

M00F03
Family Health Administration
Department of Health and Mental Hygiene

Operating Budget Data

(\$ in Thousands)

	<u>FY 11</u> <u>Actual</u>	<u>FY 12</u> <u>Working</u>	<u>FY 13</u> <u>Allowance</u>	<u>FY 12-13</u> <u>Change</u>	<u>% Change</u> <u>Prior Year</u>
General Fund	\$32,163	\$30,903	\$44,159	\$13,256	42.9%
Adjusted General Fund	\$32,163	\$30,903	\$44,159	\$13,256	42.9%
Special Fund	47,736	49,259	48,376	-884	-1.8%
Contingent & Back of Bill Reductions	0	0	-14,688	-14,688	
Adjusted Special Fund	\$47,736	\$49,259	\$33,687	-\$15,572	-31.6%
Federal Fund	131,735	138,143	144,544	6,401	4.6%
Adjusted Federal Fund	\$131,735	\$138,143	\$144,544	\$6,401	4.6%
Reimbursable Fund	50	50	0	-50	-100.0%
Adjusted Reimbursable Fund	\$50	\$50	\$0	-\$50	-100.0%
Adjusted Grand Total	\$211,684	\$218,355	\$222,390	\$4,035	1.8%

- The Governor's proposed allowance for the Family Health Administration (FHA) increases by \$4.0 million, or 1.8% over the fiscal 2012 working appropriation.
- There are two proposed deficiencies for fiscal 2012 for the Women, Infant, and Children program (\$2,500,000) and State chronic disease planning (\$1,636,694).
- General fund support increases by \$13.3 million, or 42.9%, primarily due to the grant to Prince George's County Hospital. This grant was budgeted as special funds in prior fiscal years and corresponds to the \$15.6 million decrease in special funds in fiscal 2013.

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

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Personnel Data

	<u>FY 11 Actual</u>	<u>FY 12 Working</u>	<u>FY 13 Allowance</u>	<u>FY 12-13 Change</u>
Regular Positions	164.30	156.30	158.30	2.00
Contractual FTEs	<u>3.32</u>	<u>6.21</u>	<u>6.21</u>	<u>0.00</u>
Total Personnel	167.62	162.51	164.51	2.00

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	8.65	5.57%
Positions and Percentage Vacant as of 12/31/11	11.50	7.36%

- The fiscal 2013 allowance includes a net increase of 2.0 regular positions in FHA.
- As of December 31, 2011, the agency had 11.5 vacant positions, only slightly higher than the agency’s necessary vacancies to meet its turnover rate. The agency’s turnover rate was increased from 5.01% in the fiscal 2012 working appropriation to 5.57% 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 7.2 deaths per 1,000 live births in calendar 2009 to 6.7 deaths per 1,000 live births in calendar 2010. This is the lowest infant mortality rate reported in the history of the State. Moreover, Maryland’s African American infant mortality rate decreased from 13.6 to 11.8 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

Continued Reductions to the CRF Programs: Although funding for the CRF programs is supposed to be partially restored in fiscal 2013, the Budget Reconciliation and Financing Act of 2012 includes a provision which level funds the CRF programs in fiscal 2013 and possibly future years.

Breast and Cervical Cancer Diagnosis and Treatment Program: In recent years, the expenditures for the Breast and Cervical Cancer Diagnosis and Treatment Program have been growing at a significant rate, even as patient population has decreased. This issue will evaluate program growth as well as changes in program funding.

Recommended Actions

	<u>Funds</u>
1. Strike contingent reduction for the Cigarette Restitution Fund.	
2. Concur with the reduction to the Cigarette Restitution Fund levels as proposed by the Governor as part of the budget.	\$14,688,143
Total Reductions	\$14,688,143

Updates

Maryland's Comprehensive Cancer Control Plan: The Centers for Disease Control and Prevention provide funding to every state for a Comprehensive Cancer Control Plan. In July 2011, the Department of Health and Mental Hygiene issued its first Cancer Control Plan since 2004. The plan includes 23 goals that relate to 14 different areas.

Prince George's Hospital Center: Prince George's Hospital Center recently entered into a memorandum of understanding (MOU) with the University of Maryland Medical System (UMMS) to create a new \$600 million facility in Prince George's County. The MOU outlined an 18-month, three-step process to develop the strategy, financing, and execution of a plan for UMMS to build a new regional teaching medical center and improve the primary care system in Prince George's County, and for the University of Maryland, Baltimore to establish a health sciences campus in conjunction with the new hospital.

Repeat Audit Findings: The Office of Legislative Audits audited FHA for the period beginning November 1, 2007, and ending August 3, 2010. The audit revealed that the financial eligibility criteria for Cancer Prevention, Education, Screening, and Treatment Program participants were not consistent among the local health departments. A similar finding was commented upon in FHA's preceding audit report.

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Family Health Administration
Department of Health and Mental Hygiene

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 a period of years. 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; and the Cancer Prevention, Education, Screening, and Treatment Program.

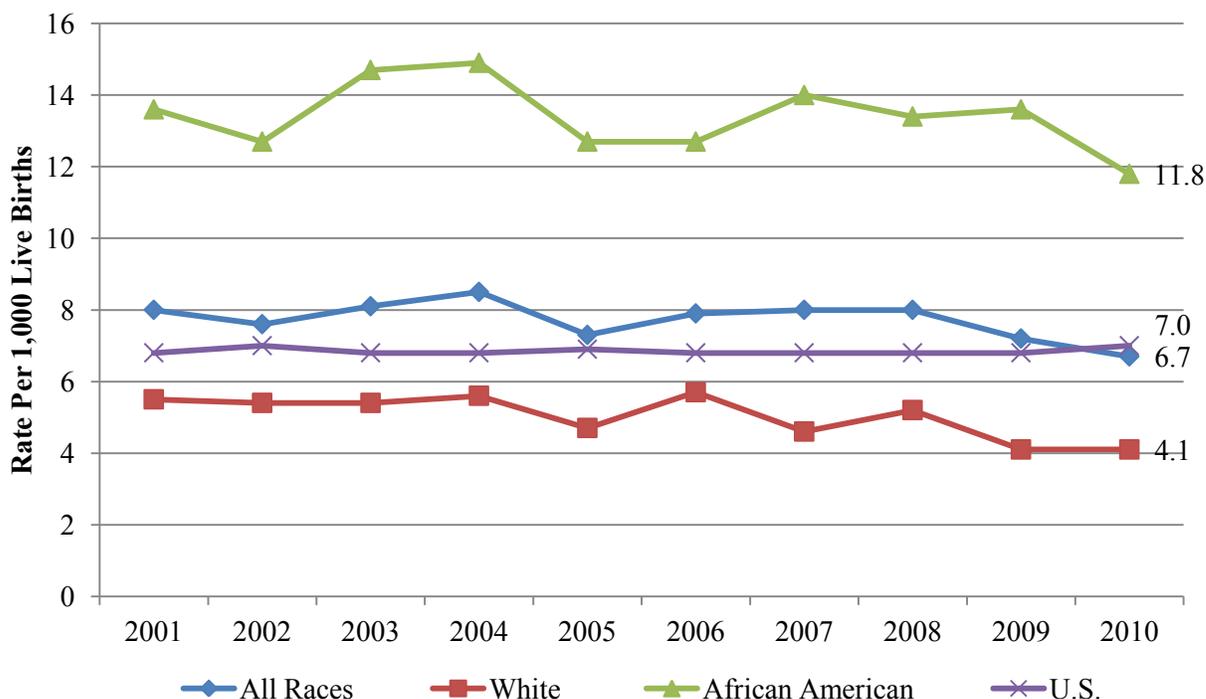
Performance Analysis: Managing for Results

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 6.7 in calendar 2010, as shown in **Exhibit 1**. It is important to note that this is the lowest rate ever recorded in Maryland and reflects a 7% decrease from the 2009 rate. The overall reduction in the infant mortality rate was driven by large declines in the number of infant deaths in Baltimore City and Montgomery County. However, as the exhibit shows, the rate has fluctuated over the past few years, and infant mortality rates have only fallen slightly over the past decade.

