
**Department of Health and
Mental Hygiene
Fiscal 2012 Budget Overview**

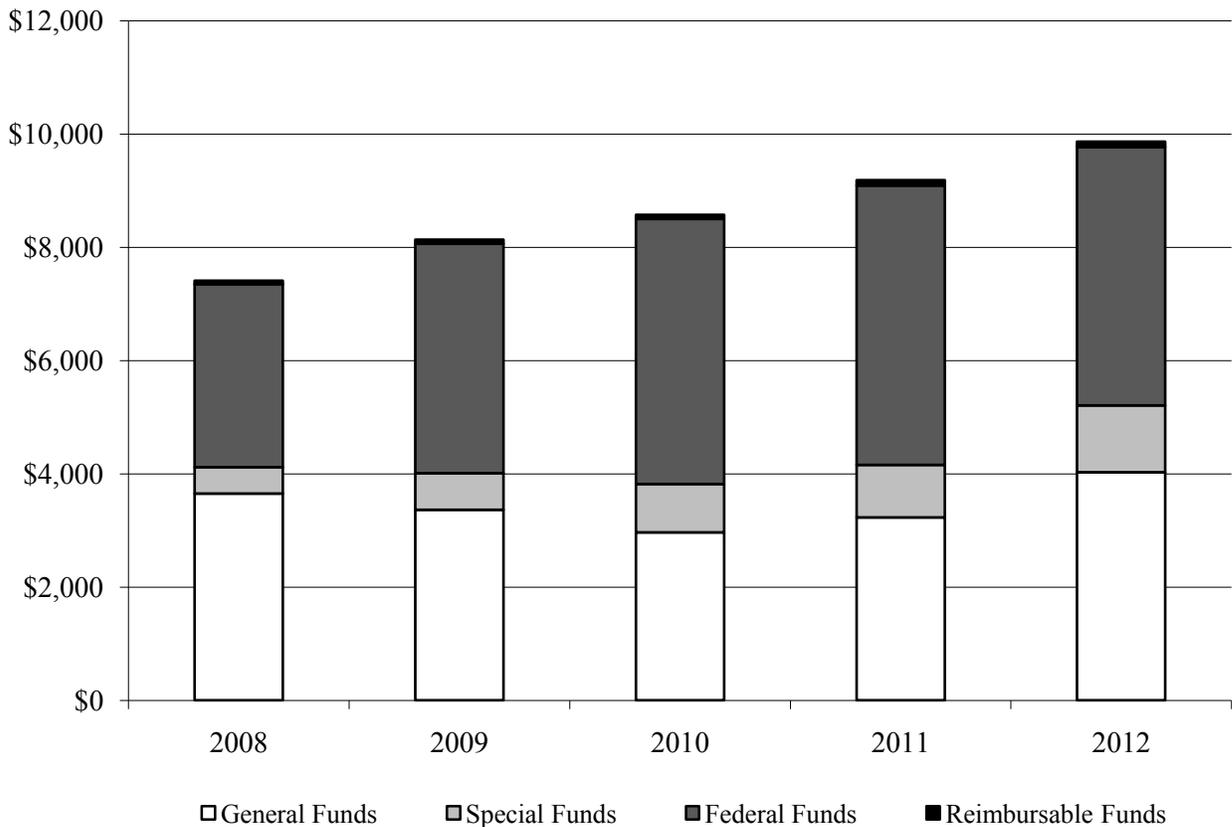
**Department of Legislative Services
Office of Policy Analysis
Annapolis, Maryland**

January 2011

M00 – DHMH – Fiscal 2012 Budget Overview

M00
Department of Health and Mental Hygiene
Fiscal 2012 Budget Overview

Department of Health and Mental Hygiene
Five-year Funding Trends
Fiscal 2008-2012
(\$ in Millions)



Note: Includes fiscal 2011 deficiencies, fiscal 2011 planned reversions, fiscal 2012 contingent reductions and related specified funds increases, fiscal 2012 Back of Bill reductions, fiscal 2012 funding included in the Department of Budget and Management earmarked for the Department of Health and Mental Hygiene, and approved fiscal 2011 budget amendments not included in the 2011 working appropriation where known.

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

M00 – DHMH – Fiscal 2012 Budget Overview

**Department of Health and Mental Hygiene
Budget Overview: Expenditure Growth Tightened Further
Fiscal 2008-2012
(\$ in Millions)**

	<u>2008</u>	<u>2009</u>	<u>2010</u>	<u>2011</u>	<u>2012</u>	<u>Change 2011-12</u>
General Funds	\$3,651	\$3,363	\$2,963	\$3,150	\$4,077	\$927
Fiscal 2011 Deficiencies				78		
Contingent, Planned, and Back of Bill Reductions					-49	
Adjusted General Funds	\$3,651	\$3,363	\$2,963	\$3,228	\$4,027	\$799
Special Funds	\$464	\$646	\$858	\$891	\$1,157	\$267
Fiscal 2011 Deficiencies				37		
Contingent and Back of Bill Reductions					24	
Adjusted Special Funds	\$464	\$646	\$858	\$927	\$1,181	\$254
Federal Funds	\$3,232	\$4,050	\$4,675	\$4,996	\$4,579	-\$418
Fiscal 2011 Deficiencies				-62		
Contingent and Back of Bill Reductions					-18	
Adjusted Federal Funds	\$3,232	\$4,050	\$4,675	\$4,934	\$4,560	-\$373
Reimbursable Funds	\$62	\$75	\$73	\$98	\$93	-\$5
Total	\$7,408	\$8,133	\$8,570	\$9,187	\$9,863	\$675
Annual % Change from Prior Year	4.0%	9.8%	5.4%	7.2%	7.4%	

Note: Includes fiscal 2011 deficiencies, fiscal 2011 planned reversions, fiscal 2012 contingent reductions and related special fund increases, fiscal 2012 Back of Bill reductions, fiscal 2012 funding included in the Department of Budget and Management earmarked for the Department of Health and Mental Hygiene, and approved fiscal 2011 budget amendments not included in the 2011 working appropriation where known.

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

M00 – DHMH – Fiscal 2012 Budget Overview

**Department of Health and Mental Hygiene
Fiscal 2011 Deficiencies**

<u>Program</u>	<u>Item</u>	<u>General Funds</u>	<u>Total Funds</u>
DHMH Administration	Funds for an H1N1 media campaign and oversight of Maryland’s Health Benefit Exchange including funding transferred to the Executive Department.	-\$35,133	\$1,726,354
DHMH Administration	Upgrade audio/video communications and implement the Electronic Verification of Vital Events System.	0	\$894,181
DHMH Administration	Establishment of the Office of Public Health Performance Management.	0	177,629
Infectious Disease and Env. Health	Supplemental funding for HIV screening, emerging infections, and infectious diseases.	0	2,047,514
Family Health	Supplemental funding for early childhood, home visiting, and parental responsibility education activities.	0	201,951
Family Health	Supplemental funding for a variety of cancer, tobacco, and other disease prevention activities.	0	3,256,094
Chief Medical Examiner	Supplemental funding for equipment.	0	83,595
Office of Preparedness and Response	Funding for public health emergency preparedness, bioterrorism hospital preparedness, and other activities.	0	5,187,103
Laboratories Administration	Supplemental funding for testing and monitoring activities.	0	1,090,752
Alcohol and Drug Abuse Administration	Funding to provide access to nontraditional recovery services.	0	3,507,858
Mental Hygiene	Funding for a three-state partnership focusing on children and youth with mental illness.	0	2,382,232
Mental Hygiene	Funding required due to declining Strategic Energy Investment Fund revenues.	2,252,786	0
Developmental Disabilities Administration	Funding for contractual positions to process Development Disabilities Administration provider claims.	190,194	288,173
Developmental Disabilities Administration	Funding required due to declining Strategic Energy Investment Fund revenues.	541,120	0

