

M00F03
Family Health Administration
Department of Health and Mental Hygiene

Operating Budget Data

(\$ in Thousands)

	<u>FY 10</u> <u>Actual</u>	<u>FY 11</u> <u>Working</u>	<u>FY 12</u> <u>Allowance</u>	<u>FY 11-12</u> <u>Change</u>	<u>% Change</u> <u>Prior Year</u>
General Fund	\$37,328	\$31,657	\$31,609	-\$48	-0.2%
Contingent & Back of Bill Reductions	0	0	-241	-241	
Adjusted General Fund	\$37,328	\$31,657	\$31,367	-\$289	-0.9%
Special Fund	44,148	49,259	49,312	53	0.1%
Contingent & Back of Bill Reductions	0	0	-9	-9	
Adjusted Special Fund	\$44,148	\$49,259	\$49,302	\$44	0.1%
Federal Fund	127,858	136,659	138,135	1,475	1.1%
Contingent & Back of Bill Reductions	0	0	-22	-22	
Adjusted Federal Fund	\$127,858	\$136,659	\$138,113	\$1,454	1.1%
Reimbursable Fund	50	50	50	0	
Contingent & Back of Bill Reductions	0	0	-1	-1	
Adjusted Reimbursable Fund	\$50	\$50	\$49	-\$1	-2.8%
Adjusted Grand Total	\$209,384	\$217,625	\$218,832	\$1,207	0.6%

- The Governor's proposed allowance for the Family Health Administration (FHA) increases by \$1.2 million, or 0.6%, over the fiscal 2011 working appropriation.
- General fund support decreases by \$0.3 million, or 0.9%, due in large part to across-the-board reductions for health insurance and employee retirement expenses.
- Federal fund support increases by \$1.5 million, or 1.1%, due in large part to new federal grants for abstinence and contraception education, a maternal and child home visiting program, tobacco cessation, chronic disease prevention, statewide cancer activities, and oral health.

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

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Personnel Data

	<u>FY 10 Actual</u>	<u>FY 11 Working</u>	<u>FY 12 Allowance</u>	<u>FY 11-12 Change</u>
Regular Positions	173.30	170.30	170.30	0.00
Contractual FTEs	<u>4.79</u>	<u>6.33</u>	<u>6.71</u>	<u>0.38</u>
Total Personnel	178.09	176.63	177.01	0.38

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	8.53	5.01%
Positions and Percentage Vacant as of 12/31/10	9.00	5.28%

- The fiscal 2012 allowance includes an increase of 0.38 full-time equivalent (FTE) contractual positions in the Maternal and Child Health program of FHA.
- As of December 31, 2010, the agency had 9.0 vacant positions, only slightly higher than the agency’s necessary vacancies to meet its turnover rate. The agency’s turnover rate was increased from 4.0% in the fiscal 2011 working appropriation to 5.01% to more accurately reflect the number of vacancies at the agency.

Analysis in Brief

Major Trends

Infant Mortality: The overall infant mortality rate in Maryland decreased from 8.0 deaths per 1,000 live births in calendar 2008 to 7.2 deaths per 1,000 live births in calendar 2009. At the same time, however, Maryland's African American infant mortality rate increased from 13.4 to 13.6 deaths per 1,000 live births.

Cancer Mortality Rates Continue to Improve: One of the main functions of the Cancer Prevention, Education, Screening, and Treatment Program within the Cigarette Restitution Fund (CRF) is to fund community-based programs that prevent, detect, and treat cancer. The mission of the program is to reduce the burden of cancer among Maryland residents by reducing overall cancer mortality in the State. The overall mortality rate for cancer in Maryland continues to decrease, as does the rate for breast cancer mortality.

Issues

Racial Disparity in Infant Mortality Rates: The Governor has prioritized the goal of reducing infant mortality in the State, focusing primarily on reducing the rate of infant mortality for African Americans. In 2009, Baltimore City and Prince George's County infant deaths accounted for 41% of all infant deaths in Maryland and 58% of all African American infant deaths. As part of its Babies Born Healthy Initiative, FHA has focused on these two jurisdictions, along with Somerset County, to improve health outcomes.

Cigarette Restitution Fund Programs: Funding Status and Program Outcomes: Although the CRF programs are level funded in fiscal 2012, they have been subject to extensive cuts in recent years. As a result, some programs have been eliminated. At the same time, survey data shows an increase in smoking rates for high school students and adults between calendar 2006 and 2010.

Breast and Cervical Cancer Activities: The Breast and Cervical Cancer Diagnosis and Treatment program is funded with CRF dollars to screen, diagnose, and treat low-income, uninsured, and underinsured women. The cost for the program is estimated to reach \$14.6 million in fiscal 2011. The availability of a federal screening program and Medicaid waiver program to treat breast and cervical cancer should be able to lessen the financial burden of the State.

Recommended Actions

	<u>Funds</u>
1. Delete special funds for the grant to Prince George’s County Hospital Center.	\$ 15,000,000
Total Reductions	\$ 15,000,000

Updates

Dental Health Initiatives: FHA’s Office of Oral Health is charged with developing statewide oral health preventive and educational strategies to decrease oral disease, conducting oral health surveys of the State’s school children, and providing grant funding for the establishment of local oral health programs targeted to populations at high-risk for oral disease. The fiscal 2012 allowance includes funding to improve the State’s public dental health infrastructure and to provide school-based dental services.

M00F03
Family Health Administration
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Operating Budget Analysis

Program Description

The Family Health Administration (FHA) promotes public health by ensuring the availability of quality primary, preventive, and specialty health care services, with special attention to at-risk and vulnerable populations. Charges include control of chronic diseases, injury prevention, public health education, and promotion of healthy behaviors.

The Cigarette Restitution Fund (CRF) Program receives a majority of its funding from payments made under the Master Settlement Agreement (MSA). Through the MSA, the settling tobacco manufacturers will pay the litigating parties, which are 46 states, five territories, and the District of Columbia, approximately \$206 billion over the next 25 years and beyond. By statute, the CRF must be appropriated to eight health- and tobacco-related priorities, and the CRF Program within FHA administers a few of these programs – the Tobacco Use Prevention and Cessation Program; the Cancer Prevention, Education, Screening, and Treatment Program; and the Minority Outreach and Technical Assistance program.

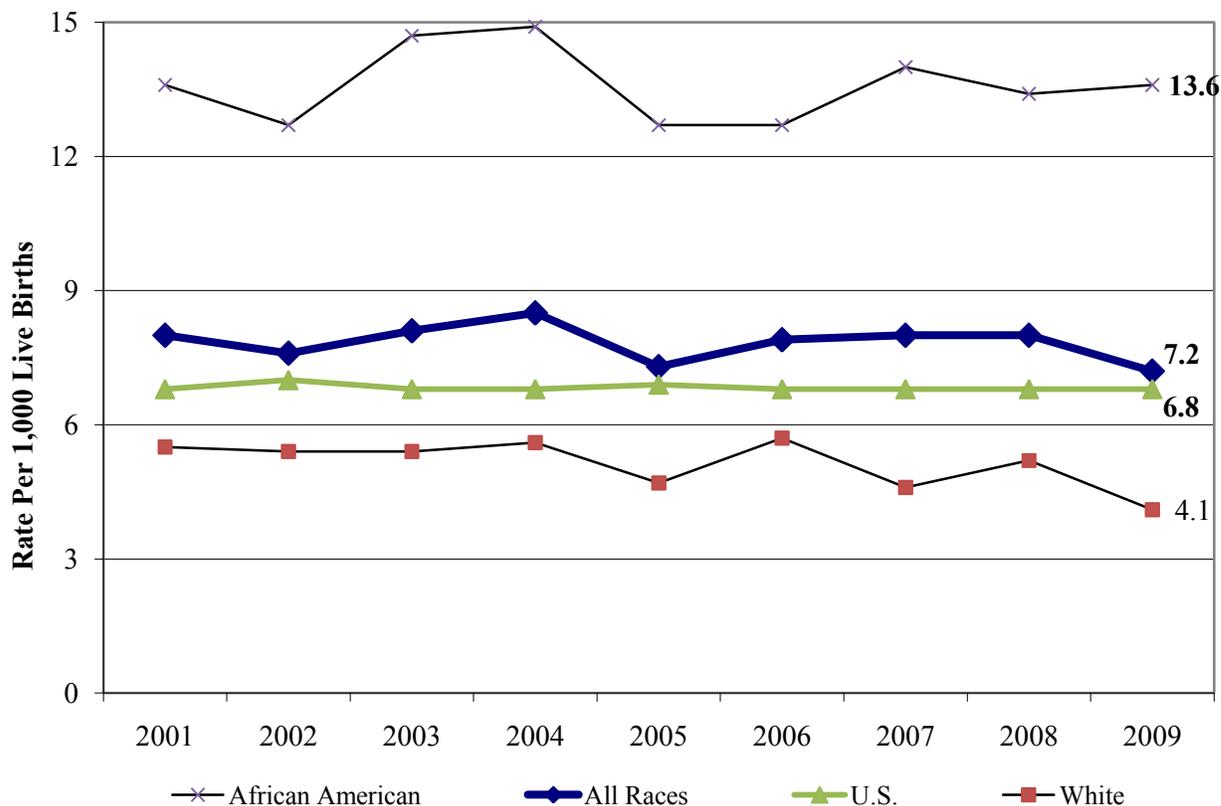
Performance Analysis: Managing for Results