Exhibit 1
Infant Mortality Rates
Calendar 2001-2010



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 7.2 to 6.7 deaths in calendar 2010, the rate for African Americans has also decreased from 13.6 to 11.8 over the same time period. This represents a 13% decline. Despite this large decrease between calendar 2009 and 2010, the infant mortality rate for African Americans remains nearly three times the rate of non-Hispanic White infants.

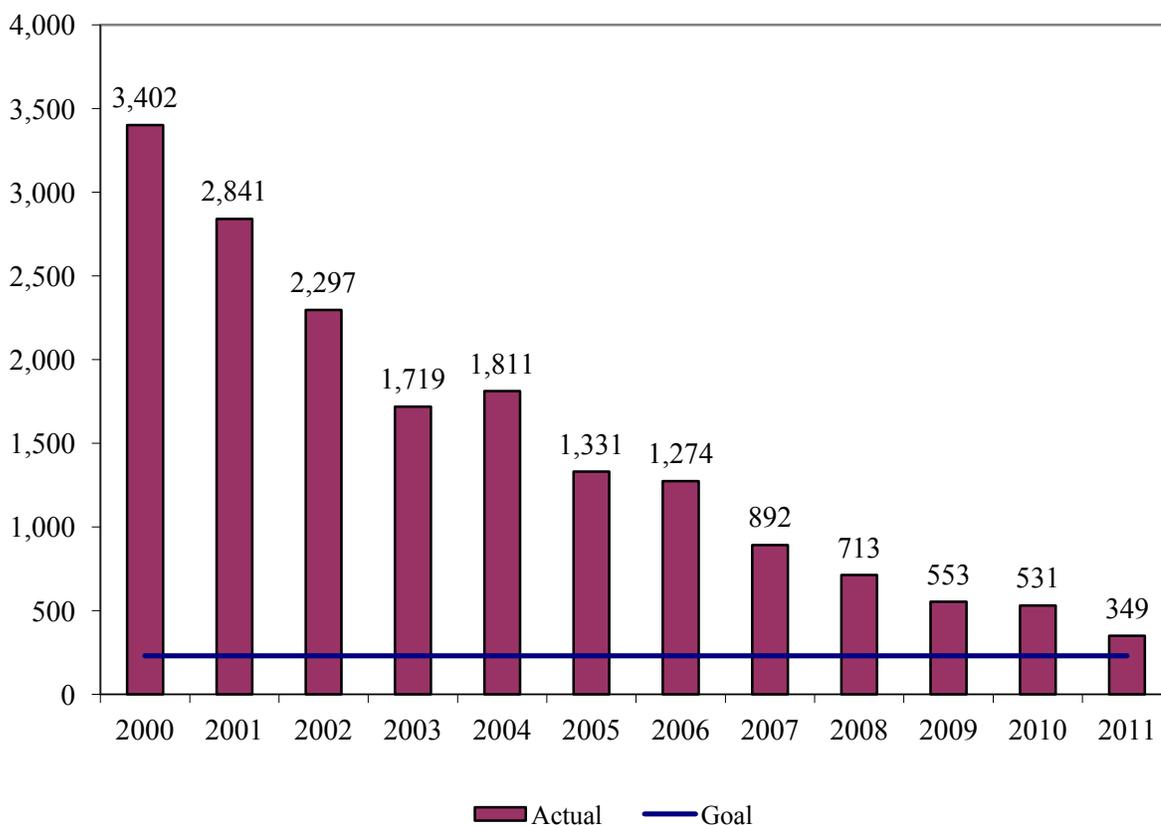
Elevated Blood Lead

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**, the number of children with elevated blood lead levels has decreased by 84% since 2000 yet remains above the 2011 goal. 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 2012.

Exhibit 2
Children Under the Age of Six with Elevated Blood Lead Levels
Calendar 2000-2011



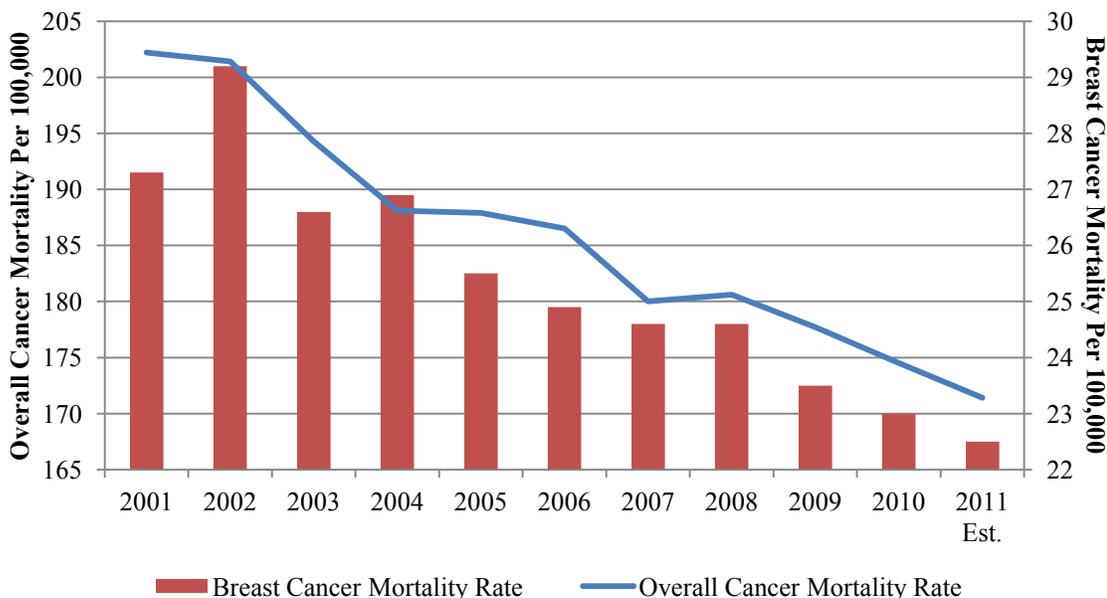
Source: Department of Health and Mental Hygiene