M00 – DHMH – Fiscal 2012 Budget Overview

<u>Program</u>	<u>Item</u>	<u>General Funds</u>	<u>Total Funds</u>
Medicaid	Funding for outreach activities related to Health-e-Kids and Emergency Room Diversion projects.	\$0	\$1,000,454
Medicaid	Funding to offset projected shortfalls in revenue from the Cigarette Restitution Fund and enhanced federal matching funds. This action includes the utilization of funds from the Senior Prescription Drug Assistance Program (\$2.5 million), contingent on legislation.	68,382,773	8,153,160
Medicaid	Funding associated with increased administrative costs associated with pharmacy claims processing (\$838,526) and a recent court settlement (\$16.0 million).	6,564,863	16,838,526
Medicaid	Reduced funding associated with the transfer of a position to the Executive Department.	-9,326	-18,652
Medicaid	Lower than estimated expenditures in the Kidney Disease Treatment program.	0	-1,000,000
Medicaid	Increased expenditure support from premium income in the Maryland Children’s Health Program.	0	6,321,003
Medicaid	Funding to reduce backlog of eligibility determinations tied to Supplemental Security Income or the Medicare Part D Low Income Subsidy.	175,000	350,000
Fiscal 2011 Deficiencies Total		\$78,062,277	\$52,487,927

DHMH: Department of Health and Mental Hygiene

Source: Department of Legislative Services; State Budget

M00 – DHMH – Fiscal 2012 Budget Overview

**Department of Health and Mental Hygiene
Fiscal 2011 Planned Reversions**

<u>Program</u>	<u>Item</u>	<u>Actual Funds</u>
Chief Medical Examiner	Building repair funds.	\$10,000
Total Fiscal 2011 Planned Reversion		\$10,000

Source: Department of Legislative Services; State Budget

M00 – DHMH – Fiscal 2012 Budget Overview

**Department of Health and Mental Hygiene
Fiscal 2012 Contingent Reductions**

<u>Agency/Program</u>	<u>Contingent Reductions</u>	<u>General Funds</u>	<u>Total Funds</u>
Infectious Disease and Environmental Health	Elimination of Youth Camp inspections.	\$334,152	\$334,152
Medicaid	Savings based on altering the methodology to account for graduate medical education in the hospital rate-setting system.	17,500,000	35,000,000
Medicaid	Reduction in general fund support for nursing homes contingent on legislation increasing the nursing home quality assessment and allowing a portion of that assessment to supplant general funds.	13,000,000	0
Medicaid	Making \$11.6 million of fiscal 2012 special fund support for the Kidney Disease Program, contingent on legislation authorizing the use of revenue from a nonprofit health service plan (CareFirst).	11,600,000	0
Total Fiscal 2012 Contingent Reductions		\$42,434,152	\$35,334,152

DHMH: Department of Health and Mental Hygiene

Source: Department of Legislative Services; State Budget

M00 – DHMH – Fiscal 2012 Budget Overview

**Department of Health and Mental Hygiene
Fiscal 2011 and 2012 Fund Transfers
Contingent on Legislation**

<u>Agency/Program</u>	<u>Item</u>	<u>2011</u>	<u>2012</u>
Family Health	Fund balance transfer from the Spinal Cord Injury Trust Fund (fiscal 2011 transfer approved in 2010 session).	\$500,000	\$500,000
Health Occupations Boards	Fund balance transfers. Fiscal 2011 transfers as approved in 2010 session. Fiscal 2012 transfers from Board of Pharmacy Fund (\$237,888) and Board of Psychologists Fund (\$44,888).	1,300,000	282,776
Regulatory Commissions	Maryland Health Care Commission fund balance.	1,000,000	0
Total Fund Transfers		\$2,800,000	\$782,776

Source: Department of Legislative Services; State Budget

M00 – DHMH – Fiscal 2012 Budget Overview

**Department of Health and Mental Hygiene
Other Actions**

Medicaid	Making \$225 million of the fiscal 2012 special fund appropriation contingent on legislation authorizing an increase in a Medicaid hospital assessment and making a change to the averted uncompensated care assessment methodology.
DHMH	Section 18. Fiscal 2012 retiree prescription drug benefit savings (\$3,165,002) contingent on legislation.
DHMH	Section 19. Fiscal 2012 higher employee prescription copays and out-of-pocket maximum (\$899,634).
DHMH	Section 20. Fiscal 2012 health insurance savings based on favorable cost trends (\$1,012,545).
DHMH	Section 21. Fiscal 2012 savings from changes in the retirement benefit and retirement contribution rates (\$3,230,636) contingent on legislation.
DHMH	Section 22. Fiscal 2012 abolition of positions due to Voluntary Separation Program (\$40,000,000 in general funds savings statewide).
DHMH	Section 24. Fiscal 2012 consolidation of law enforcement operations into the Department of General Services (\$318,000 DHMH and DLLR combined).
DHMH	Fiscal 2012. Contingent on legislation, the collection of interest on many of the health-related special funds into the general fund. This action was already taken for fiscal 2011 in the Budget Reconciliation and Financing Act of 2010.

DHMH: Department of Health and Mental Hygiene
DLLR: Department of Labor, Licensing, and Regulation

Source: Department of Legislative Services; State Budget

M00 – DHMH – Fiscal 2012 Budget Overview

**Department of Health and Mental Hygiene
Fiscal 2011 and Fiscal 2012 Revenue Adjustments**

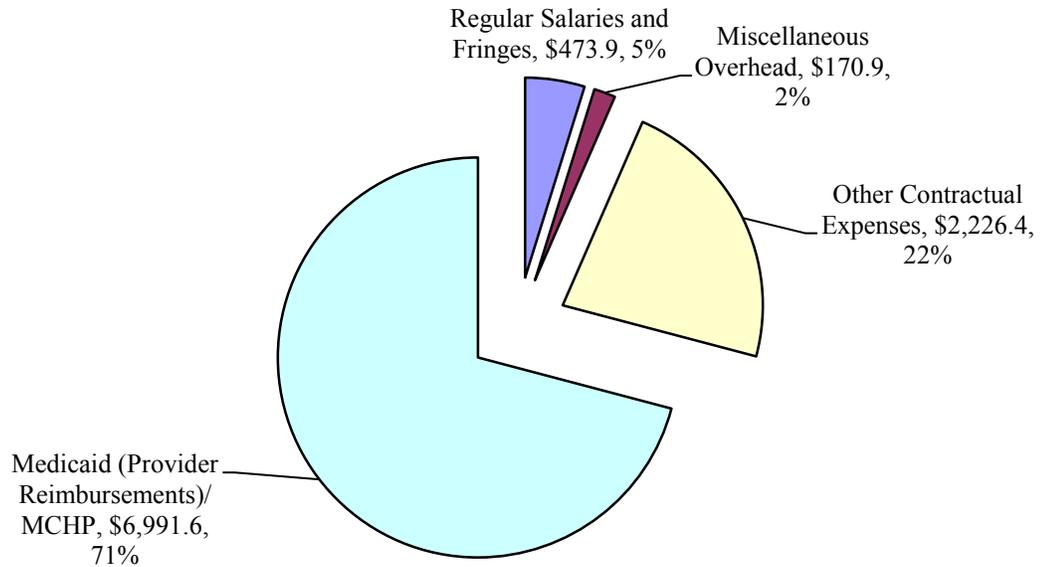
<u>Agency/Program</u>	<u>Item</u>	<u>2011</u>	<u>2012</u>
DDA	Increase in interest income based on moving provider payments to a retrospective payment system. This action is contingent on legislation.		\$525,000
DHMH	Chronic hospitals. Change in patient mix (more hospital patients and less comprehensive/nursing patients) results in higher patient recoveries than originally anticipated.	\$0	1,200,000
DHMH	Proposed increase in the Medicaid hospital assessment results in slightly higher recoveries at State-run hospitals.		300,000
DHMH	Fund balance transfers that were double-counted as DHMH miscellaneous revenues.	-2,977,129	-45,975
Total Revenue Adjustments		-\$2,977,129	\$1,454,025

