyond. **Table 2** shows the mandated funding level for each program, as specified by the Health General Article, Title 13, Subtitles 10 and 11, and the fiscal 2013 adjusted allowance.

Table 2
Cigarette Restitution Fund Allocations
Fiscal 2011-2013
(\$ in Millions)

	<u>Original Level</u>	<u>2011 Actual*</u>	<u>2012 Actual*</u>	<u>Current Law 2013 and Beyond*</u>	<u>2013 Appropriation</u>
Tobacco Use Prevention and Cessation	\$21.0	\$6.0	\$6.0	\$6.0	\$6.0
Total Statewide Academic Health Centers					
Cancer Research Grants	\$10.4	\$2.4	\$2.4	\$13.0	\$5.8
Tobacco-related Disease Research Grants	2.0	0.0	0.0	0.0	0.0
Statewide Network Grants	3.0	0.0	0.0	0.0	0.0
Total	\$15.4	\$2.4	\$2.4	\$13.0	\$5.8

*Levels specified by the Budget Reconciliation and Financing Act of 2010.

Source: *Annotated Code of Maryland*

As depicted above, the funding for Tobacco Use Prevention and Cessation and grants to the Statewide Academic Health Centers was scheduled to be partially restored in fiscal 2013. However, funding for tobacco programs, including CRF and other funds, continues to be funded at \$6.0 million, while the Statewide Academic Health Centers received a funding increase over the fiscal 2012 level to \$5.8 million in fiscal 2013.

Health Systems and Infrastructure Administration

The public health reorganization also led to the creation of the HSIA, which is focused on population health initiatives such as the State Health Improvement Plan, public health accreditation, and quality improvement. HSIA also oversees programs related to school health and primary care access, which includes rural health, community health, and coordination with Federally Qualified Health Centers. In addition, HSIA oversees the State's two Chronic Disease Hospitals – Deer's Head Hospital Center and Western Maryland Hospital Center – and administers Core Public Health funds.

Appendix 3

Local Health Department Expenditures and Revenues

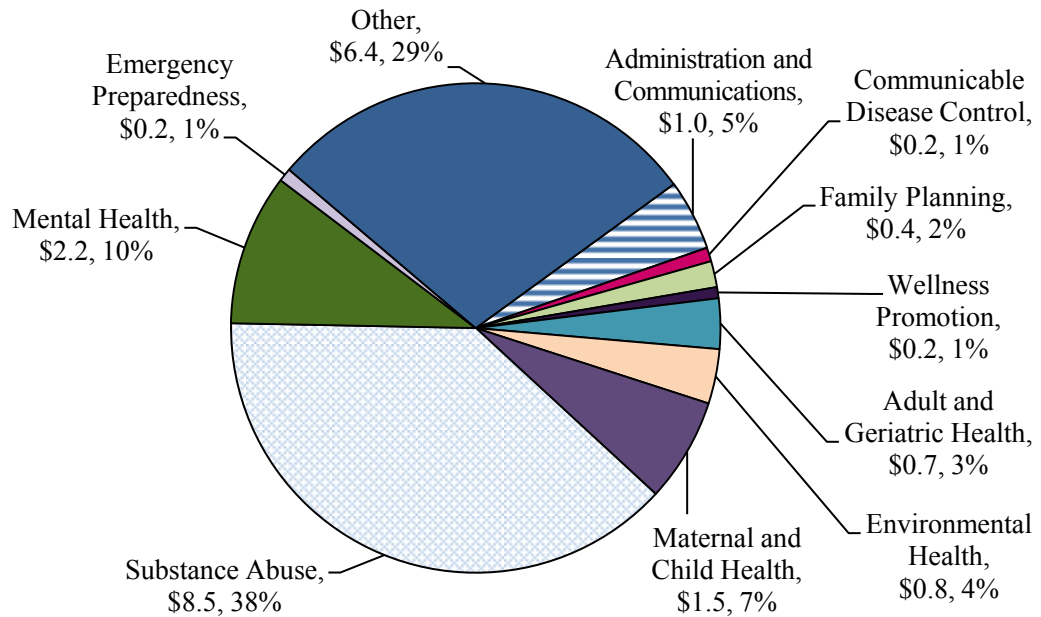
Collecting error-free data on local health department (LHD) financing that is comparable across Maryland's 24 jurisdictions was challenging as the data was self-reported. For instance, some LHDs had difficulties distinguishing between grants from the Department of Health and Mental Hygiene (DHMH) and federal pass-through funds. Similarly, other LHDs did not provide a detail of funding included in the "Other Expenditures" category. Therefore, to address this issue, staff at the Department of Legislative Services (DLS) conducted follow-up discussions with all 24 local health officers to ensure financial data was reported in a consistent manner.

DLS also notes that figures included in Appendix 3 may not sum to total due to rounding.

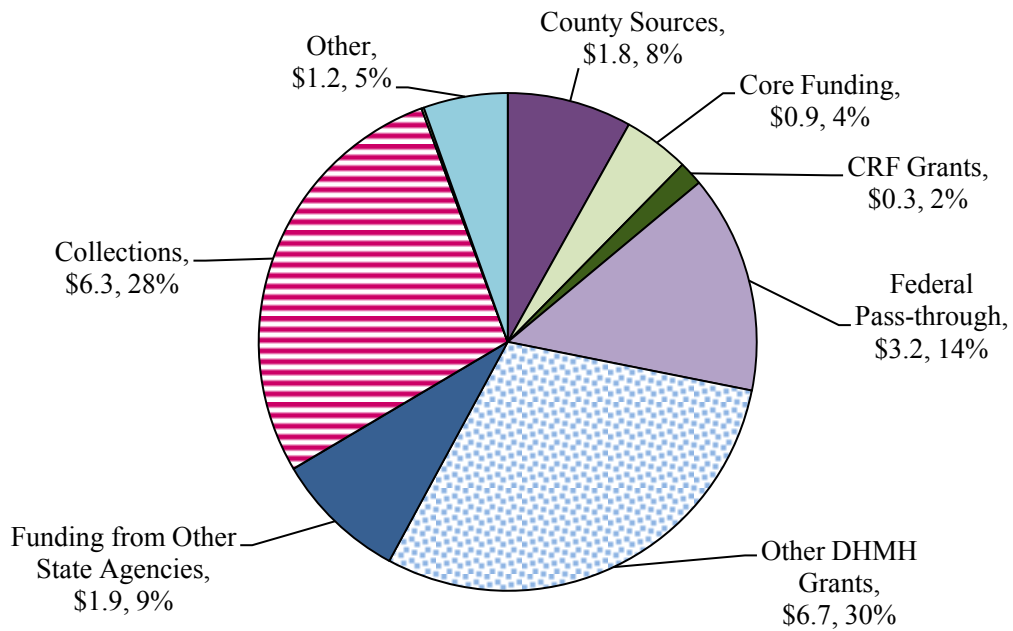
**Fiscal 2011
(\$ in Millions)**

Allegany County

Expenditures (\$22.2)



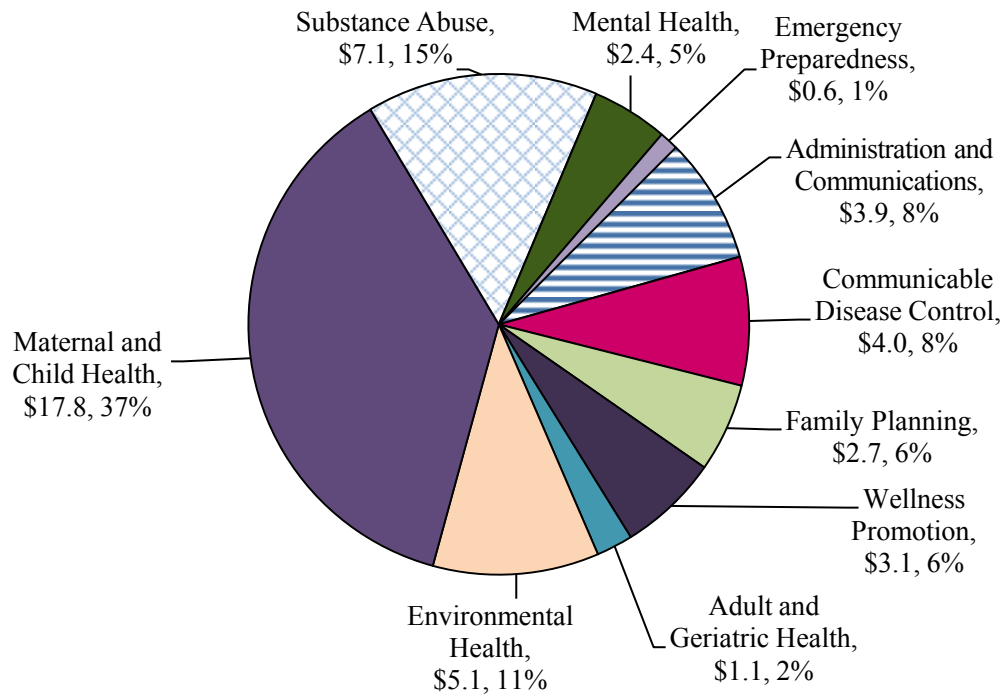
Revenues (\$22.5)



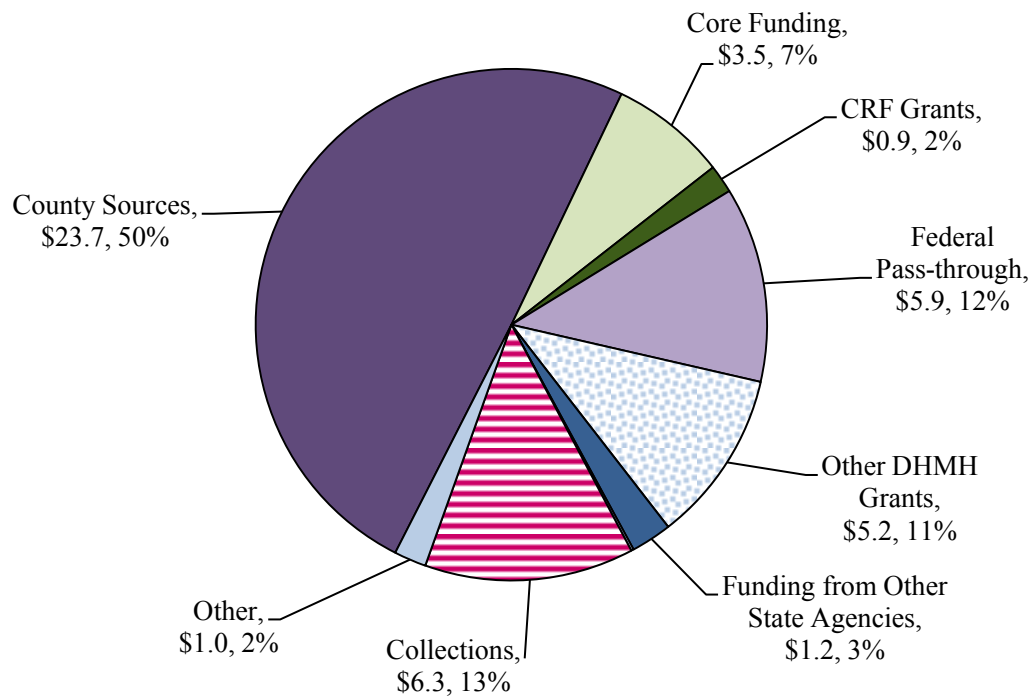
CRF: Cigarette Restitution Fund
DHMH: Department of Health and Mental Hygiene

Anne Arundel County

Expenditures (\$47.8)



Revenues (\$47.8)

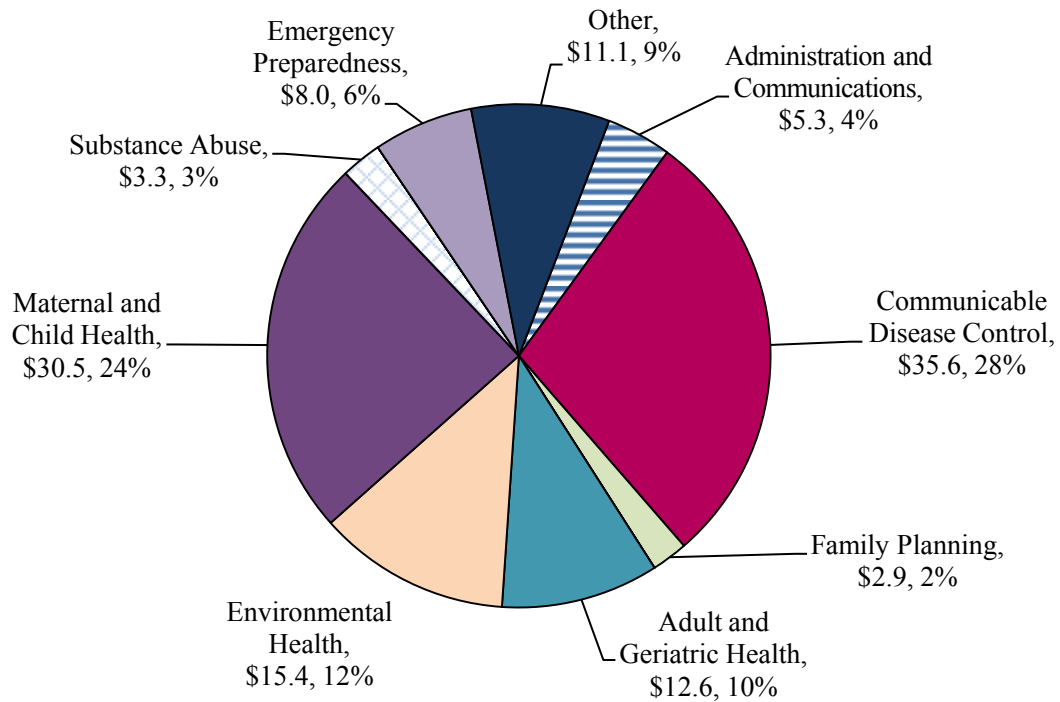


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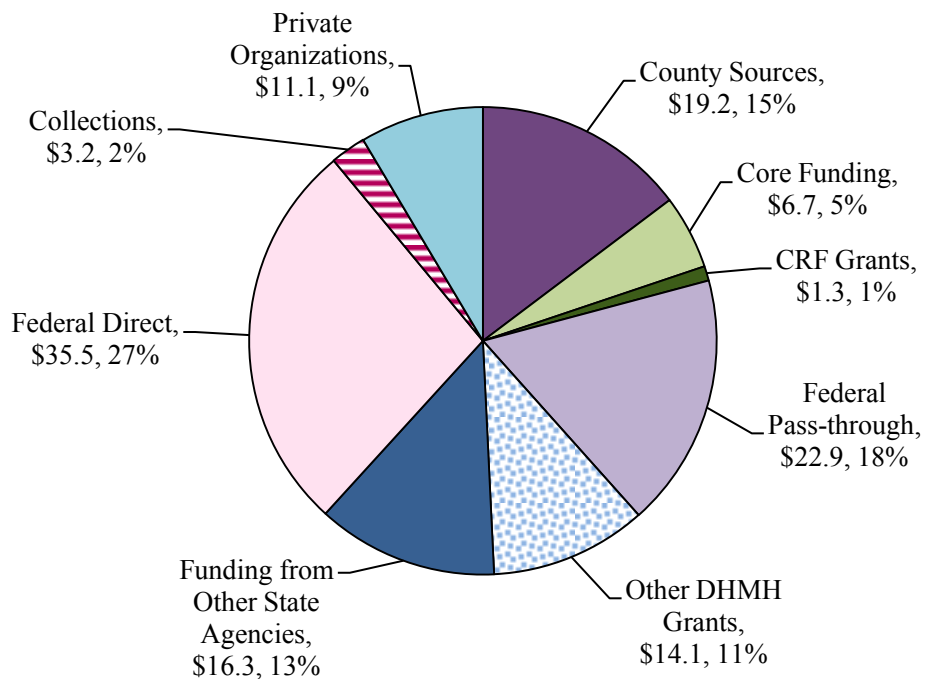
DHMH: Department of Health and Mental Hygiene