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 2001-2011



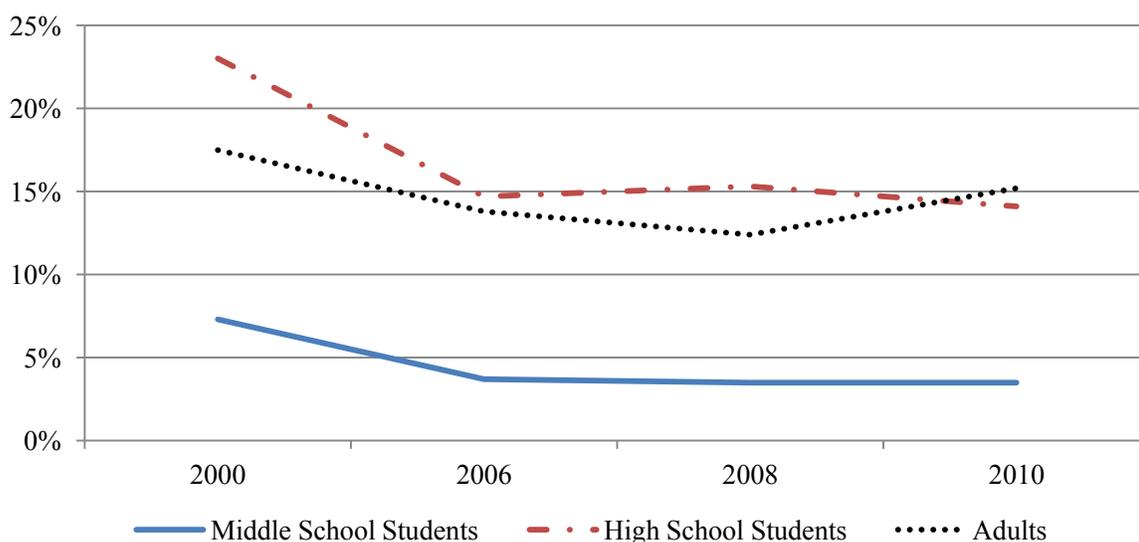
Source: Department of Health and Mental Hygiene

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, and has declined slightly in calendar 2010. One reason for the stagnation in the trend of declining 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 also increased between calendar 2008 and 2010.

Exhibit 4
Tobacco Usage Rates
Calendar 2000-2010



Source: Department of Health and Mental Hygiene

Fiscal 2012 Actions

Proposed Deficiency

The fiscal 2013 budget includes \$4,136,694 in proposed deficiency appropriations for FHA. Additional federal funds were needed for the Women, Infant, and Children (WIC) program (\$2,500,000) and to support primary care prevention activities and State chronic disease planning (\$1,636,694).

Other Action

Section 47 of the fiscal 2012 budget bill required the Governor to abolish 450 positions as of January 1, 2012. FHA’s share of the reduction was 2 positions. The annualized salary savings due to the abolition of these positions is expected to be \$147,820 in general funds.

Proposed Budget

After accounting for contingent reductions, the Governor’s proposed fiscal 2013 allowance increases by \$4.0 million, or 1.8%, over the fiscal 2012 working appropriation, as shown in **Exhibit 5**. The general fund support increases by \$13.3 million, or 42.9%; the special fund support decreases by \$14.7 million, or 31.6%; and the federal fund support increases by \$6.4 million, or 4.6%.

The increase in the general fund appropriation is primarily due to the \$15 million grant to Prince George’s Hospital System. This grant was budgeted as special funds in prior fiscal years and corresponds to a like \$15 million decrease in special funds in the Governor’s fiscal 2013 allowance. The \$15 million general fund appropriation is restricted for this purpose by budget bill language. A more in-depth discussion of funding to Prince George’s Hospital System is included in the Updates section of this document.

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

How Much It Grows:	<u>General Fund</u>	<u>Special Fund</u>	<u>Federal Fund</u>	<u>Reimb. Fund</u>	<u>Total</u>
2012 Working Appropriation	\$30,903	\$49,259	\$138,143	\$50	\$218,355
2013 Allowance	<u>44,159</u>	<u>48,376</u>	<u>144,544</u>	<u>0</u>	<u>237,079</u>
Amount Change	\$13,256	-\$884	\$6,401	-\$50	\$18,723
Percent Change	42.9%	-1.8%	4.6%	-100.0%	8.6%
Contingent Reduction	\$0	-\$14,688	\$0	\$0	-\$14,688
Adjusted Change	\$13,256	-\$15,572	\$6,401	-\$50	\$4,035
Adjusted Percent Change	42.9%	-31.6%	4.6%	-100.0%	1.8%

M00F03 – DHMH – Family Health Administration

Where It Goes:

Personnel Expenses	-\$229	
4 new positions.....		\$183
Employee retirement.....		108
Employee and retiree health insurance		76
Other changes.....		-9
Reclassifications.....		-9
Social Security contributions		-19
Turnover adjustments.....		-59
Removal of fiscal 2012 one-time \$750 bonus.....		-119
2 abolished positions		-154
Salary expenses		-227
Maternal and Child Health	\$3,118	
WIC program contractual costs, primarily increased food costs.....		3,147
PPACA – Maternal, Infant, and Early Childhood Home Visiting Program ...		2,086
Children’s Medical Services Program		512
Babies Born Healthy		-89
Maternal and child health systems improvements		-287
Administrative support for the WIC Breastfeeding Peer Counselor Program to LHDs and private providers		-331
Medical daycare services for infants and toddlers		-305
Family planning and reproductive health services.....		-1,615
Prevention and Disease Control	\$1,146	
Community Transformation Grant (federal funds)		1,945
Chronic Disease Prevention and Health Promotion Grant (federal funds)		486
Injury prevention grants		167
Funding for the Center for Health Promotion and Education's Sexual Assault Reimbursement Program.....		129
Breast and Cervical Cancer Screening Program		113
Cancer prevention grants to LHDs under the Maryland Cancer Fund.....		-176
Other adjustments		-209
LHD funding for cardiovascular risk reductions.....		-356
Removal of ARRA funds.....		-453
Breast and Cervical Cancer Program		-500
Total		\$4,035

ARRA: American Recovery and Reinvestment Act of 2009
LHD: local health departments
PPACA: Patient Protection and Affordable Care Act
WIC: Women, Infant, and Children

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

Personnel Expenses

Personnel expenses for FHA decrease by \$0.2 million over the fiscal 2012 working appropriation. New positions increase the budget by \$0.2 million. The WIC program received 3.0 additional positions – a health policy analyst, an administrative officer, and a nutritionist. The health policy analyst will support the program’s reporting and analysis projects. Presently, the data related to the WIC program has not been analyzed for several years. The administrative officer is needed to monitor vendor operations.¹ The allowance also includes a nutritionist to support the WIC Breastfeeding Peer Counselor Program. Presently, this program has 1.5 full-time equivalents. These positions are all federally funded. The fiscal 2013 allowance also transfers 1.0 position from the Laboratories Administration to FHA to support the Newborn Screening Program.

Other increases to personnel expenses include contributions to the employees’ retirement system (\$108,000) and employee and retiree health insurance (\$76,000). These increases in personnel expenses were offset by the elimination of 2 administrator positions, which decreased the budget by \$0.2 million. One position supports the Office of Health Policy and Planning which focuses on special projects. This position is currently filled. The second abolished position is within the Office of Oral Health and provides procurement and management oversight within the office. This position is currently vacant.

Other decreases to personnel expenses include salary expenses due to the annualized savings from the previously abolished positions (\$227,000); the removal of funds associated with the fiscal 2012 one-time \$750 bonus (\$119,000); increased turnover adjustments (\$59,000); Social Security contributions (\$19,000); funding for position reclassifications (\$9,000), and other miscellaneous adjustments (\$9,000).

Operating Expenses

Operating expenses for FHA increase by \$4.3 million in the fiscal 2013 allowance, as shown in Exhibit 5. The budget is driven mainly by changes to the WIC program and other federal grant programs administered by FHA. When the fiscal 2012 deficiency appropriations are added in, the operating expenses actually decrease by \$0.1 million in fiscal 2013.

