HB 1425

Department of Legislative Services

Maryland General Assembly
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FISCAL NOTE
Revised

House Bill 1425 (Delegate Rawlings, *et al.*)
Appropriations & Environmental Matters

Cigarette Restitution Fund - Tobacco Use Prevention and Cessation Program - Cancer Prevention, Education, Screening, and Treatment Program

This bill establishes a Tobacco Use Prevention and Cessation Program and a Cancer Prevention, Education, Screening, and Treatment Program within the Department of Health and Mental Hygiene (DHMH). The bill also adds both programs to the spending priorities of the Cigarette Restitution Fund.

Fiscal Summary

State Effect: Adding two additional purposes for the Cigarette Restitution Fund would not affect overall fund expenditures. Funding for the Tobacco Use Prevention and Cessation Program and the Cancer Prevention, Education, Screening, and Treatment Program is included in the FY 2001 budget, with $48,847,113 contingent upon enactment of this bill.

Local Effect: None.

Small Business Effect: None.

Analysis

Bill Summary: The bill establishes a Tobacco Use Prevention and Cessation Program and a Cancer Prevention, Education, Screening, and Treatment Program within DHMH, and requires both programs be funded through the Cigarette Restitution Fund. The bill also establishes parameters for any tobacco control or cancer control program for which there is an appropriation from the Cigarette Restitution Fund. The programs would be administered by DHMH. Legislative auditors are authorized to audit the program, including the use of

funds by outside entities that receive program funds from DHMH. The allocation of funds among the different components of each program should be included in any future budget bills.

Tobacco Use Prevention and Cessation Program

The tobacco control program consists of five components: administration, surveillance and evaluation, statewide public health, counter-marketing and media, and local public health. The allocation for each component may only be expended for the purpose for which it is appropriated, unless otherwise authorized in the State budget as enacted. The allocation for each component may only be transferred to another component, another program in the department, or another State agency as specifically authorized in this bill or in the annual budget bill. Within the program, a maximum of 10% of the total budget may be transferred among components only if authorized in the annual budget bill, as long as the department notifies the Senate Budget and Taxation and Finance committees and the House Appropriations and Environmental Matters committees within 60 days. Funds may not be transferred to the administrative component. Funds that are unspent or unobligated at the end of a fiscal year will revert to the Cigarette Restitution Fund. Any money that is reverted in one fiscal year must be appropriated for the program in the next fiscal year. By January 15 of each year, DHMH should report to: the Governor; the Senate Budget and Taxation and Finance committees; and the House Appropriations and Environmental Matters committees, on the financial status of funds received in the current and prior fiscal year.

The department shall adopt regulations that establish criteria to determine if uninsured individuals participating in the program can pay for treatment.

- Administration

The administrative component of the program will provide the infrastructure for the management of the program. It includes the administrative costs of all components of the program within DHMH. Unless otherwise specified in the annual budget bill, the annual amount for administration should not exceed 5% of the total amount allocated to the program in the State budget.

Any entity that receives funds under the program may use up to 7% for administrative expenses. These expenses are not included as part of the administrative component.

- Surveillance and Evaluation

The surveillance and evaluation component will provide the means to measure the outcome of the program. DHMH should evaluate the effectiveness of the program as a whole as well

as the effectiveness of each component.

DHMH is required to contract with an outside vendor, through a request for proposal process, to conduct a baseline study that determines the level of tobacco use in the general population as well as among youth, minorities, and pregnant women. To select the proposal, DHMH shall use the criteria specified in the bill. For these populations, the study will measure tobacco use statewide and in each jurisdiction. DHMH will use baseline data for two purposes: distributing funds for the local health program and evaluating the effectiveness of the program. In conducting the baseline study, the department may consider any data collected after March 1, 2000 from the Maryland Adolescent Survey or the Youth Tobacco Survey. The Maryland State Department of Education (MSDE), which currently assists in administering the Maryland Adolescent Survey, may not discontinue that survey until the beginning of the school year after it reports to the General Assembly on the reason behind discontinuing the survey. MSDE and county boards of education must also cooperate in administering the Youth Tobacco Survey. After the first year of the program, DHMH is required to contract with an outside vendor for an annual follow-up study. By September 1 of each year, DHMH must report to the Governor and the General Assembly on the results of the tobacco studies.

