
Cigarette Restitution Fund Fiscal 2004 Budget Overview

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

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Cigarette Restitution Fund – Fiscal 2004 Budget Overview

Cigarette Restitution Fund

Fiscal 2004 Budget Overview

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History of the Cigarette Restitution Fund

On November 23, 1998, the five major tobacco companies agreed to settle all outstanding litigation with 46 states, five territories, and the District of Columbia. Under the Master Settlement Agreement, the settling manufacturers will pay the litigating parties approximately \$206 billion over the next 25 years and beyond, as well as conform to a number of restrictions on marketing to youth and the general public.

The distribution of funds among the states was determined using a formula that assigned equal weight to the Medicaid and non-Medicaid smoking-related costs of each state; subsequent adjustments to this formula were made to allow smaller states to achieve economies of scale in providing tobacco prevention programs. According to this formula, Maryland will receive 2.26% of Master Settlement Agreement monies. In addition, the State will collect 3.3% of monies from the Strategic Contribution Fund, distributed according to each state's contribution toward resolution of the state lawsuits against the major tobacco manufacturers. Funds from these revenue streams, in addition to smaller payments related to the settlement, are estimated to result in annual variable payments of \$150 to \$200 million.

In anticipation of receiving tobacco settlement revenue, the State established the Cigarette Restitution Fund (CRF) in Chapter 173, Acts of 1999 as a special nonlapsing fund to be used for a variety of programs and initiatives. The act specified nine health- and tobacco-related priorities, listed in **Exhibit 1**, to which no less than 50% of 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 as programs within the Family Health Administration to address both the causes and effects of tobacco use. As these programs have grown, emphasis has shifted to these programs from other CRF recipients, such as primary and secondary education enhancements. The fund also supports existing health programs such as substance abuse treatment and Medical Assistance.

Overview of the Governor's Proposal

Impact of Attorney Fee Issue on Budget Decisions

The State of Maryland hired outside counsel to assist in the case against the tobacco manufacturers. At that time, the law offices of Peter G. Angelos, P.C. submitted the lowest bid on the State's Request for Proposal to retain outside counsel to represent the State of Maryland against cigarette manufacturers. The original contract between the State of Maryland and the law offices, dated March 27, 1996, was

Exhibit 1

Spending Priorities in the Cigarette Restitution Act

1. Reduction in tobacco use by youth
2. Tobacco control campaigns in schools
3. Smoking cessation programs
4. Enforcement of tobacco sales restrictions
5. Primary health care in rural areas
6. Programs concerning cancer, heart disease, lung disease, and tobacco control
7. Substance abuse treatment/prevention
8. Maryland Health Care Foundation
9. Crop conversion

Source: Chapter 173, Acts of 1999

based on a 25% contingency fee for services. Subsequent to entering into contract with the law offices many more states began to pursue litigation against the tobacco manufacturers, reducing the responsibilities of each state's individual counsel. The General Assembly passed legislation in April 1998 that simplified proof for the State's case and reduced the maximum amount of the contingency fee to 12.5%.

The State filed suit in Baltimore City Circuit Court in December 1999 after the law offices refused to request attorneys' fees from the national arbitration panel established by the Master Settlement Agreement to compensate states for their legal costs. The circuit court ordered the State to place 25% of the proceeds received by the State under the Master Settlement Agreement in escrow pending a ruling of the case. The law offices subsequently filed a contract claim before the Board of Contract Appeals. After appellate litigation, the Court of Appeals ruled that the case be tried first at the Maryland Board of Contract Appeals, with a final decision on jurisdiction pending the Board of Contract Appeals' ruling.

Prior to trial at the Board of Contract Appeals, scheduled for May 2002, the Governor announced that the State had reached a tentative agreement with the law offices. According to the terms of the settlement, approved by the Board of Public Works in April 2002, the State agreed to pay \$30 million to the law offices each year beginning in fiscal 2002 and ending in fiscal 2006. In return, the law offices released all rights to legal fees awarded by the national arbitration panel, estimated at \$132 million over 20 years, and transferred \$4.7 million to the State that the tobacco industry had previously paid into escrow in reimbursement for the law offices' expenses. The net cost of the agreement to the State is the present value cost of paying the law offices in five annual installments, rather than 20 installments under the terms of the arbitration panel, and the amount negotiated above the arbitration award, approximately \$13 million.

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The settlement made available \$123 million held in escrow pending settlement of attorneys' fees litigation. Of that amount, \$30 million was used to pay the first installment to the law offices in April 2002. The remainder was distributed in accordance with provisions in the Budget Reconciliation and Financing Act (BRFA) of 2002, which stipulated that the monies in excess of that required for payment to the law offices under the settlement be used to increase the appropriation for the Tobacco Use Prevention and Cessation Program and the Cancer Prevention, Education, Screening, and Treatment Program by \$20 million. The act earmarked the next \$73 million to increase the appropriation for the Maryland Medical Assistance Program.

The 2002 BRFA, in addition to providing for the distribution of funds in escrow, established a special reserve fund for planned fiscal 2003 escrow funds. Because the fiscal 2003 budget was developed prior to the settlement, the legislative appropriation for CRF included \$43.6 million for escrow. The special reserve fund was established to capture these funds that, but for the settlement, would have been placed in escrow. The difference between the amount of the escrow appropriation, \$43.6 million, and the second installment of the settlement payment, \$30 million, was placed in the special reserve fund for later use. These funds appear in the fiscal 2004 allowance.

Fiscal 2001 Actual Spending

The fiscal 2001 budget was developed prior to the circuit court order that required 25% of settlement payments to be placed in escrow. Funding for the tobacco and cancer programs, as well as funding for teachers' salaries, aid to nonpublic schools, and school wiring, was subsequently reduced in the 2001 working appropriation to make adequate funding available for attorneys' fees. It was expected that the Tobacco Use Prevention and Cessation Program and the Cancer Prevention, Education, Screening, and Treatment Program would experience implementation delays in their first years, making sufficient funds available for escrow. Between the legislative and the working appropriations, funding for teachers' salaries was also reduced \$6.1 million due to greater-than-anticipated revenue from the teachers' retirement fund; in addition, \$0.4 million was added for the Attorney General for the cost of outside counsel related to the Angelos case.

The legislation that established each of the tobacco and cancer programs, Chapter 17, Acts of 2000, required the Department of Health and Mental Hygiene (DHMH) to submit the results of baseline studies of tobacco use and cancer incidence before the majority of funds for these programs could be expended. The cancer baseline report was presented August 2000, allowing the release of funds shortly after the beginning of the fiscal year. The tobacco baseline was not completed until February 2001, restricting funding availability for more than six months. In addition to delays, existing health programs were unable to expand at a rate that would allow for full use of funds. Each local health department, for example, had to create capacity to accommodate the sudden growth in funds, although many programs were able to spend the full amount appropriated in fiscal 2001. The tobacco program expended \$7.3 million of \$12.8 million appropriated; the cancer program expended \$23.8 million of \$26.3 million appropriated. A total of \$8.0 million was unspent in fiscal 2001. Unused funds accrued to the CRF balance, which totaled \$10.0 million at the beginning of fiscal 2002. An additional \$7.5 million in fiscal 2001 funds was reverted during fiscal 2002 and 2003.

Fiscal 2002 Actual Spending

Funding levels in the fiscal 2002 legislative appropriation were contingent on the availability of funds. The fiscal 2002 allowance was built on the assumption that attorneys' fees would require only 9% of fiscal 2002 tobacco revenue. To comply with the requirement that 25% of the funds be placed into escrow, \$27 million of the appropriation was withheld. The majority of the reduction was allocated to specific programs and units, detailed in **Exhibit 2**. In addition, anticipated delays caused the cancellation of funding for school wiring, resulting in a total of \$30 million reduction between the fiscal 2002 legislative and working appropriations.

Although less overall funding was available in fiscal 2002, program funding increased because \$25 million appropriated for Medicaid in fiscal 2001 was redistributed to other programs in fiscal 2002. Appropriations provided level funding or amounts sufficient to annualize the cost of services over the full length of the year. Notable exceptions included the elimination of funding for teachers' salaries due to the availability of an alternate funding source and limiting funding for crop conversion to 5% of available revenue.

The majority of fiscal 2002 funds were expended or encumbered; less than \$3 million of \$122 million appropriated reverted to CRF. The majority of cancelled funds were the result of cost containment and delays in establishing cancer and tobacco programs, both at the local level and among the academic health centers. In addition, \$1.6 million in surplus funds originally appropriated to the Alcohol and Drug Administration for local substance abuse treatment was transferred to the Mental Hygiene Administration to cover projected deficits. Many health departments, especially in home-rule jurisdictions, were unable to expand substance abuse treatment services at a rate sufficient to expend the entire amount appropriated in fiscal 2002.