Infant Mortality Rates

The Center for Maternal and Child Health within FHA is charged with reducing infant mortality and promoting the health and well-being of all women and children. Infant mortality rates are used to indicate the total health of populations in the United States and internationally. During the second half of the twentieth century, infant mortality rates in the United States fell from 29.2 to 6.9 per 1,000 live births, a decline of 76%. Mirroring the national trend, Maryland's infant mortality rate decreased 23% during the 1990s due to improved access to preconception, prenatal, and family planning services. Also contributing to the decline was the development of hospital perinatal standards, high-risk consultation, and community-based perinatal health improvements.

In calendar 2002, the United States infant mortality rate increased for the first time since 1958. According to the National Center for Health Statistics, infant mortality rates were the highest among mothers who smoked, had no prenatal care, were teenagers, were unmarried, and had less education. Following the national trend, Maryland's overall infant mortality rate increased from calendar 2002 through 2004 to 8.5 deaths per 1,000 live births. Since that time, Maryland has made steady progress to reduce the infant mortality to 7.2 in calendar 2009, as shown in **Exhibit 1**. However, as the exhibit shows the rate has fluctuated over the past few years. Even more troubling is the fact that the rate for African American infant mortality has increased to 13.6 in calendar 2009.

**Exhibit 1
Infant Mortality Rates
Calendar 2001-2009**



Source: Department of Health and Mental Hygiene; World Bank data

Following national trends, Maryland’s African American infant mortality rate has consistently been higher than other races. While the overall infant mortality in the State decreased from 8.0 to 7.2 deaths in calendar 2009, the rate for African Americans has actually increased from 13.4 to 13.6 over the same time period. While there was a slight decrease between calendar 2007 and 2008, the infant mortality rate for African Americans is three times the rate of non-Hispanic white infants.

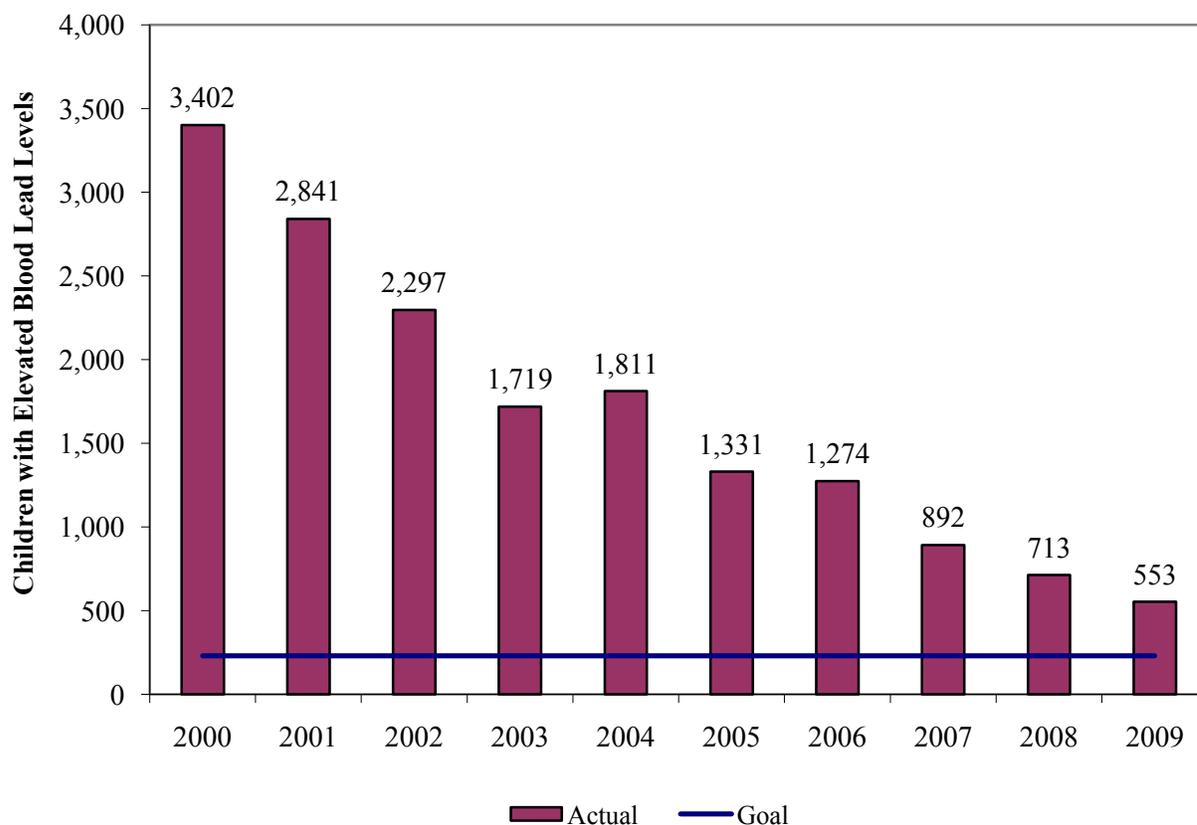
Elevated Blood Lead

It has been clinically proven that blood lead levels greater than 70 $\mu\text{g}/\text{dL}$ can cause severe neurological problems (*e.g.*, seizures, coma, and death). Also, studies have linked blood lead levels as low as 10 $\mu\text{g}/\text{dL}$ with decreased intelligence and other adverse neurodevelopmental effects. Common sources of lead exposure include house dust contaminated with lead paint, soil

contaminated with lead paint, and industrial or motor vehicle emissions. Nationally, elevated blood lead levels are more prevalent with children living in houses built before 1946.

FHA’s goal is to have no more than 230 children with elevated blood lead levels (greater than 10 $\mu\text{g}/\text{dL}$) by calendar 2011. As shown in **Exhibit 2**, since 2000, the number of children with elevated blood lead levels has been significantly above the 2011 goal. However, the number of children with elevated blood lead levels has decreased by 81% since 2000. While the State still has not met its goal, the programs in place have contributed to this significant decrease, and FHA expects to be able to meet the goal by 2011.

Exhibit 2
Children Under the Age of Six with Elevated Blood Lead Levels
Calendar 2000-2009



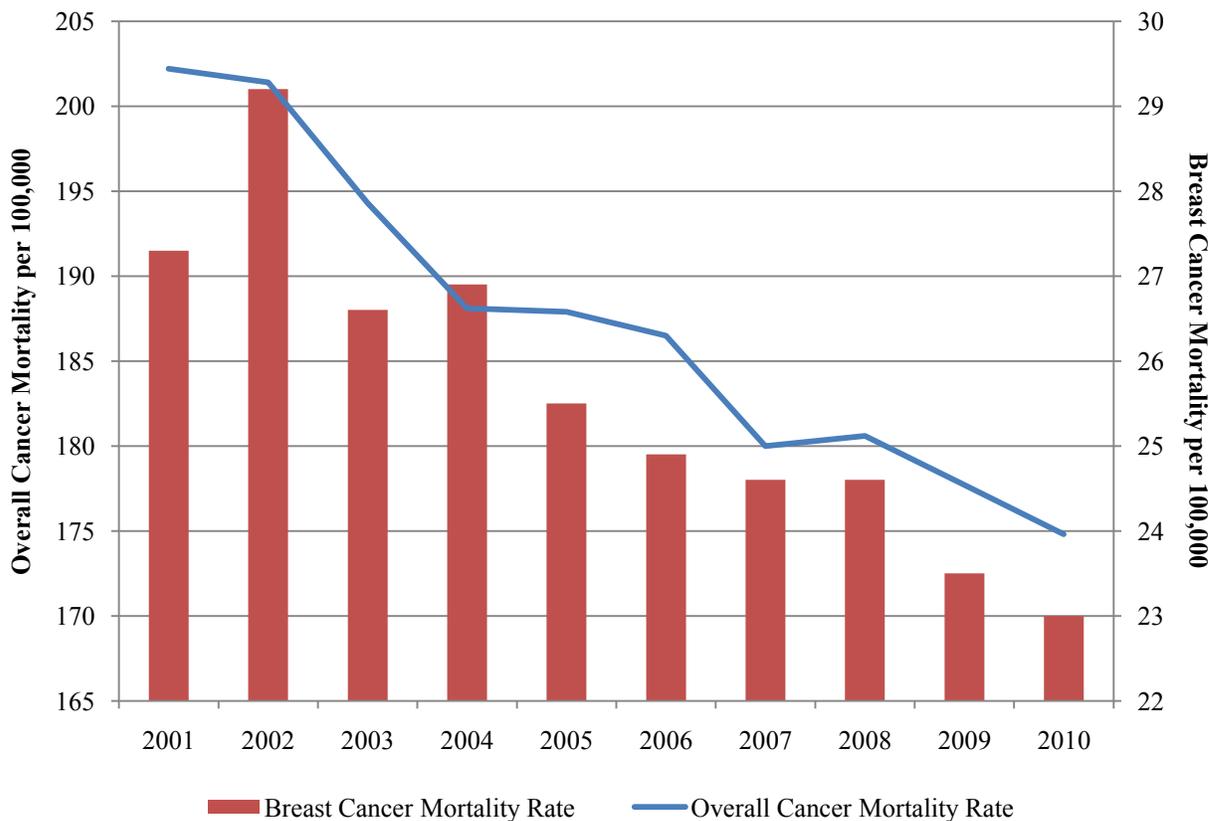
Source: Department of Health and Mental Hygiene