- Statewide Public Health

The statewide public health component will integrate all the other components of the tobacco control program. Under this component, DHMH may develop and implement tobacco control activities that are consistent with the recommendations of the Task Force to End Smoking and the Centers for Disease Control as they relate to statewide programs. Before the baseline study is completed, the department may expend at least $750,000 to support the participation of the African American community in the community health coalitions for both the tobacco and cancer programs.

- Counter-Marketing and Media

The counter-marketing and media component will discourage the use of tobacco products through a variety of methods. Although not explicitly mentioned in the bill, these methods could include television, radio, and billboard advertising. Funds for this component may not be expended until a baseline study is completed, as baseline data will be used to measure its effectiveness, except funds may be expended on conducting formative marketing research prior to the completion of the baseline tobacco study. Funds are also restricted until DHMH submits a counter-marketing plan that outlines all elements of the component to the Governor and the General Assembly by January 1, 2001; and DHMH shall submit an annual report by September 1 of each year. To implement any element of the plan, DHMH may contract with

an outside vendor through a request for proposal process. To select the proposal, DHMH shall use the criteria specified in the bill.

To the extent practicable, DHMH should maximize the cost effectiveness of the program by using counter-marketing products developed by other states and organizations, obtaining funding from other sources, including the federal government and the National Public Education Fund, and coordinating the purchase of broadcast time with other states. However, DHMH may not accept an award that would restrict the type of counter-marketing supported by the Cigarette Restitution Funds, if the restrictions are inconsistent with the purposes of the bill.

- Local Public Health

The local health component seeks to maximize the effectiveness of the tobacco control program by authorizing local coalitions to develop and implement tobacco use and cessation programs. These programs include community-based programs, school-based programs, and enforcement of tobacco restrictions. School-based programs may include tobacco control components of health care services. Except for a planning grant of no more than $10,000 to each jurisdiction, funds for this component may not be expended until a baseline study is completed, as baseline data will be used to measure its effectiveness.

After the baseline study is completed, the department will develop tobacco use prevention and cessation goals for each jurisdiction, in consultation with the local health departments. Using a formula outlined in the bill, funds will be distributed to the jurisdiction. One-half of the funds will be distributed according to the portion of minors who use tobacco in each jurisdiction, as compared to the total number of minors who use tobacco in the State. The other half of the funds will be distributed according to the portion of individuals who use tobacco in each jurisdiction, as compared to the total number of individuals who use tobacco in the State.

To apply for funds, a local health officer must first establish a community health coalition. The coalitions may consist of representatives from the following local organizations: community-based groups, local management boards, health care providers, law enforcement agencies, school systems, businesses, religious organizations, media, institutions of higher education, and other entities located outside the jurisdiction that could enhance the program. The community health coalition will identify and determine the effectiveness of existing tobacco control programs in the jurisdiction. This process will establish a maintenance of effort level that the jurisdiction must continue to meet as a condition of receiving Cigarette Restitution Funds.

The coalition will then develop a comprehensive plan for tobacco use prevention and cessation that outlines a strategy to meet the goals and requirements of DHMH. The initial and subsequent annual updates of the comprehensive plan should include the following elements: (1) list of members; (2) demonstration that progress has been made in meeting DHMH goals and the Task Force to End Smoking goals, particularly with regards to women, minorities, and individuals; (3) a budget plan for each initiative; (4) evaluation of any program funded through Cigarette Restitution Funds in the prior year; (5) financial report on funds received the prior year that includes information on who received funds as well as funds that were unspent and unobligated; (6) demonstration that the jurisdiction has met a maintenance of effort requirement; (7) a description of how the plan will increase availability of and access to cessation programs for uninsured and medically underserved individuals; (8) allocation of resources to different populations, including targeted minorities, consistent with the baseline and annual tobacco studies; and (9) allocation of resources consistent with the recommendations of the Task Force to End Smoking and the Centers for Disease Control, except if the coalition can demonstrate the reason for not following the recommendations and identify other resources being used to meet this requirement.