Baltimore City

Expenditures (\$125.2)



Revenues (\$130.3)

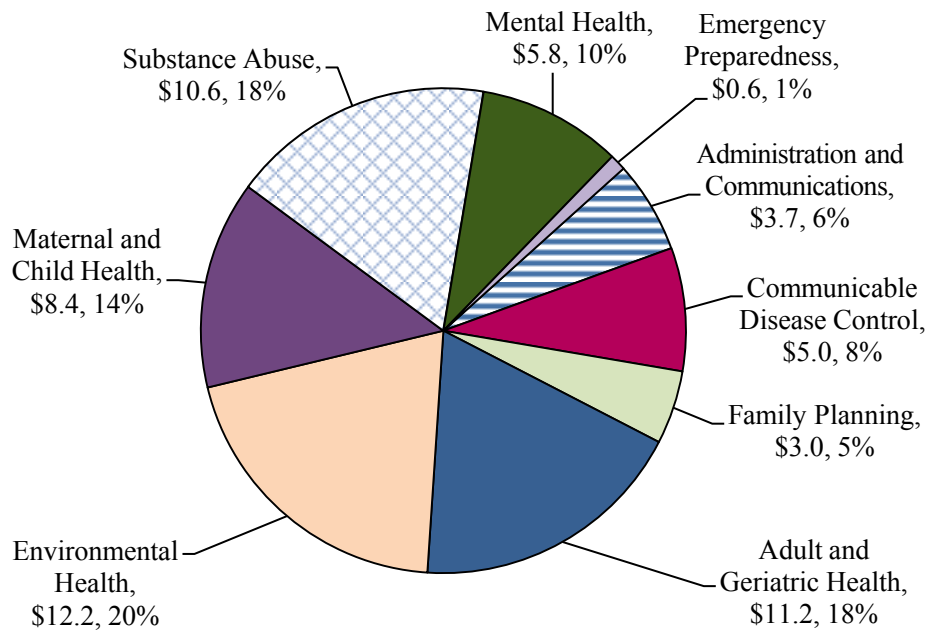


CRF: Cigarette Restitution Fund

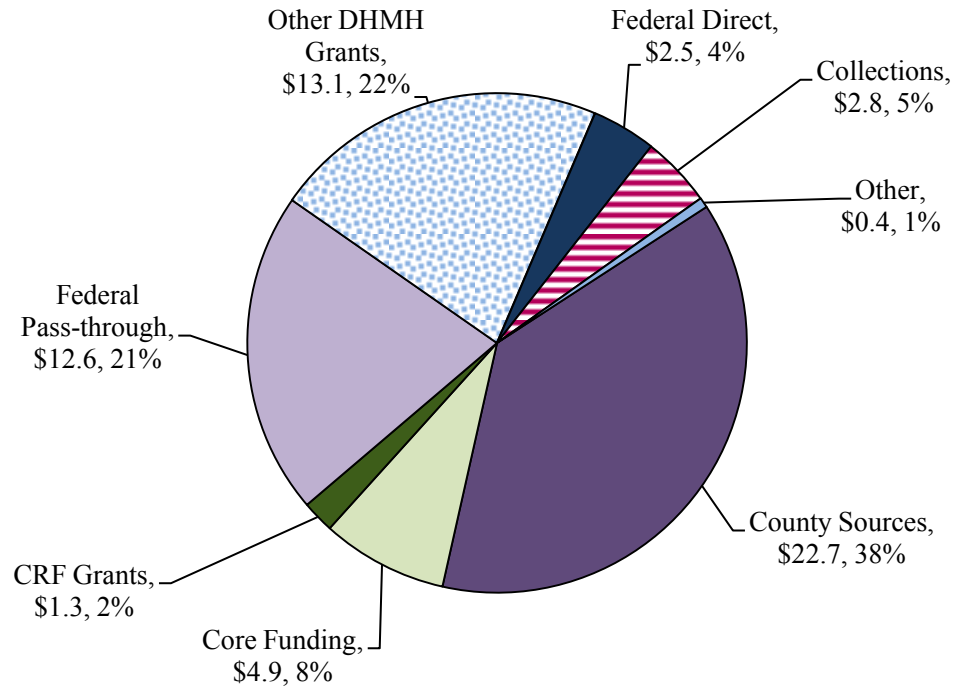
DHMH: Department of Health and Mental Hygiene

Baltimore County

Expenditures (\$60.7)



Revenues (\$60.7)

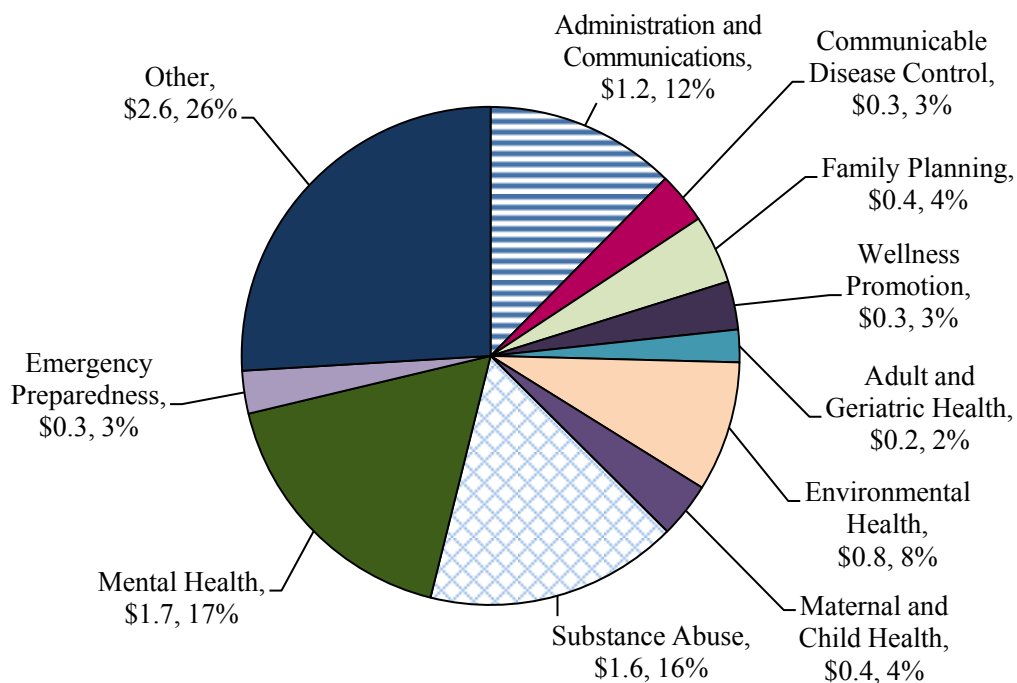


CRF: Cigarette Restitution Fund

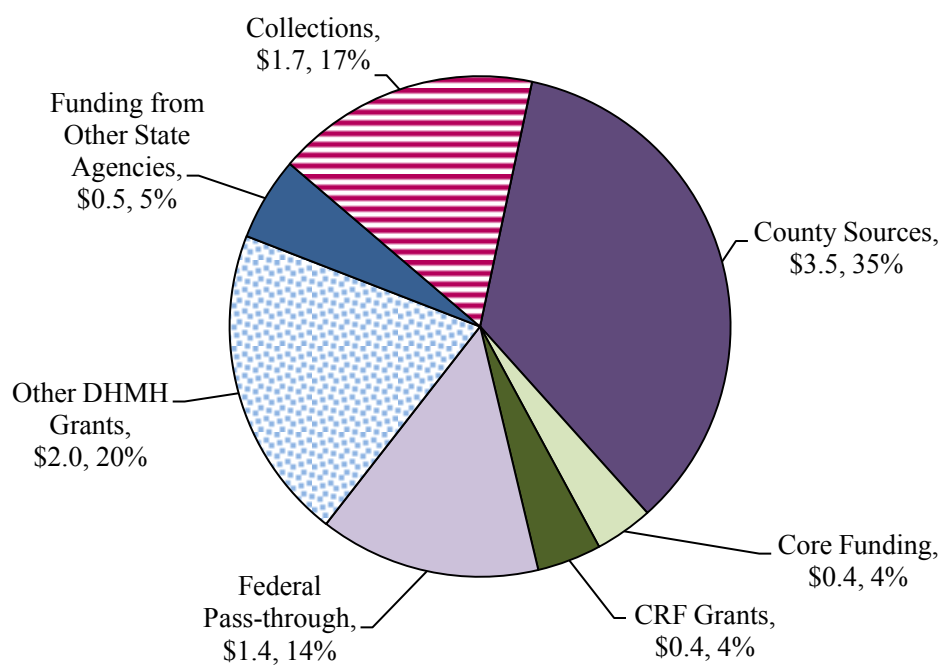
DHMH: Department of Health and Mental Hygiene

Calvert County

Expenditures (\$9.9)



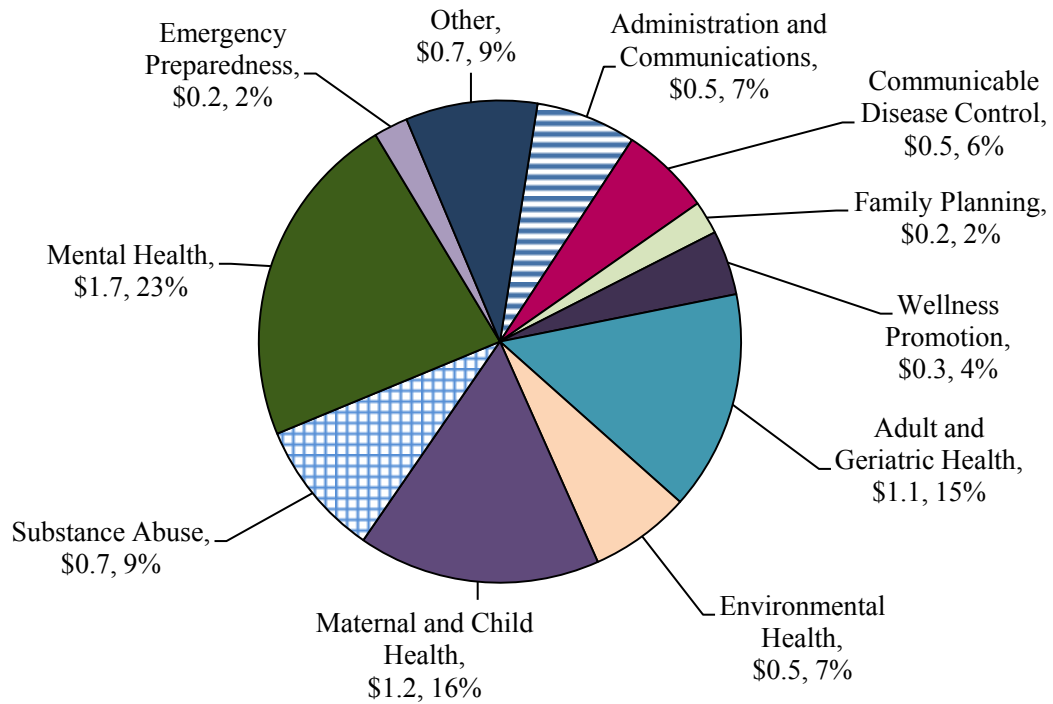
Revenues (\$9.9)



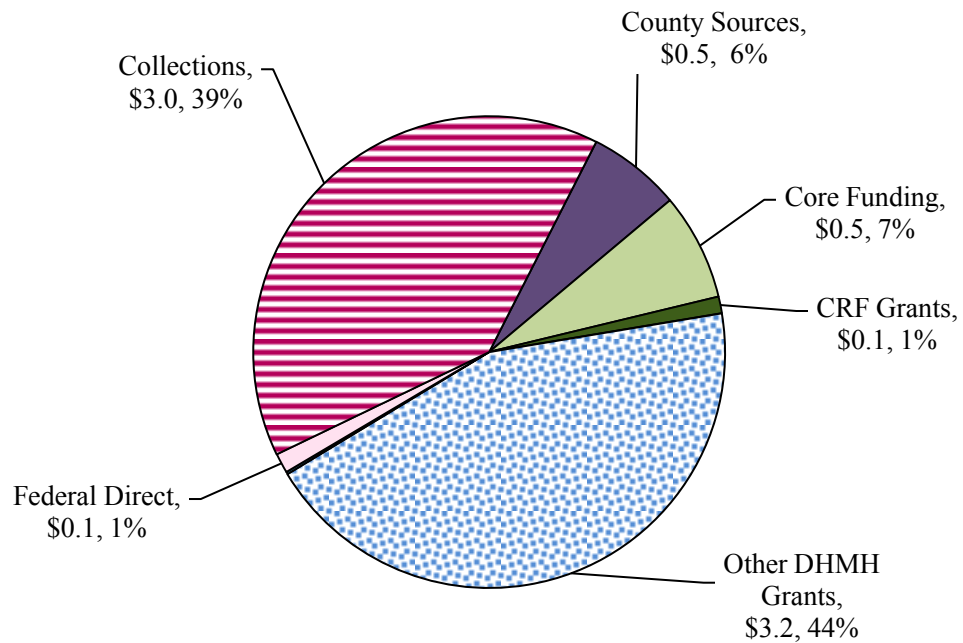
CRF: Cigarette Restitution Fund
DHMH: Department of Health and Mental Hygiene

Caroline County

Expenditures (\$7.5)



Revenues (\$7.4)