DDA: Developmental Disabilities Administration
DHMH: Department of Health and Mental Hygiene

Source: Department of Legislative Services; State Budget

M00 – DHMH – Fiscal 2012 Budget Overview

**Department of Health and Mental Hygiene
Functional Breakdown of Spending
Fiscal 2012 Allowance
(\$ in Millions)**



MCHP: Maryland Children’s Health Program

Note: Includes fiscal 2012 contingent reductions, and fiscal 2012 Back of Bill reductions where known.

Source: Department of Legislative Services; State Budget

M00 – DHMH – Fiscal 2012 Budget Overview

**Department of Health and Mental Hygiene
Budget Overview: All Funding Sources
Fiscal 2010-2012
(\$ in Thousands)**

	<u>Actual 2010</u>	<u>Working 2011</u>	<u>Allowance 2012</u>	<u>\$ Change 2011-12</u>	<u>% Change 2011-12</u>
Medical Programs/Medicaid	\$6,004,027	\$6,523,898	\$7,100,419	\$576,521	8.8%
Provider Reimbursements	5,742,171	6,232,357	6,777,948	545,592	8.8%
Maryland Children’s Health Program	192,257	197,636	208,904	11,268	5.7%
Other	69,599	93,906	113,567	19,661	20.9%
Mental Hygiene	\$944,701	\$980,849	\$1,061,455	\$80,605	8.2%
Program Direction	7,900	8,015	8,597	583	7.3%
Community Services	675,791	716,605	787,133	70,529	9.8%
Facilities	261,010	256,230	265,724	9,494	3.7%
Developmental Disabilities	\$781,805	\$805,224	\$832,446	\$27,222	3.4%
Program Direction	5,833	6,349	6,477	129	2.0%
Community Services	731,326	756,330	784,926	28,595	3.8%
Facilities	44,646	42,545	41,042	-1,502	-3.5%
Infectious Disease and Environmental Health	\$171,770	\$162,873	\$160,039	-\$2,834	-1.7%
Targeted Local Health	41,776	41,776	41,776	0	0.0%
Office of Preparedness and Response	35,370	26,316	17,406	-8,910	-33.9%
Community Health	94,623	94,780	100,857	6,077	6.4%
Family Health	209,384	221,083	219,105	-1,978	-0.9%
Women, Infants, and Children	98,715	110,709	108,232	-2,476	-2.2%
CRF Tobacco and Cancer	18,390	17,742	17,871	128	0.7%
Other	92,279	92,632	93,002	370	0.4%
Alcohol and Drug Abuse	\$140,146	\$151,384	\$150,472	-\$912	-0.6%
Other Budget Areas	\$317,758	\$342,135	\$347,119	\$4,984	1.5%
DHMH Administration	47,147	52,498	53,214	716	1.4%
Office of Health Care Quality	16,308	16,719	17,296	577	3.5%
Health Occupations Boards	24,534	27,714	29,074	1,360	4.9%
Chronic Disease Hospitals	44,493	44,814	47,267	2,454	5.5%
Chief Medical Examiner	9,977	10,405	10,326	-79	-0.8%
Laboratories Administration	24,492	24,165	23,667	-499	-2.1%
Health Regulatory Commissions	150,807	165,821	166,275	455	0.3%
Fiscal 2012 Back of Bill Sections			-8,308		
Total Funding	\$8,569,591	\$9,187,446	\$9,862,747	\$675,300	7.4%

CRF: Cigarette Restitution Fund

DHMH: Department of Health and Mental Hygiene

Note: Includes fiscal 2011 deficiencies, fiscal 2011 planned reversions, fiscal 2012 contingent reductions and related special fund increases, fiscal 2012 Back of Bill reductions, fiscal 2012 funding included in the Department of Budget and Management earmarked for the Department of Health and Mental Hygiene, and approved fiscal 2011 budget amendments not included in the 2011 working appropriation where known. Some numbers may not sum to total due to rounding.

Source: Department of Legislative Services; State Budget

M00 – DHMH – Fiscal 2012 Budget Overview

**Department of Health and Mental Hygiene
Budget Overview: General Funds Only
Fiscal 2010-2012
(\$ in Thousands)**

	<u>Actual 2010</u>	<u>Working 2011</u>	<u>Allowance 2012</u>	<u>\$ Change 2011-12</u>	<u>% Change 2011-12</u>
Medical Programs/Medicaid	\$1,593,968	\$1,846,142	\$2,599,538	\$753,396	40.8%
Provider Reimbursements	1,509,956	1,756,069	2,491,891	735,822	41.9%
Maryland Children’s Health Program	59,988	62,436	66,766	4,330	6.9%
Other	24,024	27,637	40,881	13,245	47.9%
Mental Hygiene	\$621,672	\$629,479	\$678,902	\$49,423	7.9%
Program Direction	5,640	5,779	6,150	371	6.4%
Community Services	364,078	375,721	416,885	41,164	11.0%
Facilities	251,954	247,979	255,868	7,888	3.2%
Developmental Disabilities	\$470,267	\$482,898	\$484,668	\$1,770	0.4%
Program Direction	4,074	4,435	4,435	0	0.0%
Community Services	422,373	436,212	440,447	4,235	1.0%
Facilities	43,820	42,251	39,786	-2,465	-5.8%
Infectious Disease and Environmental Health	\$47,601	\$47,151	\$47,374	\$223	0.5%
Targeted Local Health	37,283	37,283	37,283	0	0.0%
Office of Preparedness and Response	0	0	0	0	0.0%
Community Health	10,318	9,867	10,090	223	2.3%
Family Health	37,328	31,657	31,609	-\$48	-0.2%
Women, Infants, and Children	148	105	100	-5	-4.8%
CRF Tobacco and Cancer	1,155	0	0	0	0.0%
Other	36,025	31,552	31,509	-43	-0.1%
Alcohol and Drug Abuse	\$89,407	\$85,829	\$83,141	-\$2,688	-3.1%
Other Budget Areas	\$102,736	\$105,053	\$109,572	\$4,518	4.3%
DHMH Administration	24,961	27,252	28,295	1,042	3.8%
Office of Health Care Quality	9,444	9,768	10,013	245	2.5%
Health Occupations Boards	297	327	327	1	0.2%
Chronic Disease Hospitals	38,964	38,853	41,473	2,620	6.7%
Chief Medical Examiner	9,559	10,008	10,024	16	0.2%
Laboratories Administration	19,511	18,846	19,440	594	3.2%
Health Regulatory Commissions	0	0	0	0	0.0%
Fiscal 2012 Back of Bill Sections			-7,327		
Total Funding	\$2,962,979	\$3,228,208	\$4,027,476	\$799,268	24.8%

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

Note: Includes fiscal 2011 deficiencies, fiscal 2011 planned reversions, fiscal 2012 contingent reductions, fiscal 2012 Back of Bill reductions, fiscal 2012 funding included in the Department of Budget and Management earmarked for the Department of Health and Mental Hygiene, and approved fiscal 2011 budget amendments not included in the 2011 working appropriation where known. Some numbers may not sum to total due to rounding.