If DHMH determines that the local health department cannot adequately coordinate the comprehensive plan, DHMH can appoint another person, including the department itself, other than the local health officer to coordinate the community health coalition. The local health department's efforts may not be adequate if the local health department is unwilling to coordinate the program, unable to meet DHMH's goals, or lacks sufficient staff and resources.

The major provisions of the Tobacco Use Prevention and Cessation Program are summarized in **Attachment 1**.

Cancer Prevention, Education, Screening, and Treatment Program

The cancer control program consists of five components: administration, surveillance and evaluation, statewide public health, local public health, and statewide academic health centers. To maximize the effectiveness of these components, DHMH will select cancers to be targeted. The allocation for each component may only be expended for the purpose for which it is appropriated, unless otherwise authorized in the State budget as enacted. The allocation for each component may only be transferred to another component, another program in the department, or another State agency as specifically authorized in this bill or in the annual budget bill. Within the program, a maximum of 10% of the total budget may be transferred among components only if authorized in the annual budget bill, as long as the department notifies the Senate Budget and Taxation and Finance committees and the House Appropriations and Environmental Matters committees within 60 days. Funds may not be transferred to the administrative component. Funds that are unspent or unobligated at the end of a fiscal year will revert to the Cigarette Restitution Fund. Any money that is reverted in

one fiscal year must be appropriated again in the next fiscal year. By January 15 of each year, DHMH should report to: the Governor; the Senate Budget and Taxation and Finance committees; and the House Appropriations and Environmental Matters committees, on the financial status of funds received in the current and prior fiscal year.

While DHMH will administer the program, legislative auditors are authorized to audit the program, including the use of funds by outside entities that receive program funds from DHMH. In addition, the department shall adopt criteria to determine if uninsured individuals participating in the program can pay for treatment.

- Administration

The administrative component of the program will provide the infrastructure for the management of the program within the department. Unless otherwise specified in the annual budget bill, the annual amount for administration should not exceed 5% of the total amount allocated to the program.

Any entity that receives funds under the program may use up to 7% for administrative expenses. These expenses are not included as part of the administrative component.

- Surveillance and Evaluation

The surveillance and evaluation component will provide the means to measure the outcomes of the program. DHMH should evaluate the effectiveness of the program as a whole as well as the effectiveness of each component.

DHMH should conduct a baseline study by itself or through an outside vendor, by following a request for proposal process. The baseline study will determine the incidence of and mortality rates from cancer in the general and minority populations as well as the number of high-incidence cancers that can effectively be prevented, detected, or treated. For these populations, the study will measure cancer rates statewide and in each jurisdiction. In the baseline study, DHMH may use current sources of data, such as the Maryland Cancer Registry, if the data is valid. DHMH will use baseline data for two purposes: distributing funds for the local health program and evaluating the effectiveness of the program. After the first year of the program, DHMH is required to conduct an annual follow-up study by itself or through an outside vendor, by following a request for proposal process. By September 1 of each year, the department shall report the results of the cancer study to the Governor and the General Assembly.

- Statewide Public Health

The statewide public health component will integrate all the other components of the cancer

control program. The department may not expend any funds until a baseline study is completed. Any activity must be consistent with the report of Task Force to Conquer Cancer.

- Local Public Health

The local health component seeks to maximize effectiveness of the tobacco control program by authorizing local coalitions to develop and implement a cancer control program that will address prevention, identification, and treatment needs. Funds for this component may not be expended until a baseline study is completed, as baseline data will be used to measure its effectiveness, except for planning grants up to $10,000 for any participating jurisdiction.

After the baseline study is completed, the department will develop cancer control goals for each jurisdiction, in consultation with local health departments. Using a formula outlined in the bill, funds will be distributed to the jurisdictions, with the exception of Baltimore City. One-half of the funds will be distributed according to the portion of individuals with a targeted cancer in each jurisdiction, as compared to the total number of individuals with cancer who reside outside of Baltimore City. The other half of the funds will be distributed according to the portion of individuals who have died from targeted cancers in each jurisdiction, as compared to the total number of individuals who have died and resided outside of Baltimore City.

