

M00F02
Infectious Disease and Environmental Health Administration
Department of Health and Mental Hygiene

Operating Budget Data

(\$ in Thousands)

	<u>FY 09</u> <u>Actual</u>	<u>FY 10</u> <u>Working</u>	<u>FY 11</u> <u>Allowance</u>	<u>FY 10-11</u> <u>Change</u>	<u>% Change</u> <u>Prior Year</u>
General Fund	\$69,307	\$47,571	\$51,252	\$3,682	7.7%
Contingent & Back of Bill Reductions	0	0	-3,961	-3,961	
Adjusted General Fund	\$69,307	\$47,571	\$47,291	-\$280	-0.6%
Special Fund	15,801	17,579	18,125	546	3.1%
Adjusted Special Fund	\$15,801	\$17,579	\$18,125	\$546	3.1%
Federal Fund	88,431	97,687	89,116	-8,571	-8.8%
Contingent & Back of Bill Reductions	0	0	-349	-349	
Adjusted Federal Fund	\$88,431	\$97,687	\$88,768	-\$8,919	-9.1%
Reimbursable Fund	1,248	1,120	1,317	197	17.6%
Contingent & Back of Bill Reductions	0	0	-3	-3	
Adjusted Reimbursable Fund	\$1,248	\$1,120	\$1,315	\$195	17.4%
Adjusted Grand Total	\$174,787	\$163,956	\$155,498	-\$8,458	-5.2%

Note: For purposes of illustration, the Department of Legislative Services has estimated the distribution of selected across-the-board reductions. The actual allocations are to be developed by the Administration.

- The fiscal 2011 budget for the Infectious Disease and Environmental Health Administration (IDEHA) and Office of Preparedness and Response totals \$155.5 million, \$8.5 million less than the fiscal 2010 working appropriation.
- The general fund allowance is \$280,000 less than the general fund working appropriation. Federal funds decrease by \$8.9 million from the working appropriation due to one-time H1N1 funding in fiscal 2010 and the realignment of federal grant awards to more closely match the State fiscal year.

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

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Personnel Data

	<u>FY 09 Actual</u>	<u>FY 10 Working</u>	<u>FY 11 Allowance</u>	<u>FY 10-11 Change</u>
Regular Positions	253.10	252.10	251.10	-1.00
Contractual FTEs	<u>15.38</u>	<u>6.34</u>	<u>3.32</u>	<u>-3.02</u>
Total Personnel	268.48	258.44	254.42	-4.02

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	11.73	4.67%
Positions and Percentage Vacant as of 12/31/09	20.00	7.93%

- The allowance includes 1.0 fewer regular position in IDEHA. The position is an environmental program manager in the Office of Food Protection and Consumer Health and is currently filled.
- The fiscal 2011 allowance includes a net reduction of 3.02 contractual full-time equivalents (FTE). This is due to a reduction in 3.33 FTEs hired to convert confidential HIV/AIDS patient records from code-based to name-based reporting which will be completed by March 31, 2010. This reduction is offset by an increase in .31 FTE for a database specialist.
- Of the 20.0 vacant positions, 18.0 are in IDEHA and 2.0 are in the Office of Preparedness and Response. Two have been vacant for over a year, and the Department of Legislative Services is recommending deleting these positions.

Analysis in Brief

Major Trends

Childhood Vaccinations Rate Remains High: According to the United States Centers for Disease Control and Prevention (CDC), in 2008, Maryland had one of the highest percentages of children, ages 19 to 35 months, fully vaccinated with all of the vaccines in the series of recommended courses.

Syphilis and Chlamydia Rates Higher Than the National Average: Both the rate of primary and secondary syphilis and the rate of chlamydia infections in Maryland remain higher than the national average. The chlamydia rate among 15-24-year-olds also remains higher than the national average.

Third Highest AIDS Rate of Any State: In 2007, the CDC reported that Maryland had the third highest AIDS case rate in the nation behind only New York and the District of Columbia. Maryland's AIDS population continues to show some striking differences to the nation as a whole.

Varying Enrollment Trends in Health Services Programs: The Maryland AIDS Drug Assistance Program (MADAP) is the largest health service program run by IDEHA, and enrollment is steady. The MADAP-Plus program's enrollment is increasing significantly due to the downturn in the economy and the termination of the Maryland AIDS Insurance Assistance Program.

HIV/AIDS Funding Directly Related to Services Provided: Managing for Results data shows a direct relationship between funding and the number of services provided. In recent years, funding for medical services has decreased, the funding for dental services has recently begun to increase, and funding for case management services is expected to decrease.

Office of Preparedness and Response: In a national assessment of public health preparedness, Maryland received 7 out of 10 possible points tying with 10 other states.

Issues

H1N1 Influenza Activities: The H1N1 influenza (also known as Swine Flu) emerged as a public health threat in April 2009. Since that time, the Department of Health and Mental Hygiene (DHMH) has been working to track the outbreak, and throughout the fall and winter DHMH has been coordinating efforts to obtain vaccines from the federal government and ensure that Marylanders have access to the vaccine.

HIV Prevention Programs: IDEHA provides grants to local health departments and other service providers to implement HIV prevention programs throughout the State. However, Maryland's HIV infection rate remains one of the highest in the nation.

Recommended Actions

	<u>Funds</u>	<u>Positions</u>
1. Increase turnover expectancy to more accurately reflect vacancies.	\$ 163,133	
2. Delete two vacant positions.	118,164	2.0
3. Strike language making reduction to local health contingent on legislation.		
4. Add language to require a report on the use of funding by local health departments.		
5. Reduce general funds for Core Public Health Services.	3,716,516	
Total Reductions	\$ 3,997,813	2.0

M00F02

Infectious Disease and Environmental Health Administration Department of Health and Mental Hygiene

Operating Budget Analysis

Program Description

This analysis consists of two separate public health entities: the Infectious Disease and Environmental Health Administration (IDEHA) and the Office of Preparedness and Response (OPR).

IDEHA was formed from the integration of the AIDS Administration and Community Health Administration on July 23, 2009. IDEHA seeks to improve the health of Marylanders through partnerships with local health departments and public and private sector agencies. Activities include focusing on the prevention and control of infectious diseases, investigation of disease outbreaks, protection from food-related and environmental health hazards, and helping impacted persons live longer, healthier lives. The administration also funds public health services in local health departments on a matching basis with all 24 local jurisdictions.

OPR oversees programs focused on enhancing the public health preparedness activities for the State and local jurisdictions. The key aspects of the work conducted under the leadership of OPR are interagency collaboration and preparedness for public health emergencies. The projects in OPR are federally funded through (1) the Centers for Disease Control and Prevention's (CDC) Public Health Preparedness and Response for Bioterrorism Grant; (2) the CDC Pandemic Influenza Grant; (3) the CDC Cities Readiness Initiative; and (4) the Department of Health and Human Services Hospital Preparedness Program.

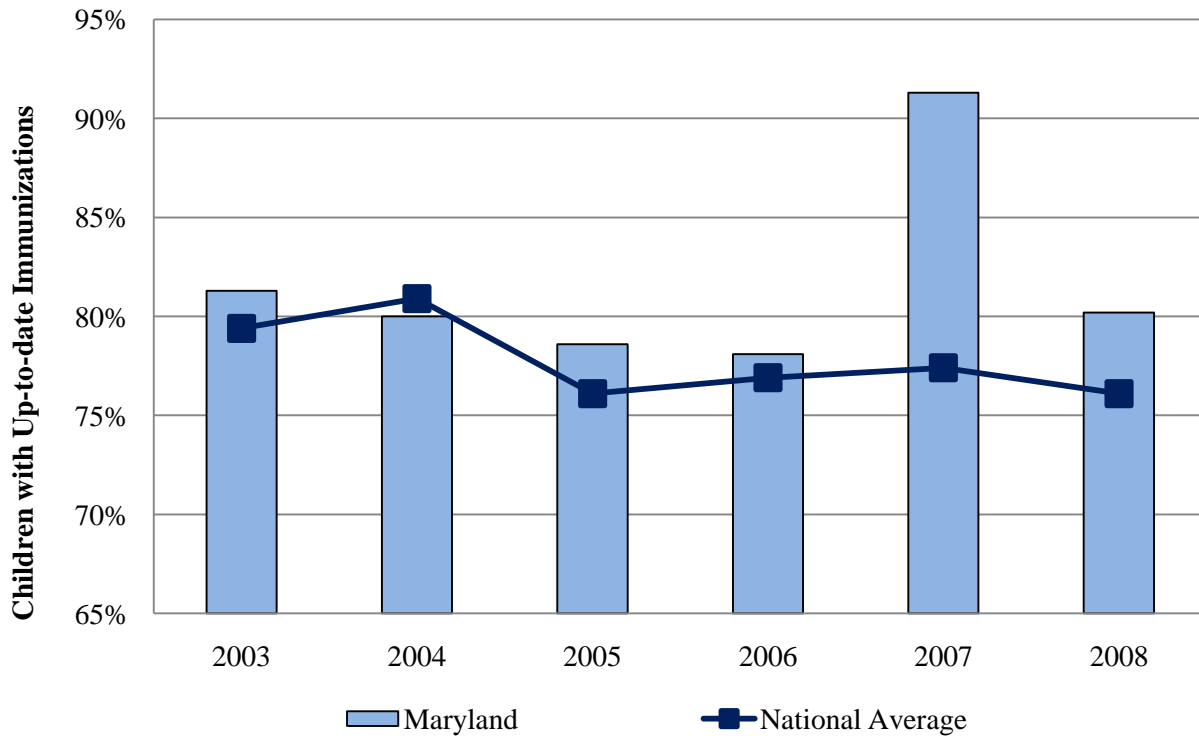
Performance Analysis: Managing for Results

Infectious Disease and Environmental Health Administration

Childhood Vaccination Rate Remains High

According to a CDC survey released August 2009, Maryland had one of the highest percentages of children, ages 19 to 35 months, fully vaccinated with all of the vaccines in the series of recommended childhood vaccines in 2008. As shown in **Exhibit 1**, 80.2% of the children in Maryland received the typical coverage of vaccinations, compared with the national average of 76.1%. Between 2006 and 2007, the rate of immunizations jumped 13 percentage points; however, reasons for this increase were unclear. In 2008, the vaccination rate returned to historical levels.