Fiscal 2003 Working Appropriation

The fiscal 2003 CRF legislative appropriation was developed prior to the State's settlement with the law offices of Peter G. Angelos, P.C.; however, language in the BRFA of 2002 stipulated that, in the event of a settlement, \$20 million of the funds held in escrow would be used to increase the appropriation for CRF's Cancer Prevention, Education, Screening, and Treatment Program and the Tobacco Use Prevention and Cessation Program and \$73 million would be used to increase the appropriation for the Maryland Medical Assistance Program. The funds increased the fiscal 2003 working appropriation but were not distributed to the cancer or tobacco programs. The Governor's allowance assumes the \$20 million for these programs reverts to CRF for use in fiscal 2004, though no formal action yet has been taken. The working appropriation in **Exhibit 3** reflects the increases to the appropriation authorized by the BRFA of 2002 and anticipated cost containment actions. The department has indicated that withheld funds may be redistributed among programs in fiscal 2003. **DHMH should comment on the proposed allocation of fiscal 2003 CRF cost containment.**

Exhibit 2

Fiscal 2002 Actual Spending
 (\$ in Millions)

	FY 02 Legislative <u>Appropriation</u>	Restricted <u>Funds</u>	FY 02 Working <u>Appropriation</u>	FY 02 <u>Actual</u>
Health				
Tobacco	\$28.4	-\$10.7	\$17.7	\$16.9
Cancer	44.3	-8.0	36.3	34.6
Substance Abuse	18.5		18.5	16.9
Mental Hygiene Administration	0.0		0.0	1.6
MD Health Care Foundation	1.5	-0.5	1.0	1.0
Subtotal	\$92.7	-\$19.2	\$73.5	\$71.0
Education (K-12)				
Baltimore City Partnership	\$3.2		\$3.2	\$3.2
Academic Intervention	19.1		19.1	19.1
Aid to Nonpublic Schools	8.0	-\$3.0	5.0	4.9
Judy Hoyer Centers	3.0		3.0	2.9
School Wiring	3.6	-3.6	0.0	0.0
Teacher Mentoring	2.5		2.5	2.5
Headquarters	3.4		3.4	3.4
Technology Academy	1.7		1.7	1.7
Readiness and Accreditation	3.0		3.0	3.0
Subtotal	\$47.5	-\$6.6	\$40.9	\$40.7
Higher Education				
MAITI Technology	\$3.7	-\$3.7	\$0.0	\$0.0
Access/Success	1.0		1.0	1.0
Digital Library	0.5	-0.5	0.0	0.0
Subtotal	\$5.2	-\$4.2	\$1.0	\$1.0
Crop Conversion	\$6.3		\$6.3	\$6.3
Attorney General	\$0.1		\$0.1	\$0.1
Total Expenses	\$151.8	-\$30.0	\$121.8	\$119.0

Source: Maryland Operating Budget

Exhibit 3

**Fiscal 2003 Working Appropriation
(\$ in Millions)**

	<u>FY 03 Working Appropriation</u>	<u>FY 03 Cost Containment</u>	<u>FY 03 Revised Appropriation</u>
Health			
Management	\$0.5		\$0.5
Tobacco	31.2	-\$11.2	20.0
Cancer	46.2	-8.8	37.4
Substance Abuse	18.5		18.5
Maryland Health Care Foundation	1.0		1.0
Medicaid	104.0		104.0
Subtotal	\$201.4	-\$20.0	\$181.4
Education			
Aid to Nonpublic Schools	3.8		3.8
Judy Hoyer Centers	4.0		4.0
School Wiring	1.9	-\$1.9	0.0
Teacher Mentoring	2.5		2.5
Teacher Certification	1.5		1.5
Technology Academy	1.7		1.7
Access/Success	1.0		1.0
Subtotal	\$16.3	-\$1.9	\$14.5
Crop Conversion	\$6.3		\$6.3
Attorney General	\$0.1		\$0.1
Total Expenses	\$224.1	-\$21.9	\$202.1
Transfer to the General Fund	-\$3.8		-\$3.8

Note: School wiring funds were not spent in fiscal 2003 due to implementation delays.

Source: Maryland Operating Budget

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The fiscal 2003 allowance assumed that CRF would carry a balance of \$1.2 million into fiscal 2004. In addition, the General Assembly reduced the appropriation for nonpublic school textbooks by \$1.25 million, adding that amount to the projected balance. The BRFA of 2002 authorized the transfer of these monies to the general fund on or before June 30, 2003.

The BRFA of 2003 would authorize the transfer of an additional \$1.4 million in CRF in fiscal 2003. This action would transfer \$0.8 million for the development of the Alcohol and Drug Abuse Administration's eSAMIS information technology project, previously supported with CRF, to the Department of Budget and Management's (DBM) information technology fund. The remainder of the transfer, \$0.6 million, would be transferred to the general fund to cover current year shortfalls.

Fiscal 2004 Allowance

The fiscal 2004 allowance includes almost \$184 million for CRF programs, \$19 million less than in fiscal 2003. The allowance reflects several changes to the source of funds and established priorities. From a revenue perspective, detailed in **Exhibit 4**, the State is expecting \$20 million less from the tobacco companies in fiscal 2004, the result of the end of the initial payment stream. This reduction is partially offset by a sizable fund balance, \$43 million due to cost containment and prior year recoveries, and \$14 million from a reserve established after the State settled attorneys' fees litigation.

The budget as submitted left a \$0.3 million balance in the CRF at the end of fiscal 2004; however, information received after the allowance was developed indicates that the State's receipt of tobacco settlement revenue will not meet fiscal 2003 and 2004 projections, resulting in a projected shortfall of \$7 million at the end of fiscal 2004. If reductions are not made to the fiscal 2004 CRF budget as presented, a supplemental budget may be necessary to redistribute funds.

The allowance continues a trend of allocating an increasing proportion of CRF to the health- and tobacco-related priorities established in statute (See Exhibit 1). The allowance includes \$179 million for these priorities and \$5 million for nonpublic school textbooks. CRF support for education initiatives is reduced, though general funds support the majority of these programs elsewhere in the allowance. The majority of funds, \$107 million, is used to continue Medicaid funding at a level similar to the fiscal 2003 working appropriation, comprising 58% of fiscal 2004 CRF appropriations. Changes to the distribution of funds for other health-related priorities are detailed in **Exhibit 5**. The fiscal 2004 allowance reduces funding below the revised fiscal 2003 appropriation, and in many instances below fiscal 2002 actual spending.

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Exhibit 4

Cigarette Restitution Fund Revenue
Fiscal 2001 through 2004
(\$ in Millions)

	FY 01	FY 02	FY 03	FY 03	FY 04
	Actual	Actual	Working	Revised	
	<u>Spending</u>	<u>Spending</u>	<u>Appropriation</u>	<u>Appropriation</u>	<u>Allowance</u>
Beginning Fund Balance	\$39.3	\$17.5	\$103.5	\$103.5	\$42.5
Settlement Payments	146.6	168.7	170.2	170.2	150.5
Less 25% in Escrow	-38.1	-43.1			
Available Revenue	\$147.9	\$143.1	\$273.7	\$273.7	\$193.0
Available from Escrow		\$123.1	\$4.7	\$4.7	
Payment to Law Offices		-30.0	-30.0	-30.0	-30.0
To Special Reserve Fund		-13.6			
From Special Reserve Fund					13.6
Total Available Revenue	\$147.9	\$222.6	\$248.4	\$248.4	\$176.6
Total Expenditures	\$130.4	\$119.0	\$224.1	\$202.1	\$183.7
Transfer to the General Fund			\$3.8	\$3.8	
Ending Balance	\$17.5	\$103.5	\$20.5	\$42.5	-\$7.1