Funds for Baltimore City are included in the statewide academic health center component of the program, under which Baltimore City would receive a minimum of $3 million in fiscal 2001 and $4 million in subsequent years. If Baltimore City would have received more funding under the local public health formula, then DHMH must transfer the difference in funds from the local health component to the statewide academic health center component.

To apply for funds, a local health officer must first establish a community health coalition. The coalition may consist of representatives from the following local organizations: community-based groups, local management boards, health care providers, religious organizations, institutions of higher education, and entities outside the jurisdiction that could enhance the program. The community health coalition will identify and determine the effectiveness of existing cancer control programs in the jurisdiction. This process will establish a maintenance of effort level that the jurisdiction must continue to meet as a condition of receiving Cigarette Restitution Funds.

Community health coalitions in Prince George's, Baltimore, and Montgomery counties should include the major community hospitals that meet the bill's criteria on the number of cancer patients, the level of clinical expertise, the amount of uncompensated care, and the level of cancer research. In Prince George's and Montgomery counties, the coalitions shall develop a plan on how the statewide academic health centers can assist in increasing the capacity for cancer-related services at the major community hospitals. In Baltimore County, the coalition must plan how the major community hospitals will enhance the capacity for cancer-related services in the county.

The coalition will develop a comprehensive plan for cancer control that outlines a strategy for meeting the goals and requirements of DHMH. The initial and subsequent annual updates of the comprehensive plan should include the following elements: (1) a list of members and their organizational affiliations; (2) a demonstration that progress has been made in meeting DHMH goals and the Task Force to Conquer Cancer goals, particularly in regards to women, minorities, and individuals; (3) a budget plan for each initiative; (4) an evaluation of any program funded through Cigarette Restitution Funds in the prior year; (5) a financial report on funds received the prior year that includes information on who received funds as well as funds that were unspent and unobligated; (6) demonstration that the jurisdiction has met a maintenance of effort requirement; (7) demonstration that treatment for individuals diagnosed with cancer under a Cigarette Restitution Fund program will be provided; (8) a description of how the plan will increase the availability of and access to health care services for uninsured and medically underserved individuals; (9) a demonstration that priority was given to entities, including federally qualified health centers, that have a demonstrated commitment and ability to provide cancer-related services; and (10) for those counties that must include a major community hospital on the coalition, a plan to increase capacity for cancer-related services.

If DHMH determines that the local health department cannot adequately coordinate the comprehensive plan, DHMH can appoint another person, including the department itself, other than the local health officer to lead the community health coalition. The local health department's efforts may not be adequate if the local health department is unwilling to

coordinate the program, unable to meet DHMH's goals, or lacks sufficient staff and resources.

- Statewide Academic Health Center

The statewide academic health center component includes four grant programs: public health grants, cancer research grants, tobacco-related diseases research grants, and network grants. Consisting of the Johns Hopkins University and the Johns Hopkins Health System, the Johns Hopkins Institutions may apply for the public health and research grants. Consisting of the University of Maryland Medical System Corporation, the University of Maryland Medical School, and the University of Maryland, Baltimore, the University of Maryland Medical Group (UMMG) may apply for public health, cancer research, tobacco-related diseases research, and network grants.

The intent of the public health grants is similar to the local public health cancer grants in other jurisdictions. In fiscal 2002 and in subsequent years, the Johns Hopkins Institutions and UMMG shall each receive the sum of $2 million and 50% of any funds transferred from the local public health component. Funds will be transferred if Baltimore City would have received more than $4 million under the local public health component, if it had been included. The amount of the transfer would be equal to any amount over and above $4 million. In fiscal 2001, the total for the two institutions is only $3 million. DHMH may not award any funds, with the exception of a $10,000 planning grant, until the baseline study is completed.

To receive the funds, the institutions must first establish a Baltimore City community health coalition, in conjunction with the Baltimore City Health Department. The coalition shall consist of representatives from community-based groups that are familiar with all the different communities and cultures in Baltimore City. The coalition should include major community hospitals that meet the criteria specified in the bill.

If one or both institutions are unwilling or unable to coordinate the public health grant, the department may award a grant to the Baltimore City Health Department or another person, including the department itself. The grant shall equal the same amount that would have been awarded to the institutions.