Maternal and Child Health

The fiscal 2013 allowance includes an additional \$3.1 million for maternal and child health programs over the fiscal 2012 working appropriation. These increases are mainly driven by increased federal funding for the WIC program (\$3.2 million) and the Maternal, Infant, and Early Childhood

¹ At the time of this writing, there are over 750 WIC vendors in the State, and during a 2010 audit, the United States Department of Agriculture expressed concern about the number of staff responsible for vendor management functions and recommended an evaluation of the staff to vendors ratio to determine an appropriate level of staff to meet all regulatory requirements, including plans to change the delivery of benefits from a paper based system to an electronic benefits system.

Home Visiting Program (\$2.1 million). The remaining increase to FHA's Maternal and Child Health budget includes a \$0.5 million increase in funding for the Children's Medical Services Program.

Women, Infant, and Children Program

Funding for the WIC program in the fiscal 2013 allowance increases by \$3.1 million. This includes a \$5.0 million increase for food expenditures and supplies to administer the program. Communications costs also increase by \$0.2 million. These increases are offset by a \$1.8 million decrease in administrative funds for private, State, and local agencies. It is important to note that administrative support for the WIC Breastfeeding Peer Counselor Program at local health departments and private providers also decreased by \$0.3 million.

The contractual costs for the program total \$107.1 million and are comprised primarily of the food service contract (\$79.1 million) and the cost to administer the program (\$27.7 million). The food service contract, which covers the expense of the WIC foods purchased by participants, increases from the fiscal 2012 working appropriation by \$4.9 million due to an increase in average monthly food package costs. The fiscal 2013 allowance is nearly \$7.0 million more than the fiscal 2011 actual expenditures.

While the food service contract increases significantly in the allowance, the funds dedicated to administer the program decrease by \$1.8 million due to a slight decline in program participants. Federal funds associated with administering the program are distributed to local health departments and private agencies for the provision of WIC services. The increase to food service contracts combined with the decrease for administrative costs nets to a \$2.9 million increase for WIC contractual services.

Supplies and materials for the WIC program account for an increase of \$0.1 million for nutrition education materials, breast pumps, and outreach activities. Communications costs for the program also increase by \$0.2 million.

Maternal, Infant, and Early Childhood Home Visiting Program

Beginning in fiscal 2012, the Department of Health and Mental Hygiene (DHMH) began receiving funding through the Patient Protection and Affordable Care Act for the Maternal, Infant, and Early Childhood Home Visiting Program. The purpose of the program is to provide evidence-based home visitation services to improve outcomes for children and families who reside in at-risk communities. The home visiting program that states choose to implement must also be linked to benchmark areas of improvement at the state level. In fiscal 2012, \$1.0 million was awarded to the department under this grant, and the fiscal 2013 allowance includes \$3.0 million for this program. A total of \$2.7 million will be provided to local health departments (LHD) for evidence-based home visiting programs in high-risk communities including Baltimore City (\$1.0 million), Dorchester and Caroline counties (\$0.4 million), Prince George's County (\$0.4 million), Washington County (\$0.4 million), and Somerset, Wicomico, and Worcester counties (\$0.5 million).

Other Maternal and Child Health Grants

Increases in funding for the WIC program, the Maternal, Infant, and Early Childhood Home Visiting Program, and the Children’s Medical Services Program are offset by decreases in funding for the following maternal and child health programs:

- Babies Born Healthy (\$89,000);
- medical day care services for children six weeks to five years of age who have complex medical conditions and/or specialized medical needs and are in need of skilled nursing services (\$0.3 million); and
- maternal and child health systems improvements such as fetal and infant mortality reviews, maternal mortality reviews, and child fatality reviews (\$0.3 million).

Funding for the Title X Family Planning Services Program also decreases by \$1.6 million. The Title X Family Planning Services Program within FHA provides free or sliding scale fee-for-service family planning services to women who are ineligible for Medicaid family planning services through LHDs, Planned Parenthood clinics, and other outpatient units. In fiscal 2012, the program served approximately 79,000 women at more than 60 clinics. These funds will be transferred to Medicaid in accordance with Chapters 537 and 538 of 2011 which expanded eligibility for family planning services in the Medicaid program, to all women whose family incomes are at or below 200% of federal poverty guidelines (FPG). Prior to the passage of Chapters 537 and 538, family planning services under Medicaid were limited to women with incomes up to 116% FPG.

While the transfer of funds to the Medicaid program will reduce funding available to LHDs under the Title X program, LHDs will increase their Medicaid billing for family planning services to the extent that women who are uninsured and have incomes between 116% and 200% FPG enroll in the Medicaid family planning program.

Prevention and Disease Control

The fiscal 2013 budget includes a \$1.1 million increase for prevention and disease control over the fiscal 2012 working appropriation. This increase is driven by newly awarded federal funds under the Community Transformation Grant and the Coordinated Chronic Disease Prevention and Health Promotion Grant.

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.² In addition, the grant will be used to build new resources that will improve wellness statewide. For instance, a 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 the State Health Improvement Process.

The fiscal 2013 allowance includes an additional \$0.9 million in federal funds for State chronic disease planning (\$0.5 million) and injury prevention grants (\$0.2 million). These funds are available through the Center for Disease Control and Prevention’s (CDC) Coordinated Chronic Disease Prevention and Health Promotion Grant, and the Injury Prevention and Control Research and State and Community Based Programs, respectively. Funding for the Center for Health Promotion and Education’s Sexual Assault Reimbursement Program also increased by \$0.1 million. Additional CDC funding (\$0.1 million) is also available for the Breast and Cervical Cancer Screening Program (BCCP).

The remaining changes to the prevention and disease control budget include reduced funding in the following areas:

- cancer prevention grants awarded to LHDs under the Maryland Cancer Fund (\$0.2 million);
- reductions to miscellaneous grants (\$0.2 million);
- cardiovascular risk reduction programs at local health departments (\$0.4 million);
- expiration of the American Recovery and Reinvestment Act of 2009 (ARRA) funding for statewide policy and environmental change (\$193,000), oral health literacy (\$129,000), and tobacco cessation through quitlines and media (\$131,000); and
- the BCCDTP (\$0.5 million).

A more in-depth discussion of funding changes to the BCCDTP is included in the Issues section of this document.

Transfers and Changes Per the Budget Reconciliation and Financing Act of 2012

The Governor’s fiscal 2013 budget is balanced through the adoption of the BRFA of 2012. As shown in **Exhibit 6**, there are two provisions in the BRFA of 2012 that affect programs within FHA. First, the BRFA of 2012 specifies a \$500,000 transfer from the balance of the Spinal Cord

² Under the terms of the federal grant requirements, Baltimore City and Anne Arundel, Baltimore, Montgomery, and Prince George’s counties were excluded.

Exhibit 6
Fund Balance Transfers and Contingent Reductions
Fiscal 2013

<u>Program</u>	<u>BRFA Action</u>	<u>Special Funds</u>
Spinal Cord Injury Research Trust Fund	Fiscal 2013 fund balance will be reduced by \$500,000 if BRFA language is adopted to transfer funds to the general fund.	-\$500,000
Total Fund Balance Transfer		-\$500,000
CRF – Tobacco Use Prevention and Cessation Program	Fiscal 2013 allowance will be reduced by \$4.1 million if BRFA language is adopted to reduce the legislative mandate to align with the fiscal 2012 appropriation.	-\$4,088,143
CRF – Statewide Academic Health Centers	Fiscal 2013 allowance will be reduced by \$10.6 million if BRFA language is adopted to reduce the legislative mandate to align with the fiscal 2012 appropriation	-10,600,000
Total Contingent Reduction		-\$14,688,143

BRFA: Budget Reconciliation and Financing Act
 CRF: Cigarette Restitution Fund

Source: Department of Legislative Services; 2013 State Budget

Injury Research Trust Fund to the general fund in fiscal 2013. This is the same amount as transferred in the 2011 session. If the legislation is approved, the balance of the fund will be depleted.

