
**Department of Health and
Mental Hygiene
Fiscal 2013 Budget Overview**

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

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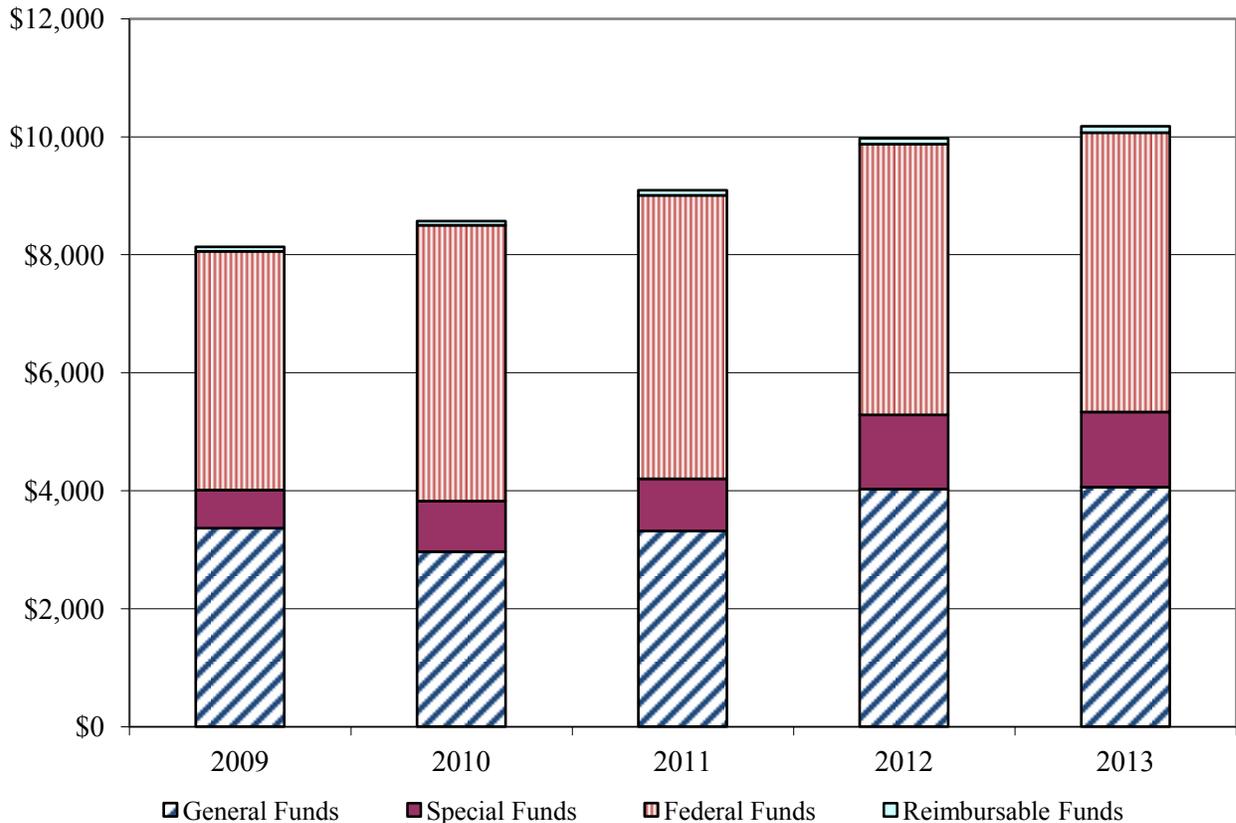
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Analysis of the FY 2013 Maryland Executive Budget, 2012

M00 – DHMH – Fiscal 2013 Budget Overview

M00
Department of Health and Mental Hygiene
Fiscal 2013 Budget Overview

Department of Health and Mental Hygiene
Five-year Funding Trends
Fiscal 2009-2013
(\$ in Millions)



Note: Includes fiscal 2012 deficiencies, fiscal 2013 contingent reductions, and fiscal 2013 funding included in the Department of Budget and Management earmarked for the Department of Health and Mental Hygiene for Targeted Local Health. The Mental Health Administration general fund deficiency and one Medicaid deficiency are allocated to fiscal 2011, as they are for bills attributable to that fiscal year but paid in fiscal 2012.

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

M00 – DHMH – Fiscal 2013 Budget Overview

**Department of Health and Mental Hygiene
Budget Overview: Expenditure Growth Tightened Further
Fiscal 2009-2013
(\$ in Millions)**

	<u>2009</u>	<u>2010</u>	<u>2011</u>	<u>2012</u>	<u>2013</u>	<u>Change 2012-13</u>
General Funds	\$3,363	\$2,963	\$3,236	\$4,029	\$4,098	
Fiscal 2012 Deficiencies			78			
Contingent, Planned, and Back of Bill Reductions					-38	
Adjusted General Funds	\$3,363	\$2,963	\$3,314	\$4,029	\$4,060	\$31
Special Funds	\$646	\$858	\$886	\$1,168	\$1,253	
Fiscal 2012 Deficiencies				90		
Contingent and Back of Bill Reductions					22	
Adjusted Special Funds	\$646	\$858	\$886	\$1,258	\$1,275	\$17
Federal Funds	\$4,050	\$4,675	\$4,739	\$4,572	\$4,736	
Fiscal 2012 Deficiencies			67	13		
Contingent and Back of Bill reductions						
Adjusted Federal Funds	\$4,050	\$4,675	\$4,806	\$4,585	\$4,736	\$151
Reimbursable Funds	\$75	\$73	\$87	\$97	\$105	
Total	\$8,133	\$8,570	\$9,093	\$9,969	\$10,175	\$206
Annual % Change from Prior Year	9.8%	5.4%	6.1%	9.6%	2.1%	

Note: Includes fiscal 2012 deficiencies, fiscal 2013 contingent reductions, and fiscal 2013 funding included in the Department of Budget and Management earmarked for the Department of Health and Mental Hygiene for Targeted Local Health. The Mental Health Administration general fund deficiency and one Medicaid deficiency are allocated to fiscal 2011, as they are for bills attributable to that fiscal year but paid in fiscal 2012.

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

M00 – DHMH – Fiscal 2013 Budget Overview

**Department of Health and Mental Hygiene
Fiscal 2012 Deficiencies**

<u>Program</u>	<u>Item</u>	<u>General Funds</u>	<u>Total Funds</u>
Medicaid	Funding to offset projected fiscal 2011 shortfalls in provider reimbursements rolled into fiscal 2012	\$63,910,000	\$130,609,086
Medicaid	Realization of special fund revenues based on the Budget Reconciliation and Financing Act of 2011 and other activities	0	64,004,245
Infectious Disease and Env. Health	Supplementary funding for a variety of HIV/AIDS activities including the Maryland AIDS Drug Assistance Program, and also immunization efforts	0	28,756,654
Mental Hygiene	Funding required to cover fiscal 2011 bills rolled over into fiscal 2012	14,100,000	14,100,000
Mental Hygiene	Funding for Maryland Mental Health Transformation activities and community alternatives to institutionalization for children and youth with mental illness	0	3,157,401
Office of Preparedness and Response	Funding for Medicaid Reserve Corps activities, emergency preparedness upgrades at Prince George's County Hospital, the purchase of an Inventory Management and Tracking System	0	2,530,162
Family Health	Additional funding for WIC	0	2,500,000
Family Health	Supplemental funding for primary care activities and State Chronic Disease planning	0	1,636,694
DHMH – Administration	Planning funds for a WIC Electronic Benefits transfer system to replace the current system which issues paper checks to WIC participants	0	384,785
Fiscal 2012 Deficiencies Total		\$78,010,000	\$247,679,027

AIDS: acquired immune deficiency syndrome
HIV: human immunodeficiency virus
DHMH: Department of Health and Mental Hygiene
WIC: Women, Infants, and Children

Source: Department of Legislative Services; State Budget

M00 – DHMH – Fiscal 2013 Budget Overview

**Department of Health and Mental Hygiene
Fiscal 2013 Contingent Reductions**

<u>Agency/Program</u>	<u>Contingent Reductions</u>	<u>General Funds</u>	<u>Total Funds</u>
Medicaid and Family Health	Reducing funding for CRF-supported Statewide Academic Health Centers and Tobacco Use Cessation and Prevention programs by \$14.7 million and reduce general funds in Medicaid by the same amount to be backfilled by those CRF funds	\$14,688,143	\$14,688,143
Medicaid	Making \$6.6 million of fiscal 2013 special fund support for the Kidney Disease Program contingent on legislation authorizing the use of revenue from a nonprofit health service plan (CareFirst) that would have otherwise funded the Maryland Community Health Resources Commission and Senior Prescription Drug Assistance Program	6,598,809	0
Mental Health	Making \$6.2 million of fiscal 2013 special fund support for community mental health services contingent on legislation authorizing the use of revenue from a nonprofit health service plan (CareFirst) that would otherwise have funded the Maryland Community Health Resources Commission	6,247,276	0
Medicaid	Reduction in general fund support for nursing homes contingent on legislation increasing the nursing home quality assessment from 5.5 to 6.0% and allowing a portion of that assessment to supplant general funds	5,520,840	0
Medicaid	Reduction in general fund support for Medical Day Care services contingent on legislation imposing a provider tax on those services and allowing a portion of that assessment to supplant general funds	3,431,947	0
Infectious Disease and Environmental Health	Level fund targeted local health grant	1,894,001	1,894,001
Total Fiscal 2013 Contingent Reductions		\$38,381,016	\$16,582,144