The coalition will develop a comprehensive plan for cancer control that outlines a strategy for meeting the goals and requirements of DHMH. The initial and subsequent annual updates of the comprehensive plan should include the following elements: (1) list of members and their organizational affiliations; (2) demonstration that progress has been made in meeting DHMH goals and Task Force to Conquer Cancer goals, particularly with regards to minority populations; (3) budget plan for each initiative; (4) evaluation of any program

funded through Cigarette Restitution Funds in the prior year; (5) financial report on funds received the prior year that includes information on who received funds as well as funds that were unspent and unobligated; (6) demonstration that the jurisdiction has met a maintenance of effort requirement; (7) demonstration that there are appropriate linkages to treatment for individuals diagnosed with cancer under a Cigarette Restitution Fund program; (8) a description of how the plan will increase the availability of and access to health care services for uninsured and medially underserved individuals; (9) a demonstration that priority was given to entities, including federally qualified health centers, that have a demonstrated commitment and ability to provide cancer-related services; and (10) for those counties that must include a major community hospital on the coalition, a plan to increase capacity for cancer-related services.

The cancer research grant's purpose is to enhance activities that may lead to a cure for targeted cancers. To receive a cancer research grant, Hopkins and UMMS must submit a research plan to DHMH. The plan will include the following: (1) for each initiative, a detailed spending plan and information on how the initiative relates to DHMH goals; (2) to establish a maintenance of effort requirement, information on the existing research programs and level of funding; (3) a certification that the research initiatives have been endorsed by an independent peer review panel; and (4) identification of individuals on the peer review panel. The institutions must also enter into a Memorandum of Understanding with DHMH and the Maryland Science, Engineering, and Technology Development Corporation. The memorandum will establish the following: (1) the scope of the State's ownership or financial interest in developments from research; (2) a plan for expediting the translation of research into treatment and clinical trials; and (3) reflects the existing intellectual property policies of the institutions. The memorandum may allow for the selection of a higher education institution or private entity to expedite the translation of cancer research activities into treatment protocols and clinical trials.

The purpose of the tobacco-related diseases research grant is to enhance UMMG activities that will reduce mortality and morbidity. The grant program may not be implemented until funds are specifically allocated in the State budget. There is not an allocation for this program in the fiscal 2001 budget. In future years, UMMG may apply for a grant to conduct health services delivery, translational, and clinic research. To receive a grant, UMMG must submit a plan that contains the following: (1) a detailed spending plan; (2) maintenance of effort information; (3) a demonstration that treatment will be provided to uninsured individuals in the program; (4) certification of an independent peer review process; and (5) a list of the peer reviewers. UMMG must also enter into a memorandum of agreement on intellectual property issues that is similar to one required for cancer research.

The statewide network and infrastructure program is a grant to UMMG. The network grant

will strengthen the cancer control and tobacco-related diseases programs through out the State through a wide variety of programs, including increasing participation in clinical trials, development of best practices models, and coordination among health care providers. Before completing the baseline study, the department may only fund the development of the network.

The major provisions of the Cancer Prevention, Education, Screening, and Treatment Program are outlined in **Attachment 2**.

Current Law: See below.

Background: In response to the 1998 tobacco settlement agreement, Chapters 172 and 173 of 1999 created the Cigarette Restitution Fund for settlement payments. All payments received by the State related to the tobacco settlement are to be placed into this nonlapsing fund. Monies in the fund can only be spent through appropriations in the annual State budget, and a minimum of $100 million, or 90% of the funds available, must be appropriated. In addition, 50% of the funds must be appropriated for the following specific purposes:

- reduction in tobacco use by youth;
- tobacco control programs in schools;
- smoking cessation programs;
- enforcement of tobacco sales restrictions;
- primary health care in rural areas;
- programs concerning cancer, heart disease, lung disease, and tobacco control;
- substance abuse treatment and prevention;
- Maryland Health Care Foundation; and
- crop conversion.

For each program receiving funds, statements of vision, mission, goals, and objectives, along with performance indicators, are to be included with the budget submission, and an annual report is required evaluating the effectiveness of the prior year's spending.

State Fiscal Effect: The bill adds two items to the list of spending priorities that may be funded through the Cigarette Restitution Fund.