Second, for fiscal 2013 through 2017, Section 15 of the BRFA of 2012 includes a provision which specifies that the Governor is not required to include an appropriation in the budget for any program or item in an amount that exceeds the fiscal 2012 appropriation for that program. Subsequently, Section 15 is being used as a general provision to grant mandate relief to nine programs in the budget – including the Tobacco Use Prevention and Cessation programs and the grants for Statewide Academic Health Centers – for fiscal 2013. This provision would reduce the mandated appropriation levels for Tobacco Use Prevention and Cessation programs and the Statewide Academic Health Centers by \$4.1 million and \$10.6 million, respectively, and transfer these funds to M00Q0103 to support the State’s Medical Assistance program.

A more in-depth discussion of changes to the CRF mandated appropriation levels as proposed by the BRFA of 2012 is included in the Issues section of this document.

Issues

1. Continued Reductions to the CRF Programs

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. Language in the BRFA of 2010 changed the mandated funding levels for cancer and tobacco programs in fiscal 2011, 2012, 2013, and beyond. **Exhibit 7** shows the mandated funding level for each program as specified by Title 13, subtitles 10 and 11, of the Health General Article and the fiscal 2013 adjusted allowance.

Exhibit 7
Cigarette Restitution Fund Allocations
Fiscal 2011-2013
(\$ in Millions)

	<u>Original Level</u>	<u>2011 Actual*</u>	<u>2012 Allowance*</u>	<u>Current Law 2013 and Beyond*</u>	<u>2013 Adjusted Allowance</u>
Tobacco Use Prevention and Cessation	\$21.0	\$6.0	\$6.0	\$10.0	\$6.0
Total Statewide Academic Health Centers					
Cancer Research Grants	10.4	2.4	2.4	13.0	2.4
Tobacco-related Disease Research Grants	2.0	0.0	0.0	0.0	0.0
Statewide Network Grants	3.0	0.0	0.0	0.0	0.0
Total	\$15.4	\$2.4	\$2.4	\$13.0	\$2.4

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

Source: *Annotated Code of Maryland*

As the exhibit shows, the funding for Tobacco Use Prevention and Cessation and grants to the Statewide Academic Health Centers was scheduled to be partially restored in fiscal 2013. Funding for tobacco programs, which includes the CRF and other funds, was set to increase to \$10 million. Although that represents a 66.7% increase over fiscal 2012, it is 52.4% lower than the original permanent amount. Funding for the Statewide Academic Health Centers was also set to increase to \$13 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.

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However, Section 15 of the BRFA of 2012 is being used as a general provision to grant mandate relief in fiscal 2013, including the grants to Statewide Academic Health Centers, and the Tobacco Use Prevention and Cessation programs. This provision would reduce the mandated appropriation levels for Tobacco Use Prevention and Cessation programs and the Statewide Academic Health Centers by \$4.1 million and \$10.6 million, as shown in Exhibit 7. **Exhibit 8** shows funding for specific CRF programs in prior years, as well as the contingent reductions included in the fiscal 2013 allowance.

While Section 15 of the BRFA of 2012 grants mandate relief for fiscal 2013 through 2017, future funding levels for the CRF programs are unclear, since Title 13, subtitles 10 and 11, of the Health General Article (which specify mandated funding levels for the CRF programs) remains unchanged.

Since the legislature can make this cut directly, DLS recommends striking the contingent reduction language and reducing funding for CRF programs by \$14,688,143 as proposed by the Governor. Furthermore, DLS recommends that the committees add a provision to the BRFA of 2012 to authorize the transfer of these funds to M00Q0103 to support the State's Medical Assistance Program.

Exhibit 8
Cigarette Restitution Fund Allocation with Contingent Reductions
Fiscal 2011-2013
(\$ in Millions)

	<u>Actual</u> <u>2011</u>	<u>Working</u> <u>Approp.</u> <u>2012</u>	<u>Allowance</u> <u>2013</u>	<u>Cont.</u> <u>Reduct.</u> <u>2013</u>	<u>Adjusted</u> <u>Allowance</u>	<u>% Change</u> <u>from</u> <u>Working</u> <u>Approp. to</u> <u>Adjusted</u> <u>Allowance</u>
Cancer Prevention, Education, Screening, and Treatment						
Local Public Health	\$7.5	\$7.5	\$7.5	\$0.0	\$7.5	0.0%
UM, JHI, and Baltimore City	2.3	2.4	2.4	0.0	2.4	0.0%
Surveillance and Evaluation	1.1	1.2	1.2	0.0	1.2	-2.0%
Administration	0.5	0.6	0.6	0.0	0.6	2.5%
Cancer Screening Data base	0.2	0.2	0.2	0.0	0.2	0.0%
Statewide Public Health	-	-	-	-	-	-
Total	\$11.7	\$12.0	\$12.0	\$0.0	\$12.0	-0.1%
Statewide Academic Health Center						
Cancer Research Grants	\$2.4	\$2.4	\$13.0	-\$10.6	\$2.4	0.0%
Tobacco Diseases Research	-	-	-	-	-	-
Network Grant	-	-	-	-	-	-
Total	\$2.4	\$2.4	\$13.0	-\$10.6	\$2.4	0.0%
Tobacco Use Prevention and Cessation Program						
Local Public Health	\$2.9	\$2.9	\$3.9	-\$1.0	\$2.9	0.0%
Countermarketing	-	-	-	-	-	-
Statewide Public Health	-	-	2.4	-2.4	0.0	0.0%
Tobacco Prevention and Cessation	0.1	0.1	0.2	-	0.2	116.0%
Surveillance and Evaluation	0.5	0.5	1.0	-0.5	0.5	0.0%
Administration	0.2	0.1	0.2	-0.1	0.1	0.2%
Management	-	-	-	-	-	-
Total	\$3.6	\$3.5	\$7.7	-\$4.1	\$3.7	3.3%
Breast and Cervical Cancer Diagnosis and Treatment Program						
	\$13.8	\$15.2	\$14.7	\$0.0	\$14.7	-3.3%
Total	31.5	33.1	47.4	-14.7	32.7	-1.2%

JHI: Johns Hopkins Institute

UM: University of Maryland

Note: This exhibit does not include general or federal fund support for the Cigarette Restitution programs. Funding for Tobacco Prevention and Cessation is increasing in fiscal 2013 due to increased contractual costs to operate the Maryland Quitline.