Cigarette Restitution Fund Program

Cancer Prevention, Education, Screening, and Treatment

One of the main functions of the Cancer Prevention, Education, Screening, and Treatment Program is to fund community-based programs that prevent, detect, and treat cancer. The mission of the program is to reduce the burden of cancer among Maryland residents by reducing overall cancer mortality in the State. **Exhibit 3** shows that there has been a significant drop in both the overall cancer mortality rate and the breast cancer mortality rate in Maryland. The cancer programs within the CRF program target colorectal cancer, prostate cancer, and cancers associated with tobacco use.

Exhibit 3
Cancer Mortality Rates
Calendar 2001-2010

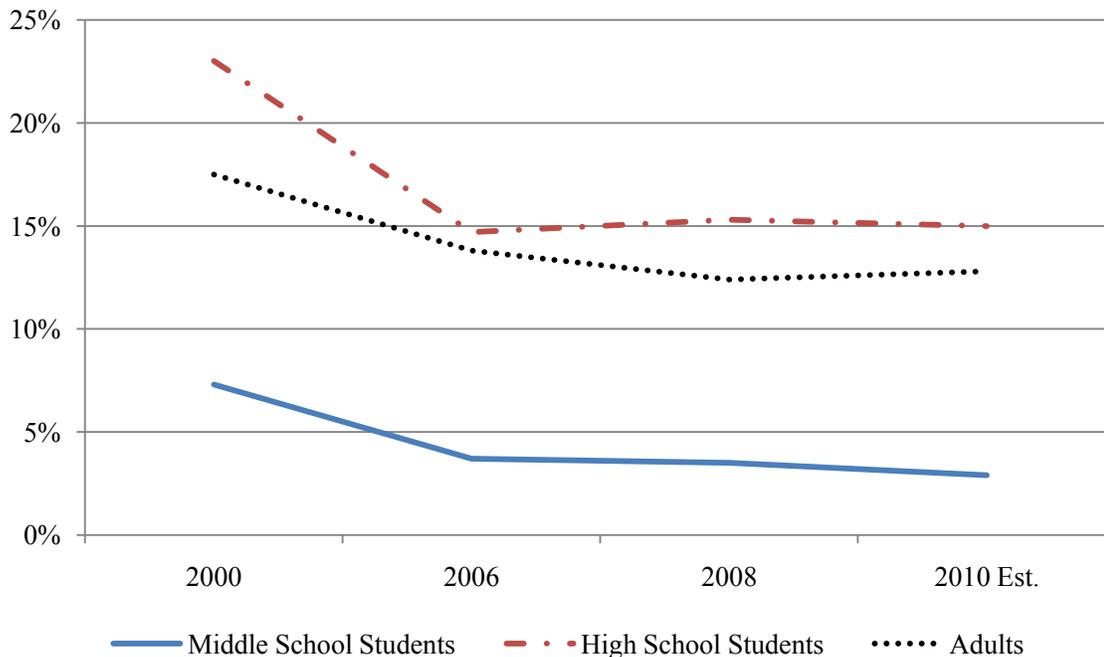


Source: Department of Health and Mental Hygiene

Tobacco Use, Prevention, and Cessation Program

The mission of the Tobacco Use, Prevention, and Cessation Program is to reduce the use of tobacco products and to reduce the burden of tobacco-related morbidity and mortality in the State. One of the goals of the program is to reduce the proportion of Maryland youth and adults who currently smoke cigarettes. Two surveys funded with CRF revenue are the Maryland Youth Tobacco Survey and the Maryland Adult Tobacco Survey. Surveys such as these are intended to track smoking preferences and usage among Marylanders. **Exhibit 4** shows tobacco usage rates for Maryland middle school students, high school students, and adults. As the graph demonstrates, there was a decrease in usage between calendar 2000 and 2006. However, since that time, usage rates have stayed relatively consistent. In the case of high school students, the usage rate went up between calendar 2006 and 2008. One reason for the stagnation of usage rates may be the elimination of funding for programs such as countermarketing and media initiatives which fund anti-smoking campaigns targeted to school-aged children, although no concrete evidence citing causation exists. The rate for adults is also estimated to increase between 2008 and 2010.

Exhibit 4
Tobacco Usage Rates
Calendar 2000-2010



Source: Department of Health and Mental Hygiene

Fiscal 2011 Actions

Proposed Deficiency

The Governor's allowance includes a deficiency appropriation of \$3.5 million for fiscal 2011. Of that amount, \$3.3 million is a federal fund appropriation for federal awards received by FHA since the approval of the fiscal 2011 budget. The remaining \$0.2 million is a special fund deficiency appropriation from the Maryland Cancer Fund due to higher than expected revenues to the fund.

The federal fund deficiency appropriation results from federal awards received through four federal grants. The details of the four grants are as follows:

- \$2,160,501 for Centers for Disease Control and Prevention (CDC) grants for statewide cancer activities, the Maryland Cancer Registry, colorectal cancer screening activities, Behavioral Risk Factor Surveillance System, tobacco use prevention activities, and oral health literacy activities;
- \$928,884 for an American Recovery and Reinvestment Act of 2009 (ARRA) grant for chronic disease prevention and control activities, and tobacco cessation activities;
- \$163,035 for an Affordable Care Act (ACA) grant for the Early Childhood and Home Visiting Program; and
- \$38,916 for an ACA grant for the Personal Responsibility Education Program.

Proposed Budget

Impact of Cost Containment

The fiscal 2012 budget reflects several across-the-board actions. In fiscal 2012, this agency's share of the reduction is \$63,000 (\$50,833 general fund, \$3,526 special fund, \$8,118 federal fund, and \$523 reimbursable fund) for changes in employee health insurance. Reductions contingent upon statutory changes include \$104,276 (\$84,139 general fund, \$5,836 special fund, \$13,436 federal fund, and \$865 reimbursable fund) for retiree prescription drug benefits and \$106,438 in general funds for retirement benefits. To the extent that this agency has positions abolished under the Voluntary Separation Program, additional reductions will be implemented by the Administration.

Personnel Expenses

Personnel expenses for FHA increase by \$0.4 million in the fiscal 2012 allowance, primarily for increased salary expenses as shown in **Exhibit 5**. Restoring the salary expenses associated with furloughs and other compensation increase the budget by \$0.3 million. Employee and retiree health insurance expenses increase by \$0.1 million and employee retirement contributions increase by \$67,412. Both of these increases include the Back of the Bill reductions mentioned above. Other fringe benefit adjustments and reclassifications account for an increase of \$31,852 and \$23,933, respectively. Finally, the turnover rate for FHA was increased from 4.0 to 5.01% resulting in a decrease of \$0.1 million.

Operating Expenses

Operating expenses for FHA increase by \$0.8 million in the fiscal 2012 allowance, as shown in Exhibit 5. The budget is driven mainly by changes to the Women, Infant, and Children (WIC) program and other federal grant programs administered by FHA. Including the fiscal 2011 deficiency appropriations, the operating expenses actually decrease by \$2.6 million in fiscal 2012.