Source: Department of Legislative Services; State Budget

M00 – DHMH – Fiscal 2012 Budget Overview

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

	<u>General Fund</u>	<u>Special Fund</u>	<u>Federal Fund</u>	<u>Reimb. Fund</u>	<u>Total</u>
2011 Working Appropriation	\$3,228,208	\$927,435	\$4,933,610	\$98,194	\$9,187,446
2012 Governor’s Allowance	4,027,476	1,181,428	\$4,560,395	93,448	9,862,747
Amount Change	799,268	253,993	-373,215	-4,746	675,300
Percent Change	24.8%	27.4%	-7.6%	-4.8%	7.4%

Where It Goes:

Major Personnel Expense Changes	\$11,668
Regular Earnings, including restoration of furloughs	10,185
Employee and retiree health insurance	5,980
Retirement contribution	5,552
Other fringe benefit adjustments	1,044
Workers’ compensation assessment.....	819
Section 19 savings from higher employee prescription co-pays and out-of-pocket maximum	-900
Section 20 savings in health insurance costs based on favorable cost trends	-1,013
Miscellaneous adjustments.....	-1,173
Savings from the closure of Brandenburg Center	-2,431
Section 18 savings from retiree prescription drug benefits.....	-3,165
Section 21 savings from changes in the retirement benefit and retirement contribution rates.....	-3,231
Major Programmatic Changes (Exc. Medicaid)	\$94,552
Mental Hygiene Administration	\$71,521
Fee-for-Service	
Community mental health fee-for-service enrollment and utilization	81,968
Statutory rate adjustment (1.13%) for non-rate regulated fee-for-service providers (Chapters 497 and 498 of 2010).....	5,435
Cost containment rate reduction (2.5% for non-rate regulated fee-for-service providers)	-12,025
Grants and Contracts	
Rate adjustment for grant and contracts (1.13%).....	590
Cost containment rate reduction (2.5%) and additional CSA cost containment (\$500,000)	-1,804
End of Transformation Grant funding (federal funds).....	-2,643
Developmental Disabilities Administration	\$27,839
Transitioning youth funding (608 placements).....	10,143
Rate adjustment associated with absence day funding.....	5,701

M00 – DHMH – Fiscal 2012 Budget Overview

Where It Goes:

Annualization of fiscal 2011 placements	4,883
Emergency placements (50 placements)	2,264
Statutory rate adjustment for community providers (Chapters 497 and 498 of 2010)	2,230
Waiting List Equity Fund placements (40 placements)	1,486
New forensic placements (26 placements)	1,132

Family Health **-\$2,476**

WIC (federal funds)	-2,476
---------------------------	--------

Infectious Disease and Environmental Health **-\$2,332**

HIV Health and Support Services	4,497
MADAP-Plus	1,587
Office of Preparedness and Response (Various federal funds)	-8,416

Medicaid/Medical Care Programs Administration **\$571,033**

Medicaid/Maryland Children’s Health Program (Programs 03 and 07) **\$674,054**

Enrollment, utilization and inflation	479,380
MCO Calendar 2011 rate increase (4.4%). Note also cost containment action below	117,920
Increase in the Medicare clawback	35,664
MCO Share of proposed fiscal 2012 hospital assessment increase.....	22,000
Medicare Part A and B premiums	9,199
Pharmacy rebates	8,217
MCO Statewide incentive payments	7,000
Nursing home cost settlements.....	4,158
Medicaid program recoveries.....	2,608
Graduate medical education payments	2,546
Community first choice offset by reduction in personal care services.....	2,400
Money Follows the Person.....	2,105
Waiver enrollment services contracts	1,974
Patient centered medical homes	1,500
Decreased estimate of available patient resources for nursing home payments	1,000
STEPS evaluations.....	-1,260
Supplemental pharmacy rebates.....	-1,318
Federally qualified health centers supplemental payments.....	-4,466
Nursing home cost settlement receipts.....	-6,830
School Based Services (Reimbursable funds).....	-9,742

Cost Containment Actions **-\$119,882**

Reduce generic drug prices	-1,000
Annualization of MCO pharmacy rebate cut	-1,813
Deny coverage of off-label use of antipsychotics	-1,720
Deny coverage of medications with no clinical benefit	-2,000

M00 – DHMH – Fiscal 2012 Budget Overview

Where It Goes:

1% cut for Private Duty Nurses and Waiver providers.....	-3,153
Third Party Liability initiative	-4,000
MCO calendar 2012 efficiency adjustment.....	-5,700
Fee-for-service/MCO 1% physician rate cut.....	-7,646
Annualize Medicaid/Medicare rate realignment savings	-7,400
Strict review of emergency room coverage for undocumented aliens	-10,000
Require Washington DC Hospitals to accept FFS rates in MCOs.....	-12,050
1% MCO rate reduction effective July 1, 2011.....	-13,400
Cost containment to be specified (derived from 2010 JCR reports).....	-15,000
Savings generated from pooling of graduate medical education rates.....	-35,000
Other Medical Care Programs Administration	\$16,860
Health Care Reform information technology project.....	8,100
Medicaid Management Information System replacement.....	3,518
Health information technology incentives to encourage the use of electronic health records	3,478
Administrative contracts (administrative change).....	1,764
Other	-1,952
Total	\$675,300

CSA: Core Service Agency
 FFS: fee-for-service
 JCR: *Joint Chairmen's Report*
 MADAP: Maryland Aids Drug Assistance Program
 MCO: Managed Care Organization
 WIC: Women, Infants, and Children Food Program

Note: Includes fiscal 2011 deficiencies, fiscal 2011 planned reversions, fiscal 2012 contingent reductions and related special fund increases, fiscal 2012 Back of Bill reductions, fiscal 2012 funding included in the Department of Budget and Management earmarked for the Department of Health and Mental Hygiene, and approved fiscal 2011 budget amendments not included in the 2011 working appropriation where known.

M00 – DHMH – Fiscal 2012 Budget Overview

**Department of Health and Mental Hygiene
Regular Employees (FTE)
Fiscal 2010-2012**

	<u>Actual 2010</u>	<u>Working 2011</u>	<u>Allowance 2012</u>	<u>Change 2011-12</u>	<u>% Change 2011-12</u>
DHMH Administration	441.5	444.5	444.5	0.0	0.0%
Office of Health Care Quality	186.2	183.7	183.7	0.0	0.0%
Health Occupations Boards	247.3	253.1	258.6	5.5	2.2%
Infectious Disease and Environmental Health	252.1	249.0	249.0	0.0	0.0%
Family Health	173.3	170.3	170.3	0.0	0.0%
Chief Medical Examiner	81.0	81.0	80.4	-0.6	-0.7%
Chronic Hospitals	547.1	537.1	537.1	0.0	0.0%
Laboratories Administration	243.0	243.0	242.0	-1.0	-0.4%
Alcohol and Drug Abuse Administration	62.5	64.5	64.5	0.0	0.0%
Mental Hygiene Administration	2,913.1	2,891.1	2,891.1	0.0	0.0%
Administration	90.5	85.5	85.5	0.0	0.0%
Institutions	2,822.6	2,805.6	2,805.6	0.0	0.0%
Developmental Disabilities Administration	730.3	685.5	685.5	0.0	0.0%
Administration	167.5	166.5	166.5	0.0	0.0%
Institutions	562.8	519.0	519.0	0.0	0.0%
Medical Care Programs Administration	610.0	612.0	619.0	7.0	1.1%
Health Regulatory Commissions	96.6	96.6	99.7	3.1	3.2%
Total Regular Positions	6,583.9	6,511.3	6,525.3	14.0	0.2%