Source: Maryland Operating Budget

Exhibit 5

**Cigarette Restitution Fund
Fiscal 2001 through 2004
(\$ in Millions)**

	<u>FY 01</u> <u>Actual</u> <u>Spending</u>	<u>FY 02</u> <u>Actual</u> <u>Spending</u>	<u>FY 03</u> <u>Revised</u> <u>Approp.</u>	<u>FY 04</u> <u>Allowance</u>
Health				
Management	\$0.0	\$0.0	\$0.5	\$0.6
Tobacco	7.3	16.9	20.0	15.2
Cancer	23.8	34.6	37.4	32.8
Substance Abuse	16.3	16.9	18.5	17.1
Mental Hygiene Administration	2.2	1.6	0.0	0.0
Maryland Health Care Foundation	1.5	1.0	1.0	0.3
Medicaid	24.6	0.0	104.0	106.6
Subtotal	\$75.7	\$71.0	\$181.4	\$172.6
Education				
Teachers Salaries	\$6.9	\$0.0	\$0.0	\$0.0
Baltimore City Partnership	8.0	3.2	0.0	0.0
Academic Intervention	12.0	19.1	0.0	0.0
Aid to Nonpublic Schools	5.0	4.9	3.8	5.0
Judy Hoyer Centers	4.0	2.9	4.0	0.0
School Wiring	0.0	0.0	0.0	0.0
Education Modernization	2.5	0.0	0.0	0.0
Teacher Mentoring	2.5	2.5	2.5	0.0
Teacher Certification	2.0	3.4	1.5	0.0
Technology Academy	1.6	1.7	1.7	0.0
Readiness and Accreditation	3.0	3.0	0.0	0.0
Subtotal	\$47.5	\$40.7	\$13.5	\$5.0
Higher Education				
Maryland Applied Information Technology Initiative	\$3.7	\$0.0	\$0.0	\$0.0
Access/Success	1.0	1.0	1.0	0.0
Digital Library	0.5	0.0	0.0	0.0
Subtotal	\$5.2	\$1.0	\$1.0	\$0.0
Crop Conversion	\$9.0	\$6.3	\$6.3	\$6.1
Attorney General	\$0.4	\$0.1	\$0.1	\$0.0
Additional Reversion	-\$7.5	\$0.0	\$0.0	\$0.0
Total Expenses	\$130.4	\$119.0	\$202.1	\$183.7
Transfer to the General Fund			3.8	

Note: Fiscal 2001 reversion represents funds encumbered at the end of the fiscal year and reverted in future fiscal years. The programs from which funds were reverted is unknown.

Source: Department of Budget and Management

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The allowance provides \$15 million for the tobacco program and \$33 million for the cancer program; however, fiscal 2004 budget bill language stipulates that \$2.9 million intended for the cancer program shall be transferred to the tobacco program unless legislation is enacted to alter the minimum amount required to be included by the Governor in the annual budget for reducing tobacco use. Language in the legislation that authorized the 1999 increase in the tobacco tax required the Governor to include at least \$21 million in the annual budget for activities aimed at reducing tobacco use in Maryland as recommended by the Centers for Disease Control and Prevention. Language in the BRFA of 2003 would lower the required amount to \$18 million, which would allow the Governor to meet the requirement with CRF tobacco program funding and other Family Health Administration anti-smoking initiatives. **The department should comment on the redistribution of cancer and tobacco funds if legislation fails to alter the minimum amount required to be included by the Governor in the annual budget for reducing tobacco use.**

Tobacco Use Prevention and Cessation Program

Funding for the Tobacco Use Prevention and Cessation Program comprises 8% of appropriations from CRF in fiscal 2004. This program, established by Chapter 17, Acts of 2000 is charged with developing initiatives to reduce tobacco use in Maryland and otherwise benefit public health. This and the Cancer Prevention, Education, Screening, and Treatment program are the basis of the State's CRF Program. Changes in funding for the tobacco program, detailed in **Exhibit 6**, include:

- ***Surveillance and Evaluation:*** This program, budgeted at \$2.7 million in fiscal 2003, is not funded in the fiscal 2004 allowance. The program was charged with collecting and analyzing data relating to tobacco use in the State, starting with a baseline study of tobacco use in fiscal 2001 and following up with studies each year thereafter. DHMH has used the results of these studies to measure progress in reducing tobacco use and distributing local public health funds for tobacco use prevention and cessation. This program, in conjunction with the evaluation component of the cancer program, also provided funding for a comprehensive evaluation of the CRF program, as required by Section 9, Chapters 17 and 18, Acts of 2000. Reductions to these programs were made with the intention of deferring these activities to future fiscal years; however, State law requires the department to conduct studies on an annual basis. **The department should comment on the impact of discontinuing funding for the annual tobacco study and the comprehensive evaluation of the Tobacco Use Prevention and Cessation program.**
- ***Local Public Health:*** Local health departments in each of the 24 jurisdictions provide prevention and cessation programming in each of four areas: community education, school-based programs, cessation, and enforcement. Funding decreases from \$9.2 million in fiscal 2003 to \$8 million in fiscal 2004, reducing funding below fiscal 2002 actual levels.
- ***Statewide Public Health:*** This component was developed to ensure that the tobacco program was implemented in a coordinated and integrated manner, as well as to ensure participation by minority and underrepresented populations. This component of the tobacco program includes five subprograms, listed in Exhibit 6, most notably minority outreach and legal and technical assistance

Exhibit 6

Tobacco Use Prevention and Cessation
Fiscal 2001 through 2004
(\$ in Millions)

	<u>FY 01</u> <u>Actual</u>	<u>FY 02</u> <u>Actual</u>	<u>FY 03</u> <u>Working</u> <u>Approp.</u>	<u>FY 04</u> <u>Allowance</u>
Surveillance and Evaluation	\$1.2	\$1.4	\$2.7	\$0.0
Local Public Health	4.0	8.8	9.2	8.0
Statewide Public Health				
Minority outreach and technical assistance	1.5	1.4	1.5	0.5
Statewide enforcement	0.0	0.0	0.5	0.0
Telephone quitline	0.0	0.0	0.4	0.0
University of Maryland School of Law	0.0	0.2	0.4	0.3
Maryland Occupational Safety and Health Administration	0.0	0.0	0.1	0.0
Subtotal	\$1.5	\$1.6	\$2.9	\$0.8
Countermarketing	0.0	4.3	4.5	5.9
Administration	0.6	0.8	0.8	0.5
Total	\$7.3	\$16.9	\$20.0	\$15.2

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

provided by the University of Maryland School of Law. Funding is reduced from \$2.9 million in fiscal 2003 to \$0.8 million in fiscal 2004, as funding for programs new in fiscal 2003 was discontinued. **The department should comment on the effect of proposed reductions to the minority outreach program and University of Maryland School of Law technical assistance.**

- **Countermarketing:** In January 2002 the Board of Public Works approved a contract between the Family Health Administration and Gray/Kirk/Vansant Advertising to develop a media campaign to counteract tobacco advertising. The contract included the development of print and electronic advertising as well as the purchase of print space and airtime. The program was funded at \$4.5 million in fiscal 2003, increasing to \$5.9 million in fiscal 2004. The increase will allow for continuation of the Smoking Stops Here campaign, purchase of advertising, and community-based promotional activities.

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- **Administration:** Funding declines \$0.2 million due to the abolition of three vacant positions and the restructuring of administrative and management functions.

The net result of the changes in the fiscal 2004 allowance is a reduction of \$4.8 million to components of the Tobacco Use Prevention and Cessation program, \$1.7 million below fiscal 2002 actual spending.

Cancer Prevention, Education, Screening, and Treatment Program

Funding for the Cancer Prevention, Education, Screening, and Treatment Program comprises 18% of appropriations from CRF in fiscal 2004. This program, established by Chapter 17, Acts of 2000 is charged with developing initiatives to reduce morbidity and mortality rates for cancer- and tobacco-related diseases and otherwise benefit public health. This and the Tobacco Use Prevention and Cessation program are the basis of the State's CRF Program. Changes in funding for the cancer program, detailed in **Exhibit 7**, include:

- **Surveillance and Evaluation:** Funding for this component of the cancer program, responsible for producing the annual report of State cancer incidence, declines \$0.3 million in fiscal 2004. The reduction eliminates funding for a comprehensive evaluation of the CRF program, as required by Section 9, Chapters 17 and 18, Acts of 2000. This reduction complements deletion of funds for this initiative in the surveillance and evaluation component of the tobacco program.
- **Local Public Health:** This component of the cancer program mirrors the efforts of the local public health component of the tobacco program. Local health departments in each of the 23 counties provide services to complement existing cancer screening and treatment programs with emphasis on ensuring that the uninsured and underinsured receive appropriate treatment. Funding decreases from \$11 million in fiscal 2003 to \$8.6 million in fiscal 2004, reducing funding below fiscal 2002 actual levels. **DHMH should discuss the impact these reductions will have on cancer screening and treatment efforts.**
- **Statewide Academic Health Centers:** The allowance includes \$21 million for research and public health initiatives at the University of Maryland Medical Group (UMMG) and the Johns Hopkins Institutions (JHI). The distribution of funds among initiatives at the academic health centers has not yet been determined. **The department should comment on the anticipated distribution of academic health center funds among initiatives.**

Research funds, which comprise approximately half of funds for the academic health centers, support clinical and population-based research activities relating to the cancers targeted by CRF and increasing the rate at which cancer research is translated into treatment protocols. The ultimate goal of both of these programs is to reduce the cancer rates attributable to tobacco use in the State. In addition to cancer research programs, UMMG is the recipient of \$2.3 million in CRF in fiscal 2004 for tobacco-related research, especially as it relates to prevention of heart and lung disease.