Federal Grant Activity

The fiscal 2012 allowance includes eight new federal grant programs that were not included in the fiscal 2011 legislative appropriation and account for a \$3.1 million increase. Funding for many of these grants was received by the agency after the approval of the fiscal 2011 budget and are included as deficiency appropriations. In many instances, FHA had received funds to support similar grant programs in fiscal 2010 or earlier. Some of the larger grant programs include:

- Maternal, Infant, and Early Childhood Home Visiting program authorized by the ACA which provides in-home visits to improve outcomes for children and families who reside in at-risk communities (\$1.0 million);
- Personal Responsibility Education Program authorized by the ACA which provides abstinence and contraception education to Maryland youths aged 10-19 for the prevention of pregnancy and sexually transmitted diseases (\$1.0 million);
- Abstinence Education Program (\$0.5 million);
- Communities Putting Prevention to Work Program authorized by the ARRA to implement policy, systems, and environmental changes for chronic disease prevention (\$0.3 million);
- Tobacco Cessation through Quitlines and Media authorized by the ARRA to expand and promote the Maryland Tobacco Quitline (\$0.2 million); and
- Oral Health Literacy Campaign which aims to decrease dental health disparities in low-income children (\$0.1 million).

Exhibit 5
Proposed Budget
DHMH – Family Health Administration
(\$ in Thousands)

How Much It Grows:	<u>General</u> <u>Fund</u>	<u>Special</u> <u>Fund</u>	<u>Federal</u> <u>Fund</u>	<u>Reimb.</u> <u>Fund</u>	<u>Total</u>
2011 Working Appropriation	\$31,657	\$49,259	\$136,659	\$50	\$217,625
2012 Allowance	<u>31,609</u>	<u>49,312</u>	<u>138,135</u>	<u>50</u>	<u>219,105</u>
Amount Change	-\$48	\$53	\$1,475	\$0	\$1,480
Percent Change	-0.2%	0.1%	1.1%		0.7%
 Contingent Reduction	 -\$241	 -\$9	 -\$22	 -\$1	 -\$274
Adjusted Change	-\$289	\$44	\$1,454	-\$1	\$1,207
Adjusted Percent Change	-0.9%	0.1%	1.1%	-2.8%	0.6%
 Where It Goes:					
Personnel Expenses					
Salary expenses, including restoration of furloughs					\$274
Employee and retiree health insurance (net of contingent and across-the-board reductions)					94
Employee retirement contribution (net of contingent reductions)					67
Other fringe benefit adjustments					32
Reclassifications					24
Turnover adjustments					-133
 Other Changes					
Federal grants received in fiscal 2011 (Personal responsibility abstinence and contraception education, maternal/child home visit program, tobacco cessation, chronic disease prevention, statewide cancer activities, and oral health)					3,144
Children’s Medical Services Program					233
Increase to Cigarette Restitution Funding programs.....					128
Women, Infant, and Children program contractual costs, primarily decreased food costs.....					-2,649
Other					-9
Total					\$1,207

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

Women, Infant, and Children Program

Funding for the WIC program in the fiscal 2012 allowance decreases collectively by \$2.6 million, including a decrease of \$3.4 million for contractual costs to administer the program and an increase of \$0.7 million for supplies and materials for the program.

The contractual costs for the program total \$104.2 million and are comprised primarily of the food service contract (\$74.2 million) and the cost to administer the program (\$29.7 million). The food service contract, which covers the expense of WIC foods purchased by participants, decreases from the fiscal 2011 working appropriation by \$6.9 million due to overestimated costs in fiscal 2011. Food expenditures are based on average monthly food package costs. The fiscal 2012 allowance aligns much more closely to the fiscal 2010 actual expenditures.

While the food service contract decreases significantly in the allowance, the funds dedicated to administer the program increase by \$3.5 million. Federal funds associated with administering the program are distributed to the local health departments and private agencies for the provision of WIC services. The decrease to food service contracts combined with the increase for administrative costs nets to a \$3.4 million decrease for WIC contractual services.

Supplies and materials for the WIC program account for an increase of \$0.7 million for nutrition education materials, breast pumps, and outreach activities associated with the End Hunger Initiative.

Other Changes

The remaining changes in FHA's fiscal 2012 allowance include an increase to the Children's Medical Services Program, a fee-for-service program for low-income uninsured and underinsured children with special health needs. The program pays for specialty care services to prevent morbidity and mortality in this population. Economic conditions have made more children eligible for this program resulting in an increase of \$0.2 million in the fiscal 2012 allowance. Finally, CRF funding for cancer and tobacco programs increases by \$0.1 million for the administration of those programs in FHA, surveillance and evaluation, and grants to local health departments for tobacco use prevention and cessation programs. A more in-depth discussion of CRF program activity and funding is included in the Issues section of this document.

Transfers and Changes Per Budget Reconciliation and Financing Act of 2011

House Bill 72, the Budget Reconciliation and Financing Act of 2011, authorizes the transfer of \$500,000 from the special fund balance of the Spinal Cord Injury Research Trust Fund in fiscal 2012. The bill also makes permanent the transfer of interest earned on certain special fund balances to the general fund, including the Spinal Cord Injury Research Trust Fund.

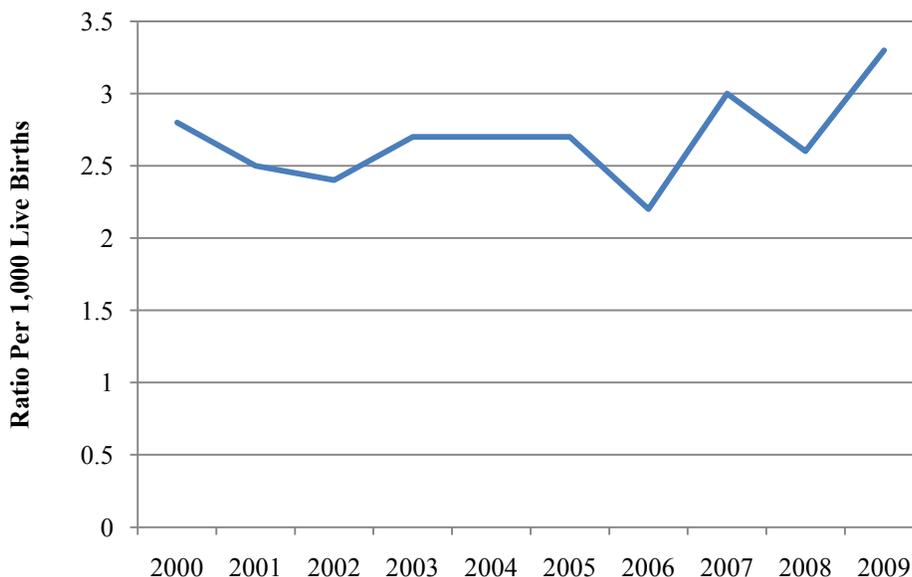
Issues

1. Racial Disparity in Infant Mortality Rates

Infant mortality, the rate at which babies less than one year of age die, is used to compare the health and well-being of populations. Nationally, the infant mortality rate has steadily declined over the past several decades, from 26.0 per 1,000 live births in 1960 to 6.8 per 1,000 live births in 2009, according to the CDC. As seen in the performance measures of this document, Maryland has mirrored the national average over the same time period. However, while there have been several decades of improvement in infant mortality, progress in Maryland has slowed and Maryland's infant mortality rate remains higher than the national average.

Even more troubling is the disparity in the rate of infant mortality by race. African American infants continue to be at greater risk, with a disparity of nearly to 2:1 in prematurity rates, and over 3:1 in infant death rates in calendar 2009. As shown in **Exhibit 6**, the disparity ratio between African American infants and non-Hispanic White infants has hovered around 2.5:1 since 2000 and dropped to as low as 2.2:1 in 2006. However, since that time, the disparity has increased to 3.3 African American infant deaths per every 1.0 non-Hispanic White infant death.

Exhibit 6
Ratio of African American to Non-Hispanic White Infant Mortality
Calendar 2000-2009



Source: Department of Health and Mental Hygiene

The disparity by race is greater in Maryland than the national average. In 2005, the infant mortality rate for African Americans was 2.4 times the rate for non-Hispanic White infants nationally, compared to a ratio of 2.7:1 in Maryland.

Baltimore City and Prince George's County infant deaths contribute the greatest proportion (41%) of all infant deaths in Maryland and the greatest proportion of African American infant deaths (58%) in 2009. While the infant mortality rate has dropped in Prince George's County between 2008 and 2009, the rates in Baltimore (12.1 deaths per 1,000 births) and in Prince George's County (9.8 deaths per 1,000 births) remain well above the State's average of 7.2 deaths per 1,000 births.

One factor that greatly influences health outcomes is the percent of women receiving prenatal care in the first trimester. In 2007, only 79.5% of women received prenatal care. Among White women in the State, 82.0% received early prenatal care, compared with 73.5% of African American women and only 63.0% of Hispanic women.