The Cigarette Restitution Act of 1999 outlined nine legislative spending priorities (mentioned above) for the Cigarette Restitution Fund addressing health- and tobacco- related issues. While the statute mandates that at least 50% of the spending should be focused on the nine priority areas, the Governor has considerable latitude in constructing a budget proposal for the use of the funds. The fiscal 2001 budget (including Supplemental Budget No. 1) meets the statutory requirements, with $102.5 million, or 63% of the settlement funds, allocated to health- and tobacco-related programs. The total fiscal 2001 allowance for the Cigarette Restitution Fund is $163.7 million.

Adding two purposes for the Cigarette Restitution Fund would not increase expenditures from the fund because current law does not require all spending priorities to be funded in a given year. The fiscal 2001 budget contains $48,847,113 contingent on the enactment of this bill or Senate Bill 896.

Additional Information

Prior Introductions: None.

Cross File: This bill and Senate Bill 896 were amended in conference committee to be identical bills.

Information Source(s): Department of Legislative Services

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Attachment 1
Tobacco Use Prevention and Cessation Program

Surveillance and Evaluation Component	Statewide Public Health Component	Counter-Marketing and Media Component	Local Public Health Component	Administrative Component
DHMH will contract with a higher ed institution or private entity to conduct: - a baseline tobacco use survey; and - an annual tobacco use survey	DHMH may develop and implement programs: - to ensure a coordinated and integrated statewide implementation of the tobacco control program	For the media program, there must be: - a description of components and implementation; and - a description of the target audiences Funds should be sought from the Public Education Fund and other sources, but not accepted if restrictions are placed on media content Existing resources should be utilized State should coordinate the purchase broadcast time with other states	DHMH may make grants to counties for programs that are: - community based; - school based; or - related to enforcement Funds available to a county are based on the proportion of underage smokers and the proportion of total smokers Local health departments must: - have a Community Health Coalition; - meet a maintenance of effort requirement; and - have a comprehensive plan for tobacco control	DHMH is allocated funds by the budget for the administrative costs of the department The amount allocated to the administrative cost component may not exceed 5% of the amount allocated to all components of the program Other entities that receive funds may use up to 7% for administrative expenses

Attachment 2
Cancer Prevention, Education, Screening, and Treatment Program

Surveillance and Evaluation Component	Statewide Public Health Component	Statewide Academic Health Center Component	Local Public Health Component	Administrative Component
DHMH will conduct or contract with a higher education institution or private entity to conduct: - a baseline cancer survey; and - an annual cancer survey	DHMH may develop and implement programs: - necessary to ensure a coordinated and integrated statewide implementation of the cancer control program	DHMH may make public health grants to the UMMG and the Johns Hopkins Institutions. Both institutions, with the Baltimore City Health Department, must: - establish a Community Health Coalition that includes major community hospitals; - meet a maintenance of effort requirement; and - develop a comprehensive plan for cancer control For each institution, funding equals $2 million plus 50% of any funds transferred from the Local Health Component, except funding is only a total of $3 million in fiscal 2001. Both institutions can apply for a cancer research grant if they have a cancer research plan and a memorandum of understanding with the State concerning ownership and other benefits of results, products, etc. UMMG can apply for a tobacco-related diseases research grant if funding is specifically appropriated in the State budget. UMMG can apply for a network grant to establish a statewide network and infrastructure	DHMH will establish goals for each county and make public health grants Funds available to a jurisdiction, other than Baltimore City, are based on the proportion of individuals with a targeted cancer and the proportion of individuals who died from a targeted cancer in the prior year. Funds must be transferred to the Medical Institution Component if Baltimore City would have received more than $4 million (or $3 million in fiscal 2001) under the local public health formula. Local health departments must: - have a Community Health Coalition; - meet a maintenance of effort requirement; and - have a comprehensive plan for cancer control Community health coalitions in Prince George's, Montgomery, and Baltimore counties must include major community hospitals. In Prince George's and Montgomery counties, the statewide academic health centers must work with the major community hospitals.	DHMH is allocated funds by the budget for the administrative costs of the department. The amount allocated to the administrative cost component may not exceed 5% of the total amount allocated to the program. Other entities receiving funds may use up to 7% for administrative costs.