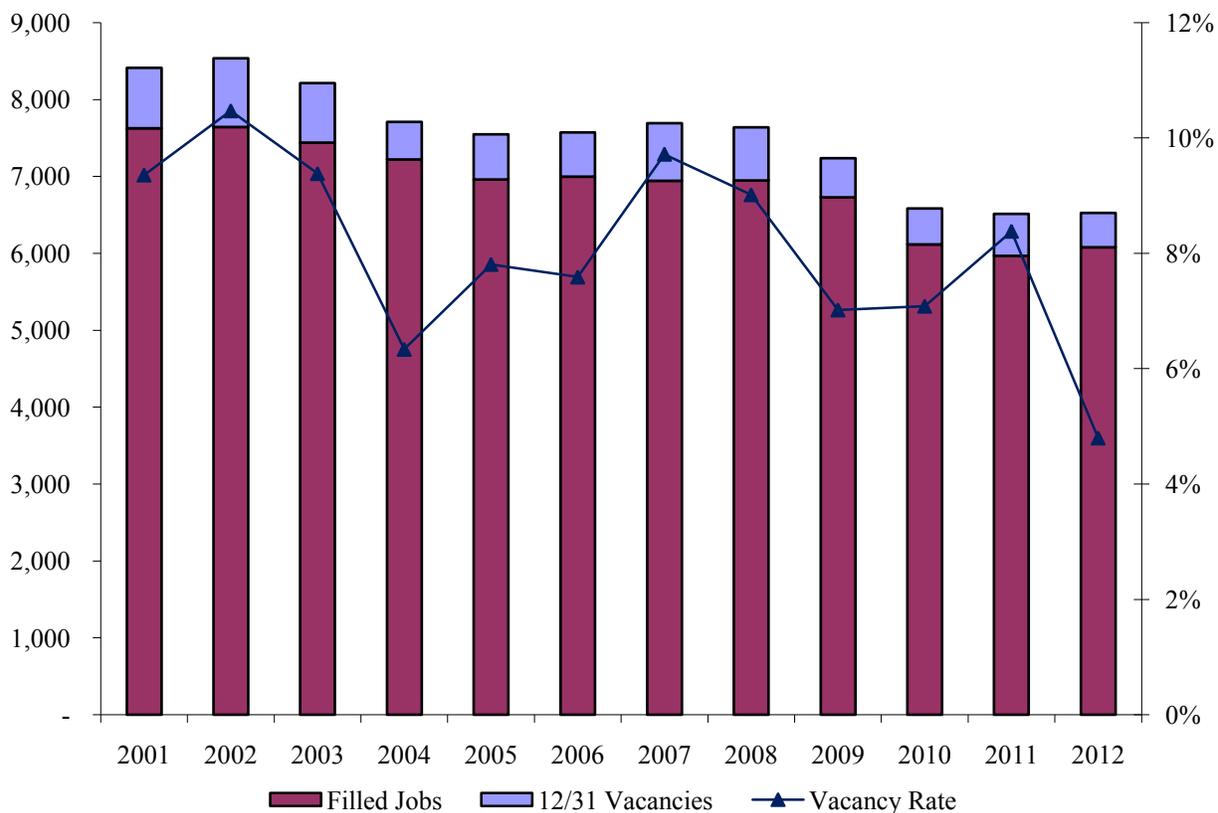
DHMH: Department of Mental Health and Hygiene
FTE: full-time equivalent

Note: Infectious Disease and Environmental Health includes Office of Preparedness and Response.

Source: State Budget

M00 – DHMH – Fiscal 2012 Budget Overview

**Department of Health and Mental Hygiene
Regular Employee Filled Jobs and Vacancy Rates
Fiscal 2001-2012**



Note: Fiscal 2012 reflects budgeted turnover rate.

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

M00 – DHMH – Fiscal 2012 Budget Overview

**Department of Health and Mental Hygiene
Regular Employees – Vacancy Rates
December 31, 2010**

	<u>FTE Vacancies</u>	<u>FTE Positions</u>	<u>Vacancy Rate</u>
DHMH Administration	43.0	444.5	9.7%
DHMH Office of Health Care Quality	23.3	183.7	12.7%
DHMH Health Occupation Boards	29.8	253.1	11.8%
DHMH Infectious Disease and Environmental Health	26.4	249.0	10.6%
DHMH Family Health	9.0	170.3	5.3%
DHMH Office of the Chief Medical Examiner	8.0	81.0	9.9%
DHMH Chronic Hospitals	46.5	537.1	8.7%
DHMH Laboratories Administration	16.0	243.0	6.6%
DHMH Alcohol and Drug Abuse Administration	10	64.5	15.5%
DHMH Mental Hygiene Administration	203.7	2,891.1	7.0%
DHMH Developmental Disabilities Administration	67.5	685.5	9.8%
DHMH Medical Care Programs Administration	52.6	612.0	8.6%
DHMH Health Regulatory Commissions	10.0	96.6	10.4%
DHMH Total	545.8	6,511.3	8.4%

DHMH: Department of Health and Mental Hygiene
FTE: full-time equivalent

Note: Infectious Disease and Environmental Health includes Office of Preparedness and Response.

Source: State Budget; Department of Budget and Management

M00 – DHMH – Fiscal 2012 Budget Overview

**Department of Health and Mental Hygiene
Contractual Employees (FTE)
Fiscal 2010-2012**

	<u>Actual 2010</u>	<u>Working 2011</u>	<u>Allowance 2012</u>	<u>Change 2011-12</u>	<u>% Change 2011-12</u>
DHMH Administration	10.28	12.63	9.26	-3.37	-26.7%
Office of Health Care Quality	4.51	5.40	11.90	6.50	120.4%
Health Occupations Boards	7.78	9.10	12.11	3.01	33.1%
Infectious Disease and Environmental Health	5.74	2.52	2.57	0.05	2.0%
Family Health	4.79	6.33	6.71	0.38	6.0%
Chief Medical Examiner	6.07	5.55	5.55	0.00	0.0%
Chronic Hospitals	21.92	18.86	18.54	-0.32	-1.7%
Laboratories Administration	6.01	5.28	3.88	-1.40	-26.5%
Alcohol and Drug Abuse Administration	2.16	4.67	8.67	4.00	85.7%
Mental Hygiene Administration	166.79	184.51	183.11	-1.40	-0.8%
Administration	1.83	2.00	2.00	0.00	0.0%
Institutions	164.96	182.51	181.11	-1.40	-0.8%
Developmental Disabilities Administration	28.78	33.40	31.13	-2.27	-6.8%
Administration	6.40	9.50	8.50	-1.00	-10.5%
Institutions	22.38	23.90	22.63	-1.27	-5.3%
Medical Care Programs Administration	42.02	42.82	64.14	21.32	49.8%
Health Regulatory Commissions	0.00	0.00	0.00	0.00	0.0%
DHMH Administration	306.85	331.07	357.57	26.50	8.0%

DHMH: Department of Health and Mental Hygiene
FTE: full-time equivalents

Note: Infectious Disease and Environmental Health includes Office of Preparedness and Response.