Strategies to Reduce Infant Mortality and Address Disparity

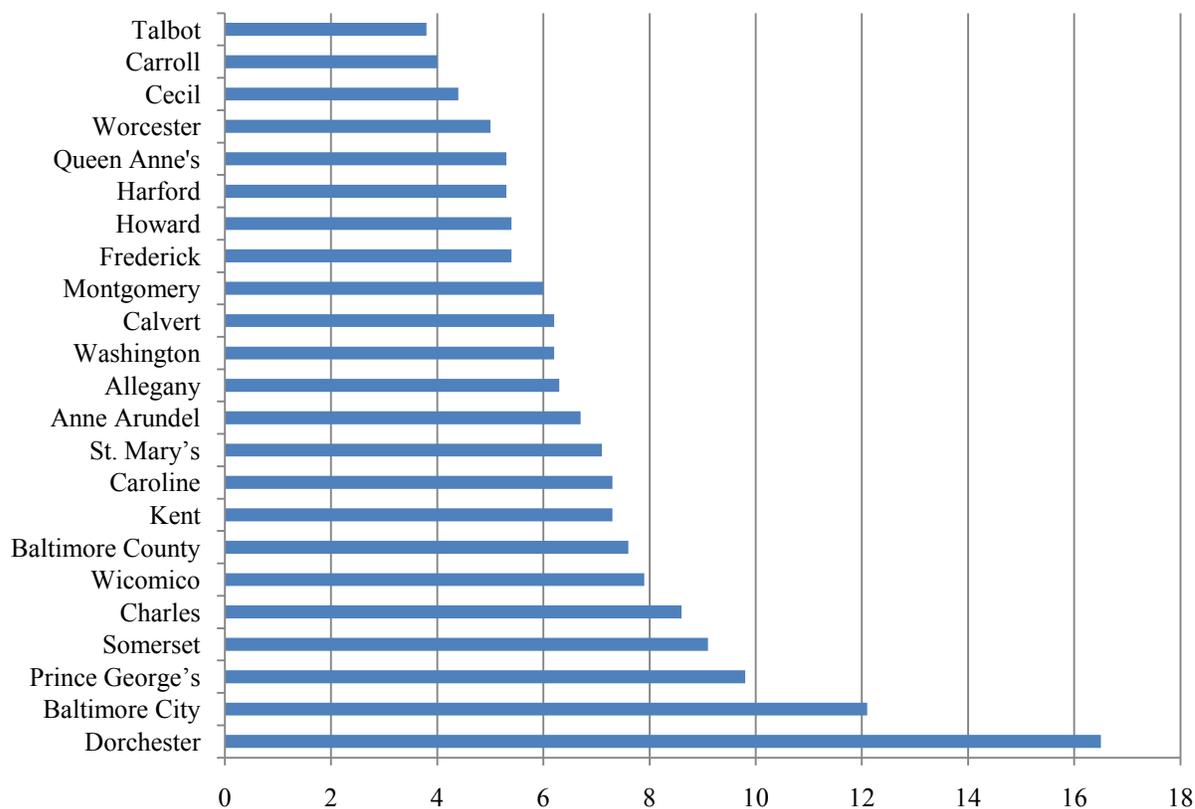
An infant death or pregnancy loss is a signal that there may be broader problems within the community. Strategies to address infant mortality cover the whole spectrum of reproductive health for women and families and focus on modifying the behaviors, lifestyles, and conditions that affect birth outcomes, such as smoking, substance abuse, poor nutrition, lack of prenatal care, medical problems, and chronic illness.

Babies Born Healthy Program

The Babies Born Healthy (BBH) program, within FHA, aims to combat infant mortality by utilizing the strategies mentioned above and focusing on areas of the State with high rates and where access to care is limited. **Exhibit 7** shows the average infant mortality rate between 2005 and 2009 by county, excluding Garrett County whose infant death total was less than 5.0. Baltimore City, Charles, Dorchester, Prince George's, and Somerset counties all had average rates greater than 8.0 deaths per 1,000 live births during this period.

BBH focuses on the main factors that contribute to Maryland's high infant mortality rate, including the high rate of unintended pregnancies, lack of early prenatal care, and a high racial disparity in birth outcomes. In order to address these issues, BBH is initially targeting interventions in three jurisdictions with high infant mortality rates: Baltimore City, Prince George's County, and Somerset County. After successful programs are established in these jurisdictions, the model will be expanded statewide.

**Exhibit 7
Infant Mortality by County
Calendar 2005-2009 average**



Source: Department of Health and Mental Hygiene

The BBH program focuses on the full span of pregnancy – before pregnancy to ensure women are healthier at the time of conception, during pregnancy to facilitate earlier entry into prenatal care, and after delivery for perinatal and neonatal interventions to ensure comprehensive follow up care as needed. Strategies include the development of comprehensive women’s health centers, expediting Medicaid eligibility for prenatal care, and establishing standardized hospital discharge protocols for ensuring risk-appropriate follow up to mothers and infants.

The agency should comment on the status of the BBH projects and whether they can be successfully implemented in other parts of the State. The agency should also comment on other ways that the disparity of health outcomes for African Americans can be reduced.

Other State-funded Programs and Collaboration

FHA has sought to collaborate with other agencies and programs to increase access to preconception (before pregnancy) and interconception (between pregnancies) health services. One such initiative links Maternal and Child Health (MCH) services (which include family planning, folic

acid distribution, and others women's health services) to WIC services in order to optimize women's health. Model MCH-WIC Collaborative projects are in Baltimore City, Baltimore, Charles, and Wicomico counties.

Beginning in fiscal 2010, the Maryland Community Health Resources Commission, an independent commission tasked with expanding access to care for low-income, underinsured, and uninsured Marylanders, began to disburse infant mortality grants. To date, nine grants totaling \$1.7 million has been disbursed to local community health resource centers to combat infant mortality.

The Office of Minority Health and Health Disparities (MHHD) within the Department of Health and Mental Hygiene (DHMH) Office of the Secretary also has an initiative to reduce infant mortality in minority populations. The goal of the MHHD initiative is to support the development of local infrastructure, increase capacity, assist in obtaining resources, provide technical assistance, and facilitate sustainability for local programs. MHHD and FHA have collaborated on these initiatives to develop culturally competent approaches to addressing infant mortality statewide and through cooperative projects in certain counties.

DHMH should ensure open communication and collaboration between the various infant mortality programs to make the most efficient use of the State's financial resources to combat this issue in the State and to ensure that services are not duplicative.

The State has dedicated resources to reducing infant mortality in the State, with particular emphasis on reducing infant mortality in minority communities since the 1990s. The initiatives have spanned multiple agencies, including the Governor's Office for Children and DHMH. Even so, the disparity ratio among races has not improved and has further deteriorated over the past year. **The agency should comment on the lessons learned from previous initiatives to combat infant mortality and the reasons that the disparity still exists.**

2. Cigarette Restitution Fund Programs: Funding Status and Program Outcomes

There are two main programs administered by FHA with CRF support (1) cancer prevention, screening, and diagnosis, including the grants to Statewide Academic Health Centers for cancer research; and (2) tobacco use prevention and cessation. As mentioned in the discussion of the Governor's fiscal 2012 allowance, the CRF programs within FHA are basically level funded. **Exhibit 8** shows the detail of the funding by program area.

Exhibit 8
Funding for Cigarette Restitution Fund Programs
Fiscal 2009-2012
(\$ in Millions)

	<u>Actual</u> <u>2009</u>	<u>Actual</u> <u>2010</u>	<u>Working</u> <u>Appropriation</u> <u>2011</u>	<u>Allowance</u> <u>2012</u>
Cancer Prevention, Education, Screening, and Treatment				
Local Public Health	\$7.2	\$5.3	\$7.5	\$7.5
University of Maryland	1.2	0.9	1.2	1.2
Johns Hopkins Institutes	1.2	0.9	1.2	–
Baltimore City	–	0.0	0.0	1.2
Surveillance and Evaluation	1.3	1.1	1.2	1.2
Administration	0.8	0.6	0.5	0.6
Cancer Screening Data base	0.2	0.2	0.2	0.2
Statewide Public Health	0.1	0.0	–	–
Total	\$11.8	\$9.0	\$11.9	\$12.0
Statewide Academic Health Center				
Cancer Research Grants	\$6.8	\$1.7	\$2.4	\$2.4
Tobacco Diseases Research	1.3	0.3	–	–
Network Grant	1.9	0.5	–	–
Total	\$10.0	\$2.5	\$2.4	\$2.4
Tobacco Use Prevention and Cessation Program				
Local Public Health	\$11.6	\$2.9	\$2.9	\$2.9
Countermarketing	0.1	–	–	–
Statewide Public Health	1.7	–	–	–
Tobacco Prevention and Cessation	–	–	0.1	0.1
Minority Outreach and Technical Assistance	1.0	0.6	–	–
Surveillance and Evaluation	1.3	0.5	0.5	0.5
Administration	0.7	0.2	0.2	0.2
Management	0.9	1.0	–	–
Total	\$17.2	\$5.0	\$3.6	\$3.6
Breast and Cervical Cancer Program	–	\$14.6	\$15.2	\$15.2
Total	\$39.1	\$31.1	\$33.0	\$33.2