Exhibit 7

**Cancer Prevention, Education, Screening, and Treatment
Fiscal 2001 through 2004
(\$ in Millions)**

	FY 01	FY 02	FY 03	FY 04
	<u>Actual</u>	<u>Actual</u>	<u>Working</u>	<u>Allowance</u>
			<u>Approp.</u>	
Surveillance and evaluation	\$0.3	\$0.8	\$1.7	\$1.4
Local public health	8.4	10.9	11.0	8.6
Statewide academic health centers				
University of Maryland Medical Group				
Tobacco-related disease research	0.0	3.0	3.0	2.3
Cancer research	7.1	9.0	9.0	n/a
Statewide network	2.6	4.0	4.0	n/a
Baltimore City public health	1.5	1.4	2.0	n/a
Subtotal	\$11.2	\$17.4	\$18.0	\$16.1
The Johns Hopkins Health System				
Cancer research	2.2	3.0	3.0	n/a
Baltimore City public health	1.2	1.4	2.0	n/a
Subtotal	\$3.4	\$4.4	\$5.0	\$4.6
Administration	0.4	1.0	1.1	1.0
Cancer screening database	0.0	0.0	0.6	0.6
Statewide public health	0.0	0.0	0.0	0.6
Total	\$23.8	\$34.6	\$37.4	\$32.8

Note: The distribution of funds among academic health center programs in fiscal 2004 is currently unknown.

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

CRF also provides funds for statewide network development to UMMG. Network development is intended to increase minority participation in clinical trials, develop best practices for addressing cancer- and tobacco-related disease, and coordinate State screening and treatment activities among health providers and hospitals. UMMG has established five regional offices, with service areas including the majority of the State's jurisdictions, to make health promotion and disease prevention resources available to local health departments, hospitals, and community-based organizations. In addition, the network has supported the expansion of telemedicine projects among faculty and local health providers. These programs would have been most effective had they been available to local

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health departments as they developed their tobacco and cancer programs; however, after several years of funding, the network does not yet serve all jurisdictions. Several jurisdictions in which the network currently operates report that they have had minimal contact with the network.

UMMG and JHI, rather than the Baltimore City Health Department, provide cancer screening and treatment to city residents as part of the local public health initiative. Unlike other jurisdictions, which have focused their efforts on colorectal cancer, the academic health centers have primarily focused on oral, breast, cervical, and prostate cancer, with screening provided by local community-based agencies and organizations. UMMG has screened 742 women for breast cancer, 599 women for cervical cancer, and 1,672 individuals for oral cancer. Five women have been diagnosed with breast cancer and one individual has been diagnosed with oral cancer. JHI has screened 467 men through the program, of which 37 were referred for further diagnosis and treatment. Five men have been diagnosed with prostate cancer as a result of the JHI local public health program.

- **Administration:** Funding declines \$0.1 million due to the restructuring of administrative and management functions.
- **Database Development:** This project provides funds to the University of Maryland to develop a database of cancer screening and treatment recipients and services provided. This program, started in fiscal 2003, is level-funded at \$0.6 million in fiscal 2004.
- **Statewide Public Health:** This program, new in fiscal 2004, provides \$0.5 million for treatment of individuals identified with cancer as part of the local public health program. Funding will be distributed on a first-come, first-serve basis to provide treatment to an estimated 15 individuals in fiscal 2004. Local health departments that currently provide for treatment will be able to access these funds only if they exhaust their budgeted treatment funds. The program also includes \$0.1 million for technical assistance to medical providers regarding prevention, education, screening, and treatment of the cancers targeted by the CRF program.

The net result of the changes in the fiscal 2004 allowance is a reduction of \$4.6 million to components of the Cancer Prevention, Education, Screening, and Treatment program, \$1.7 million below fiscal 2002 actual spending.

Other Public Health Initiatives

In addition to the tobacco and cancer programs, CRF provides funding for other health priorities established in statute. These initiatives include:

- **Substance Abuse Treatment:** Beginning in 2001, the Alcohol and Drug Abuse Administration began receiving \$18.5 million in CRF appropriations to expand substance abuse treatment services in each of the State's 24 jurisdictions. Inability to spend funds in prior fiscal years resulted in transfer of \$2.2 million in fiscal 2001 and \$1.6 million in fiscal 2002 to the Mental Hygiene Administration to cover the costs of substance abuse treatment provided to patients in the mental health system. Beginning in fiscal 2003, \$1.3 million of the \$18.5 million appropriation to the Alcohol and Drug Abuse Administration was dedicated to development of the eSAMIS information technology project.

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In fiscal 2004 funds for the eSAMIS project will be transferred to the general fund for oversight by DBM's information technology fund.

- **Medicaid:** In fiscal 2000, \$100 million, or 98% of CRF revenue, supported the Medicaid program. With the introduction of the tobacco and cancer programs in fiscal 2001, Medicaid funding was reduced to \$25 million. Funding for Medicaid was eliminated in fiscal 2002, requiring the State to identify additional general funds to support program costs. To preserve continuity in appropriations, language was added to the BRFA of 2002 that required, for each of fiscal 2003 through 2006, at least 25% of CRF appropriations be made to Medicaid. This amount was exceeded in fiscal 2003, as funds made available from escrow were used to increase the appropriation to Medicaid by \$73 to \$104 million. This level of funding continues in fiscal 2004, with \$107 million included in the CRF allowance for Medicaid.
- **Maryland Health Care Foundation:** Fiscal 2004 is the fourth year of a grant to support programs that increase access to health care, identified as a priority in 1999 CRF legislation. The fiscal 2004 allowance includes \$0.25 million for this program, a reduction of \$0.75 below the fiscal 2003 appropriation.
- **Management:** Funding for this program, which provides administrative support to the tobacco and cancer programs, as well as coordinates grants to outside organizations, increases \$0.1 to \$0.6 million in fiscal 2004.

Other Cigarette Restitution Fund Initiatives

CRF initially supported 14 education initiatives and tobacco transition as well as health initiatives. As health-related CRF programs have grown, the number of other initiatives supported with CRF has declined. The allowance includes CRF for only two non-health initiatives in fiscal 2004:

- **Tobacco Transition Program:** From fiscal 2000 through 2002, the tobacco transition program was budgeted through the Maryland Department of Agriculture's (MDA) operating budget. In fiscal 2003 the program was entirely funded in the PAYGO budget, because appropriations from prior years were available in the operating budget to cover the Tri-County Council for Southern Maryland's (TCC) operating expenses. For fiscal 2004 the CRF allowance includes \$1.1 million for administrative expenses and noncapital grants for alternative agriculture enterprises and \$5 million for the tobacco buyout and land preservation program. An additional \$5 million in general obligation bonds is included in the capital budget for this program.
- **Nonpublic Student Textbook Program:** The Governor's allowance includes \$5.0 million for a fourth year of the Nonpublic Student Textbook Program. Over the three years of its operation, the State has spent \$13.8 million for textbooks for nonpublic school students. The State requires that eligible nonpublic schools with 20% or more of their students designated as eligible for free and reduced price meals receive \$90 per student. For those eligible nonpublic schools with less than 20% of their students designated as eligible for free and reduced price meals, schools can receive up to

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\$60 per student. The allowance increases funds for this program from \$3.75 million in fiscal 2003 to \$5 million in fiscal 2004.

The fiscal 2004 allowance discontinues the use of CRF for five primary and secondary education initiatives, instead substituting general funds for CRF. Each of these programs, with the exception of the Technology Academy, are provided for elsewhere in the fiscal 2004 allowance.

Future Tobacco Settlement Revenue

The Master Settlement Agreement established three types of payments: initial, annual, and strategic contribution payments.

- Initial payments are scheduled from fiscal 1999 through 2003. Maryland received initial payments of approximately \$60 million annually for each of five years.
- Annual payments began in 2000 and will continue as long as the settling manufacturers continue to ship tobacco products domestically. These payments are adjusted annually based on domestic consumption of tobacco products and inflation. Maryland's annual payment is expected to vary from \$140 to \$150 million in the near future.
- Strategic contribution payments, beginning in fiscal 2008 and continuing through fiscal 2017, reflect states' legal contributions to the tobacco settlement. Maryland's share of these payments is estimated at \$28 million annually.

In addition to these three payment streams, the national arbitration panel established by the Master Settlement Agreement to compensate states for their legal costs is expected to award the State \$132 million for the State's contribution to the legal settlement. Annual award payments, which began in fiscal 2003, are estimated between \$5 and \$7 million over the next 20 years.