CRF: Cigarette Restitution Fund

Source: Department of Legislative Services; State Budget

M00 – DHMH – Fiscal 2013 Budget Overview

**Department of Health and Mental Hygiene
Fiscal 2012 and 2013 Fund Transfers
Contingent on Legislation**

<u>Agency/Program</u>	<u>Item</u>	<u>2012</u>	<u>2013</u>
Family Health	Fund balance transfer from the Spinal Cord Injury Trust Fund (fiscal 2012 transfer approved in the 2011 Session)	\$500,000	\$500,000
Health Occupations Boards	Fund balance transfers. Fiscal 2012 transfers as approved in the 2011 session (Board of Pharmacy Fund (\$237,888) and Board of Psychologists Fund (\$44,888)). Fiscal 2013 transfers from various sources	282,776	426,529
Total Fund Transfers		\$782,776	\$926,529

Source: Department of Legislative Services; State Budget

M00 – DHMH – Fiscal 2013 Budget Overview

**Department of Health and Mental Hygiene
Other Actions
Fiscal 2012-2013**

<u>Agency/Program</u>	<u>Action</u>	<u>2012</u>	<u>2013</u>
Medicaid	Special fund revenues resulting from Section 22 of the fiscal 2012 budget bill implementing the Voluntary Separation Program.	\$424,023	
Medicaid	The BRFA of 2012 includes a provision eliminating bed hold payments for nursing homes. The savings from this action (\$5.1 million) will be used to expand personal care services.		
Medicaid	The BRFA of 2012 includes a provision allowing for the alteration of the distribution of disproportionate share payment funds or other action determined by the HSCRC, which will generate \$18.2 million in savings to the Medicaid program.		-\$18,200,000
Mental Hygiene Administration	The BRFA of 2012 includes a program allowing the use of MHIP fund balance for community mental health services.		
Developmental Disabilities Administration	DBM's fiscal 2013 allowance includes \$183,253 (all general funds) to create a new class of Forensic Behavioral Specialists at one SETT unit.		\$183,253
DHMH	Section 19 of the fiscal 2013 budget bill transfers 1 regular position and \$83,652 in general funds to the Department of Information Technology and another 1 regular position and DoIT's costs for that position also to DoIT for web design functions.		
DHMH	Section 20 of the fiscal 2013 budget bill transfers 1 regular position and \$76,265 in general funds to DoIT for GIS and DoIT's costs for GIS rendered.		

BRFA: Budget Reconciliation and Financing Act
 DBM: Department of Budget and Management
 DHMH: Department of Health and Mental Hygiene
 DoIT: Department of Information Technology
 GIS: Geographic Information Systems
 HSCRC: Health Services Cost Review Commission
 MHIP: Maryland Health Insurance Plan
 SETT: Secure Evaluation and Therapeutic Treatment

Source: Department of Legislative Services; State Budget

M00 – DHMH – Fiscal 2013 Budget Overview

**Department of Health and Mental Hygiene
Fiscal 2013 Revenue Adjustments**

<u>Agency/Program</u>	<u>Item</u>	<u>2013</u>
DHMH	Glaxo Medicaid settlement	\$7,500,000
DHMH	OHCQ fees	2,173,800
DHMH	Merck Medicaid settlement	1,596,570
DHMH	Newborn screening fee	1,360,000
DHMH	Death Certificate and other vital records fees*	738,540
DHMH	Food control fees	480,250
DHMH	Community Services fees	50,000
DHMH	Hospital patient recoveries (loss based on closure of assisted living units at Springfield and Spring Grove)	-23,347
Total Revenue Adjustments		\$13,875,813

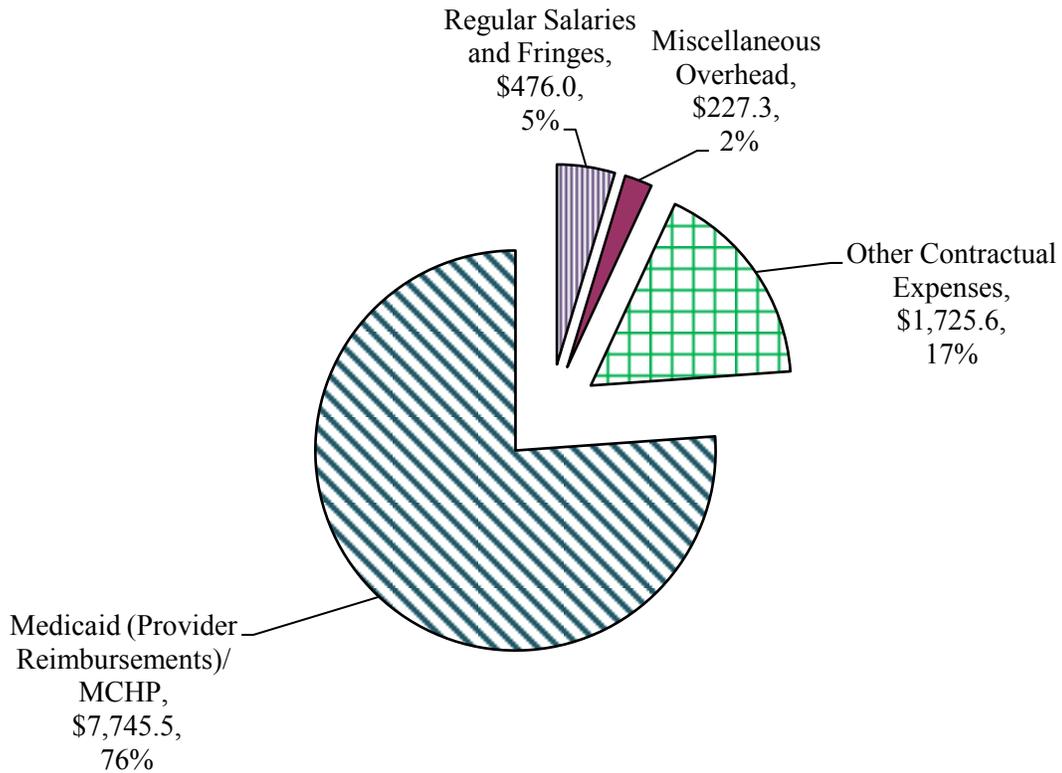
* Contingent of the Budget Reconciliation and Financing Act of 2012

DHMH: Department of Health and Mental Hygiene
OHCQ: Office of Health Care Quality

Source: Department of Legislative Services; State Budget

M00 – DHMH – Fiscal 2013 Budget Overview

**Department of Health and Mental Hygiene
Functional Breakdown of Spending
Fiscal 2013 Allowance
(\$ in Millions)**



MCHP: Maryland Children's Health Program

Note: Includes fiscal 2013 contingent reductions and fiscal 2013 funding included in the Department of Budget and Management earmarked for the Department of Health and Mental Hygiene for Targeted Local Health.

Source: Department of Legislative Services; State Budget

M00 – DHMH – Fiscal 2013 Budget Overview

**Department of Health and Mental Hygiene
Budget Overview: All Funding Sources
Fiscal 2011-2013
(\$ in Thousands)**

	<u>Actual 2011</u>	<u>Working 2012</u>	<u>Allowance 2013</u>	<u>\$ Change 2012-13</u>	<u>% Change 2012-13</u>
Medical Programs/Medicaid	\$6,446,908	\$7,141,727	\$7,315,699	\$173,972	2.4%
Provider Reimbursements	6,185,849	6,819,028	7,001,113	182,086	2.7%
Maryland Children’s Health Program	184,857	208,904	199,873	-9,031	-4.3%
Other	76,202	113,796	114,713	917	0.8%
Mental Hygiene	\$1,016,780	\$1,072,051	\$1,067,301	-\$4,750	-0.4%
Program Direction	8,051	8,580	9,053	473	5.5%
Community Services	752,291	800,190	795,046	-5,144	-0.6%
Facilities	256,438	263,281	263,201	-79	0.0%
Developmental Disabilities	\$788,746	\$846,076	\$876,296	\$30,220	3.6%
Program Direction	5,895	6,352	6,430	78	1.2%
Community Services	739,393	799,714	830,682	30,968	3.9%
Facilities	43,458	40,010	39,183	-827	-2.1%
Infectious Disease and Environmental Health	\$167,778	\$192,125	\$185,497	-\$6,628	-3.4%
Targeted Local Health	41,776	42,766	42,544	-222	-0.5%
Office of Preparedness & Response	25,145	19,932	15,830	-4,102	-20.6%
Community Health	100,857	129,427	127,123	-2,303	-1.8%
Family Health	211,684	222,492	222,390	-102	0.0%
Women, Infants, and Children	103,591	110,596	111,422	826	0.7%
CRF Tobacco and Cancer	19,579	19,787	19,902	115	0.6%
Other	88,514	92,109	91,067	-1,042	-1.1%
Alcohol and Drug Abuse	\$141,105	\$150,325	\$158,713	\$8,388	5.6%
Other Budget Areas	\$319,676	\$343,997	\$349,304	\$5,308	1.5%
DHMH Administration	50,848	52,427	57,349	4,921	9.4%
Office of Health Care Quality	15,517	16,930	17,420	491	2.9%
Health Occupations Boards	26,230	28,782	30,477	1,695	5.9%
Chronic Disease Hospitals	44,961	46,695	46,529	-166	-0.4%
Chief Medical Examiner	10,955	9,983	10,340	357	3.6%
Laboratories Administration	23,911	22,923	22,169	-754	-3.3%
Health Regulatory Commissions	147,254	166,256	165,020	-1,236	-0.7%
Total Funding	\$9,092,679	\$9,968,793	\$10,175,201	\$206,408	2.1%

CRF: Cigarette Restitution Fund

DHMH: Department of Health and Mental Hygiene

Note: Includes fiscal 2012 deficiencies, fiscal 2013 contingent reductions, and fiscal 2013 funding included in the Department of Budget and Management earmarked for the Department of Health and Mental Hygiene for Targeted Local Health. The Mental Health Administration general fund deficiency and one Medicaid deficiency are allocated to fiscal 2011, as they are for bills attributable to that fiscal year but paid in fiscal 2012.