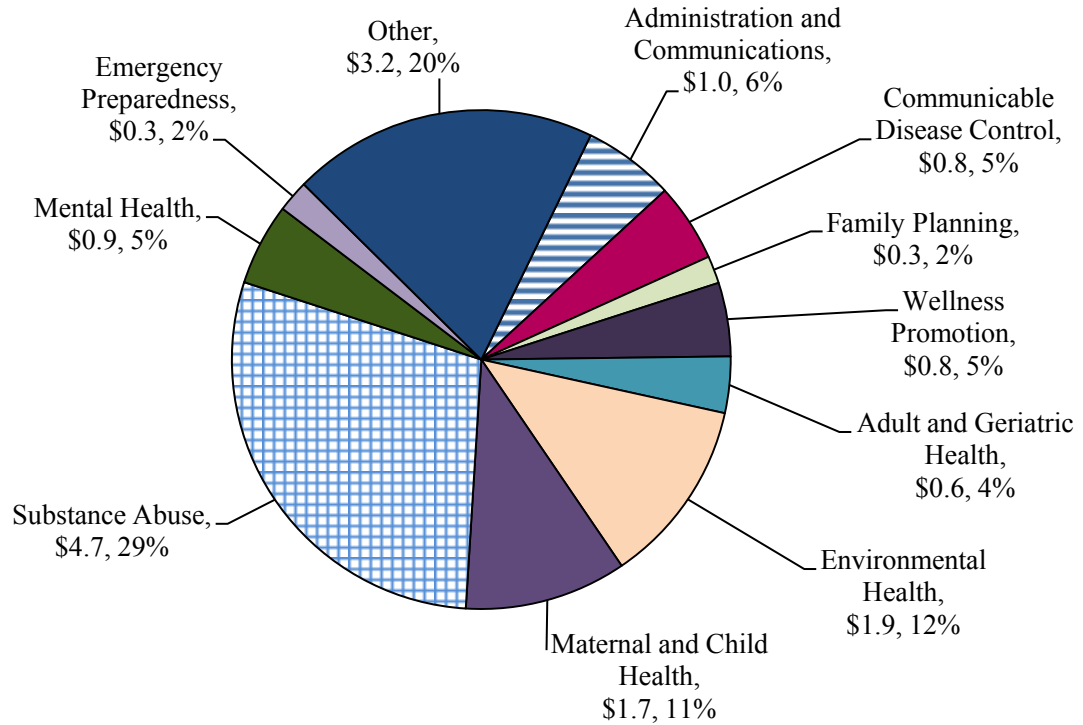


CRF: Cigarette Restitution Fund

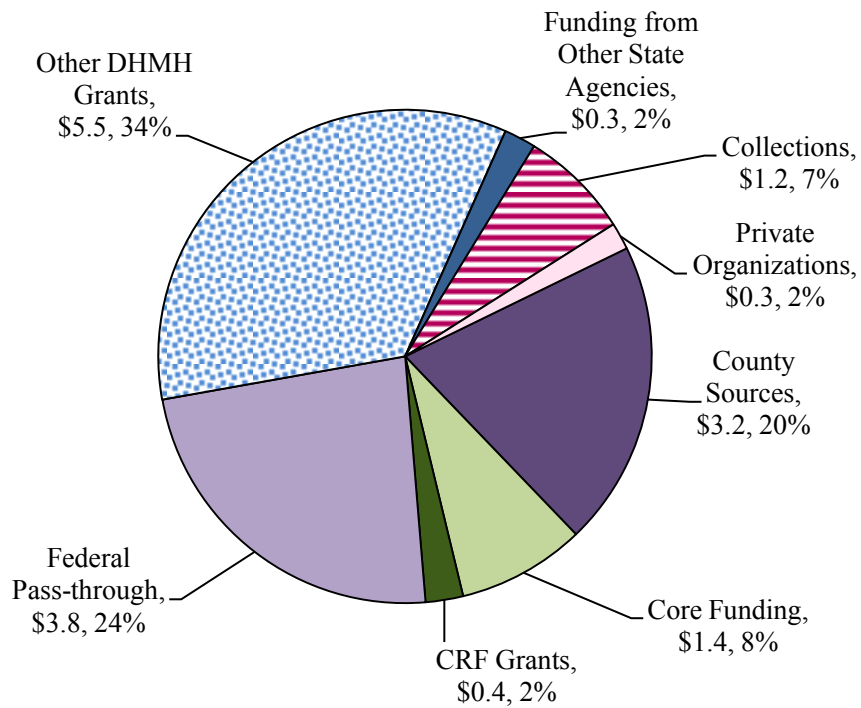
DHMH: Department of Health and Mental Hygiene

Carroll County

Expenditures (\$16.0)



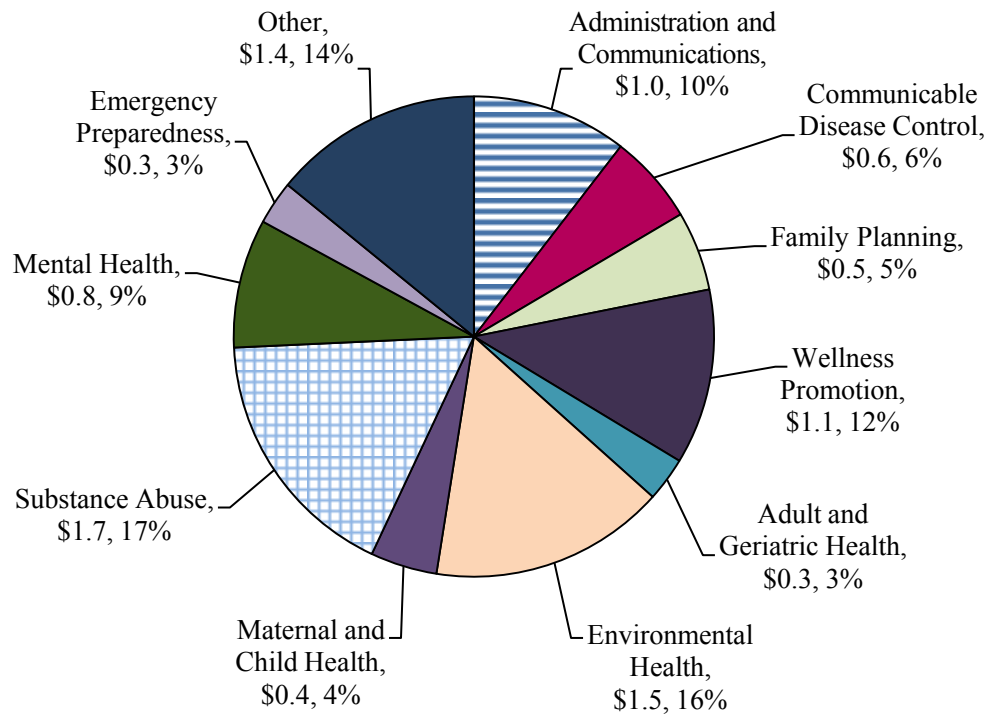
Revenues (\$16.0)



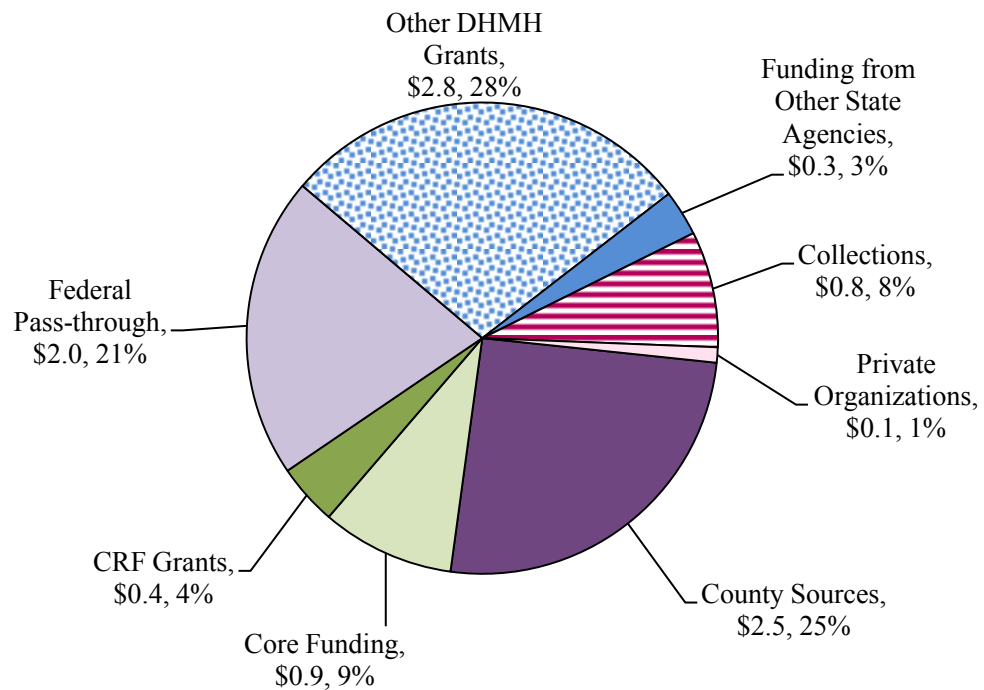
CRF: Cigarette Restitution Fund
DHMH: Department of Health and Mental Hygiene

Cecil County

Expenditures (\$9.7)



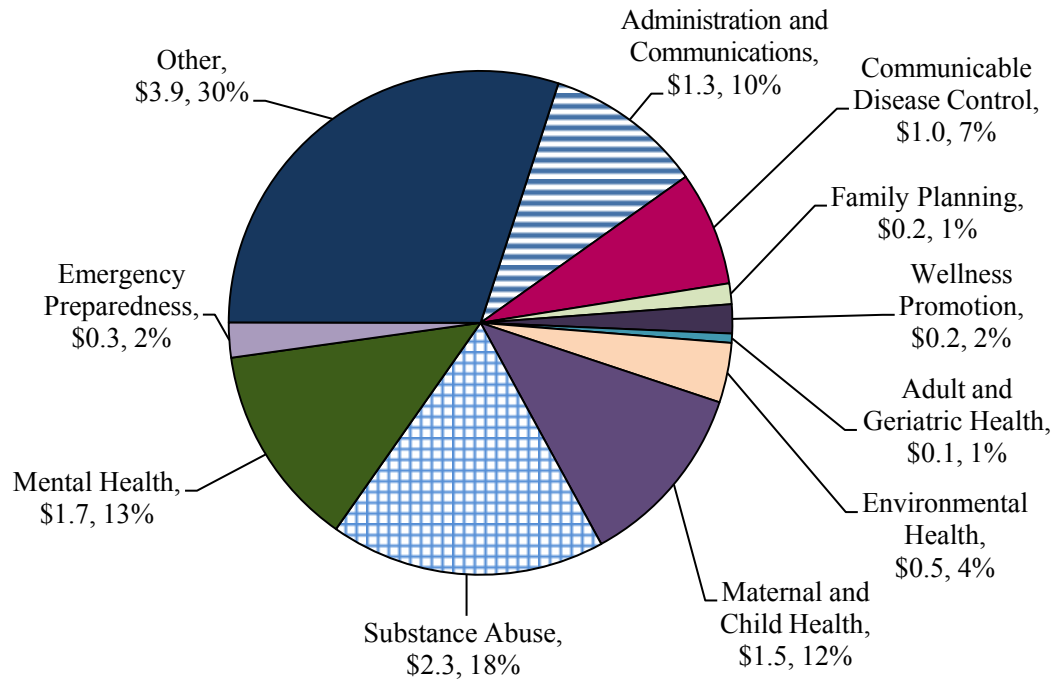
Revenues (\$9.7)



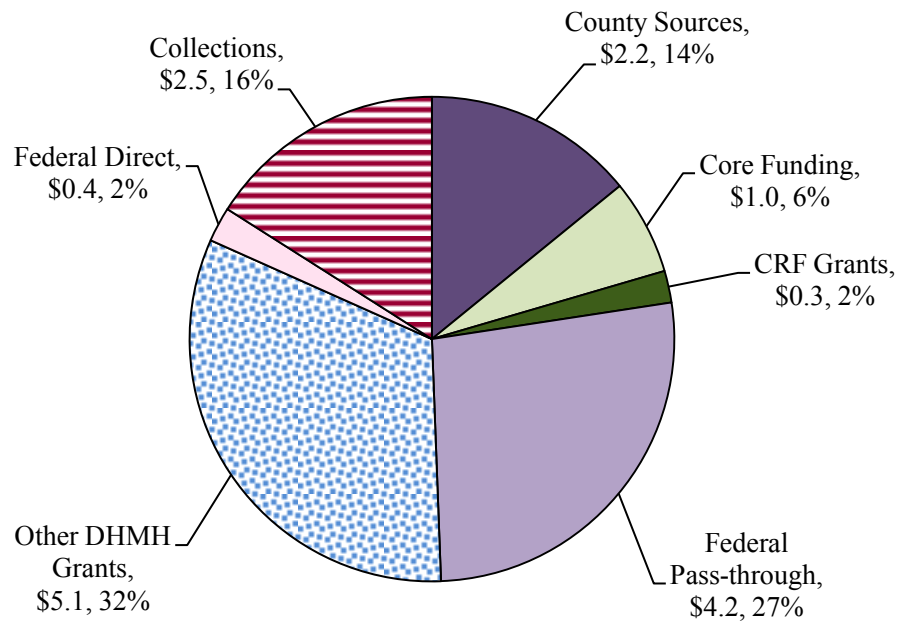
CRF: Cigarette Restitution Fund
 DHMH: Department of Health and Mental Hygiene

Charles County

Expenditures (\$13.0)



Revenues (\$15.7)

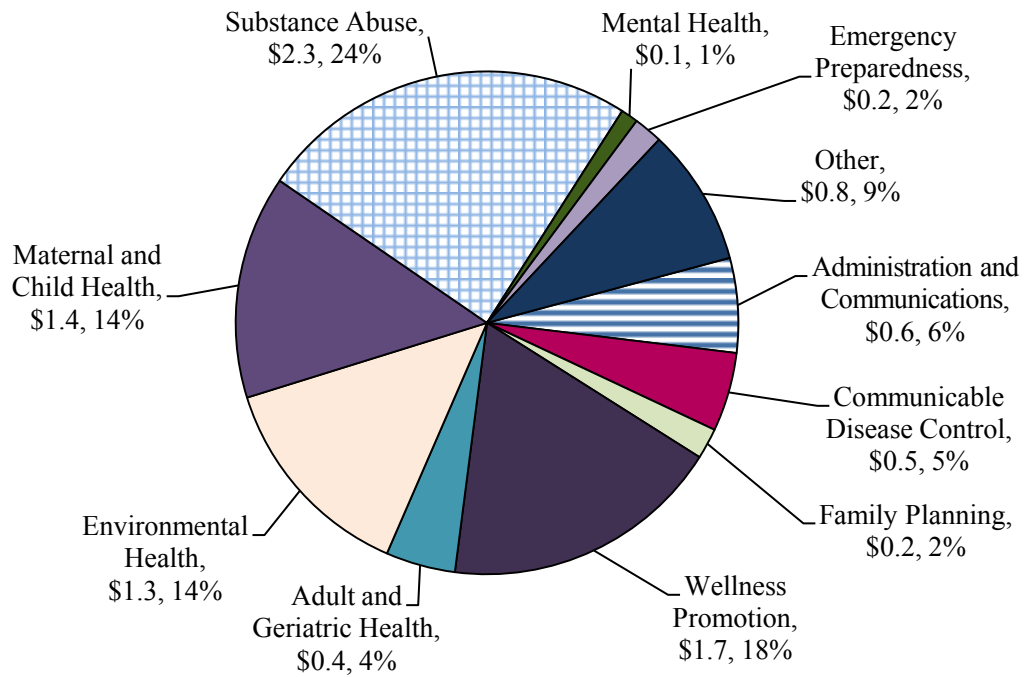


CRF: Cigarette Restitution Fund

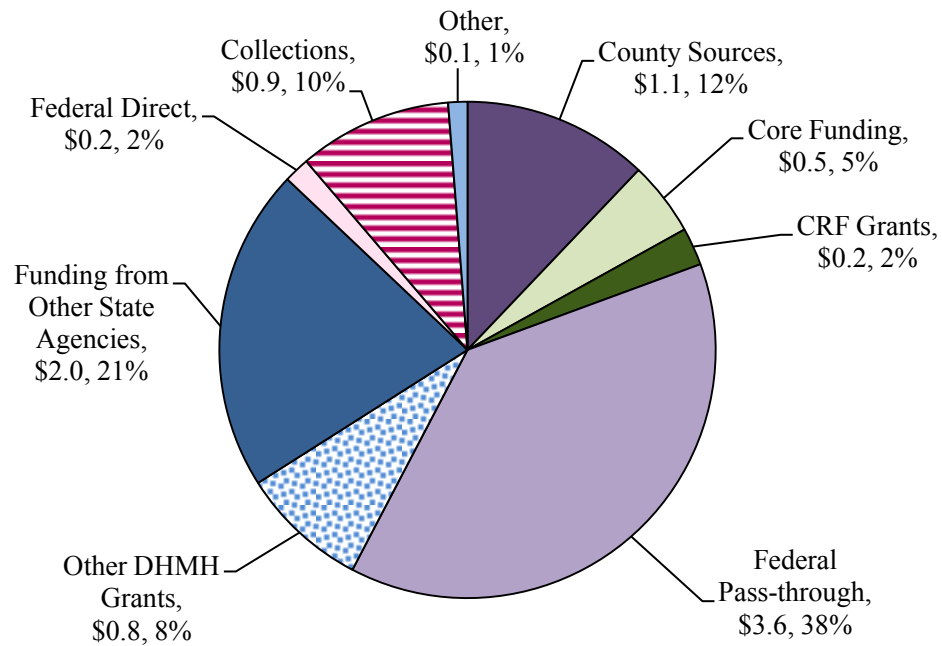
DHMH: Department of Health and Mental Hygiene