As detailed in **Exhibit 8**, the State's tobacco settlement revenue is at a low from the end of the initial payment stream in fiscal 2003 to the beginning of the strategic contribution payment stream in fiscal 2008. The release of funds previously held in escrow for attorneys' fees moderated the financial impact of the end of the initial payments; however, the infusion of escrow funds was a one-time occurrence and is insufficient to maintain current spending levels. Lower-than-anticipated receipt of tobacco settlement revenue in fiscal 2004 starts a series of shortfalls that continue through fiscal 2007. Shortfalls are exacerbated by settlement payments to the Law Offices of Peter Angelos, P.C. of \$30 million annually continuing through fiscal 2006. The confluence of these factors results in funding insufficient to support current levels of CRF spending in fiscal 2004 through 2007. **The department should comment on funding priorities given limited resources in future fiscal years.**

Exhibit 8

**Estimated Cigarette Restitution Fund Receipts and Expenditures
Fiscal 2003 through 2010
(\$ in Millions)**

Fiscal Year	Balance ¹	Estimated Tobacco Settlement Revenue ²	Settlement Payment to the Law Offices	Health ³	Crop Conversion	Education	Ending Balance ⁴
2003	\$108	\$170	-\$30	-\$181	-\$6	-\$14	\$42
2004	56	151	-30	-173	-6	-5	-7
2005	0	157	-30	-173	-6	-5	-57
2006	0	156	-30	-173	-6	-5	-58
2007	0	157		-173	-6	-5	-27
2008	0	189		-173	-6	-5	5
2009	5	192		-173	-6	-5	13
2010	13	195		-173	-6	-5	24

¹ Balance includes \$5 million from the Law Offices of Peter Angelos as required by the State settlement in fiscal 2003 and release of \$13 million in reserves in fiscal 2004.

² Tobacco settlement revenue includes national arbitration panel award (\$5 to \$7 million annually).

³ Health includes several programs, including CRF cancer and tobacco programs and Medicaid. By law, 25% of CRF appropriations must be directed to Medicaid through fiscal 2006. The fiscal 2004 appropriation exceeds that amount. It is assumed that the Medicaid funding amount will be held constant beyond fiscal 2006.

⁴ Balance reflects the transfer of \$4 million to the general fund in fiscal 2003.

Source: Department of Legislative Services

Local Public Health Initiatives

The tobacco and cancer programs are the foundation of DHMH's efforts to reduce tobacco use and the incidence of smoking-related illness statewide. Although the programs encompass a variety of statewide components, the primary component of both the tobacco and cancer program is the delivery of services through the local public health system. As required by law, local health departments, in coordination with DHMH, have formed community coalitions to develop and implement comprehensive tobacco and cancer programs. Programs across jurisdictions contain common elements, as required by statute, but have been designed to address community-specific needs. Although the law allows for joint grant applications from two or more counties, no jurisdictions have pursued this option.

Fiscal 2001 Actual Spending

As detailed in **Exhibit 9**, local health departments spent approximately half of the funding included in the fiscal 2001 working appropriation for local tobacco and cancer initiatives. Given the difficulties in developing and establishing 24 distinct tobacco prevention and cessation programs and 24 distinct cancer control programs statewide, the cancellation of fiscal 2001 was not unexpected. Several factors contributed to inability to spend the funds allocated:

- ***Timing of Release of Funds:*** The legislation that established the tobacco and cancer programs required DHMH to withhold funding for local health departments pending completion of baseline tobacco and cancer studies. As the baseline cancer study was not completed until August 2000 and the baseline tobacco study not completed until February 2001, local health departments were given an abbreviated amount of time in which to spend the funds. These delays, in addition to departmental delays in approving local plans, resulted in local health departments' receiving funds as few as six weeks prior to the end of the fiscal year. Funds for the tobacco program were released between March and May 2001. Funds for the cancer program were released between October 2000 and May 2001, depending on when DHMH received completed local cancer plans.
- ***Administrative Requirements:*** The legislation that requires comprehensive annual data collection also establishes requirements for tobacco and cancer local public health funds to ensure that local funds are spent responsibly. Each of the local health departments was required to form a coalition of community members to develop a comprehensive plan for local use of tobacco and cancer funds. Due to inability to fully compose these coalitions and develop comprehensive plans, many jurisdictions were not fully prepared to spend the funds upon their release.

Exhibit 9

**Spending of Cigarette Restitution Fund Local Public Health Funds by Jurisdiction
Fiscal 2001**

	Tobacco			Cancer		
	<u>Award</u>	<u>Expenditure</u>	<u>Percent Expended</u>	<u>Award</u>	<u>Expenditure</u>	<u>Percent Expended</u>
Allegany	\$64,576	\$57,166	89%	\$328,460	\$70,598	21%
Anne Arundel	358,931	258,732	72%	1,023,220	572,071	56%
Baltimore County	780,530	180,724	23%	2,653,872	167,855	6%
Calvert	68,655	56,792	83%	171,361	52,410	31%
Caroline	49,311	47,513	96%	73,426	40,994	56%
Carroll	118,064	28,344	24%	335,001	83,992	25%
Cecil	121,421	70,438	58%	257,190	82,799	32%
Charles	170,390	141,371	83%	279,130	140,806	50%
Dorchester	39,977	37,922	95%	134,956	87,165	65%
Frederick	220,480	128,762	58%	449,366	179,296	40%
Garrett	39,756	30,499	77%	85,258	85,258	100%
Harford	291,442	205,227	70%	546,459	249,197	46%
Howard	226,110	187,261	83%	433,811	230,753	53%
Kent	26,261	21,794	83%	78,000	77,999	100%
Montgomery	403,400	195,072	48%	1,841,125	939,664	51%
Prince George's	673,865	244,770	36%	1,024,800	320,801	31%
Queen Anne's	56,065	22,219	40%	80,234	35,267	44%
St. Mary's	116,061	98,889	85%	212,936	212,936	100%
Somerset	32,976	22,463	68%	114,508	60,788	53%
Talbot	36,951	23,634	64%	98,370	44,976	46%
Washington	176,363	160,632	91%	383,857	345,846	90%
Wicomico	108,610	93,540	86%	326,987	174,769	53%
Worcester	58,724	56,328	96%	196,734	140,057	71%
Baltimore City	766,406	695,995	91%			
Total*	\$5,005,325	\$3,066,087	61%	\$11,129,061	\$4,396,297	40%

*Totals do not match previous exhibits as a portion of unexpended funds were included in the lump sum recovery of fiscal 2001 expenditures in future fiscal years.

Note: Baltimore City cancer programs are administered by the University of Maryland Medical Group and the Johns Hopkins Institutions and are not included in the total.

Source: Department of Health and Mental Hygiene

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- ***Local Bureaucratic Processes:*** Local public health programs required jurisdictions to develop a new administrative infrastructure. In many jurisdictions the addition of personnel or issuance of grant monies required a lengthy process of approval from the health department and county bureaucratic units. In jurisdictions that contracted for tobacco prevention and cessation services, for example, the county was required to issue a request for proposal, evaluate applications, make funding determinations, and gain final approval from the county council or Board of Estimates before funds could be distributed. Similarly, jurisdictions that chose to hire new personnel to staff CRF programs found that the recruitment and approval process could not be completed in the period between the release of funds and the close of the fiscal year. In these instances, fiscal 2001 funds were forfeited.
- ***Cancer Treatment Reserves:*** In the first year of the program, local cancer programs were unable to determine the demand for cancer treatment. Although small jurisdictions provided referral to treatment resources in lieu of treatment, jurisdictions of moderate and large size reserved a portion of cancer funds to treat those positively identified with cancer. As the demand for treatment did not meet expected levels in the majority of jurisdictions, a portion of cancer program funds was cancelled.
- ***Need to Identify Participating Providers:*** Each jurisdiction independently identified health care providers to participate in the cancer screening and treatment process. Enrolling providers often required navigating decentralized hospital systems; securing authorization for a single procedure often required the involvement of several distinct hospital functions. Furthermore, the absence of a contract template led to frequent revisions to the provider contract in many jurisdictions, leading to delays in program implementation.

All unused local public health funds, like all allocations made from CRF, reverted to the fund for use in future fiscal years.

Fiscal 2002 Actual Spending

Many of the difficulties local health departments encountered in spending CRF in fiscal 2001, the initial year of the program, were resolved or mitigated over the course of fiscal 2002. **Exhibit 10**, which details spending levels by jurisdiction, reflects the increased availability of funds as well as jurisdictions' ability to spend a greater percentage of funds allocated. The data reflects funds both expended and encumbered in fiscal 2002. The larger jurisdictions – Baltimore City, Baltimore County, and Montgomery County – often contract for the majority of services provided and have encumbered but not expended the majority of their local public health funds; figures for these jurisdictions remain subject to revision.