Source: Department of Legislative Services; State Budget

M00 – DHMH – Fiscal 2013 Budget Overview

**Department of Health and Mental Hygiene
Budget Overview: General Funds Only
Fiscal 2011-2013
(\$ in Thousands)**

	<u>Actual 2011</u>	<u>Working 2012</u>	<u>Allowance 2013</u>	<u>\$ Change 2012-13</u>	<u>% Change 2012-13</u>
Medical Programs/Medicaid	\$1,904,975	\$2,580,739	\$2,578,914	-\$1,825	-0.1%
Provider Reimbursements	1,817,479	2,485,027	2,481,234	-3,793	-0.2%
Maryland Children’s Health Program	60,022	66,766	64,241	-2,525	-3.8%
Other	27,473	28,947	33,439	4,492	15.5%
Mental Hygiene	\$656,047	\$681,365	\$684,596	\$3,232	0.5%
Program Direction	5,708	6,150	6,603	454	7.4%
Community Services	401,784	421,785	424,212	2,428	0.6%
Facilities	248,555	253,431	253,781	350	0.1%
Developmental Disabilities	\$483,104	\$498,167	\$501,831	\$3,663	0.7%
Program Direction	3,987	4,314	4,415	101	2.4%
Community Services	436,146	455,100	459,096	3,995	0.9%
Facilities	42,971	38,753	38,320	-434	-1.1%
Infectious Disease and Environmental Health	\$47,178	\$48,154	\$47,953	-\$201	-0.4%
Targeted Local Health	37,283	38,273	38,051	-222	-0.6%
Office of Preparedness & Response	0	0	0	0	0.0%
Community Health	9,894	9,881	9,902	21	0.2%
Family Health	32,163	30,903	44,159	\$13,256	42.9%
Women, Infants, and Children	105	100	65	-35	-35.0%
CRF Tobacco and Cancer	844	777	779	2	0.2%
Other	31,214	30,026	43,315	13,289	44.3%
Alcohol and Drug Abuse	\$85,198	\$82,994	\$87,876	\$4,882	5.9%
Other Budget Areas	\$104,995	\$106,491	\$114,364	\$7,873	7.4%
DHMH Administration	26,261	27,197	33,379	6,182	22.7%
Office of Health Care Quality	9,304	9,690	10,410	720	7.4%
Health Occupations Boards	309	324	389	65	20.1%
Chronic Disease Hospitals	39,646	40,908	41,714	805	2.0%
Chief Medical Examiner	10,629	9,681	10,134	453	4.7%
Laboratories Administration	18,846	18,691	18,338	-352	-1.9%
Health Regulatory Commissions	0	0	0	0	0.0%
Total Funding	\$3,313,660	\$4,028,814	\$4,059,693	\$30,879	0.8%

CRF: Cigarette Restitution Fund

DHMH: Department of Health and Mental Hygiene

Note: Includes fiscal 2012 deficiencies, fiscal 2013 contingent reductions, and fiscal 2013 funding included in the Department of Budget and Management earmarked for the Department of Health and Mental Hygiene for Targeted Local Health. The Mental Health Administration general fund deficiency and one Medicaid deficiency are allocated to fiscal 2011, as they are for bills attributable to that fiscal year but paid in fiscal 2012.

Source: Department of Legislative Services; State Budget

M00 – DHMH – Fiscal 2013 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>
2012 Working Appropriation	\$4,028,814	\$1,257,917	\$4,585,143	\$96,918	\$9,968,793
2013 Governor’s Allowance	4,059,693	1,275,029	4,735,952	104,527	10,175,201
Amount Change	30,879	17,112	150,809	7,609	206,408
Percent Change	0.8%	1.4%	3.3%	7.9%	2.1%

Where It Goes:

Major Personnel Expenses

\$3,991

New positions (126.5 FTEs).....	5,989
Retirement contribution.....	5,708
Employee and retiree health insurance.....	4,435
Other fringe benefit adjustments	-66
Reclassifications	-218
Additional assistance, overtime and shift differential	-226
Social Security contributions.....	-260
Abolished positions (20 FTEs).....	-1,180
Turnover expectancy	-2,450
Regular earnings.....	-3,001
Removal of funding for the fiscal 2012 one-time bonus.....	-4,739

Major Programmatic Changes (Exc. Medicaid)

\$29,354

Mental Hygiene Administration

-\$5,246

Fee-for-Service

MA enrollment/utilization.....	22,841
Statutory rate adjustment for non-rate regulated providers, 0.88% (Chapters 497 and 498 of 2010)	5,185
Community services related to hospital ALU closures	1,900
Reduce utilization of psychiatric rehabilitation services by the uninsured	-1,500
Reduce utilization of purchase of care beds for the uninsured.....	-4,250
Fraud and abuse savings.....	-5,360
Utilization review savings	-20,000

M00 – DHMH – Fiscal 2013 Budget Overview

Where It Goes:

Grants and Contracts

Housing subsidies.....	1,000
Identification documents initiative to facilitate enrollment.....	500
Reduction in SAMHSA federal grant.....	-1,068
Other CSA and Administrative service contracts.....	-1,322
Reduction in RTC alternatives	-3,173

Developmental Disabilities Administration **\$29,626**

Additional funding for annualization and expansion	13,899
Statutory rate adjustment for community providers, 1.03% (Chapters 497 and 498 of 2010).....	8,099
Additional rate adjustment (0.97%)	7,628

Family Health **-\$1,041**

PPACA – Maternal, Infant and Early Childhood Homevisiting Program.....	2,086
Various federal grants	-1,513
Family Planning	-1,615

Infectious Disease and Environmental Health **-\$2,303**

MADAP and MADAP – Plus Programs	6,306
HIV counseling and testing services	1,548
HIV Prevention Grants at LHDs	-1,726
Various federal grants	-2,686
Expanded HIV testing in Baltimore City and Prince George’s County	-2,416
HIV primary and specialty medical care	-3,329

Office of Preparedness and Response **-\$4,102**

Various federal grants	-1,583
Telehealth grant for Prince George’s County Hospital	-2,520

Alcohol and Drug Abuse Administration **\$7,968**

Treatment grants	4,802
Problem Gambling Center of Excellence (special funds).....	1,725
Substance Abuse Prevention and Treatment Block Grant (federal funds).....	1,441

Regulatory Commissions **-\$2,314**

CHRC Health Empowerment Zone initiative.....	4,000
MHCC Health Information Technology	-1,314
HSCRC Uncompensated Care Fund	-5,000

Miscellaneous **\$6,768**

Statewide personnel IT system.....	4,359
OAG/Retirement/DoIT assigned charges.....	1,872
Contractual employment	757
Travel.....	529
Fuel and utilities	-749

M00 – DHMH – Fiscal 2013 Budget Overview

Where It Goes:

Medicaid/Medical Care Programs Administration	\$171,786	
Medicaid/Maryland Children's Health Program (Programs 03 and 07)	\$356,293	
Enrollment/utilization (includes 300 new slots under the older adults waiver)		259,008
Primary Adult Care program		37,436
Medicare Part A and B premium assistance		30,709
MMIS contracts		25,185
Offset of fiscal 2012 cost containment		25,000
Living-at-home waiver 180 additional slots		21,770
Chronic Medical Home Initiative		15,000
School-based services (reimbursable funds)		9,290
Money Follows the Person		8,554
Pharmacy Clawback		5,978
Administrative contracts		5,903
Medicaid recoveries		5,183
Personal Services expansion		5,100
Transportation grants		4,115
Family Planning		3,973
FQHC supplemental payments		2,908
Pharmacy administrative contracts		2,550
GME payments		2,033
Nursing home cost settlements		1,586
Patient centers medical homes		1,398
Living-at-home case management		1,167
Community First Choice		-1,472
Third-party liability recoveries contract		-3,027
Medicare Advantage		-5,897
Maryland Children's Health Program		-9,863
Pharmacy offsets and rebates		-97,290
Rate Actions	\$11,425	
Physician rate increase for certain providers and diagnostic codes		75,300
Nursing homes (1.0%)		11,042
Medical day care (1.5%)		1,546
Private duty nursing (1.5%)		1,433
Older adult waiver services (1.5%)		1,401
Living-at-home waiver services (1.5%)		738
Personal care (1.5%)		536
Additional MCO Rate Reduction (calendar 2012; -1.0%)		-31,990
Impact of calendar 2012 MCO rate reduction (calendar 2012; -1.5%)		-48,581

M00 – DHMH – Fiscal 2013 Budget Overview

Where It Goes:

Cost containment actions	-\$210,870	
Annualization of frozen rates DC and non-HSCRC hospitals.....		-1,970
Require Medicare participation.....		-2,000
Examine denied services.....		-2,000
Identify dual eligibles for Medicare.....		-2,000
Reduce durable equipment.....		-2,000
Move End Stage Renal Disease to Medicare.....		-2,000
Increase Third Party Liability recoveries.....		-3,000
Eliminate nursing home bed hold payments (to be used for increase in personal care services).		-5,100
Monitoring of in-home provider services.....		-5,600
Accelerate medical loss ratio.....		-6,000
Social Security Insurance eligibility review.....		-7,200
Annualization of atypical anti-psychotics.....		-10,200
Eliminate communicable disease reimbursements for nursing homes.....		-11,600
Reduce disproportionate share payments.....		-18,200
Implement tiered rates for outpatient services.....		-60,000
Reduce medically needy inpatient funding.....		-72,000
 Other Medicaid Expenditures	 \$14,938	
Major IT projects.....		14,938
 Other		 1,277
 Total		 \$206,408

- | | |
|---|--|
| ALU: assisted living unit | JCR: <i>Joint Chairmen’s Report</i> |
| CHRC: Community Health Resource Commission | LHD: local health department |
| CSA: Core Service Agency | MADAP: Maryland Aids Drug Assistance Program |
| DoIT: Department of Information Technology | MCO: Managed Care Organization |
| FFS: fee-for-service | MHCC: Maryland Health Care Commission |
| FQHC: federal quality health center | MMIS: Medicaid Management Information System |
| FTE: full-time equivalent | OAG: Office of the Attorney General |
| GME: graduate medical degree | PPACA: Patient Protection and Affordable Care Act |
| HSCRC: Health Services Cost Review Commission | RTC: residential treatment center |
| HIV: human immunodeficiency virus | SAMHSA: Substance Abuse and Mental Health Services |
| IT: information technology | WIC: Women, Infants, and Children Food Program |

Note: Includes fiscal 2012 deficiencies, fiscal 2013 contingent reductions, and fiscal 2013 funding included in the Department of Budget and Management earmarked for the Department of Health and Mental Hygiene for Targeted Local Health. The Mental Health Administration general fund deficiency and one Medicaid deficiency are allocated to fiscal 2011, as they are for bills attributable to that fiscal year but paid in fiscal 2012.

M00 – DHMH – Fiscal 2013 Budget Overview

**Department of Health and Mental Hygiene
Regular Employees (FTE)
Fiscal 2011-2013**

	<u>Actual 2011</u>	<u>Working 2012</u>	<u>Allowance 2013</u>	<u>Change 2012-13</u>	<u>% Change 2012-13</u>
DHMH Administration	430.5	433.5	433.5	0.0	0.0%
Office of Health Care Quality	180.7	180.7	185.7	5.0	2.8%
Health Occupations Boards	247.1	250.7	260.2	9.5	3.8%
Infectious Disease and Environmental Health	245.0	241.0	237.0	-4.0	-1.7%
Family Health	164.3	156.3	158.3	2.0	1.3%
Chief Medical Examiner	77.0	76.4	81.4	5.0	6.5%
Chronic Hospitals	530.1	528.1	522.1	-6.0	-1.1%
Laboratories Administration	233.0	229.0	228.0	-1.0	-0.4%
Alcohol and Drug Abuse Administration	64.5	68.5	68.5	0.0	0.0%
Mental Hygiene Administration	2,861.1	2,826.0	2,919.0	93.0	3.3%
Administration	82.5	82.5	82.5	0.0	0.0%
Institutions	2,778.6	2,743.5	2,836.5	93.0	3.4%
Developmental Disabilities Administration	667.5	659.5	657.5	-2.0	-0.3%
Administration	162.5	160.0	159.0	-1.0	-0.6%
Institutions	505.0	499.5	498.5	-1.0	-0.2%
Medical Care Programs Administration	592.0	602.0	606.0	4.0	0.7%
Health Regulatory Commissions	95.6	98.7	99.7	1.0	1.0%
Total Regular Positions	6,388.3	6,350.3	6,456.8	106.5	1.7%

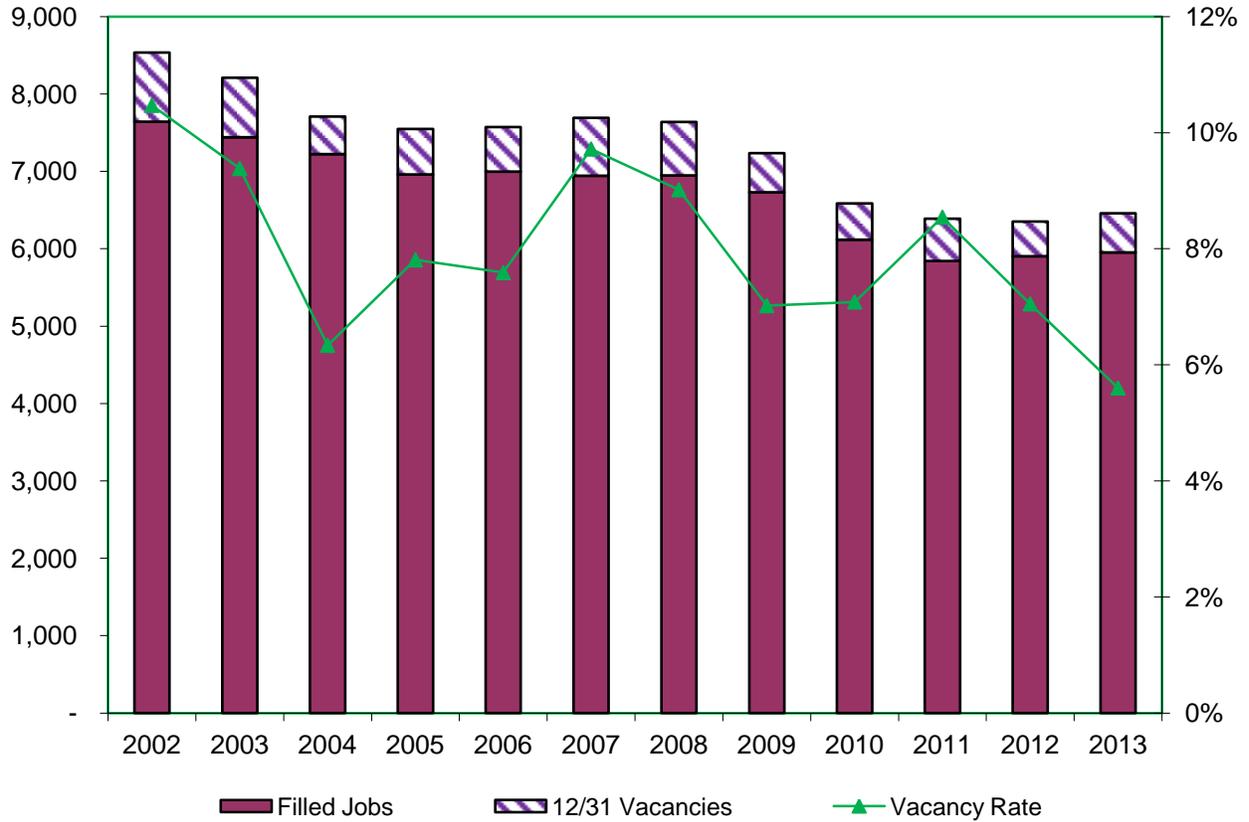
DHMH: Department of Mental Health and Hygiene
FTE: full-time equivalent

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

Source: State Budget

M00 – DHMH – Fiscal 2013 Budget Overview

**Department of Health and Mental Hygiene
Regular Employee Filled Jobs and Vacancy Rates
Fiscal 2002-2013**



Note: Fiscal 2013 reflects budgeted turnover rate.

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

M00 – DHMH – Fiscal 2013 Budget Overview

**Department of Health and Mental Hygiene
Regular Employees – Vacancy Rates
December 31, 2011**

	<u>FTE Vacancies</u>	<u>FTE Positions</u>	<u>Vacancy Rate</u>
DHMH Administration	37.6	433.5	8.7%
Office of Health Care Quality	8.5	180.7	4.7%
Health Occupations Boards	17.5	250.7	7.0%
Infectious Disease and Environmental Health	15.4	241.0	6.4%
Family Health	11.5	156.3	7.4%
Chief Medical Examiner	5	76.4	6.5%
Chronic Hospitals	44.5	528.1	8.4%
Laboratories Administration	7	229.0	3.1%
Alcohol and Drug Abuse Administration	15	68.5	21.9%
Mental Hygiene Administration	150.95	2,826.0	5.3%
Developmental Disabilities Administration	71	659.5	10.8%
Medical Care Programs Administration	50.8	602.0	8.4%
Health Regulatory Commissions	13	98.7	13.2%
Total Regular Positions	447.8	6,350.3	7.1%