Source: Department of Health and Mental Hygiene

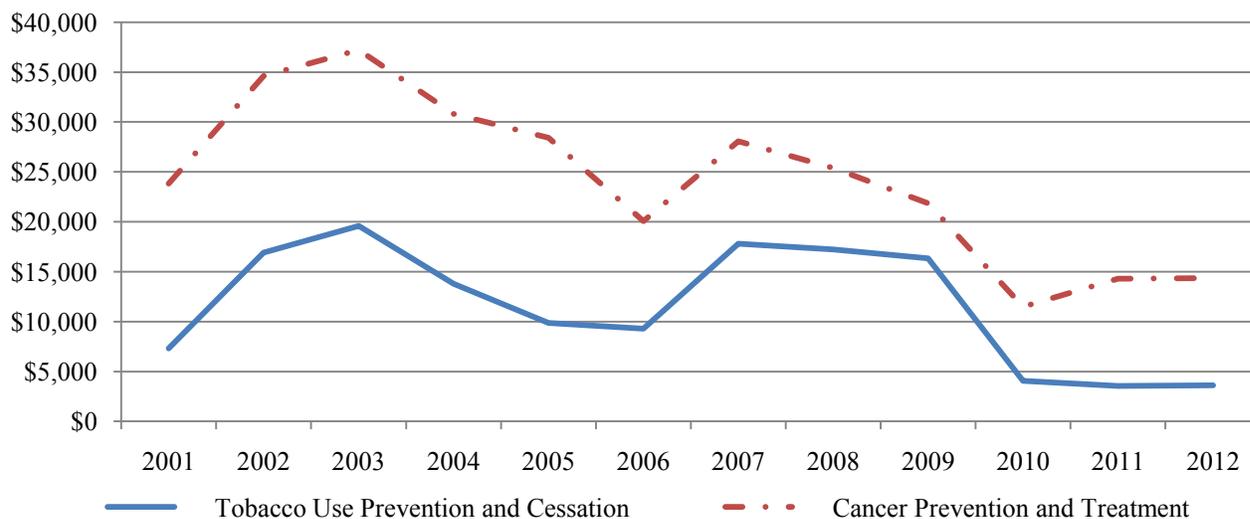
The one major programmatic change in CRF funding occurs within the grants to Baltimore City for cancer screening. In the past, the University of Maryland and Johns Hopkins Institutes (JHI) received the bulk of the money to screen Baltimore City residents for breast, cervical, prostate, and colorectal cancers. The allocation for fiscal 2012 eliminates the grant to JHI due to poor performance measures produced by its screening programs. As a result, the Baltimore City Health Department will receive the screening funds in fiscal 2012. FHA has been working with the city to get the screening program up and running.

Both the tobacco and cancer programs have been subject to deep budget cuts in recent years, as shown in **Exhibit 9** below. Although funding for cancer prevention, education, screening and treatment increased between fiscal 2010 and the fiscal 2012 allowance, funding for tobacco use prevention and cessation programs continued to decrease during the same time period. Some of the programs that have been eliminated include countermarketing and media campaigns, statewide tobacco cessation initiatives, and programs targeted to minority populations.

Campaign for Tobacco Free Kids – Tobacco Prevention Programs

Although CRF funds are unrestricted, interest groups such as the Campaign for Tobacco Free Kids follow the states' use of CRF funds for specific purposes. In its November 2010 report, *A Broken Promise to Our Children: The 1998 State Tobacco Settlement 12 Years Later: A Report on the States' Allocation of Tobacco Settlement Dollars*, the Campaign for Tobacco Free Kids assessed and ranked the states based on whether they were funding tobacco prevention programs at levels recommended by CDC. CDC first recommended funding levels for comprehensive tobacco control programs in 1999. Since that time, CDC has updated its recommendations to include the following program elements: (1) state and community interventions that incorporate a variety of activities including chronic disease and tobacco-related disparity elimination initiatives and interventions specifically aimed at influencing youth; (2) health communications interventions; (3) cessation interventions; (4) surveillance and evaluation; and (5) administration and management. For each element, CDC established upper and lower spending limits and a recommended spending amount.

Exhibit 9
Funding for Cigarette Restitution Fund Programs
(\$ in Thousands)



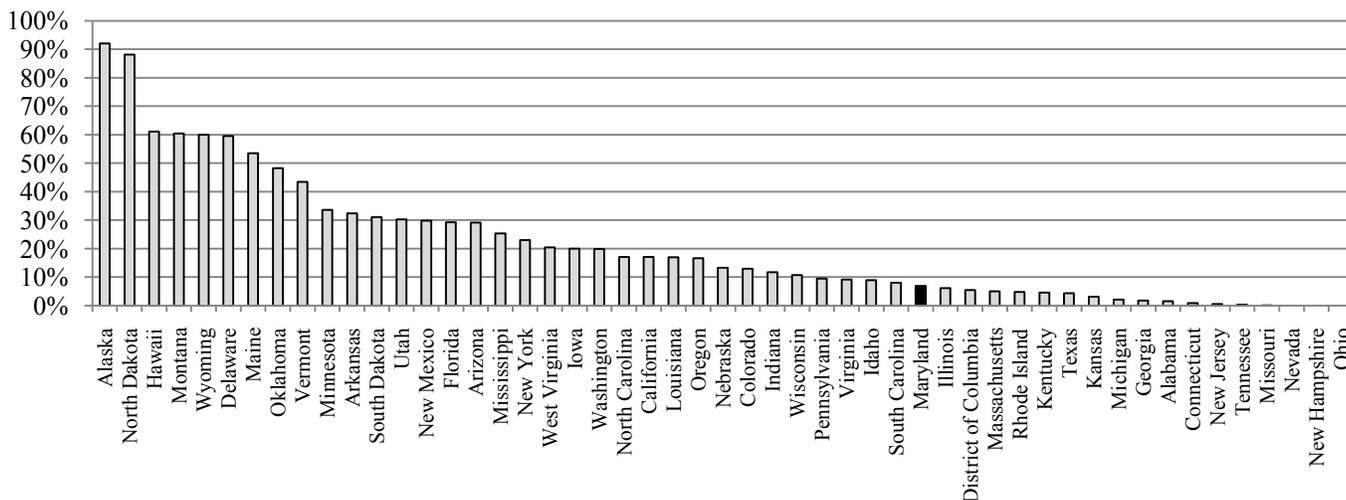
Source: Department of Health and Mental Hygiene

The report found that states have reduced funding for tobacco prevention and cessation programs to the lowest level since 1999. The report found that only 2 states, North Dakota and Alaska, currently fund tobacco prevention programs near the CDC-recommended level. Only 5 other states are funding tobacco prevention programs near even half the CDC recommended levels, while 33 states and the District of Columbia are providing less than a quarter of the CDC-recommended amounts. Nevada, New Hampshire, and Ohio provide no state funding for tobacco prevention programs.

Like other states, Maryland has reduced funding for tobacco cessation programs since receiving settlement funds in 1999. In fiscal 2011, the Campaign for Tobacco Free Kids reported that Maryland spent \$4.3 million on tobacco cessation (which is less than 10% of CDC-recommended levels for tobacco cessation) and ranked thirty-fourth among states for spending recommended amounts on tobacco cessation.¹ In fiscal 2000, Maryland spent \$30.0 million on tobacco cessation, which was 99% of CDC-recommended levels. **Exhibit 10** shows how states ranked in fiscal 2011 for spending CDC-recommended levels on tobacco prevention and cessation programs.

¹ The Campaign for Tobacco Free Kids does not include federal funding in its estimate of spending. This particular accounting explains the variation between the amount used by the campaign in its material compared to the figure noted elsewhere in this document for tobacco cessation and prevention activities.

Exhibit 10
Relative Spending on Tobacco Prevention and Cessation Programs
Fiscal 2011
(% of CDC-recommended Levels)



CDC: Centers for Disease Control

Source: Campaign for Tobacco Free Kids

Outcomes

As reported in the performance management section of this document, smoking utilization rates appear to have increased for high school students and adults, according to surveys collected by FHA. Although the percent of adults in Maryland who smoke cigarettes has been decreasing since 2000, the statistic increases for the first time between calendar 2008 and 2010, when the percentage of smokers increased from 12.4 to 12.8%. For high school aged children, the smoking rate increased between calendar 2006 and 2008 from 14.7 to 15.3%.