Exhibit 1
Rates of Children, Ages 19 to 35 Months, with Up-to-date Immunizations
Calendar 2003-2008



Source: Department of Health and Mental Hygiene; Centers for Disease Control and Prevention

Maryland is able to keep the vaccination rates of children high for a couple of reasons. First, the State allows parents to opt out of vaccinating toddlers for medical or religious reasons, but not for philosophical reasons. Also, the Department of Health and Mental Hygiene (DHMH) operates the Maryland Vaccines for Children program, which works with 750 providers at 1,000 public and private practice vaccine delivery sites to provide all routinely recommended vaccines, free of cost to children 18 years old or younger who:

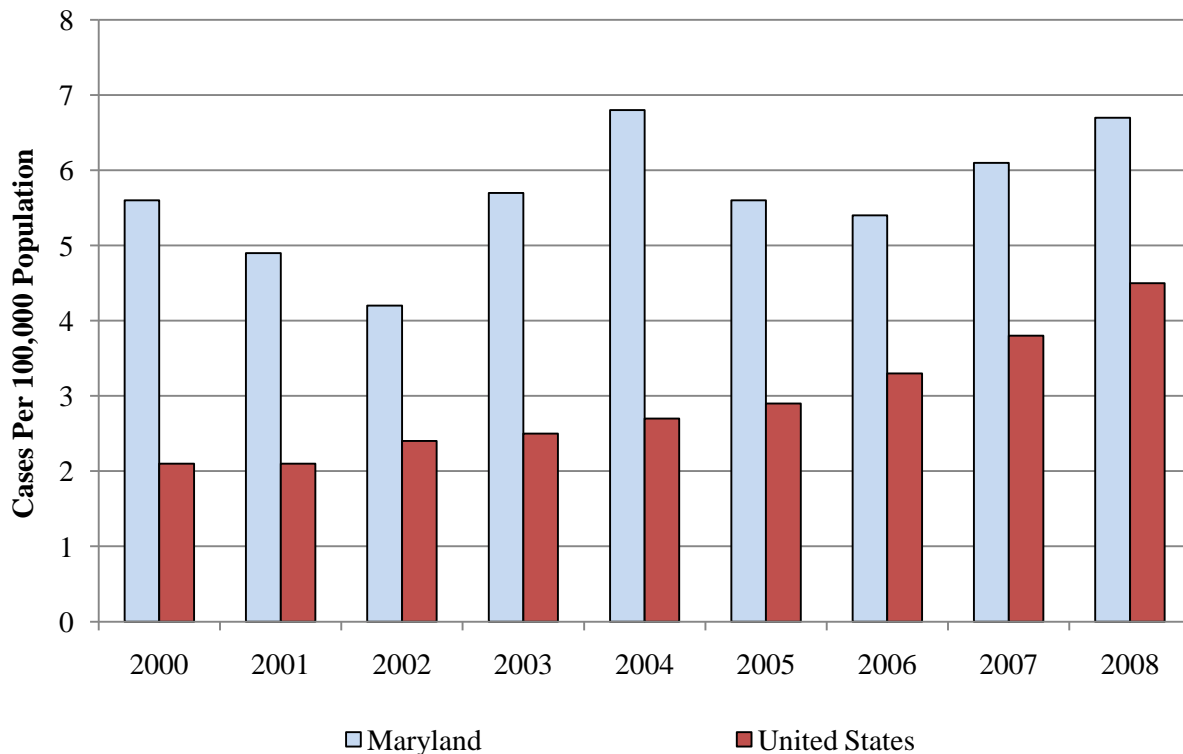
- are Maryland Medicaid eligible;
- are uninsured;
- are Native American or Alaskan Native; or
- are underinsured (children who have health insurance that does not cover immunization).

Syphilis and Chlamydia Rates Remain Higher Than the National Average

IDEHA is charged with preventing and controlling the transmission of infectious diseases, including sexually transmitted diseases (STDs). The administration has developed initiatives to reduce the spread of STDs, with an emphasis on populations at risk, such as economically disadvantaged and incarcerated populations. Syphilis continues to be a major concern in the State, with the rate of infection in Maryland the fifth highest in the nation (as of the most recent national comparison which was conducted with data from calendar 2008). In addition to its primary effects, syphilis presents public health concerns for its role in facilitating transmission of the human immunodeficiency virus (HIV). Syphilis also causes fetal death in 40% of pregnant women with the disease.

Syphilis rates in Maryland compared to the national average are displayed in **Exhibit 2**. In 2008, CDC reported a statewide infection rate of primary and secondary syphilis in Maryland of 6.7 cases per 100,000 population, 9.8% over the 2007 rate. Furthermore, the syphilis rate is significantly higher than the national rate of 4.5 cases per 100,000.

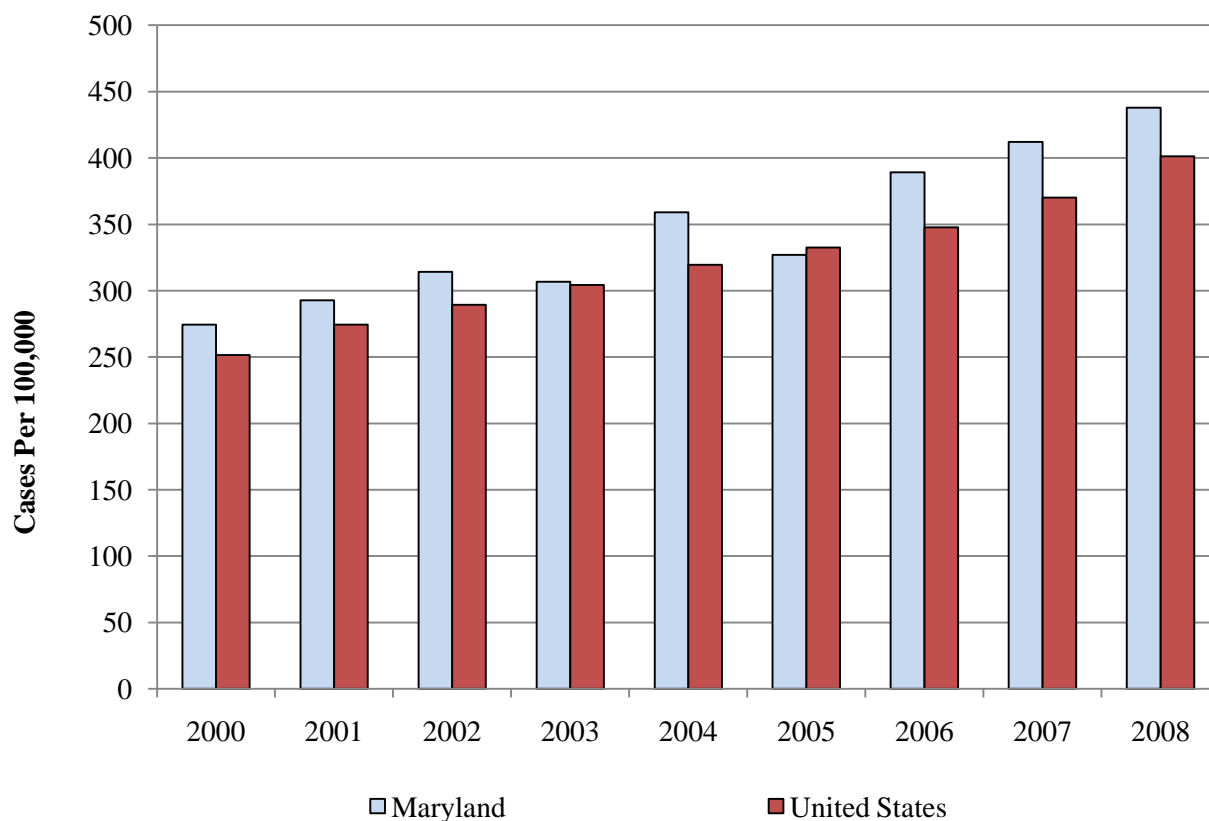
Exhibit 2
Rates of Primary/Secondary Syphilis
Calendar 2000-2008



Source: Department of Health and Mental Hygiene; Centers for Disease Control and Prevention

Chlamydia also continues to be a concern throughout the State, especially among young adults ages 15-24, as the State’s rate of infection continues to trend above the national average. **Exhibit 3** shows the chlamydia rate in Maryland compared to the national average for all ages from calendar 2000 to 2008. In 2008, the chlamydia rate in Maryland was 437.9 per 100,000 population compared to the national average of 401.3. The chlamydia rate among 15-24 year olds is more striking, at 2,251.9 per 100,000 in Maryland, compared to 1,843 cases per 100,000 nationally.

Exhibit 3
Rate of Chlamydia
Calendar 2000-2008

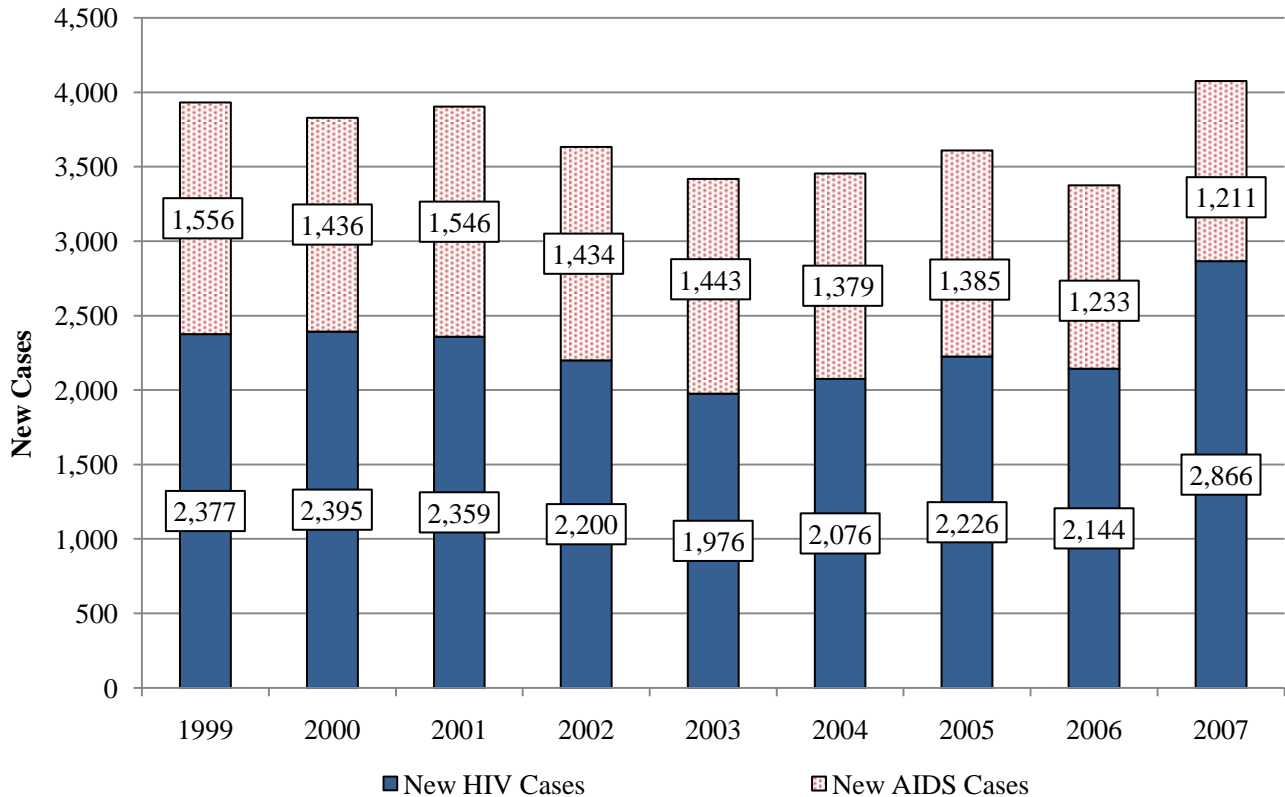


Source: Department of Health and Mental Hygiene; Centers for Disease Control and Prevention

Third Highest AIDS Rate of Any State (including the District of Columbia)

In calendar 2007, there were an estimated 28,270 Marylanders living with HIV or AIDS (12,588 with HIV and 15,682 with AIDS). That same year, the State had 2,866 new HIV diagnoses and 1,211 new AIDS diagnoses. **Exhibit 4** details the trends in new reported cases of HIV and AIDS in Maryland.

**Exhibit 4
Incidence of HIV and AIDS in Maryland
Calendar 1999-2007**



Note: All estimates are produced from trends in data through December 30, 2008. Figures are based on date of diagnosis not date of reporting.