Source: Department of Legislative Services

2. Breast and Cervical Cancer Diagnosis and Treatment Program

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 the 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 had 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, the 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 the 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 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 2012, the budget included \$3.3 million general funds and \$4.6 million federal funds to be distributed to local health agencies to perform the screenings. The agency expects to screen over 10,730 women in fiscal 2012. Most of the women screened under this program are eligible for the WBCCHP. Before Maryland was approved for the WBCCHP Medicaid waiver program, women screened under the 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. The BCCDTP covers the following services:

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

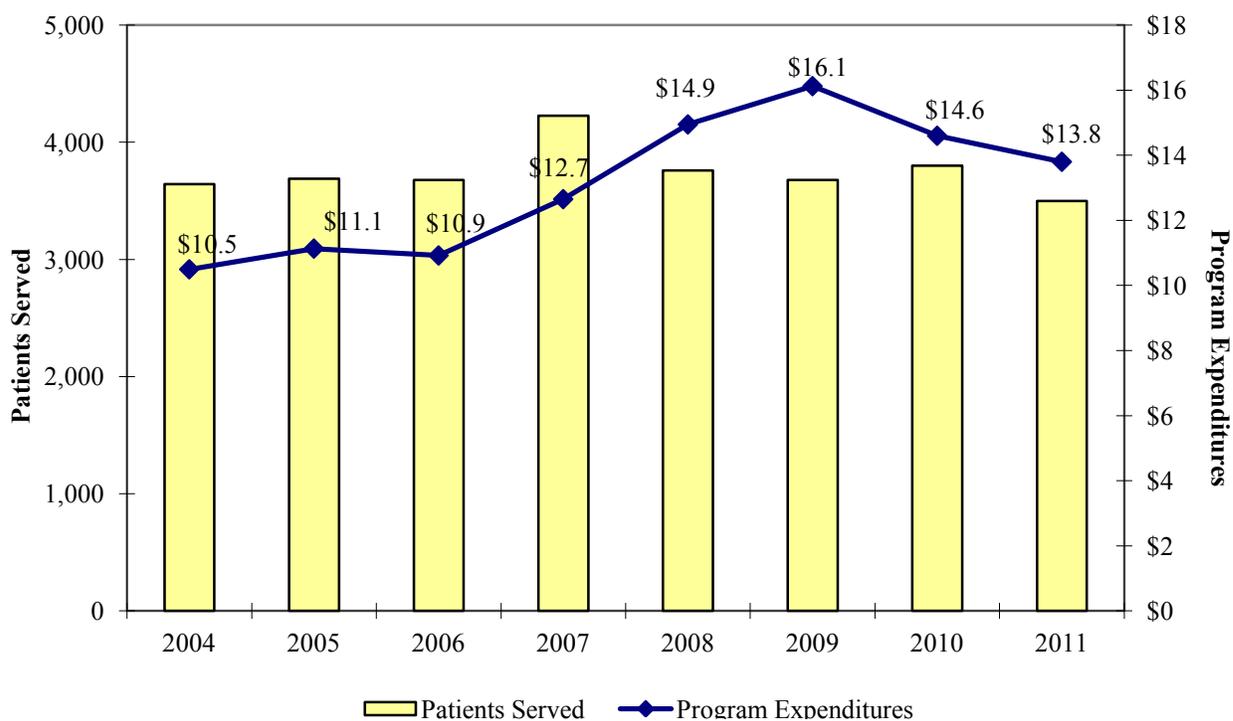
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- breast and cervical cancer treatment procedures including cryotherapy, laser hysterectomy, lumpectomy, mastectomy, radiation therapy, and chemotherapy;
- physical therapy, occupational therapy, and a home health nurse, when required because of breast 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 2011, the program served approximately 3,498 patients at a cost of \$13.8 million. **Exhibit 9** shows the number of patients served by the BCCDTP from fiscal 2004 through 2011 and the program costs for the BCCDTP. While the number of patients served has leveled off in recent years, the program's expenditures peaked in 2009 at \$16.1 million.

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 the WBCHHP that may have otherwise been enrolled into the 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 the BCCDTP. This savings is recognized by a \$0.5 million decrease in funding in the fiscal 2013 budget.

Exhibit 9
Enrollment and Expenditures for the Breast and Cervical Cancer Diagnosis
And Treatment Program
Fiscal 2004-2011
(\$ in Millions)



Source: Department of Health and Mental Hygiene

Women’s Breast and Cervical Cancer Health Program

The 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 the WBCCHP. Treatment for breast and cervical cancer is available to women diagnosed with precancer or cancer through the BCCP mentioned above. The federal government provides a 65% match for costs associated with the WBCCHP.

Given that the MHIP program is anticipated to end in the middle of fiscal 2014, the agency should comment on the future enrollment and costs of the BCCDTP.

Recommended Actions

1. Strike the following language from the special fund appropriation:

~~; provided that this appropriation shall be reduced by \$14,688,143 contingent upon the enactment of legislation reducing funding from the Cigarette Restitution Fund.~~

Explanation: Strike contingent reduction for the Cigarette Restitution Fund.

	<u>Amount Reduction</u>
2. Concur with the reduction to the Cigarette Restitution Fund levels as proposed by the Governor as part of the budget.	\$14,688,143 SF
Total Special Fund Reductions	\$14,688,143

Updates

1. Maryland’s Comprehensive Cancer Control Plan

CDC provides funding to every state for a Comprehensive Cancer Control Program. One of the roles of the program is to create and promote a Comprehensive Cancer Control Plan. In July 2011, DHMH released its Comprehensive Cancer Control Plan, which will act as a road map for preventing, detecting, and treating cancer from calendar 2011 to 2015. This is the first plan issued by the department since 2004.

Comprehensive Cancer Control is a method of communities working together to control cancer by reducing risk, detecting cancer early, improving cancer treatment, and enhancing cancer survivorship. The plan is a resource for individuals, healthcare providers, and organization on cancer control topics. It also serves as a guide for health professionals who are involved in planning, directing, implementing, evaluating, or performing research on cancer control in the State. The goals, objectives, and strategies in the plan can be used to guide health professionals in their cancer control activities. Ultimately, the plan’s goal is to encourage collaboration and cohesiveness among stakeholders to reduce cancer mortality to 160 deaths per 100,000 Maryland residents. This is a 14% decrease from the 2006 rate of 187 deaths per 100,000 Maryland residents.

As shown in **Appendix 3**, the plan includes 23 goals that fall within 14 areas related to cancer: surveillance; disparities; patient issues and cancer survivorship; tobacco use prevention and cessation and lung cancer; nutrition, physical activity and healthy weight; ultraviolet radiation and skin cancer; environment/occupational issues; colorectal cancer; breast cancer; prostate cancer; oral cancer; cervical cancer; pain management; and palliative and hospice care. It is important to note that many goals are focused on reducing racial and ethnic disparities.

2. Prince George’s Hospital Center

The Prince George’s County Health System consists of a number of parts – Prince George’s Hospital Center, a 269-bed acute-care hospital and regional referral center; Laurel Regional Hospital, a 138-bed acute-care community hospital; the Gladys Spellman Specialty Hospital and Nursing Center, a 110-bed comprehensive care and chronic care facility; and the Bowie Health Center. The system has experienced lost market share, revenue losses, low liquidity, significant deferred capital needs, poor bond ratings, and a disadvantageous payor mix. Both the State and Prince George’s County have provided significant financial support in recent years in order to keep the system functional and avoid significant operational deficits, potential bankruptcy, and even closure.

During the 2008 legislative session, the Prince George’s County Hospital Authority (Chapter 680 of 2008 subsequently amended by Chapters 166 and 117 of 2009) was established to implement a competitive bidding process for transferring the Prince George’s County Health System to a new owner or owners. Following the creation of the authority and stemming from the desire to facilitate the transfer of the health care system by providing financial support to the new owners in

order to assist their efforts to stabilize and improve the system, the State and the county entered into a memorandum of understanding (MOU) in 2008 that specified the terms and conditions of the financial support provided by each party. The MOU included a total commitment of \$150 million over five years in operating support split equally between the State and county and \$24 million over three years in State capital support. In fiscal 2010, Prince George's County only partially fulfilled its fiscal 2010 operating support obligation to the system (providing \$9 million rather than the \$12 million original commitment). In comparison, the county fulfilled its fiscal 2011 obligation to the system, matching the \$15 million provided in State funding, for a total of \$30 million in support in fiscal 2011.