Dorchester County

Expenditures (\$9.4)



Revenues (\$9.5)

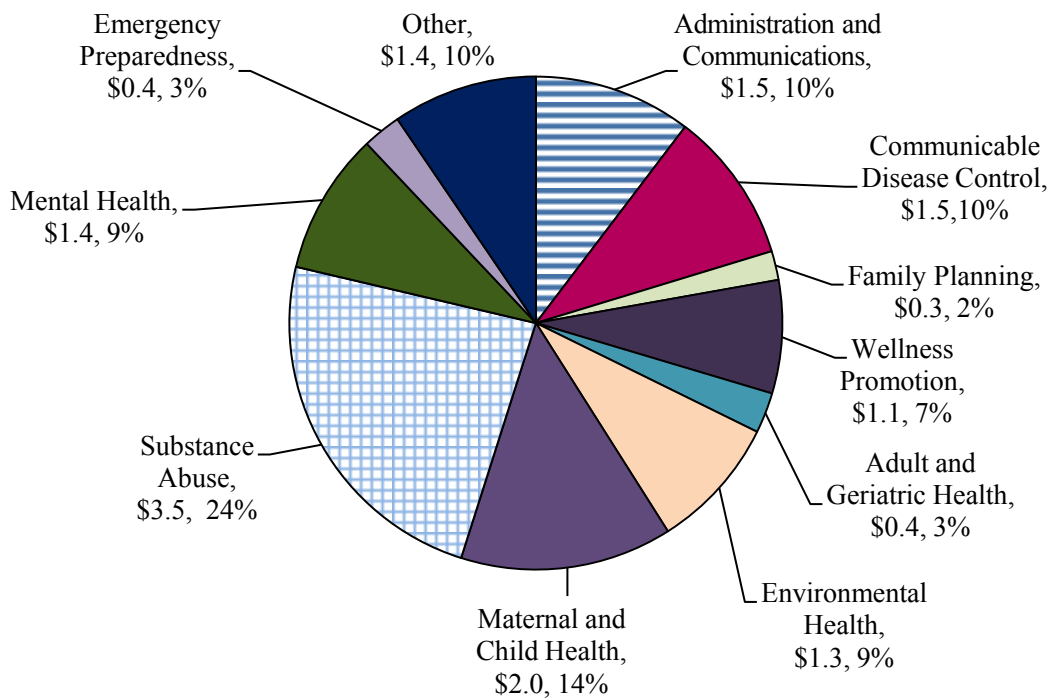


CRF: Cigarette Restitution Fund

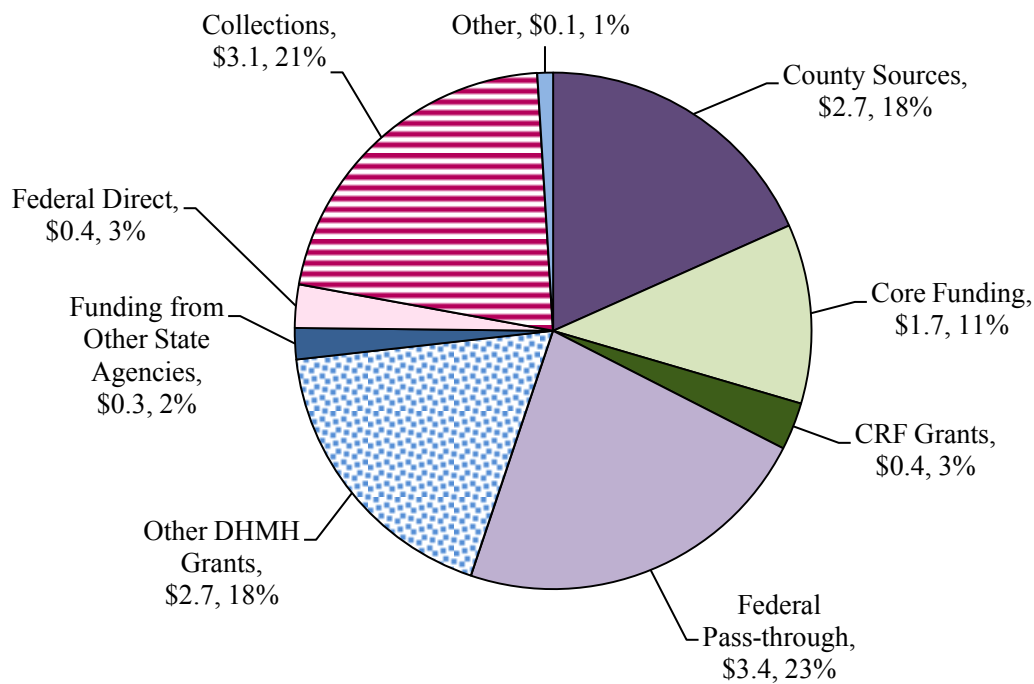
DHMH: Department of Health and Mental Hygiene

Frederick County

Expenditures (\$14.7)



Revenues (\$14.9)

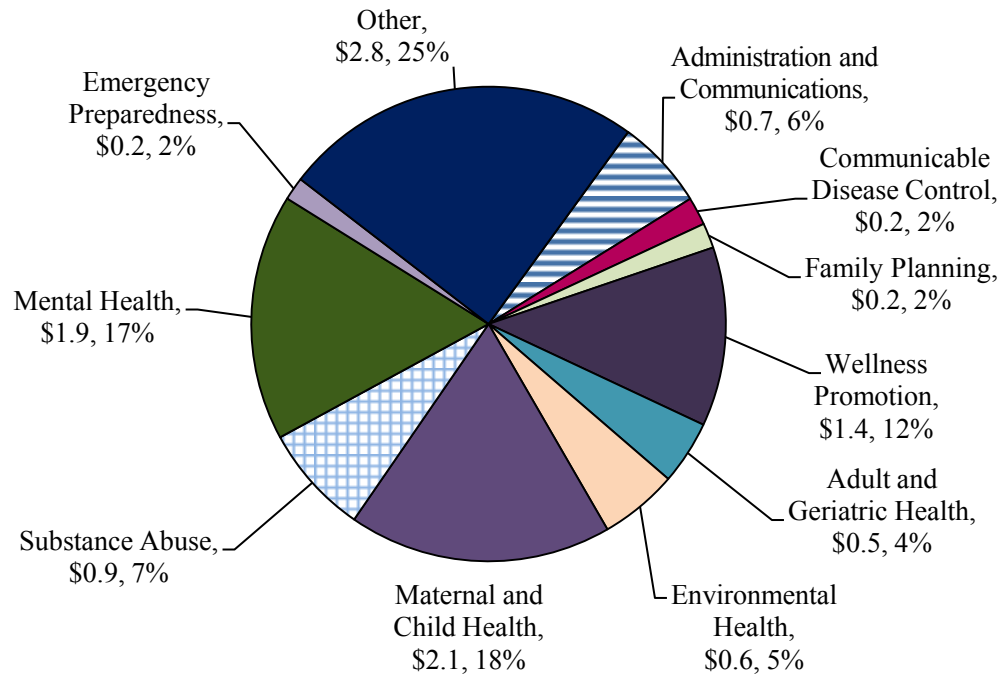


CRF: Cigarette Restitution Fund

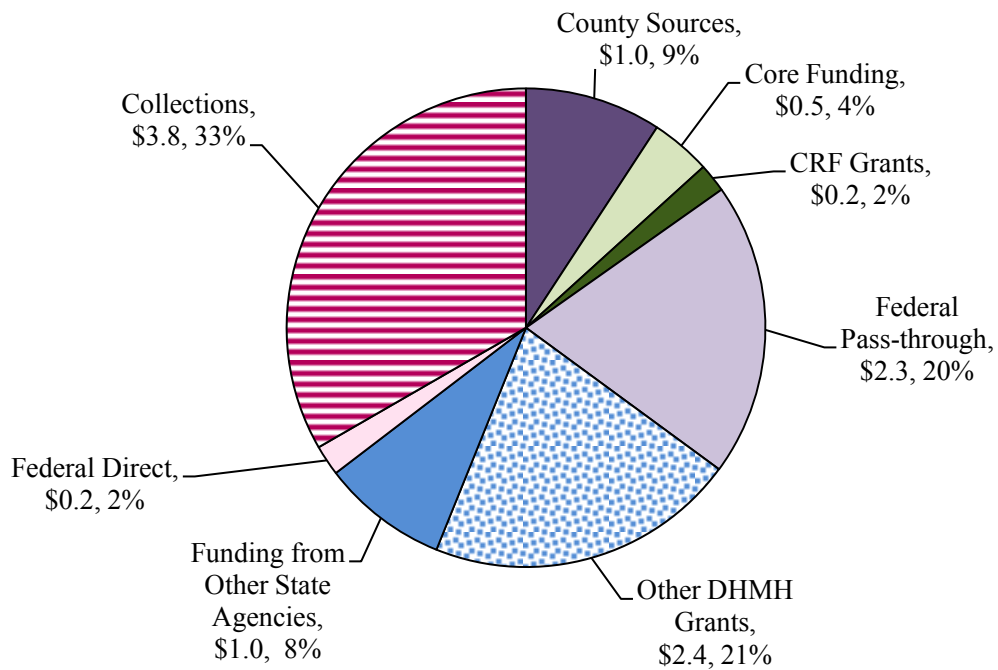
DHMH: Department of Health and Mental Hygiene

Garrett County

Expenditures (\$11.5)



Revenues (\$11.4)

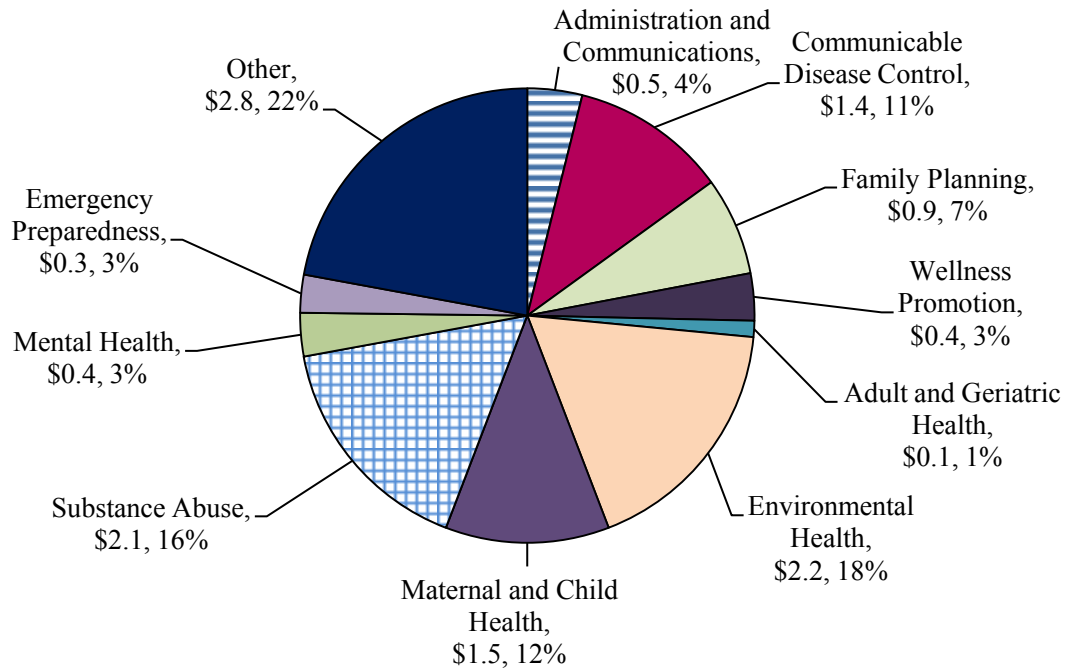


CRF: Cigarette Restitution Fund

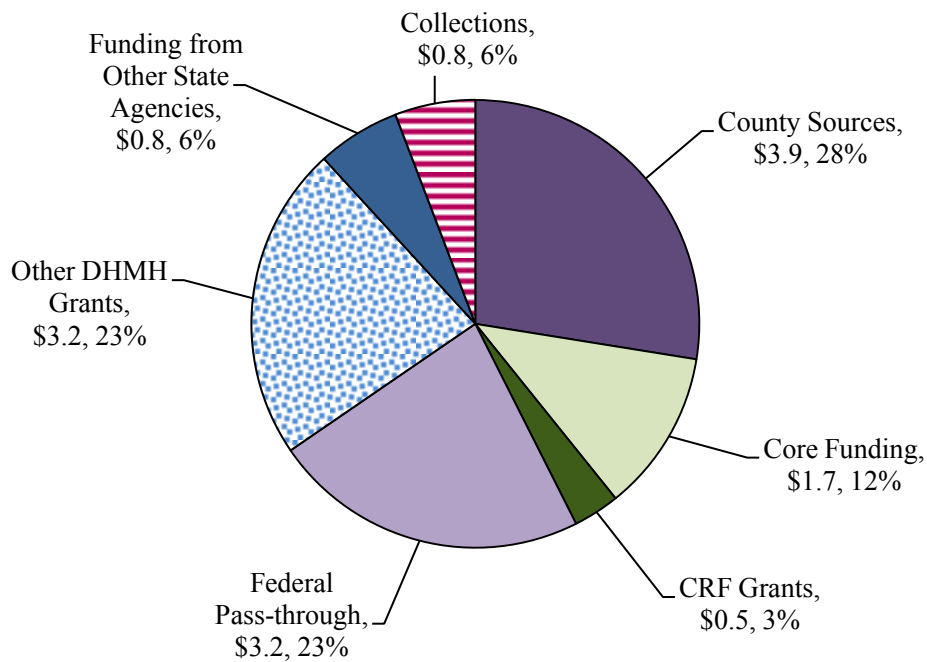
DHMH: Department of Health and Mental Hygiene

Harford County

Expenditures (\$12.7)



Revenues (\$14.1)