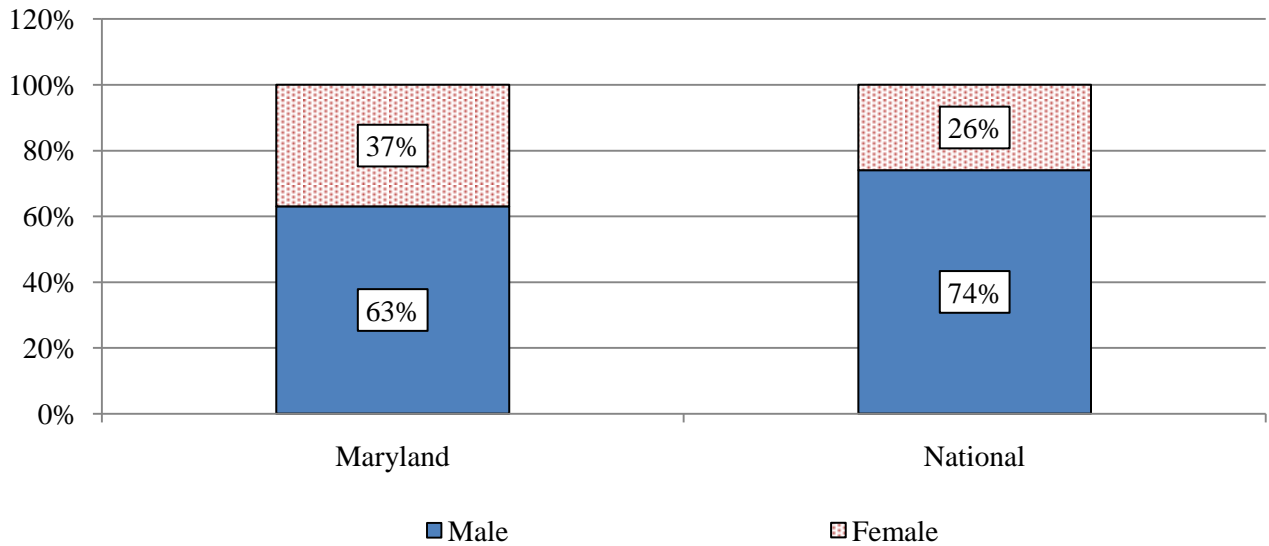
Source: Department of Health and Mental Hygiene; Centers for Disease Control and Prevention

According to the national comparison conducted by the CDC of the calendar 2007 data, Maryland had the ninth highest number of cumulative AIDS cases, the seventh highest number of newly reported AIDS cases, and the third highest AIDS rate, behind only Washington, DC and New York. The CDC analysis reported that in 2007 nationally the AIDS rate was 12.5 AIDS cases per 100,000 population compared to the Maryland average of 24.8 per 100,000 population.

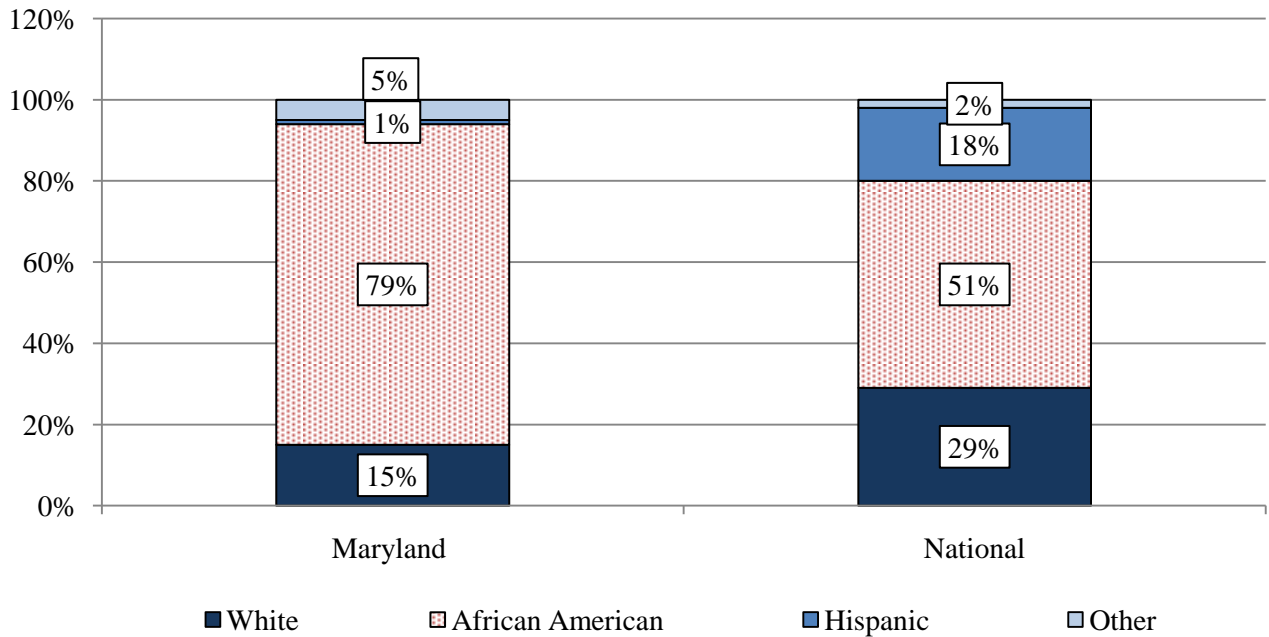
Maryland’s AIDS population continues to show some striking differences to the nation as a whole. As shown in **Exhibit 5**, Maryland’s AIDS population is more female and more African American than the national AIDS population. Exhibit 5 also shows Maryland’s exposure categories for the AIDS population include more injection drug use and heterosexual contact than the national AIDS population.

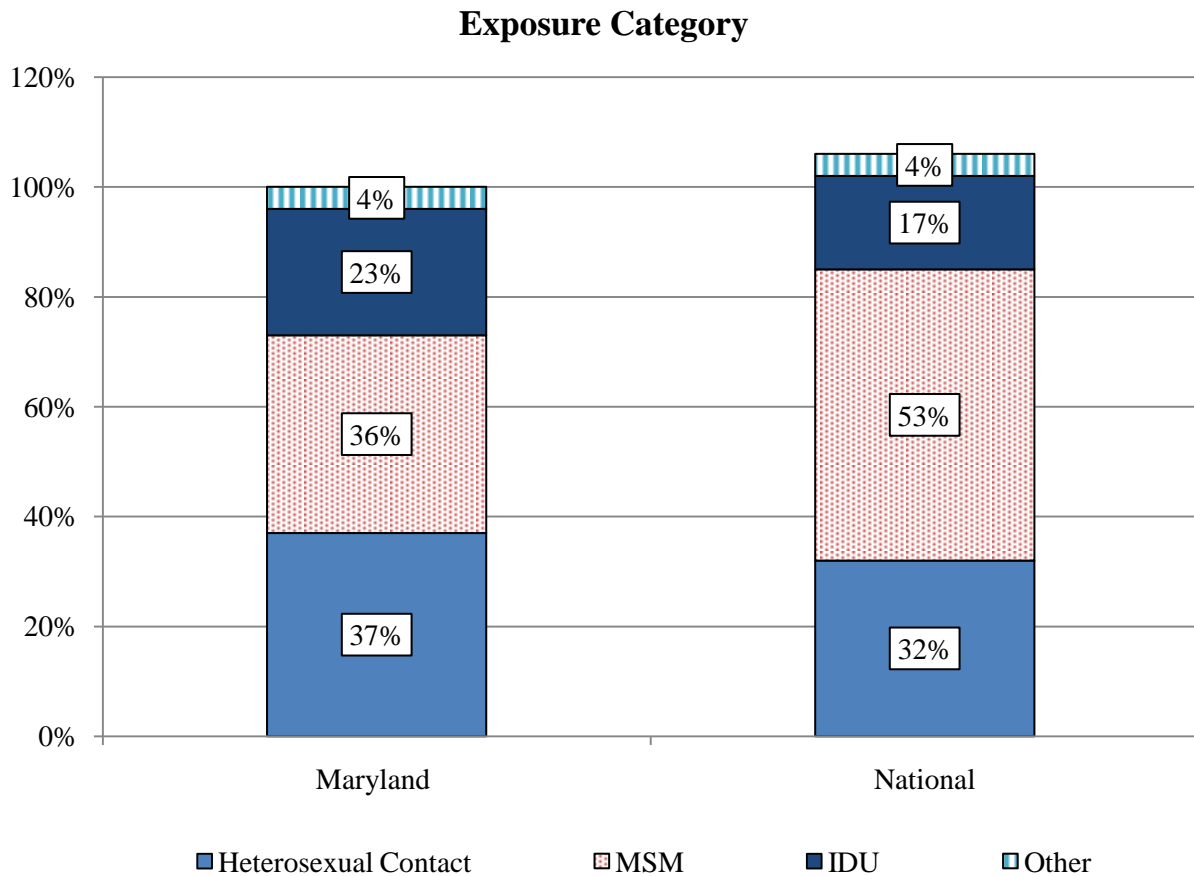
**Exhibit 5
Demographics of Maryland’s AIDS Population
Versus the National AIDS Population
Calendar 2007**

Gender



Race/ Ethnicity





IDU: injection drug use
MSM: men who have sex with men

Source: Department of Health and Mental Hygiene; Centers for Disease Control and Prevention

Varying Enrollment Trends in Health Services Programs

IDEHA provides three major health services programs: Maryland AIDS Drug Assistance Program (MADAP), MADAP-Plus, and the Maryland AIDS Insurance Assistance Program (MAIAP). These are outlined in **Exhibit 6**.

Exhibit 6
IDEHA Health Services Programs for HIV/AIDS

	<u>Benefit</u>	<u>Income Eligibility</u>	<u>Fund Source</u>
MADAP	Assistance with HIV/AIDS related drug formulary costs	0 to 500% of FPL	Federal and Special Funds
MADAP-Plus	Maintains health insurance for individuals testing positive for HIV who can no longer work due to their illness	116 to 300% of the FPL	Federal and Special Funds
MAIAP*	Provided health insurance assistance to persons at risk of losing private health insurance coverage	301 to 500% of the FPL	General Funds

FPL: Federal Poverty Level

HIV: Human Immunodeficiency Virus

IDEHA: Infectious Disease and Environmental Health Administration

MADAP: Maryland AIDS Drug Assistance Program

MAIAP: Maryland AIDS Insurance Assistance Program

* MAIAP ended on June 30, 2009.