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 2013 Budget Overview

**Department of Health and Mental Hygiene
Contractual Employees (FTE)
Fiscal 2011-2013**

	<u>Actual 2011</u>	<u>Working 2012</u>	<u>Allowance 2013</u>	<u>Change 2012-13</u>	<u>% Change 2012-13</u>
DHMH Administration	8.84	9.23	13.33	4.10	44.4%
Office of Health Care Quality	4.17	13.04	11.80	-1.24	-9.5%
Health Occupations Boards	15.99	11.60	18.40	6.80	58.6%
Infectious Disease and Environmental Health	2.55	3.57	3.57	0.00	0.0%
Family Health	3.32	6.21	6.21	0.00	0.0%
Chief Medical Examiner	7.37	5.55	5.55	0.00	0.0%
Chronic Hospitals	25.12	16.94	13.97	-2.97	-17.5%
Laboratories Administration	3.94	3.88	3.88	0.00	0.0%
Alcohol and Drug Abuse Administration	3.51	8.67	6.77	-1.90	-21.9%
Mental Hygiene Administration	171.46	191.66	189.02	-2.64	-1.4%
Administration	1.79	2.00	6.00	4.00	200.0%
Institutions	169.67	189.66	183.02	-6.64	-3.5%
Developmental Disabilities Administration	30.54	30.63	27.63	-3.00	-9.8%
Administration	6.28	8.00	5.00	-3.00	-37.5%
Institutions	24.26	22.63	22.63	0.00	0.0%
Medical Care Programs Administration	42.61	68.88	96.19	27.31	39.6%
Health Regulatory Commissions	0.00	0.00	0.00	0.00	0.00%
Total Contractual Positions	319.42	369.86	396.32	26.46	7.2%

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

M00 – DHMH – Fiscal 2013 Budget Overview

**Department of Health and Mental Hygiene
Budget Overview: Selected Caseload Measures
Fiscal 2009-2013**

	<u>2009</u>	<u>2010</u>	<u>2011</u>	<u>Working 2012</u>	<u>Allowance 2013</u>	<u>\$ Change 2012-13</u>	<u>% Change 2012-13</u>
Medical Programs/Medicaid							
Medicaid Enrollees	541,446	621,514	690,738	733,838	774,877	41,039	5.6%
Maryland Children's Healthcare Program	105,617	97,998	98,013	99,124	100,191	1,067	1.1%
Medicaid Expansion to Parents	29,273	55,250	72,433	83,848	94,706	10,858	12.9%
Primary Adult Care	28,771	40,397	51,483	60,445	68,642	8,197	13.6%
Developmental Disabilities Administration							
Residential Services	5,264	5,335	5,626	5,602	5,879	277	4.9%
Day Services	6,395	6,693	7,055	6,861	7,258	397	5.8%
Supported Employment	4,137	4,362	4,693	5,600	5,743	143	2.6%
In-home support services	6,998	5,518	5,249	5,947	6,430	483	8.1%
Other alternative residential support services ¹	2,056	2,102	2,145	2,138	2,143	5	0.2%
Average daily census at institutions ²	245	186	182	173	172	-1	-0.6%
Mental Hygiene Administration							
Average daily populations at State-run psychiatric hospitals:							
Hospitals excluding RICAs and Assisted Living							
	1,075	957	931	965	965	0	0.0%
RICAs	93	78	67	68	68	0	0.0%
Assisted Living	105	133	141	145	72	-73	-50.3%
Total	1,273	1,168	1,139	1,178	1,105	-73	-6.2%
Number receiving community mental health services:							
Medicaid eligible	93,432	108,896	132,600	142,041	144,132	2,091	1.5%
Medicaid ineligible	18,246	13,150	20,353	20,437	11,240	-9,197	-45.0%
Total	111,678	122,046	152,953	162,478	155,372	-7,106	-4.4%
Alcohol and Drug Abuse Administration							
Clients served in various settings	61,223	63,165	66,202	67,200	67,350	150	0.2%

RICAs: Regional Institutions for Children and Adolescents

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 Secure Evaluation and Therapeutic Treatment Center 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, Mississippi, and Texas 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 and is assumed again in the fiscal 2013 allowance.

The Office of the Attorney General notes that arbitration on sales year 2003 began during calendar 2010 and is still ongoing. Individual hearings will begin in May, but Maryland is not expected to have its case heard until fall 2012. No decisions will be issued until all State hearings are completed, likely some time in 2013.

Fiscal 2011-2013 CRF Programmatic Support

Exhibit 1 provides CRF revenue and expenditure detail for fiscal 2011 to 2013. Since the adoption of the fiscal 2011 budget, a number of key changes have occurred to the CRF fiscal 2012 revenue assumptions and fiscal 2012 spending plan:

- The NPM withhold amount increased from \$12.0 million to \$20.1 million (a similar change occurred for fiscal 2011). This reflected additional participating manufacturers choosing to escrow rather than continue to make full payments pending the resolution of this litigation.
- The reduction in revenues resulting from the increased withhold amount was almost completely offset by slightly higher settlement payments and a higher than anticipated fund balance. As a result, no changes have been made to the fiscal 2012 expenditures supported by CRF revenues.

For fiscal 2013, with a projected fund balance of only \$0.1 million, an expectation of slightly lower settlement payments and NPM withholding at \$20.1 million, the amount of funding available in fiscal 2013 is \$4.7 million lower than in fiscal 2012. 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). However, the Budget Reconciliation and Financing Act of 2012 proposes to level fund those programs and moves the funding to Medicaid. Overall, the drop in revenue is reflected in the lower amount of CRF funding expected to support Medicaid in fiscal 2013.

Exhibit 1
Cigarette Restitution Fund Budget
Fiscal 2011-2013
(\$ in Millions)

	<u>2011</u> <u>Actual</u>	<u>2012</u> <u>Working</u>	<u>2013</u> <u>Allowance</u>
Beginning Fund Balance	\$2.4	\$3.4	\$0.1
Settlement Payments	133.4	131.3	129.9
NPM and Other Shortfalls in Payments ¹	-20.1	-20.1	-20.1
Awards from Disputed Account	0.0	0.0	0.0
Other Adjustments ²	35.0	33.6	33.6
Subtotal	\$150.7	\$148.2	\$143.5
Prior Year Recoveries	\$2.1	\$1.0	\$1.0
Total Available Revenue	\$152.8	\$149.2	\$144.5
Health			
Tobacco	\$3.6	\$3.5	\$3.6
Cancer	14.1	14.4	14.4
Substance Abuse	21.1	21.0	21.0
Medicaid	86.7	84.0	79.1
Breast and Cervical Cancer	13.8	15.2	14.7
Subtotal	\$139.2	\$138.1	\$132.8
Other			
Aid to Nonpublic School	\$4.5	\$4.5	\$4.5
Crop Conversion	5.0	5.5	5.1
Attorney General	0.7	0.9	0.9
Subtotal	\$10.2	\$11.0	\$10.6
Total Expenses	\$149.4	\$149.1	\$143.4
Ending Fund Balance	\$3.4	\$0.1	\$1.1

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.

Note: Tobacco and Cancer funding represent funding levels as proposed by the Governor based on proposals in the Budget Reconciliation and Financing Act of 2012 with the funding allocated to support Medicaid. Numbers may not sum to total due to rounding.

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

2. Patient Protection and Affordable Care Act and the Five-year Forecast

One of the key provisions of federal health care reform is the expansion of the Medicaid program to all persons under 138% of the federal poverty level (FPL).¹ In Maryland, this will mean an expansion for parents and childless adults from 116 to 138%, but also the provision of full Medicaid benefits for childless adults currently in the Primary Adult Care (PAC) Program, which offers only a limited benefit package. However, while 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, much of the funding for implementation planning and subsequent service delivery is currently scheduled to be underwritten by the federal government. For example, for the newly-eligible populations (including existing PAC enrollees), through the first half of State fiscal 2017, 100% of the costs will be borne by the federal government, falling only to 95% of the costs in the second half of fiscal 2017.

As part of its long-term planning process, the Department of Legislative Services (DLS) prepares a five-year forecast at various points in the fiscal year. Beginning with the fiscal 2013 forecast, DLS included the expenditures and revenues associated with the Patient Protection and Affordable Care Act (PPACA) into its estimates. The forecast builds off the assumptions made by the Hilltop Institute in its work on behalf of the Governor's Health Care Reform Coordinating Council and released in December 2010. Underlying the estimate were a variety of assumptions including:

- enrollment projections and cost estimates developed from various data sources including the Maryland Health Care Commission (MHCC), Hilltop Institute, the Kaiser Foundation, as well as internal models;
- the discontinuation of the Maryland Health Insurance Plan (MHIP) assessment effective January 1, 2014, when individuals currently enrolled in that program can access care through the Maryland Health Benefit Exchange;
- a modest reduction (less than assumed by the estimate developed for the Coordinating Council) in State-only safety-net programs; and
- revenue estimates (which include an estimate of lower Medicaid disproportionate share payments) as developed by the Hilltop Institute for the Coordinating Council and for the purpose of the forecast, attributed to the general fund.

¹ The language of the PPACA specifies that childless adults are Medicaid-eligible with modified adjusted gross income at or below 133% of FPL. That definition of adjusted gross income is based on the Internal Revenue Code but is subsequently modified by the PPACA to add an additional 5% deduction from the FPL, effectively changing the threshold to 138% of FPL.

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Beginning in the middle of fiscal 2014, as shown in **Exhibit 2**, Medicaid expansion is anticipated to result in significant additional spending, but as noted above virtually all of the costs will accrue to the federal government. This continues, even as expenditures are anticipated to rise sharply in fiscal 2015 as program awareness and, therefore, enrollment increases. Indeed, the State is expected to save money in fiscal 2014 through 2017, primarily because the State expenditures currently associated with the PAC Program will disappear through the first half of State fiscal 2017, because of an expectation that increased Medicaid enrollment as well as access to health insurance through the Maryland Health Benefit Exchange will be accompanied by a reduction in spending on existing safety-net programs, and because of increased revenues.