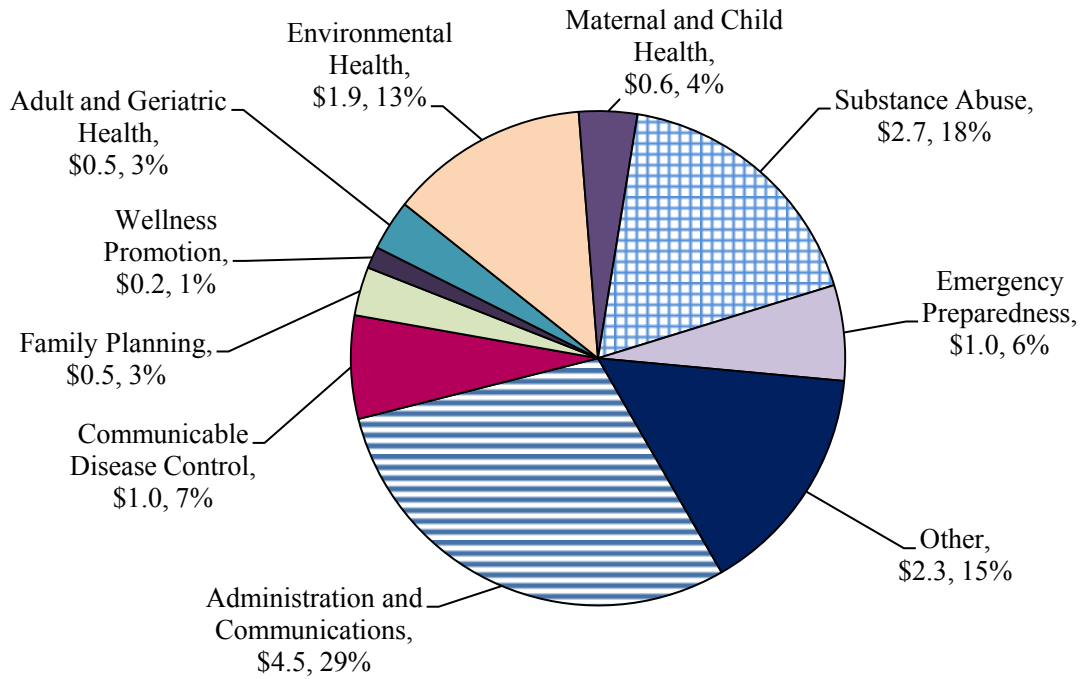


CRF: Cigarette Restitution Fund

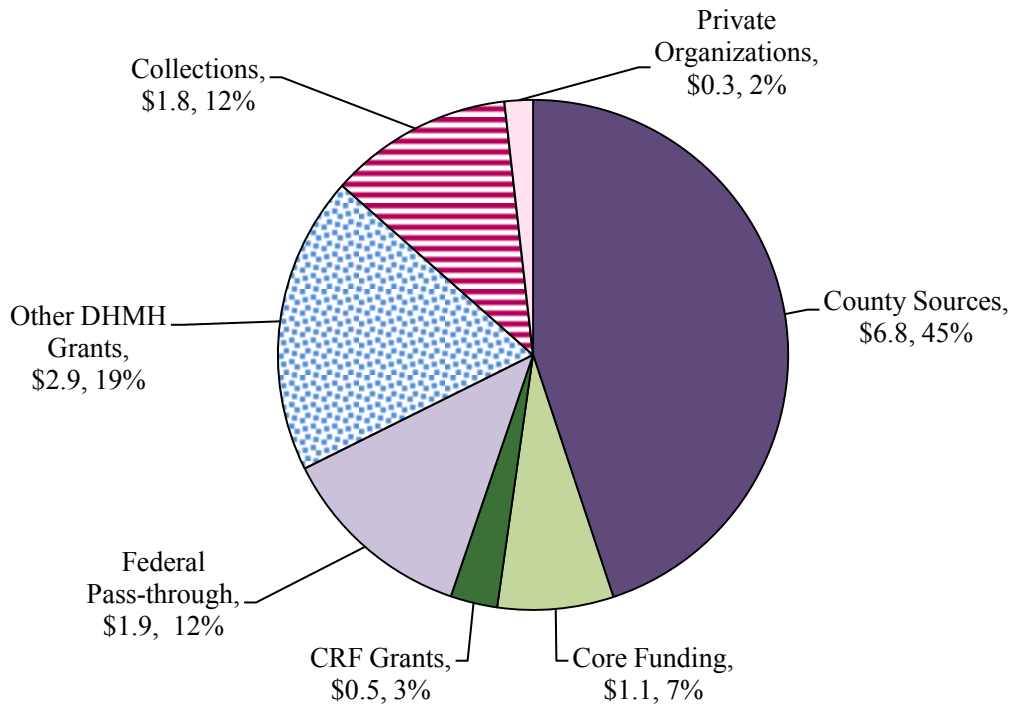
DHMH: Department of Health and Mental Hygiene

Howard County

Expenditures (\$15.3)



Revenues (\$15.3)

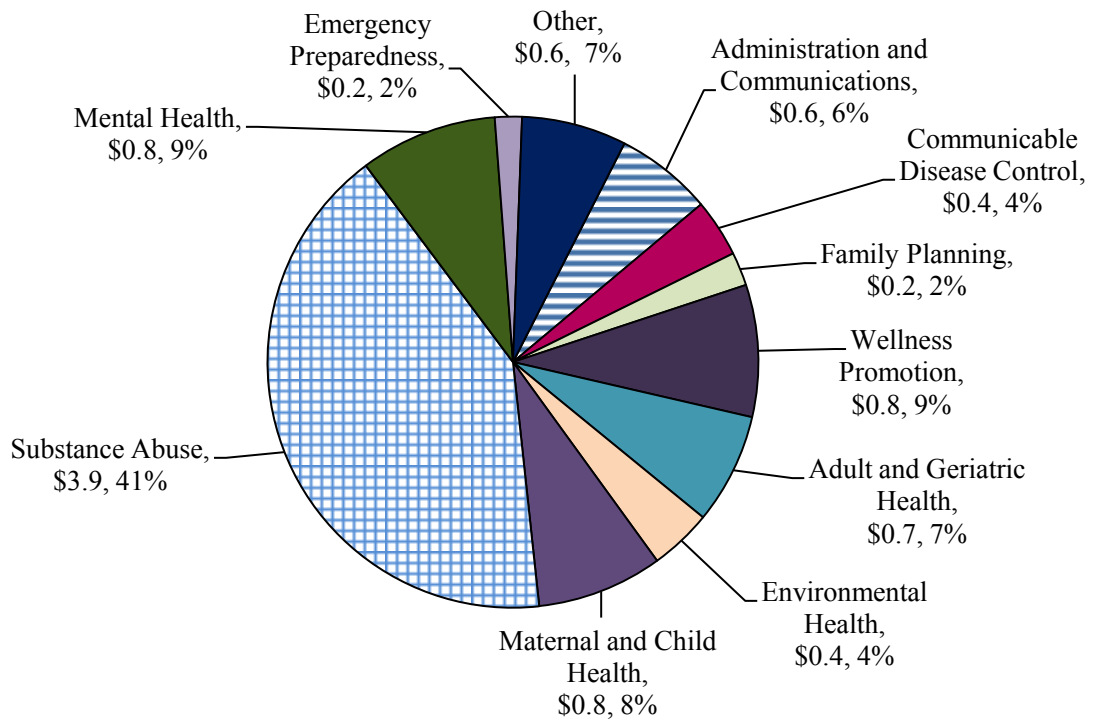


CRF: Cigarette Restitution Fund

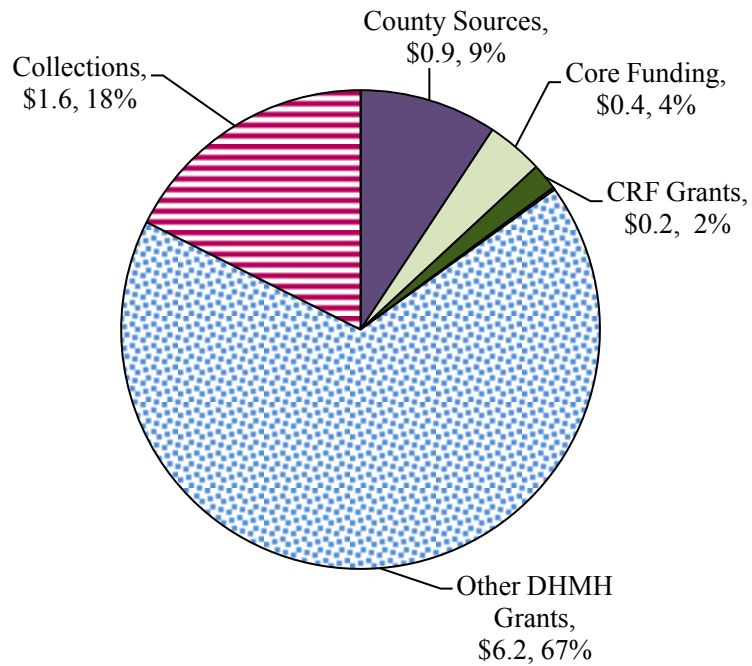
DHMH: Department of Health and Mental Hygiene

Kent County

Expenditures (\$9.4)



Revenues (\$9.2)

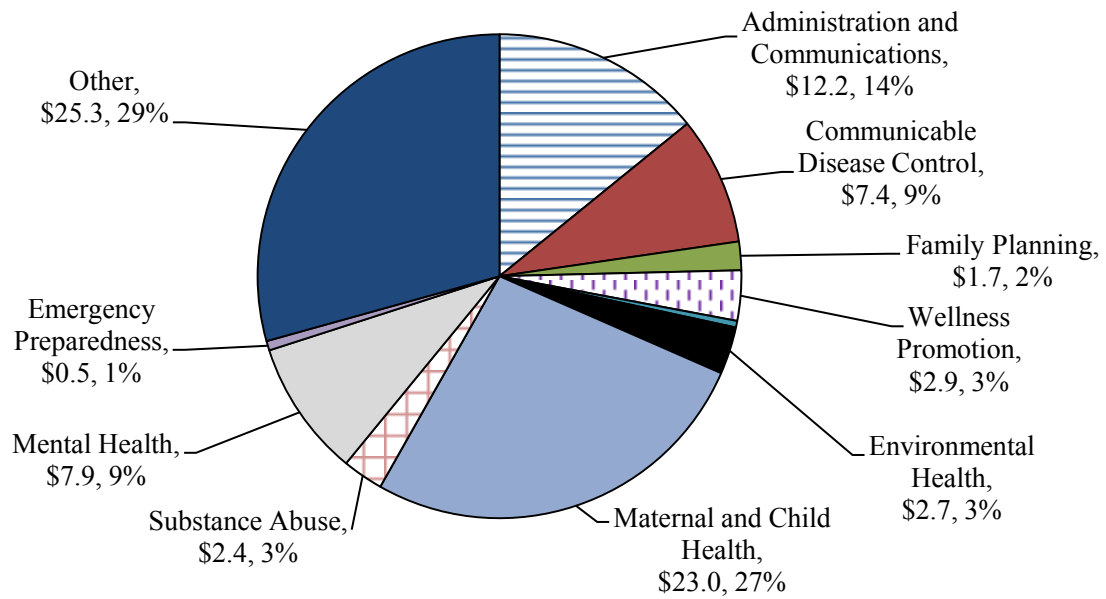


CRF: Cigarette Restitution Fund

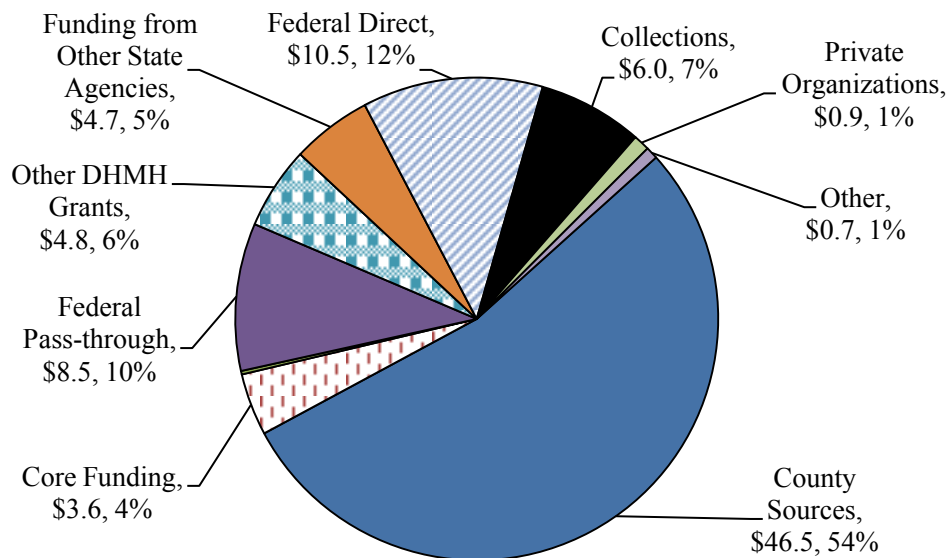
DHMH: Department of Health and Mental Hygiene

Montgomery County

Expenditures (\$86.4)



Revenues (\$86.4)