Source: Department of Health and Mental Hygiene

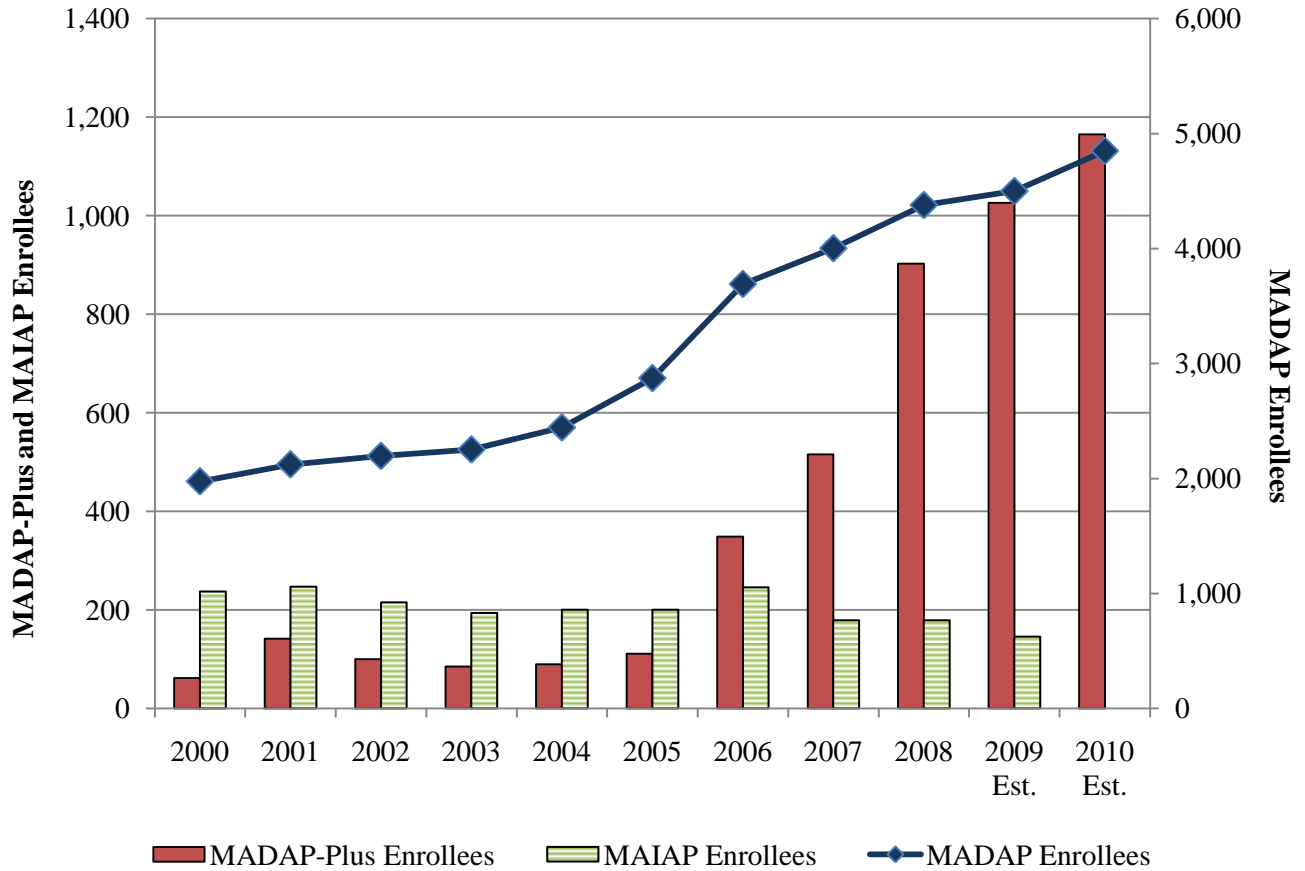
MADAP is the largest program run by the AIDS Administration with over 4,000 enrollees in 2008. Clients are certified eligible for MADAP for a one-year period, after which time they may reapply for certification. Following the increase in eligibility limits promulgated by the AIDS Administration in 2004, MADAP has one of the nation's most expansive eligibility requirements alongside extremely generous drug coverage.

MADAP-Plus offers health insurance assistance to individuals living with HIV/AIDS. Both had failed to live up to enrollment expectations for a number of years. MADAP-Plus had significant enrollment increases in calendar 2006 and 2007; the program finally surpassed the original enrollment target of 300 and has grown to over 900 enrollees in 2008. MAIAP's program enrollment was capped at 450, but actual enrollment had been much lower. In calendar 2007, fewer than 200 individuals were enrolled in the insurance program.

MAIAP was due to sunset in 2002, but Chapter 30 of 2002 extended the program until June 30, 2010. However, due to budget constraints the program ended June 30, 2009. Special funds available through MADAP drug rebates allowed for clients served in the MAIAP program to be transferred into the MADAP-Plus program. Insurance purchased with these rebates must adhere to the MADAP prescription drug formulary. MAIAP did not have the same restrictions. IDEHA renegotiated insurance contracts and enrolled MAIAP clients in MADAP-Plus a year before the sunset of the program.

As shown in **Exhibit 7**, MADAP, MADAP-Plus, and MAIAP all experienced enrollment growth through calendar 2006. Since then, MADAP enrollment has stabilized, MADAP-Plus enrollment has significantly increased, and MAIAP enrollment has decreased and is completely eliminated in 2010.

Exhibit 7
MADAP, MADAP-Plus, and MAIAP Enrollment
Calendar 2000-2010

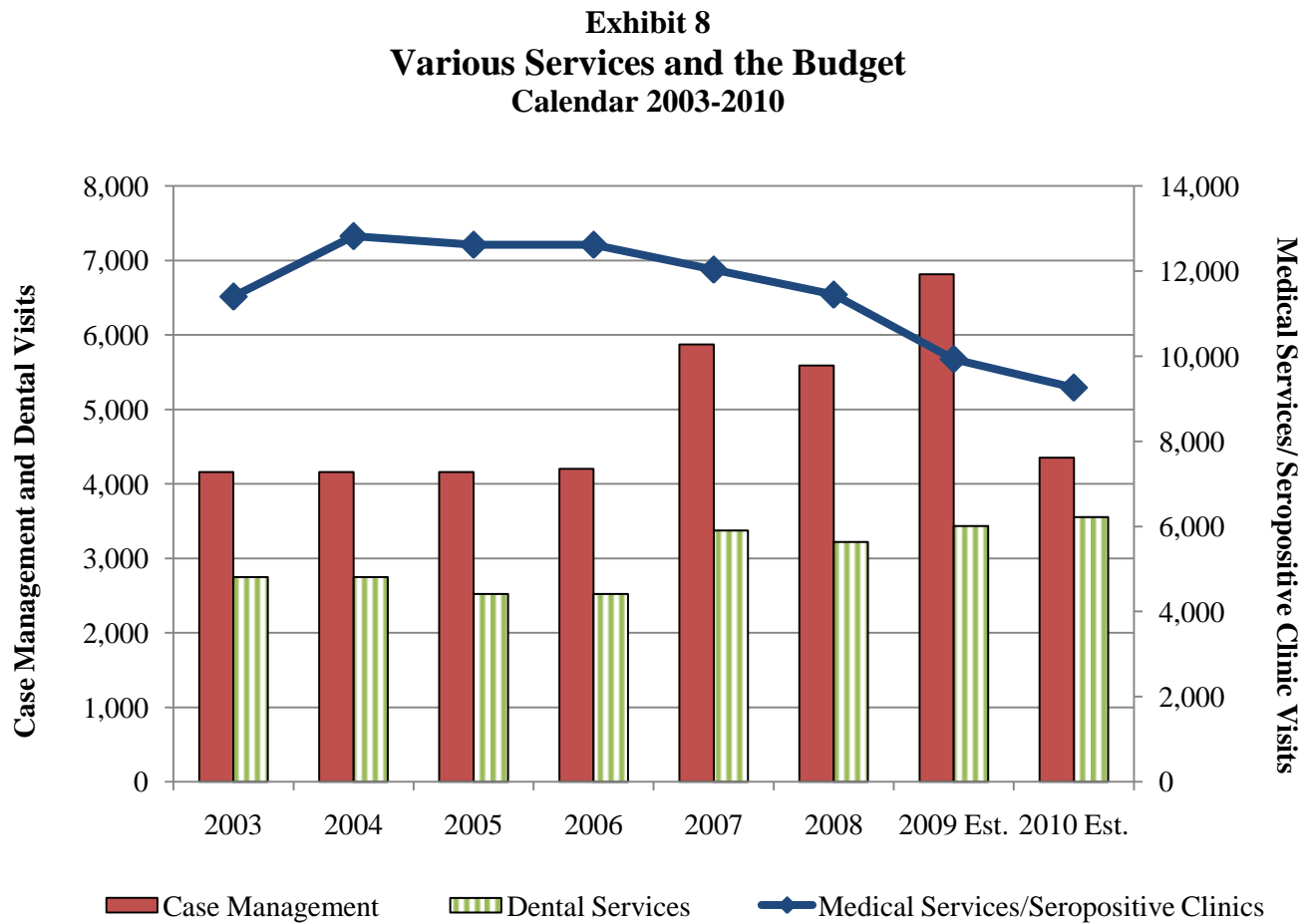


MADAP: Maryland AIDS Drug Assistance Program
 MAIAP: Maryland AIDS Insurance Assistance Program

Source: Department of Health and Mental Hygiene

HIV/AIDS Funding Directly Related to Services Provided

Exhibit 8 demonstrates the direct relationship between funding level and amount of services provided by the AIDS Administration in the areas of medical services, case management, and dental services. In recent years, funding for medical services has decreased, and the funding for dental services has remained level. Funding for case management decreased in 2010.



(\$ in Millions)

	<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>Est. 2009</u>	<u>Est. 2010.</u>
Budget for Medical Services/Seropositive Clinics	\$2.5	\$3.3	\$3.3	\$3.3	\$3.3	\$3.0	\$2.9
Budget for Case Management	2.4	2.4	2.4	3.5	3.5	4.5	3.0
Budget for Dental Services	0.4	0.4	0.4	0.6	0.6	0.6	0.7
Total Budget	\$5.3	\$6.0	\$6.0	\$7.3	\$7.3	\$8.1	\$6.6

Source: Department of Health and Mental Hygiene

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Medical services consist of doctor visits at the local health departments and community agencies. The level of funding for medical services was flat from calendar 2005 through 2008, which caused the number of medical services provided to decrease because the cost to provide the services increased year over year. In calendar 2009, the funding for medical services decreased by 9.0% which reduced the number of services provided by 13.0%. This decline is expected to continue in 2010. The budget for medical services is expected to decline by 2.4%, and the number of services provided is expected to be reduced by 7.0%.

IDEHA provides funding to the local health departments to provide case management services for people enrolled in MADAP. Between calendar 2003 and 2006, the funding level and number of case management services remained flat. Funding for case management services increased in calendar 2007 through 2009. However, the funding for these services is expected to decline by 33% in calendar 2010.

Dental services are provided at some health departments and two dental clinics in Baltimore City. The funding for dental services was level from calendar 2005 to 2006, which caused the number of services provided to remain level. In calendar 2007, funding increased 41%, and the number of services provided increased by 34%. Then, in calendar 2008, the funding remained level causing the number of dental services provided to decrease by 5%. In calendar 2009, the funding for dental services increased allowing services provided to increase. This is expected to continue in calendar 2010 with funding for dental services increasing by 8% which is expected to lead to a 4% increase in dental services provided.

Office of Preparedness and Response

Maryland's Public Health Preparedness Compared with Other States

The Trust for America's Health, a nonprofit organization dedicated to disease prevention, issued a December 2009 report titled *Ready or Not? Protecting the Public's Health from Disease, Disaster and Bioterrorism*. The report assessed readiness in each of the 50 states and DC according to 10 indicators of emergency response capabilities. This is the seventh consecutive year this report has been released, but some indicators change from year to year.