Source: State Budget

M00 – DHMH – Fiscal 2012 Budget Overview

**Department of Health and Mental Hygiene
Budget Overview: Selected Caseload Measures
Fiscal 2008-2012**

	<u>2008</u>	<u>2008</u>	<u>2010</u>	<u>Working 2011</u>	<u>Allowance 2012</u>	<u>Change 2011-12</u>	<u>% Change 2011-12</u>
Medical Programs/Medicaid							
Medicaid Enrollees	512,247	541,446	621,585	692,210	733,450	41,240	6.0%
Maryland Children’s Healthcare Program	104,991	105,617	97,998	98,000	101,000	3,000	3.1%
Medicaid Expansion to Parents		29,273	55,250	72,800	82,000	9,200	12.6%
Primary Adult Care	29,221	28,771	40,397	50,000	56,000	6,000	12.0%
Developmental Disabilities Administration							
Residential Services	5,105	5,264	5,335	5,537	5,615	78	1.4%
Day Services	6,153	6,395	6,693	6,816	6,854	38	0.6%
Supported Employment	3,932	4,137	4,362	4,992	5,600	608	12.2%
In-home support services	8,090	6,998	5,518	5,947	5,947	0	0.0%
Other alternative residential support services ¹	1,980	2,056	2,102	2,134	2,134	0	0.0%
Average daily census at institutions ²	324	254	185	186	180	-6	-3.2%
Mental Hygiene Administration							
Average daily populations at State-run psychiatric hospitals:							
Hospitals excluding RICAs and Assisted Living							
	1,112	1,075	994	958	955	-3	-0.3%
RICAs							
	106	93	78	68	68	0	0.0%
Assisted Living							
	101	105	133	142	145	3	2.1%
Total	1,319	1,273	1,205	1,168	1,168	0	0.0%
Number receiving community mental health services							
Medicaid eligible	82,256	93,432	108,896	116,075	121,825	5,750	5.0%
Medicaid ineligible	17,126	18,246	13,150	12,000	12,000	0	0.0%
Total	99,382	111,678	122,046	128,075	133,825	5,750	4.5%
Alcohol and Drug Abuse Administration							
Clients served in various settings	59,341	61,223	63,165	63,200	63,450	250	0.4%

RICAs: Regional Institutions for Children and Adolescents
SETT: Secure evaluation and therapeutic treatment

¹ Other alternative residential support services includes Community Supported Living Arrangements, Self Directed Services, and Individual Family Care

² Developmental Disabilities Administration institutional data includes SETT units

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

Issues

1. Cigarette Restitution Fund Issues

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

Background

The distribution of MSA funds among the states is determined by formula, with Maryland receiving 2.26% of MSA monies, which are adjusted for inflation, volume, and prior settlements. In addition, the State will collect 3.3% 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.

The use of the CRF is restricted by statute in a variety of ways. For example:

- at least 50.0% of the funds must be appropriated to fund the Tobacco Use Prevention and Cessation Program, the Cancer Prevention, Education, Screening, and Treatment Program, eight health-related priorities including tobacco control and cessation, cancer prevention, treatment and research, and substance abuse treatment and prevention, and tobacco production alternatives;
- mandated appropriations to the Tobacco Use Prevention and Cessation Program and the Cancer Prevention, Education, Screening, and Treatment Program;
- at least 30.0% of the funds must be appropriated to Medicaid;
- at least 0.15% of the fund is dedicated to enforcement of Title 16, Subtitle 5 of the Business Regulation Article (Escrow Requirements for Nonparticipating Tobacco Product Manufacturers) by the Office of the Attorney General; and
- the Governor is required to appropriate at least the lesser of \$100 million or 90.0% of the estimated funds available in the annual budget.

These guidelines were primarily part of Chapters 172 and 173 of 1999 which originally created the CRF, although the Medicaid requirements were added later.

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

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

The Office of the Attorney General notes that arbitration on sales year 2003 began during calendar 2010. At this stage, the hearings are dealing with preliminary legal and jurisdictional issues. Rulings are unlikely for another year or perhaps longer. At this point, this ongoing delay calls into question assumptions made in terms of the fiscal 2011 CRF revenues that the State would be receiving \$12 million from prior year escrowing associated with the NPM litigation.

Fiscal 2010-2012 CRF Programmatic Support

Exhibit 1 provides CRF revenue and expenditure detail for fiscal 2010 to 2012. Since the adoption of the fiscal 2011 budget, a number of key changes have occurred to the CRF fiscal 2011 revenue assumptions and fiscal 2011 spending plan:

- Settlement payments were sharply lower primarily as a result of an increased volume reduction. As shown in Exhibit 1, settlement payments are projected to shrink further in fiscal 2012.
- The lower than anticipated settlement payment resulted in an \$8.2 million reduction in CRF support for Medicaid, necessitating a fiscal 2011 deficiency appropriation.

One assumption that remains unchanged for fiscal 2011, as noted above, concerns the receipt of \$12 million from prior year escrowing associated with the NPM litigation. Given the state of that litigation, it is unlikely that such funding will be available and presumably will require an additional deficiency requirement for Medicaid or the rolling of fiscal 2011 bills into fiscal 2012.

With the State's fiscal problems, many of the statutory funding restrictions on CRF funding were altered in the Budget Reconciliation and Financing Act of 2010, freezing most fiscal 2012 mandatory spending at fiscal 2011 levels. Indeed, with the exception of Medicaid, CRF-supported program spending in fiscal 2012 is virtually the same as fiscal 2011.

Exhibit 1
Cigarette Restitution Fund Budget
Fiscal 2010-2012
(\$ in Millions)

	<u>2010</u>	<u>Working 2011</u>	<u>Allowance 2012</u>
Beginning Fund Balance	\$10.3	\$2.4	\$0.1
Settlement Payments	135.0	130.0	128.2
NPM and Other Shortfalls in Payments ¹	-12.7	-12.0	-12.0
Awards from Disputed Account	0.0	12.0 ³	
Other Adjustments ²	34.8	34.8	33.4
Subtotal	\$167.4	\$167.2	\$149.7
Prior Year Recoveries	1.4	1.5	0.0
Total Available Revenue	\$168.7	\$168.7	\$149.7
Health			
Tobacco	\$4.1	\$3.6	\$3.6
Cancer	11.5	14.3	14.4
Substance Abuse	17.1	21.1	21.0
Medicaid	106.2	104.0	84.0
Administration	1.0	0.0	0.0
Breast and Cervical Cancer	14.6	15.2	15.2
Subtotal	\$154.4	\$158.1	\$138.2
Other			
Aid to Nonpublic School	\$4.5	\$4.5	\$4.5
Crop Conversion	7.0	5.0	5.5
Attorney General	0.4	1.0	0.9
Subtotal	\$11.9	\$10.5	\$11.0
Total Expenses	\$166.4	\$168.6	\$149.2
Ending Fund Balance	\$2.4	\$0.1	\$0.5

NPM: nonparticipating manufacturer

¹The NPM adjustment represents the bulk of this total adjustment.

²Other adjustments include the strategic contribution payments and the National Arbitration Panel award.

³Given the status of NPM litigation, this award is unlikely. See text for additional details.

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

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

The decline in anticipated settlement payments and the fiscal 2012 assumption of escrowing associated with NPM litigation is reflected in that lower support for Medicaid. This same decline in the available settlement payments also does not bode well for fiscal 2013. Under current law, in fiscal 2013 mandated funding levels for tobacco use prevention and cessation programs are scheduled to increase by \$4.0 million from 2012 levels (\$6.0 million to \$10.0 million) and funding for statewide academic health centers by \$10.6 million (\$2.4 million to \$13.0 million). Absent any immediate relief from NPM litigation, this will likely result in less CRF support for Medicaid and increase the need for general fund support.

2. Patient Protection and Affordable Care Act: What It Means for the 2011 Session

The federal Patient Protection and Affordable Care Act is intended to expand health care coverage, control health care costs, and improve the health care delivery system. The new law has far-reaching implications for the states, as well as individuals.