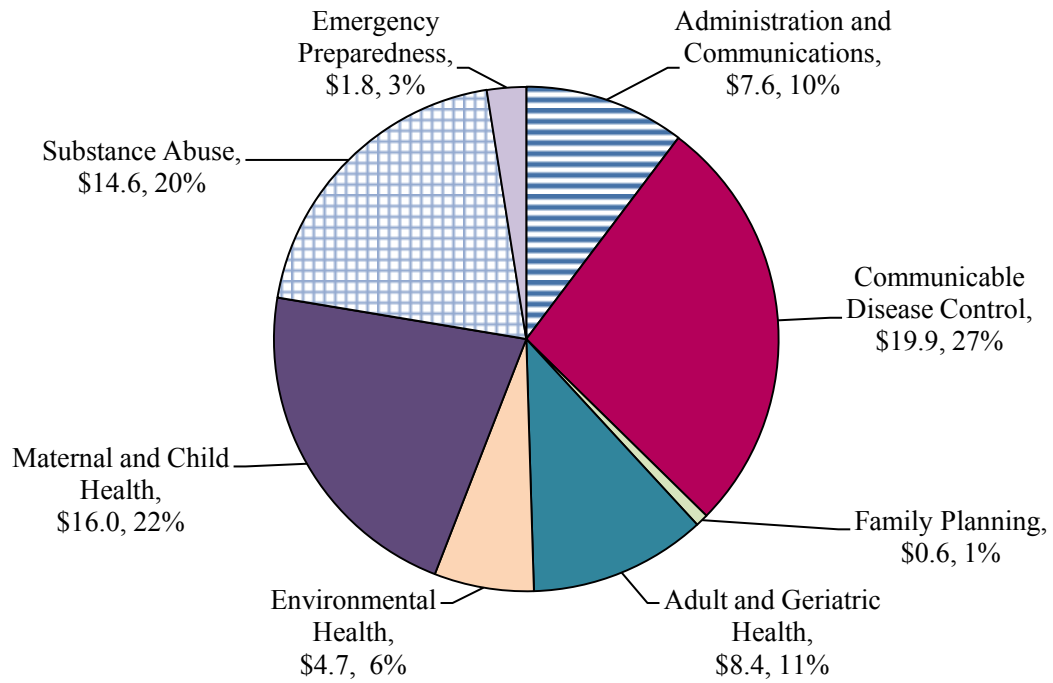


CRF: Cigarette Restitution Fund

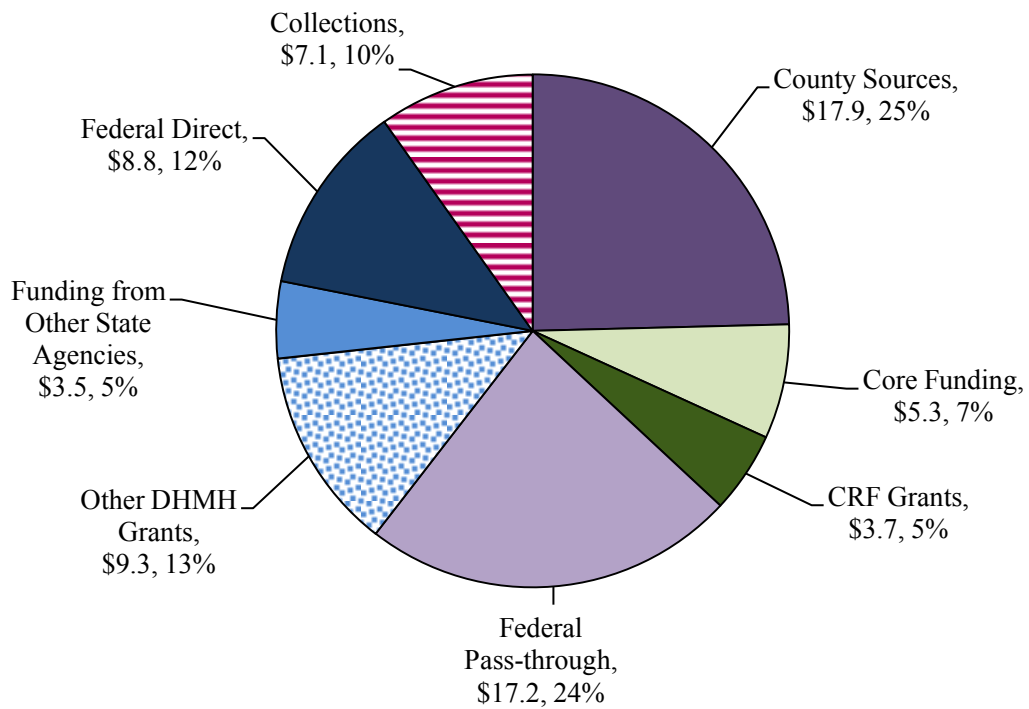
DHMH: Department of Health and Mental Hygiene

Prince George's County

Expenditures (\$73.7)



Revenues (\$72.9)

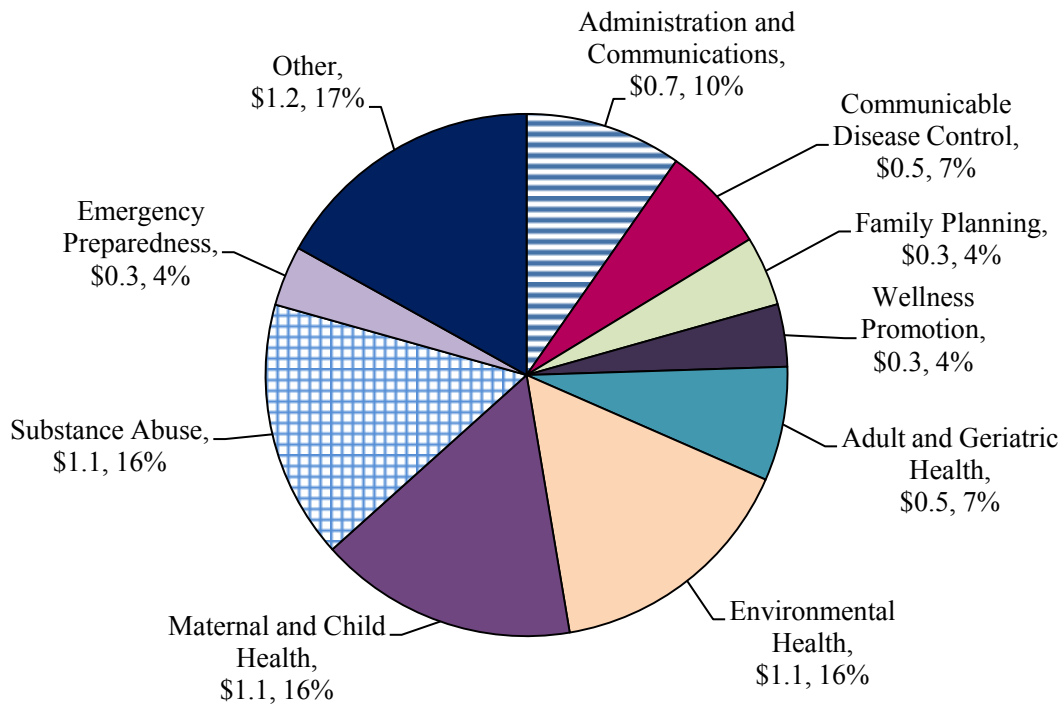


CRF: Cigarette Restitution Fund

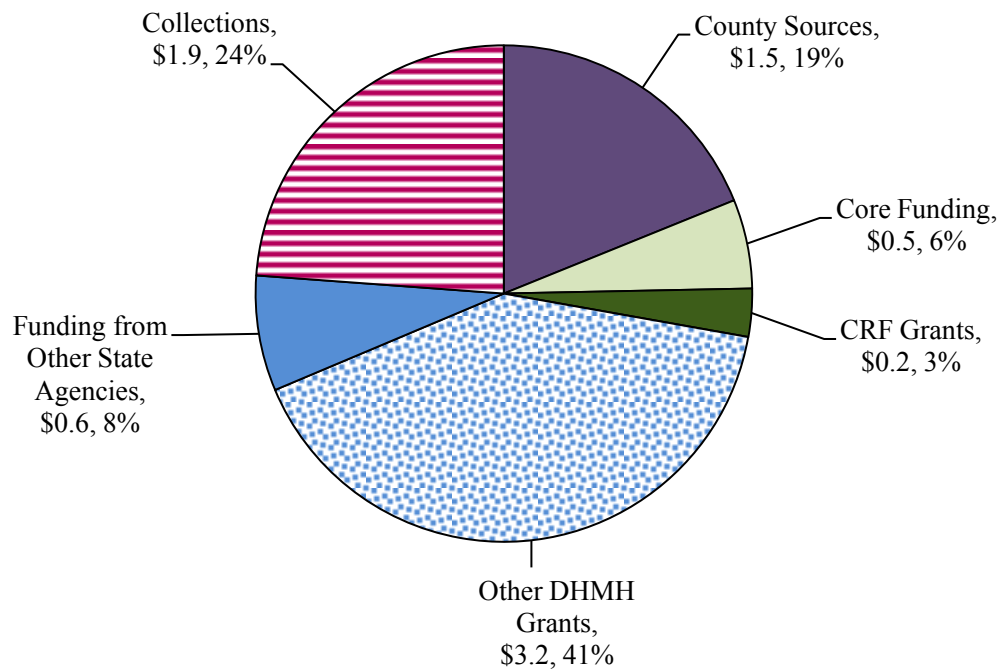
DHMH: Department of Health and Mental Hygiene

Queen Anne's County

Expenditures (\$7.2)



Revenues (\$7.8)

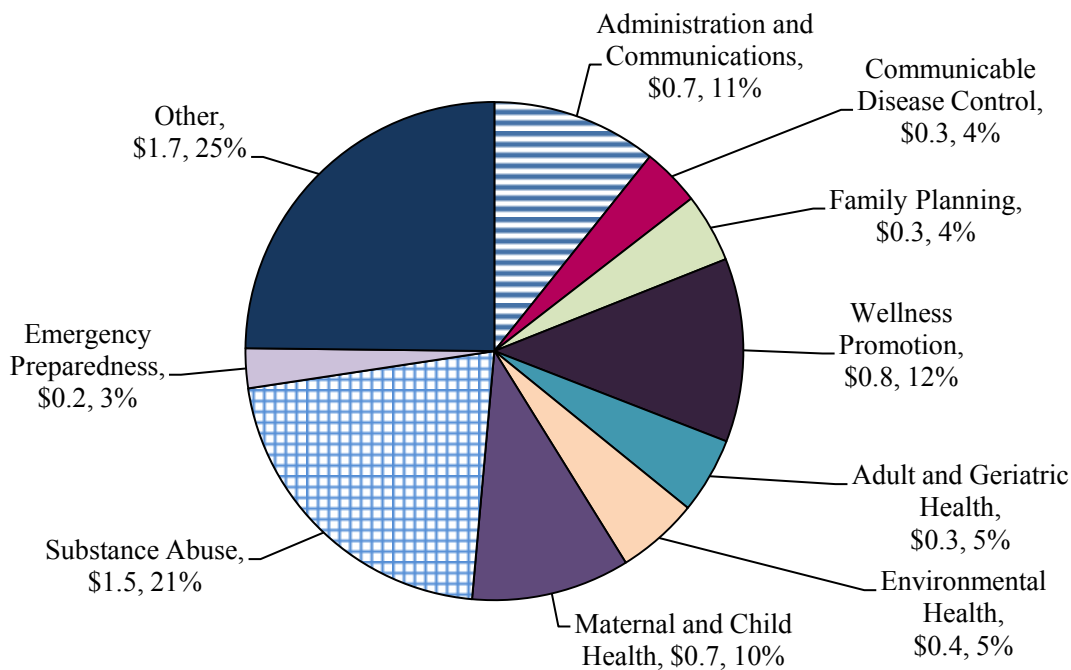


CRF: Cigarette Restitution Fund

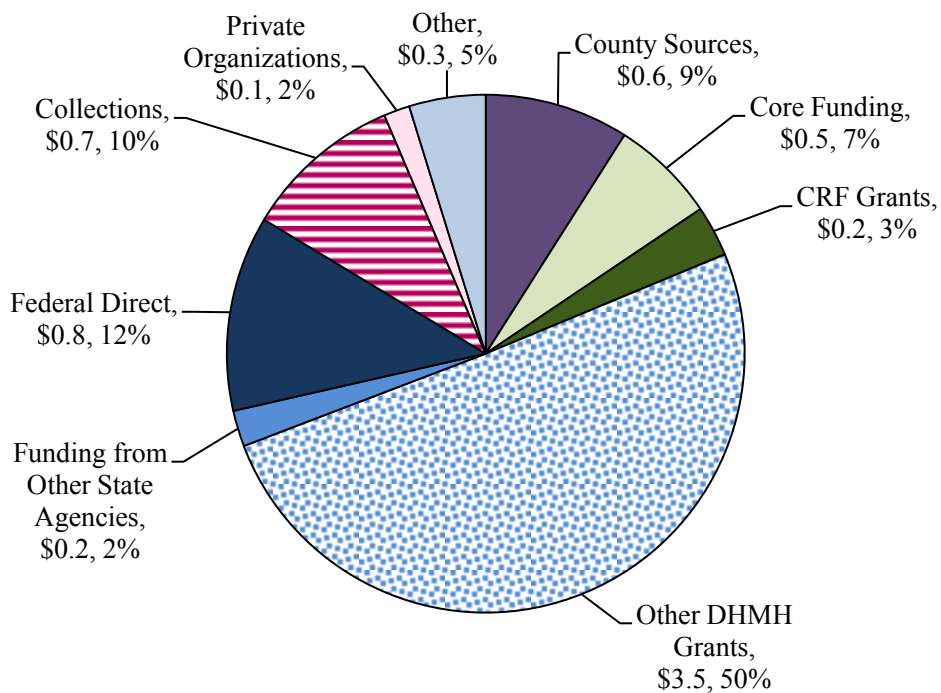
DHMH: Department of Health and Mental Hygiene

Somerset County

Expenditures (\$6.9)



Revenues (\$6.9)

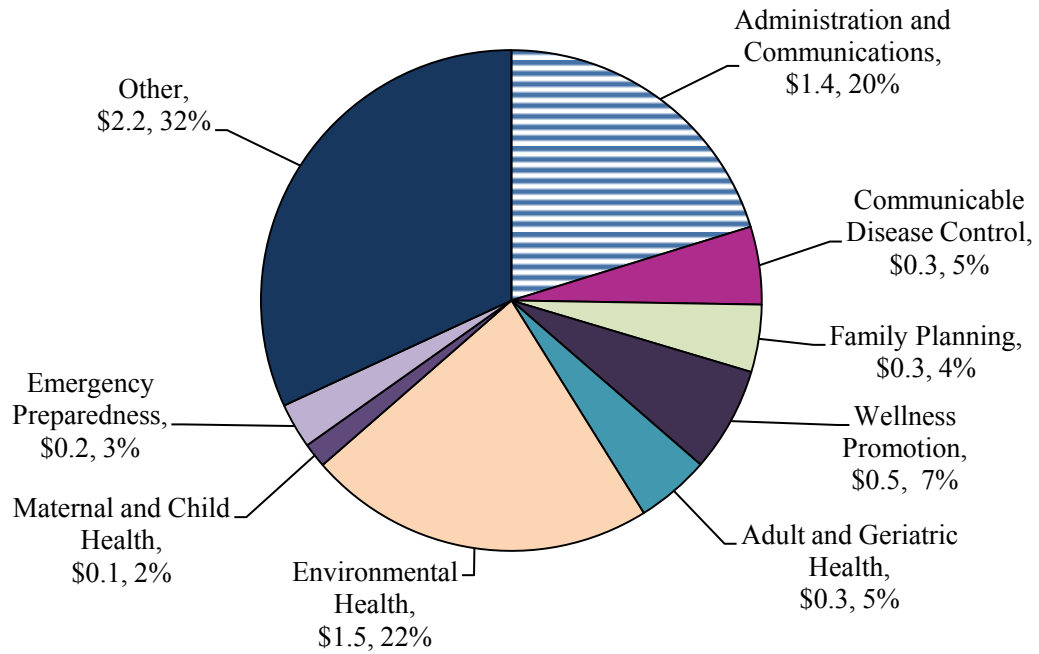


CRF: Cigarette Restitution Fund

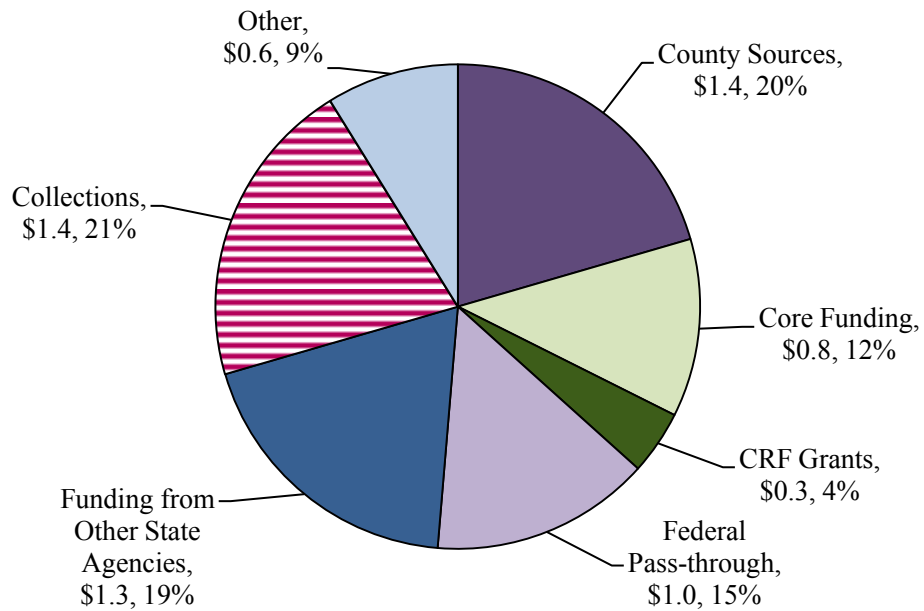
DHMH: Department of Health and Mental Hygiene