The general findings from the 2009 report were that investments made in public health preparedness have demonstrated payoff; however, concerns still exist. These include the need to strengthen the public health workforce, increase health care surge capacity and increase disease tracking and surveillance throughout the county. Maryland, along with 10 other states, received 1 point for 7 out of 10 indicators, 18 states and DC received 8 or 9 points out of 10. The State received 1 point for achieving each of the following indicators:

- has purchased 50% or more of the share of federally subsidized antivirals available;
- submitting data on available hospital beds weekly to the federal HAvBED system;

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- public health laboratory has an intrastate courier system that has the capacity to operate 24 hours a day;
- public health laboratory has enough staffing capacity to work five 12-hour days for six to eight weeks;
- has a disease tracking system;
- meets the Medical Reserve Corps readiness criteria; and
- requires all licensed childcare facilities to have multi-hazard written evacuation and relocation plan.

Maryland is 1 of 14 states that were not able to identify the pathogen responsible for reported foodborne disease outbreaks at a rate meeting or exceeding the national average of 46% between calendar 2005 and 2007. Maryland had 27 confirmed outbreaks in this period, and was able to identify the pathogen 39% of the time according to data in the report.

The State lost one point for not having in statute provisions that extend some level of immunity to business and nonprofit organizations providing charitable emergency or disaster relief services. Maryland and 18 other states did not have these “Good Samaritan” provisions in law.

Finally, Maryland lost one point for not increasing or maintaining the level of funding for public health services from fiscal 2008 to 2009. Along with 27 other states, Maryland decreased funding for public health services in this time period. The reductions taken by the 27 states ranged from less than 1.0 to 24.5%. Maryland’s reduction in this time period was 2.7%. **Exhibit 9** shows the states, including Maryland, in which funding for public health decreased.

Exhibit 9
States Reducing Public Health Funding
Fiscal 2008-2009

<u>State</u>	<u>Percent Public Health Funding Decrease</u>
Hawaii	-0.7%
Alaska	-1.1%
Pennsylvania	-1.2%
Massachusetts	-1.5%
Wisconsin	-1.9%
Wyoming	-2.3%
Maryland	-2.7%
Maine	-4.0%
New Hampshire	-4.0%
Rhode Island	-4.0%
Virginia	-5.0%
Montana	-5.1%
Ohio	-5.3%
Utah	-5.4%
New Jersey	-6.1%
Louisiana	-7.3%
Minnesota	-7.8%
Tennessee	-8.4%
Washington	-9.7%
North Carolina	-10.5%
Kansas	-10.6%
Florida	-13.2%
California	-13.9%
Mississippi	-16.0%
Indiana	-17.1%
South Carolina	-22.0%
Arizona	-24.5%

Note: Public health is defined broadly to include all health spending with the exception of Medicaid, State Children’s Health Insurance Program, or comparable health coverage programs for low-income residents. Also not included were federal funds; funds for behavioral health; Women, Infants, and Children food program funds; services related to developmental disabilities or severely disabled persons; and State-sponsored pharmaceutical programs.

Source: Trust for America’s Health

Fiscal 2010 Actions

Impact of Cost Containment

The Board of Public Works (BPW) decreased the fiscal 2010 working appropriation by \$21.6 million. This includes a \$30,000 reduction to the former Community Health Administration (CHA) for summer camp temporary employment and \$769,135 in federal funds swaps for AIDS programs in the former AIDS Administration.

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Effective July 23, 2009, the Secretary of DHMH integrated CHA with the AIDS Administration forming IDEHA. This resulted in \$493,669 in salary savings in August and an additional \$143,033 salary savings in November. The number of field inspector positions in the Office of Food Protection and Consumer Health Services was reduced from 20 to 17 (\$118,831), and HIV Prevention and Care Service Grants were reduced by \$130,000.

Lastly, the funding for the targeted local health formula which funds local health departments with State general funds was reduced by 35% to each jurisdiction. Funding for the formula was reduced by \$20.1 million, leaving \$37.3 million for the 24 local health departments.

Proposed Budget

The fiscal 2011 budget for IDEHA and OPR, as shown in **Exhibit 10**, totals \$155.5 million. This is \$8.5 million less than the fiscal 2010 working appropriation. General funds, including a contingent reduction to the local health formula and Back of the Bill reductions for personnel expenses is \$280,000 less than the fiscal 2010 allowance. Special and reimbursable funds increase by \$546,000 and \$195,000, respectively from the fiscal 2010 allowance while federal funds decrease by \$8.9 million due to reductions in the Office of Preparedness and Response and one-time H1N1 federal funding available only in fiscal 2010.

Impact of Cost Containment

The fiscal 2011 budget reflects several across-the-board actions to be allocated by the Administration. This includes a combination of employee furloughs and government shut-down days similar to the plan adopted in fiscal 2010; a reduction in overtime based on accident leave management; streamlining of State operations; hiring freeze and attrition savings; a change in the injured workers' settlement policy and administrative costs; and a savings in health insurance to reflect a balance in that account. For purposes of illustration, the Department of Legislative Services has estimated the distribution of selected actions relating to employee furloughs, health insurance, and the Injured Workers' Insurance Fund cost savings.

The Budget Reconciliation and Financing Act (BRFA) of 2010 includes a contingent reduction of \$3.7 million for the Targeted Local Health Formula. For the previous two years, the Administration determined the statute mandates annual inflationary adjustments to the targeted local health formula only from the base year of 1997. Specifically, the statute states for "...fiscal year 1998 and each subsequent fiscal year, the amount of funding for fiscal year 1997 adjusted for..." (Health-General § 2-302) inflation and population growth. However, since the inception of the targeted local health formula, the inflationary adjustment has been made to the previous year's allocation, not the level in 1997.

Exhibit 10
Proposed Budget
DHMH – Infectious Disease and Environmental Health Administration
(\$ in Thousands)

How Much It Grows:	<u>General</u> <u>Fund</u>	<u>Special</u> <u>Fund</u>	<u>Federal</u> <u>Fund</u>	<u>Reimb.</u> <u>Fund</u>	<u>Total</u>
2010 Working Appropriation	\$47,571	\$17,579	\$97,687	\$1,120	\$163,956
2011 Allowance	<u>51,252</u>	<u>18,125</u>	<u>89,116</u>	<u>1,317</u>	<u>159,810</u>
Amount Change	\$3,682	\$546	-\$8,571	\$197	-\$4,146
Percent Change	7.7%	3.1%	-8.8%	17.6%	-2.5%
Contingent Reduction	-\$3,961	\$0	-\$349	-\$3	-\$4,313
Adjusted Change	-\$280	\$546	-\$8,919	\$195	-\$8,458
Adjusted Percent Change	-0.6%	3.1%	-9.1%	17.4%	-5.2%

Where It Goes:

Personnel Expenses

Employee and retiree health insurance including estimated of Section 19 reductions	\$391
Turnover adjustments.....	299
Employees’ Retirement System.....	273
Unemployment compensation	27
Workers’ compensation premium including estimate of Sections 21 and 23 reductions	-51
Abolished positions.....	-94
Temporary assistance in fiscal 2010 for summer camp inspections	-101
Salary adjustments including estimated Section 18 furlough reductions.....	-119
Efficiency savings from Board of Public Works’ consolidation of personnel responsibility	-130
Other fringe benefit adjustments.....	7

Infectious Disease and Environmental Health Administration

MADAP-Plus program	2,024
ARRA funds for school-based vaccinations, the development of HAI prevention program and to provide a grant to JHU to study vaccine effectiveness	1,387
Federal funding of the State’s H1N1 vaccination campaign	-1,026

Office of Preparedness and Response

Antiviral public-private partnerships purchases.....	-494
Antiviral stockpile purchases	-1,986

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Where It Goes:

One-time statewide purchase of interoperable communication equipment for all hospitals and local health departments	-4,427
One-time H1N1 preparedness funding	-4,616
Other changes.....	178
Total	-\$8,458

ARRA: American Recovery and Reinvestment Act of 2009
HAI: Healthcare-associated Infections
JHU: Johns Hopkins University
MADAP: Maryland AIDS Drug Assistance Program

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

The population grew less than 1.0%, and the consumer price index decreased -1.43% for the fiscal 2011 formula. Due to these factors, the allowance includes \$41.0 million for fiscal 2011, which is exactly the base amount in 1997. In the allowance, each county receives the amount received in fiscal 1997 as per statute.

The BRFA proposes to level fund the formula at the fiscal 2010 level, after cost containment actions and rebases the formula at this level. This would reduce the fiscal 2011 appropriation to \$37.3 million, a \$3.7 million decrease. This level of funding would be provided in both fiscal 2011 and 2012 and beginning with the fiscal 2013 formula would be adjusted for inflation and population growth off of the new base amount. **Exhibit 11** shows the fiscal 2010, fiscal 2011 allowance amount, and the fiscal 2011 BRFA proposed appropriation including the BRFA adjustment. The BRFA of 2010 allocates fiscal 2011 funding for each jurisdiction at the current fiscal 2010 level. This allocation is markedly different than would result if a proportional reduction was applied to the 2011 formula calculation. A proportional reduction is also shown in Exhibit 11 and was the method used in implementing the fiscal 2010 cost containment action.

The agency should discuss the impact the reductions to local health department funding have had on services provided by the local departments, including cost containment activities taken by the health departments and service reductions. The agency should also discuss the rationale for the allocation provided in the BRFA.

Personnel

Personnel expenses increase by \$502,000 in the fiscal 2011 allowance. The largest increase is in health insurance costs for employees and retirees, including estimated Section 19 reductions. These costs are expected to increase by \$391,000 due to higher rates throughout the State. Other increases include turnover adjustments (\$299,000) and the employee retirement system (\$273,000).

The AIDS Administration and Community Health Administration merged to form IDEHA leading to a \$130,000 efficiency savings in the fiscal 2011 allowance. Other reductions include \$101,000 for temporary assistance to inspect summer camps and \$119,000 for salary adjustments after accounting for the furlough in Section 18 of the budget bill.

Exhibit 11
Targeted Local Health Department Formula
Fiscal 2010-2011

<u>Jurisdiction</u>	<u>2010 Working Appropriation</u>	<u>2011 Allowance</u>	<u>BRFA Contingent Reduction</u>	<u>2011 Proposed Allowance</u>	<u>Proportional Reduction Allowance</u>	<u>Difference from 2011 Allowance</u>
Allegany	\$908,719	\$752,461	\$156,258	\$908,719	\$684,253	-\$68,208
Anne Arundel	3,141,951	3,179,815	-37,864	3,141,951	2,891,575	-288,240
Baltimore City	6,675,053	8,125,356	-1,450,303	6,675,053	7,388,819	-736,537
Baltimore County	4,302,255	5,507,797	-1,205,542	4,302,255	5,008,533	-499,264
Calvert	369,812	260,413	109,399	369,812	236,807	-23,606
Caroline	538,253	453,404	84,849	538,253	412,304	-41,100
Carroll	1,231,995	1,260,824	-28,829	1,231,995	1,146,534	-114,290
Cecil	806,392	751,875	54,517	806,392	683,720	-68,155
Charles	994,528	958,689	35,839	994,528	871,787	-86,902
Dorchester	428,709	396,800	31,909	428,709	360,831	-35,969
Frederick	1,512,159	1,492,496	19,663	1,512,159	1,357,206	-135,290
Garrett	437,403	357,280	80,123	437,403	324,894	-32,386
Harford	1,737,473	1,988,513	-251,040	1,737,473	1,808,261	-180,252
Howard	1,215,070	1,378,941	-163,871	1,215,070	1,253,945	-124,996
Kent	335,941	301,397	34,544	335,941	274,076	-27,321
Montgomery	3,014,680	3,183,424	-168,744	3,014,680	2,894,857	-288,567
Prince George's	5,007,057	6,445,381	-1,438,324	5,007,057	5,861,128	-584,253
Queen Anne's	417,744	370,606	47,138	417,744	337,012	-33,594
St. Mary's	808,576	878,934	-70,358	808,576	799,262	-79,672
Somerset	429,385	439,284	-9,899	429,385	399,464	-39,820
Talbot	328,705	234,443	94,262	328,705	213,192	-21,251
Washington	1,381,306	1,309,998	71,308	1,381,306	1,191,251	-118,747
Wicomico	947,374	820,944	126,430	947,374	746,528	-74,416
Worcester	312,944	150,925	162,019	312,944	137,244	-13,681
Total	\$37,283,484	\$41,000,000	-\$3,716,516	\$37,283,484	\$37,283,484	-\$3,716,516

BRFA: Budget Reconciliation and Financing Act of 2010

Source: Department of Health and Mental Hygiene

Infectious Disease and Environmental Health Administration

IDEHA includes the programs from the former AIDS Administration and the former Community Health Administration. Total funding for IDEHA, including a contingent reduction to Targeted Local Health Grant program, increases by \$3.4 million. Federal funds increase by \$2.2 million and special funds increase by \$1.0 million. Reimbursable funds from the Department of Human Resources increase by \$197,460. General funds decrease by \$276,090.