At the same time that the smoking rates have increased, funding for tobacco use prevention and cessation programs have been cut and initiatives such as media and marketing targeted to school-aged children have been eliminated.

Future Funding

Language in the Budget Reconciliation and Financing Act of 2010 changed the mandated funding levels for cancer and tobacco programs in fiscal 2011, 2012, 2013, and beyond. **Exhibit 11** shows the mandated funding level for each program as specified by the legislation.

Exhibit 11
Temporary and Permanent Reductions to Mandated Appropriation Levels of the
Cigarette Restitution Fund Programs
(\$ in Millions)

	<u>Original Level</u>	<u>2011 Working Appropriation</u>	<u>2012 Allowance</u>	<u>2013 And Beyond</u>	<u>% Change from Original Level to Permanent Level</u>
Tobacco Use Prevention and Cessation	\$21.0	\$6.0	\$6.0	\$10.0	-52.4%
Statewide Academic Health Centers					
Cancer Research Grants	10.4	2.4	2.4	13.0	25.0%
Tobacco-related Disease Research Grants	2.0	0.0	0.0	0.0	-100.0%
Statewide Network Grants	3.0	0.0	0.0	0.0	-100.0%
Total	\$15.4	\$2.4	\$2.4	\$13.0	-15.6%

Source: Annotated Code of Maryland

As the chart shows, the funding for Tobacco Use Prevention and Cessation and grants to the Statewide Academic Health Centers is partially restored in fiscal 2013. Funding for tobacco programs, which includes CRF and other funds, is set to increase to \$10.0 million. Although that represents a 66.7% increase over fiscal 2012, it is 52.4% lower than the original permanent amount.

Funding for Statewide Academic Health Centers increases to \$13.0 million in fiscal 2013, a 441.7% increase over the fiscal 2012 level and only 15.6% lower than the original permanent amount.

The statute requiring funding for these two programs does not specify the fund source that must be used; historically the majority of the funding originated from the CRF. Revenue to the CRF is dependent on a variety of factors including the status of litigation, changes to escrow payments and tobacco revenues. In fiscal 2012, the revenue to CRF is expected to be \$15.2 million lower than the fiscal 2011 estimated revenue. Although the funding for tobacco programs and Statewide Academic Health Centers is projected to increase in fiscal 2013, the CRF revenue may not be sufficient to cover those expenses and other fund sources will be needed.

The agency should comment on the funding source for the tobacco and cancer programs should CRF funds not be available. The agency should also comment on the trend that reflects higher smoking rates among certain populations in Maryland and how Maryland compares to other states.

3. Breast and Cervical Cancer Activities

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

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

Breast and Cervical Cancer Screening Program

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

In fiscal 2011, the budget included \$2.7 million general funds and \$4.5 million federal funds to be distributed to local health agencies to perform the screenings. The agency expects to screen over 13,000 women in fiscal 2011. Most of the women screened under this program are eligible for WBCCHP. Before Maryland was approved for the WBCCHP Medicaid waiver program, women screened under BCCP would have been enrolled in the BCCDTP using State funds to treat any instance of breast or cervical cancer.

Breast and Cervical Cancer Diagnosis and Treatment Program

FHA administers the BCCDTP, which funds breast and cervical cancer diagnostic and treatment services for uninsured, low-income (below 250% of the federal poverty level) women age 19 and older. BCCDTP covers the following services:

- breast and cervical cancer diagnostic procedures including ultrasound, biopsy, colposcopy, surgical consultations, etc.;

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

In fiscal 2010, the program served approximately 3,799 patients at a cost of \$14.6 million. **Exhibit 12** shows the number of patients served by BCCDTP from fiscal 2004 through 2010 and the program costs for BCCDTP. While the number of patients served has leveled off in recent years, the program's expenditures peaked in 2009 at \$16.1 million.

Exhibit 12
Enrollment and Expenditures for the Breast and Cervical
Cancer Diagnosis and Treatment Program
Fiscal 2004-2010
(\$ in Millions)



Source: Department of Health and Mental Hygiene

The expenses of the program decreased in fiscal 2010 for the first time since 2006, partially due to the availability of State and federal screening programs that identify women eligible for WBCCHP that may have otherwise been enrolled into BCCDTP. The department has also reached an agreement with the Maryland Health Insurance Plan (MHIP) to enroll high cost patients into MHIP, which will further decrease the amount of funding needed for BCCDTP.

Women’s Breast and Cervical Cancer Health Program

WBCCHP was established by the Breast and Cervical Cancer Prevention and Treatment Act passed by the U.S. Congress in 2000. In 2002, Maryland was approved for a Medicaid waiver for WBCCHP. Treatment for breast and cervical cancer is available to women diagnosed with precancer

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or cancer through the BCCP mentioned above. The federal government provides a 65% match for costs associated with WBCCHP.

The availability of WBCCHP provides an alternative to the BCCDTP for treatment of breast and cervical cancer in Maryland. FHA has the ability to alleviate the financial burden of the BCCDTP by directing eligible women into WBCCHP.

The agency should comment on the enrollment and costs of the BCCDTP and the viability of identifying women for WBCCHP.

Recommended Actions

	<u>Amount Reduction</u>
1. Delete \$15 million for the grant to Prince George’s County Hospital Center. The funds are double budgeted in the fiscal 2012 allowance as special funds in the Family Health Administration and general funds in the Dedicated Purpose Account (DPA). In previous years, funds from the DPA were transferred by budget amendment for this grant in order to provide the budget and policy committees with the oversight afforded in the State Finance and Procurement Article §7-310. This reduction is a technical amendment and the agency should submit a budget amendment in accordance with existing statutory process.	\$ 15,000,000 SF
Total Special Fund Reductions	\$ 15,000,000

Updates

1. Dental Health Initiatives

Since fiscal 2009, the FHA budget has included funding to improve the State's public dental health infrastructure and to provide school-based dental services. FHA's Office of Oral Health (OOH) is charged with developing statewide oral health preventive and educational strategies to decrease oral disease, conducting oral health surveys of the State's school children, and providing grant funding for the establishment of local oral health programs targeted to populations at high-risk for oral disease.

Background

The issue of dental access came to the forefront in Maryland in 2007 with the untimely death of a 12-year-old Prince George's County child who had an untreated tooth infection that spread to his brain. At the time the child fell ill, the child's Medicaid coverage had lapsed. Nonetheless, when covered by Medicaid, the mother said it took her seven months to obtain dental treatment for another child that appeared to have more serious dental problems.

Concern over dental access in Maryland is not new. Nor is the problem isolated to the Medicaid population. For example, the *Survey of the Oral Health of Maryland School Children: 2005-2006* conducted by the Department of Pediatric Dentistry, University of Maryland, Baltimore College of Dental Surgery, and the DHMH OOH, found that:

- 33% of Maryland children in kindergarten and grade 3 had untreated decay; and
- less than 30% of Maryland children in kindergarten and grade 3 had dental sealants.

With regard to the first measure, the survey revealed some improvement over the *2000-2001 Survey of the Oral Health Status of Maryland School Children*, which found that 53% of Maryland children in kindergarten and grade 3 had untreated decay in their primary teeth.

In response to the tragic death of the 12-year-old youth, numerous actions were taken to address the issue of dental access in Maryland. First, during the 2007 regular session, the General Assembly passed a bill establishing the Oral Health Safety Net Program. A Dental Action Committee (DAC) was also formed to develop recommendations to ensure that every Maryland child has a dental home and has access to oral health care. As part of its overall report to the Secretary of DHMH, the DAC found a lack of dental public health infrastructure in Maryland and recommended funding to correct this situation.

Office of Oral Health Initiatives

In response to the findings of DAC and the priorities of the Administration to improve dental health care for Marylanders, funding to build dental health clinics and school-based oral health programs has been included in the annual budget beginning in fiscal 2009. Since that time, the office has received \$1.55 million in each fiscal year to invest in the dental public health infrastructure across the State including expanding dental education, diagnostic, prevention, and treatment services.

Other initiatives include establishing new oral health services and increasing capacity of dental practitioners through grants to local health departments, and improving school-based oral health services to provide children with preventive oral health services, education, oral screening, and access to a dental home. OOH supports three school-based programs: a mobile dental van program operated in Prince George's County; school-based dental prevention services in Allegany, Baltimore, Caroline, Cecil, Garrett, Howard, Somerset, and St. Mary's counties and Baltimore City; and school-based oral health access programs sponsored by OOH and CDC.