Despite the diligent efforts of the authority, in January 2010, the authority announced that it did not believe that the system could be sold, and the authority expired without a transfer in place. However, the authority did make a series of broad recommendations, including continuing to search for a permanent owner and getting stakeholder and regulatory approval for a new inpatient facility to replace the Prince George's Hospital. The \$15 million included in the fiscal 2012 Dedicated Purpose Account (DPA) for Prince George's County Health System equates to the State's original long-term financial commitment under the 2008 MOU with Prince George's County. That long-term commitment was linked to the eventual transfer of the system by the authority.

Proposed Utilization of Funds

Although a transfer agreement has not yet materialized, on July 21, 2011, Prince George's County, the State of Maryland, the University of Maryland Medical System (UMMS), the University System of Maryland, and Dimensions Health Corporation, entered into an MOU that outlines an 18-month, three-step process to develop the strategy, financing, and execution of a plan for UMMS to build a new regional teaching medical center and improve the primary care system in Prince George's County, and for the University of Maryland, Baltimore to establish a health sciences campus in conjunction with the new hospital. The first step of the process is currently underway and is anticipated to be completed in March 2012. During the 18-month process, UMMS and Dimensions Health Corporation will work collaboratively to increase the quality of care and to reduce operating losses at Prince George's Hospital Center. The parties will also develop a plan to transfer the assets and to discharge Dimensions Health System's current debt and liabilities. The MOU indicates the State and Prince George's County will seek funding as needed to sustain operations during the transition and to assist in the discharge of liabilities. This project is currently estimated to cost over \$600 million. It remains unclear how this plan will be financed; however it is important to note that the State will likely fund a large portion of the project.

On October 20, 2011, the Governor and the Prince George's County Executive jointly signed a letter of intent that reflects the county and the State's commitment to provide \$30 million in total funding in fiscal 2012. Furthermore, the letter specifies that either party's contribution is contingent on a like match from the other. In accordance with the MOU signed on July 21, 2011, funding provided by the State and the county may be used for the following purposes: (1) to support Dimension's continued provision of critical health care services during the transition; (2) to begin satisfaction of the System's current liabilities; (3) to help facilitate cost containment measures necessary to stem current operating losses; and (4) to finance the State and county's share of the cost to develop financial projections, site selection, and architectural plans for a new hospital facility in

Prince George's County. It is important to note that the Governor's fiscal 2013 allowance for FHA includes \$15 million in operating support.

Restriction of Capital Budget Support in Fiscal 2012

The Governor's fiscal 2012 capital budget included \$4 million for infrastructure improvements to Prince George's Hospital System. The planned uses of the \$4 million included both equipment replacement and infrastructure improvements for the system. Due to speculation that a new inpatient facility would be built to replace the Prince George's Hospital Center, DLS recommended restricting funding for the improvement of the Prince George's Hospital System until the transfer of ownership is complete, per language in the 2008 MOU, which dictated a long-term funding commitment for the system. DLS also advised that the grant funds in fiscal 2012 should not be used for Prince George's Hospital Center if it is indeed scheduled to close. Ultimately, the General Assembly adopted the recommendation to restrict funding and required DHMH and Prince George's County to submit a report updating the budget committees on the planned use of the \$4 million in general obligation bonds.

The October 20, 2011 letter of intent reiterates the commitment of capital funding in fiscal 2012, subject to the conditions set forth above. Additionally, the letter specifies that funding may be used for infrastructure improvements necessary to advance the goal of transitioning the system to a new owner or owners as outlined in the July 21, 2011 MOU. At the time of this writing, the fiscal 2012 capital funding for Prince George's Hospital System has not been released, and the fiscal 2013 budget includes an additional \$10 million in capital support.

3. Repeat Audit Findings

The Office of Legislative Audits (OLA) audited FHA for the period beginning November 1, 2007, and ending August 3, 2010. The audit revealed that the financial eligibility criteria for Cancer Prevention, Education, Screening, and Treatment Program participants were not consistent among LHDs. A similar finding was commented upon in FHA's preceding audit report.

More specifically, OLA found 15 LHDs anticipated using a portion of their grant awards to pay for treatment services for eligible clients and, therefore, were required to submit eligibility criteria to FHA for review. However, there were inconsistencies amongst LHDs in determining maximum income levels and family unit size for purposes of establishing a client's financial eligibility to receive services. This had occurred because State regulations require LHDs to develop financial eligibility criteria for their individual jurisdictions.

As a result of this repeat audit finding, FHA established statewide standard eligibility criteria for the Cancer Prevention, Education, Screening, and Treatment Program for LHDs and academic center programs for clients who undergo treatment. These eligibility standards went into effect in fiscal 2012.

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 2011					
Legislative Appropriation	\$33,725	\$34,259	\$136,812	\$50	\$204,845
Deficiency Appropriation	0	167	3,291	0	3,458
Budget Amendments	-1,562	15,000	-152	0	13,286
Reversions and Cancellations	0	-1,690	-8,216	0	-9,905
Actual Expenditures	\$32,163	\$47,736	\$131,735	\$50	\$211,684
Fiscal 2012					
Legislative Appropriation	\$31,282	\$34,241	\$138,082	\$50	\$203,655
Budget Amendments	-378	15,018	61	0	14,700
Working Appropriation	\$30,903	\$49,259	\$138,143	\$50	\$218,355

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

Fiscal 2011

In fiscal 2011, the budget for FHA closed at \$211.7 million, an increase of \$6.8 million over the legislative appropriation.

Budget amendments increased the budget by \$13.3 million. The general fund amendments decreased the budget by \$1.5 million. As a result of legislation in the 2010 session, the Office of Minority Health and Health Disparities 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. This decrease was offset by a \$0.5 million increase in general funds to realign appropriations within DHMH from programs with surpluses to those with deficits. One special fund amendment increased the budget for FHA by \$15.0 million for the grant to Prince George's Hospital System. This action transferred funds from the DPA to FHA for the purpose of disbursement of the grant and required approval by the budget and legislative policy committees.

Deficiency appropriations increased FHA's legislative appropriation by \$3.5 million. Of that amount, \$3.3 million in federal funds was received by the agency through four federal grants. The details of the four grants are as follows:

- \$2,160,501 for CDC grants for statewide cancer activities, the Maryland Cancer Registry, colorectal cancer screening activities, Behavioral Risk Factor Surveillance System, tobacco use and prevention activities, and oral health literacy activities;
- \$928,884 for an 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 Home Visiting Program; and
- \$38,916 for an ACA grant for the Personal Responsibility Education program.

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.

At the end of the year, the agency cancelled \$1.7 million in special funds due to lower CRF expenditures. Finally, \$8.2 million of the federal fund appropriation was cancelled for expending less than was budgeted in the WIC program (\$7.4 million) and various programs, including injury prevention and chronic disease (\$0.8 million).

Fiscal 2012

The fiscal 2012 working appropriation is \$18.4 million, an increase of \$14.7 million over the original legislative appropriation. The fiscal 2012 budget for the Department of Budget and Management (DBM) included centrally budgeted funds for the \$750 one-time bonus for State employees. This resulted in the transfer of funds from DBM to FHA (\$60,534 in federal funds, \$45,426 in general funds, and \$12,912 in special funds).