Funds for the MADAP-Plus program increase by \$2 million in fiscal 2011. MADAP-Plus is funded with special funds available through drug rebates from the MADAP program and federal funds. The program enables income-eligible persons living with HIV and AIDS access to health insurance coverage. The funding increase reflects an increase in the expected number of applicants due to economic decline and an increase in average monthly premium costs. Fiscal 2010 budget bill language required MADAP drug rebates to be transferred to the MAIAP program in order to facilitate a general fund reduction for that program. However, federal regulations on the uses of drug rebate funds required that funds could only be used to purchase insurance that adheres to the MADAP drug formulary. Therefore, MAIAP clients were transferred to the MADAP-Plus program, and their insurance coverage was renegotiated to adhere to federal regulations.

There is a \$1 million decrease in federal funds due to one-time funding for the State's H1N1 vaccination campaign in fiscal 2010 that is no longer available in fiscal 2011. As discussed earlier, the BRFA includes a contingent reduction to the Targeted Local Health Formula, level funding the program for fiscal 2011 and 2012.

Federal Stimulus Funds Available in IDEHA

The fiscal 2011 allowance includes \$1.8 million in new American Recovery and Reinvestment Act (ARRA) federal stimulus funds. ARRA appropriated \$300.0 million to the Immunization program which funds immunization programs across the country. Maryland received \$1.2 million to fund two vaccine effectiveness studies and to fund vaccination programs at local health departments including school-based influenza vaccination clinics.

The State also received \$656,398 for through the Preventing Healthcare-associated Infections (HAI) program. These funds will be used to develop an HAI prevention plan for the State; to expand HAI data collection; to work with the Maryland Patient Safety Center on patient safety collaboratives; to study risk factors for infection among dialysis patients; and to expand data collection in dialysis centers.

Office of Preparedness and Response

The Office of Preparedness and Response fiscal 2011 allowance is \$21.2, almost completely funded with federal funds. This represents an \$11.3 million decline in the appropriation from fiscal 2010. This is mainly due to one-time funding for equipment costs (\$4.4 million) and H1N1 preparedness (\$4.6 million), which is no longer available in fiscal 2011. Other reductions include

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\$1.9 million for purchase of Maryland's allotment of antiviral medications available through the CDC's Pandemic Influenza Strategy Program. As of February 2010, the State had purchased 100% of the total allotment allowed for Maryland at the federally subsidized price. These medications have a shelf life of approximately four years.

There is \$494,401 in special funds for purchase of antiviral medications through public-private partnerships with critical infrastructure partners, including banks, utility providers, hospitals, and other private entities that would need continual functioning in the event of a pandemic flu outbreak. In fiscal 2010, \$988,802 was appropriated; however, only half was spent with the intention of the second half to be spent in fiscal 2011.

Issues

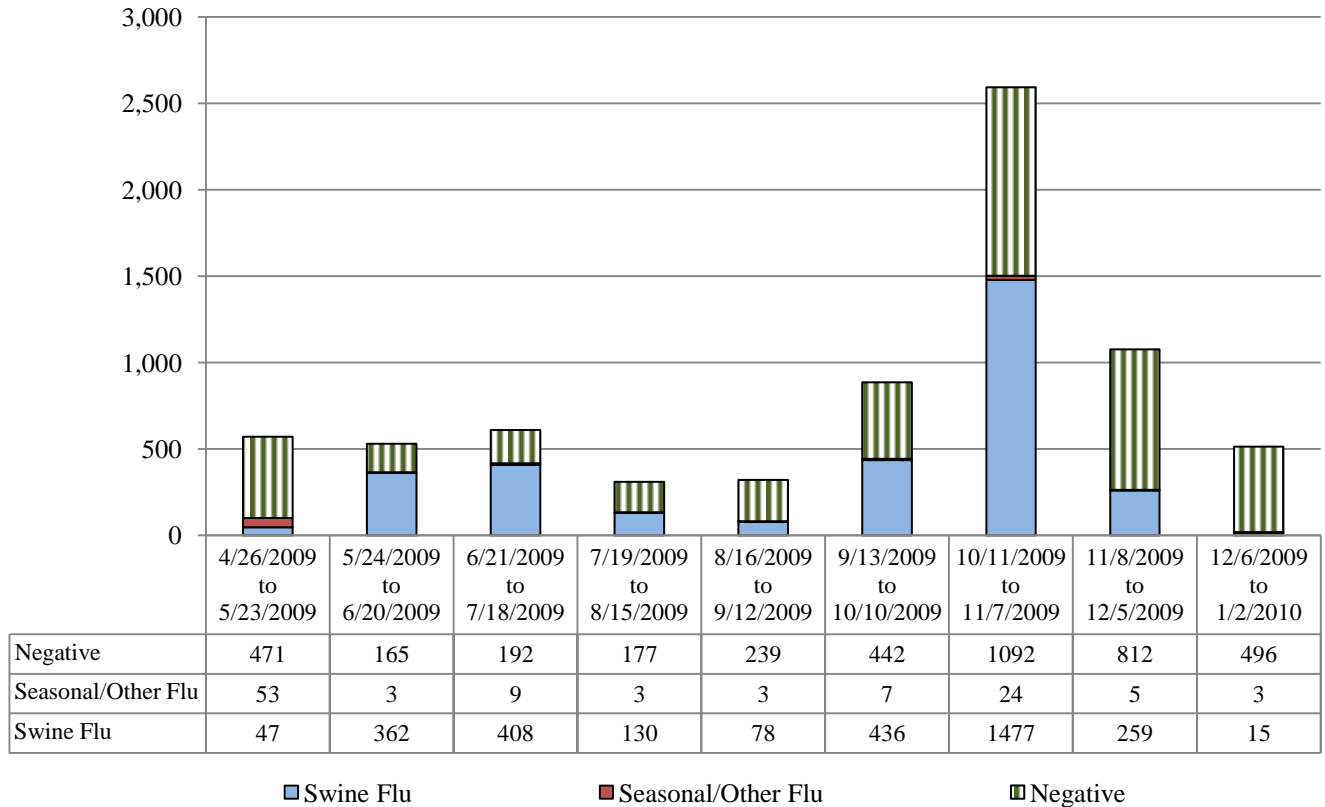
1. H1N1 Influenza Activities

A new influenza virus causing illness in people emerged late-March 2009 in Mexico, and this new virus is the Type A (H1N1) 2009 influenza virus, formerly called the “swine” flu. The Maryland Laboratories Administration identified the first few H1N1 influenza cases in Maryland on April 29, 2009, and the Governor signed an executive order – Declaration of Emergency for Influenza Response and Mitigation – on May 1, 2009.

The United States is currently in the end of the second wave of the H1N1 influenza. The first wave of H1N1 influenza hit its highest point at the end of June 2009. While the number of cases decreased in July and August, H1N1 influenza was still present throughout the summer months, which is abnormal because influenza generally has a low transmission rate in the hot and humid days of summer.

In early September, Maryland (along with the rest of the country) began to experience the second wave of the H1N1 influenza. At the present time, the H1N1 activity in Maryland is considered “sporadic,” meaning there are isolated cases of lab-confirmed influenza in the State. However, from the week ending September 5, 2009, until the week ending November 28, 2009, Maryland was at the “widespread” level. Specifically, “widespread” means increased influenza cases and/or institutional outbreaks of respiratory disease reported in at least half of the regions in the State, and there should be recent evidence of lab-confirmed influenza in the affected regions. The majority of the confirmed laboratory tests for influenza virus are still the H1N1 strain. **Exhibit 12** shows the specimens processed by the Laboratories Administration the first and second waves of the H1N1 pandemic.

Exhibit 12
Lab Specimens Processed
April 26, 2009 – January 2, 2010



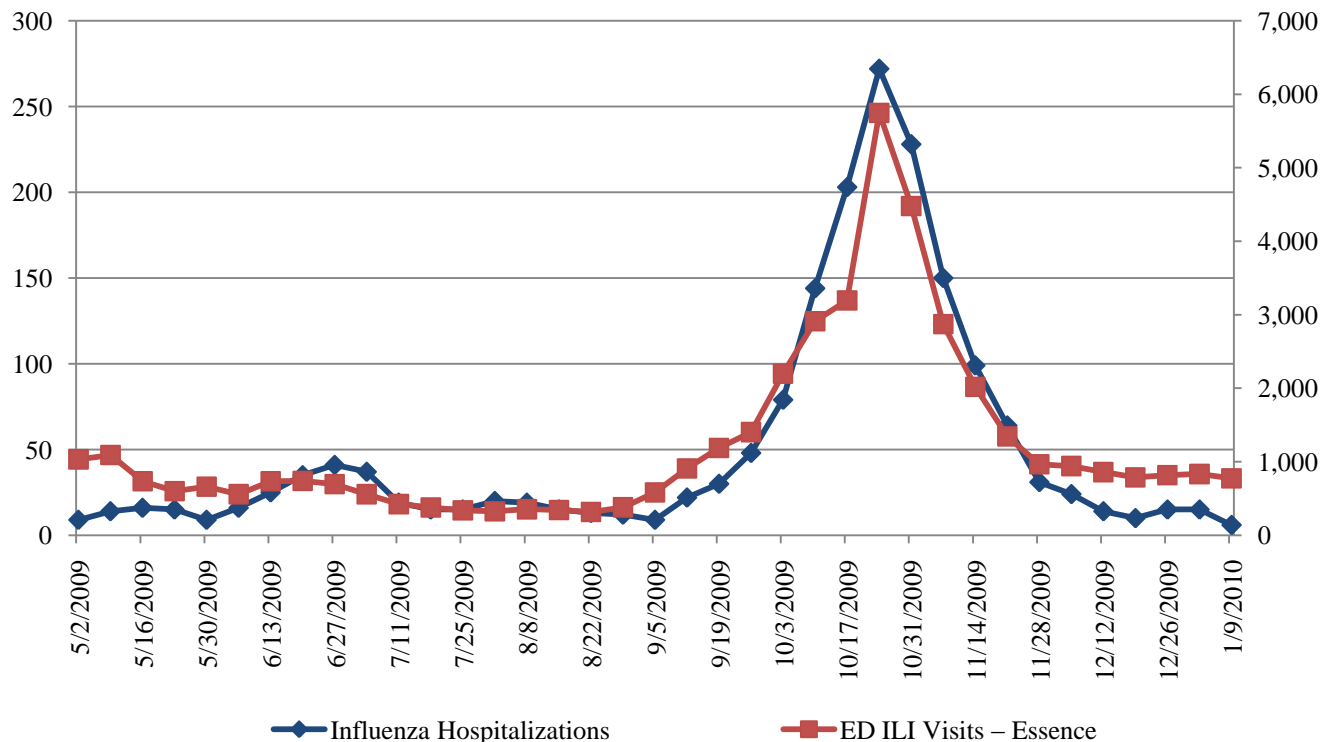
Source: Department of Health and Mental Hygiene

DHMH is monitoring the H1N1 influenza with surveillance data from a variety of sources, such as laboratories, outpatient sentinel providers, the Maryland Resident Influenza Tracking Survey, the Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE), outbreak investigations, the Emerging Infections Program, and the Facility Resource Emergency Database.