Exhibit 2
PPACA and the Five-year Forecast
Fiscal 2014-2017
(\$ in Millions)

	2014		2015		2016		2017	
	<u>General Funds</u>	<u>Federal Funds</u>						
Costs								
Medicaid Expansion, Woodwork, Crowd Out and PAC Savings	-\$18	\$569	\$27	\$2,374	\$46	\$2,475	\$128	\$2,521
MHIP Hospital Offset	-12	-12	-12	-12	-12	-12	-13	-13
Medicaid and MCHP Admin	12	12	25	25	26	26	27	27
Transfer of 6-19 yr olds from MCHP to Medicaid	1	1	3	3	3	3	3	3
Subtotal	-\$17	\$570	\$43	\$2,390	\$63	\$2,492	\$145	\$2,538
Savings								
Enhanced MCHP Matching Rate		-			-\$36	\$36	-\$52	\$52
Medicaid Breast and Cervical Cancer	-\$2	-\$2	-\$4	-\$4	-4	-4	-4	-4
Reductions in State-only Programs/Grants	-20		-40		-40		-40	
Subtotal	-\$22	-\$2	-\$44	-\$4	-\$80	\$32	-\$96	\$48
Revenues	-\$34		-\$68		-\$74		-\$78	
Total	-\$73	\$568	-\$69	\$2,386	-\$91	\$2,524	-\$29	\$2,586

MCHP: Maryland Children’s Health Program
 MHIP: Maryland Health Insurance Plan

PAC: Primary Adult Care
 PPACA: Patient Protection and Affordable Care Act

Note: For the purposes of this exhibit, new revenues are reflected as negative numbers or savings as they offset State expenditures. Numbers may not sum to total due to rounding.

Source: Department of Legislative Services

Four major points can be made about the forecast:

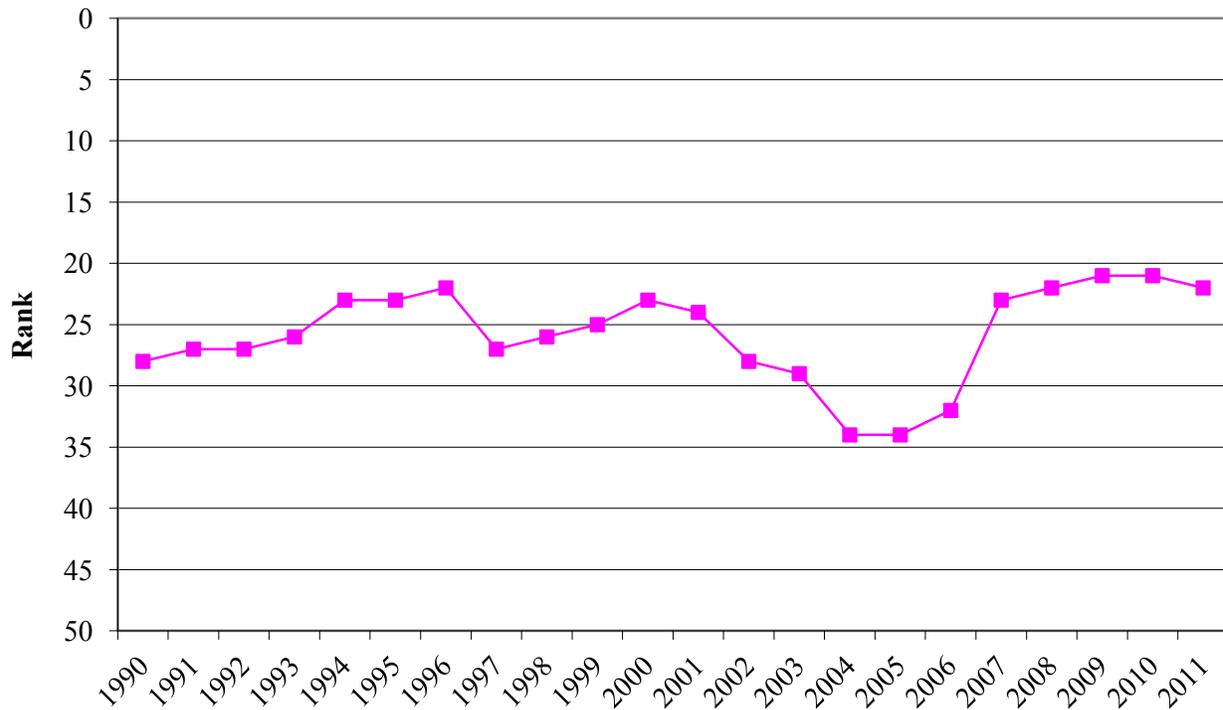
- In the current five-year forecast, State costs are anticipated to be fully offset. Indeed, the State should save money as a result of federal health care reform, although this may change to some degree depending on decisions involving reductions to safety net programs and the implementation of the Basic Health Plan through the Maryland Health Benefit Exchange. It is important to note that the major expenses for the State were always anticipated to come in the later years of this decade beyond the current five-year window.
- Estimates of Medicaid costs for the newly enrolled populations, in particular for childless adults, are high based on the levels of need currently demonstrated by the PAC population. However, from a State funding perspective, given the level of federal support for service costs for the expansion population, if this turns out to be overstated, there is no change in expected costs or savings.
- The extent of additional federal support that is anticipated in the forecast period is significant, over \$8 billion. Thus, it is important that the current funding stream remain in place. Further, given the legal challenges to the PPACA (most especially the individual mandate but also the requirement to expand Medicaid), the data underscores the difficulty of the State proceeding independent of the federal support.
- Even if the impact of Medicaid expansion on the State budget is not immediately significant, the need for the department to ensure that there is an adequate network of providers for enrollees to access should not be underestimated. That may require the department to increase provider rates, for example. While not necessarily required by the PPACA (and thus not currently built into the forecast beyond normal expectations of growth), such increases would most likely require additional State general fund support.

3. Measuring Progress in Health: *America's Health* Rankings, 2011

One of the more comprehensive and longstanding 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 2011 edition of *America's Health*, Maryland's overall ranking fell one place from the prior year to 22.

Exhibit 3
America's Health: State Health Rankings
1990-2011
Maryland



Source: *America's Health*, State Health Rankings, 2011 Edition

The rankings continue to note particular strengths in terms of the relative low prevalence of smoking, access to primary care, and low child poverty. Challenges remain in terms of relative levels of air pollution, high violent crime rates, and infant mortality rates (even though the State has seen absolute improvements in violent crime and infant mortality rates). Health disparities persist. For example, non-Hispanic Blacks are significantly more likely to be obese and have diabetes than non-Hispanic Whites. Health disparities are, perhaps unsurprisingly, mirrored by a relatively high level of geographic disparity in terms of overall variation in mortality rates among the counties within Maryland, indicating that poor outcomes are geographically localized.

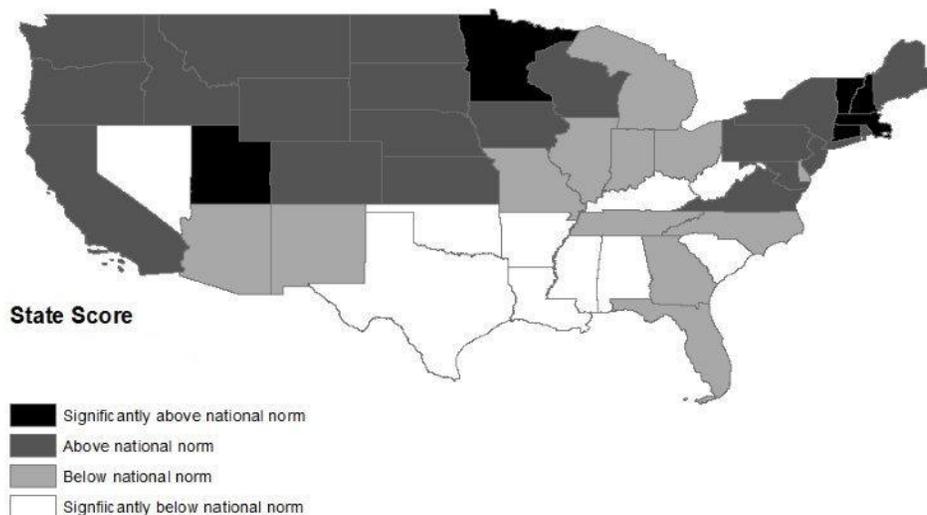
America's Health rankings are developed from a variety of so-called determinant factors that include behaviors (e.g., the prevalence of smoking), community and environmental factors (e.g., air pollution levels), public health policies (e.g., rates of health insurance), and clinical care (e.g., the

level of early prenatal care) as well as a variety of outcomes (e.g., rate of adult diabetes). Maryland has for some years ranked relatively higher on determinants compared to outcomes, which theoretically presages improvements in outcomes over time. Indeed, Maryland has seen absolute improvements in outcomes, but not always at the same pace as other states.