One special fund amendment increased the budget for FHA by \$15 million for the grant to Prince George's Hospital System. This action transferred funds from the DPA to FHA for the purpose of disbursement of the grant and required approval by the budget and legislative policy committees. Additional special funds were also needed for the ChopChop Maryland program that distributes healthy dietary recipes using Maryland ingredients (\$5,000).

One amendment transferred \$0.4 million in general funds from the Family Health Services and Primary Care program in FHA to the Office of the Secretary.

Audit Findings

Audit Period for Last Audit:	November 1, 2007 – August 3, 2010
Issue Date:	August 2011
Number of Findings:	3
Number of Repeat Findings:	1
% of Repeat Findings:	33.3%
Rating: (if applicable)	n/a

Finding 1: FHA did not have sufficient procedures in place to ensure that only management authorized changes were made to the Electronic Claims Management System production programs and related databases

Finding 2: FHA did not establish adequate policies regarding the identification and investigation of certain questionable claims.

Finding 3: **The financial eligibility criteria for Cancer Prevention, Education, Screening, and Treatment Program participants were not consistent among the local health departments.**

*Bold denotes item repeated in full or part from preceding audit report.

Maryland Cancer Control Plan Goals

<u>Area</u>	<u>Goal</u>
Cancer Surveillance	1. Collect, analyze, develop, and disseminate Maryland cancer information.
Cancer Disparities	2. Reduce cancer disparities in Maryland.
Patient Issues and Cancer Survivorship	3. Enhance the quality of life of cancer survivors in Maryland through information and supportive services.
Tobacco Use Prevention and Cessation and Lung Cancer	4. Substantially reduce tobacco use and exposure to secondhand smoke by high-risk Maryland adult and youth. 5. Implement the Centers for Disease Control's Best Practice recommendations (2007) for Maryland's Comprehensive Tobacco Control Program.
Nutrition, Physical Activity, and Healthy Weight	6. Reduce the burden of cancer in Maryland by improving the nutrition and physical activity and promoting the healthy weight of Marylanders across the lifespan.
Ultraviolet Radiation and Skin Cancer	7. Increase awareness of skin safe behaviors. 8. Increase the utilization of skin safe behaviors.
Environment/ Occupational Issues and Cancer	9. Reduce cancer incidence in Maryland by minimizing exposures to known environmental and occupational carcinogens. 10. Improve Maryland-specific data and strengthen research and education related to environmental and occupational factors and cancer.
Colorectal Cancer	11. Reduce colorectal cancer incidence and mortality. 12. Reduce disparities in the incidence and mortality of colorectal cancer.
Breast Cancer	13. Reduce the incidence of breast cancer in Maryland. 14. Reduce the morbidity and mortality from breast cancer in Maryland.
Prostate Cancer	15. Reduce morbidity related to the detection and management of prostate cancer in Maryland men. 16. Continue to reduce the prostate cancer mortality rate in men.
Oral Cancer	17. Reduce oral cancer incidence and mortality. 18. Reduce disparities in the incidence and mortality of oral cancer.

<u>Area</u>	<u>Goal</u>
Cervical Cancer	19. Decrease the incidence of invasive cervical cancer in Maryland by reducing risk and improving detection. 20. Decrease the mortality and morbidity of cervical cancer in Maryland.
Pain Management	21. Empower cancer patients to take an active role in partnering with healthcare providers in managing pain and minimizing impact on quality of life. 22. Educate and involve clinicians to optimize cancer pain control and take an active role in partnering with other healthcare providers and patients in managing pain and minimizing impact on quality of life.
Palliative and Hospice Care	23. Implement a blueprint for success for palliative and hospice care for patients and families experiencing cancer in the State of Maryland.

Source: Department of Health and Mental Hygiene

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

<u>Object/Fund</u>	<u>FY 11 Actual</u>	<u>FY 12 Working Appropriation</u>	<u>FY 13 Allowance</u>	<u>FY 12 - FY 13 Amount Change</u>	<u>Percent Change</u>
Positions					
01 Regular	164.30	156.30	158.30	2.00	1.3%
02 Contractual	3.32	6.21	6.21	0.00	0%
Total Positions	167.62	162.51	164.51	2.00	1.2%
Objects					
01 Salaries and Wages	\$ 13,379,071	\$ 13,777,858	\$ 13,548,371	-\$ 229,487	-1.7%
02 Technical and Spec. Fees	126,508	207,240	199,955	-7,285	-3.5%
03 Communication	256,440	314,224	428,676	114,452	36.4%
04 Travel	262,389	236,099	347,109	111,010	47.0%
07 Motor Vehicles	11,226	19,972	5,521	-14,451	-72.4%
08 Contractual Services	168,161,411	172,647,032	178,900,522	6,253,490	3.6%
09 Supplies and Materials	2,366,579	2,460,947	2,476,772	15,825	0.6%
10 Equipment – Replacement	22,974	0	0	0	0.0%
11 Equipment – Additional	556,737	644,766	632,018	-12,748	-2.0%
12 Grants, Subsidies, and Contributions	26,443,786	28,002,512	40,197,688	12,195,176	43.6%
13 Fixed Charges	96,988	44,646	341,931	297,285	665.9%
Total Objects	\$ 211,684,109	\$ 218,355,296	\$ 237,078,563	\$ 18,723,267	8.6%
Funds					
01 General Fund	\$ 32,163,306	\$ 30,903,368	\$ 44,159,325	\$ 13,255,957	42.9%
03 Special Fund	47,735,788	49,259,222	48,375,600	-883,622	-1.8%
05 Federal Fund	131,735,015	138,142,706	144,543,638	6,400,932	4.6%
09 Reimbursable Fund	50,000	50,000	0	-50,000	-100.0%
Total Funds	\$ 211,684,109	\$ 218,355,296	\$ 237,078,563	\$ 18,723,267	8.6%

Note: The fiscal 2012 appropriation does not include deficiencies.

Fiscal Summary
DHMH – Family Health Administration

<u>Program/Unit</u>	<u>FY 11 Actual</u>	<u>FY 12 Wrk Approp</u>	<u>FY 13 Allowance</u>	<u>Change</u>	<u>FY 12 - FY 13 % Change</u>
02 Family Health Services and Primary Care	\$ 153,361,116	\$ 160,304,297	\$ 163,292,476	\$ 2,988,179	1.9%
06 Prevention and Disease Control	58,322,993	58,050,999	73,786,087	15,735,088	27.1%
Total Expenditures	\$ 211,684,109	\$ 218,355,296	\$ 237,078,563	\$ 18,723,267	8.6%
General Fund	\$ 32,163,306	\$ 30,903,368	\$ 44,159,325	\$ 13,255,957	42.9%
Special Fund	47,735,788	49,259,222	48,375,600	-883,622	-1.8%
Federal Fund	131,735,015	138,142,706	144,543,638	6,400,932	4.6%
Total Appropriations	\$ 211,634,109	\$ 218,305,296	\$ 237,078,563	\$ 18,773,267	8.6%
Reimbursable Fund	\$ 50,000	\$ 50,000	\$ 0	-\$ 50,000	-100.0%
Total Funds	\$ 211,684,109	\$ 218,355,296	\$ 237,078,563	\$ 18,723,267	8.6%

Note: The fiscal 2012 appropriation does not include deficiencies.