In fact, with the outbreak of the H1N1 influenza, DHMH was able to get all of the 46 acute-care hospitals to voluntarily agree to participate in the ESSENCE tracking system. Specifically, hospitals in the State will collect and transmit symptom data, stripped of all patient identifiers, to DHMH where it will then be tested and analyzed. The data can then be compared against other public health databases that track information such as hospital admissions, lab results, patient transport information, and mandatory physician disease reporting. Maryland’s ESSENCE system also monitors retail sales of over-the-counter medications at 280 pharmacies throughout the State to help capture data on individuals not seeking emergency care for their symptoms.

Exhibit 13 shows the weekly number of influenza-related hospitalizations from the week ending May 2, 2009, until the week ending January 9, 2010. The exhibit also shows the number of people visiting an emergency room with influenza like symptoms from the ESSENCE system. As of January 23, 2010, there have been 43 deaths in Maryland attributed to H1N1 since June 30, 2009.

Exhibit 13
Influenza Hospitalizations and Emergency Room Visits
 May 2, 2009 – January 9, 2010



ED: emergency department
 ILI: influenza like illness

Source: Department of Health and Mental Hygiene

H1N1 Vaccine

Federal Public Health Campaign

On September 15, 2009, four influenza vaccine manufacturers received approval from the Food and Drug Administration for use of H1N1 influenza vaccines for the prevention of influenza caused by the 2009 pandemic H1N1 virus. The United States government has procured a total of 250 million doses of H1N1 influenza vaccine from these manufacturers for its H1N1 vaccination campaign. The vaccine is being made available as it is produced, so initially it has been available

only in limited quantities. Allocations are made in proportion to a jurisdiction's population. The goal of the H1N1 vaccination campaign is to make the H1N1 vaccine available to all Americans and makes additional allocations to states daily based on supply.

While initially the CDC recommended administration of the H1N1 influenza vaccine to people in certain target groups, currently, there is sufficient supply that H1N1 vaccinations have been made available to all Maryland residents. Conversely, the seasonal flu vaccine is available in limited quantities.

Antiviral Treatments

Influenza antiviral drugs are prescription drugs (pill, liquid, or inhaler) that reduce the severity and duration of influenza illness and can reduce the risk of influenza-related complications, including severe illness and death. CDC notes that most healthy people seem to be recovering from the H1N1 influenza without the aid of the antiviral medication. However, the antiviral medication is recommended for use in people with underlying health conditions, pregnant women, and people requiring hospitalization.

Antiviral medications are available in the private sector at a pharmacy with a prescription from a physician, but the State also has a stockpile of antiviral treatments. The federal government has encouraged states to stockpile enough antiviral treatments to cover approximately 25% of each state's population and has assisted in meeting this goal by subsidizing the cost of the treatment. Maryland has successfully purchased all of the antiviral treatments offered at the federally subsidized price, which means there are roughly 580,000 antiviral treatments in the State's stockpile. Also, during the summer, the federal government provided additional antiviral treatments to states for their stockpile in response to the outbreak of the H1N1 influenza.

Tamiflu and Relenza are the two antiviral treatments being recommended in association with H1N1 influenza. Tamiflu is approved for use in children ages one and older, while Relenza is only approved for ages seven and older. Nationally, stockpiles and commercial supplies of Tamiflu in the pediatric doses are limited, and in Maryland, commercial supply of the pediatric doses of Tamiflu is currently dwindling. In the absence of the pediatric doses, there is another option to meet the need for a pediatric prescription of Tamiflu: adult dose capsules can be compounded by a pharmacist to create a pediatric formulation. However, pharmacists have been reluctant to compound the adult capsules. DHMH released 3,454 pediatric doses from the stockpile and sent 1,924 to pharmacies and 1,530 to local health departments and federally qualified health centers to ease pediatric treatment supply issues. Recently, a major statewide pharmacy has promised to compound the adult capsules of Tamiflu to pediatric doses when necessary.

DHMH Communication Efforts

Since the first outbreak of the H1N1 virus in April 2009, DHMH has been constantly working on enhancing its communication efforts. Maryland has a dedicated H1N1 web site and has set up a toll-free flu hotline to provide information and answer questions about the illness. In addition, DHMH has established a speaker's bureau, in conjunction with local health departments, to handle

the considerable volume of requests for speaking engagements on H1N1. DHMH is also coordinating with the Office of Minority Health and Health Disparities to utilize an infrastructure network that is already established under the Minority Outreach and Technical Assistance grant program to provide outreach to communities on the H1N1 vaccine. DHMH regularly communicates with federal, State, and local officials; licensed physicians and nurses; school officials; emergency management officials; large employers; nonprofits; universities; hospitals; and federally qualified health centers. As a vehicle to primarily update providers regarding the H1N1 situation, DHMH, in collaboration with the Johns Hopkins Bloomberg School of Public Health, coordinated a web cast entitled “H1N1 Disease and Vaccine in Maryland Update – What Healthcare Providers Need to Know.” Links to the web casts are posted on DHMH’s H1N1 web site.

Funding

Federal funding from CDC has been provided to states to upgrade H1N1 influenza preparedness and response capacity. These Public Health Emergency Response (PHER) grants were appropriated by Congress in June 2009, and the funding is being distributed in phases.

Phase I of the PHER grant is intended to help states assess their current capabilities in pandemic influenza response and to address remaining gaps in two focus areas. The first focus area relates to vaccination, antiviral distribution/dispensing and administration, and community mitigation activities. The second focus area is laboratory, epidemiology, and surveillance activities. Maryland received \$4.8 million under Phase I of the PHER grant.

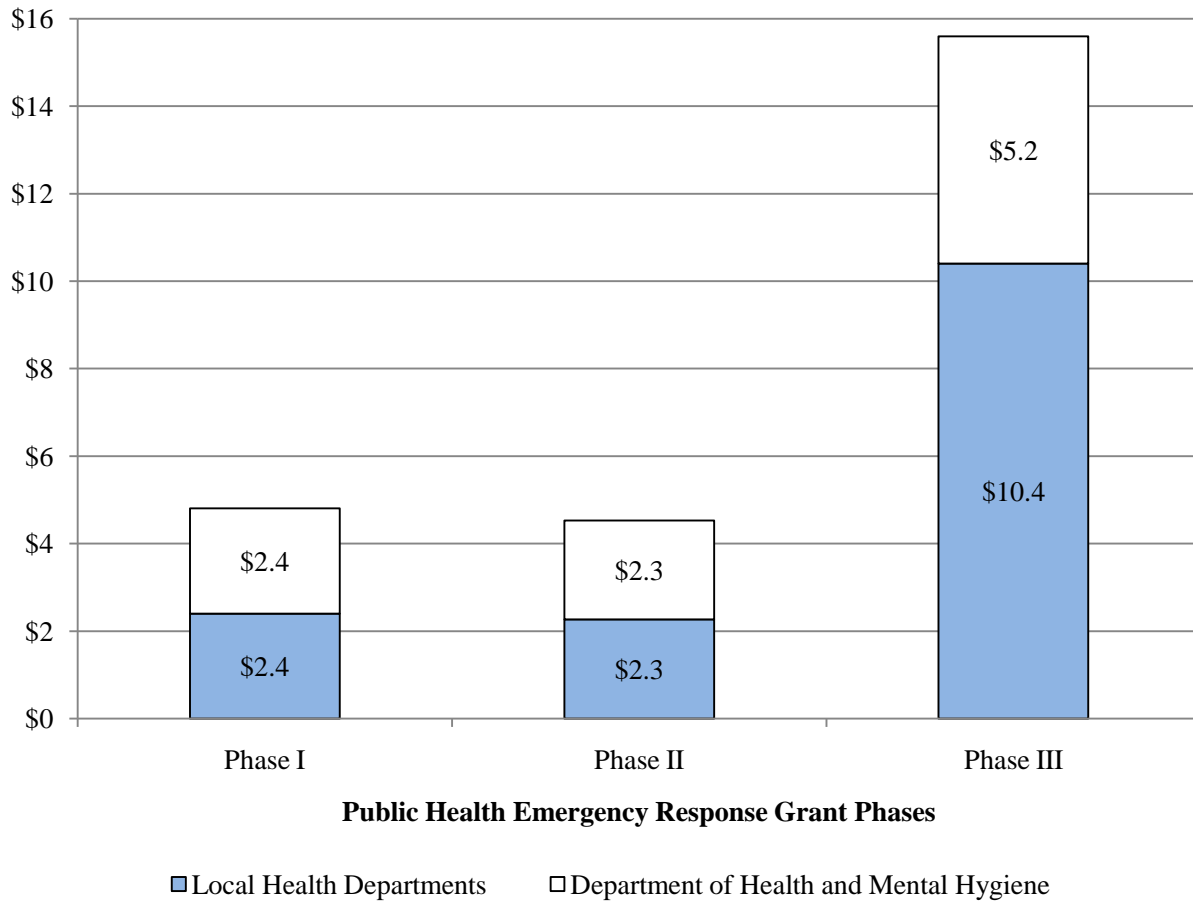
PHER Phase II funding has been awarded to supplement the Phase I funding, and the grant is intended to provide additional resources to states to accelerate mass vaccination planning and implementation preparedness activities. Phase II funding may also be used for vaccine delivery, vaccine administration, and related communications planning and implementation. Maryland received \$4.5 million in PHER Phase II funding.

The Phase III funding has been provided to assist with the implementation of the H1N1 influenza mass vaccination campaign. Maryland received \$15.6 million for Phase III of the PHER grant.

As shown in **Exhibit 14**, the department is sending half of the Phase I and II funding to the local health departments, and two-thirds of the Phase III funding will go to the local health departments. The remaining funding will stay at DHMH to fund the department’s activities. This fund-split benefitting the local health departments comes at a time when they are planning and responding to a public health emergency at the same time as facing substantial budget cuts.

The agency should update the committees on the status of the H1N1 virus in Maryland and what steps have been taken to ensure the maximum number of vaccines have been administered.

Exhibit 14
Public Health Emergency Response Funding by Phase
(\$ in Millions)



Source: Department of Health and Mental Hygiene

2. HIV Prevention Programs

IDEHA, and the AIDS Administration before that, provides funding to local health departments and other organizations to administer HIV prevention programs. These include health communication programs, health education and risk reduction programs, perinatal transmission prevention, and partner services. Funds are distributed using a regional formula that includes HIV and AIDS prevalence, three years of HIV incidence, chlamydia prevalence, population, and poverty.