For Maryland, the most immediate responsibilities for the State fall into the following areas: Medicaid, an insurance exchange, insurance regulation, federal high risk pool, and the State Employee and Retiree Health and Welfare Benefits Program. These responsibilities will translate into legislative or budget decisions in the 2011 session. Specifically:

- The State is responsible for implementing the Medicaid expansion, transitioning to a new income eligibility methodology based on modified adjusted gross income, maintaining adequate provider networks for Medicaid enrollees, and most notably, developing a new eligibility system that will coordinate with a State health insurance exchange and existing programs. Planning funding for the eligibility system is included in the 2012 budget.
- By 2014, the State must establish an American Health Benefit Exchange that facilitates the individual purchase of qualified health plans and includes an exchange for small businesses. The State will need to enact legislation to establish the exchange. Key decisions to be made include governance and operation of the exchange; how many exchanges to establish; functions of the exchange; market considerations; participation by small businesses (whether to allow employers with up to 50 or up to 100 employees to participate); and required benefits (with approximately 42 benefits currently mandated by law, Maryland has more mandated benefits than most other states). At a minimum, legislation concerning governance or the creation of an entity to develop more substantive recommendations for the insurance exchange may be introduced in the 2011 session.
- The Maryland Insurance Administration (MIA) is responsible for overseeing and enforcing many of the new federal and State insurance requirements. MIA will ensure that insurers are adhering to all of the new consumer protections in the federal law and is already doing so for the protections that took effect on September 23, 2010. Legislation is anticipated at the 2011 session to amend the specific sections of the Insurance Article that are out of compliance with the provisions of federal law that took effect in 2010 or will take effect in 2011.

M00 – DHMH – Fiscal 2012 Budget Overview

- The federal law establishes a temporary high-risk pool to help uninsured individuals gain access to health insurance before the major health care reforms take effect in January 2014. In Maryland, as a result of Chapter 173 of 2010, the high-risk pool is already operated by the Maryland Health Insurance Plan (MHIP), operating side-by-side with the existing State high-risk pool, and funding is included in the 2012 budget.
- The Department of Budget and Management (DBM) had initially determined that the State Employee and Retiree Health and Welfare Benefits Program is a grandfathered plan under the reform law and, as such, is exempt from a prohibition on employee cost-sharing for certain preventive health services and from a requirement to set up a more structured internal and external benefits appeal process. However, proposed changes to the plan in the fiscal 2012 budget mean the plan is no longer grandfathered. Losing the exemption from the preventive services cost-sharing prohibition will cost the State approximately \$2.0 million. The State will also need to make other changes for the fiscal 2012 plan year, including expanding coverage to adult children from age 25 up to age 26 (children no longer need to be dependents); and eliminating the lifetime maximum benefits in the preferred provider organization and point of service plans. DBM expects the changes (almost entirely from the expanded young adult coverage) to cost approximately \$16.0 million.
- Finally, the fiscal 2012 budget includes funding to create a three-person office within the Governor's Office to coordinate health care reform.

In addition to legislative and budget activities around federal health care reform implementation, the 2011 session may also see legislation to limit, alter, or oppose selected state or federal actions, including single-payer provisions and the individual mandate (three bills were introduced in the 2010 session). However, it is more likely to be at the federal level where significant legal challenges are decided.

There have been at least 24 legal challenges filed in the wake of the passage of the Patient Protection and Affordable Care Act of 2010. The cases involve at least 26 states, as well as public interest groups, educational institutions, and numerous individuals. Although other provisions have been included in the complaints, by far the most challenged provisions of the law are the minimum essential coverage provision, which is commonly referred to as the individual mandate, and the related penalty. Those provisions have been most often challenged on the grounds that they violate the Commerce Clause. Of the 24 cases, 4 cases have received the most attention: *Thomas More Law Center v. Obama*, where the lower court's denial of the plaintiffs' claim for an injunction and relief and ruling that the health care reform law was constitutional under the Commerce Clause is on appeal to the U.S. Court of Appeals for the Sixth Circuit; *Liberty University v. Geithner*, where the lower court's granting of a motion to dismiss after finding that the challenged provisions, including the individual mandate and penalty, were constitutional is on appeal to the U.S. Court of Appeals for the Fourth Circuit Court; *Virginia v. Sebelius*, where the lower court ruled that the individual mandate and penalty were unconstitutional and an appeal has not yet been filed; and *Florida v. U.S. Department of Health and Human Services*, where the lower court dismissed part of the complaint, but ruled that the plaintiffs had standing to challenge the individual mandate and penalty and the

expansion of Medicaid and oral arguments were heard on December 16, 2010, but no ruling on those issues has been made.

Budgetary Implications of Federal Health Care Reform Implementation

With the exception of the potential impact on the State Employee and Retiree Health and Welfare Benefits Program, the immediate fiscal impact of implementing federal health care reform is minimal. In the longer term, however, there are significant budget decisions that the State will face.

As part of its work in the 2010 interim, the Maryland Health Care Coordinating Council, established by executive order, analyzed the potential cost implications of health care reform implementation. In its evaluation, the council estimated that health care reform would cut the State's uninsured rate by half, from 800,000 to approximately 400,000. The council also estimated that the State would realize net savings of \$829 million over the period of 2010 through 2020.

Exhibit 2 summarizes the financial discussion of the Council. More detail on the assumptions underpinning this exhibit can be found at <http://www.healthreform.maryland.gov/documents/100726appendixf.pdf>. For the purpose of this overview, rather than examine in detail all the assumptions behind the exhibit, a number of broader observations about the decisions that the legislature may face in this term if health care reform implementation proceeds as expected can be made:

- Although the Department of Health and Mental Hygiene (DHMH) will likely expend tremendous effort on preparing for the Medicaid expansion and establishment of eligibility systems for the exchange, the initial cost of Medicaid expansion will be negligible. As noted in the exhibit, the impact on State finances does not really begin until fiscal 2015, before growing sharply toward the end of the decade.
- In order to achieve the savings envisaged in Exhibit 2, it is assumed that the legislature will need to redirect revenues currently raised from the MHIP hospital assessment (1%) to offset Medicaid costs when the MHIP is presumably phased out beginning in fiscal 2014. The imposition of a hospital assessment to support Medicaid in the fiscal 2011 budget and the proposal to significantly increase such an assessment as a statutory provision in the fiscal 2012 budget may well play into any decision to re-direct the MHIP revenues.
- Similarly, Exhibit 2 assumes cuts to existing safety net programs (based on the assumption that there will be fewer under- and uninsured). During meetings of the Health Care Reform Coordinating Council and its workgroups, it is already clear that advocates see an opportunity to improve the quality and scope of existing safety net programs rather than cutting them to generate savings.
- Finally, even if savings from MHIP and safety net programs can be achieved, it is important to note from Exhibit 2 that those savings would have to be accumulated in the middle of the decade to offset the greater expenditures anticipated toward the end of the decade. Resisting the temptation to expand or create other programs may be difficult.