The fiscal 2012 budget includes support to continue the programmatic activities of OOH. The office will continue to fund the programs identified at local health departments and school-based activities.

Federal Grants

FHA also received federal grants in fiscal 2011 and 2012 for oral health promotion. In particular, a federal grant was awarded to Maryland to conduct a statewide needs assessment to study and evaluate the current public oral health programs. The State has also received federal funds for an Oral Health Literacy program.

Current and Prior Year Budgets

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

	<u>General Fund</u>	<u>Special Fund</u>	<u>Federal Fund</u>	<u>Reimb. Fund</u>	<u>Total</u>
Fiscal 2010					
Legislative Appropriation	\$33,029	\$41,228	\$123,144	\$50	\$197,451
Deficiency Appropriation	0	0	0	0	0
Budget Amendments	5,131	15,838	6,893	0	27,862
Cost Containment	-816	-12,577	0	0	-13,393
Reversions and Cancellations	-16	-341	-2,180	0	-2,536
Actual Expenditures	\$37,328	\$44,148	\$127,858	\$50	\$209,384
Fiscal 2011					
Legislative Appropriation	\$33,725	\$34,259	\$136,812	\$50	\$204,845
Budget Amendments	-2,068	15,000	-152	0	12,780
Working Appropriation	\$31,657	\$49,259	\$136,659	\$50	\$217,625

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

Fiscal 2010

In fiscal 2010, the budget for FHA closed at \$209.4 million, an increase of \$11.9 million over the legislative appropriation.

Budget amendments increased the budget by \$27.9 million, consisting of an increase of \$5.1 million in general funds, \$15.8 million in special funds, and \$6.9 million in federal funds. The general fund amendments increased the budget to disburse the grant for Bon Secours Hospital (\$5.0 million) and to realign appropriations within DHMH from programs with surpluses to those with deficits (\$0.1 million).

The special fund amendments increased the budget to recognize the transfer of funds from the CRF programs to the BCCDTP (\$14.8 million), to conform to legislative action that restricted funds allocated in the Medical Care Programs Administration to be used only to fund the Minority Outreach and Technical Assistance program (\$0.8 million), and to fund the Maryland Cancer Fund and the Spinal Cord Injury Fund (\$0.2 million).

The federal fund amendments increased the budget to recognize federal funds for the WIC program (\$4.3 million), to fund various grants in the family planning program, colorectal cancer screening program, chronic disease prevention, and tobacco cessation programs (\$1.4 million), to develop strategies to reach ethnic and racial underserved and priority populations for the H1N1 vaccine (\$1.0 million), and to cover the cost of the Loan Repayment program and to update the Primary Care Office database (\$0.1 million)

Cost containment actions reduced the budget by \$13.4 million, consisting of \$0.8 million in general funds and \$12.6 million in special funds. The following reductions were made according to the approved Board of Public Works (BPW) actions:

- reduction to Statewide Academic Health Centers (\$7.5 million special funds);
- reduction to Cancer Prevention, Education, Screening, and Treatment programs (\$3.0 million special funds);
- reduction to Tobacco Use, Prevention, and Cessation programs (\$1.3 million special funds);
- reduction to Spinal Cord Injury Fund grants (\$0.4 million special funds);
- implementation of statewide furloughs (\$0.3 million general funds);
- reductions for salary expenses in the MCH program and conversion of a state funded contract for dental health to a federal grant (\$260,000 general funds);

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- abolition of 5 positions in CRF programs, including 3 from the CRF Cancer Administration program and 2 from CRF Tobacco Administration (\$200,000 in special funds);
- elimination of the general fund portion of grants to two children’s medical day centers (\$150,000 general funds);
- reduction to funding for health professions education at the Eastern Shore and the Western Maryland Area Health Education Centers (\$100,600 general funds); and
- other miscellaneous reductions to travel, family planning supplies, and personnel consolidation (\$5,000 general funds and \$0.1 million special funds).

At the end of the year, the agency reverted \$15,724 in general funds in accordance with a fiscal 2009 BPW item affecting the Office of Minority Health and Health Disparities (MHHD). There were insufficient funds to carry this action out in fiscal 2009, so the balance was carried over to fiscal 2010. Also, \$0.3 million in special fund appropriation was cancelled for expending less than was budgeted from various programs including prior year grant activity, child abuse and neglect program, the Maryland Cancer Fund, and CRF administration. Finally, \$2.2 million in federal fund appropriation was cancelled for expending less than was budgeted in the WIC program and the colorectal cancer screening program.

Fiscal 2011

The fiscal 2011 working appropriation is \$217.6 million, an increase of \$12.8 million over the original legislative appropriation. As a result of legislation in the 2010 session, MHHD was moved from FHA to the Office of the Secretary. This move resulted in the transfer of 1 position and reduction of \$2.1 million general funds and \$0.2 million federal funds.

A budget amendment for the grant to Prince George’s County Hospital System was authorized for \$15 million. This action transferred funds from the Dedicated Purpose Account to FHA for the purpose of disbursement of the grant and required approval by the budget and legislative policy committees.

**Object/Fund Difference Report
DHMH – Family Health Administration**

<u>Object/Fund</u>	<u>FY 10 Actual</u>	<u>FY 11 Working Appropriation</u>	<u>FY 12 Allowance</u>	<u>FY 11 - FY 12 Amount Change</u>	<u>Percent Change</u>
Positions					
01 Regular	173.30	170.30	170.30	0.00	0%
02 Contractual	4.79	6.33	6.71	0.38	6.0%
Total Positions	178.09	176.63	177.01	0.38	0.2%
Objects					
01 Salaries and Wages	\$ 14,347,156	\$ 13,825,514	\$ 14,458,375	\$ 632,861	4.6%
02 Technical and Spec. Fees	183,280	214,028	224,059	10,031	4.7%
03 Communication	265,469	294,881	312,606	17,725	6.0%
04 Travel	349,049	349,922	236,799	-113,123	-32.3%
07 Motor Vehicles	44,960	24,564	19,972	-4,592	-18.7%
08 Contractual Services	161,307,820	173,154,384	171,088,347	-2,066,037	-1.2%
09 Supplies and Materials	2,611,187	1,755,051	2,462,671	707,620	40.3%
10 Equipment – Replacement	33,287	0	0	0	0.0%
11 Equipment – Additional	775,567	630,096	644,864	14,768	2.3%
12 Grants, Subsidies, and Contributions	29,421,812	27,322,355	29,613,802	2,291,447	8.4%
13 Fixed Charges	44,744	54,187	43,810	-10,377	-19.2%
Total Objects	\$ 209,384,331	\$ 217,624,982	\$ 219,105,305	\$ 1,480,323	0.7%
Funds					
01 General Fund	\$ 37,328,237	\$ 31,656,878	\$ 31,608,815	-\$ 48,063	-0.2%
03 Special Fund	44,148,397	49,258,633	49,311,858	53,225	0.1%
05 Federal Fund	127,857,697	136,659,471	138,134,632	1,475,161	1.1%
09 Reimbursable Fund	50,000	50,000	50,000	0	0%
Total Funds	\$ 209,384,331	\$ 217,624,982	\$ 219,105,305	\$ 1,480,323	0.7%

Note: The fiscal 2011 appropriation does not include deficiencies. The fiscal 2012 allowance does not include contingent reductions.

Fiscal Summary
DHMH – Family Health Administration

<u>Program/Unit</u>	<u>FY 10 Actual</u>	<u>FY 11 Wrk Approp</u>	<u>FY 12 Allowance</u>	<u>Change</u>	<u>FY 11 - FY 12 % Change</u>
02 Family Health Services and Primary Care	\$ 151,381,369	\$ 160,445,904	\$ 160,861,432	\$ 415,528	0.3%
06 Prevention and Disease Control	58,002,962	57,179,078	58,243,873	1,064,795	1.9%
Total Expenditures	\$ 209,384,331	\$ 217,624,982	\$ 219,105,305	\$ 1,480,323	0.7%
General Fund	\$ 37,328,237	\$ 31,656,878	\$ 31,608,815	-\$ 48,063	-0.2%
Special Fund	44,148,397	49,258,633	49,311,858	53,225	0.1%
Federal Fund	127,857,697	136,659,471	138,134,632	1,475,161	1.1%
Total Appropriations	\$ 209,334,331	\$ 217,574,982	\$ 219,055,305	\$ 1,480,323	0.7%
Reimbursable Fund	\$ 50,000	\$ 50,000	\$ 50,000	\$ 0	0%
Total Funds	\$ 209,384,331	\$ 217,624,982	\$ 219,105,305	\$ 1,480,323	0.7%

Note: The fiscal 2011 appropriation does not include deficiencies. The fiscal 2012 allowance does not include contingent reductions.