Exhibit 10

**Spending of Cigarette Restitution Fund Local Public Health Funds by
Jurisdiction
Fiscal 2002**

	Tobacco			Cancer		
	<u>Award</u>	<u>Expenditure</u>	<u>Percent Expended</u>	<u>Award</u>	<u>Expenditure</u>	<u>Percent Expended</u>
Allegany	\$175,086	\$161,049	92%	\$307,031	\$261,787	85%
Anne Arundel	942,200	942,200	100%	1,318,828	1,318,828	100%
Baltimore County	1,268,791	1,268,791	100%	2,599,833	2,267,734	87%
Calvert	179,651	130,462	73%	184,653	112,299	61%
Caroline	80,156	71,558	89%	85,658	79,215	92%
Carroll	311,183	227,916	73%	374,643	220,013	59%
Cecil	197,377	187,589	95%	250,292	140,302	56%
Charles	276,979	271,918	98%	296,160	188,724	64%
Dorchester	64,984	64,833	100%	138,125	125,912	91%
Frederick	419,518	419,518	100%	448,681	448,681	100%
Garrett	64,625	64,156	99%	84,928	40,145	47%
Harford	473,754	443,165	94%	551,899	373,503	68%
Howard	367,554	367,554	100%	451,751	451,751	100%
Kent	42,689	20,533	48%	80,662	60,313	75%
Montgomery	1,067,275	1,067,275	100%	1,848,703	1,848,703	100%
Prince George's	1,095,403	966,111	88%	1,734,585	1,734,585	100%
Queen Anne's	91,137	70,451	77%	119,705	106,944	89%
St. Mary's	188,664	180,197	96%	184,337	137,200	74%
Somerset	53,604	51,993	97%	83,907	69,563	83%
Talbot	60,063	45,484	76%	135,743	116,697	86%
Washington	286,720	286,720	100%	420,029	420,029	100%
Wicomico	176,551	176,372	100%	235,658	188,285	80%
Worcester	95,203	95,203	100%	220,886	203,839	92%
Baltimore City	1,245,833	1,245,833	100%	2,860,952	2,860,952	100%
Total	\$9,225,000	\$8,826,881	96%	\$12,156,697	\$10,915,052	90%

Note: Baltimore City cancer programs are administered by the University of Maryland Medical Group and the Johns Hopkins Institutions and are not included in the total.

Source: Department of Health and Mental Hygiene

Current Structural Fiscal Issues

The legislation that established the Tobacco Use Prevention and Cessation Program and the Cancer Prevention, Education, Screening, and Treatment Program included several mechanisms designed to maximize accountability between local health departments and DHMH, and ultimately between the department and the General Assembly. These mechanisms, intended to ensure responsible use of the unprecedented influx of tobacco settlement revenue, have had the unintended consequence of limiting jurisdictions' ability to engage in long-term planning. Ongoing structural issues are discussed below.

Calculation of Local Grant Awards

The allocation of local public health funding is determined by formulae established in Health-General Article 13-1007 and 13-1108. Funding amounts are calculated using data from surveys of tobacco use and cancer incidence conducted annually by DHMH. Tobacco funds are distributed according to a formula that gives equal weight to tobacco use by youth and tobacco use by the general population in a given jurisdiction. Cancer funds are similarly distributed, using a formula that equally weights cancer incidence and cancer mortality.

Annual recalculation of local grant awards has led to significant fluctuations in annual grant awards for local public health cancer awards, as shown in **Exhibit 11**. Notable are large reductions in funding, such as a 28% reduction in cancer funds for Wicomico County from fiscal 2001 to 2002. As counties continue to invest in establishing an administrative infrastructure for local public health programs, unexpected changes in funding, especially significant reductions, will limit a jurisdiction's ability to engage in long-term program planning. Small counties may be unable to absorb large reductions without eliminating program personnel. **DLS recommends amending the CRF statute to limit the annual percentage change in grant awards or to recalculate grant awards with less frequency, perhaps at five-year intervals.**

Lapses in Program Funding

The amount of local public health funding available to a jurisdiction is dependent on the amount of total funding available to CRF as well as a formula calculation of jurisdictional need. As these figures have traditionally not been available until the spring, local health departments have had a limited amount of time to develop and submit a grant application prior to the beginning of the fiscal year. In the past, local plans were often revised by DHMH, sometimes delaying approval for several months. In fiscal 2003, applications for cancer funds were approved in June 2002, and applications for tobacco funds were approved in July and August 2002, reducing delays in releasing funds to local health departments relative to prior years, but not entirely eliminating program lapses.

Exhibit 11

**Variation in Local Cancer Grant Awards
Fiscal 2001 through 2003**

	<u>FY 01</u>	<u>FY 02</u>	<u>FY 03</u> ¹	<u>% Change FY 01-02</u>	<u>% Change FY 02-03</u>
Allegany	\$328,460	\$307,031	\$306,693	-7%	-0%
Anne Arundel	1,023,220	1,318,828	1,248,141	29%	-5%
Baltimore County	2,653,872	2,599,833	2,565,759	-2%	-1%
Calvert	171,361	184,653	188,996	8%	2%
Caroline	73,426	85,658	105,831	17%	24%
Carroll	335,001	374,643	353,080	12%	-6%
Cecil	257,190	250,292	264,433	-3%	6%
Charles	279,130	296,160	281,871	6%	-5%
Dorchester	134,956	138,125	160,107	2%	16%
Frederick	449,366	448,681	454,724	-0%	1%
Garrett	85,258	84,928	96,012	-0%	13%
Harford	546,459	551,899	573,233	1%	4%
Howard	433,811	451,751	454,971	4%	1%
Kent	78,000	80,662	74,625	3%	-8%
Montgomery	1,841,125	1,848,703	1,871,515	0%	1%
Prince George's	1,024,800	1,734,585	1,665,959	69%	-4%
Queen Anne's	80,234	119,705	127,278	49%	6%
St. Mary's	212,936	184,337	195,399	-13%	6%
Somerset	114,508	83,907	90,312	-27%	8%
Talbot	98,370	135,743	154,881	38%	14%
Washington	383,857	420,029	415,593	9%	-1%
Wicomico	326,987	235,658	304,071	-28%	29%
Worcester	196,734	220,886	205,564	12%	-7%
Total	\$11,129,061	\$12,156,697	\$12,159,048	9%	0%

¹ Indicates initial fiscal 2003 awards for comparison purposes. Awards may be reduced given reduced availability of funds.

Note: Baltimore City cancer programs are administered by the University of Maryland Medical Group and the Johns Hopkins Institutions and are calculated separately.

Source: Department of Health and Mental Hygiene

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Despite reductions in turnaround times, several local health departments have found it necessary to discontinue services for a period of months at the beginning of the fiscal year. Many local health departments contract with community-based organizations to provide services – especially tobacco prevention and cessation activities – a process that involves establishing contracts, including issuing requests for proposals, selecting vendors, and gaining contract approval. Local health departments can begin this process once awards are determined, but the process may take several months. As a consequence, services provided by community-based organizations often are not available until the fall, leaving a critical lapse in service provision. **Earlier announcements of grant award amounts and less frequent recalculation of formula funding would allow local health departments more time to establish contracts prior to the beginning of the fiscal year, thereby allowing them to provide greater continuity in providing services to their residents.**

Anticipating Demand for Cancer Treatment

Statutory language requires local health departments to demonstrate that any cancer early detection or screening program provides necessary treatment or linkages to treatment for uninsured individuals diagnosed with one of the cancers targeted by the CRF program. While there is broad consensus on the moral and legal obligation to do so, local health departments have struggled to determine how to maximize the number of people screened while retaining sufficient reserves for treatment. Smaller jurisdictions do not have the resources to pay for treatment, instead enrolling those requiring treatment in Medicaid when possible or referring them to hospitals that participate in the Hill-Burton free health care program. Larger jurisdictions have reserved a certain percentage of annual funds for treatment, leaving open the possibility that higher-than-anticipated demand for cancer treatment may overwhelm the department's ability to continue to provide screening or treatment services in a given year.

A cancer treatment task force assembled by DHMH made several recommendations to maximize the availability of funds for cancer prevention, education, and screening, as well as provide sufficient resources for treatment. Among the recommendations of the task force was using modeling software to determine the anticipated demand for and cost of treatment and establish eligibility criteria for screening and treatment. The task force further recommended designating a certain percentage of local public health dollars for treatment statewide, administered centrally to insure against variations in need across jurisdictions and across years.

The fiscal 2004 allowance provides \$0.5 million for treatment of individuals identified with cancer as part of the local public health program. Funding will be distributed on a first-come, first-serve basis to provide treatment to an estimated 15 individuals in fiscal 2004. Local health departments that currently provide for treatment will be able to access these funds only if they exhaust their budgeted treatment funds.

Implementation of Local Tobacco Use Prevention and Cessation Programs

The local public health component of the Tobacco Use Prevention and Cessation program is divided into five broad categories: community, school, enforcement, cessation, and administration. Program activity and structure vary considerably among jurisdictions, with service delivery largely dependent on the size of the population. Smaller jurisdictions, where a single staff member can consume a majority of financial resources, tend to provide a greater proportion of services in-house, whereas larger jurisdictions more frequently contract with private community-based organizations to provide services. Regardless of size, each jurisdiction has designed a program to reach the medically underserved, as well as populations disproportionately targeted by the tobacco industry. Annual surveys of tobacco use overseen by DHMH will serve as a tool to evaluate the effect these programs have on local tobacco use in future years.