Exhibit 2

**Appendix F. Maryland Health Care Reform Financial Modeling Tool: Detailed Analysis and Methodology
(State funds only, midpoint of range, in millions)**

I. Required Elements	FY 11	FY 12	FY 13	FY 14	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20	Total
A. Increased Costs											
1. Medicaid Coverage Expansion	\$0	\$0	\$0	-\$42	-\$98	-\$109	\$3	\$68	\$105	\$198	\$126
2. Medicaid "Woodwork" Effect	0	0	0	12	72	96	111	116	122	127	657
3. Medicaid and MCHP Admin	0	10	15	34	68	74	78	81	85	88	533
4. Reduction in supplemental Rx rebate	14	14	15	15	14	15	16	19	21	25	167
5. Reduction in Medicaid DSH	0	0	0	0	9	10	11	12	12	13	67
6. State Exchange Admin necessary/permitted by law	0	0	0	13	13	13	13	13	13	13	91
7. State Employees/Retirees Health Ins.	-14	-4	9	11	20	21	22	27	30	33	155
8. Admin costs (non-DHMH agencies, outreach, etc.)	3	3	4	4	4	4	4	4	3	3	36
9. Transfer of 6-19 yo (100%-133% FPL): XXI to XIX	0	0	0	1	3	3	3	3	4	4	21
Overall Category Total	\$3	\$23	\$43	\$49	\$105	\$127	\$262	\$344	\$395	\$504	\$1,853
B. Programmatic Savings											
1. Enhanced Title XXI match rate	\$0	\$0	\$0	\$0	\$0	-\$46	-\$63	-\$65	-\$68	-70	-\$311
2. Hospital assessment: MHIP-Related	0	0	0	-70	-147	-154	-160	-167	-174	-182	-1,055
3. Rate Stabilization Offset: 100% Medicaid PCP	0	0	-11	-22	-11	0	0	0	0	0	-43
4. Medicaid: Rx rebates extended to MCO	-17	-18	-19	-20	-22	-23	-25	-27	-30	-32	-232
5. Medicaid: Breast&Cervical converts to ins.	0	0	0	-2	-4	-4	-4	-4	-4	-4	-26
6. Reductions in state-only programs/grants	0	0	0	-33	-65	-65	-65	-65	-65	-65	-423
7. Seniors Prescript Drug Assist (SPDAP)	0	-1	-1	-1	-1	-1	-2	-2	-2	-3	-15
Overall Category Total	-\$18	-\$19	-\$30	-\$148	-\$250	-\$293	-\$319	-\$330	-\$343	-\$356	-\$2,106
C. New Revenue											
1. Insurance Premium Assessment: for Profit Carriers	\$0	\$0	\$0	-\$28	-\$65	-\$71	-\$75	-\$78	-\$82	-\$86	-\$486
2. Premium Assessment Equiv.: Nonprofit Carriers	0	0	0	-5	-12	-13	-14	-15	-15	-16	-90
Overall Category Total	\$0	\$0	\$0	-\$34	-\$77	-\$84	-\$89	-\$93	-\$98	-\$102	-\$576
Total	-\$15	\$4	\$12	-\$133	-\$222	-\$250	-\$145	-\$80	-\$46	\$46	-\$829

Note: Analysis excludes baseline programs that predated Health Reform and were not altered by Health Reform

Source: Maryland Health Care Reform Coordinating Council

3. Measuring Progress in Health: America’s Health Rankings, 2010

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

As shown in **Exhibit 3**, in the 2010 edition of *America’s Health*, Maryland’s overall ranking remained at 21.

Exhibit 3
America’s Health: State Health Rankings
1990-2010
Maryland



Source: *America’s Health*, State Health Rankings, 2010 Edition

The rankings continue to note particular strengths in terms of the relative low prevalence of smoking, access to primary care, low child poverty, and high immunization rates. Challenges remain in terms of the relative rate of infectious disease, high violent crime rates, and infant mortality rates. Based on the data used in the rankings, Maryland was noted as making recent strong gains in terms of prevalence of smoking and the rate of cancer and cardiovascular disease deaths and improvements in preventable hospitalizations amongst Medicare enrollees. Health disparities remain an issue. For example, nonHispanic blacks are significantly more likely to be obese and have diabetes than nonHispanic whites.

4. Prince George’s County Health System

The Prince George’s County Health System consists of a number of parts: Prince George’s Hospital Center, a 269-bed acute-care hospital and regional referral center; Laurel Regional Hospital, a 138-bed acute-care community hospital; the Gladys Spellman Specialty Hospital and Nursing Center, a 110-bed comprehensive care and chronic care facility; and the Bowie Health Center. The system has been faced with financial difficulties for the past several years. The system has experienced lost market share, revenue losses, low liquidity, significant deferred capital needs, poor bond ratings, and a disadvantageous payor mix. Both the State and Prince George’s County have provided significant financial support in recent years. Without that financial support, the system would have faced sizable operational deficits, potential bankruptcy, and even closure.

The most recent effort to improve the financial situation of the system was the establishment of the Prince George’s County Hospital Authority (Chapter 680 of 2008 subsequently amended by Chapters 116 and 117 of 2009). The authority was established as a State entity to implement a competitive bidding process for transferring the Prince George’s County Health System to a new owner or owners. Despite the diligent efforts of the authority, in January 2010, it announced that it did not believe that the system could be sold and the authority expired without a transfer agreement in place. However, the authority did make a series of broad recommendations as to the future of the system. These recommendations can be summarized as follows:

- the outline of a transition process by primary stakeholders including continued commitment to the long-term financial support outlined in an earlier MOU (see below) and a transition strategy;
- development of a strategic restructuring and cost containment plan;
- the interim transfer of system assets from the county to the current system operator;
- cleaning-up the system’s balance sheet;
- continuing the search for a permanent owner; and

M00 – DHMH – Fiscal 2012 Budget Overview

- getting stakeholder and regulatory approval for a new inpatient facility to replace the Prince George’s County hospital.

In fiscal 2011, \$15 million was included in the Dedicated Purpose Account for Prince George’s County Health System, an amount equal to the State’s original long-term financial commitment under a 2008 memorandum of understanding (MOU) with Prince George’s County (a total commitment of \$150 million over five years in operating support split equally between the State and county and \$24 million over three years in State capital support). That long-term commitment was linked to the eventual transfer of the system by the authority. A similar \$15 million is included in the fiscal 2012 Dedicated Purpose Account together with \$4 million in the fiscal 2012 capital budget.

At this point, while efforts are ongoing to find a workable long-term solution for the system, the financial support provided in fiscal 2011 and most likely fiscal 2012 appear to be a short-term cash infusion to stabilize the system rather than a longer-term solution. Indeed, the goals of a letter of intent jointly signed by the Governor and the Prince George’s County Executive on September 7, 2010, (the \$15 million in State funding matched by a like amount of funds from the county for a total of \$30 million in support in fiscal 2011) underscores this point through its emphasis on the need to maintain critical health care services provided by the system as well as to support the furtherance of the recommendations made by the authority to facilitate the transfer to new ownership. There remains interest in acquisition of the system, although at this time the Department of Legislative Services (DLS) does not have a sense of how developed that interest is.

In addition to providing some context for the proposed expenditure of the \$15 million in State funds, the one-year letter of intent does include an element that DLS recommended (ultimately unsuccessfully) be added to the Dedicated Purpose Account appropriation during the fiscal 2010 session, specifically a matching requirement from the county and a provision that the either party’s contribution is contingent on a like match from the other. DLS’ concern sprang from the fact that although the county has traditionally been a strong partner with the State in supporting the system, it only partially fulfilled its fiscal 2010 operating support obligation to the system (providing \$9 million rather than the \$12 million original commitment).

The letter of intent provides some assurance that this partnership will continue on equal footing. As of mid-January 2011, the State has made two payments of \$3.75 million each to the system, Prince George’s County one payment of \$2.25 million. However, the department has had a recent conversation with Prince George’s County officials that indicates the county intends to live up to the requirements of the September 7, 2010, letter of intent. This will require the county to rearrange its fiscal 2011 budget since the current budget only provides support of \$9.0 million. DLS would also note that the fiscal 2012 appropriation in the Dedicated Purpose Account contains no contingent or other language referencing any requirements concerning future funding levels.