Exhibit 4 groups states into four categories based on the individual state combined health scores used in the *America's Health* rankings relative to the national norm. As shown:

- Southern states have markedly poorer scores than those in the north.
- States with significantly higher scores are clustered mainly in the northeast.
- DLS last did this analysis six years ago. Since that time, the major change is that the number of states that were scoring significantly above the national norm has fallen, particularly in the upper-midwest and most likely reflects the impact of the recession on such things as public health spending and the rate of uninsured.

Exhibit 4
America's Health: State Health Rankings – 2011



Note: Alaska's state score was below the national norm; Hawaii had a state score significantly above the national norm.
Source: *America's Health*, State Health Rankings, 2011 Edition

4. Special Audit on Managing for Results Performance Measures: Health

Audit Findings

	Special Audit on Managing for Results Performance Measures: Health
Audit Period	Measures used in fiscal 2011 budget request
Issue Date	February 2011
Findings	<p>Four measures were certified (<i>i.e.</i>, reasonably accurate)</p> <p>Three measures were certified with qualification (<i>i.e.</i>, reasonably accurate although with minor deficiencies)</p> <p>Five measures were considered to have factors preventing certification (<i>i.e.</i>, reported performance could not be verified, accuracy could not be ensured, or results were presented inconsistently with the measure description)</p>

Note: There are 13 measures contained in the Health portion of the State Comprehensive Plan. The Department of Health and Mental Hygiene (DHMH) is responsible for reporting results for 12 measures, with the Maryland State Department of Education responsible for the other. For the purposes of this presentation, only those measures that are the responsibility of DHMH will be discussed.

Certified Measures

- Infant mortality rate for all races.
- Rate of live birth to adolescents between 15 and 19.
- Overall cancer mortality rate per 100,000 persons.
- Percent of Maryland children fully immunized by 24 months of age.

Measures Certified with Qualification

- Cumulative percent change from calendar 2000 baseline for underage high school students smoking cigarettes. Reason for qualification: lack of verification of third-party data used to calculate the measure.
- Percent change in number of new HIV cases from calendar 2007 baseline. Reason for qualification: lack of documentation of site reviews from local health departments which are responsible for adequately monitoring medical providers to ensure that new HIV cases are reported.

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- Rate of primary/secondary syphilis incidence. Reason for qualification: lack of sufficient quality control process to ensure that syphilis cases were correctly reported.

Measures with Factors Preventing Qualification

- Number of children under six years of age with elevated blood lead levels. Issues: no evaluation or verification of data received from the Maryland Department of Environment (MDE) used to determine the performance measure; and MDE also failed to independently verify completeness and reliability of blood lead data it compiled.
- Number of reported cases of vaccine preventable communicable diseases. Issue: sufficient procedures did not exist to ensure that all cases of vaccine preventable diseases were reported.
- Percent of Developmental Disabilities Administration (DDA) community services respondents to the “ASK ME!” survey who expressed satisfaction with physical well-being, personal development, and self-determination. Issues: a lack of independence over the gathering and processing of survey data, specifically that the contractor responsible for administering the survey was affiliated with several community providers; and no independent review of the survey methodology and data collected undertaken by DDA.
- Percent of patients with substance abuse decrease upon exiting substance abuse treatment. Issues: documentation of the results reported by treatment centers was lacking; and the Alcohol and Drug Abuse Administration’s data verification procedures were also inadequate.
- Percent of adults who report that mental health services have allowed them to deal more effectively with daily problems. Issues: lack of independence over the survey data; lack of source documentation; and no audit of survey controls and quality control documentation.

Audit Recommendations

- Establish procedures to ensure that all relevant data are included in the measure calculation and that the data, including data obtained from third parties, are reasonably accurate and complete.
- Ensure that third parties involved in data collection are sufficiently independent.
- Establish and follow clear written definitions for all measures.

The department generally concurred with the findings of the audit. It noted areas of concern only with regard to recommendations made in the following areas: percent change in number of new HIV cases from calendar 2007 baseline; rate of primary/secondary syphilis incidence; and the number of reported cases of vaccine preventable communicable diseases. In each case, it noted that its ability

to audit reported positive test results received from medical providers was limited by the fact that current law does not require the Department of Health and Mental Hygiene (DHMH) or local health departments to audit the licensed laboratories that perform the tests. Further, the department and local health departments are not staffed or funded to do those audits.

5. Local Health Departments’ Role in Health Care Reform

The Maryland Health Care Reform Coordinating Council (HCRCC), established by executive order, cited that the public health infrastructure, including local health departments (LHDs) and population-based programs, provide unique functions that will not be replaced by the health insurance coverage aspects of reform. HCRCC developed 16 recommendations on how Maryland should undertake health care reform and implementation. The following 3 recommendations are specifically applicable to LHDs: (1) develop State and local strategic plans to improve health outcomes; (2) encourage active participation of safety net providers in health reform and new insurance options; and (3) achieve reduction of health disparities through exploration of financial performance-based incentives and incorporation of other strategies.

State and Local Health Improvement Process

HCRCC’s first recommendation related to LHDs was that Maryland undertake interconnected State and local planning efforts to address opportunities to improve coordination of care for those remaining uninsured even after reform implementation. Furthermore, HCRCC advised that DHMH develop a State Health Improvement Process (SHIP) that included a health needs assessment with identified priorities and that set goals for health status, access, provider capacity, consumer concerns, and health equity within the State. Through SHIP, the department has designated public and private sector partners to work with the State and LHDs to monitor SHIP performance metrics. HCRCC further recommended that local implementation processes should be developed and involve collaborations led by LHDs to identify systemic issues which must be addressed to achieve SHIP goals. Finally, HCRCC recommended that the Community Health Resources Commission (CHRC) should provide technical assistance in the development of these processes, piloting models, and sharing lessons learned.

State Health Improvement Process

In September 2011, DHMH launched SHIP to improve accountability and reduce health disparities in Maryland by 2014 through implementing local action and engaging the public. As shown in **Appendix 1**, SHIP includes 39 measures of health in six key areas – healthy babies, healthy social environments, safe physical environments, infectious disease, chronic disease, and healthcare access. Of the 39 SHIP measures, 24 objectives have been identified as critical racial/ethnic health disparities measures. It is important to note that health disparities exist for all measures related to the following vision areas – healthy babies, infectious diseases, and chronic diseases. Each measure has a data source and a target, and where possible, can be assessed at the city or county level. In addition, SHIP provides counties with tools to set local priorities and mobilize communities to improve residents’

health. Examples of tools include the access to materials promoting the Maryland Tobacco “Quitline.”

Local Health Improvement Process

SHIP supports local health improvement coalitions in counties and regions around the State to identify priorities, make plans, and take action by creating a local health improvement process. Maryland has 18 active local or regional health coalitions, with memberships ranging from 10 to 60 people.² Each coalition has met, assessed the health of their communities, and developed their health priorities. Once coalitions are established, each jurisdiction or region is required to develop an action plan for 2012 that includes three to five community health priorities that align with SHIP goals. Priorities may also include locally identified issues. These action plans are expected to serve as each coalition’s short-term work schedule for 2012, as local coalitions begin to develop a local health improvement process.

Funding for local coalitions and the development of local health improvement processes has been improved by the Maryland Hospital Association (MHA) and through CHRC. MHA agreed to provide start-up funds to support the operations of local coalitions in counties and regions where hospitals were not already supporting existing coalitions. These funds will be used to provide the needed infrastructure to get the coalitions organized, appointed, convened and staffed for fiscal 2012. At the time of this writing, MHA has facilitated hospital support for nine local planning coalitions in counties and regions. Furthermore, the fiscal 2012 budget for CHRC included \$0.5 million in grant funds to assist with local health coalition development in accordance with HCRCC’s recommendation. It is important to note that the fiscal 2013 budget does not include additional funding for local health improvement processes or local coalitions; however, newly awarded federal funding supports SHIP initiatives.

Community Transformation Grant

The PPACA established the Prevention and Public Health Fund to prevent illness and injury before they occur, thereby resulting in significantly lower health care costs. For example, the fund authorizes funding for the Community Transformation Grant Program, which provides competitive grants to reduce chronic disease rates, address health disparities, and develop a stronger evidence base of effective prevention programming at the local level. In September 2011, DHMH was awarded \$9.5 million in federal funding (\$1.9 million a year for five years) through the Community Transformation Grant. Overall, the Department of Health and Human Services awarded approximately \$103.0 million in prevention grants to 61 states and communities. In Maryland, this funding will be used to support efforts among 19 of Maryland’s smaller jurisdictions.³ In addition, the grant will be used to build new resources that will improve wellness statewide. For instance, a

² The Lower Shore (Somerset, Wicomico, and Worcester counties) and the Upper Shore (Caroline, Dorchester, Kent, Queen Anne’s, and Talbot counties) are the only two local coalitions that include more than one county.

³ Under the terms of the federal grant requirements, Baltimore City and Anne Arundel, Baltimore, Montgomery, and Prince George’s counties were excluded.

portion of grant funding is being used to establish the Institute for a Healthiest Maryland. The institute's mission will focus on obesity prevention, tobacco cessation and the reduction of hypertension and high cholesterol, and will link LHDs and community leaders to proven interventions in health and wellness. The institute will also coordinate the "Healthiest Maryland Advocacy Network," an initiative that will support local coalitions under SHIP.