St. Mary's County

Expenditures (\$6.8)



Revenues (\$6.8)

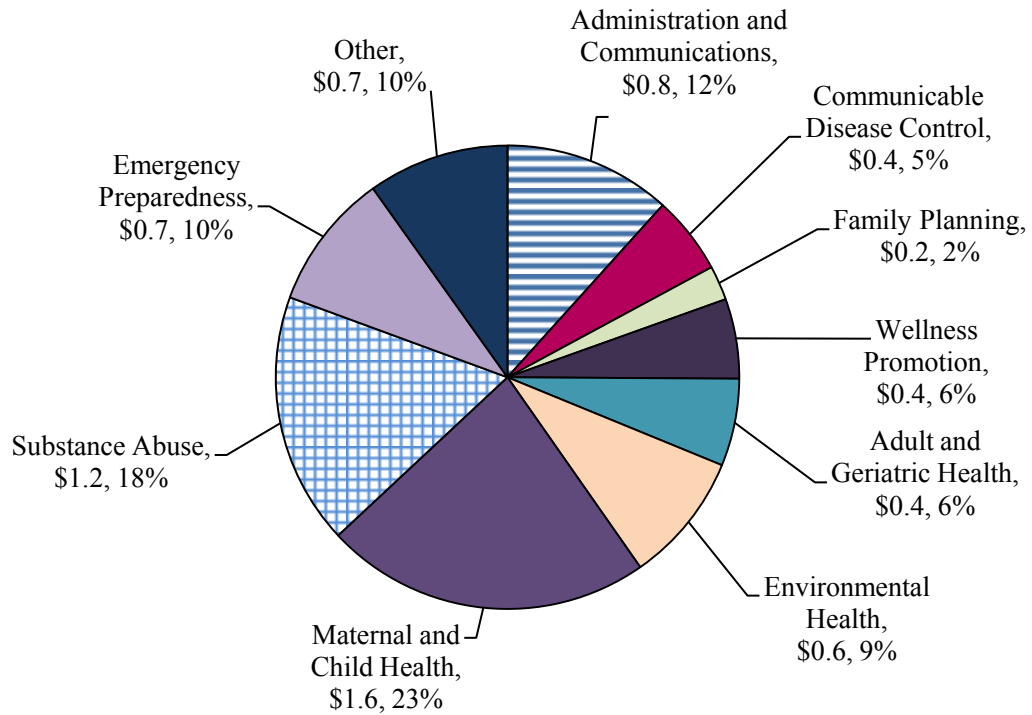


CRF: Cigarette Restitution Fund

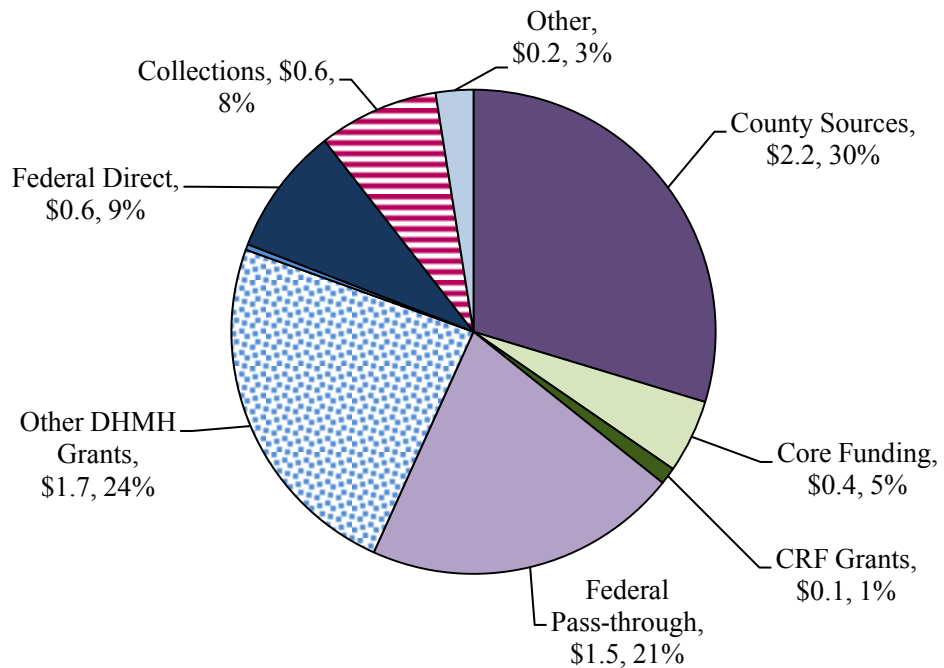
DHMH: Department of Health and Mental Hygiene

Talbot County

Expenditures (\$7.1)



Revenues (\$7.3)

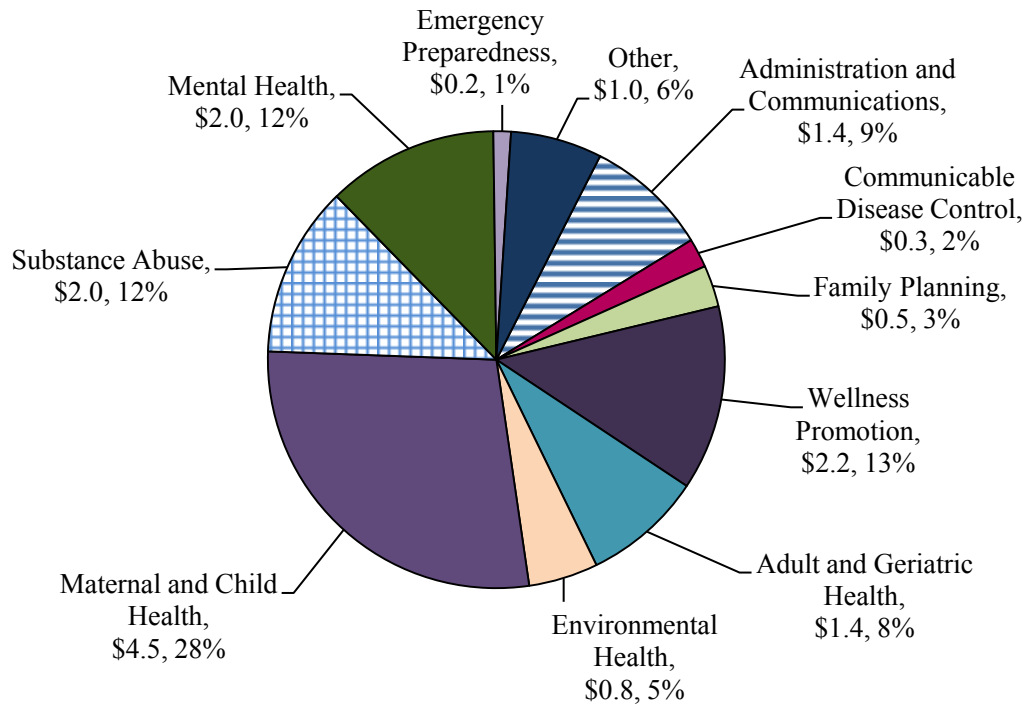


CRF: Cigarette Restitution Fund

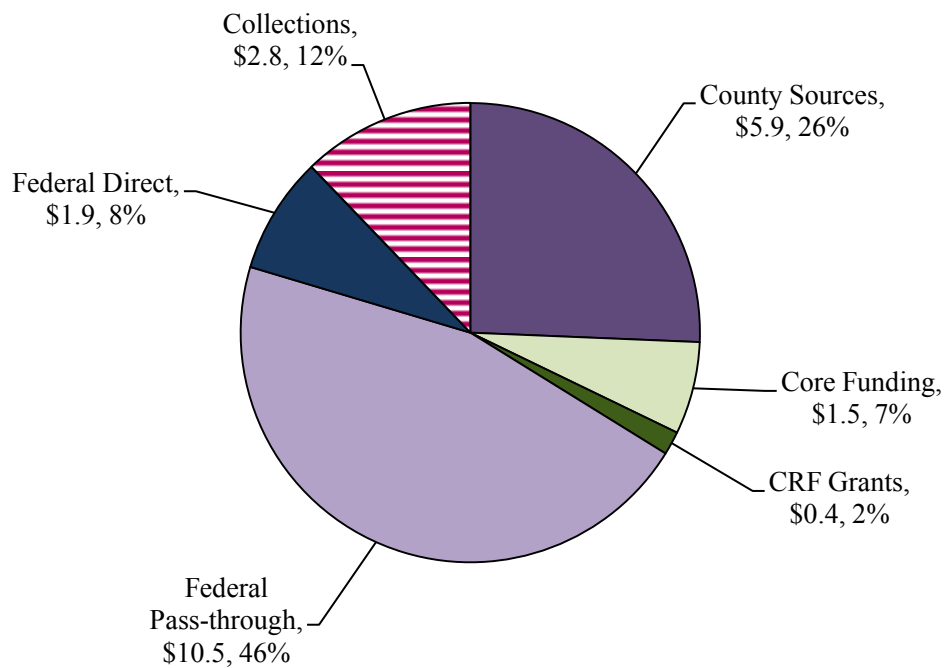
DHMH: Department of Health and Mental Hygiene

Washington County

Expenditures (\$16.2)



Revenues (\$22.9)

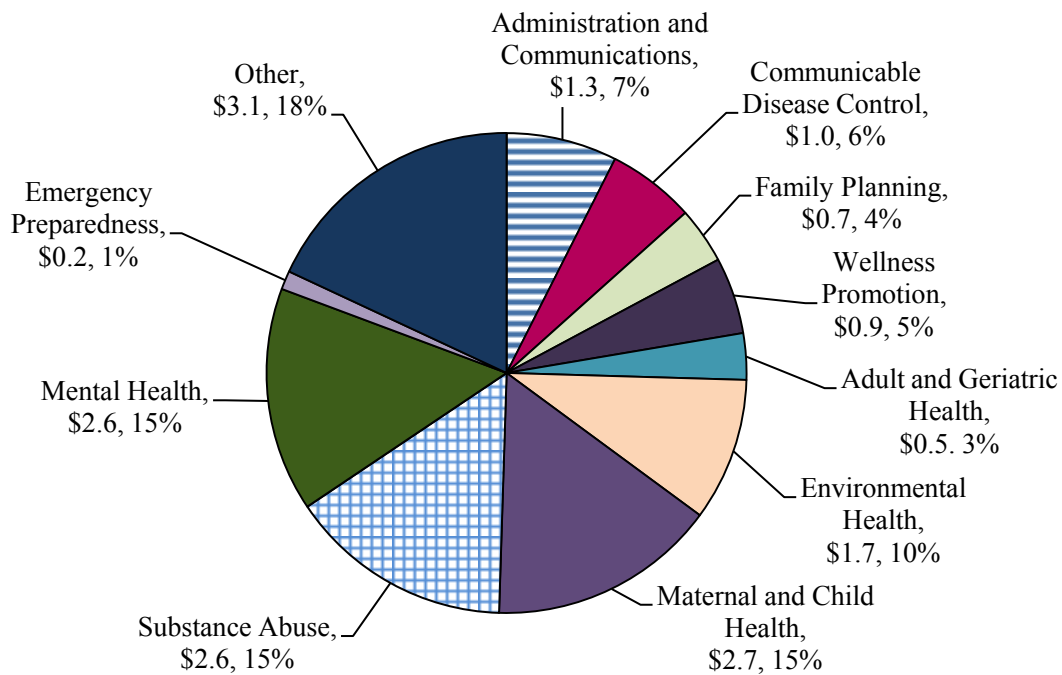


CRF: Cigarette Restitution Fund

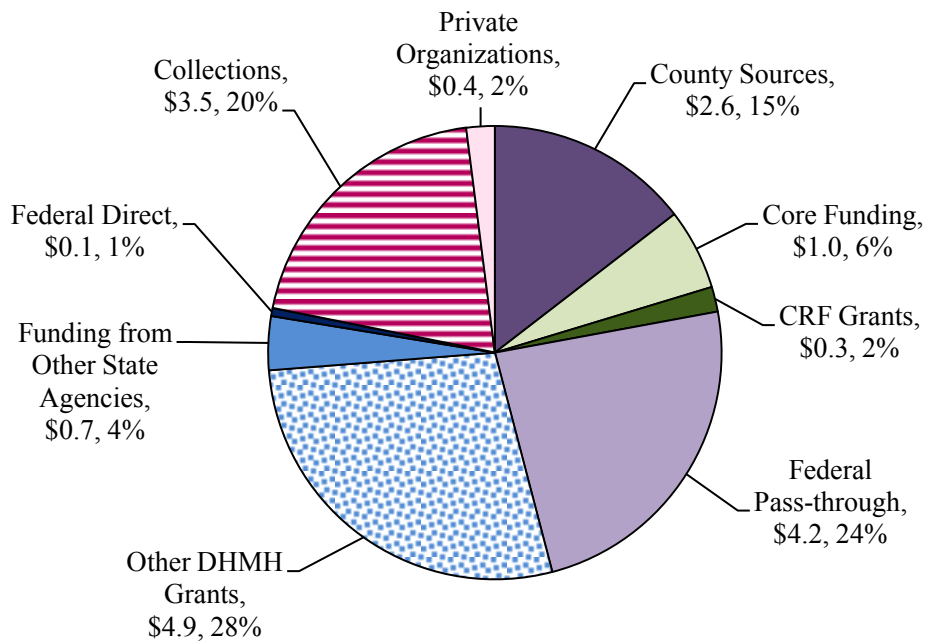
DHMH: Department of Health and Mental Hygiene

Wicomico County

Expenditures (\$17.4)



Revenues (\$17.7)