Community-based Programming

Forty percent of a jurisdiction's tobacco funding is directed to community-based programming, from a low of \$17,000 in Kent County to a high of \$500,000 in Baltimore City and Baltimore County. In smaller jurisdictions, the majority of community funds are often dedicated to partial funding of an outreach worker responsible for increasing community awareness of the dangers of tobacco use through frequent contact with local organizations and media sources. Larger jurisdictions generally provide services through community-based organizations, media campaigns, and program staff.

Each jurisdiction is required to address, in its comprehensive plan for tobacco use prevention and cessation, initiatives to reduce tobacco use among women, minority individuals, and individuals under the age of 18. Many jurisdictions have contracted with churches and community organizations to develop culturally appropriate materials to increase awareness among these populations. Two primary concerns have developed from the program's focus on these communities:

- ***Availability of Community Organizations:*** The targeted minority population includes individuals of African American, Hispanic, Native American, and Asian descent. Many jurisdictions have had difficulty finding organizations that represent each of these communities within their borders. In jurisdictions where appropriate organizations have been identified, some groups have been reluctant or unable to complete the grant process; others have not been able to establish a functional program without exceeding the 7% limit on administrative expenses. Baltimore City has responded to this challenge by requiring organizations to apply for funding in tandem with another organization; as a result, large organizations with an administrative infrastructure sufficient to support the program have paired with smaller community-based organizations to reach the targeted populations.
- ***Need Exists Outside Targeted Populations:*** Several jurisdictions, namely rural counties with small minority populations, have indicated that the population with the greatest incidence of tobacco use is white and male. As currently structured, local health departments are limited in their ability to reach this population with CRF. Many counties have extended their reach to the uninsured and medically underserved populations, as required by statute, but many others have been unable to target

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working-class white men, a segment of the population often with the highest smoking rates in many areas.

School-based Programming

Thirty percent of a jurisdiction's tobacco funding is directed to school-based programming. Jurisdictions enter into a memorandum of understanding with the local school district to provide the majority of school-based programming, with smaller amounts directed to pre-school programs, private schools, community colleges, and local universities. These schools have used funds to purchase anti-smoking curricula and promotional items, train educators in tobacco prevention and cessation, and provide school-based cessation counseling.

The school-based segment of the program is critical, as many jurisdictions have indicated that it has been difficult to recruit minors to participate in community coalition meetings. Attracting youth input is a priority for many jurisdictions in coming fiscal years. A concern in selected jurisdictions has been their ability to provide afternoon tobacco prevention programs; greater discretion in using school funds would allow jurisdictions to provide tobacco prevention activities in unsupervised periods after school.

Enforcement

Ten percent of a jurisdiction's tobacco funding is directed to enforcement activities. For many jurisdictions, this has been the most difficult element of the program to implement. Enforcement is highly dependent on the cooperation of local law enforcement agencies, many of which have been required to absorb additional responsibilities in the last year. As a result, many jurisdictions have taken measures to allow the health department to cite retailers for illegal placement of tobacco products or sale of tobacco products to minors. Funds are being used to educate retailers, provide police overtime pay, sponsor youth decoy operations, and cite minors in possession of tobacco. Any revenue generated by enforcement activities has provided a discretionary source of income for participating jurisdictions; in Baltimore City, revenue generated from civil citations has been used to purchase drug treatment slots.

Cessation

Thirteen percent of a jurisdiction's tobacco funding is directed to cessation activities. In the first year of the program, the majority of cessation funding was used to purchase pharmacotherapies, such as nicotine replacement patches and gums for use once programs had been established. Cessation activities vary across jurisdictions and include training sessions for health care providers, contracts with hospital-based cessation programs, workplace activities, and purchase of pharmacotherapies.

Administration

By law, administrative expenses and indirect costs may not exceed 7% of a jurisdiction's award. Most jurisdictions are using the maximum amount allotted for such costs. In many jurisdictions, this has been made possible by the use of the local health departments' existing resources, including physical space, office supplies and equipment, and personnel for CRF activity.

Implementation of Local Cancer Prevention, Education, Screening, and Treatment Programs

The local public health component of the Cancer Prevention, Education, Screening, and Treatment Program is administered by each of the State's 23 counties. Cancer screening and treatment in Baltimore City is jointly administered by UMMG and JHI; as that program differs significantly from county programs, it is discussed separately.

DHMH has identified seven CRF targeted cancers based on their relation to tobacco use: lung and bronchus, colorectal, breast, prostate, oral, melanoma, and cervical cancers. In the first year of the CRF program, the department directed counties to focus their resources on colorectal cancer screening and treatment. Colorectal cancer was chosen for a variety of reasons, among them:

- colorectal cancer is easily detected and readily treatable when diagnosed in its early stages;
- colorectal cancer is the second leading cause of cancer deaths in Maryland; and
- many of the targeted cancers are being addressed with existing resources.

The effect of local cancer programs on morbidity and mortality will be reflected in DHMH's annual cancer report.

Since fiscal 2001, the first year of the program, five counties have added limited screening services for other of the targeted cancers; several others have included prostate and skin cancer education in their local programs. Many jurisdictions are waiting to target additional cancers until their colorectal cancer programs are fully functional and they are able to estimate annual demand for screening and treatment.

Screening

Colorectal cancer screening has been provided with a combination of one or more screening elements:

- ***Fecal Occult Blood Test (FOBT)***: A noninvasive test that detects blood in the stools, a possible indicator of colon polyps. Positive results require further diagnostic measures to determine the cause of bleeding. Test materials cost less than one dollar; lab testing adds minimal cost.

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- ***Flexible Sigmoidoscopy:*** An invasive procedure used to detect inflammation, abnormal growths, and ulcers in the colon. This procedure detects polyps or cancer only in the lower third of the colon. The procedure costs between \$250 and \$500.
- ***Colonoscopy:*** An invasive procedure used to detect inflammation, abnormal growths, and ulcers in the colon. This procedure detects polyps or cancer in the entire colon. The procedure costs between \$750 and \$1,500.

In the first two years of the program, the majority of counties used the FOBT to identify individuals in need of further diagnosis. Counties collectively distributed thousands of FOBT kits in fiscal 2001 and 2002. As the kits are inexpensive and the procedure noninvasive, counties were able to cast a wide net, involving people that may not be willing to undergo a more invasive procedure. The primary disadvantage of this strategy has been that the FOBT is an imprecise method for detecting colorectal cancer, as blood in the stools may be indicated by a variety of causes; conversely, the test will not detect all cases of colorectal cancer. From an administrative perspective, many counties have found kits submitted for testing contain illegible contact information or improperly collected samples.

Approximately half of the counties that were using FOBT as a diagnostic tool in fiscal 2002 have discontinued use of the kits in fiscal 2003 in favor of colonoscopy; however, local health departments are expecting to increase the rates of all three forms of testing as the programs continue to expand. Local health departments tested approximately 1,200 FOBT samples in fiscal 2002; 2,000 are expected in fiscal 2003. Local health departments provided for approximately 375 colonoscopies in fiscal 2002; 2,500 are expected in fiscal 2003. Although these numbers may be optimistic in what are still the nascent years of the program, the increased time and financial resources available to the local health departments should allow for an increase in testing from previous years' levels.

Treatment

As discussed previously, the ability of local health departments to provide treatment has been of ongoing concern. Treatment or linkage to treatment was provided to each of the eight individuals identified with colorectal cancer through the cancer program in fiscal 2002; however, the number of cancer cases identified by the program is expected to rise as local health departments are able to reach a greater audience. Currently, treatment is provided by one of three sources:

- ***Medicaid:*** Local health departments have assisted low-income individuals in enrolling in the Medicaid program.
- ***Hill-Burton Facilities:*** The Hill-Burton program provides money to hospitals and health care facilities for construction and modernization. In return, Hill-Burton facilities provide a reasonable volume of services to persons residing in the community who are unable to pay. As of August 2002, Dorchester General Hospital in Cambridge is the only inpatient facility in the State of Maryland participating in this program; however, several other jurisdictions maintain similar relationships with local hospitals.

Cigarette Restitution Fund – Fiscal 2004 Budget Overview

- **Local Health Departments:** When other resources are exhausted, many of the larger jurisdictions pay for services with CRF reserved for treatment.

The fiscal 2004 allowance provides for a \$0.5 million reserve, sufficient to provide treatment to an estimated 15 individuals, for treatment as necessary. Distribution of funds will be prioritized among local health departments who are currently unable to provide funding for treatment. The level of demand for cancer treatment in fiscal 2003 will be critical in determining how to provide adequate funding for treatment locally and statewide in future years.