However, Maryland has one of the most severe HIV/AIDS problems in the nation. The State has the third highest HIV/AIDS rate in the nation behind Washington, DC and New York. Maryland recently made the transition to confidential named-based reporting and will be able to track the number of newly infected HIV cases.

The agency should discuss activities taken to address the HIV/AIDS incidence by the State, local health departments, and other service providers. Specifically, the agency should discuss the effectiveness of the programs and the administration's ability to measure outcomes and fund programs accordingly.

HIV Testing at Correctional Facilities

As a jurisdiction, correctional facilities in the State had 1,391 inmates living with HIV/AIDS as of December 31, 2007, the most recently reported data available. This is 4.9% of the total population living with HIV/AIDS in the State.

In response to the HIV/AIDS prevalence in correctional facilities, the 2009 *Joint Chairmen's Report* included narrative requesting the Department of Health and Mental Hygiene to consult with the Department of Public Safety and Correctional Services (DPSCS) regarding the feasibility of testing inmates for HIV at release and connecting those individuals found to be HIV positive with medical services. The report was submitted to the budget committees on December 3, 2009.

DHMH and DPSCS consulted with Dr. David Holtgrave, Chair, Department of Health, Behavior, and Society, The Johns Hopkins University Bloomberg School of Public Health, to assess the current procedure for HIV testing and linkages to community care at Division of Correction's facilities. The study also attempted to determine the potential expenditures and savings of a prerelease HIV testing program.

The final report estimated the annual cost of a prerelease HIV testing and treatment program to be between approximately \$815,000 and \$3.1 million. The costs included HIV testing, treatment during the remaining period of incarceration, partner notification services, and transitional case management. The feasibility study also estimated that the program would avert between 5.27 and 35.56 new HIV transmissions resulting in an estimated savings between \$1.66 million and \$11.2 million associated medical costs. The net savings estimated by the study is between \$845,000 and \$8.1 million.

The agency should discuss prevention activities taken to address the HIV/AIDS incidence in correctional facilities.

Recommended Actions

- | | <u>Amount
Reduction</u> | | <u>Position
Reduction</u> |
|--|-----------------------------|----|-------------------------------|
| 1. Increase turnover in the Infectious Disease and Environmental Health Administration from 5.01% to 6.06% to more accurately reflect current vacancies. | \$ 163,133 | GF | |
| 2. Delete two vacant positions from the Emerging Infections Program. These positions have been vacant since January and May of 2008. | 118,164 | FF | 2.0 |
| 3. Strike the following language from the general fund appropriation: | | | |

~~, provided that \$3,716,516 of this appropriation shall be reduced contingent upon the enactment of legislation reducing funding for Core Public Health Services~~

Explanation: This language is unnecessary as the General Assembly can choose to reduce funding for the Core Public Health Services Targeted Local Health Department formula without legislation.

4. Add the following language to the general fund appropriation:

, provided that \$100,000 of this appropriation may not be expended until the Department of Health and Mental Hygiene in conjunction with the local health departments provide a report to the budget committees on the budgets of the 24 local health departments. Specifically, the report should outline how State funds were used programmatically by the departments in fiscal 2010 and how they will be used in fiscal 2011. Lastly, the report should describe programmatic and budgetary changes made in response to cost containment measures in fiscal 2010 and 2011. The report shall be submitted by January 1, 2011, and the budget committees shall have 45 days to review and comment. Funds restricted pending the receipt of the report may not be transferred by budget amendment or otherwise to any other purpose and shall revert to the General Fund if the report is not submitted to the budget committees.

Explanation: Since 1997 the State has been providing funds to local health departments through the Core Public Health formula. During fiscal 2010, these funds were reduced by \$20.1 million. The budget committees should be informed on how the funds are being used and how the reductions have affected the local health services.

Information Request	Author	Due Date
Report on local health department funding	Department of Health and Mental Hygiene	January 1, 2011

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	<u>Amount Reduction</u>	<u>Position Reduction</u>
5. Reduce the general fund appropriation for the targeted local health formula.	3,716,516 GF	
Total Reductions	\$ 3,997,813	2.0
Total General Fund Reductions	\$ 3,879,649	
Total Federal Fund Reductions	\$ 118,164	

Current and Prior Year Budgets

Current and Prior Year Budgets					
DHMH – Infectious Disease and Environmental Health Administration					
(\$ in Thousands)					
	<u>General</u>	<u>Special</u>	<u>Federal</u>	<u>Reimb.</u>	<u>Total</u>
Fiscal 2009	Fund	Fund	Fund	Fund	
Legislative Appropriation	\$82,173	\$15,046	\$84,913	\$809	\$182,941
Deficiency Appropriation	-10,122	1,700	0	0	-8,422
Budget Amendments	519	6	4,027	548	5,100
Cost Containment	-3,263	0	-67	0	-3,330
Reversions and Cancellations	0	-950	-442	-109	-1,501
Actual Expenditures	\$69,307	\$15,801	\$88,431	\$1,248	\$174,787
Fiscal 2010					
Legislative Appropriation	\$69,354	\$15,723	\$83,571	\$1,120	\$169,768
Cost Containment	-21,648	0	0	0	-21,648
Budget Amendments	-135	1,856	14,115	0	15,836
Working Appropriation	\$47,571	\$17,579	\$97,686	\$1,120	\$163,956

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

Fiscal 2009

The Infectious Disease and Environmental Health Administration spent \$174.8 million in fiscal 2009, which is \$8.2 million less than the legislative appropriation. General funds decreased by \$12.9 million. General funds increased for cost-of-living increases (\$0.6 million) and annual salary review adjustments (\$0.2 million). These increases were more than offset by cost containment and other reductions, such as reducing to the targeted local health formula (\$12.0 million), replacing general funds with federal and special funds for the Maryland AIDS Insurance Assistance Program (\$1.0 million), reducing salaries (\$0.5 million), and eliminating the Public Health Residency Program (\$0.2 million).

Special funds increased by \$1.7 million, which is mostly attributable to the \$1.7 million special fund deficiency appropriation provided to the Office of Preparedness and Response to purchase antiviral treatments for the State's stockpile.

Federal funds increased by a total of \$4.0 million. The increases in federal funds were for emergency preparedness for hospitals (\$2.9 million), the Maryland Institute for Emergency Medical Services System (\$0.5 million), H1N1 influenza-related expenses (\$0.4 million), and salaries (\$0.2 million). These increases were slightly offset by cost containment to salaries.

The Infectious Disease and Environmental Health Administration cancelled \$1.5 million in fiscal 2009. Special funds were cancelled due to lower than anticipated expenditures on antiviral treatments for the State's stockpile (\$0.9 million) and lower than anticipated Maryland AIDS Drug Assistance Program expenditures (\$0.1 million). Federal funds were cancelled due to an accounting oversight in which contract services were not accrued (\$0.3 million) and over estimation of federal fund attainment for epidemiology and lab capacity (\$0.1 million). Reimbursable funds were cancelled due to less than anticipated expenditures in the local health department refugee programs (\$0.1 million).

Fiscal 2010

The fiscal 2010 working appropriation is \$5.8 million less than the legislative appropriation. General funds have been reduced by \$21.8 million due mainly to a \$21.6 million reduction during cost containment for the targeted local health formula. Federal funds increased by \$14.1 million through a budget amendment which made funds available for H1N1. Special funds increase by \$1.9 million for funding to purchase antiviral treatments and MADAP drug rebates.

Object/Fund Difference Report
DHMH – Infectious Disease and Environmental Health Administration

<u>Object/Fund</u>	<u>FY09 Actual</u>	<u>FY10 Working Appropriation</u>	<u>FY11 Allowance</u>	<u>FY10 - FY11 Amount Change</u>	<u>Percent Change</u>
Positions					
01 Regular	253.10	252.10	251.10	-1.00	-0.4%
02 Contractual	15.38	6.34	3.32	-3.02	-47.6%
Total Positions	268.48	258.44	254.42	-4.02	-1.6%
Objects					
01 Salaries and Wages	\$ 18,714,021	\$ 17,987,455	\$ 19,358,619	\$ 1,371,164	7.6%
02 Technical and Spec. Fees	694,215	244,828	156,175	-88,653	-36.2%
03 Communication	307,555	363,006	274,625	-88,381	-24.3%
04 Travel	216,429	457,186	398,665	-58,521	-12.8%
06 Fuel and Utilities	10	18,000	0	-18,000	-100.0%
07 Motor Vehicles	163,754	142,875	115,804	-27,071	-18.9%
08 Contractual Services	49,941,174	53,101,637	53,865,646	764,009	1.4%
09 Supplies and Materials	35,557,901	35,954,796	33,328,724	-2,626,072	-7.3%
10 Equipment – Replacement	94,920	0	0	0	0.0%
11 Equipment – Additional	664,207	4,597,310	106,200	-4,491,110	-97.7%
12 Grants, Subsidies, and Contributions	68,353,034	50,833,217	51,965,041	1,131,824	2.2%
13 Fixed Charges	79,947	255,599	240,868	-14,731	-5.8%
Total Objects	\$ 174,787,167	\$ 163,955,909	\$ 159,810,367	-\$ 4,145,542	-2.5%
Funds					
01 General Fund	\$ 69,307,496	\$ 47,570,533	\$ 51,252,068	\$ 3,681,535	7.7%
03 Special Fund	15,800,967	17,578,640	18,124,757	546,117	3.1%
05 Federal Fund	88,431,163	97,686,834	89,116,180	-8,570,654	-8.8%
09 Reimbursable Fund	1,247,541	1,119,902	1,317,362	197,460	17.6%
Total Funds	\$ 174,787,167	\$ 163,955,909	\$ 159,810,367	-\$ 4,145,542	-2.5%

Note: The fiscal 2010 appropriation does not include deficiencies.

Fiscal Summary
DHMH – Infectious Disease and Environmental Health Administration

<u>Program/Unit</u>	<u>FY09 Actual</u>	<u>FY10 Wrk Approp</u>	<u>FY11 Allowance</u>	<u>Change</u>	<u>FY10 - FY11 % Change</u>
03 Community Health Services	\$ 88,268,911	\$ 89,684,096	\$ 93,124,522	\$ 3,440,426	3.8%
07 Core Public Health Services	61,852,203	41,776,484	45,493,000	3,716,516	8.9%
01 Office of Preparedness and Response	24,666,053	32,495,329	21,192,845	-11,302,484	-34.8%
Total Expenditures	\$ 174,787,167	\$ 163,955,909	\$ 159,810,367	-\$ 4,145,542	-2.5%
General Fund	\$ 69,307,496	\$ 47,570,533	\$ 51,252,068	\$ 3,681,535	7.7%
Special Fund	15,800,967	17,578,640	18,124,757	546,117	3.1%
Federal Fund	88,431,163	97,686,834	89,116,180	-8,570,654	-8.8%
Total Appropriations	\$ 173,539,626	\$ 162,836,007	\$ 158,493,005	-\$ 4,343,002	-2.7%
Reimbursable Fund	\$ 1,247,541	\$ 1,119,902	\$ 1,317,362	\$ 197,460	17.6%
Total Funds	\$ 174,787,167	\$ 163,955,909	\$ 159,810,367	-\$ 4,145,542	-2.5%

Note: The fiscal 2010 appropriation does not include deficiencies.