Encourage Active Participation of Safety Net Providers in Health Reform and New Insurance Options

HCRC's second recommendation pertaining to LHDs included removing certain statutory and administrative barriers to contracting between LHDs and private entities. This recommendation was addressed through the passage of Chapters 235 and 236 of 2011 which authorized a county health officer (subject to the written approval of the Secretary of DHMH and the consent of the county's governing body) to enter into a contract or written agreement to participate in the financing, coordination, or delivery of health care services with an individual who is authorized to provide health care services in the State.

Budget constraints have resulted in cutbacks in services provided by some LHDs, and prior to the passage of Chapters 235 and 236, LHDs were unable to recoup service costs through agreements with private insurers. (LHDs currently use income-based sliding scales – subsidized through block grants – to bill individuals who are uninsured or privately insured.) According to the Maryland Association of Counties, these limitations may impede the delivery of health services (to rural parts of the State, in particular). For example, Garrett County advised that its LHD currently offers privately insured individuals certain services – such as home health care and mental health and substance abuse outpatient services – because its LHD is the only provider for those services in the county. Garrett County further advised that its ability to continue to provide these and other services (such as family planning services) increasingly depends on its ability to bill in full for its services.

While Chapters 235 and 236 took effect on October 1, 2011, the Maryland Association of County Health Officers advises that LHDs have not been able to contract with private insurers as they lack expertise in negotiating contracts with private entities. DHMH has indicated that they will be assisting LHDs in resolving this issue by developing uniform contract terms to act as a guideline for LHDs when negotiating with private insurers.

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

HCRCC's final recommendation related to LHDs required the Maryland Health Quality and Cost Council Health Disparities Workgroup to develop recommendations to address disparities including using local health improvement processes to identify and address disparities and to monitor the performance of efforts to mitigate them. Furthermore, HCRCC recommended that the State improve data collection and analysis of disparities through SHIP and local health implementation processes, as well as MHCC's ongoing work to encourage common reporting of race and ethnicity among health plans.

On January 5, 2012, the workgroup provided its recommendations to HCRCC and proposed three interventions to address disparities: (1) create the "Maryland Health Innovation Prize;" (2) expand the scope of Maryland's current reimbursement incentives for quality and make them race and ethnicity-specific; and (3) create Health Enterprise Zones.⁴ This issue will focus on the third recommendation, as it directly relates to local jurisdictions and utilizes health disparity data available through SHIP and local health improvement processes. Furthermore, the fiscal 2013 allowance for CHRC includes \$4 million for Health Enterprise Zones.

A Health Enterprise Zone is a geographic area in Maryland that has documented health disparities within its jurisdiction. These zones would also have increased minority hospital admissions and/or emergency department visit rates for asthma, diabetes, hypertension, and other ambulatory care sensitive conditions. In order to address disparities, entities in these areas would be eligible for specific policy incentives and funding opportunities for both new and existing primary care providers, community-based organizations, or LHDs. The intended goal of Health Enterprise Zones is to increase the supply and diversity of the local health care workforce, especially in primary care; increase use of community health workers; improve community leadership development; reduce racial and ethnic minority health disparities and improve minority health outcomes; and reduce preventable hospital admission and/or emergency department visit rates for asthma, diabetes, hypertension, and other conditions.

The workgroup recommended creating two groups of incentives in Health Enterprise Zones: statute-based incentives and contract-based incentives. The creation of statute-based incentives would include tax incentives such as hiring credits; free or low rent; funding and assistance for health information technology implementation; and loan assistance repayment programs for qualifying service in the Health Enterprise Zone. Contract-based interventions would allocate funding to a zone that applies and is approved for funding. Funding could be used for training and deploying community health workers; providing financial assistance to providers for language interpretation

⁴ The Maryland Health Innovation Prize would be a financial reward to an individual, group, organization, or coalition to acknowledge innovative health interventions. The workgroup's second recommendation included proposing legislation directing Health Services Cost Review Commission (HSCRC) and MHCC to include racial and ethnic data as part of their data collection, or requiring HSCRC and MHCC to study the feasibility of including racial/ethnic performance data tracking in quality incentive program and report to the General Assembly by the 2013 session.

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services; providing cultural competency training to health care providers; and developing and supporting a local coalition.

On January 17, 2012, the Lieutenant Governor announced that legislation would be introduced during the 2012 session to create a pilot program for Health Enterprise Zones. It is likely that the program would be limited to two or three geographic areas.

Maryland's State Health Improvement Process

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

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<u>SHIP Measurement</u>	<u>Current Maryland Baseline</u>	<u>Maryland 2014 Target</u>
11. Increase proportion of students who graduate from high school*	80.7% students graduate from high school in four years after entering grade 9	84.7% students graduate high school in four years after entering grade 9
12. Reduce domestic violence*	69.6 emergency department visits for domestic violence per 100,000 population	66.0 emergency department visits for domestic violence per 100,000 population
Vision Area 3: Safe Physical Environments		
13. Reduce blood lead levels in children	79.1 per 100,000 population	39.6 per 100,000 population
14. Decrease fall-related deaths	7.3 fall-related deaths per 100,000 population	6.9 fall-related deaths per 100,000 population
15. Reduce pedestrian injuries on public roads	39.0 pedestrian injuries per 100,000 population	29.7 pedestrian injuries per 100,000 population
16. Reduce salmonella infections transmitted through food	14.1 salmonella infections per 100,000 population	12.7 salmonella infections per 100,000 population
17. Reduce hospital emergency department visits from asthma*	85.0 emergency department visits for asthma per 100,000 population	67.1 emergency department visits for asthma per 100,000 population
18. Increase access to healthy food	5.8% of census tracts in MD are considered food deserts	5.5% of census tracts in MD are considered food deserts
19. Reduce the number of days the Air Quality Index exceeds 100	17 days was the maximum number of days in the State that the air quality index exceeded 100	13 days is the maximum number of days in the State that the air quality index exceeds 100
Vision Area 4: Infectious Disease		
20. Reduce HIV infections among adults and adolescents*	32.0 newly diagnosed HIV cases per 100,000 population	30.4 newly diagnosed HIV cases per 100,000 population

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<u>SHIP Measurement</u>	<u>Current Maryland Baseline</u>	<u>Maryland 2014 Target</u>
21. Reduce Chlamydia trachomatis infections among young people*	2,131 Chlamydia cases per 100,000 15-24 year olds	2,205 Chlamydia cases per 100,000 15-24 year olds
22. Increase treatment completion rate among tuberculosis patients*	88.1% of patients complete treatment within 12 months	90.6% of patients will complete treatment within 12 months
23. Increase vaccination coverage for recommended vaccines among young children*	78% of children age 19-35 months received recommended vaccine doses	80% of children age 19-35 months will receive recommended vaccine doses
24. Increase the percentage of people vaccinated annually against seasonal influenza*	45.9% of adults received a flu shot last year	65.6% of adults will receive a flu shot
Vision Area 5: Chronic Disease		
25. Reduce deaths from heart disease*	194.0 heart disease deaths per 100,000 population	173.3 heart disease deaths per 100,000 population
26. Reduce the overall cancer death rate*	177.7 cancer deaths per 100,000 population	169.2 cancer deaths per 100,000 population
27. Reduce diabetes-related emergency department visits*	347.2 emergency department visits for diabetes per 100,000 population	330.0 emergency department visits for diabetes per 100,000 population
28. Reduce hypertension-related emergency department visits*	237.9 emergency department visits for hypertension per 100,000 population	225.0 emergency department visits for hypertension per 100,000 population
29. Reduce drug-induced deaths*	13.4 drug-induced deaths per 100,000 population	12.4 drug-induced deaths per 100,000 population
30. Increase proportion of adults who are at a healthy weight*	34.0% of Maryland adults are at a healthy weight	35.7% of Maryland adults will be at a healthy weight
31. Reduce the proportion of children and adolescents who are considered obese*	11.9% of children ages 12-19 are considered obese	11.3% of children ages 12-19 will be considered obese

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<u>SHIP Measurement</u>	<u>Current Maryland Baseline</u>	<u>Maryland 2014 Target</u>
32. Reduce cigarette smoking among adults*	15.2% of adults reported currently smoking cigarettes	14.6% of adults report that they are currently smoking cigarettes
33. Reduce tobacco use among adolescents*	24.8% of adolescents used tobacco in the last 30 days	22.3% of adolescents will use tobacco in the last 30 days
34. Reduce the number of emergency department visits related to behavioral health conditions*	1,206.3 emergency department visits for behavioral health conditions per 100,000 population	1,146.0 emergency department visits for behavioral health conditions per 100,000 population
35. Reduce the proportion of hospitalizations related to Alzheimer’s disease and other dementias*	17.3 hospitalizations for Alzheimer’s disease and other dementias per 100,000 population	16.4 hospitalizations for Alzheimer’s disease and other dementias per 100,000 population

Vision Area 6: Health Care Access

36. Increase the proportion of persons with health insurance*	81.7% of nonelderly had health insurance	92.8% of nonelderly will have health insurance
37. Increase the proportion of adolescents who have an annual wellness checkup	46.0% had a wellness checkup in the past year	60.8% will have a wellness checkup in the past year
38. Increase the proportion of low income children and adolescents who receive dental care	53.6% of low income children and adolescents received preventive dental services in the last year	56.3% of low income children and adolescents will receive preventive dental services in the last year
39. Reduce the proportion of individuals who are unable to afford to see a doctor*	12.0% reported that they were unable to afford to see a doctor	11.4% report that they were unable to afford to see a doctor

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

Source: Department of Health and Mental Hygiene