Baltimore City

Cancer screening and treatment are administered in Baltimore City by UMMG and JHI, as specified by law. Working collaboratively, the academic institutions have established partnerships with a variety of community-based organizations to provide cancer screening and treatment at sites throughout the city. The institutions, in consultation with a community coalition, have focused their screening efforts on prostate cancer, although each is also testing for breast, cervical, and oral cancers. Cumulatively, the institutions provided more than 4,000 cancer screenings; fewer than 1% of those participating in screening were diagnosed with cancer. Surgical and medical oncology care is provided by the academic institutions.

Tobacco Transition Program

Under the legislation, CRF is to fund the “...implementation of the Southern Maryland Regional Strategy Action Plan for Agriculture adopted by TCC with an emphasis on alternative crop uses for agricultural land now used for growing tobacco.” Funds are appropriated to MDA, which issues grants to the Tri-County Council for Southern Maryland (TCC). TCC is a nonprofit, quasi-governmental body that was created by the Southern Maryland Agricultural Development Commission to develop a program to stabilize the region’s agricultural economy as Maryland growers transition away from tobacco production.

TCC’s Strategy Action Plan has three main components: tobacco buyout, infrastructure/agricultural development, and agricultural land preservation.

- The tobacco buyout component is a voluntary program that provides funds to (a) support all eligible Maryland tobacco growers who choose to give up tobacco production forever while remaining in agricultural production, and (b) restrict the land from tobacco production for ten years should the land transfer to new ownership.
- The infrastructure/agricultural development program seeks to foster profitable natural resource based economic development for Southern Maryland by assisting farmers and related businesses to diversify and develop and/or expand market-driven agricultural enterprises in the region through economic development and education.
- The agricultural land preservation component seeks to provide an incentive to tobacco farmers to place land in agricultural preservation, enhance participation in existing preservation programs, and assist in the acquisition of land for farmers’ markets.

Tobacco Transition Program Fiscal 2004 Funding

From fiscal 2000 through 2002, the tobacco transition program was budgeted through MDA’s operating budget. In fiscal 2003 the program was entirely funded in the PAYGO budget because appropriations from prior years were available in the operating budget to cover TCC’s operational expenses. For fiscal 2004 the tobacco transition program allowance includes:

- \$1,060,000 in CRF special funds in the operating budget for administrative expenses and noncapital grants for alternative agriculture enterprises;
- \$5.0 million in CRF special funds for the tobacco buyout and land preservation program; and
- \$5.0 million in general obligation bonds in the capital budget.

Tobacco Transition Program Issue

The statute authorizing the tobacco transition program put one limit on the funds: funds shall be used to implement the Southern Maryland Regional Strategy-Action Plan for Agriculture adopted by TCC for Southern Maryland. In other words, the plan is controlling. In December 2002, TCC submitted a revised Strategy-action Plan that provides considerably more detail than in the past. The plan lays out recent successes and an aggressive strategy for implementing a wide variety of land preservation, and infrastructure and agricultural development activities in the future.

To some extent, the tobacco conversion program competes for funds with cancer programs, anti-smoking programs, and education programs. However, in the 1999 *Joint Chairmen’s Report*, the General Assembly expressed its intent for the crop conversion program to be allocated 5% of the available funds from CRF (only 3.3% of available funds are allocated to crop conversion in the fiscal 2004 allowance). Furthermore, the budget committees have expressed that upholding the contractual obligation to fund tobacco buyout payments is of paramount importance over other program expenditures in the Strategy-action Plan.

The tobacco buyout program has been more successful than originally anticipated, as seen in **Exhibit 12**. As of January 2003, 6.8 million pounds of tobacco (83% of cumulative total) and 711 growers (71% of cumulative total) have been taken out of tobacco production for human consumption.

Exhibit 12

**Tobacco Buyout Program
Fiscal 2001 through 2005**

	<u>FY 01</u> <u>Actual</u>	<u>FY 02</u> <u>Actual</u>	<u>FY 03</u> <u>Goal</u>	<u>FY 04</u> <u>Goal</u>	<u>FY 05</u> <u>Goal</u>
Growers Out of Tobacco					
Cumulative Number	559	655	712	825	895
Cumulative %	57%	66%	71%	83%	90%
Pounds of Eligible Tobacco Out of Production					
Cumulative Number (Millions)	5.44	6.41	6.81	7.33	7.7
Cumulative %	66%	78%	83%	90%	95%

Source: Tri-County Council for Southern Maryland

Growers who participate in the buyout program are paid \$1.00 per pound of tobacco for ten years. **Exhibit 13** illustrates tobacco buyout program funding trends. Fiscal 2004 buyout payments are projected for 7.33 million pounds of tobacco, so \$7.3 million is required to cover this cost. However, the estimated fiscal 2004 CRF revenues are only \$6.1 million, approximately \$1.2 million less than the projected buyout payment total. MDA intends to address this shortfall by supplementing the program with \$5.0 million in general obligation bonds. Legislation was passed in 2001 authorizing \$5.0 million

Exhibit 13

Tobacco Buyout Allocations
Fiscal 2001 through 2005
(\$ in Millions)

<u>Fiscal Year</u>	<u>Budget</u>
2001	\$5.4
2002	6.4
2003	6.8
2004	7.3
2005	7.7

Source: Tri-County Council for Southern Maryland

annually in general obligation bonds for fiscal 2003 through 2008 – a total authorization of \$30 million. The bonds are only to be issued each year if the funds provided by CRF are not sufficient to implement the Strategy-action Plan.

Since buyout projections far exceed anticipated fiscal 2004 CRF funds, and TCC has contractual obligations to buyout participants, funding priorities should be established. **DLS recommends that language be added to the special fund appropriation requiring fiscal 2004 funds to be used to fully-fund existing (fiscal 2003) buyout contract payments. TCC should determine what infrastructure development and land preservation programs are important and affordable in the funding stream available; and direct farmers to similar existing programs administered by MDA. DLS also recommends narrative requiring the submittal of an updated Southern Maryland Regional Strategy-action Plan to the budget committees by December 15, 2003, in advance of the 2004 session.**

Language and Reductions for Consideration

- ***Delete Funding for the Maryland Health Care Foundation:*** Funding for the Maryland Health Care Foundation was reduced from \$1 million in the fiscal 2003 working appropriation to \$0.25 million in the fiscal 2004 allowance. Originally created to solicit private funds to provide grants for health care initiatives, the foundation spends more on salaries than it generates in private contributions. Deleting CRF for the Maryland Health Care Foundation produces cost savings of \$250,000.
- ***Delete Funding for the Statewide Health Network:*** The University of Maryland Medical Group receives an estimated \$3.7 million in the fiscal 2004 allowance for continuation of the Statewide Health Network. This program is intended to increase minority participation in clinical trials, develop best practices for addressing cancer- and tobacco-related disease, and coordinate State screening and treatment activities among health providers and hospitals. These services would have been most effective had they been available to local health departments as they developed their tobacco and cancer programs; however, after several years of funding, the network does not yet serve all jurisdictions. Certain components of the program, such as including minority participation in clinical trials, may be absorbed by remaining research funds.
- ***Delete Funding for Nonpublic School Textbooks:*** The Governor's allowance includes \$5.0 million for a fourth year of the Nonpublic Student Textbook Program. Funding for nonpublic schools is not a part of the Maryland State Department of Education's mission to provide effective systems of public education.
- ***Consider Language to Limit Recalculation of Local Public Health Awards:*** The allocation of local public health funding is determined by formulae established in Health-General Article 13-1007 and 13-1108. Funding amounts are calculated using data from surveys of tobacco use and cancer incidence conducted annually by DHMH. Annual recalculation of local grant awards has led to significant fluctuations in local public health grant awards. As counties continue to invest in establishing an administrative infrastructure for local public health programs, unexpected changes in funding, especially significant reductions, will limit a jurisdiction's ability to provide continuity in service delivery. Statutory language that would limit recalculation of grant awards to every four to five years would allow jurisdictions to improve their long-term fiscal and program planning.
- ***Consider Language Requiring Tobacco Transition Funds to Be Used to Fully Fund Existing Buyout Contract Programs:*** Buyout projects far exceed anticipated fiscal 2004 funds and the Tri-County Council of Southern Maryland has contractual obligations to buyout participants. This language would establish existing buyout contracts as a priority for fiscal 2004 funds. The Tri-County Council should determine what infrastructure development and land preservation programs are important and affordable in the funding stream available and direct farmers to similar existing programs administered by the Maryland Department of Agriculture. DLS also recommends narrative requiring the submittal of an updated Southern Maryland Regional Strategy Action Plan to the budget committees by December 15, 2003.