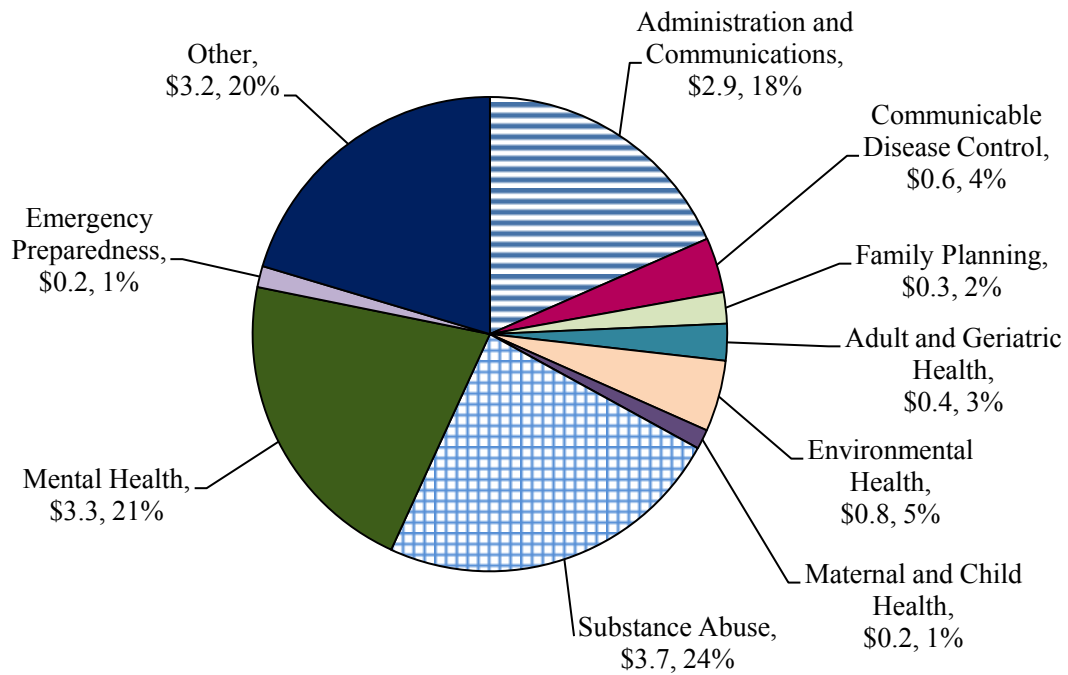


CRF: Cigarette Restitution Fund

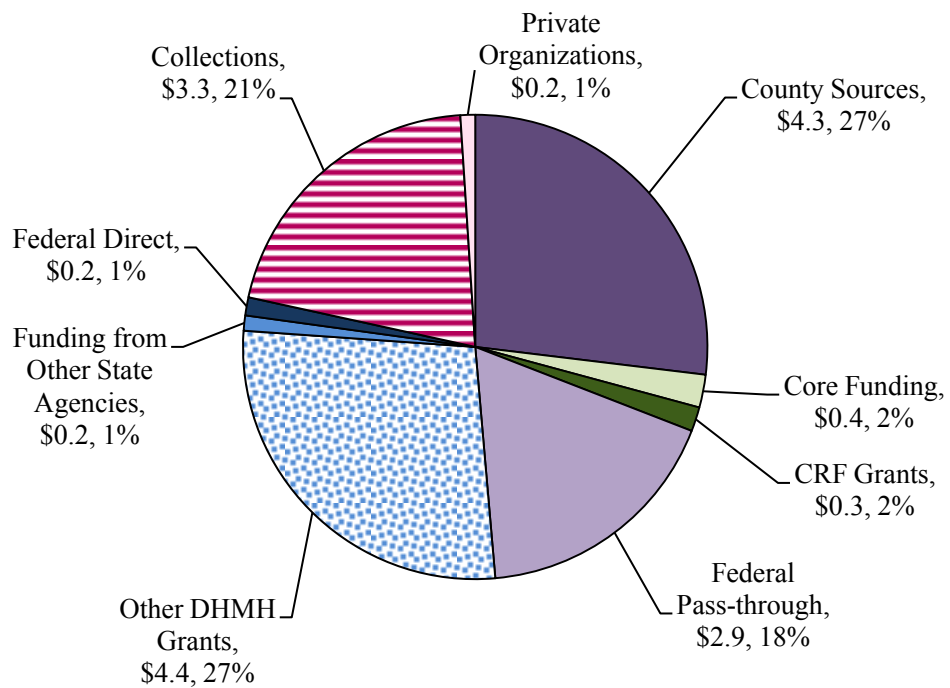
DHMH: Department of Health and Mental Hygiene

Worcester County

Expenditures (\$15.6)



Revenues (\$16.1)



CRF: Cigarette Restitution Fund

DHMH: Department of Health and Mental Hygiene

Appendix 4

Maryland's State Health Improvement Process

<u>SHIP Measurement</u>	<u>Current Maryland Baseline</u>	<u>Maryland 2014 Target</u>
1. Increase life expectancy*	78.6 years	82.5 years
Vision Area 1: Healthy Babies		
2. Reduce infant deaths*	7.2 infant deaths per 1,000 live births	6.6 infant deaths per 1,000 live births
3. Reduce low birth weight and very low birth weight*	9.2% of live births were low birth weight; 1.8% were very low birth weight	8.5% of live births are low birth weight; 1.8% of live births are very low birth weight
4. Reduce sudden unexpected infant deaths*	0.95 sudden unexpected infant deaths per 1,000 live births	0.89 sudden unexpected infant deaths per 1,000 live births
5. Increase the proportion of pregnancies that are intended*	55.0% of pregnancies were intended	58.0% of pregnancies are intended
6. Increase the proportion of pregnant women starting prenatal care in the first trimester*	80.2% received prenatal care beginning in the first trimester	84.2% will receive prenatal care beginning in the first trimester
Vision Area 2: Healthy Social Environments		
7. Reduce child maltreatment	5.0 victims of nonfatal child maltreatment per 1,000 children	4.8 victims of nonfatal child maltreatment per 1,000 children
8. Reduce the suicide rate*	9.6 suicides per 100,000 population	9.1 suicides per 100,000 population
9. Decrease the rate of alcohol-impaired driving fatalities	0.28 driving fatalities per 100,000 vehicle miles traveled	0.27 driving fatalities per 100,000 vehicle miles traveled
10. Increase the proportion of students who enter kindergarten ready to learn*	81.0% of students entered kindergarten fully ready to learn	85.0% of students enter kindergarten fully ready to learn
11. Increase proportion of students who graduate from high school*	80.7% students graduate from high school in four years after entering grade 9	84.7% students graduate high school in four years after entering grade 9

<u>SHIP Measurement</u>	<u>Current Maryland Baseline</u>	<u>Maryland 2014 Target</u>
12. Reduce domestic violence*	69.6 emergency department visits for domestic violence per 100,000 population	66.0 emergency department visits for domestic violence per 100,000 population
Vision Area 3: Safe Physical Environments		
13. Reduce blood lead levels in children	79.1 per 100,000 population	39.6 per 100,000 population
14. Decrease fall-related deaths	7.3 fall-related deaths per 100,000 population	6.9 fall-related deaths per 100,000 population
15. Reduce pedestrian injuries on public roads	39.0 pedestrian injuries per 100,000 population	29.7 pedestrian injuries per 100,000 population
16. Reduce salmonella infections transmitted through food	14.1 salmonella infections per 100,000 population	12.7 salmonella infections per 100,000 population
17. Reduce hospital emergency department visits from asthma*	85.0 emergency department visits for asthma per 100,000 population	67.1 emergency department visits for asthma per 100,000 population
18. Increase access to healthy food	5.8% of census tracts in MD are considered food deserts	5.5% of census tracts in MD are considered food deserts
19. Reduce the number of days the Air Quality Index exceeds 100	17 days was the maximum number of days in the State that the air quality index exceeded 100	13 days is the maximum number of days in the State that the air quality index exceeds 100
Vision Area 4: Infectious Disease		
20. Reduce HIV infections among adults and adolescents*	32.0 newly diagnosed HIV cases per 100,000 population	30.4 newly diagnosed HIV cases per 100,000 population
21. Reduce Chlamydia trachomatis infections among young people*	2,131 Chlamydia cases per 100,000 15-24 year olds	2,205 Chlamydia cases per 100,000 15-24 year olds
22. Increase treatment completion rate among tuberculosis patients*	88.1% of patients complete treatment within 12 months	90.6% of patients will complete treatment within 12 months

<u>SHIP Measurement</u>	<u>Current Maryland Baseline</u>	<u>Maryland 2014 Target</u>
23. Increase vaccination coverage for recommended vaccines among young children*	78% of children age 19-35 months received recommended vaccine doses	80% of children age 19-35 months will receive recommended vaccine doses
24. Increase the percentage of people vaccinated annually against seasonal influenza*	45.9% of adults received a flu shot last year	65.6% of adults will receive a flu shot
Vision Area 5: Chronic Disease		
25. Reduce deaths from heart disease*	194.0 heart disease deaths per 100,000 population	173.3 heart disease deaths per 100,000 population
26. Reduce the overall cancer death rate*	177.7 cancer deaths per 100,000 population	169.2 cancer deaths per 100,000 population
27. Reduce diabetes-related emergency department visits*	347.2 emergency department visits for diabetes per 100,000 population	330.0 emergency department visits for diabetes per 100,000 population
28. Reduce hypertension-related emergency department visits*	237.9 emergency department visits for hypertension per 100,000 population	225.0 emergency department visits for hypertension per 100,000 population
29. Reduce drug-induced deaths*	13.4 drug-induced deaths per 100,000 population	12.4 drug-induced deaths per 100,000 population
30. Increase proportion of adults who are at a healthy weight*	34.0% of Maryland adults are at a healthy weight	35.7% of Maryland adults will be at a healthy weight
31. Reduce the proportion of children and adolescents who are considered obese*	11.9% of children ages 12-19 are considered obese	11.3% of children ages 12-19 will be considered obese
32. Reduce cigarette smoking among adults*	15.2% of adults reported currently smoking cigarettes	14.6% of adults report that they are currently smoking cigarettes
33. Reduce tobacco use among adolescents*	24.8% of adolescents used tobacco in the last 30 days	22.3% of adolescents will use tobacco in the last 30 days
34. Reduce the number of emergency department visits related to behavioral health conditions*	1,206.3 emergency department visits for behavioral health conditions per 100,000 population	1,146.0 emergency department visits for behavioral health conditions per 100,000 population

<u>SHIP Measurement</u>	<u>Current Maryland Baseline</u>	<u>Maryland 2014 Target</u>
35. Reduce the proportion of hospitalizations related to Alzheimer's disease and other dementias*	17.3 hospitalizations for Alzheimer's disease and other dementias per 100,000 population	16.4 hospitalizations for Alzheimer's disease and other dementias per 100,000 population
Vision Area 6: Health Care Access		
36. Increase the proportion of persons with health insurance*	81.7% of nonelderly had health insurance	92.8% of nonelderly will have health insurance
37. Increase the proportion of adolescents who have an annual wellness checkup	46.0% had a wellness checkup in the past year	60.8% will have a wellness checkup in the next year
38. Increase the proportion of low income children and adolescents who receive dental care	53.6% of low income children and adolescents received preventative dental services in the past year	56.3% of low income children and adolescents will receive preventative dental services in the next year
39. Reduce the proportion of individuals who are unable to afford to see a doctor*	12.0% reported that they were unable to afford to see a doctor	11.4% report that they were unable to afford to see a doctor

*Indicates a State Health Improvement Process measurement where racial and/or ethnic health disparities exist.

Source: Department of Health and Mental Hygiene

Appendix 5

HEZ Eligibility and Review Criteria

Implementation of Health Enterprise Zones (HEZ) in Maryland: Eligibility Criteria

In August 2012, following a public participation and comment process, the Department of Health and Mental Hygiene (DHMH) and the Community Health Resources Commission (CHRC) submitted a report to the budget and relevant policy committees that defined criteria for consideration as an HEZ. These criteria are as follows:

- HEZs must be a contiguous geographic area defined by zip code boundaries and contain at least 5,000 people (although DHMH and CHRC will entertain applications from sub-zip code areas as long as they are contiguous and meet the 5,000 person threshold);
- HEZs must be economically disadvantaged based on relative participation in the Medicaid or federally funded health and nutrition program for women, infants, and children (WIC) programs; and
- HEZs must demonstrate poor health outcomes based on relative life expectancy or the percentage of low-birth weight infants.

If an HEZ is composed of multiple zip codes, each of the zip codes in that HEZ must meet the economic and health eligibility criteria.

There are an estimated 609 zip codes in Maryland. Of these, as shown in **Table 1**, 105 meet the eligibility criteria. It should be noted that many zip codes overlap jurisdictional boundaries and are indicated as such in the exhibit. An estimated 267 zip codes fail to meet the basic population threshold. As such, it is difficult to determine if these zip codes meet the economic and/or health eligibility criteria. Applications may be made for these zip codes in combination with adjacent zip codes, and DHMH will have to determine eligibility on a case by case basis.

Two observations can be made from Table 1:

- With the exception of Talbot County, there is clear opportunity for the development of HEZs in every jurisdiction in the State.
- In many instances, because zip codes are not contiguous with jurisdictional boundaries, there will be opportunities for applications from more than one jurisdiction. It will be interesting to see to what extent, especially in the urban jurisdictions, there is a multi-jurisdictional approach. Generally, in the health arena, multi-jurisdictional approaches tend to be more common in rural areas.

Table 1
Health Enterprise Zones – Number of Eligible Zip Codes by Jurisdiction

<u>Jurisdiction (Number of Eligible Zip Codes)</u>	<u>Eligible USPS Zip Codes</u>
Allegany (2)	21502 and 21532
Anne Arundel (15)	20640, 20707 , 20711, 20724 , 20755, 21060, 21061, 21144, 21208, 21218, 21224, 21225, 21226, 21237 , and 21401
Baltimore City (30)	21201, 21202, 21205, 21206, 21207, 21208, 21211, 21212, 21213, 21214, 21215, 21216, 21217, 21218, 21219, 21220, 21221, 21222, 21223, 21224, 21225, 21226, 21227, 21229, 21230, 21231, 21234, 21237, 21239, and 21244
Baltimore County (31)	21117, 21133, 21201, 21202, 21205, 21206, 21207, 21208, 21211, 21212, 21213, 21214, 21215, 21216, 21217, 21218, 21219, 21220, 21221, 21222, 21223, 21224, 21225, 21227, 21229, 21230, 21231, 21234, 21237, 21239, 21244
Calvert (1)	20678
Caroline (3)	21629, 21632 , and 21655
Carroll (1)	21787
Cecil (5)	21901, 21903, 21904, 21911, and 21921
Charles (5)	20601 , 20602, 20616, 20640 , and 20695
Dorchester (3)	21613, 21632 , and 21643
Frederick (4)	21702, 21787 , 21788, and 21793
Garrett (1)	21550
Harford (3)	21001, 21040, and 21078
Howard (3)	20707, 20724 , and 21045
Kent (1)	21620
Montgomery (9)	20707 , 20851, 20866, 20874, 20879, 20886, 20903, 20904 , and 20912
Prince George's (25)	20601, 20640 , 20705, 20706, 20707 , 20708, 20710, 20712, 20722, 20724 , 20737, 20743, 20745, 20746, 20747, 20748, 20770, 20781, 20782, 20783, 20784, 20785, 20903, 20904 , and 20912
Queen Anne's (1)	21620
Somerset (3)	21817, 21851 , and 21853
St. Mary's (2)	20634 and 20653
Washington (2)	21740 and 21795
Wicomico (3)	21801, 21804 , and 21875
Worcester (3)	21804 , 21842, and 21851

USPS: United States Postal Service

Note: Zip codes can overlap multiple jurisdictions. Zip codes listed for two or more jurisdictions are shown in **bold**.

Source: Department of Health and Mental Hygiene; Maryland Community Health Resources Commission

Implementation of HEZs in Maryland: Review Criteria

The same August 2012 report also established the criteria that will be used to review HEZ applications. These criteria include description of need; targets for improvement; measurable goals; strategies for meeting goals; ensuring cultural competence; contributions from local partners; the breadth of the coalition supporting the application; work-plan; program management; sustainability; and evaluation and progress monitoring.

DHMH and the Maryland Community Health Resources Commission note that a full list of available outcomes by zip code will be made available to applicants to assist in the development of applications. Since applicants are required to demonstrate measurable progress toward identified goals, the availability of data at the HEZ level is critical. While the application notes that the goal-setting has a target date of 2016, incremental progress and specific processes identified to achieve goals will be part of the internal monitoring and review process.